

EMSC Partnership for Children

**National Association
of EMS Physicians**

Model Pediatric Protocols

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Introduction

The Need for Standardized Protocols

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

Broadly speaking, the term *medical oversight* encompasses both direct and indirect facets of medical control. Direct medical control is the on-line guidance provided by designated physicians to prehospital providers during emergency calls. Indirect medical control consists of training programs, patient care protocols, and quality assurance measures that are initiated by local, regional, state, and agency medical directors or advisory boards. Throughout this document, the term *regional medical direction* represents all forms of medical oversight as applied by any state, region or agency.

To make a delegated system work, regional medical direction must ensure that all prehospital providers are equipped to meet appropriate standards of patient care. This requires education and training, treatment protocols to guide rescuers' actions in the field, and support from qualified on-line medical control physicians as needed. The responsibilities of regional medical direction include authorizing an accepted scope of practice for EMTs of varying skill levels; verifying that EMTs have received the necessary training to render field care swiftly and skillfully; and developing and approving protocols that delineate the proper steps in patient management.

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

Putting the Protocols to Use

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

The ultimate authority for prehospital patient care rests with regional medical direction and the state EMS agency. Each EMS jurisdiction must authorize each of these protocols prior to their use. Each EMS jurisdiction must review these protocols and further designate the following:

- interventions that are considered standing orders, requiring no consultation with on-line medical control
- interventions that are considered medical control options, to be carried out only after obtaining approval from an on-line physician
- interventions that are not applicable due to local conditions, training, and resources

Because this is a highly individual determination, these model protocols do not designate these aspects of practice for any specific EMS system

In deciding which interventions should be standing orders and which will require authorization, EMS systems and regional medical direction should consider critical time factors. For certain lifesaving interventions, taking the time to consult an on-line medical control physician before initiating the action could have a detrimental effect on patient survival. These interventions should be designated standing orders.

Examples of such actions would include

- any measure needed to establish or maintain airway patency, including advanced airway procedures
- treatment for respiratory distress, failure or arrest
- defibrillation or cardioversion for cardiopulmonary failure or arrest
- treatment for shock
- treatment for active seizures
- treatment for anaphylaxis

In addition to standing orders for life-threatening conditions, contingency guidelines should be established to address circumstances in which an on-line medical control physician is not available.

While these protocols address both basic and advanced life support measures, they do not attempt to differentiate between the two, nor do they specify which actions are appropriate for EMS providers of varying certification levels. Proper patient care does not vary, regardless of the provider's skills or certification. Ideally, every necessary action should be carried out as specified in the protocol. Realistically, the EMT's skill level will limit the actions that can be provided in the field. Defining how these limitations will be applied to providers at different certification levels is up to regional medical direction. However, it is important to emphasize that basic life support of airway and breathing are, in most cases, the only actions necessary to deliver a pediatric patient safely to definitive care.

Protocols require constant reevaluation to ensure that they reflect advances in EMS training, medical knowledge, science, and technology. Regional medical direction must continually evaluate providers' skills to ensure competency and compliance with applicable EMS standards. Implementing new protocols may necessitate that educational and training programs be updated in both initial and continuing prehospital education to ensure that providers have the necessary skills and training to carry out their responsibilities. Regional medical direction must maintain an ongoing commitment to keep abreast of changes in medical knowledge that may affect the protocols. It is also essential for regional medical direction to implement continual quality improvement efforts that may lead to further clarification or revision of the protocols and amended standards for provider training.

Protocol Development Process

To develop these protocols, the process employed by the writing team was a combination of literature based and expert consensus judgement. To start the process the writing team reviewed more than 250 representative protocols selected from a national sample, then generated a list of commonly encountered protocols and collated the individual steps associated with each.

To ensure compliance with accepted national standards, the draft protocols were compared with practices described in the EMT-Basic and EMT-Paramedic *National Standard Curricula*, AHA *Pediatric Advanced Life Support* program, AAP and AHA *Neonatal Resuscitation* program, ACS *Advanced Trauma Life Support* program, the Center for Pediatric Emergency Medicine's *Teaching Resource for Instructors in Prehospital Pediatrics*, and NAEMT's *Prehospital Trauma Life Support* program. The published literature was also reviewed for prehospital pediatric studies that would provide additional guidance. If a point of controversy was not addressed in the prehospital literature, a search of the literature in pediatric emergency medicine was conducted and conclusions were extrapolated for applicability to the prehospital environment. Further guidance was obtained when needed from an expert consensus group representing major national professional organizations in EMSC, EMS, pediatric emergency medicine, and emergency medicine.

The resultant draft version of the protocols was mailed to representatives named by major EMS and medical professional organizations with a request for written comments. Based on the responses received, a second draft was developed.

In August 1998, a meeting was held in Washington, DC at which individuals representing the national EMS, EMSC, and medical professional organizations reviewed this second draft. Each protocol was then evaluated to see if it was either supported by predominance of scientific literature or based on accepted national standards. All protocols that met one of these criteria were considered acceptable. Participants then reviewed the remaining protocols and based on consensus judgement decided which would be accepted and which would be modified to meet specific recommendations.

In addition to content decisions the group also addressed formatting and overall medical direction issues. The group determined that the protocols should be constructed so that any single protocol could be used independently. Although this strategy necessitates repeating many standard patient care steps from one protocol to the next, it serves to stress the universal importance of initial airway and breathing interventions in pediatric care and highlights the concept that many children may require only basic life support measures as delineated. Furthermore establishing stand-alone protocols greatly facilitates the selection of individual protocols from the overall document as appropriate for various regions.

The group discussed the advisability of designating which actions should be considered standing orders for each protocol, but concluded that this should be a regional decision depending on many variables, including the level of medical oversight, the training received by EMS providers at different certification levels, the clinical experience of individual EMS providers, and the frequency with which the skills are performed. The group ultimately established its recommendation that certain lifesaving procedures should be considered standing orders in all regions based on critical time factors involved. Additional factors governing standing orders should be determined by regional medical direction.

The group also discussed the advisability of designating separate BLS and ALS protocols and designating which steps applied to which EMS provider certification levels. While the Department of Transportation's National Highway and Traffic Safety Administration has established national training guidelines for Certified First Responder, EMT-Basic, EMT-Intermediate, and EMT-Paramedic, significant variations exist among regional EMS systems regarding the actual level of provider training, scope of practice, and certification levels for each

of these designations. Therefore, the group concluded that while these protocols define the care to be provided, regional EMS systems should determine which actions fall within specific providers' scope of practice.

Finally, the group noted that several protocols include decision points at which more than one treatment option or medication choice could be considered medically acceptable. For those protocols, all options would be listed and regional medical direction could select the option they would implement. Similarly, when a useful treatment option exists that might exceed providers' capabilities, system resources or system needs in certain regions, the step is listed with the qualifier that it should be considered as permitted by regional medical direction.

At the conclusion of this meeting, a third draft was generated and distributed to the writing team for comments, which were incorporated into the fourth draft.

This draft was copyedited, then forwarded to the review panel and all state and territorial EMS directors. In an effort to further broaden the input into the development process and to be as inclusive as possible, the protocols were also posted on the NAEMSP web site for download with a comment form to be returned to the writing team. The web site posting was also available through links from other major EMS and EMSC web sites. The comments obtained from this draft were incorporated into the final document. In addition to review of the document, the state EMS directors were asked to suggest mechanisms for distributing the finished protocols nationally and within their individual states and territories.

These protocols are intended to represent model treatment practices. EMS agencies can rely on them to direct patient care, whether they are implemented as standing orders or as medical control options authorized by on-line physicians. In either case, the protocols should serve as a quality measure to ensure uniformity of care. The authors hope that individuals, EMS providers, and medical directors will use these protocols to help improve the care children receive in emergencies.

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American Academy of Family Physicians	Douglas Long, MD
American Academy of Pediatrics	Joseph Wright, MD, MPH
American Ambulance Association	Karen Oldham, MD
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National Association of State EMS Directors	Mark King
National Council of State EMS Training Coordinators	Alonzo Smith
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Joint Review Committee on Educational Programs for the EMT-Paramedic	Peter Glaeser, MD
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GENERAL PATIENT CARE

This protocol provides general guidelines for patient management. Refer to additional protocols as appropriate for treatment of specific conditions. A length-based resuscitation tape is recommended to help EMS personnel quickly determine appropriate equipment size, normal vital signs, and correct drug dosages.

