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SAINT JAMES - JOHN W. ALBRECHT
MEDICAL CENTER

EMS System



Pediatric Pre-hospital Care Manual

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Updated July 2016 – Dr. Neal Rushforth, Medical Director

**ILS/ALS providers
should use the
HandTevy System
for Pediatric calls.**

*****If uncertain, revert to weight based protocols.*****

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Pediatric Assessment Process and Management

A patient **the age of fifteen (15) and under** is considered to be a pediatric patient. Utilization of pediatric treatment guidelines and the extent of care rendered is based on the general impression of the pediatric patient's condition, physical examination findings and the history of the event. *Patients 16 years or older will treated with adult protocols.*

The goal of the pediatric patient assessment process is similar to that of the adult patient. However, children are **not** "little adults". The causes of catastrophic events, such as cardiac arrest, are most often related to respiratory failure, shock or central nervous system injuries. Early recognition and treatment of the pediatric patient's injuries or illness is important to ensure the best outcome.

Special attention and awareness must be given to the pediatric patient's exceptional ability to compensate for respiratory failure and shock. Vital signs are valuable in the assessment of the pediatric patient but do have significant limitations and can be dangerously misleading. For example, hypotension is a late and often sudden sign of cardiovascular decompensation. Tachycardia (which varies by age group) will persist until cardiac reserve is depleted. Bradycardia is an ominous sign of impending cardiac arrest.

Infants and children are able to maintain their blood pressure by increasing peripheral vascular resistance (shunting) and heart rate. **The pediatric patient can be in compensated shock and exhibit a normal blood pressure and skin condition.** This increases the importance of the EMS provider's understanding of pediatric vital signs and behavior patterns.

The EMS provider must establish a general impression of the pediatric patient. This impression, which is critical, should be done from the doorway of the room. Therefore, the pediatric patient will not be disturbed by a "hands-on" assessment. A simple question to ask yourself is, "How sick is this child?"

Three (3) key areas of importance of a general impression are:

- 1. Appearance**
- 2. Work of breathing**
- 3. Circulation to skin**

The three components are known as the *Pediatric Assessment Triangle (PAT)* established by the American Academy of Pediatrics (2000).

Pediatric Assessment Process and Management

Pediatric Assessment Triangle (PAT)

Appearance

The appearance of the pediatric patient should be assessed from the doorway. This is the most important aspect to consider when determining how sick or injured the child is. *Appearance* will give the EMS provider insight on oxygenation, neurological status and ventilation. Remember, the sick child may be alert on the conventional AVPU scale, but still have an abnormal appearance. Children need a more subtle assessment tool so that life-threatening injuries can be identified earlier. A good mnemonic to remember when assessing appearance is “tickles” (TICLS):

<i>Characteristic</i>	<i>Features to look for:</i>
Tone	Is he/she moving or resisting examination vigorously? Does he/she have good muscle tone? Or, is he/she limp, listless or flaccid?
Interactiveness	How alert is the child? How readily does a person, object, or sound distract him/her or draw his/her attention? Will he/she reach for, grasp and play with a toy or exam instrument such as a penlight or tongue blade? Or, is he/she uninterested in playing or interacting with the caregiver or prehospital professional?
Consolability	Can he/she be consoled or comforted by the caregiver or by the prehospital professional? Or, is his/her crying or agitation unrelieved by gentle assurance?
Look/Gaze	Does he/she fix his/her gaze on a face? Or, is there a “nobody home,” glassy-eyed stare?
Speech/Cry	Is his/her cry strong and spontaneous, or weak or high-pitched? Is the content of speech age-appropriate, or confused or garbled?

The *TICLS* Mnemonic (PEPP/AAP 2nd Edition 2006)

Pediatric Assessment Process and Management

Pediatric Assessment Triangle (PAT)

Work of Breathing

Assessing work of breathing must go beyond the rate and quality of respirations that is used for adult patients. Work of breathing is an accurate indicator of the oxygenation and ventilation status of the pediatric patient. This is another “hands off” evaluation method in order to avoid disturbing the pediatric patient and causing anymore respiratory distress (other than what is already present).

<i>Characteristic</i>	<i>Features to look for:</i>
Abnormal Airway Sounds	Snoring, muffled or hoarse speech; stridor; grunting; wheezing
Abnormal Positioning	Sniffing position, tripodding, refusing to lie down
Retractions	Supraclavicular, intercostal, or substernal retractions of the chest wall; “head bobbing” in infants
Flaring	Flaring of the nares on inspiration

Characteristics of Work of Breathing (PEPP/AAP 2nd Edition 2006)

Pediatric Assessment Process and Management

Pediatric Assessment Triangle (PAT)

Circulation to Skin

A rapid circulatory assessment is needed to determine the perfusion status of the pediatric patient. The key is to assess the core perfusion status of the child. Assessing the skin and mucous membranes can do this. Circulation to the skin reflects the overall status of core circulation.

<i>Characteristic</i>	<i>Features to look for:</i>
Pallor	White or pale skin/mucous membrane coloration from inadequate blood flow
Mottling	Patchy skin discoloration due to vasoconstriction/vasodilation
Cyanosis	Bluish discoloration of skin and mucous membranes

Characteristics of Circulation to Skin (PEPP/AAP 2nd Edition 2006)

Pediatric Assessment Process and Management

Pediatric Assessment Triangle (PAT)

Putting it all Together

The goal of pediatric patient care is to identify patients in shock or at risk of shock, initiating care that will directly assist maintaining the patient's perfusion and safely transporting the patient to an emergency department or trauma center in a timely manner. The benefit of remaining on scene to establish specific treatments versus prompt transport to a definitive care facility should be a consideration of each patient contact. Requesting advanced assistance is another important resource that BLS & ILS providers should consider.

Notes on Pediatric Shock:

<i>Mechanism</i>	<i>Medical</i>	<i>Traumatic</i>
Hypovolemia	Blood Loss – Internal Bleeding Fluid Loss – Dehydration	Blood Loss – Trauma Fluid Loss – Burns
Cardiogenic (Pump Failure)	Respiratory Failure Airway Obstruction Dysrhythmia	Chest Trauma Pneumothorax Pericardial Tamponade
Vessel Failure	Sepsis Anaphylaxis Chemical/Poisoning Endocrine Dysfunction	Spinal Cord Injury (Neurogenic)

****** ILS/ALS Units should defer to the Handtevy system guide for Medication dosages as they are aligned with system Protocols.**

Pediatric Assessment Process and Management

Pediatric Age Definitions & Assessment Considerations

Neonate (0-1 Month):

- Utilization of APGAR Scoring is helpful in assessing the neonate patient.

Infant (1-12 Months):

- Approach the infant slowly and calmly. Fast motion and loud noises may startle or agitate the infant.
- Use warm hands and assessment tools.
- Avoid doing anything potentially painful or distressing until after the assessment is completed.
- Have the caregiver assist in care – this is less threatening to the infant.
- Children over six (6) months of age are usually best examined in the arms of a parent. “Stranger anxiety” may be present and could eliminate other assessment options.
- If needed, calm the infant with a pacifier, blanket or favorite toy.

Toddler (1-3 Years):

- Approach the toddler slowly. Keep physical contact at a minimum until he/she feels familiar with you.
- Perform the assessment at the level of the toddler by sitting or squatting next to them and **allow the toddler to remain in the caregiver’s lap** whenever possible.
- Assessment should be **toe to head**. This is less threatening to the toddler.
- Give limited choices such as “Do you want me to listen to your chest or feel your wrist first?”

Pediatric Assessment Process and Management

Pediatric Age Definitions & Assessment Considerations

Toddler (1-3 Years) {Continued}:

- Use simple, concrete terms and continually reassure the toddler.
- Do not expect the toddler to sit still and cooperate – be flexible.

Preschooler (3-5 Years):

- A preschool aged child is a “magical thinker.” Concrete concepts must be described in short, simple terms.
- A preschooler is often very cooperative during the assessment process and may be able to provide a history.
- Questions should be simple and direct.
- Allow the child to handle equipment.
- Use distractions.
- **Do not lie to the child. If the procedure is going to hurt, tell them.**
- Set limits on behavior (*e.g.* “You can cry or scream, but don’t bite or kick.”).
- Focus on one thing at a time.
- Play games with immobilized preschoolers to distract him/her and prevent them from squirming.

Pediatric Assessment Process and Management

Pediatric Age Definitions & Assessment Considerations

School Age (5-13 Years):

- The school aged child is usually cooperative and can be the primary sources for the patient history.
- Explain all procedures simply and completely and respect the patient's modesty.
- Substance abuse issues may be present in this age group and should be considered during the care of altered level of consciousness cases.
- Children at this age are afraid of losing control, so let him/her be involved in the care. However, do not negotiate patient care unless the child really has a choice.
- Reassure the child that being ill or injured is not a punishment and praise them for cooperating.

Adolescent (13-16 Years):

- **The adolescent is more of an adult than a child and should be treated as such.** Depending on the nature of the problem, an accurate history may not be possible with parents observing. It may be necessary to separate the parent and child during the assessment.
- Regardless of who is present, respect the patient's modesty. Avoid exposing the adolescent unnecessarily.
- Explain what you are doing and *why* you are doing it!
- Show respect – speak to the adolescent directly. Do not turn to the caregiver for the initial information.

Pediatric Assessment Process and Management

Assessment of the Pediatric Patient

1. Scene Size-Up

- Identify possible hazards and initiate appropriate proper BSI
- Note anything suspicious at the scene (*e.g.* medications, household chemicals, other ill family members, etc.).
- Assess for any discrepancies between the history and the patient presentation (*e.g.* infant fell on hard floor but there is carpet throughout the house).

