

REGIONAL EMERGENCY MEDICAL ADVISORY COMMITTEE

NEW YORK CITY



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PREHOSPITAL TREATMENT PROTOCOLS

BASIC LIFE SUPPORT PROTOCOLS

Effective September 1, 2017

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BASIC EMERGENCY MEDICAL TECHNICIAN PROTOCOLS

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WEAPONS OF MASS DESTRUCTION NERVE AGENT EXPOSURE PROTOCOL

Authorization for the use of the Nerve Agent Antidote kits comes *ONLY* from the FDNY Office of Medical Affairs (OMA) through a class order* issued by a FDNY-OMA Medical Director who is on-scene or as relayed by an FDNY-OMA Medical Director through On-Line Medical Control (Telemetry) or through FDNY Emergency Medical Dispatch.

NOTE: The issuance of any class order shall be conveyed to all regional medical control facilities for relay to units in the field.

Treatment within the “hot” and “warm” zones may be performed only by appropriately trained personnel wearing appropriate chemical protective clothing (CPC) as determined by the FDNY Incident Commander.

- **RED Tag** may be treated simultaneously with decontamination.
- **YELLOW / ORANGE Tag** will be treated as soon as possible following decontamination.
- **GREEN Tag** (asymptomatic) will be decontaminated and receive close observation.

NOTE: Nerve agent kit contains one (1) each: 2 mg Atropine auto-injector, and 600 mg 2-PAM (Pralidoxime Chloride) auto-injector.

For this protocol, when the term “Auto-injector Kit” is used, it refers to either a dual-injector set (one atropine auto-injector and one pralidoxime auto-injector) or a single injector containing both medications (atropine and pralidoxime).

Initial Treatment (Table 1)

Tag Color	Signs & Symptoms	Auto-injector Administration	Atropine Dose and Monitor Interval
RED	Severe Respiratory Distress, Agitation SLUDGEM	3 Auto-injector Kits	6 mg Monitor every 5 minutes.
YELLOW	Respiratory Distress, SLUDGEM	2 Auto-injector Kits	4 mg Monitor every 10 minutes
GREEN	Asymptomatic None	None	None Monitor every 15 minutes.

NOTE: Do not give more than three auto-injector kits to any patient.

* Class Order - A general order given by a FDNY-OMA Medical Director to perform a specific intervention or interventions at a specific location/s during a specified time period. This order is generally reserved for disaster situations.

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All treatment subsequent to the initial doses shall follow Table 2. This will include extended on-scene operations, transport to ambulance destinations, and treatment at casualty collection points. The end point of treatment is drying of secretions and resolution of other symptoms.

Extended Re-Evaluation & Treatment (Table 2)

Tag Color	Signs & Symptoms	Monitor Interval	Auto-injector Administration	Atropine Repeat Dosing Frequency
RED	Severe Respiratory Distress, Agitation, SLUDGEM	Monitor every 5 minutes	Up to a total maximum of 3 auto-injectors	2mg every 3-5 minutes as needed
YELLOW / ORANGE	Respiratory Distress SLUDGEM	Monitor every 5 to 15 minutes	Up to a total maximum of 2 auto-injector	2mg every 5-10 minutes as needed
GREEN	Asymptomatic	Monitor every 15 minutes	None	None

NOTE: DO NOT GIVE MORE THAN THREE AUTO-INJECTOR KITS TO ANY PATIENT.

RECORD ON THE TRIAGE TAG THE NUMBER OF ATROPINE AND AUTO-INJECTOR KITS USED

ASYMPTOMATIC PATIENTS DO NOT REQUIRE TREATMENT

MONITOR EVERY 15 MINUTES

IN THE SETTING OF A NERVE AGENT EXPOSURE, ALL SYMPTOMATIC CHILDREN AGE 0-8 SHALL BE ASSIGNED A RED TAG.

PEDIATRIC PATIENTS

Tag Color	Exposure, and/or Signs of Respiratory Distress, Agitation, SLUDGEM	Atropine and Antidote Kit Doses Monitor Interval		Atropine Repeat Dosing Frequency
RED (Peds)	Yes	Age <1 years	1 Peds Atropine Auto-injector (0.5 mg) No Antidote Kit Monitor every 3 minutes	Atropine every 3 minutes as needed
		Age 1-8 years	1 Antidote Kit Monitor every 3 minutes	
GREEN (Peds)	No	None Monitor every 10 minutes for evidence of exposure		

NOTE: Pediatric patients older than 8 years old should be treated via the adult protocol.

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RESPIRATORY DISTRESS/FAILURE

NOTE: All patients who are in respiratory arrest must have ventilatory assistance unless a valid New York State Prehospital DNR Order and/or MOLST is presented to the crew.

1. Monitor the airway.
2. If an obstructed airway is suspected, see Protocol #402.
3. Administer oxygen.
4. For patients over one (1) year of age who are experiencing exacerbation of asthma or wheezing, see protocol #407.
5. Do **NOT** permit physical activity.
6. Request Advanced Life Support assistance.
7. Monitor breathing for adequacy.

NOTE: Monitor breathing continuously. Be alert for signs of hypoxia and/or increasing respiratory distress.

8. Place the patient in a Fowler's, semi-Fowler's position, or in a position of comfort.
9. Transport.
10. For the patient with signs of on-going hypoxia, inability to adequately protect their airway, and/or exhibiting signs of inadequate respiration, assisted ventilations may be required. This should be done utilizing one of the following methods:
 - a. Pocket mask with supplemental oxygen set at 10-15 liters/minute.
 - b. Bag-Valve-Mask and reservoir with flow set at 10-15 liters/minute.

NOTE: Do not use a demand valve resuscitator due to the possibility of causing severe, life-threatening complications

11. Transport.

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OBSTRUCTED AIRWAY

1. If the patient is conscious and **can breathe**, cough, speak, or cry:
 - a. Encourage coughing.
2. If the patient is unconscious or **cannot breathe**, cough, speak, or cry:
 - a. Perform obstructed airway clearing maneuvers.
 - b. Request Advanced Life Support assistance.
3. Transport
4. Continue obstructed airway maneuvers enroute to the hospital until the foreign body is dislodged.

NOTE: The patient must be taken to the hospital for evaluation even if the airway is cleared.

5. If airway obstruction is relieved:
 - a. Monitor the airway.
 - b. Begin Basic Cardiac Life Support procedures, if appropriate. (See Protocol #403.)
 - c. Administer oxygen.
 - d. Monitor breathing for adequacy.
 - e. Continue transport.

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NON-TRAUMATIC CARDIAC ARREST

1. Begin Basic Cardiac Life Support procedures.
2. Request Advanced Life Support assistance.
3. Apply an automated external defibrillator, perform CPR until defibrillator is attached.

NOTE: IF PEDIATRIC PATIENT, UNDER 9 YEARS OF AGE, SEE PROTOCOL #453.