1. Ensure scene safety.
2. Perform a scene survey to assess environmental conditions and mechanism of illness or injury. If hazardous conditions are present (such as swift water, hazardous materials, electrical hazard, or confined space), contact an appropriate agency before approaching the patient. Wait for the designated specialist to secure the scene and patient as necessary.
3. Form a general impression of the patient's condition.
4. Observe standard precautions.
5. Establish patient responsiveness. If cervical spine trauma is suspected, manually stabilize the spine.
6. Assess the patient's airway for patency, protective reflexes and the possible need for advanced airway management. Look for signs of airway obstruction.
7. Open the airway using head tilt/chin lift if no spinal trauma is suspected, or modified jaw thrust if spinal trauma is suspected.
8. Suction as necessary.
9. Consider placing an oropharyngeal or nasopharyngeal airway adjunct if the airway cannot be maintained with positioning and the patient is unconscious.
10. Assess the patient's breathing, including rate, auscultation, inspection, effort, and adequacy of ventilation as indicated by chest rise. Obtain pulse oximeter reading.
11. If chest rise indicates inadequate ventilation, reposition airway and reassess.
12. If inadequate chest rise is noted after repositioning airway, suspect a foreign body obstruction of the airway. Refer to the appropriate protocol for treatment options.
13. Assess for signs of respiratory distress, failure, or arrest. If present, refer to the appropriate protocol for treatment options.
14. If the child is not breathing or breathing is inadequate, initiate assisted ventilation using a bag-valve-mask device with high-flow, 100% concentration oxygen. Begin with two slow, deep breaths of about 1-1/2 seconds' duration, then ventilate at 20 breaths/minute for all ages. If abdominal distention arises, consider placing a nasogastric tube to decompress the stomach.
15. If the airway cannot be maintained by other means, including attempts at assisted ventilation,

or if prolonged assisted ventilation is anticipated, perform endotracheal intubation. Consider administration of pharmacological adjuncts, such as sedatives and paralytic agents, to aid with intubation as permitted by regional medical direction. Confirm placement of endotracheal tube using clinical assessment and end-tidal CO₂ monitoring as per regional medical direction.

16. If breathing is adequate, place the child in a position of comfort and administer high-flow, 100% concentration oxygen as necessary. Use a nonrebreather mask or blow-by as tolerated.
17. Control hemorrhage using direct pressure or a pressure dressing.
18. Assess circulation and perfusion by measuring heart rate and observing skin color and temperature, capillary refill time, and the quality of central and peripheral pulses. Blood pressure should be measured only in children older than three years.
19. For children with absent pulses, initiate cardiopulmonary resuscitation at a combined rate of 120 compressions/40 breaths per minute for neonates (three compressions to each breath) or 100 compressions/20 breaths per minute for infants and children (five compressions to each breath). Compression depth is 1/2 to 3/4 inch for neonates, 1/2 to 1 inch for infants, and 1 to 1-1/2 inches for children.
20. Initiate cardiac monitoring.
21. If there is evidence of shock, obtain vascular access using an age-appropriate large-bore catheter with large-caliber tubing. If intravenous access cannot be obtained in a child younger than six years, proceed with intraosseous access. Administer a fluid bolus of normal saline at 20 ml/kg set to maximum flow rate. Reassess patient after bolus. If signs of shock persist, bolus may be repeated at the same dose up to two times for a maximum total of 60 ml/kg.
22. Evaluate mental status, including pupillary reaction, distal function and sensation, and AVPU assessment.
23. If spinal trauma is suspected, continue manual stabilization, place a rigid cervical collar, and immobilize the patient on long backboard or similar device.
24. Expose the child only as necessary to perform further assessments. Maintain the child's body temperature throughout the examination.
25. If the child's condition is critical or unstable, initiate transport. Perform focused history and detailed physical examination en route to the hospital if patient status and management of resources permit.
26. If the child's condition is stable, perform focused history and detailed physical examination on the scene, then initiate transport.
27. Reassess the patient frequently.
28. Contact medical direction for additional instructions.

TRAUMA

The priorities in pediatric trauma management are to prevent further injury, provide rapid transport, notify the receiving facility, and initiate definitive treatment. On-scene time for a traumatic injury should be no longer than 10 minutes unless there are extenuating circumstances, such as extrication, hazardous conditions, or multiple victims. Document these circumstances on the patient record. Inform the receiving hospital as early as possible about the patient's status and condition. This will allow hospital personnel extra time to mobilize resources.

1. Ensure scene safety.
2. Perform a scene survey to assess environmental conditions and mechanism of injury. If hazardous conditions are present (such as swift water, hazardous materials, electrical hazard, or confined space), contact an appropriate agency before approaching the patient. Wait for the designated specialist to secure the scene and patient as necessary.
3. Form a general impression of the patient's condition.
4. Observe standard precautions.
5. Establish patient responsiveness. Manually stabilize the spine.
6. Assess the patient's airway for patency, protective reflexes and the possible need for advanced airway management. Look for signs of airway obstruction.
7. Open the airway using a modified jaw thrust.
8. Suction as necessary.
9. Considering placing an oropharyngeal or nasopharyngeal airway adjunct if the airway cannot be maintained with positioning and the patient is unconscious. Note that the nasopharyngeal airway is contraindicated in the presence of facial trauma.
10. Evaluate breathing. Assess for symmetry of chest expansion, equal breath sounds, and adequate chest rise. Inspect the chest wall for signs of trauma. Obtain pulse oximeter reading.
11. If breathing is inadequate, assist ventilation using a bag-valve-mask device with high-flow, 100% concentration oxygen. If abdominal distention arises, consider placing a nasogastric tube to decompress the stomach. If facial trauma is present or a basilar skull fracture is suspected, use an orogastric tube instead.
12. If the airway cannot be maintained by other means, including attempts at assisted ventilation, or if prolonged assisted ventilation is anticipated, perform endotracheal intubation. Consider administration of pharmacological adjuncts, such as sedatives and paralytic agents, to aid with intubation as permitted by regional medical direction. Confirm placement of endotracheal tube using clinical assessment and end-tidal CO₂ monitoring as per regional medical direction.
13. If breathing is adequate, place the child in a position of comfort and administer high-flow,

100% concentration oxygen as necessary. Use a nonrebreather mask or blow-by as tolerated.

14. If absent breath sounds or signs of severe respiratory distress are noted together with a mechanism of injury that could cause a tension pneumothorax, perform needle decompression. Use an 18- or 20-gauge over-the-needle catheter. Insert the needle in the mid-clavicular line at the second intercostal space, just above the third rib.
15. Control hemorrhage using direct pressure or a pressure dressing.
16. Assess circulation and perfusion.
17. Initiate cardiac monitoring.
18. Assess mental status.
19. Continue manual stabilization while placing a rigid cervical collar. Immobilize the patient on a long backboard or similar device.
20. Expose the child only as necessary to perform further assessments. Maintain the child's body temperature throughout the examination.
21. Initiate transport to an appropriate trauma facility no more than 10 minutes after arriving on the scene unless extenuating circumstances exist or directed by regional medical direction.
22. Obtain vascular access using an age-appropriate large-bore catheter with large-caliber tubing and administer normal saline at a sufficient rate to keep the vein open. If extenuating circumstances delay transport, obtain vascular access on the scene, but do not delay transport to obtain vascular access.
23. If there is evidence of shock, initiate vascular access in two sites. If intravenous access cannot be obtained in a child younger than six years, proceed with intraosseous access. Administer a fluid bolus of normal saline at 20 ml/kg set to maximum flow rate. Reassess patient after bolus. If signs of shock persist, bolus may be repeated at the same dose up to two times for a maximum total of 60 ml/kg.
24. Splint obvious fractures of long bones.
25. Perform focused history and detailed physical examination en route to the hospital if patient status and management of resources permit.
26. Reassess the patient frequently.
27. Contact medical direction for additional instructions.

BURNS

1. Ensure scene safety.
2. Perform a scene survey to assess environmental conditions and mechanism of illness or injury. If hazardous conditions are present (such as swift water, hazardous materials, electrical hazard, or confined space), contact an appropriate agency before approaching the patient. Wait for the designated specialist to secure the scene and patient as necessary.
3. Form a general impression of the patient's condition.
4. Observe standard precautions.
5. Stop the burning process. If a dry chemical is involved, brush it off, then flush with copious amounts of water. If a caustic liquid is involved, flush with copious amounts of water. Remove all of patient's clothing prior to irrigation. Be prepared to treat hypothermia, which may arise secondary to these interventions. For chemical burns with eye involvement, immediately begin flushing the eye with normal saline. Continue flushing throughout assessment and transport.
6. Establish patient responsiveness. If cervical spine trauma is suspected, manually stabilize the spine. Remove the patient's clothing and jewelry in any affected area.
7. Assess the patient's airway for patency, protective reflexes and the possible need for advanced airway management. Look for signs of airway obstruction.
8. Open the airway using head tilt/chin lift if no spinal trauma is suspected, or modified jaw thrust if spinal trauma is suspected.
9. Suction as necessary.
10. Consider placing an oropharyngeal or nasopharyngeal airway adjunct if the airway cannot be maintained with positioning and the patient is unconscious.
11. Assess breathing. Obtain pulse oximeter reading. Refer to the appropriate protocol for management of respiratory distress.
12. If breathing is inadequate, assist ventilation using a bag-valve-mask device with high-flow, 100% concentration oxygen. If abdominal distention arises, consider placing a nasogastric tube to decompress the stomach.
13. If the airway cannot be maintained by other means, including attempts at assisted ventilation, or if prolonged assisted ventilation is anticipated, perform endotracheal intubation. This step should also be undertaken if inhalation injury is suspected. Consider administration of pharmacological adjuncts, such as sedatives and paralytic agents, to aid with intubation as permitted by regional medical direction. Confirm placement of endotracheal tube using clinical assessment and end-tidal CO₂ monitoring as per regional medical direction.
14. If breathing is adequate, place the child in a position of comfort and administer high-flow,

100% concentration oxygen as necessary. Use a nonrebreather mask for potential inhalation injury or any serious thermal burn.