2. General Approach to the Stable/Conscious Pediatric Patient

- Utilize the *PAT (Pediatric Assessment Triangle)* to gain a general impression of the child.
- Assessments and interventions must be tailored to each child in terms of age, size and development.
- Smile, if appropriate to the situation.
- Keep voice at an even, quiet tone – do not yell.
- Speak slowly. Use simple, age appropriate terms.
- Keep small children with their caregiver(s) whenever possible and complete assessment while the caregiver is holding the child.
- Kneel down to the level of the child if possible.
- Be cautious in the use of touch. In the stable child, make as many observations as possible before touching (and potentially upsetting) the child.
- Adolescents may need to be interviewed without their caregivers present if accurate information is to be obtained regarding drug use, alcohol use, LMP, sexual activity or child abuse.
- ❖ Observe general appearance and determine if behavior is age appropriate.
- ❖ Observe for respiratory distress or extreme pain.
- ❖ Look at the position of the child.
- ❖ What is the level of consciousness?
- ❖ Muscle tone: good vs. limp.
- ❖ Movement: spontaneous, purposeful or symmetrical.
- ❖ Color: pink, pale, flushed, cyanotic or mottled.
- ❖ Obvious injuries: bleeding, bruising, gross deformities, etc.
- ❖ **Determine weight** – ask patient, caregiver(s) or use Broselow tape.

Pediatric Assessment Process and Management

Assessment of the Pediatric Patient

3. Initial Assessment

- Airway access/maintenance with c-spine control
 - Maintain with assistance: positioning
 - Maintain with adjuncts: oral airway, nasal airway
 - Maintain with endotracheal tube. **Studies have shown that BLS management of pediatric airways may be just as effective as intubation. Do not spend time on scene with intubation procedures.**
 - Listen for any audible airway noises (*e.g.* stridor, snoring, gurgling, wheezing)
 - Patency: suction secretions as necessary
- Breathing
 - Rate & rhythm of respirations – compare to normal rate for age and situation
 - Chest expansion – symmetrical?
 - Breath sounds – compare both sides and listen for sounds (present, absent, normal, abnormal)
 - Positioning – sniffing position, tripod position
 - Work of breathing – retractions, nasal flaring, accessory muscle use, head bobbing, grunting
- Circulation
 - Heart rate – compare to normal rate for age and situation
 - Central pulses (*e.g.* brachial, carotid, femoral) – strong, weak or absent
 - Distal/Peripheral pulses (*e.g.* radial) – present/absent, thready, weak or strong
 - Color – pink, pale, flushed, cyanotic, mottled
 - Skin temperature – hot, warm, cool, or cold
 - Blood pressure – use appropriately sized cuff and compare to normal for the age of the child
 - Hydration status – observe anterior fontanel in infants, mucous membranes, skin turgor, crying tears, urine output, history to determine

Pediatric Assessment Process and Management

Assessment of the Pediatric Patient

- Disability – Brief Neurological Examination:
 - Assess responsiveness – APGAR, AVPU or TICLS
 - Assess pupils
 - Assess for transient numbness/tingling
- Expose and Examine:
 - Expose the patient as appropriate based on age and severity of illness.
 - Initiate measures to prevent heat loss and keep the child from becoming hypothermic.

4. Rapid Assessment vs. Focused History & Physical Assessment

- Tailor assessment to the needs and age of the patient.
- Rapidly examine areas specific to the chief complaint.
- *Responsive medical patients*: Perform focused assessment based on chief complaint. A full review of systems may not be necessary. If the chief complaint is vague, examine all systems and proceed to detailed exam.
- *Unresponsive medical patients*: Perform rapid assessment (*i.e.* ABCs & a quick head-to-toe exam). Render emergency care based on signs & symptoms, initial impression and standard operating procedures. Proceed to detailed exam.
- *Trauma patients with NO significant mechanism of injury*: Focused assessment is based on specific injury site.
- *Trauma patients with significant mechanism of injury*: Perform rapid assessment of all body systems and then proceed to detailed exam.

5. Detailed Assessment

- SAMPLE history – acquire/incorporate into physical exam.
- Vitals (pulse, BP, respirations, skin condition, pulse ox, breath sounds)
- Assessment performed (usually en route) to detect non life-threatening conditions and to provide care for those conditions or injuries
- Inspect body for **D**eformities, **C**ontusions, **A**brasions, **P**enetrations, **B**urns, **L**acerations, **S**welling, **T**enderness, **I**nstability, and **C**repitus

Pediatric Assessment Process and Management

Assessment of the Pediatric Patient

6. Ongoing Assessment

- To effectively maintain awareness of changes in the patient's condition, repeated assessments are essential and should be performed **at least every 5 minutes on the unstable patient** and **at least every 15 minutes on the stable patient.**

<i>Normal Pediatric Vital Sign Ranges</i>			
	Heart Rate	Respiratory Rate	Blood Pressure
Infant	100-160 bpm	30-60 rpm	> 60mmHg systolic
Toddler	90-150 bpm	24-40 rpm	> 70mmHg systolic
Preschooler	80-140 bpm	22-34 rpm	> 75mmHg systolic
School Age	70-120 bpm	18-30 rpm	> 80mmHg systolic
Adolescent	60-100 bpm	12-16 rpm	> 90mmHg systolic

Critical Thinking Elements

- Remember: Pediatric patients have extraordinary ability to compensate and may show normal vital signs even though they are in shock.**

Routine Pediatric Care Protocol

EMR

EMR Care should be focused on assessing the situation and establishing initial care to treat and prevent shock:

1. Open and/or maintain an open airway. Have suction equipment readily available to suction nose and mouth as needed.
2. Protect the child from environmental exposure. Give special consideration to the warmth of the infant (*e.g.* cover the head to prevent heat loss).
3. Reassure the patient and caregiver(s). Speak softly and calmly, maintaining conversation and explanation of exam and treatment. Use age-appropriate communication techniques.
4. Patient positioning will be based on assessment / patient condition, age / development and safety. Both the patient and caregiver should have the appropriate safety restraint devices / seat belts in place for transport.
5. Attach pulse oximeter and obtain analysis, if indicated.
6. Administer oxygen, preferably 10-15 L/min via non-rebreather mask (either on the child's face or holding the mask close to the face). If the patient does not tolerate a mask, then administer 4-6 L/min by nasal cannula.
7. Obtain Blood sugar level
8. Ensure that EMS has been activated for further care and transport. Provide responding units with pertinent patient information.
9. Monitor the patient's level of consciousness, vital signs, etc. for any acute changes.

Routine Pediatric Care Protocol

BLS Care

BLS Care should be directed at conducting a thorough patient assessment, providing care to treat for shock and preparing or providing patient transportation.

1. BLS Care includes the components of *EMR Care*.
2. Attach pulse oximeter and obtain analysis, if indicated.
3. Attach cardiac monitor and print rhythm strip for documentation, if indicated.
4. Initiate ILS/ALS intercept, if indicated.
5. Simultaneously with above, perform physical exam/assessment, obtain baseline vital signs and obtain patient history.
6. Obtain Blood sugar level
7. Establish on-line Medical Control as indicated.
8. Continue to reassess patient en route to the hospital.
9. Transport should be initiated at the earliest possible opportunity.

ILS/ALS Care

ILS/ALS Care should be directed at conducting a thorough patient assessment, providing care to treat for shock and preparing or providing patient transportation. The necessity of establishing IV access is determined by the patient's condition and chief complaint. Consideration should also be given to the proximity of the receiving facility.

Routine Pediatric Care Protocol

ILS/ALS Care

1. ILS/ALS Care includes all of the components of *BLS Care*.
2. If indicated, establish IV access using a 1000mL solution of 0.9% Normal Saline. No more than one (1) attempt should be made on scene. Infuse at a rate to keep the vein open (TKO) – approximately 8 to 15 drops (gtts) per minute. Dependent upon patient condition, consider initiating IV access en route to the hospital.

Critical Thinking Elements

- When determining the extent of care needed to stabilize the pediatric patient, the EMS provider should take into consideration the patient's presentation, chief complaint, risk of shock and proximity to the receiving facility.
- IV access in pediatric patients is difficult and may complicate the situation. Indications and benefits vs. patient disturbance and complications should be considered.
- If the patient exhibits signs of shock, administer fluid bolus (0.9% Normal Saline) at 20mL/kg over 2 minutes.
- If the pediatric patient is in emergent need of fluids and/or medications (*i.e.* cardiac arrest, trauma, decompensated shock or severe burns) and peripheral IV access is unobtainable, proceed with intraosseous infusion (**ILS & ALS only**).
- Saline locks may be used as a drug administration route if fluid replacement is not indicated.
- IV access should not significantly delay initiation of transportation or be attempted on scene with a trauma patient meeting load-and-go criteria.

Pediatric Pain Control Protocol

Pain, and the lack of relief from the pain, is one of the most common complaints among patients. Pediatric pain must not be ignored and must be identified and treated if appropriate. The prehospital provider must use clinical observations and a pain scale to rate the pain of the child.

EMR

EMR Care should focus on the reduction of the patient's anxiety due to the pain.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. Assess level of pain using the *Pain Assessment Scale (0-10)* or the *Wong-Baker Faces Pain Rating Scale*.
3. Place patient in a position of comfort.
4. Reassure the patient.
5. Use distraction therapy to help reduce the patient's anxiety (*e.g.* stuffed animals, discussing favorite foods, toys, etc.)
6. Consider ice or splinting.
7. Reassess level of pain using the approved pain scale.

BLS Care

BLS Care should focus on the reduction of the patient's anxiety due to the pain.

1. BLS Care includes all of the components of *EMR Care*.
2. Initiate ILS/ALS intercept, if indicated.

Pediatric Pain Control Protocol

ILS/ALS Care

ILS/ALS Care should focus on the pharmaceutical management of pain.