4. Analyze (do not perform CPR while the machine is analyzing).
 - Whenever the “NO SHOCK INDICATED” message appears, CPR should be performed for 2 minutes followed by the next analysis.
5. After a total of three (3) cycles of CPR and analysis, continue CPR.
6. Transport. During transport, or if transport is delayed, continue CPR, re-analyze every 2 minutes, and shock as indicated.

Special Considerations When Using an AED

- If present, remove Nitroglycerin patch and wipe off remaining paste; avoid contact with your skin.
- Prior to pad placement, the chest should be dry and, if needed, shave chest hair
- Attach automated external defibrillator pads
- If the patient has a pacemaker, position the pads at least one (1) inch away from the pacemaker device.

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SUSPECTED MYOCARDIAL INFARCTION

NOTE: Acute coronary syndrome is a term used for any condition brought on by sudden reduced blood flow to the heart.

1. Monitor the airway.
2. Administer oxygen.
3. Do **not** permit physical activity.
4. Request Advanced Life Support assistance. Do **NOT** delay transport.
5. Monitor breathing for adequacy.
6. Place patient in a position of comfort.
7. Administer two (2) Chewable Aspirins, totaling 162 mg, by mouth, unless the patient has a known Aspirin allergy or hypersensitivity.
8. When EMTs are on the scene of an assignment and requesting Advanced Life Support assistance, transport procedures should begin. If the time of arrival of Advanced Life Support exceeds the time to the hospital or is unknown, transport from the scene should not be delayed.
9. Either during transport or while waiting for the arrival of an ALS unit, if chest pain is still present, assist the patient with self-administration of the patient's own previously prescribed Nitroglycerin, if available. One tablet or spray may be taken provided that the patient's **systolic** pressure is at least 120 mm Hg.

NOTE: Unless otherwise directed by On-Line Medical Control, patients who have used erectile dysfunction medications in the previous 72 hours shall not be given Nitroglycerin.

10. Transport.

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WHEEZING

For patients over one (1) year of age who are experiencing exacerbation of asthma or wheezing

1. Assess the airway
2. Administer oxygen
3. Monitor breathing

NOTE: If patient exhibits signs of imminent respiratory failure, refer to protocol #401 – Adult Respiratory Distress/Failure or #450 – Pediatric Respiratory Distress/Failure.

4. Do not permit physical activity
5. Place the patient in a Fowler's or Semi-Fowler's position
6. Assess the following prior to administration of the first nebulized treatment:
 - Vital signs
 - Patient's ability to speak in complete sentences
 - Accessory muscle use
7. **Administer Albuterol Sulfate 0.083%, one (1) unit dose or 3 cc via nebulizer at a flow rate that will deliver the solution over 5 minutes to 15 minutes. Do not delay transport to complete medication administration.**
8. Begin transport.

NOTE: For patients in severe respiratory distress, call for advanced life support assistance. Do not delay transport for any reason, including waiting for a potential second dose of epinephrine.

9. If symptoms persist, Albuterol Sulfate 0.083% may be repeated twice for a total of three (3) doses, with the third occurring during transport.
10. If the patient is having severe respiratory distress or shock, administer Epinephrine (**one dose only**) via an auto-injector.

NOTE: Patients 9 years of age and older or weighing more than 30 kg (66 lbs) use adult Epinephrine auto-injector (0.3 mg); patients younger than 9 years of age or weighing less than 30 kg (66 lbs) use pediatric Epinephrine auto-injector (0.15 mg). Administration of epinephrine via auto-injector must be reported to your agency's medical director as soon as possible

11. Contact On-Line Medical Control for authorization to administer a second dose of Epinephrine, via an auto-injector, if needed and if available.
12. Upon completion of patient treatment or transfer of patient care to an ALS Provider or a 911 Receiving Hospital, reassess the patient. See Step # 6.

NOTE: Medical control must be contacted for any patient refusing medical assistance or transport.

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ANAPHYLACTIC REACTION

NOTE: Anaphylaxis can be a potentially life threatening situation most often associated with a history of exposure to an inciting agent/allergen (bee sting or other insect venom, medications/drugs, or foods such as peanuts, seafood, etc.). The presence of respiratory distress (upper airway obstruction [stridor], severe bronchospasm [wheezing]) and/or cardiovascular collapse/hypotensive shock characterize the clinical findings that authorize and require treatment according to this protocol.

Patients 9 years of age and older or weighing more than 30 kg (66 lbs) use adult Epi-auto injector (0.3 mg); patients younger than 9 years of age or weighing less than 30 kg (66 lbs) use pediatric Epi-auto injector (0.15 mg).

1. Determine that the patient's history includes a history of anaphylaxis, severe allergic reaction and/or recent exposure to an allergen or inciting agent.
2. Request Advanced Life Support assistance. Do NOT delay transport for any reason, including waiting for a potential second dose of epinephrine.
3. Administer high concentration oxygen.
4. Assess the cardiac and respiratory status of the patient.
 - a. If both the cardiac and respiratory status of the patient are normal, initiate transport.
 - b. If either the cardiac or respiratory status of the patient is abnormal, proceed as follows:
 - i. If the patient is having severe respiratory distress or shock and has been prescribed an Epinephrine auto-injector, assist the patient in administering the Epinephrine. If the patient's auto-injector is not available or expired administer Epinephrine via an auto-injector.
 - ii. If the patient has not been prescribed an Epinephrine auto-injector, administer Epinephrine (ONE DOSE ONLY) via an auto-injector.

NOTE: Administration of epinephrine via auto-injector must be reported to your agency's medical director as soon as possible

- iii. Contact On-Line Medical Control for authorization to administer a second dose of Epinephrine via an auto-injector, if needed and if available.
 - iv. Refer immediately to the REMAC Prehospital Treatment Protocol for Respiratory Distress/Failure (#401), Obstructed Airway (#402), or Shock (#415) as appropriate.
5. If cardiac arrest occurs, refer immediately to the REMAC Prehospital Treatment Protocol for Non-Traumatic Cardiac Arrest (#403).

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ALTERED MENTAL STATUS

NOTE: Emotionally disturbed patients must be presumed to have an underlying medical or traumatic condition causing an altered mental status.

Assess such patients for an underlying medical or traumatic condition causing an altered mental status and treat as necessary.

1. Assess the situation for potential or actual danger and establish a safe zone, if necessary.

NOTE: All suicidal or violent threats or gestures must be taken seriously. These patients should be in police custody if they pose a danger to themselves and/or others.

2. If an underlying medical or traumatic condition causing an altered mental status is not apparent; the patient is fully conscious, alert, and able to communicate; and an emotional disturbance is suspected, see Protocol #430.
3. Monitor the airway.
4. Administer oxygen.

NOTE: IF OVERDOSE IS SUSPECTED, USE HIGH FLOW OXYGEN.