15. Assess circulation and perfusion.
16. For electrical burns, initiate cardiac monitoring and determine rhythm. If a dysrhythmia is present, refer to the appropriate protocol for treatment options.
17. If there is evidence of shock in a patient with major thermal burns, obtain vascular access using an age-appropriate large-bore catheter with large-caliber tubing. If intravenous access cannot be obtained in a child younger than six years, proceed with intraosseous access. Administer a fluid bolus of normal saline at 20 ml/kg set to maximum flow rate. Reassess patient after bolus. If signs of shock persist, bolus may be repeated at the same dose up to two times for a maximum total of 60 ml/kg.
18. Assess mental status.
19. If spinal trauma is suspected, continue manual stabilization, place a rigid cervical collar, and immobilize the patient on a long backboard or similar device.
20. Expose the child only as necessary to perform further assessments. Maintain the child's body temperature throughout the examination.
21. Apply a burn sheet or dry sterile dressings to burned areas. To prevent hypothermia, avoid moist or cool dressings and do not leave wounds or skin exposed.
22. Initiate transport. Perform focused history and detailed physical examination en route to the hospital if patient status and management of resources permit.
23. Pain management is usually indicated. Refer to the appropriate protocol for treatment options.
24. Reassess the patient frequently.
25. Contact medical direction for additional instructions.

FOREIGN BODY AIRWAY OBSTRUCTION

The following protocol applies to an unconscious child or infant with a foreign body obstruction of the airway.

1. Ensure scene safety.
2. Perform a scene survey to assess environmental conditions and mechanism of illness or injury.
3. Form a general impression of the patient's condition.
4. Observe standard precautions.
5. Confirm that the patient is unresponsive.
6. Open the airway using a head tilt/chin lift.
7. Attempt assisted ventilation using a bag-valve-mask device with high-flow, 100% concentration oxygen. If unsuccessful, reposition airway and attempt bag-valve-mask assisted ventilation again.
8. Use age-appropriate techniques to dislodge the obstruction (for infants younger than one year, apply back blows with chest thrusts; for children one year and older, use abdominal thrusts).
9. If unsuccessful, establish a direct view of the object and attempt to remove it with Magill forceps.
10. If unsuccessful, attempt endotracheal intubation and ventilate the patient.
11. If unsuccessful, perform needle cricothyrotomy and needle jet insufflation.
12. Assess circulation and perfusion.
13. Assess mental status.
14. Expose the child only as necessary to perform further assessments. Maintain the child's body temperature throughout the examination.
15. Initiate transport. Perform focused history and detailed physical examination en route to the hospital if patient status and management of resources permit.
16. Reassess the patient frequently.
17. Contact medical direction for additional instructions.

RESPIRATORY DISTRESS, FAILURE, OR ARREST

*A patient who presents with acute respiratory distress of sudden onset accompanied by fever, drooling, hoarseness, stridor, and tripod positioning may have a partial airway obstruction. **Do nothing to upset the child.** Perform critical assessments only. Enlist the parent to administer blow-by oxygen. Place the patient in a position of comfort. Do not attempt vascular access. Transport immediately.*

Definitions

Respiratory distress is indicated by the following findings:

- alert, irritable, anxious
- stridor
- audible wheezing
- respiratory rate faster than normal for age
- intercostal retractions
- nasal flaring
- neck muscle use
- central cyanosis that resolves with oxygen administration
- mild tachycardia
- able to maintain sitting position (children older than four months)

Respiratory failure involves the findings above with any of the following additions or modifications:

- sleepy, intermittently combative, or agitated
- increased respiratory effort at sternal notch
- marked use of accessory muscles
- retractions, head bobbing, grunting
- central cyanosis
- marked tachycardia
- poor peripheral perfusion
- decreased muscle tone

Respiratory arrest involves the findings above with any of the following additions or modifications:

- unresponsive to voice or touch
- absent or shallow chest wall motion
- absent breath sounds
- respiratory rate slower than 10 breaths per minute
- weak to absent pulses
- bradycardia or asystole
- limp muscle tone
- unable to maintain sitting position (children older than four months)

Procedure

1. Ensure scene safety.

2. Perform a scene survey to assess environmental conditions and mechanism of illness or injury.
3. Form a general impression of the patient's condition.
4. Observe standard precautions.
5. Establish patient responsiveness. If cervical spine trauma is suspected, manually stabilize the spine.
6. Assess the patient's airway for patency, protective reflexes and the possible need for advanced airway management. Look for signs of airway obstruction. Signs include
 - absent breath sounds
 - tachypnea
 - intercostal retractions
 - stridor or drooling
 - choking
 - bradycardia
 - cyanosis
7. If foreign body obstruction of the airway is suspected, refer to the appropriate protocol for treatment options.
8. Open the airway using head tilt/chin lift if no spinal trauma is suspected, or modified jaw thrust if spinal trauma is suspected.
9. Suction as necessary.
10. Consider placing an oropharyngeal or nasopharyngeal airway adjunct if the airway cannot be maintained with positioning and the patient is unconscious.
11. Assess the patient's breathing, including rate, auscultation, inspection, effort, and adequacy of ventilation as indicated by chest rise. Obtain pulse oximeter reading.
12. If chest rise indicates inadequate ventilation, reposition airway and reassess.
13. If inadequate chest rise is noted after repositioning airway, suspect a foreign body obstruction of the airway. Refer to the appropriate protocol for treatment options.
14. Assess for signs of respiratory distress, failure, or arrest. If signs of respiratory failure or arrest are present, assist ventilation using a bag-valve-mask device with high-flow, 100% concentration oxygen.
15. If abdominal distention arises, consider placing a nasogastric tube to decompress the stomach.
16. If the airway cannot be maintained by other means, including attempts at assisted ventilation, or if prolonged assisted ventilation is anticipated, perform endotracheal intubation. Consider administration of pharmacological adjuncts, such as sedatives and paralytic agents, to aid with intubation as permitted by regional medical direction. Confirm placement of

endotracheal tube using clinical assessment and end-tidal CO₂ monitoring as per regional medical direction.

17. If breathing is adequate and patient exhibits signs of respiratory distress, administer high-flow, 100% concentration oxygen as necessary. Use a nonrebreather mask or blow-by as tolerated.
18. If bronchospasm is present, refer to the appropriate protocol for treatment options.
19. Assess circulation and perfusion.
20. Initiate cardiac monitoring.
21. If the patient shows signs of severe respiratory failure or respiratory arrest, consider establishing vascular access and administering normal saline at a sufficient rate to keep the vein open. If intravenous access cannot be obtained in a patient younger than six years, proceed with intraosseous access. Do not delay transport to obtain vascular access.
22. Assess mental status.
23. Expose the child only as necessary to perform further assessments. Maintain the child's body temperature throughout the examination.
24. Initiate transport. Perform focused history and detailed physical examination en route to the hospital if patient status and management of resources permit.
25. Reassess the patient frequently.
26. Contact medical direction for additional instructions.

BRONCHOSPASM

A silent chest is an ominous sign indicating that respiratory failure or arrest is imminent.

Definition

Bronchospasm is usually accompanied by respiratory distress with the following findings:

- wheezing
- prolonged expiration
- increased respiratory effort (decreased effort may be noted as patient's condition approaches respiratory failure)
- severe agitation, lethargy
- suprasternal and substernal retractions
- tripod positioning

Procedure

1. Ensure scene safety.
2. Perform a scene survey to assess environmental conditions and mechanism of illness or injury.
3. Form a general impression of the patient's condition.
4. Observe standard precautions.
5. Establish patient responsiveness. If cervical spine trauma is suspected, manually stabilize the spine.
6. Assess the patient's airway for patency, protective reflexes and the possible need for advanced airway management. Look for signs of airway obstruction.
7. Open the airway using head tilt/chin lift if no spinal trauma is suspected, or modified jaw thrust if spinal trauma is suspected.
8. Suction as necessary.
9. Consider placing an oropharyngeal or nasopharyngeal airway adjunct if the airway cannot be maintained with positioning and the patient is unconscious.
10. Assess breathing. Obtain pulse oximeter reading.
11. If breathing is inadequate, assist ventilation using a bag-valve-mask device with high-flow, 100% concentration oxygen. If abdominal distention arises, consider placing a nasogastric tube to decompress the stomach.
12. If the airway cannot be maintained by other means, including attempts at assisted ventilation,

or if prolonged assisted ventilation is anticipated, perform endotracheal intubation. Consider administration of pharmacological adjuncts, such as sedatives and paralytic agents, to aid with intubation as permitted by regional medical direction. Confirm placement of endotracheal tube using clinical assessment and end-tidal CO₂ monitoring as per regional medical direction.