1. ILS/ALS Care includes all of the components of *BLS Care*.
2. Cases involving pain control of the pediatric patient:

Morphine Sulfate: 0.1mg/kg IV/IM/IO to reduce the patient's anxiety and severity of pain. **Contact Medical Direction after a total of 5mg.**

If the patient is allergic to Morphine or if Morphine is not effective:

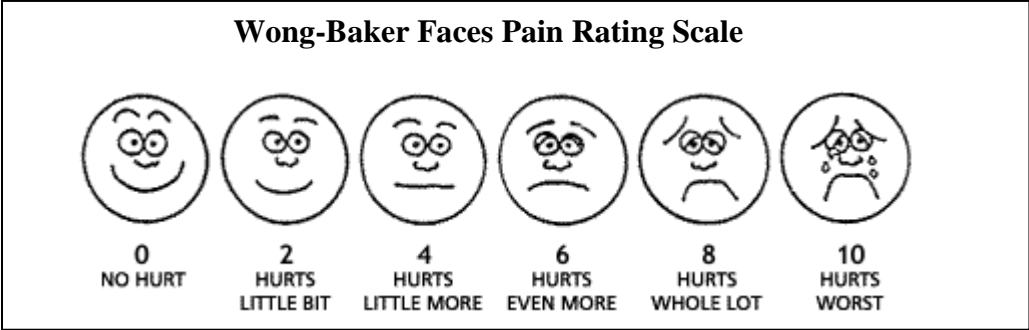
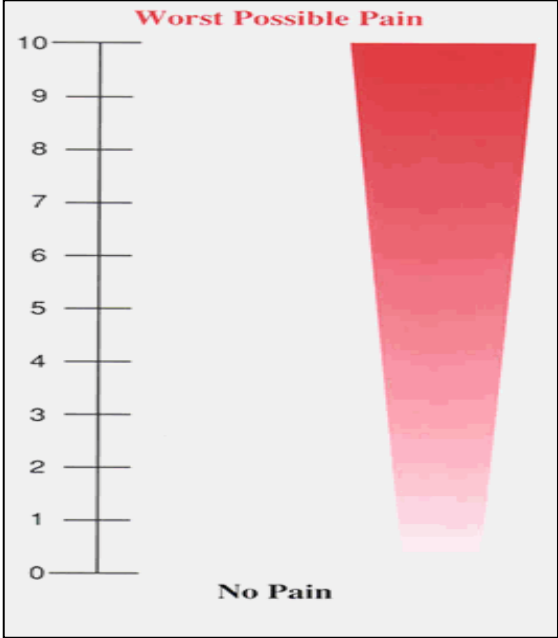
Fentanyl: 1mcg/kg IV over 2 minutes for pain (*max single dose: 50mcg*). Fentanyl 2mcg/kg IN may be used if no other access is possible.

Critical Thinking Elements

- Closely monitor the patient's airway – have BVM, suction and/or intubation equipment readily available.
- In patients with known renal failure, the Fentanyl dose must be reduced to 0.5mcg/kg (*max single dose: 25mcg*). The dose may be repeated one time

Pediatric Pain Control Protocol

Pain Assessment Scales



Pediatric Cardiac Arrest Protocol

The successful resuscitation of a child in cardiac arrest is dependent on a systematic approach of initiating life-saving CPR, recognition of any airway obstructions, adequate oxygenation & ventilation, early defibrillation and transferring care to advanced life support providers in a timely manner. The majority of pediatric patients found in non-traumatic cardiac arrest are found to have some form of airway obstruction or respiratory failure. Providing good BLS care with regards to relieving foreign body airway obstructions and/or initiating CPR, pediatric patients have a better chance at a positive outcome. Adequate ventilation is the most important step in pediatric resuscitation.

EMR

EMR Care should be focused on confirming that the patient is in full arrest and in need of CPR. Resuscitative efforts should be initiated by opening the airway and initiating ventilations & chest compressions while attaching a defibrillator. It is important to assure that CPR is being performed correctly following current AHA guidelines.

1. Assess Airway, Breathing, and Circulation.
2. Assess for a pulse.
3. Perform CPR in accordance to current AHA Guidelines until AED is attached.
4. Insert oral or nasal airway.
5. Confirm that a transporting unit (and ILS/ALS intercept) has been activated.
6. When AED is present, stop CPR and Analyze.
 - a) ***PEDIATRIC PADS***– apply as pictured on each of the AED electrodes with proper contact and without any overlap of the pads. If overlap of the pads occurs, use anterior (front) / posterior (back) placement with cervical spine precautions if neck/back injury is suspected.
 - b) *According to AHA Guidelines, if for any reason no Peds pads are available, use ADULT PADS* – apply anterior (front) / posterior (back) with cervical spine precautions if neck/back injury is suspected (see diagram at the end of this protocol).

SHOCK ADVISED:

- a) If the AED indicates “SHOCK ADVISED”, call out “*CLEAR!*” check for the safety of others, and push the SHOCK button (or stand clear if the AED device does not require shock activation).
- b) Immediately resume CPR for 2 minutes.
- c) Reassess the patient and allow the AED to analyze.
- d) If the AED indicates “SHOCK ADVISED”, call out “*CLEAR!*” check for the safety of others, and push the SHOCK button (or stand clear if the AED device does not require shock activation).
- e) Follow further AED prompts.

Pediatric Cardiac Arrest Protocol

NO SHOCK ADVISED:

- a) Continue CPR if pulse is absent.
 - b) Reassess every 2 minutes. Shock if indicated.
 - c) If the patient regains a pulse at any time during resuscitation, then maintain the airway and assist ventilations.
 - d) Re-analyze the patient's rhythm with the AED if the patient returns to a pulseless state. Shock if indicated.
 - e) Follow further AED prompts
7. Immediately turn patient care over to the transporting provider or ILS/ALS intercept crew upon their arrival.
 8. Complete all necessary cardiac arrest documentation.

BLS Care

BLS Care should focus on maintaining the continuity of care by confirming the patient is in cardiac arrest and continuing resuscitative efforts initiated by the EMR's. Transporting BLS units **should initiate an ALS intercept as soon as possible.**

1. Assess Airway, Breathing, and Circulation.
2. Assess for a pulse.
3. Perform CPR in accordance to current AHA Guidelines until AED is attached.
4. Insert oral or nasal airway.
5. Confirm that a transporting unit (and ILS/ALS intercept) has been activated.
6. When AED is present, stop CPR and Analyze.

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- a) If the AED indicates "SHOCK ADVISED", call out "CLEAR!" check for the safety of others, and push the SHOCK button (or stand clear if the AED device does not require shock activation).
- b) Immediately resume CPR for 2 minutes.
- c) Reassess the patient and allow the AED to analyze.
- d) If the AED indicates "SHOCK ADVISED", call out "CLEAR!" check for the safety of others, and push the SHOCK button (or stand clear if the AED device does not require shock activation).
- e) Follow further AED prompts.

NO SHOCK ADVISED:

- a) Continue CPR if pulse is absent.
- b) Reassess every 2 minutes. Shock if indicated.
- c) If the patient regains a pulse at any time during resuscitation, then maintain the airway and assist ventilations.

Pediatric Cardiac Arrest Protocol

- d) Re-analyze the patient's rhythm with the AED if the patient returns to a pulseless state. Shock if indicated.
 - e) Follow further AED prompts.
7. Immediately turn patient care over to the transporting provider or ILS/ALS intercept crew upon their arrival.
 8. Complete all necessary cardiac arrest documentation.
 9. It cannot be overemphasized how vital early, appropriate, aggressive CPR and defibrillation is to successful resuscitation of cardiac arrest victims, particularly in the rural setting in which we practice. For these patients, the chances of a functional post-arrest existence rests not on the Cardiologist, Emergency Physician, or EMS Personnel, but almost solely on well trained first responders performing excellent CPR with early defibrillation.

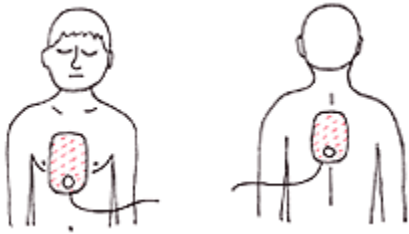
ILS/ALS Care

ILS/ALS Care should focus on maintaining the continuity of care by confirming that the patient is in cardiac arrest and beginning resuscitative efforts or continuing resuscitative efforts initiated by the First Responders.

1. Assess Airway, Breathing, and Circulation.
2. Assess for a pulse.
3. Perform CPR in accordance to current AHA Guidelines.
4. Intubate if necessary. If unsuccessful, place Blind Insertion Airway Device.
5. Establish IV/IO
6. Identify and treat cardiac dysrhythmias according to the appropriate protocol.

Pediatric Cardiac Arrest Protocol

Anterior/posterior pad placement: Placement of the anterior AED pad (electrode) on the front of the patient mid-chest and the posterior pad on the back of the patient mid-chest. (Always follow manufacturer's recommendations and diagrams for pad placement). - see following diagram **



****Use the anterior/posterior pad placement if no pediatric pads are available and adult Quick Combos or Fast Patches are being utilized for a pediatric patient.**

Critical Thinking Elements

- **If the cardiac arrest is witnessed by EMS personnel, start CPR and defibrillate immediately after the Fast Patches or Quick Combos are placed.**
- Treat the patient – not the monitor. A rhythm present on the monitor screen should NOT be used to determine pulse. If the monitor shows a rhythm and the patient has no pulse, begin CPR (the patient is in PEA – *pulseless electrical activity*).

Resuscitation of Pediatric Pulseless Rhythms Protocol

The successful resuscitation of patients in cardiac arrest is dependent on a systematic approach to resuscitation. ACLS medications are an important factor in successful resuscitation of the pulseless patient when the initial rhythm is not ventricular fibrillation (V-fib) or in cases where defibrillation has been unsuccessful. It is important that BLS providers understand the value of effective CPR and an ALS intercept in providing the patient with ACLS therapy.

EMR

Not applicable. EMR are not equipped with ACLS medications and shall treat the patient in accordance with the *Pediatric Cardiac Arrest Protocol*.

BLS Care

Not applicable. BLS providers are not equipped with ACLS medications and shall treat the patient in accordance with the *Pediatric Cardiac Arrest Protocol*.