5. Request Advanced Life Support assistance, if appropriate.
6. If an overdose is strongly suspected, and the patient's respiratory rate is less than 10/minute, administer intra-nasal (IN) Naloxone, via:

a. Mucosal Atomizer Device (MAD):

- i. **ADULT** patient: 1mg/ml in each nostril. Total of 2 mg/2ml
- ii. **PEDIATRIC** patient: 0.5 mg/0.5 ml in each nostril. Total of 1 mg/1 ml.

OR

b. Narcan® Nasal Spray

- i. **Adult AND Pediatric patients:** 4 mg/0.1ml in ONE nostril. If, after 2- 3 minutes if there is no or minimal response, repeat administration of 4mg/0.1ml with a second device into OTHER nostril.

Relative Contraindications:

- Cardiopulmonary Arrest,

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- Active seizure,
- Evidence of nasal trauma, nasal obstruction and/or epistaxis.

7. Initiate transport.

8. If after 5 minutes, the patient's respiratory rate is not greater than 10 breaths/minute, administer a repeat dose of naloxone, following the same procedure described in #6.

NOTE: A GLUCOMETER (IF AVAILABLE) SHOULD BE USED TO DOCUMENT BLOOD GLUCOSE LEVEL PRIOR TO ADMINISTRATION OF GLUCOSE, FRUIT JUICE OR SODA. IF THE GLUCOMETER READING IS ABOVE 60 MG/DL, WITHHOLD TREATMENT FOR HYPOGLYCEMIA.

DIABETIC PATIENTS WITH A BLOOD GLUCOSE LEVEL READING BETWEEN 60-80 MAY STILL BE EXPERIENCING HYPOGLYCEMIA, AND IF THEY DISPLAY SUCH SIGNS AND SYMPTOMS SHOULD BE TREATED ACCORDINGLY.

9. If the patient is conscious, can swallow, and can drink without assistance, provide a glucose solution, fruit juice, or non-diet soda by mouth.

- a. Do **not** give oral solutions to unconscious patients.
- b. Do **not** give oral solutions to patients with head injuries.

10. Transport.

11. Assess and monitor the Glasgow Coma score. (See Appendix E.)

- a. Do **not** delay transport.

Mandatory Quality Assurance Component

For every administration of intra-nasal (IN) Naloxone), the ACR/PCR documentation must be reviewed by the service medical director who is responsible for forwarding ACR/PCR data electronically to the NY REMAC via an online survey tool for system-wide QA purposes. Patient specific identifiers are omitted. This QA component is effective immediately. For the purposes of patient confidentiality, email mdiglio@nycremsco.org for directions on how to submit data electronically.

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STROKE (CEREBROVASCULAR ACCIDENT)

1. Monitor the airway.
2. Administer oxygen.
3. Place the patient in a head-elevated (Semi-Fowler's) or left lateral recumbent (recovery) position as necessary to maintain the airway.

NOTE: A GLUCOMETER (IF AVAILABLE) SHOULD BE USED TO DOCUMENT BLOOD GLUCOSE LEVEL PRIOR TO ADMINISTRATION OF GLUCOSE, FRUIT JUICE OR SODA.

IF THE GLUCOMETER READING IS ABOVE 60 MG/DL, TREATMENT FOR HYPOGLYCEMIA SHOULD BE WITHHELD.

IF GLUCOSE IS BELOW 60, REFER TO PROTOCOL 411 AMS.

4. Assess for Stroke Patient Criteria. (See Appendix R.)
 - a. Do **not** delay transport.
5. Transport.

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SEIZURES

1. Protect the patient from injury.
2. Monitor the airway.
3. Do **not** force anything into the patient's mouth.
4. Attempt to position the patient to maintain airway patency.
5. Avoid unnecessary or excessive restraint.
6. Administer oxygen.
7. Monitor breathing for adequacy.

NOTE: A GLUCOMETER (IF AVAILABLE) SHOULD BE USED TO DOCUMENT BLOOD GLUCOSE LEVEL PRIOR TO ADMINISTRATION OF GLUCOSE, FRUIT JUICE OR SODA.

IF THE GLUCOMETER READING IS ABOVE 60 MG/DL, WITHHOLD TREATMENT FOR HYPOGLYCEMIA.

IF THE GLUCOMETER READING IS ABOVE 60 MG/DL, TREATMENT FOR HYPOGLYCEMIA SHOULD BE WITHHELD. IF GLUCOSE IS BELOW 60, REFER TO PROTOCOL 411 AMS.

8. Request Advanced Life Support assistance for ongoing seizures at time of patient contact.
9. Treat all injuries as appropriate.
10. Transport.

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POISONING OR DRUG OVERDOSE

1. Monitor the airway.
2. Administer oxygen.
3. Request Advanced Life Support assistance for patients with respiratory distress/failure or altered mental status, or if so directed by Medical Control.
4. For Special Considerations, see below.
5. Document the name of the substance(s) involved.
6. Transport.

SPECIAL CONSIDERATIONS

INGESTED SUBSTANCES

1. Do **not** induce vomiting.
2. Do **not** attempt to neutralize the substance.

INHALED SUBSTANCES

NOTE: Ensure that the scene is safe to enter.

1. Remove the patient from the contaminated environment.
2. Administer oxygen, especially if carbon monoxide poisoning is suspected.

ENVENOMATIONS VENOMOUS BITE (Adult & Pediatric Patients)

1. Request Advanced Life Support assistance. DO NOT delay transport. Refer immediately to BLS Protocols #410 (Anaphylaxis), #401 (Respiratory Distress/failure), or #415 (Shock), as appropriate.
2. Move the patient to the ambulance with minimal patient movement, i.e., on a stretcher or wheeled stair chair.
3. Do not attempt to capture the envenomating animal (snake, scorpion, spider, etc.) nor remove the venom with suction devices.
4. Insect stings:
 - a. Remove stinger by scraping.
 - b. Cover with a sterile dressing.
 - c. Apply cold compresses to the site.
5. Marine:
 - a. Remove stinging bristles by patting the area with adhesive tape, then wipe with alcohol.
 - b. Remove stinging spine.
 - c. Cover with a sterile dressing.

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NOTE: Transport should not be delayed for this treatment.

6. Snakebite:
 - a. If the venomous bite occurred on an extremity, immobilize the extremity and place a Constriction Band proximal to the bite.
 1. When a tourniquet device is being used for a venomous bite to an extremity, place the tourniquet on the proximal area of the affected limb. Tighten the tourniquet in the usual fashion but NOT until pulses are lost. The tourniquet should be tightened to the point where 1-2 gloved fingers can be placed between the tourniquet and the skin. Ensure pulses remain present for the duration of transport.
 2. If extremity swelling is extensive and compartment syndrome (limb edema causing constriction at the tourniquet, worsening pain, paresthesias, skin pallor/coolness, or loss of pulses) is suspected, remove the tourniquet.
 - b. Transport to Venomous Bite Center. (See Appendix H.)