13. If breathing is adequate, place the child in a position of comfort and administer high-flow, 100% concentration oxygen as necessary. Use a nonrebreather mask or blow-by as tolerated.
14. If the patient shows signs of respiratory distress or respiratory failure together with clinical evidence of bronchospasm or a history of asthma, administer 2.5 mg albuterol via nebulizer over a 10- to 15-minute period. If these respiratory findings persist, repeat 2.5 mg albuterol via nebulizer at 15-minute intervals throughout transport. Do not delay transport to administer medications.
15. If the patient shows signs of severe respiratory distress or respiratory failure together with clinical evidence of bronchospasm and inadequate ventilation, administer a systemic agent for bronchodilation. Use either epinephrine 1:1000 at 0.01 mg/kg (maximum individual dose 0.3 mg) or terbutaline at 0.01 mg/kg (maximum individual dose 0.4 mg) administered via subcutaneous route.
16. If severe respiratory distress and bronchospasm persist despite albuterol administration, consider administering 500 mcg ipratropium bromide via nebulizer over a 10- to 15-minute period as permitted by regional medical direction. Ipratropium bromide and albuterol may be mixed together and administered simultaneously.
17. Assess circulation and perfusion.
18. Initiate cardiac monitoring.
19. If the patient shows signs of severe respiratory distress, respiratory failure, or respiratory arrest, consider establishing vascular access and administering normal saline at a sufficient rate to keep the vein open. If intravenous access cannot be obtained in a patient younger than six years with respiratory arrest, proceed with intraosseous access. Do not delay transport to obtain vascular access.
20. Consider administration of steroids as permitted by regional medical direction. The usual choices are prednisone at 2.0 mg/kg (maximum individual dose 60 mg) administered by mouth, methylprednisolone at 2.0 mg/kg (maximum individual dose 120 mg) by intravenous route, or hydrocortisone at 4.0 mg/kg (maximum individual dose 250 mg) by intravenous route.
21. Assess mental status.
22. Expose the child only as necessary to perform further assessments. Maintain the child's body temperature throughout the examination.
23. Initiate transport. Perform focused history and detailed physical examination en route to the hospital if patient status and management of resources permit.

24. Reassess the patient frequently.
25. Contact medical direction for additional instructions.

NEWBORN RESUSCITATION

This protocol describes procedures for the resuscitation of a newly delivered infant.

1. Ensure scene safety.
2. Perform a scene survey to assess environmental conditions.
3. Observe standard precautions.
4. Suction the infant's airway using a bulb syringe as soon as the infant's head is delivered and before delivery of the body. Suction the mouth first, then the nasopharynx.
5. Once the body is fully delivered, dry the baby, replace wet towels with dry ones, and wrap the baby in a thermal blanket or dry towel. Cover the infant's scalp to preserve warmth.
6. Open and position the airway. Suction the infant's airway again using a bulb syringe. Suction the mouth first, then the nasopharynx.
7. If thick meconium is present, initiate endotracheal intubation before the infant takes a first breath. Suction the airway using an appropriate suction adapter while withdrawing the endotracheal tube. Repeat this procedure until the endotracheal tube is clear of meconium. If the infant's heart rate slows, discontinue suctioning immediately and provide ventilation until the infant recovers. Note: If the infant is already breathing or crying, this step may be omitted.
8. Assess breathing and adequacy of ventilation.
9. If ventilation is inadequate, stimulate the infant by gently rubbing the back and flicking the soles of the feet.
10. If ventilation is still inadequate after brief stimulation, begin assisted ventilation at 40 to 60 breaths per minute using a bag-valve-mask device with high-flow, 100% concentration oxygen.
11. If ventilation is adequate and the infant displays central cyanosis, administer high-flow, 100% concentration oxygen via blow-by. Hold the tubing 1 to 1-1/2 inches from the infant's mouth and nose and cup a hand around the end of the tubing to help direct the oxygen flow toward the infant's face.
12. Assess heart rate by auscultation or by palpation of the umbilical cord stump.

13. If the heart rate is slower than 60 beats per minute after 30 seconds of assisted ventilation with high-flow, 100% concentration oxygen, initiate the following actions:
 - Continue assisted ventilation.
 - Begin chest compressions at a combined rate of 120/minute (three compressions to each ventilation).
 - If there is no improvement in heart rate after 30 seconds, perform endotracheal intubation.
 - If there is no improvement in heart rate after intubation and ventilation, administer 1:10,000 epinephrine solution at 0.01 mg/kg (maximum individual dose 1.0 mg) via endotracheal tube, or establish vascular access and administer the same dose. In the neonate, vascular access may be obtained intraosseously, intravenously, or through the umbilical vein (if regional medical direction permits). Repeat epinephrine at the same dose every 3 to 5 minutes as needed.
 - Initiate transport. Reassess heart rate and respirations en route.
14. If the heart rate is between 60 and 80 beats per minute, initiate the following actions:
 - Continue assisted ventilation with high-flow, 100% concentration oxygen.
 - If there is no improvement in heart rate after 30 seconds, initiate management sequence described in step 13, beginning with chest compressions.
 - Initiate transport. Reassess heart rate and respirations en route.
15. If the heart rate is between 80 and 100 beats per minute, initiate the following actions:
 - Continue assisted ventilation with high-flow, 100% concentration oxygen.
 - Stimulate as previously described.
 - Initiate transport. Reassess heart rate after 15 to 30 seconds.
16. If the heart rate is faster than 100 beats per minute, initiate the following actions:
 - Assess skin color. If central cyanosis is still present, continue blow-by oxygen.
 - Initiate transport. Reassess heart rate and respirations en route.
17. Reassess the patient frequently.
18. Contact medical direction for additional instructions.

BRADYCARDIA

Bradycardia generally arises due to hypoxia. Therefore, airway, ventilation, and oxygenation are the highest management priorities. The cause of the hypoxia should be identified and corrected.

Definition

Severe cardiopulmonary compromise is indicated by

- poor perfusion as evidenced by delayed capillary refill, weak or absent peripheral pulses, or altered mental status
- hypotension
- respiratory difficulty

Procedure

1. Ensure scene safety.
2. Perform a scene survey to assess environmental conditions and mechanism of illness or injury.
3. Form a general impression of the patient's condition.
4. Observe standard precautions.
5. Establish patient responsiveness. If cervical spine trauma is suspected, manually stabilize the spine.
6. Assess the patient's airway for patency, protective reflexes and the possible need for advanced airway management. Look for signs of airway obstruction.
7. Open the airway using head tilt/chin lift if no spinal trauma is suspected, or modified jaw thrust if spinal trauma is suspected.
8. Suction as necessary.
9. Consider placing an oropharyngeal or nasopharyngeal airway adjunct if the airway cannot be maintained with positioning and the patient is unconscious.
10. Assess breathing. Obtain pulse oximeter reading.
11. If breathing is inadequate, assist ventilation using a bag-valve-mask device with high-flow, 100% concentration oxygen. If abdominal distention arises, consider placing a nasogastric tube to decompress the stomach.

12. If the airway cannot be maintained by other means, including attempts at assisted ventilation, or if prolonged assisted ventilation is anticipated, perform endotracheal intubation. Consider administration of pharmacological adjuncts, such as sedatives and paralytic agents, to aid with intubation as permitted by regional medical direction. Confirm placement of endotracheal tube using clinical assessment and end-tidal CO₂ monitoring as per regional medical direction.
13. If breathing is adequate, place the child in a position of comfort and administer high-flow, 100% concentration oxygen as necessary. Use a nonrebreather mask or blow-by as tolerated.
14. Assess circulation and perfusion.
15. Initiate cardiac monitoring and determine rhythm.
16. If signs of severe cardiopulmonary compromise are present in an infant or neonate and the heart rate remains slower than 60 beats per minute despite oxygenation and ventilation, initiate chest compressions.
17. If the patient shows signs of severe cardiopulmonary compromise, establish vascular access and administering normal saline at a sufficient rate to keep the vein open. If intravenous access cannot be obtained in a child younger than six years, proceed with intraosseous access. Do not delay transport to obtain vascular access.
18. Check blood glucose.
19. If signs of severe cardiopulmonary compromise persist, administer epinephrine using the first available route as follows: 1:1000 solution at 0.1 mg/kg (maximum individual dose 10 mg) via endotracheal tube *or* 1:10,000 solution at 0.01 mg/kg (maximum individual dose 1.0 mg) via intravenous or intraosseous route. Repeat the dose every 3 to 5 minutes until either the bradycardia or severe cardiopulmonary compromise resolves.
20. If signs of severe cardiopulmonary compromise and bradycardia persist despite epinephrine, administer atropine at 0.02 mg/kg via intravenous route, intraosseous route, or endotracheal tube. The minimum dose is 0.1 mg; the maximum individual dose is 0.5 mg for a child and 1.0 mg for an adolescent. Atropine may be repeated once after 3 to 5 minutes.
21. For persistent bradycardia with severe cardiopulmonary compromise, consider external pacing as permitted by regional medical direction.
22. Assess mental status.
23. Expose the child only as necessary to perform further assessments. Maintain the child's body temperature throughout the examination.
24. If the child's condition is critical or unstable, initiate transport. Perform focused history and detailed physical examination en route to the hospital if patient status and management of resources permit.
25. If the child's condition is stable, perform focused history and detailed physical examination on the scene, then initiate transport.