Ventricular Fibrillation (V-fib) or Pulseless Ventricular Tachycardia (V-tach)

Resuscitation of Pediatric Pulseless Rhythms Protocol

Ventricular Fibrillation (V-fib) or Pulseless Ventricular Tachycardia (V-tach) (continued)

ILS/ALS Care

1. Initiate *Pediatric Cardiac Arrest Protocol*.
2. Evaluate the rhythm after 2 minutes of CPR. If V-fib or pulseless V-tach:
Defibrillate at 2 Joules / kg. **
3. **Immediately resume CPR for 2 minutes** and re-evaluate the patient/rhythm.
4. **Epinephrine 1:10,000:** 0.01mg/kg IV/IO. (*Minimum dose 0.1mg*) (**Max single dose: 1mg**) and repeat every **5 minutes** as needed.
OR
Epinephrine 1:1,000: 0.1mg/kg ETT (**Max single dose: 1mg**) and repeat every **5 minutes** as needed.
5. If pulseless V-fib/V-tach persists: **Defibrillate at 4 J/kg.**
6. **Immediately resume CPR for 2 minutes** and re-evaluate the patient/rhythm.
7. **Amiodarone 5mg/kg IV/IO** for refractory V-fib/V-tach.
8. If pulseless V-fib/V-tach persists: **Defibrillate at 4 J/kg.**
9. **Immediately resume CPR** and re-evaluate the patient/rhythm every 2 minutes.
10. **Administer D10W 5mL/kg. Max dose of 250mL.**
11. **Narcan:** 0.1mg/kg IV/IO/ETT (**Max single dose: 2mg**) if suspected narcotic overdose.
12. **Contact Medical Control** as soon as possible.
13. Transport as soon as possible.

Resuscitation of Pediatric Pulseless Rhythms Protocol

Pulseless Electrical Activity & Asystole

ILS/ALS Care

1. Initiate *Cardiac Arrest Protocol*.
2. Evaluate rhythm after 2 minutes of CPR.
3. **Epinephrine 1:10,000:** 0.01mg/kg IV/IO (*Minimum dose 0.1mg*) (*Max single dose: 1mg*) and repeat every *5 minutes* as needed.

OR

- Epinephrine 1:1,000:** 0.1mg/kg ETT (*Max single dose: 1mg*) and repeat every *5 minutes* as needed.
4. **Continue CPR** and re-evaluate patient/rhythm every 2 minutes.
 5. **IV Fluid Therapy:** 20mL/kg fluid bolus for suspected hypovolemia.
 6. **Administer D10W 5mL/kg. Max dose of 250mL.**
 7. **Narcan:** 0.1mg/kg IV/IO/ETT/IN (*Max single dose: 2mg*) if suspected narcotic overdose.
 8. **Needle chest decompression** for a patient in *traumatic* cardiac arrest with suspected tension pneumothorax.
 9. **Contact Medical Control** as soon as possible.
 10. Transport as soon as possible.

Critical Thinking Elements

- Pediatric cardiac arrest is often related to hypoxia and poor ventilation. Ensure proper oxygenation and ventilation.
- Prompt transport of the pediatric patient is an important aspect of successful resuscitation. *Do not spend time at the scene attempting to do procedures you may not feel confident in or experienced in doing.* CPR and good BVM ventilation are the only procedures needed initially.
- **Handtevy system should be used .**

Pediatric Bradycardia Protocol

Pediatric bradycardia is defined as a heart rate less than the normal beats per minute for a given age group. Determining the stability of the pediatric patient with bradycardia is an important factor in patient care decisions. The assessment of the patient with bradycardia should include evaluation for signs and symptoms of hypoperfusion and hypoventilation.

EMR/BLS Care

EMR/BLS Care should be focused on assessing the situation and initiating routine patient care to treat for shock.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. Assess the pediatric patient for signs and symptoms of hypoperfusion and possible causes, including:
 - Respiratory difficulty
 - Cyanosis
 - Cool/Cold skin
 - Hypotension/Lack of palpable blood pressure
 - Decreasing level of consciousness
3. **Oxygen:** 15 L/min via BVM if the child is in respiratory distress. If the child is alert, 10-15 L/min via non-rebreather mask or 4-6 L/min via nasal cannula if the child will not tolerate a mask.
4. For children **<12 months of age:** If, despite oxygen and ventilation the child continues to appear hypoperfused and has a pulse **<60 beats per minute, initiate chest compressions.**
5. *Immediately* turn patient care over to the transporting provider or ILS/ALS intercept upon their arrival.

Pediatric Bradycardia Protocol

ILS/ALS Care

ILS/ALS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, stabilizing the patient's perfusion and preparing for or providing patient transport.

1. ILS/ALS Care includes all components of *EMR & BLS Care*.
2. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
3. **Oxygen:** 15 L/min via BVM if the child is in respiratory distress. If the child is alert, 10-15 L/min via non-rebreather mask or 4-6 L/min via nasal cannula if the child will not tolerate a mask.
4. **IV Fluid Therapy:** 20mL/kg bolus of 0.9% Normal Saline if hypovolemia is suspected.
5. **Contact Medical Control** as soon as possible.
6. **Epinephrine 1:10,000:** 0.01mg/kg IV/IO (*Minimum dose* 0.1mg) (*Max single dose: 1mg*) and repeat every *3 to 5 minutes* as needed.

OR

- Epinephrine 1:1,000:** 0.1mg/kg ETT (*Max single dose: 1mg*) and repeat every *5 minutes* as needed.
7. **Atropine:** 0.02mg/kg IV/IO (*Minimum dose:* 0.1mg) (*Max single dose: 1 mg*) for children who are greater than 6 months of age.

OR

- Atropine:** 0.03mg/kg ETT (*Minimum dose:* 0.1mg) (*Max single dose: 1mg*) for Children who are greater than 6 months of age.
8. **Immediate Transcutaneous Pacing:** If the patient remains bradycardic with continued signs of hypo-perfusion.
 - ➡ Current should be set at minimum to start and increased until capture is achieved.

Pediatric Bradycardia Protocol

ILS/ALS Care

- ➡ Refer to the *Transcutaneous Pacing Procedure* for additional information.
9. **Fentanyl:** 1mcg/kg IV/IO/IM or 2mcg/kg IN can be used for patient comfort or **Midazolam (Versed):** 0.1mg/kg IV/IO (**Max single dose: 2mg**) for patient comfort after pacing is initiated. Re-check vital signs 5 minutes after administration. May repeat dose one time if systolic BP > 100mmHg and respiratory rate is > 10 rpm. Additional doses require **Medical Control order**.
10. Transport as soon as possible (*Transport can be initiated at any time during this sequence*). **Contact Med Control as soon as possible.**

Critical Thinking Elements

- Before administering epinephrine, always assess for mechanical problems with oxygen delivery. (Oxygen on?, Oxygen flowing, etc)
- Atropine is contraindicated for infants <6 months of age.
- Handtevy system should be used.
- ILS/ALS: Search for possible contributing factors:
 - ➡ Hypovolemia, Hypoxia, Hypoglycemia, Hypothermia, Toxins, Cardiac Tamponade, Trauma (hypovolemia, increased ICP)

Pediatric Narrow Complex Tachycardia Protocol

Tachycardia may be a nonspecific sign of fear, anxiety, pain, fever, or shock in the pediatric patient. The heart rate needs to be assessed in conjunction with the PAT & ABCDEs. As with all cardiac dysrhythmias, assess the heart rate and EKG with knowledge based on ACLS principles and normal ranges for children. Always ask the child/caregiver about history of illness, congenital heart disease or cardiac surgery. **Pediatric Supraventricular Tachycardia is defined as a narrow QRS (<0.08 seconds) and a heart rate greater than 220 bpm in Infants and greater than 180 bpm in Children.**

EMR/BLS Care

BLS Care should be directed at conducting a thorough patient assessment, initiating routine patient care to treat for shock and preparing the patient for or providing transport.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. **Oxygen:** 10-15 L/min via non-rebreather mask or 4-6 L/min via nasal cannula if the patient does not tolerate a mask.
3. Initiate ILS/ALS intercept and transport as soon as possible.

ILS/ALS Care

ILS/ALS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, stabilizing the patient's perfusion and preparing for or providing patient transport.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. **Oxygen:** 10-15 L/min via non-rebreather mask or 4-6 L/min via nasal cannula if the patient does not tolerate a mask.
3. **IV Fluid Therapy:** 20mL/kg bolus of 0.9% Normal Saline.
4. **Contact Medical Control** as soon as possible.
5. **If Stable-Adenosine (Adenocard):** 0.1mg/kg IV {rapid IV push} (*Max single dose: 6mg*) if the child is alert and still has a HR greater than 220 bpm. If no response after *2 minutes*, administer 0.2mg/kg IV {rapid IV push} (*Max single dose: 12mg*).
7. **Midazolam (Versed):** 0.1mg/kg IV/IO/IN **in preparation for synchronized cardioversion** if the patient has a respiratory rate > 10 rpm. If the patient's respiratory rate is < 10 rpm, proceed to immediate synchronized cardioversion without sedation.

8. If Unstable - Contact Medical Control for Orders for Synchronized Cardioversion: If the patient has an altered level of consciousness, diaphoresis, pale/mottled skin and/or is hypotensive:

- b) Synchronized cardioversion at **1 Joule/kg** if tachycardia persists.
- c) Synchronized cardioversion at **2 Joules/kg** if tachycardia persists.

- **Handtevy system should be used.**

Pediatric Wide Complex Tachycardia Protocol

Tachycardia should be assessed in conjunction with the PAT & ABCDEs. Pediatric ventricular tachycardia is defined as a wide complex QRS and a heart rate >180 bpm. The child may have a history of serious systemic illness/congenital heart defects.

EMR/BLS Care

BLS Care should be directed at conducting a thorough patient assessment, initiating routine patient care to treat for shock and preparing the patient for or providing transport.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. **Oxygen:** 10-15 L/min via non-rebreather mask or 4-6 L/min via nasal cannula if the patient does not tolerate a mask.
3. Initiate ILS/ALS intercept and transport as soon as possible.