ABSORPTIONS

NOTE: Take precautions to avoid contamination of yourself and others.

1. Remove all contaminated clothing.
2. Brush away any dry agents or blot away any excess liquids from the skin.
3. Flush the area with sterile saline, sterile water, or plain water for at least 10 minutes.
4. Bandage any contact burns with a **saline-moistened**, sterile dressing.

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SHOCK

1. Monitor the airway.
2. Administer oxygen.
3. Control external bleeding.
4. Request Advanced Life Support assistance.
5. Transport.
6. Monitor vital signs.
7. Elevate the legs.
8. Treat all injuries as appropriate.
9. Maintain body temperature.

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ABDOMINAL PAIN

1. Administer oxygen, if appropriate.
2. If a traumatic cause is suspected, see Protocol #424.
3. Do **not** allow the patient to eat or drink.
4. Assess for shock and treat, if appropriate. (See Protocol #415.)
5. Place patient in a position of comfort.
6. Transport.

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TRAUMATIC CARDIAC ARREST

1. Simultaneously begin transportation of the patient and Basic Cardiac Life Support procedures, as circumstances permit.
2. Excluding patients with penetrating chest trauma, apply AED as described in Protocol 403 (Non-Traumatic Cardiac Arrest).
 - a. If the “Shock indicated” message is received, continue with treatment as described in Protocol 403.
 - b. If the “No shock indicated” message is received, begin transport immediately.

NOTE: Traumatic cardiac arrest is a critical, life-threatening emergency and should be transported immediately.

3. Observe spinal injury precautions, if appropriate. (See Protocol #421.)
4. Request Advanced Life Support assistance.

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HEAD AND SPINE INJURIES

1. Establish and maintain airway control while stabilizing the cervical spine.

NOTE **Do not use a nasopharyngeal airway in patients with facial injuries or if severe head injury has occurred.**

2. Patients meeting one or more of the following criteria, either at the time of evaluation or at any time following the injury in question, must have spinal injury precautions during care and transport. Do not use Rapid Takedown technique.
 - a. Altered mental status for any reason, including possible intoxication due to drugs or alcohol.
 - b. GCS <15
 - c. Complaint of, or inability of the provider to assess for, neck and/or spine pain or tenderness.
 - d. Weakness, paralysis, tingling, or numbness of the trunk or extremities at any time since the injury.
 - e. Deformity of the spine not present prior to the injury.
 - f. Distracting injury or circumstances, including anything producing an unreliable physical exam or history.
 - g. High risk mechanism (axial load such as diving or tackling, high-speed motor vehicle accidents, rollover accidents, falls greater than standing height).
 - h. Provider concern for potential spinal injury.

3. Monitor breathing for adequacy.

NOTE: **Monitor breathing continuously. Be alert for signs of hypoxia and/or increasing respiratory distress.**

4. Control external bleeding.
5. If the patient meets any of the criteria described in #2, is not awake or is unstable, apply a rigid cervical collar.
6. Continue to monitor the Glasgow Coma Score. (See Appendix E.)
7. Hyperventilation should NOT be performed.
8. Transport. (See Appendix F.)

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NECK INJURIES

NOTE: **Be alert for airway problems and cervical spine injuries.**

1. Monitor the airway.
2. Observe spinal injury precautions. (See Protocol #421.)
3. Administer oxygen.
4. Monitor breathing for adequacy.
5. Control external bleeding.
6. Seal the wound with an **occlusive** dressing.
 - a. Do **not** bandage completely around the neck.
7. Assess for shock and treat, if appropriate. (See Protocol #415.)
8. Transport. (See Appendix F.)

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CHEST INJURIES

1. Monitor the airway.
2. Observe spinal injury precautions, if appropriate. (See Protocol #421.)
3. Administer oxygen.

NOTE: Do not use a demand valve resuscitator due to the possibility of causing severe, life-threatening complications.

4. Monitor breathing for adequacy.
5. Control external bleeding.
6. For Special Considerations, see below.
7. Assess for shock and treat, if appropriate. (See Protocol #415.)
8. Position the patient on the affected side unless it will complicate the injury.
9. Transport. (See Appendix F.)

NOTE: Decreased breath sounds and muffled heart sounds indicate life-threatening chest injuries. The patient should be transported immediately.

SPECIAL CONSIDERATIONS

OPEN CHEST WOUND

1. Place an occlusive dressing over the wound and tape on three sides.
2. If the patient's condition worsens, remove the occlusive dressing and have the patient fully exhale. Replace and re-tape the occlusive dressing on three sides after exhalation, and request Advanced Life Support assistance.

CLOSED CHEST WOUND

1. If the patient's condition worsens, request Advanced Life Support assistance.

FLAIL CHEST

1. If the patient's condition worsens, request Advanced Life Support assistance

IMPALED OBJECTS

1. Do **not** remove the object.
2. Support and secure the object with bulky dressings.

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ABDOMINAL INJURIES

1. Monitor the airway.
2. Administer oxygen.
3. Monitor breathing for adequacy.
4. Control external bleeding.
5. Assess for shock and treat, if appropriate. (See Protocol #415.)
6. For Special Considerations, see below.
7. Transport. (See Appendix F.)

SPECIAL CONSIDERATIONS

EVISCEATION:

1. Do **not** replace the protruding organ.
2. Place **saline-moistened**, sterile dressings over the organ.
3. Do **not** pour fluid directly onto the wound.
4. Secure dry, bulky dressings over the moistened dressings.
5. An occlusive dressing may be placed as the final layer to maintain body heat.
6. Position the patient appropriately with knees slightly bent.

IMPALED OBJECTS:

1. Do **not** remove the object.
2. Support and secure the object with bulky dressings.

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BONE AND JOINT INJURIES

1. Monitor the airway.
2. Administer oxygen, if appropriate.
3. Control external bleeding.
 - a. Avoid excessive pressure over injury sites.
4. Assess for shock and treat, if appropriate. (See Protocol #415.)
5. Manually stabilize the injury.
6. Cover protruding bones and associated wounds with dry, sterile dressings.
7. Immobilize the injury.

NOTE: Check for peripheral (distal) pulses, motor function, and sensation in the injured extremity before and after immobilization.

- a. Angulated long bone deformities should be straightened provided resistance is not felt, into a splintable position.
- b. Joints above and below the deformity should be immobilized.
- c. A deformed joint should be immobilized in the position found, unless it cannot be effectively immobilized in this position.
- d. A traction splint is the splint of choice for all isolated closed femur fractures.
- e. Elevate the injury site, if possible.

NOTE: Splinting should not delay transport of the critical or unstable patient.

8. Transport. (See Appendix F.)

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SOFT TISSUE INJURIES

NOTE: Infection control precautions must be followed when making contact with the patient's blood or secretions.