26. Reassess the patient frequently.

27. Contact medical direction for additional instructions, including

- initiation of external pacing
- repeated administration of epinephrine
- repeated administration of atropine

TACHYCARDIA

Definitions

Severe cardiopulmonary compromise is indicated by

- poor perfusion as evidenced by delayed capillary refill, weak or absent peripheral pulses, or altered mental status
- hypotension
- respiratory difficulty

The three types of tachycardia may be distinguished by the following signs:

Sinus tachycardia is usually present when

- An infant exhibits tachycardia in which the heart rate is slower than 220 beats per minute or a child exhibits tachycardia in which the heart rate is slower than 180 beats per minute
- There is a normal QRS duration for age (less than or equal to 0.08 seconds)
- Normal P waves are present, the R-R interval is variable, and the P-R interval is constant

Supraventricular tachycardia is usually present when

- An infant exhibits tachycardia in which the heart rate is faster than 220 beats per minute or a child exhibits tachycardia in which the heart rate is faster than 180 beats per minute
- There is a normal QRS duration for age (less than or equal to 0.08 seconds)
- P waves are abnormal or absent

Presumptive ventricular tachycardia is present when

- The QRS duration is wide for age (greater than 0.08 seconds)

Procedure

1. Ensure scene safety.
2. Perform a scene survey to assess environmental conditions and mechanism of illness or injury.
3. Form a general impression of the patient's condition.
4. Observe standard precautions.
5. Establish patient responsiveness. If cervical spine trauma is suspected, manually stabilize the spine.
6. Assess the patient's airway for patency, protective reflexes and the possible need for advanced airway management. Look for signs of airway obstruction.
7. Open the airway using head tilt/chin lift if no spinal trauma is suspected, or modified jaw thrust if spinal trauma is suspected.
8. Suction as necessary.

9. Consider placing an oropharyngeal or nasopharyngeal airway adjunct if the airway cannot be maintained with positioning and the patient is unconscious.
10. Assess breathing. Obtain pulse oximeter reading.
11. If breathing is inadequate, assist ventilation using a bag-valve-mask device with high-flow, 100% concentration oxygen. If abdominal distention arises, consider placing a nasogastric tube to decompress the stomach.
12. If the airway cannot be maintained by other means, including attempts at assisted ventilation, or if prolonged assisted ventilation is anticipated, perform endotracheal intubation. Consider administration of pharmacological adjuncts, such as sedatives and paralytic agents, to aid with intubation as permitted by regional medical direction. Confirm placement of endotracheal tube using clinical assessment and end-tidal CO₂ monitoring as per regional medical direction.
13. If breathing is adequate, place the child in a position of comfort and administer high-flow, 100% concentration oxygen as necessary. Use a nonrebreather mask or blow-by as tolerated.
14. Assess circulation and perfusion.
15. Initiate cardiac monitoring and determine rhythm.
16. Establish vascular access and administering normal saline at a sufficient rate to keep the vein open. If intravenous access cannot be obtained in a child younger than six years and the patient shows signs of severe cardiopulmonary compromise, proceed with intraosseous access. Do not delay transport to obtain vascular access.
17. Check blood glucose.
18. For probable sinus tachycardia, identify and treat possible causes, such as hypovolemia, shock, hypoxia, or pneumothorax.
19. For probable supraventricular tachycardia with signs of severe cardiopulmonary compromise, the following steps should be taken:
 - If vascular access is readily available, administer adenosine at 0.1 mg/kg (maximum individual dose 6.0 mg) via rapid IV bolus at the port closest to IV hub. Adenosine may be repeated twice at 0.2 mg/kg (maximum individual dose 12 mg) as needed.
 - Perform synchronized cardioversion at 0.5 to 1.0 J/kg. If the patient remains in supraventricular tachycardia, repeat cardioversion at double the energy. Sedate the patient before cardioversion as permitted by regional medical direction. Sedation may be accomplished by administering midazolam at 0.1 mg/kg (maximum individual dose 2.0 mg) or diazepam at 0.2 mg/kg (maximum individual dose 5.0 mg) via intravenous route.
20. For probable ventricular tachycardia with a pulse, the following steps should be taken:
 - If vascular access is readily available *or* if the patient has adequate perfusion, first

administer lidocaine at 1.0 mg/kg via intravenous route. This dose may be repeated twice as necessary to a maximum total dose of 3.0 mg/kg. Note: If vascular access is not readily available and patient is poorly perfused, go directly to cardioversion.

- Perform synchronized cardioversion at 0.5 to 1.0 J/kg. If the patient remains in ventricular tachycardia with a pulse, repeat cardioversion at double the energy. Sedate the patient before cardioversion as permitted by regional medical direction. Sedation may be accomplished by administering midazolam at 0.1 mg/kg (maximum individual dose 2.0 mg) or diazepam at 0.2 mg/kg (maximum individual dose 5.0 mg) via intravenous route.
- If rhythm is converted successfully, start lidocaine infusion at 20 to 50 mcg/kg/min.

21. Assess mental status.
22. Expose the child only as necessary to perform further assessments. Maintain the child's body temperature throughout the examination.
23. If the child's condition is critical or unstable, initiate transport. Perform focused history and detailed physical examination en route to the hospital if patient status and management of resources permit.
24. If the child's condition is stable, perform focused history and detailed physical examination on the scene, then initiate transport.
25. Reassess the patient frequently.
26. Contact medical direction for additional instructions

NON-TRAUMATIC CARDIAC ARREST

1. Ensure scene safety.
2. Perform a scene survey to assess environmental conditions and mechanism of illness or injury.
3. Form a general impression of the patient's condition.
4. Observe standard precautions.
5. Establish patient responsiveness. If cervical spine trauma is suspected, manually stabilize the spine.
6. Confirm apnea and provide assisted ventilation using a bag-valve-mask device with high-flow, 100% concentration oxygen. If abdominal distention arises, consider placing a nasogastric tube to decompress the stomach.
7. Confirm absent pulse and begin chest compressions at age-appropriate rate and ratio.
8. Perform endotracheal intubation.
9. Obtain vascular access. If intravenous access cannot be obtained in a child younger than six years, proceed with intraosseous access.
10. Initiate cardiac monitoring and determine rhythm.
11. Refer to appropriate protocol for further management actions:
 - Ventricular Fibrillation/Pulseless Ventricular Tachycardia
 - Asystole
 - Pulseless Electrical Activity

VENTRICULAR FIBRILLATION OR PULSELESS VENTRICULAR TACHYCARDIA

Throughout the following resuscitation sequence, check pulses and cardiac rhythm after each shock and drug administration.

1. Perform steps 1 through 11 as listed in the protocol for non-traumatic cardiac arrest. Confirm the presence of ventricular fibrillation (VF) or pulseless ventricular tachycardia (VT).
2. Defibrillate at 2.0 J/kg (maximum 200 joules).
3. Defibrillate at 4.0 J/kg (maximum 360 joules).
4. Defibrillate at 4.0 J/kg (maximum 360 joules).
5. Using the most readily available route, administer epinephrine 1:1000 solution at 0.1 mg/kg (maximum individual dose 10 mg) via endotracheal tube *or* 1:10,000 solution at 0.01 mg/kg (maximum individual dose 1.0 mg) via intravenous or intraosseous route. Subsequent doses of epinephrine 1:1000 solution should be administered every 3 to 5 minutes at 0.1 mg/kg via ET, IV, or IO for the duration of resuscitation.
6. Flush the medication port with 10 to 20 ml of intravenous fluid after each dose of IV medication to aid entry of drugs into central circulation.
7. Defibrillate at 4.0 J/kg (maximum 360 joules) 30 to 60 seconds after each medication bolus.
8. Administer lidocaine at 1.0 mg/kg via intravenous route. This step is necessary even if a perfusing rhythm has been reestablished. If defibrillation is unsuccessful, the same dose of lidocaine may be repeated in 5 minutes to a maximum total dose of 3.0 mg/kg.
9. Defibrillate at 4.0 J/kg (maximum 360 joules).
10. Consider administering bretylium at 5.0 mg/kg via intravenous route. Bretylium may be repeated at 10 mg/kg up to two times. The maximum total dose should not exceed 30 mg/kg.
11. Defibrillate at 4.0 J/kg (maximum 360 joules).
12. If VF or pulseless VT recurs after successful defibrillation, repeat defibrillation using the last energy level that restored perfusing rhythm.
13. Contact medical direction for additional instructions.
14. Initiate transport.
15. Assess mental status.
16. Expose the child only as necessary to perform further assessments. Maintain the child's body temperature throughout the examination.

17. Perform focused history and detailed physical examination en route to the hospital if patient status and management of resources permit.
18. Reassess the patient frequently.

ASYSTOLE

Potentially treatable causes of asystole include severe hypoxemia, severe acidosis, severe hypovolemia, tension pneumothorax, cardiac tamponade, profound hypothermia, toxic ingestion, severe bradycardia, and hyperkalemia (renal failure).

1. Perform steps 1 through 11 as listed in the protocol for non-traumatic cardiac arrest. Confirm the presence of asystole in two leads.
2. Using the most readily available route, administer epinephrine 1:1000 solution at 0.1 mg/kg (maximum individual dose 10 mg) via endotracheal tube *or* 1:10,000 solution at 0.01 mg/kg (maximum individual dose 1.0 mg) via intravenous or intraosseous route.
3. Repeat epinephrine 1:1000 solution every 3 to 5 minutes at 0.1 mg/kg via ET, IV, or IO. Consider increasing subsequent doses to 0.2 mg/kg via ET, IV, or IO. Note: If vascular access is obtained after giving an initial dose of epinephrine via endotracheal tube, give the second dose intravenously 3 to 5 minutes after the endotracheal dose.
4. Flush the medication port with 10 to 20 ml of intravenous fluid after each dose of IV medication to aid entry of drugs into central circulation.
5. Contact medical direction for additional instructions.
6. Initiate transport.
7. Assess mental status.
8. Expose the child only as necessary to perform further assessments. Maintain the child's body temperature throughout the examination.
9. Perform focused history and detailed physical examination en route to the hospital if patient status and management of resources permit.
10. Asystole that does not respond to the above treatment sequence may be considered refractory. It may be appropriate to discontinue resuscitative efforts in refractory asystole as permitted by regional medical direction.
11. Reassess the patient frequently.