ILS/ALS Care

ILS/ALS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, stabilizing the patient's perfusion and preparing for or providing patient transport.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. **Oxygen:** 10-15 L/min via non-rebreather mask or 4-6 L/min via nasal cannula if the patient does not tolerate a mask.
3. Transport as soon as possible. (*Transport can be initiated at any time during this sequence*).
4. **IV Fluid Therapy:** 20mL/kg bolus of 0.9% Normal Saline.
5. If the patient becomes pulseless at any time, refer to the *Resuscitation of Pediatric Pulseless Rhythms Protocol (V-fib or Pulseless V-tach)*.
6. **If Stable –Amiodarone:** 5mg/kg IV/IO
7. **Midazolam (Versed):** 0.1mg/kg IV/IO for patient comfort in preparation for to cardioversion (**with Medical Control order**). Re-check vital signs 5 minutes after administration. Additional doses also require **Medical Control order**.
8. **If Unstable - Synchronized Cardioversion:** If the patient has an altered level of consciousness, is in shock and is in V-tach with a heart rate >180 bpm:
 - a) Synchronized cardioversion at **1 Joule/kg** if tachycardia persists.
 - b) Synchronized cardioversion at **2 Joules/kg** if tachycardia persists

Pediatric Wide Complex Tachycardia Protocol

Critical Thinking Elements

- **Cardiac dysrhythmias such as V-tach are rare in children. Ask the caregiver if the child has chronic or genetic cardiac condition.**
- **V-tach with a pulse could be from a serious system illness, hypoxia or dehydration.**
- **Handtevy system should be used.**

Pediatric Respiratory Distress Protocol

Respiratory distress is common in the pediatric patient. The small airways of children are compromised more quickly during medical and traumatic problems. Identifying the degree of respiratory distress is crucial for stopping a process that can lead into respiratory failure. At that point, the child has lost ability to compensate for the lack of oxygen. If not treated immediately, respiratory failure will lead to arrest.

EMR

EMR Care should be focused on assessing the situation and initiating routine patient care to treat for shock.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. **Oxygen:** 15 L/min via non-rebreather mask or 6 L/min via nasal cannula if the patient cannot tolerate a mask.
3. Utilize the *Pediatric Assessment Triangle* to gain a general impression.
4. Assess abnormal airway sounds.
5. Place patient in a position of comfort.

BLS Care

BLS Care should be directed at conducting a thorough patient assessment, initiating routine patient care to treat for shock and preparing the patient for or providing transport.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. **Oxygen:** 15 L/min via non-rebreather mask or 6 L/min via nasal cannula if the patient does not tolerate a mask. Be prepared to support with BVM if necessary.
3. **Albuterol:** 2.5mg in 3mL of normal saline via nebulizer over 15 minutes for wheezing or absent/diminished breath sounds. May repeat Albuterol 2.5mg every *15 minutes* as needed.
4. Initiate ILS/ALS intercept and transport as soon as possible.

ILS/ALS Care

ALS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, stabilizing the patient's perfusion and preparing for or providing patient transport.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. **Oxygen:** 15 L/min via non-rebreather mask or 6 L/min via nasal cannula if the patient does not tolerate a mask.

3. **Albuterol- Atrovent “DuoNeb” Nebulizer:** (2.5mg of Albuterol & 0.5mg Atrovent) over 15 minutes. Repeat Albuterol every *15 minutes* as needed. In-line nebulizer may be utilized if patient is unresponsive or in respiratory arrest.
 4. **Epinephrine 1:1000:** 0.01mg/kg IM (*Max single dose: 0.3mg*) if the patient is suffering status asthmaticus and does not improve with Albuterol treatment.
 5. Transport as soon as possible.
 6. Contact the receiving hospital as soon as possible or Medical Control if necessary
- **Handtevy system should be used.**

Pediatric Respiratory³⁴ Distress Protocol

Epiglottitis

Symptoms of Epiglottitis may include:

- ALOC, Fever
- Hoarseness
- Brassy cough
- Inspiratory stridor
- Drooling
- Tripod position

If Epiglottitis is suspected:

EMR Care, BLS Care, ILS Care & ALS Care

1. Initiate *Routine Pediatric Care Protocol*.
2. **Do not look in the child's mouth or attempt to visualize the interior of the throat.**
3. **Do not agitate the child.** He/she should be kept as calm as possible – do not attempt to obtain IV access.
4. **Oxygen:** 10-15 L/min via non-rebreather mask or by best means tolerated by the patient (*e.g.* blow-by or 4-6 L/min via nasal cannula).
5. Transport the child sitting up.

Pediatric Tracheostomy Protocol

With today's technology and improving home health care, more critical care patients are being sent home early. Home health care professionals and family members can duplicate the care the child receives in the hospital. This allows the patient to return home, spending less time in the hospital. EMS is activated when there is a problem with complex medical equipment, or the patient relapses into a more critical condition. EMS providers need to gain knowledge of critical care medicine not previously needed.

EMR

EMR Care should be focused on ensuring a patent airway.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. **Oxygen:** 15 L/min via tracheostomy collar.
3. Assess work of breathing.
4. Assess abnormal airway sounds.
5. Place patient in a position of comfort.
6. If tracheostomy tube is obstructed with secretions:
 - a. Suction with whistle-tip catheter.
 - b. Repeat suction after removing inner catheter of tracheostomy tube.
 - c. Have caregiver change tracheostomy tube.
7. If the airway continues to be obstructed or if ventilatory effort is inadequate, **ventilate with 100% oxygen** by attaching a BVM to the tracheostomy tube. **If the patient is difficult to ventilate with BVM, DO NOT USE EXCESSIVE FORCE. Attempt to suction the patient, and try to ventilate again, if unsuccessful move to step 8.**
8. If the tracheostomy tube is still not patent, ventilate **mask to mouth** while covering the stoma.
 - ➡ The balloon on the trach must be deflated prior to attempting mask to mouth ventilation.
9. Initiate ILS/ALS intercept as soon as possible.

Pediatric Tracheostomy Protocol

BLS Care

BLS Care should be directed at conducting a thorough patient assessment and ensuring that the child has a patent airway.

1. BLS Care includes all components of *EMR Care*.

ILS Care

ILS Care should be directed at continuing or establishing care, conducting a thorough patient assessment and ensuring a patent airway.

1. ILS Care includes all components of *EMR/BLS Care*.
2. If the airway is still obstructed:
 - a. Insert appropriately sized ETT in stoma.
 - b. Reassess patency of the airway.

ALS Care

ALS Care should be directed at continuing or establishing care, conducting a thorough patient assessment and ensuring a patent airway.

1. ALS Care includes all components of *EMR/BLS/ILS Care*.
 2. If the airway is still obstructed:
 - a. Insert appropriately sized ETT in stoma.
 - b. Reassess patency of the airway.
- **Handtevy system should be used.**

Pediatric Respiratory Arrest Protocol

When the pediatric patient enters respiratory arrest, cardiac arrest (and poor outcome) is sure to follow. Assisted ventilations with a BVM can be the most useful skill in resuscitation of the child in respiratory arrest. Remember – the pediatric patient responds to oxygenation very favorably. Therefore, it is important to try to identify the cause of the respiratory arrest after securing a patent airway and providing proper ventilation.

EMR

EMR Care should be focused on ensuring a patent airway and proper ventilation.

1. Assess airway. If agonal respirations are present or the child is not breathing at all:
 - a. Perform jaw thrust
 - b. Suction airway
 - c. Oropharyngeal or nasopharyngeal airway
2. Administer **100% oxygen** using appropriately sized BVM.
3. If chest rise is inadequate:
 - a. Relieve upper airway obstruction.
 - b. Reposition airway.
 - c. Refer to *Basic Airway Management of the Pediatric Patient Protocol*.
4. Refer to *Pediatric Respiratory Distress Protocol* if breathing resumes.
5. If hypoperfusion is present, refer to *Pediatric Shock Protocol*.
6. *Routine Pediatric Care Protocol*.
7. Initiate transport as soon as possible.

BLS Care

BLS Care should be directed at conducting a thorough patient assessment, ensuring that the child has a patent airway and proper ventilation.

1. BLS Care includes all components of *EMR Care*.
2. Apply pulse oximetry and document oxygen saturation.
3. Initiate ILS/ALS intercept and transport as soon as possible.

Pediatric Respiratory Arrest Protocol

ILS Care

ILS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, ensuring a patent airway and proper ventilation.

1. ILS Care includes all components of *EMR Care/BLS Care*.
2. Consider underlying etiologies and treat according to the appropriate protocol:
 - Airway obstruction
 - Cardiac dysrhythmias
 - CNS injury
 - Anaphylaxis
 - Poisoning/Overdose
 - Suffocation
 - Metabolic (refer to *Pediatric ALOC Protocol*)
 - Hypovolemia (refer to *Pediatric Shock Protocol*)
 - Near drowning
 - Carbon monoxide exposure
3. Intubate or BIAD the patient and/or provide ventilation at 20-30 breaths/minute.
4. Initiate IV access, if possible.
5. Initiate ALS intercept if available and transport as soon as possible.

ALS Care

ALS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, ensuring a patent airway and proper ventilation.

1. ALS Care includes all components of *EMR/BLS/ILS Care*.
2. **Needle chest decompression** on the affected side with a 14g, 16g, or 18g IV catheter if tension pneumothorax is suspected. (**with Medical Control order only**).
3. **Consider Needle Cric if indicated (with Medical Control orders only)**
4. Transport as soon as possible and Contact Medical Control ASAP.

Critical Thinking Elements

- Studies have shown that BLS management of pediatric airways may be just as effective as intubation. **Do not spend time on scene with intubation procedures.**
- Gastric distention is very common in pediatric patients and may cause poor compliance. Ventilating too fast or giving too much tidal volume is the top two reasons for distention. Use proper ventilation techniques and an appropriately sized BVM for the pediatric patient.

Pediatric Altered Level of Consciousness Protocol

The EMS Professional needs to consider all causes of a child's altered level of consciousness. A good assessment is paramount to identify life-threatening injuries. Focus should also be on causes for the event and the child's past medical history.