1. Monitor the airway.
2. Administer oxygen, if appropriate.
3. Control external bleeding.
 - a. If a severe extremity hemorrhage cannot be controlled by direct pressure, apply a tourniquet (see Appendix T).
4. Assess for shock and treat, if appropriate. (See Protocol #415.)
5. For Special Considerations, see below.
6. Transport to the nearest appropriate hospital according to the patient's condition. (See Appendices F and H.)

SPECIAL CONSIDERATIONS

IMPALED OBJECT

1. Do **not** remove the object.
2. Support and secure the object with bulky dressings.

NOTE: If the object is impaled in the cheek and is compromising the airway, remove it and bandage both sides of the wound.

AMPUTATED OR COMPLETELY AVULSED TISSUE

1. Wrap the part in **saline-moistened, sterile** dressings.
 - a. Do **not** soak.
2. Place the part into a plastic bag and seal the bag.
3. Label the bag with the patient's name and time of injury.
4. Place the bag in ice, or a cooled area.
5. Protect the stump with a **saline-moistened**, sterile dressing.

NOTE: Avoid freezing the tissue. Do not use dry ice.

BASIC EMERGENCY MEDICAL TECHNICIAN PROTOCOLS

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EYE INJURIES

1. Monitor the airway.
2. Administer oxygen, if appropriate.
3. Control external bleeding.
4. Do **not** apply pressure to the globe of the eye.
5. Remove contact lenses, if possible.
6. For Special Considerations, see below.
7. Bandage both eyes loosely.
8. Transport. (See Appendix F.)

SPECIAL CONSIDERATIONS

FOREIGN OBJECT

1. Immediately and continuously flush the affected eye(s) with Normal Saline (0.9% NS) for a minimum of 20 minutes, continuing therapy enroute to the hospital.

AVULSED EYE

1. Do **not** attempt to replace the eye back into the socket.
2. Wrap the eye with **saline-moistened**, sterile dressings.
3. Stabilize this with a paper cup or similar object.

BASIC EMERGENCY MEDICAL TECHNICIAN PROTOCOLS

428

BURNS

1. Monitor the airway.
2. Observe spinal injury precautions, if appropriate. (See Protocol #421.)
3. Administer oxygen.
NOTE: Patients with inhalation injury should receive humidified oxygen (if available) and require advanced life support assistance.
4. Stop the burning process.
5. Prevent contamination of the wound. Avoid making contact with non-sterile materials if possible. Do not remove clothing adherent to the wound.
6. Monitor breathing for adequacy.
7. Assess for shock and treat, if appropriate. (See Protocol #415.)
8. For Special Considerations, see below.
9. Calculate the percentage and degree of affected areas. (See Appendix G.)
10. For burns less than 10% BSA, cover the affected areas with saline-moistened, sterile dressings, then wrap in dry, sterile sheets. For burns greater than 10% BSA, cover the affected areas with dry, sterile dressings, then wrap in dry, sterile sheets.
11. Maintain body temperature.
NOTE: Large body surface area involvement may lead to rapid heat loss in the burn patient.
12. Transport. (See Appendices G and H.)

SPECIAL CONSIDERATIONS

THERMAL BURNS

1. Cool hot or smoldering skin (up to 20% of the body surface area at a time) with cool water or Normal Saline (0.9% NS).

CHEMICAL BURNS

NOTE: Take precautions to avoid contamination of yourself and others.

1. Obtain the name of the product, if possible.
2. Remove any contaminated clothing or personal articles.
3. Brush dry agents off the skin, then flush with water for at least 10 minutes.
4. Blot any excessive liquids from the skin, then flush liquid chemical agents with water:
 - a. From the skin for at least 10 minutes.
 - b. From the eyes for at least 20 minutes.

BASIC EMERGENCY MEDICAL TECHNICIAN PROTOCOLS

ELECTRICAL BURNS

Note: **Be alert for cervical spine and other skeletal injuries.**

1. Begin Basic Cardiac Life Support procedures, if appropriate. (See Protocol #403.)
2. Observe spinal injury precautions, if appropriate. (See Protocol #421.)
3. Request Advanced Life Support assistance.
4. Locate and bandage the **obvious** entrance and exit wounds.
5. Treat skeletal injuries, if appropriate. (See Protocol #425.)

BASIC EMERGENCY MEDICAL TECHNICIAN PROTOCOLS

430

EXCITED DELIRIUM

NOTE: Agitated patients must be presumed to have an underlying medical or traumatic condition.

1) Assess the situation for potential danger and establish a safe zone, if necessary.

NOTE: All suicidal or violent threats must be taken seriously. Law enforcement presence is strongly recommended.

2) If the patient is agitated and presents a risk of physical harm to providers, public or self:

a) Request law enforcement assistance.

b) If the patient continues to struggle while being physically restrained, request Advanced Life Support assistance.

c) Attempt to verbally de-escalate the patient's situation.

d) The EMT/Paramedic may participate in restraining a patient if a police officer requests assistance or when it becomes necessary for self-protection.

NOTE: Only the amount of force required to effectively restrain the patient may be used.

3) Transport.

BASIC EMERGENCY MEDICAL TECHNICIAN PROTOCOLS

431

HEAT-RELATED EMERGENCIES

1. Cool the environment or move the patient to a cooler environment.
2. Remove excessive clothing.
3. Administer oxygen.
4. Restrict physical activity.
5. Assess for shock and treat, if appropriate. (See Protocol #415.)
6. For Special Considerations, see below.
7. Transport.

SPECIAL CONSIDERATIONS

HEAT CRAMPS

1. Provide water by mouth.

HEAT EXHAUSTION

1. Provide water by mouth if the patient is conscious, has a gag reflex, and is able to drink without assistance.

HEAT STROKE

1. Monitor the airway.
2. Cool the patient **rapidly**.

NOTE: Do not lower body temperature so as to produce shivering. The cooling of the patient should not delay transport.

BASIC EMERGENCY MEDICAL TECHNICIAN PROTOCOLS

432

COLD-RELATED EMERGENCIES

1. Warm the environment or move the patient to a warmer environment.
2. Prevent further loss of body heat.
3. Do **not** allow the patient to smoke or drink either alcohol or caffeinated beverages.
4. For Special Considerations, see below.
5. Transport.

SPECIAL CONSIDERATIONS

FROSTNIP, FROSTBITE, FREEZING (Local)

1. Remove clothing from the affected area.
2. Wrap the area in dry, bulky dressings.
3. Do **not** rub the area or rupture blisters.

HYPOTHERMIA (General)

1. Monitor the airway.
2. Begin Basic Cardiac Life Support procedures, if appropriate. (See Protocol #403.)

NOTE: Hypothermic patients remain viable for a longer period of time. Therefore, CPR should be initiated on all pulseless and apneic hypothermic patients.

3. Administer oxygen.
4. Monitor breathing for adequacy.
5. Gently remove any wet clothing.
6. Wrap the patient in dry blankets.