PULSELESS ELECTRICAL ACTIVITY

Potentially treatable causes of PEA include severe hypoxemia, severe acidosis, severe hypovolemia, tension pneumothorax, cardiac tamponade, profound hypothermia, toxic ingestion, severe bradycardia, and hyperkalemia (renal failure).

Definition

Pulseless electrical activity (PEA) appears upon cardiac monitoring as absent pulses with organized QRS complexes. The following dysrhythmias may present as PEA:

- electromechanical dissociation (EMD)
- pseudo-EMD
- idioventricular rhythms
- ventricular escape rhythms
- bradysystolic rhythms
- post-defibrillation idioventricular rhythms

Procedure

1. Perform steps 1 through 11 as listed in the protocol for non-traumatic cardiac arrest. Confirm the presence of PEA.
2. Using the most readily available route, administer epinephrine 1:1000 solution at 0.1 mg/kg (maximum individual dose 10 mg) via endotracheal tube *or* 1:10,000 solution at 0.01 mg/kg (maximum individual dose 1.0 mg) via intravenous or intraosseous route.
3. Repeat epinephrine 1:1000 solution every 3 to 5 minutes at 0.1 mg/kg via ET, IV, or IO. Consider increasing subsequent doses to 0.2 mg/kg via ET, IV, or IO. Note: If vascular access is obtained after giving an initial dose of epinephrine via endotracheal tube, give the second dose intravenously 3 to 5 minutes after the endotracheal dose.
4. Flush the medication port with 10 to 20 ml of intravenous fluid after each dose of IV medication to aid entry of drugs into central circulation.
5. Contact medical direction for additional instructions.
6. Initiate transport.
7. Assess mental status.
8. Expose the child only as necessary to perform further assessments. Maintain the child's body temperature throughout the examination.
9. Perform focused history and detailed physical examination en route to the hospital if patient status and management of resources permit.
10. Reassess the patient frequently.

ALTERED MENTAL STATUS

This protocol is intended for patients with an altered mental status of unknown etiology.

1. Ensure scene safety.
2. Perform a scene survey to assess environmental conditions and mechanism of illness or injury.
3. Form a general impression of the patient's condition.
4. Observe standard precautions.
5. Establish patient responsiveness. If cervical spine trauma is suspected, manually stabilize the spine.
6. Assess the patient's airway for patency, protective reflexes and the possible need for advanced airway management. Look for signs of airway obstruction.
7. Open the airway using head tilt/chin lift if no spinal trauma is suspected, or modified jaw thrust if spinal trauma is suspected.
8. Suction as necessary.
9. Consider placing an oropharyngeal or nasopharyngeal airway adjunct if the airway cannot be maintained with positioning and the patient is unconscious.
10. Assess breathing. Obtain pulse oximeter reading.
11. If breathing is inadequate, assist ventilation using a bag-valve-mask device with high-flow, 100% concentration oxygen. If abdominal distention arises, consider placing a nasogastric tube to decompress the stomach.
12. If the airway cannot be maintained by other means, including attempts at assisted ventilation, or if prolonged assisted ventilation is anticipated, perform endotracheal intubation. Consider administration of pharmacological adjuncts, such as lidocaine, sedatives, and paralytic agents, to aid with intubation as permitted by regional medical direction. Confirm placement of endotracheal tube using clinical assessment and end-tidal CO₂ monitoring as per regional medical direction.
13. If breathing is adequate, place the child in a position of comfort and administer high-flow, 100% concentration oxygen as necessary. Use a nonrebreather mask or blow-by as tolerated.
14. If signs of respiratory distress, respiratory failure, or respiratory arrest are present, refer to the appropriate protocol for treatment options.
15. Assess circulation and perfusion.
16. Initiate cardiac monitoring.

17. Obtain vascular access. If intravenous access cannot be obtained in a child younger than six years, proceed with intraosseous access. Determine blood glucose level.
 18. If blood glucose level is lower than 80 mg/dl or cannot be determined, administer dextrose via intravenous or intraosseous route as follows:
 - D₅₀W at 1.0 ml/kg for children older than two years
 - D₂₅W at 2.0 ml/kg for children younger than two years
 - D₁₀W at 5.0 ml/kg for neonates
- If vascular access is unavailable, administer 1.0 mg glucagon via intramuscular injection.
19. Repeat blood glucose determination 1 to 2 minutes after dextrose is administered.
 20. Dextrose may be repeated once at the same dosage if blood glucose level remains lower than 80 mg/dl *or* if the blood glucose level cannot be determined and there is no change in the patient's mental status after the initial dose.
 21. Administer naloxone at 0.1 mg/kg (maximum individual dose 2.0 mg) via intravenous or intraosseous route. Naloxone may be given via endotracheal tube or intramuscular injection at the same dose if vascular access is not available.
 22. If there is evidence of shock or a history of dehydration, administer a fluid bolus of normal saline at 20 ml/kg set to maximum flow rate. Reassess patient after bolus. If signs of shock persist, bolus may be repeated at the same dose up to two times for a maximum total of 60 ml/kg.
 23. Assess mental status.
 24. Expose the child only as necessary to perform further assessments. Maintain the child's body temperature throughout the examination.
 25. If the child's condition is critical or unstable, initiate transport. Perform focused history and detailed physical examination en route to the hospital if patient status and management of resources permit.
 26. If the child's condition is stable, perform focused history and detailed physical examination on the scene, then initiate transport.
 27. Consider causes of altered mental status, such as chemical or drug intoxication, toxic exposure, head trauma, or seizure.
 28. Reassess the patient frequently.
 29. Contact medical direction for additional instructions.

SEIZURES

This protocol is intended for patients who are experiencing status epilepticus. To manage seizures in patients who are not experiencing status epilepticus, contact on-line medical control for instructions.

Definition

In status epilepticus, the patient will be experiencing an active seizure when rescuers arrive, with

- a single episode of seizure activity lasting longer than 5 minutes, *or*
- two or more episodes of seizure activity between which the patient does not regain consciousness

Procedure

1. Ensure scene safety.
2. Perform a scene survey to assess environmental conditions and mechanism of illness or injury.
3. Form a general impression of the patient's condition.
4. Observe standard precautions.
5. Establish patient responsiveness. Protect the patient from injury during involuntary muscular movements.
6. Assess the patient's airway for patency, protective reflexes and the possible need for advanced airway management. Look for signs of airway obstruction.
7. Open the airway using head tilt/chin lift if no spinal trauma is suspected, or modified jaw thrust if spinal trauma is suspected.
8. Suction as necessary.
9. Consider placing an oropharyngeal or nasopharyngeal airway adjunct if the airway cannot be maintained with positioning and the patient is unconscious.
10. Assess breathing. Obtain pulse oximeter reading.
11. If breathing is inadequate, assist ventilation using a bag-valve-mask device with high-flow, 100% concentration oxygen. If abdominal distention arises, consider placing a nasogastric tube to decompress the stomach.

12. If the airway cannot be maintained by other means, including attempts at assisted ventilation, or if prolonged assisted ventilation is anticipated, perform endotracheal intubation. Consider administration of pharmacological adjuncts, such as sedatives and paralytic agents, to aid with intubation as permitted by regional medical direction. The actively seizing patient should not be intubated without the usage of pharmacological agents. Confirm placement of endotracheal tube using clinical assessment and end-tidal CO₂ monitoring as per regional medical direction.
 13. If breathing is adequate, place the child in a position of comfort and administer high-flow, 100% concentration oxygen as necessary. Use a nonrebreather mask or blow-by as tolerated.
 14. Assess circulation and perfusion.
 15. Initiate cardiac monitoring.
 16. Establish vascular access. Administer normal saline at a sufficient rate to keep the vein open.
 17. Determine blood glucose level.
 18. If blood glucose level is lower than 80 mg/dl or cannot be determined, administer intravenous dextrose as follows:
 - D₅₀W at 1.0 ml/kg for children older than two years
 - D₂₅W at 2.0 ml/kg for children younger than two years
 - D₁₀W at 5.0 ml/kg for neonates
- If vascular access is unavailable, administer 1.0 mg glucagon via intramuscular injection.
19. Repeat blood glucose determination 1 to 2 minutes after dextrose is administered.
 20. Dextrose may be repeated once at the same dosage if blood glucose level remains lower than 80 mg/dl *or* if the blood glucose level cannot be determined and the patient is still in status epilepticus after the initial dose.
 21. Administer one of the following anticonvulsants, all intravenous anticonvulsants should be given slowly (over 1-2 minutes) to avoid apnea:
 - Diazepam 0.2 mg/kg (maximum individual dose 10 mg) via intravenous route *or* 0.5 mg/kg (maximum individual dose 10 mg) via rectal route
 - Lorazepam 0.1 mg/kg (maximum individual dose 5.0 mg) via intravenous or intramuscular route
 - Midazolam 0.15 mg/kg (maximum individual dose 5.0 mg) via intravenous or intramuscular route
 - Fosphenytoin 20 phenytoin equivalents/kg (maximum individual dose 1000 phenytoin equivalents) via intravenous or intramuscular route
 22. If seizures persist, repeat any listed anticonvulsant except fosphenytoin at the same dose or contact medical direction for further instructions.
 23. Assess mental status.