EMR

EMR Care should be focused on assessing the situation and initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. **Oxygen:** 10-15 L/min via non-rebreather mask or 4-6 L/min via nasal cannula if the patient cannot tolerate a mask.
3. Perform **blood glucose level test**.
4. **Oral Glucose:** One tube (15g) PO if the patient's blood sugar is < 60mg/dL, the patient is alert to verbal stimuli, is able to sit in an upright position, has good airway control and has an intact gag reflex.
5. Perform a 2nd **blood glucose level test** to re-evaluate blood sugar 5 minutes after administration of Oral Glucose. If blood sugar remains <60mg/dL, administer a 2nd dose of Oral Glucose (15g).

BLS Care

BLS Care should be directed at conducting a thorough patient assessment, initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock and preparing the patient for or providing transport.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. **Oxygen:** 15 L/min via non-rebreather mask or 6 L/min via nasal cannula if the patient does not tolerate a mask.
3. Perform **blood glucose level test**.
4. **Oral Glucose:** One tube (15g) PO if the patient's blood sugar is < 60mg/dL, the patient is alert to verbal stimuli, is able to sit in an upright position, has good airway control and has an intact gag reflex.
5. Perform a 2nd **blood glucose level test** to re-evaluate blood sugar 5 minutes after administration of Oral Glucose. If blood sugar remains <60mg/dL, administer a 2nd dose of Oral Glucose (15g).
6. **If patient is altered and airway is not controlled, Glucagon:** 0.5mg IM for <8 yrs, 1mg IM for >8 yrs if the patient's blood sugar is < 60mg/dL
7. Initiate ILS/ALS intercept if needed and transport as soon as possible.
8. Contact the receiving hospital as soon as possible.

Pediatric Altered Level of Consciousness Protocol

ILS/ALS Care

ILS/ALS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, stabilizing the patient's perfusion and preparing for or providing patient transport.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
 2. **Oxygen:** 10-15 L/min via non-rebreather mask or 4-6 L/min via nasal cannula if the patient does not tolerate a mask.
 3. Perform **blood glucose level test**.
 4. **Administer D10W 5mL/kg. Max dose of 250mL.**
 5. **6. GLUCAGON 0.1mg/kg IM if no IV/IO is established and patient is symptomatic**
 6. **7. Blood sugar 60-250mg/dl maintain blood sugar and use appropriate protocol**
 7. **8. Blood sugar greater than 250mg/dl. Dehydration with no evidence of CHF/fluid overload. LACTATED RINGERS BOLUS 20ml/kg. Repeat as needed to maintain age appropriate blood pressure max 60ml/kg**
 8. **Narcan: 0.1mg/kg IV/IM (Max single dose: 2mg) if suspected narcotic overdose.**
 - a) **Contact Medical Control** As soon as possible.
- **Handtevy system should be used.**

Critical Thinking Elements

- **ALOC in a child can range from trauma to a systemic infection (sepsis). A good medical history might provide clues as to the reason for the ALOC.**
- **Accidental (or intentional, in the setting of abuse, or depression/suicide) overdose/ingestion of medications can be a cause of the ALOC.**

Seizures are common in childhood. About 5% of all children will have at least one seizure by the age of three (febrile seizures account for the largest percentage of pediatric seizures). This condition can cause much concern and anxiety in the caregiver and EMS is called. Pediatric seizures are usually short-lived and stop before the arrival of EMS. Since there are many causes of pediatric seizures, treatment and transport to an appropriately equipped emergency department is necessary.

Classification of Seizures (PEPP 2001)	
Generalized Seizure	Description
Tonic-Clonic (Grand Mal Seizure)	Trunk rigidity and loss of consciousness with sudden, jerking movements of both arms and/or both legs; may be only tonic (rigidity) or clonic (jerking) seizure activity.
Absence (Petit Mal Seizure)	Brief loss of awareness without any abnormal movements; child may appear to be staring.
Partial (Focal) Seizure	Description
Simple Seizure	Focal motor jerking without loss of consciousness; may be sensory, autonomic or psychic without jerking.
Complex Seizure	Focal motor jerking with loss of consciousness; secondary generalization to a tonic-clonic seizure.

Common causes of Seizures in Pediatric Patients:

- Fever
- Trauma
- Hypoxia
- Hypoglycemia
- Infection/Sepsis
- Ingestion of toxins
- Cerebral hemorrhage
- Metabolic disorders
- Congenital neurological problems

EMR

EMR Care should be focused on assessing the situation and initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. **Oxygen:** 10-15 L/min via non-rebreather mask or 4-6 L/min via nasal cannula if the patient cannot tolerate a mask. Be prepared to support the patient's respirations with BVM if necessary and have suction readily available.
3. Perform **blood glucose level test**.

BLS Care

BLS Care should be directed at conducting a thorough patient assessment, initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock and preparing the patient for or providing transport.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. **Oxygen:** 10-15 L/min via non-rebreather mask or 4-6 L/min via nasal cannula if the patient does not tolerate a mask. Be prepared to support the patient's respirations with BVM if necessary and have suction readily available.
3. Perform **blood glucose level test**.
4. Initiate ILS/ALS intercept and **transport without delay**.
5. Check and record vital signs and GCS every *5 minutes*.

ILS/ALS Care

ILS/ALS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, stabilizing the patient's perfusion and preparing for or providing patient transport.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. **Oxygen:** 10-15 L/min via non-rebreather mask or 4-6 L/min via nasal cannula if the patient does not tolerate a mask. Be prepared to support the patient's respirations with BVM if necessary and have suction readily available.
3. Perform **blood glucose level test**.

ILS/ALS Care Continued

2. . Administer D10W 5mL/kg. Max dose of 250mL.
 3. 6. GLUCAGON 0.1mg/kg IM if no IV/IO is established and patient is symptomatic
 4. 7. Blood sugar 60-250mg/dl maintain blood sugar and use appropriate protocol
 5. 8. **Blood sugar greater than 250mg/dl. Dehydration with no evidence of CHF/fluid overload. LACTATED RINGERS BOLUS 20ml/kg. Repeat as needed to maintain age appropriate blood pressure max 60ml/kg**
 6. **Midazolam (Versed): 0.1mg/kg IV/IO or 0.2mg/kg IM/IN over 1 minute for seizure activity. May repeat after 5min if child is still seizing**
 7. Transport as soon as possible.
 8. Contact the receiving hospital as soon as possible.
- **Handtevy system should be used.**

Critical Thinking Elements

- **30% of all pediatric seizures are febrile in nature. However, the presence of a fever may not necessarily be the cause of the seizure. The child needs to be transported to the hospital for further evaluation.**
- **Seizure activity usually indicates a serious underlying problem. Check the oxygenation and perfusion of the child along with the blood glucose level and temperature. Treat accordingly.**

Pediatric Allergic Reaction / Anaphylaxis Protocol

Allergic reactions or anaphylaxis in children can cause respiratory distress very quickly in pediatric patients due to the small size of the airway. Bee stings and nuts are the common reasons for anaphylaxis in children.

EMR

EMR Care should be focused on assessing the situation and initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. **Oxygen:** 10-15 L/min via non-rebreather mask or 4-6 L/min via nasal cannula if the patient cannot tolerate a mask. Be prepared to support the patient's respirations with BVM if necessary.

BLS Care

BLS Care should be directed at conducting a thorough patient assessment, initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock and preparing the patient for or providing transport. **Call Immediately for ILS/ALS Intercept.**

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. **Oxygen:** 10-15 L/min via non-rebreather mask or 4-6 L/min via nasal cannula if the patient does not tolerate a mask. Be prepared to support the patient's respirations with BVM if necessary.
3. Initiate ILS/ALS intercept and transport as soon as possible.
4. **Contact Medical Control for Orders for Epi-Pen auto-injector if 60 pounds or more. If under 60 pounds get order for Epi-Pen Jr. or Epi 1:1000 0.15mg IM if drawing from a vial**
5. **Contact Medical Control** as soon as possible.

Pediatric Allergic Reaction / Anaphylaxis Protocol

ILS/ALS Care

ILS/ALS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, stabilizing the patient's perfusion and preparing for or providing patient transport.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. **Oxygen:** 10-15 L/min via non-rebreather mask or 4-6 L/min via nasal cannula if the patient does not tolerate a mask. Be prepared to support the patient's respirations with BVM (or intubate) if necessary.
3. **Epinephrine 1:1000:** 0.01mg/kg SQ (**Max single dose: 0.3mg**) if the patient has respiratory distress (inspiratory & expiratory wheezing, stridor and/or laryngeal edema), hypotension and/or ALOC.

OR

- Epinephrine 1:10,000:** 0.01mg/kg IV (**Max single dose: 0.3mg**) if peripheral access has been established and the patient has respiratory distress (inspiratory & expiratory wheezing, stridor and/or laryngeal edema), hypotension and/or ALOC.
4. **Benadryl:** 1mg/kg IV or IM (**Max single dose: 50mg**) for severe itching and/or hives.
 5. **Albuterol- Atrovent "DuoNeb" Nebulizer:** (2.5mg of Albuterol & 0.5mg Atrovent) over 15 minutes. Repeat Albuterol-Atrovent DuoNeb every **15 minutes** as needed. In-line nebulizer may be utilized if patient is unresponsive or in respiratory arrest.
 6. **IV Fluid Therapy:** 20mL/kg fluid bolus of 0.9% Normal Saline if patient is hypotensive. May Repeat. .
 7. Transport as soon as possible.
 8. Contact the receiving hospital as soon as possible.
- **Handtevy system should be used.**

Critical Thinking Elements

- **Patients who have an allergic reaction can develop anaphylaxis over time. Monitor patients very closely.**
- **Avoid establishing an IV in the same extremity as a bee sting / allergy site.**
- **Both an allergic reaction & anaphylaxis can present with hives. Remember: an allergic reaction is localized while anaphylaxis is a systemic reaction.**
- **Do not waste time on scene – begin transport as soon as possible and treat en route.**

Pediatric Ingestion / Overdose / Toxic Exposure Protocol

This protocol focuses on two problems. First, exposure to a chemical substance that causes adverse medical effects. Secondly, the protocol covers accidental or intentional ingestion of harmful substances into the body. Toddlers explore their environment with all five senses and ingestion of toxic substances is common for this age group. The adolescent age group deals mainly with intentional overdoses due to attempted suicide or recreational pharmaceuticals & alcohol use.