NOTE: Avoid rough handling of the hypothermic patient so as to reduce the risk of inducing cardiac arrest.

7. If the patient is conscious, is able to swallow, and is able to drink without assistance, give warm liquids slowly by mouth.
8. If the patient has an altered mental status, request Advanced Life Support assistance.

BASIC EMERGENCY MEDICAL TECHNICIAN PROTOCOLS

433

DROWNING OR NEAR DROWNING

1. Remove the patient from the water.
2. Observe spinal injury precautions, if appropriate. (See Protocol #421.)
3. Monitor the airway.
4. Assist ventilations, if appropriate. (See Protocol #401.)
5. Begin Basic Cardiac Life Support procedures, if appropriate. (See Protocol #403.)

NOTE: Hypothermic patients remain viable for a longer period of time. Therefore, CPR should be initiated on all pulseless and apneic hypothermic patients.

6. Administer oxygen.
7. Monitor breathing for adequacy.
8. Assess for shock and treat, if appropriate. (See Protocol #415.)
9. Transport.

NOTE: In cases of cold water drowning (water temperature below 70° F), treat for hypothermia. (see Protocol #432.)

BASIC EMERGENCY MEDICAL TECHNICIAN PROTOCOLS

434

DECOMPRESSION SICKNESS

1. Monitor the airway.
2. Administer oxygen.
3. Place the patient in a **left** lateral recumbent position.
4. If possible, obtain the following information:
 - a. recent dive history;
 - b. the maximum depth of the dive(s);
 - c. the total time spent underwater;
 - d. the mixture of compressed gases used.
5. Transport the patient and companion divers via ground transportation to the nearest appropriate hospital. (See Appendix H.)

BASIC EMERGENCY MEDICAL TECHNICIAN PROTOCOLS

440

OBSTETRIC EMERGENCIES

1. Monitor the airway.
2. Administer oxygen.
3. Place the patient in a left lateral recumbent position.
4. If the patient is immobilized, elevate the right side of the long board a few inches.
5. Assess for shock and treat, if appropriate. (See Protocol #415.)

NOTE: Consider Supine Hypotension Syndrome as a cause of shock.

6. For Special Considerations, request Advanced Life Support assistance, and see below.
7. Transport.

SPECIAL CONSIDERATIONS

HYPERTENSION

1. Keep the mother calm, avoid loud noises, and transport with dim lighting in the patient compartment of the ambulance.

SEIZURES

1. If seizures occur, see Protocol #413.

IMMINENT DELIVERY

1. If delivery has begun, refer to protocol #441

POST-PARTUM HEMORRHAGE

1. Massage the mother's abdomen over the uterus.
2. Place a sanitary napkin over the vaginal opening.

BASIC EMERGENCY MEDICAL TECHNICIAN PROTOCOLS

441

EMERGENCY CHILDBIRTH

1. Assess the mother for shock and treat, if appropriate. (See Protocol #415.)
2. If the mother is in active labor, perform a visual inspection of the perineum for bulging or crowning.
3. If delivery has begun, proceed as follows:
 - a. Request Advanced Life Support assistance.
4. If any of the following are present, refer to the Special Conditions section:
 - a. Prolapsed umbilical cord (cord protruding through vaginal opening)
 - b. Umbilical cord (cord wrapped around the neonate's neck)
 - c. Breech (buttocks) presentation
 - d. Limb (extremity) presentation
 - e. Multiple births
 - f. Premature births
 - g. Amniotic sac not ruptured
 - h. Amniotic fluid that is meconium stained

NOTE: Advanced life support assistance must be requested for premature or multiple births, or if the amniotic fluid is meconium stained.

5. Apply gentle pressure against the neonate's head to prevent tearing of the perineum.
 - a. Do **not** apply pressure to the soft spots (fontanel).
6. As the head presents, clear the airway of secretions, as follows:
 - a. First suction the mouth, inserting the bulb syringe, no more than 1½ inches, then the nose, inserting the bulb syringe no more than ½ inch. Depress the bulb syringe prior to insertion into the neonate's mouth and nose.

NOTE: Suctioning is critical.

7. Support the head and thorax as the neonate delivers.
 - a. Momentarily position the head lower than the body to allow for drainage. Repeat suctioning as necessary prior to spontaneous or stimulated respirations.
8. Thoroughly but rapidly dry the newborn with a clean, dry towel.
9. Monitor the neonate's airway.
 - a. To stimulate breathing, first rub the lower back, then gently snap the soles of the feet.

NOTE: Spontaneous respirations should begin within 30 seconds after birth.

10. Resuscitate if necessary. (See Protocol #443.)
11. Place the first clamp 8 to 10 inches from the neonate and the second clamp approximately 4 finger widths from the neonate. Cut between the clamps and immediately check both ends for bleeding.
12. If continuous bleeding is seen from either end of the cord, leave the clamps already applied and add a second clamp to the end that is bleeding.

BASIC EMERGENCY MEDICAL TECHNICIAN PROTOCOLS

13. Cover the neonate with a clean, dry towel or blanket, then wrap in a silver swaddler, exposing only the neonate's face.

NOTE: Neonates are subject to rapid heat loss and must be kept warm and dry.

14. For Special Considerations, **administer oxygen to the mother**, and see below.
15. Re-assess the mother for shock and treat, if appropriate. (See Protocol #415.) If postpartum hemorrhage occurs, see Protocol #440.
16. For care of the neonate, see Protocol #442.
17. Transport.
 - a. Do **not** delay transport waiting for the placenta to deliver.

NOTE: If miscarriage or stillbirth occurs, bring all expelled material to the hospital with the mother.

SPECIAL CONSIDERATIONS

NOTE: An abnormal delivery should be treated as an emergency with transport being a priority while providing appropriate care.

ABNORMAL PRESENTATION

Breech Presentation

1. Support the thorax of the neonate as it delivers.

NOTE: A full delivery may occur.
2. If the head does not deliver immediately, place sterile, gloved fingers between the neonate's face and the wall of the birth canal to establish an air passageway. This position must be maintained until the head delivers.

Limb Presentation

1. Elevate the mother's hips and legs.

Prolapsed Cord

1. Elevate the mother's hips and legs.
2. If the cord is not pulsatile, place sterile, gloved fingers into the birth canal and push the head back 1 to 2 inches towards the cervix until the cord begins to pulsate.
3. Wrap **saline-moistened**, sterile dressings around the cord.

NOTE: Do not attempt to insert the cord back into the uterus. The cord should be continuously monitored for the presence of a pulse.

COMPLICATIONS DURING BIRTH

Cord Around the Neck

1. If the cord is loose, gently slip the cord over the neonate's head.
2. If this is not possible, immediately place 2 clamps on the cord and cut between them.