24. Expose the child only as necessary to perform further assessments. Maintain the child's body temperature throughout the examination.
25. If the child's condition is critical or unstable, initiate transport. Perform focused history and detailed physical examination en route to the hospital if patient status and management of resources permit.
26. If the child's condition is stable, perform focused history and detailed physical examination on the scene, then initiate transport.
27. Reassess the patient frequently.
28. Contact medical direction for additional instructions.

NON-TRAUMATIC HYPOPERFUSION (SHOCK)

Definition

Shock may be categorized as hypovolemic, distributive, or cardiogenic. Manifestations of shock include

- altered mental status
- tachypnea
- tachycardia
- absent peripheral pulses
- cool, clammy, mottled skin
- capillary refill time longer than 2 seconds
- hypotension and/or bradycardia (late findings)

Procedure

1. Ensure scene safety.
2. Perform a scene survey to assess environmental conditions and mechanism of illness or injury.
3. Form a general impression of the patient's condition.
4. Observe standard precautions.
5. Establish patient responsiveness. If cervical spine trauma is suspected, manually stabilize the spine.
6. Assess the patient's airway for patency, protective reflexes and the possible need for advanced airway management. Look for signs of airway obstruction.
7. Open the airway using head tilt/chin lift if no spinal trauma is suspected, or modified jaw thrust if spinal trauma is suspected.
8. Suction as necessary.
9. Consider placing an oropharyngeal or nasopharyngeal airway adjunct if the airway cannot be maintained with positioning and the patient is unconscious.
10. Assess breathing. Obtain pulse oximeter reading.
11. If breathing is inadequate, assist ventilation using a bag-valve-mask device with high-flow, 100% concentration oxygen. If abdominal distention arises, consider placing a nasogastric tube to decompress the stomach.
12. If breathing is adequate, place the child in a position of comfort and administer high-flow,

100% concentration oxygen as necessary. Use a nonrebreather mask or blow-by as tolerated.

13. If the airway cannot be maintained by other means, including attempts at assisted ventilation, or if prolonged assisted ventilation is anticipated, perform endotracheal intubation. Consider administration of pharmacological adjuncts, such as sedatives and paralytic agents, to aid with intubation as permitted by regional medical direction. Confirm placement of endotracheal tube using clinical assessment and end-tidal CO₂ monitoring as per regional medical direction.
14. Assess circulation and perfusion.
15. Initiate cardiac monitoring.
16. Establish vascular access using an age-appropriate large-bore catheter with large-caliber tubing. If intravenous access cannot be obtained in a child younger than six years, proceed with intraosseous access. Do not delay transport to obtain vascular access.
17. If there is still evidence of shock, administer a fluid bolus of normal saline at 20 ml/kg set to maximum flow rate. Reassess patient after bolus. If signs of shock persist, bolus may be repeated at the same dose up to two times for a maximum total of 60 ml/kg.
18. Assess mental status.
19. Expose the child only as necessary to perform further assessments. Maintain the child's body temperature throughout the examination.
20. Initiate transport. Perform focused history and detailed physical examination en route to the hospital if patient status and management of resources permit.
21. Reassess the patient frequently.
22. Contact medical direction for additional instructions.

ANAPHYLACTIC SHOCK/ALLERGIC REACTION

The following protocol is intended for patients with allergic reaction or anaphylactic shock. For patients with generalized allergic manifestations that do not meet the criteria listed below, contact medical direction prior to treatment.

Definitions

The patient with an allergic reaction will have

- generalized allergic manifestations, such as urticaria (hives)
- a history of allergic exposure

To meet the criteria for anaphylactic shock, the patient must have the findings listed above *plus* one of the following:

- partial or complete airway obstruction
- signs of shock, such as altered mental status, respiratory distress, weak or absent peripheral pulses, cyanosis

Procedure

1. Ensure scene safety.
2. Perform a scene survey to assess environmental conditions and mechanism of illness or injury.
3. Form a general impression of the patient's condition.
4. Observe standard precautions.
5. Establish patient responsiveness. If cervical spine trauma is suspected, manually stabilize the spine.
6. Assess the patient's airway for patency, protective reflexes and the possible need for advanced airway management. Look for signs of airway obstruction.
7. Open the airway using head tilt/chin lift if no spinal trauma is suspected, or modified jaw thrust if spinal trauma is possible.
8. Suction as necessary.
9. Consider placing an oropharyngeal or nasopharyngeal airway adjunct if the airway cannot be maintained with positioning and the patient is unconscious.
10. If patient meets criteria for anaphylactic shock, administer epinephrine 1:1000 solution at 0.01 mg/kg (maximum individual dose 0.3 mg) via subcutaneous injection. Massage the injection site vigorously for 30 to 60 seconds.
11. Assess breathing. Obtain pulse oximeter reading.

12. If breathing is inadequate, assist ventilation using a bag-valve-mask device with high-flow, 100% concentration oxygen. If abdominal distention arises, consider placing a nasogastric tube to decompress the stomach.
13. If the airway cannot be maintained by other means, including attempts at assisted ventilation, or if prolonged assisted ventilation is anticipated, perform endotracheal intubation. Consider administration of pharmacological adjuncts, such as sedatives and paralytic agents, to aid with intubation as permitted by regional medical direction. Confirm placement of endotracheal tube using clinical assessment and end-tidal CO₂ monitoring as per regional medical direction.
14. If breathing is adequate, place the child in a position of comfort and administer high-flow, 100% concentration oxygen as necessary. Use a nonrebreather mask or blow-by as tolerated.
15. If bronchospasm is present in a patient with adequate ventilation, administer 2.5 mg albuterol via nebulizer over a 10- to 15-minute period. If bronchospasm persists, repeat 2.5 mg albuterol via nebulizer at 15-minute intervals throughout transport.
16. Assess circulation and perfusion.
17. Reassess patient for signs of anaphylactic shock. If criteria are still present, repeat epinephrine 1:1000 solution at 0.01 mg/kg (maximum individual dose 0.3 mg) via subcutaneous injection.
18. Initiate cardiac monitoring.
19. If the patient meets criteria for anaphylactic shock, establish vascular access using an age-appropriate large-bore catheter with large-caliber tubing. If intravenous access cannot be obtained in a child younger than six years, proceed with intraosseous access. Do not delay transport to obtain vascular access.
20. If evidence of shock persists, administer a fluid bolus of normal saline at 20 ml/kg set to maximum flow rate. Reassess patient after bolus. If signs of shock persist, bolus may be repeated at the same dose up to two times for a maximum total of 60 ml/kg.
21. Administer diphenhydramine at 1.0 mg/kg (maximum individual dose 50 mg) via intravenous route or deep intramuscular injection.
22. Consider administering steroids (such as methylprednisolone at 1.0 mg/kg) via intravenous route as permitted by regional medical direction.
23. Assess mental status.
24. Expose the child only as necessary to perform further assessments. Maintain the child's body temperature throughout the examination.
25. If the child's condition is critical or unstable, initiate transport. Perform focused history and detailed physical examination en route to the hospital if patient status and management of resources permit.

26. If the child's condition is stable, perform focused history and detailed physical examination on the scene, then initiate transport.
27. Reassess the patient frequently.
28. Contact medical direction for additional instructions.

TOXIC EXPOSURE

1. Ensure scene safety.
2. Perform a scene survey to assess environmental conditions and mechanism of illness or injury. If hazardous conditions are present (such as swift water, hazardous materials, electrical hazard, or confined space), contact an appropriate agency before approaching the patient. Wait for the designated specialist to secure the scene and patient as necessary.
3. Look for the source of the toxic exposure. Collect any containers or medication bottles to transport with the patient to the hospital. Consult a local poison control center as appropriate.
4. Form a general impression of the patient's condition.
5. Observe standard precautions.
6. Establish patient responsiveness. If cervical spine trauma is suspected, manually stabilize the spine.
7. Assess the patient's airway for patency, protective reflexes and the possible need for advanced airway management. Look for signs of airway obstruction.
8. Open the airway using head tilt/chin lift if no spinal trauma is suspected, or modified jaw thrust if spinal trauma is suspected.
9. Suction as necessary.
10. Consider placing an oropharyngeal or nasopharyngeal airway adjunct if the airway cannot be maintained with positioning and the patient is unconscious.
11. Assess breathing. Obtain pulse oximeter reading.
12. If breathing is inadequate, assist ventilation using a bag-valve-mask device with high-flow, 100% concentration oxygen. If abdominal distention arises, consider placing a nasogastric tube to decompress the stomach.
13. If the airway cannot be maintained by other means, including attempts at assisted ventilation, or if prolonged assisted ventilation is anticipated, perform endotracheal intubation. Consider administration of pharmacological adjuncts, such as sedatives and paralytic agents, to aid with intubation as permitted by regional medical direction. Confirm placement of endotracheal tube using clinical assessment and end-tidal CO₂ monitoring as per regional medical direction.
14. If breathing is adequate, place the child in a position of comfort and administer high-flow, 100% concentration oxygen as necessary. Use a nonrebreather mask or blow-by as tolerated.
15. Assess circulation and perfusion.
16. Initiate cardiac monitoring.