EMR Care, BLS Care, ILS Care, & ALS Care (General Approach)

1. If the scene is considered a *Hazardous Materials* incident, do not treat patients unless they are decontaminated or proper precautions have been implemented to protect EMS personnel.
2. In the event that the patient has not been decontaminated when EMS makes patient contact, removing all of patient's clothing takes away 80-90% of the contaminated materials. Get patient to decontamination area as soon as possible.
3. If there is no patient contact but EMS has determined this to be a *Hazardous Materials* incident, **do not enter the scene under any circumstances.**

EMR/BLS Care

EMR/BLS Care should be directed at conducting a thorough patient assessment, initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock and preparing the patient for or providing transport.

1. Consider possible scene & patient contamination and follow agency safety procedures.
2. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
3. **Oxygen:** 10-15 L/min via non-rebreather mask or 4-6 L/min via nasal cannula if the patient cannot tolerate a mask. Be prepared to support the patient's respirations with BVM if necessary.
4. **Narcan** 0.1 mg/kg IM/IN (Max single Dose: 2mg) if suspected Narcotic Overdose. ******* EMR's can only administer Narcan IN.*******

Pediatric Ingestion / Overdose / Toxic Exposure Protocol

ILS/ALS Care

ILS/ALS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, stabilizing the patient's perfusion and preparing for or providing patient transport.

1. Consider possible scene & patient contamination and follow agency safety procedures.
 2. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
 - a) **Oxygen:** 15 L/min via non-rebreather mask or 6 L/min via nasal cannula if the patient does not tolerate a mask. Be prepared to support the patient's respirations with BVM (or intubate) if necessary.
 - b) **IV Fluid Therapy:** 20mL/kg fluid bolus of 0.9% Normal Saline if the patient is hypotensive. May repeat bolus
 - c) If patient is seizing, follow *Pediatric Seizure Protocol*.
 3. **Narcan:** 0.1mg/kg IV/IM (**Max single dose: 2mg**) if suspected narcotic overdose.
 4. **Contact Medical Control** as soon as possible.
 5. **Contact Medical Control for Orders for Sodium Bicarbonate:** 1meq/kg IV (**Max single dose: 50meq**) (**with Medical Control order only**) if known tricyclic antidepressant (TCA) or Aspirin (ASA) overdose.
 6. If the patient has signs & symptoms of *organophosphate poisoning* or *nerve agent* exposure, **contact Medical Control:**
 - i. Ensure that the patient has been decontaminated prior to transport.
 - ii. **Atropine:** 0.02mg/kg IV (**Max single dose: 2mg**) every 5 minutes until symptoms are suppressed.

OR

Atropine: 0.05mg/kg IM (**Max single dose: 2mg**) every 5 minutes until symptoms are suppressed.
 - iii. If patient is actively seizing due to nerve agent exposure, refer to *Pediatric Seizure Protocol*.
 7. Transport as soon as possible.
- **Handtevy system should be used.**

Routine Pediatric Trauma Care Protocol

The majority of pediatric contacts the prehospital professional will face involve traumatic injuries. Trauma care in the pediatric patient must be aggressive, due to the child's ability to compensate and mask otherwise obvious signs and symptoms of shock. Early recognition of potential life-threatening injuries due to trauma will help save the pediatric patient.

In addition, pediatric patients may not always have obvious injuries. The anatomical position and size of internal organs are drastically different compared to the adult trauma patient. Children may not bruise or show marks of impact, thus disguising underlying life-threatening problems. When the pediatric patient presents as a possible trauma patient, treat them as such. Stay within the "*platinum 10 minutes*" of scene time, effectively immobilize the spine, keep the child warm and treat pain and anxiety.

EMR Care, BLS Care, ILS Care & ALS Care

1. Scene Assessment (Scene Size-Up)

- Ensure scene safety – identify any hazards (e.g. fire, downed power lines, unstable vehicle, leaking fuel, weapons).
- Determine the number of patients.
- Identify the **mechanism of injury** (gunshot wound, vehicle rollover, high speed crash, ejection from the vehicle).
- Identify special extrication needs, if any.
- Call for additional resources if needed.

2. Primary Survey (Initial Assessment)

The purpose of the primary assessment is for the prehospital provider to rapidly identify and manage life-threatening conditions:

- Obtain a general impression of the patient's condition.
- Assess, secure and maintain a patent airway while simultaneously using C-spine precautions.
- Assess breathing and respiratory effort:
 - ◆ Approximate respiratory rate.
 - ◆ Assess quality of respiratory effort (depth of ventilation and movement of air).

Oxygen: 15 L/min via non-rebreather mask. Be prepared to suction the airway and support the patient's respirations with BVM (or intubate) if necessary.

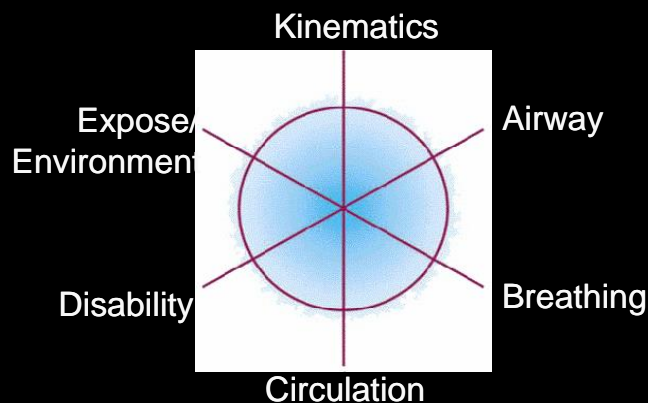
Routine Pediatric Trauma Care Protocol

EMR Care, BLS Care, ILS Care, & ALS Care

2. Primary Survey (Initial Assessment) (continued)

- Assess circulation:
 - ◆ Evaluate carotid and radial pulses.
 - ◆ Evaluate skin color, temperature and condition.
 - ◆ Immediately control major external bleeding.
- **Critical Decision** (based on mechanism of injury & initial exam):
 - ◆ Limit scene time to 10 minutes or < if the patient has a significant mechanism of injury or meets “Load & Go” criteria.
- Determine disability:
 - ◆ **T – Tone**
 - ◆ **I – Interactiveness**
 - ◆ **C – Consolability**
 - ◆ **L – Look/Gaze**
 - ◆ **S – Speech/Cry**
- Expose the patient:
 - ◆ Cut the patient’s clothing away quickly to adequately assess for the presence (or absence) of injuries.

Scene Assessment & Primary Survey



Adapted from PHTLS Revised 5th Edition Mosby 2003

Routine Pediatric Trauma Care Protocol

EMR Care, BLS Care, ILS Care, & ALS Care

3. Secondary Survey (Focused History & Physical Exam)

The secondary survey is a head-to-toe evaluation of the patient. The object of this survey is to identify injuries or problems that were not identified during the primary survey.

- Examine the head:
 - ◆ Search for any soft tissue injuries.
 - ◆ Palpate the bones of the face & skull to identify deformity, depression, crepitus or other injury.
 - ◆ Check pupils for size, reactivity to light, equality, accommodation, roundness and shape.

- Examine the neck:
 - ◆ Examine for contusions, abrasions, lacerations or other injury.
 - ◆ Check for JVD, tracheal deviation, deformity.
 - ◆ Palpate the c-spine for deformity & tenderness.

- Examine the chest:
 - ◆ Closely examine for deformity, contusions, redness, abrasions, lacerations, penetrating trauma or other injury.
 - ◆ Look for flail segments, paradoxical movement & crepitus.
 - ◆ Auscultate breath sounds.
 - ◆ Watch for supraclavicular and intercostals retractions.

- Examine the abdomen:
 - ◆ Examine for contusions, redness, abrasions, lacerations, penetrating trauma or other injury.
 - ◆ Palpate the abdomen and examine for tenderness, rigidity and distention.

- Examine the pelvis:
 - ◆ Examine for contusions, redness, abrasions, lacerations, deformity or other injury.
 - ◆ Palpate for instability and crepitus.

Routine Pediatric Trauma Care Protocol

EMR Care, BLS Care, ILS Care, & ALS Care

3. Secondary Survey (Focused History & Physical Exam) (continued)

- Examine the back:
 - ◆ Log roll with a minimum of 2 rescuers protecting the spine.
 - ◆ Look for contusions, abrasions, lacerations, penetrating trauma, deformity or any other injury.
 - ◆ Log roll onto long spine board with padding or approved pediatric spinal immobilization device.

- Examine the extremities:
 - ◆ Examine for contusions abrasions, lacerations, penetrating trauma, deformity or any other injury.
 - ◆ Manage injuries en route to the hospital.