BASIC EMERGENCY MEDICAL TECHNICIAN PROTOCOLS

Amniotic Sac Not Ruptured

1. Immediately remove the sac from around the face using sterile, gloved fingers only.

Wedged Shoulders

1. Guide the head downward to aid in the delivery of the upper shoulder.

MULTIPLE BIRTHS

1. Clamp and cut the umbilical cord of the first neonate prior to the next birth.
2. If the second birth does not occur within 10 minutes, begin transport.

BASIC EMERGENCY MEDICAL TECHNICIAN PROTOCOLS

442

CARE OF THE NEONATE

For neonates, minutes to hours old

1. Thoroughly but rapidly dry the neonate with a clean, dry towel, and then wrap the neonate in a silver swaddler, exposing only the neonate's face.
2. Monitor the neonate's airway.
3. Suction the mouth and nose using a bulb syringe.
4. Administer oxygen to the neonate unless the neonate remains completely pink.
5. Monitor breathing for adequacy.

NOTE: If the neonate is unresponsive, limp, or has:

- **persistent central cyanosis (longer than 15 to 30 seconds);**
- **respiratory rate is less than 30 breaths per minute (hypoventilation); OR,**
- **heart rate is less than 100 beats per minute (bradycardia) see Protocol #443.**

6. Assess for shock and treat, if appropriate. (See Protocol #458.)
7. Monitor the umbilical cord for bleeding.
8. Cover the neonate with a clean, dry towel or blanket, then wrap in a silver swaddler, exposing only the neonate's face.
9. Determine the Apgar Score at 1 and 5 minutes after delivery. (See Appendix K.)

NOTE: Do not delay transport or resuscitation in order to obtain an Apgar Score.

10. Transport, keeping the neonate warm.

NOTE: Neonate infants are subject to rapid heat loss and must be kept warm and dry.

BASIC EMERGENCY MEDICAL TECHNICIAN PROTOCOLS

443

NEONATE RESUSCITATION

For neonate with:

- Persistent central cyanosis (longer than 15 to 30 seconds);
 - Respiratory rate less than 30 breaths per minute (hypoventilation);
 - Heart rate less than 100 beats per minute (bradycardia); **OR**
 - Cardiac arrest (absence of breathing and pulse):
1. Initiate neonate resuscitation procedures. (See guidelines below.)
 2. Request Advanced Life Support assistance.
 3. Transport, keeping the neonate warm.

GUIDELINES FOR NEONATE RESUSCITATION

NOTE: **Cardiopulmonary resuscitation in a neonate is performed utilizing chest compressions with interposed ventilations in a ratio of 3:1 at a rate of 120 (90 compressions, 30 ventilations) per minute.**

If the neonate has:

- Persistent Central Cyanosis;
 - A Respiratory Rate Less Than 30 Breaths Per Minute; **OR**
 - A Heart Rate Between 60 And 100 Beats Per Minute:
1. Assist ventilation at a rate of 30 to 60 breaths per minute.
 2. Switch to high concentration mask or “blow by” oxygen once the respiratory rate is greater than 30 breaths per minute, the heart rate is greater than 100 beats per minute, and central cyanosis disappears.

If the neonate has:

- A Heart Rate Less Than 60 Beats Per Minute; **OR**
 - Cardiac Arrest:
1. Start CPR immediately.
 2. Stop CPR and begin assisted ventilation at a rate of 30 to 60 breaths per minute once the heart rate is greater than 60 beats per minute and rapidly increasing.
 3. Switch to high concentration mask or “blow by” oxygen once the heart rate is greater than 120 beats per minute, the respiratory rate is greater than 30 breaths per minute, and central cyanosis disappears.

BASIC EMERGENCY MEDICAL TECHNICIAN PROTOCOLS

450

PEDIATRIC RESPIRATORY DISTRESS/FAILURE

NOTE: Respiratory distress in a child is characterized by increased respiratory effort without central cyanosis, i.e., anxiety, tachypnea, nasal flaring, and intercostal retractions.

Respiratory failure in a child is characterized by ineffective respiratory effort with central cyanosis, i.e., agitation or lethargy, severe dyspnea or labored breathing, bobbing or grunting, and marked intercostal and parasternal retractions.

Bradycardia is an ominous sign that indicates hypoxic cardiac arrest may be imminent.

1. Monitor the airway.
2. If an obstructed airway is suspected, see Protocol #451.
3. If croup or epiglottitis is suspected, see Protocol #452.
4. If respiratory **distress** is present:
 - a. Administer oxygen and allow patient to maintain a comfortable, upright position.

NOTE: High concentration oxygen should always be used in pediatric patients. Do not allow the mask to press against the eyes.

5. If respiratory **failure** is present:
 - a. Assist ventilations at a rate of 20 breaths per minute.

NOTE: Do not use a demand valve resuscitator due to the possibility of causing severe life threatening complications.

Chest rise is the best indication of adequate ventilation in the pediatric patient.

6. Request Advanced Life Support assistance.
7. Monitor breathing for adequacy.
8. Transport, keeping the child warm.

BASIC EMERGENCY MEDICAL TECHNICIAN PROTOCOLS

451

PEDIATRIC OBSTRUCTED AIRWAY

1. If the patient is conscious and **can** breathe, cough, speak, or cry:
 - a. Administer oxygen.

NOTE: Avoid agitating the patient.
2. If the patient is unconscious or **cannot** breathe, cough, speak, or cry:
 - a. Perform obstructed airway clearing maneuvers appropriate for age.

NOTE: If an enlarged epiglottis is seen when attempting to clear a foreign body, see protocol #452.
3. Request Advanced Life Support assistance.
4. Transport, keeping the child warm.
5. Continue obstructed airway maneuvers until the obstruction is relieved.

NOTE: The patient must be taken to the hospital for evaluation even if the airway is cleared.
6. If airway obstruction is relieved:
 - a. Monitor the airway.
 - b. Begin Basic Cardiac Life Support procedures, if appropriate. (See Protocol #403.)
 - c. Administer oxygen.
 - d. Monitor breathing for adequacy.
7. Continue transport, keeping the child warm.

BASIC EMERGENCY MEDICAL TECHNICIAN PROTOCOLS

452

PEDIATRIC CROUP/EPIGLOTTITIS

NOTE: Croup should be suspected in a child with stridor, retractions, barking cough, normal or slightly elevated temperature, and a history of upper respiratory infection.

Epiglottitis should be suspected in a child with stridor, retractions, muffled voice, high fever, and drooling.

1. If the child is conscious:

a. Administer oxygen.

NOTE: Pediatric patients with croup/epiglottitis should receive humidified oxygen (if available).

b. Request Advanced Life Support assistance.

c. Monitor breathing for adequacy.

d. Transport in a sitting position, keeping the child warm. When feasible, allow a parent to accompany the child in the patient compartment.

NOTE: Avoid agitating the patient. Do not examine oropharynx. Allow saliva to drain from the mouth. Do not place patient in a supine position.

2. If the child is unconscious:

a. Assist ventilations.