17. Obtain vascular access as indicated.
18. If respiratory depression is present and a narcotic overdose is suspected, administer naloxone at 0.1 mg/kg (maximum individual dose 2.0 mg) via intravenous, intraosseous, or intramuscular route.
19. Treatment for other toxic exposures may be instituted as permitted by regional medical direction, including the following:
 - High-dose atropine for organophosphates
 - Sodium bicarbonate for tricyclic antidepressants
 - Glucagon for calcium channel blockers or beta-blockers
 - Diphenhydramine for dystonic reactions
 - Dextrose for insulin overdose

Contact medical direction for specific information about individual toxic exposures and treatments.
20. Assess mental status.
21. Expose the child only as necessary to perform further assessments. Maintain the child's body temperature throughout the examination.
22. If the child's condition is critical or unstable, initiate transport. Perform focused history and detailed physical examination en route to the hospital if patient status and management of resources permit.
23. If the child's condition is stable, perform focused history and detailed physical examination on the scene, then initiate transport.
24. Reassess the patient frequently.
25. Contact medical direction for additional instructions.

NEAR-DROWNING

Hypothermia may offer some degree of cerebral protection in a near-drowning incident, but it also increases cardiac irritability. Refractory dysrhythmias may arise during assessment and treatment. Contact medical direction as early as possible.

1. Ensure scene safety.
2. Perform a scene survey to assess environmental conditions and mechanism of illness or injury. If hazardous conditions are present (such as swift water, hazardous materials, electrical hazard, or confined space), contact an appropriate agency before approaching the patient. Wait for the designated specialist to secure the scene and patient as necessary.
3. Form a general impression of the patient's condition.
4. Observe standard precautions.
5. Establish patient responsiveness. If cervical spine trauma is suspected, manually stabilize the spine.
6. Assess the patient's airway for patency, protective reflexes and the possible need for advanced airway management. Look for signs of airway obstruction.
7. Open the airway using head tilt/chin lift if no spinal trauma is suspected, or modified jaw thrust if spinal trauma is suspected.
8. Suction as necessary.
9. Consider placing an oropharyngeal or nasopharyngeal airway adjunct if the airway cannot be maintained with positioning and the patient is unconscious.
10. Assess breathing. Obtain pulse oximeter reading.
11. If breathing is inadequate, assist ventilation using a bag-valve-mask device with high-flow, 100% concentration oxygen. If abdominal distention arises, consider placing a nasogastric tube to decompress the stomach.
12. If the airway cannot be maintained by other means, including attempts at assisted ventilation, or if prolonged assisted ventilation is anticipated, perform endotracheal intubation. Consider administration of pharmacological adjuncts, such as sedatives and paralytic agents, to aid with intubation as permitted by regional medical direction. Confirm placement of endotracheal tube using clinical assessment and end-tidal CO₂ monitoring as per regional medical direction.
13. If breathing is adequate, place the child in a position of comfort and administer high-flow, 100% concentration oxygen as necessary. Use a nonrebreather mask or blow-by as tolerated.
14. Assess circulation and perfusion.

15. Initiate cardiac monitoring and determine rhythm. Consult the appropriate protocol for treatment of specific dysrhythmias.
16. Obtain vascular access. Administer normal saline at a sufficient rate to keep the vein open.
17. Assess mental status.
18. If spinal trauma is suspected, continue manual stabilization, apply a rigid cervical collar, and immobilize the patient on a long backboard or similar device.
19. Expose the child only as necessary to perform further assessments. Maintain the child's body temperature throughout the examination.
20. If the child's condition is critical or unstable, initiate transport as quickly as possible. Perform focused history and detailed physical examination en route to the hospital if patient status and management of resources permit.
21. If the child's condition is stable, perform focused history and detailed physical examination on the scene, then initiate transport.
22. Reassess patient frequently.
23. Contact medical direction for additional instructions.

PAIN MANAGEMENT

This protocol is intended for patients who require pain management in addition to other clinical interventions. Pain medication often causes sedation and affects a patient's mental status. As a result analgesia should not be administered in a patient with head trauma.

1. Ensure scene safety.
2. Perform a scene survey to assess environmental conditions and mechanism of illness or injury.
3. Form a general impression of the patient's condition.
4. Observe standard precautions.
5. Establish patient responsiveness. If cervical spine trauma is suspected, manually stabilize the spine.
6. Assess the patient's airway for patency, protective reflexes and the possible need for advanced airway management. Look for signs of airway obstruction.
7. Open the airway using head tilt/chin lift if no spinal trauma is suspected, or modified jaw thrust if spinal trauma is suspected.
8. Suction as necessary.
9. Consider placing an oropharyngeal or nasopharyngeal airway adjunct if the airway cannot be maintained with positioning and the patient is unconscious.
10. If the airway cannot be maintained by other means, including attempts at assisted ventilation, or if prolonged assisted ventilation is anticipated, perform endotracheal intubation. Consider administration of pharmacological adjuncts, such as sedatives and paralytic agents, to aid with intubation as permitted by regional medical direction. Confirm placement of endotracheal tube using clinical assessment and end-tidal CO₂ monitoring as per regional medical direction.
11. Assess breathing. Carefully note adequacy of ventilation. Obtain pulse oximeter reading.
12. If breathing is inadequate, assist ventilation using a bag-valve-mask device with high-flow, 100% concentration oxygen. If abdominal distention arises, consider placing a nasogastric tube to decompress the stomach.
13. If breathing is adequate, place the child in a position of comfort and administer high-flow, 100% concentration oxygen as necessary. Use a nonrebreather mask or blow-by as tolerated.
14. Assess circulation and perfusion. Obtain baseline blood pressure.
15. Obtain vascular access. Administer normal saline at a sufficient rate to keep the vein open.

16. Assess mental status.
17. Expose the child only as necessary to perform further assessments. Maintain the child's body temperature throughout the examination.
18. If the child's condition is critical or unstable, initiate transport. Perform focused history and detailed physical examination en route to the hospital if patient status and management of resources permit.
19. If the child's condition is stable, perform focused history and detailed physical examination on the scene, then initiate transport.
20. Assess the patient's pain using a numerical scale or visual analogue scale as appropriate to child's abilities.
21. Administer one of the following analgesic agents:
 - Morphine: 0.1 mg/kg (maximum individual dose 10 mg) via intravenous or subcutaneous route
 - Fentanyl: 1.0 mcg/kg (maximum individual dose 100 mcg) via intravenous route
 - Nitrous oxide
22. After drug administration, reassess the patient using the appropriate pain scale. Carefully note adequacy of ventilation and perfusion.
23. Reassess the patient frequently.
24. Contact medical direction for further instructions.

DEATH OF A CHILD AND SUDDEN INFANT DEATH SYNDROME (SIDS)

*There is no normal parental reaction to the death of a child or a SIDS event. Individual responses may range from emotional outbursts to apparent withdrawal. **Rescuers should not make any assumptions or judgments.** Maintain a professional demeanor at all times. Perform the initial assessment, environmental assessment, and focused history as part of the clinical process. Observe, assess, and document accurately and objectively.*

1. Ensure scene safety.
2. Perform a scene survey to assess environmental conditions and mechanism of illness or injury.
3. Form a general impression of the patient's condition.
4. Observe standard precautions.
5. Establish patient responsiveness.
6. Assess airway and breathing. Confirm apnea.
7. Assess circulation and perfusion.
8. Initiate cardiac monitoring. Confirm absent pulse.
9. Determine whether to perform further resuscitation measures:
 - If patient does not exhibit lividity or rigor, proceed with cardiopulmonary resuscitation as permitted by regional medical direction, following the protocol for non-traumatic cardiac arrest. During resuscitation, perform steps 11 and 12 below. Initiate transport.
 - If patient exhibits lividity and rigor, do not resuscitate as permitted by regional medical direction. Proceed with step 10. Note: Lividity can be mistaken for bruising and evidence of abuse. **Do not make any assumptions or judgments.**
10. Provide supportive measures for parents and siblings:
 - Explain the resuscitation process, transport decision, and further actions to be taken by hospital personnel or the medical examiner.
 - Reassure parents that there was nothing they could have done to prevent death.
 - Allow the parents to see the child and say goodbye.
 - Maintain a supportive, professional attitude no matter how the parents react.
 - Whenever possible, be responsive to parental requests. Be sensitive to ethnic and religious needs or responses and make allowances for them.

11. Obtain patient history using a nonjudgmental approach. Ask open-ended questions as follows:

- Has the child been sick?
- Can you describe what happened?
- Who found the child? Where?
- What actions were taken after the child was discovered?
- Has the child been moved?
- When was the child last seen before this occurred, and by whom?
- How did the child seem when last seen?
- When was the last feeding provided?

12. Reassess the environment. Document findings, noting the following:

- Where the child was located upon arrival
- Description of objects located near the child upon arrival
- Unusual environmental conditions, such as a high temperature in the room, abnormal odors, or other significant findings

13. If the parents interfere with treatment or attempt to alter the scene, initiate the following actions:

- Remain supportive, sympathetic, and professional
- Avoid arguing with the parents or exhibiting anger
- Do not restrain the parents or request that they be restrained unless scene safety is clearly threatened

14. Document the emergency call, including the following information:

- Time of arrival
- Initial assessment findings and basis for resuscitation decision
- Time of resuscitation decision
- Time of arrival at hospital if resuscitation and transport were initiated
- Parental support measures provided if resuscitation was not initiated
- History obtained (note who provided the information)
- Environmental conditions
- Time law enforcement personnel arrived on scene
- Time that scene responsibility was turned over to law enforcement personnel