NOTE: High pressure bag-valve-mask, mouth-to-mouth, or mouth-to-mask ventilation may be required.

b. Request Advanced Life Support assistance.

c. Monitor breathing for adequacy.

3. Transport, keeping the child warm.

BASIC EMERGENCY MEDICAL TECHNICIAN PROTOCOLS

453

PEDIATRIC NON-TRAUMATIC CARDIAC ARREST AND SEVERE BRADYCARDIA

For infants and children in non-traumatic cardiac arrest, or infants and children under 9 years of age with a heart rate less than 60 beats per minute (severe bradycardia) and signs of inadequate central (proximal) perfusion (decompensated shock)

1. Initiate Basic Cardiac Life Support procedures. (For infants and children, see guidelines below.)

NOTE: Do not delay CPR to wait for the automated external defibrillator (AED).

2. Request Advanced Life Support assistance.
3. Pediatric AED-capable pads and cables should be used for all pediatric patients under 9 years of age.
4. If Pediatric AED-capable pads and cables are not available, the adult AED and adult AED-capable pads and cables shall be used for all pediatric patients.

NOTE: Do not delay or withhold automated external defibrillation for any reason in pediatric patients who present with non-traumatic cardiac arrest.

5. Transport, keeping the child warm.

GUIDELINES FOR INFANT AND CHILD RESUSCITATION

NOTE: Cardiopulmonary resuscitation in an infant is performed utilizing chest compressions with interposed ventilations in a ratio of 15:2 at a rate of 120 events (105 compressions, 15 ventilations) per minute.

If The Infant Or Child Has A Heart Rate Less Than 60 Beats Per Minute:

1. Assist ventilation at a rate of 20 breaths per minute.
2. Start CPR if the heart rate is not rapidly increasing following 30 seconds of assisted ventilation.
3. Stop CPR and resume assisted ventilation at a rate of 20 breaths per minute once the heart rate is greater than 60 beats per minute and rapidly increasing.
4. Switch to high concentration mask or “blow by” oxygen once the heart rate is greater than 100 beats per minute, the respiratory rate is greater than 20 breaths per minute, and central cyanosis disappears.

BASIC EMERGENCY MEDICAL TECHNICIAN PROTOCOLS

If The Infant Or Child Is in Cardiac Arrest:

1. Start CPR immediately.
2. Stop CPR and begin assisted ventilation at a rate of 20 breaths per minute once the heart rate is greater than 60 beats per minute and rapidly increasing.
3. Switch to high concentration mask or “blow by” oxygen once the heart rate is greater than 100 beats per minute, the respiratory rate is greater than 20 breaths per minute, and central cyanosis disappears.

Mandatory Quality Assurance Component

For every application of an AED on a pediatric patient (even if no shock is delivered), the ACR/PCR documentation must be reviewed by the service medical director who is responsible for forwarding ACR/PCR data electronically to the NY REMAC for system-wide QA purposes. Patient specific identifiers can be omitted. This QA component is effective immediately. For the purposes of patient confidentiality, email mdiglio@nycremsco.org for directions on how to submit data electronically.

BASIC EMERGENCY MEDICAL TECHNICIAN PROTOCOLS

455

PEDIATRIC ANAPHYLACTIC REACTION

NOTE: Anaphylaxis can be a potentially life threatening situation most often associated with a history of exposure to an inciting agent/allergen (bee sting or other insect venom, medications/drugs, or foods such as peanuts, seafood, etc.). The presence of respiratory distress (upper airway obstruction [stridor], lower airway disease/severe bronchospasm [wheezing]) and/or cardiovascular collapse/hypotensive shock characterize the clinical findings that authorize and require treatment according to this protocol. This protocol applies to patients under 9 years old or patients weighing less than 30 kg (66 lbs). For patients 9 years of age or older, or over 30 kg (66 lbs) refer to the adult anaphylaxis protocol (#410).

1. Determine that the patient's history includes a history of anaphylaxis, severe allergic reaction and/or recent exposure to an allergen or inciting agent.

NOTE: Do not delay transport to the hospital

2. Administer high concentration oxygen.
3. Assess the cardiac and respiratory status of the patient.
4. If **both** the cardiac and respiratory status of the patient are normal, initiate transport.
5. If **either** the cardiac or respiratory status of the patient is **abnormal**, proceed as follows:
6. If the patient is having severe respiratory distress **or** shock **and** has been prescribed a pediatric (0.15 mg) Epinephrine auto-injector, assist the patient in administering the Epinephrine 0.15 mg via an auto-injector. If the patient's auto-injector is not available or expired, administer the Epinephrine, 0.15 mg.
7. If the patient has not been prescribed a pediatric (0.15 mg) Epinephrine auto-injector, begin transport and contact On-Line Medical Control for authorization to administer a pediatric (0.15 mg) Epinephrine auto-injector.

NOTE: In the event that you are unable to make contact with On-Line Medical Control (radio failure, no communications), you may administer the Epinephrine auto-injector (0.15 mg), if indicated. The incident must be reported to on-line medical control and your agency's medical director as soon as possible.

8. Contact On-Line Medical Control for authorization to administer a second administration of a pediatric (0.15 mg) Epinephrine auto-injector, if needed.
9. Refer immediately to the REMAC Prehospital Treatment Protocol for Respiratory Distress/Failure (#450), Obstructed Airway (#451), or Shock (#458) as appropriate.
10. If cardiac arrest occurs, refer immediately to the REMAC Prehospital Treatment Protocol for Non-Traumatic Cardiac Arrest (#453)

MANDATORY QUALITY ASSURANCE COMPONENT

For every administration of Epinephrine via auto-injector, the ACR/PCR documentation must be reviewed by the service medical director who is responsible for forwarding ACR/PCR data electronically to the NY REMAC for system-wide QA purposes. Patient specific identifiers can be omitted. This QA component is effective immediately. For the purposes of patient confidentiality, email mdiglio@nycremsco.org for directions on how to submit data electronically.

BASIC EMERGENCY MEDICAL TECHNICIAN PROTOCOLS

458

PEDIATRIC SHOCK

NOTE: Shock in the child is characterized by signs of inadequate peripheral (distal) perfusion, which may include altered mental status; tachycardia; pallor; cool, cyanotic lower extremities; mottling; weak or absent peripheral (distal) pulses. The definition of shock in the child does not depend upon blood pressure.

1. Monitor the airway.
2. Observe spinal injury precautions, if appropriate. (See Protocol #421.).
3. Administer oxygen.

NOTE: High concentration oxygen should always be used in pediatric patients.

4. If patient has an altered mental status, the patient must be ventilated at the rate of at least 25 breaths per minute.
5. Control external bleeding.
6. Request Advanced Life Support assistance.

NOTE: Do not delay transport to the hospital.

7. Transport, keeping the child warm.
8. Elevate the legs.
9. Treat all injuries as appropriate.