- Neurological exam:
 - ◆ Calculate Glasgow Coma Scale (GCS)
 - ◆ Reassess pupils
 - ◆ Assess grip strength & equality and sensation.
 - ◆ Calculate Revised Trauma Score (RTS)

- Vital signs:
 - ◆ Blood pressure
 - ◆ Pulse
 - ◆ Respirations
 - ◆ Pulse Oximetry

- History:
 - ◆ Obtain a SAMPLE history if possible.
 - ◆ Signs & symptoms
 - ◆ Allergies
 - ◆ Medications
 - ◆ Past medical history
 - ◆ Last oral intake
 - ◆ Events of the incident

Routine Pediatric Trauma Care Protocol

EMR Care, BLS Care, ILS Care, & ALS Care

3. Secondary Survey (Focused History & Physical Exam) (continued)

- **Interventions (en route)**
 - ◆ Cardiac monitor (ALS Only)
 - ◆ Blood glucose level
 - ◆ IV access / fluid bolus (ALS Only)
 - ◆ Wound care
 - ◆ Splinting

4. Monitoring and Reassessment (Ongoing Assessment)

- Evaluate effectiveness of interventions
- Vital signs every *5 minutes*
- Reassess mental status (GCS) every *5 minutes*

5. CONTACT MEDICAL CONTROL AS SOON AS POSSIBLE

Critical Thinking Elements

- Prompt transport with EARLY Medical Control contact & receiving hospital notification will expedite the care of the trauma patient.
- IVs should be established en route to the hospital thereby not delaying transport of critical trauma patients (unless scene time is extended due to prolonged extrication).
- Trauma patients should be transported to the closest most appropriate Trauma Center. Medical Control should be contacted immediately if there is ANY question as to which Trauma Center the patient should be transported to.
- Children are prone to hypothermia in traumatic situations – keep the patient warm!!!!

The ED Physician may determine a trauma patient may benefit from the authorize transport directly to a level II Trauma Center; likewise, the ED Physician may authorize transport directly to level I Trauma Center, rather than transport to the closest hospital that is not a trauma center. This determination may only be made by the ED Physician and in compliance with the time requirements as mandated in the "Minimum Trauma Field Triage Criteria" policy (page 92 adult protocol)

Routine Pediatric Trauma Care Protocol

PEDIATRIC GLASGOW COMA SCALE (PGCS)				
	> 1 Year		< 1 Year	Score
EYE OPENING	Spontaneously		Spontaneously	4
	To verbal command		To shout	3
	To pain		To pain	2
	No response		No response	1
MOTOR RESPONSE	Obeys		Spontaneous	6
	Localizes pain		Localizes pain	5
	Flexion-withdrawal		Flexion-withdrawal	4
	Flexion-abnormal (decorticate rigidity)		Flexion-abnormal (decorticate rigidity)	3
	Extension (decerebrate rigidity)		Extension (decerebrate rigidity)	2
	No response		No response	1
	> 5 Years	2-5 Years	0-23 months	
VERBAL RESPONSE	Oriented	Appropriate words/phrases	Smiles/coos appropriately	5
	Disoriented/confused	Inappropriate words	Cries and is consolable	4
	Inappropriate words	Persistent cries and screams	Persistent inappropriate crying and/or screaming	3
	Incomprehensible sounds	Grunts	Grunts, agitated, and restless	2
	No response	No response	No response	1
TOTAL PEDIATRIC GLASGOW COMA SCORE:				(3-15)

Pediatric Shock Protocol

The pediatric patient in shock can pose a challenge to the prehospital professional. Since pediatric patients have young, strong cardiovascular systems, they can compensate extremely well. This can mask the signs and symptoms of shock until the child's cardiovascular system tires and begins to decompensate. Once the pediatric patient enters into a state of decompensated shock, prognosis for a full recovery is poor.

Conditions that may indicate impending shock include:

- Significant mechanism of injury
- Tender and/or distended abdomen
- Pelvic instability
- Bilateral femur fractures

“Load & Go” with any trauma patient with signs and symptoms of shock – on scene treatment should be minimal. Conduct a *Primary Survey*, manage the airway, take C-spine precautions & immobilize and control any life-threatening hemorrhage. Contact Medical Control as early as possible.

EMR

EMR Care should be focused on assessing the situation and initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol* and *Routine Pediatric Trauma Care Protocol*.
2. **Oxygen:** 15 L/min via non-rebreather mask or 6 L/min via nasal cannula if the patient cannot tolerate a mask. Be prepared to support the patient's respirations with BVM if necessary.
3. Control bleeding using direct pressure, and pressure dressings.

BLS Care

BLS Care should be directed at conducting a thorough patient assessment, initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock and preparing the patient for or providing transport.

Pediatric Shock Protocol

BLS Care Continued

1. Render initial care in accordance with the *Routine Pediatric Care Protocol* and *Routine Pediatric Trauma Care Protocol*.
2. **Oxygen:** 15 L/min via non-rebreather mask or 6 L/min via nasal cannula if the patient does not tolerate a mask. Be prepared to support the patient's respirations with BVM if necessary.
3. Control bleeding using direct pressure, and pressure dressings.
4. Initiate ILS/ALS intercept and transport as soon as possible.
5. Contact Medical Control as soon as possible.

ILS/ALS Care

ILS/ALS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, stabilizing the patient's perfusion and preparing for or providing patient transport.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol* and *Routine Pediatric Trauma Care Protocol*.
2. **Oxygen:** 15 L/min via non-rebreather mask or 6 L/min via nasal cannula if the patient does not tolerate a mask. Be prepared to support the patient's respirations with BVM (or intubate) if necessary.
3. Control bleeding using direct pressure and pressure dressings.
4. **IV Fluid Therapy:** 20mL/kg fluid bolus of 0.9% Normal Saline. May repeat once.
5. Transport as soon as possible.
6. **Contact Medical Control** as soon as possible.

- **Handtevy system should be used.**

Critical Thinking Elements

- **Pediatric patients will compensate for shock as long as they have the energy to do so. Once pediatric patients start to decompensate due to shock, it is exceedingly difficult to reverse the process. Therefore, it is imperative that shock is identified and treated early!**
- **Consider using a Tourniquet if arterial bleed.**

Pediatric Closed Head Injury Protocol

The causes of closed head injuries in pediatric patients are numerous. Injuries resulting from vehicular accidents or failure to wear proper safety gear (e.g. helmets) are common. The most effective way of determining the extent of closed head injury is mechanism of injury and level of consciousness.

The head is the largest body part of a pediatric patient which makes him/her “top heavy” and to fall head first during a trauma. The head is usually more seriously injured than any other area of the body in pediatric trauma. Proper initial management of a closed head injury patient can significantly impact long term prognosis.

Priorities for the treatment of head injury patients include airway management, maintenance of adequate oxygenation & blood pressure as well as appropriate C-spine control & immobilization.

EMR

EMR Care should be focused on assessing the situation and initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol and Routine Pediatric Trauma Care Protocol*.
2. Be prepared for vomiting and have suction readily available.
3. **Oxygen:** 15 L/min via non-rebreather mask. Be prepared to support the patient’s respirations with BVM if necessary.
4. Control bleeding using direct pressure, or pressure dressings.

BLS Care

BLS Care should be directed at conducting a thorough patient assessment, initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock and preparing the patient for or providing transport.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol and Routine Trauma Care Protocol*.
2. Be prepared for vomiting and have suction readily available.

Pediatric Closed Head Injury Protocol

BLS Care Continued

3. **Oxygen:** 15 L/min via non-rebreather mask or 6 L/min via nasal cannula if the patient does not tolerate a mask. Be prepared to support the patient's respirations with BVM if necessary.
4. Control bleeding using direct pressure, and pressure dressings.
5. Repeat vital signs, GCS & RTS every *5 minutes*.
6. Initiate ILS/ALS intercept and transport as soon as possible.
7. Contact Medical Control as soon as possible.

ILS/ALS Care

ILS/ALS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, stabilizing the patient's perfusion and preparing for or providing patient transport.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol* and *Routine Trauma Care Protocol*.
2. Be prepared for vomiting and have suction readily available.
3. **Oxygen:** 15 L/min via non-rebreather mask or 6 L/min via nasal cannula if the patient does not tolerate a mask. Be prepared to support the patient's respirations with BVM (or intubate) if necessary.
4. Control bleeding using direct pressure and pressure dressings.
6. Repeat vital signs, GCS & RTS every *5 minutes*.
7. **IV Fluid Therapy:** 20mL/kg fluid bolus of 0.9% Normal Saline, may repeat once.
8. **Contact Medical Control** as soon as possible.
9. **Handtevy system should be used.**

Pediatric Burn Protocol

The primary goal in the treatment of the pediatric burn patient is the same as when caring for an adult – to stop the acute burning process by removing the patient from direct contact with the source of the burn and maintaining the patient’s body fluids. Special attention should be given to limit further pain and damage of the burn to the patient. However, burn care should not interfere with lifesaving measures.

One aspect of pediatric burn care is different and prehospital providers need to be aware of it – **suspicious burns**. Suspicious burns include burns that have a familiar pattern (e.g. circumferential burns, burns from a cigarette lighter, etc.) or a story that does not fit the injury sustained. Pediatric burns carry a high index of suspicion for abuse and neglect. Follow local protocol for reporting abuse and neglect if suspected.

EMR

EMR Care should be focused on assessing the situation, removing the child from harm and initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. Make sure the scene is safe to enter.
3. **Oxygen:** 15 L/min via non-rebreather mask. Be prepared to support the patient’s respirations with BVM if necessary.
4. **THERMAL BURN TREATMENT:**
5.
 - a) If the burn occurred within the last 20 minutes, reverse the burning process and cool the area by flushing the area with **1 Liter of Sterile Saline** (or Sterile Water if Sterile Saline is not available). The goal of cooling is to extinguish the burning process – not to systemically cool the patient. Fluid application should be held to a minimum and discontinued if the patient begins shivering.
 - b) Remove jewelry and loose clothing. Do not pull away clothing that is stuck to the burn.
 - c) Cover the wound with sterile dressings***
 - d) Place a sterile burn sheet on the stretcher. If the patient’s posterior is burned, place a sterile burn pad on top of the sheet with the absorbent side toward the patient.

Pediatric Burn Protocol

EMR (continued)

- e) Place patient on the stretcher.
- f) Cover the patient with additional sterile burn sheets and blanket to conserve body heat.

6. ELECTRICAL BURN TREATMENT:

- a) Assure that the power service has been cut off and remove the patient from the source of electricity.
- b) Fully immobilize the patient due to forces of electrical current and possible trauma.
- c) Assess for entry and exit wounds. No cooling or flushing is necessary due to the type of burn.
- d) Cover the burn with dry, sterile dressings.
- e) Closely monitor the patient.

7. CHEMICAL BURN TREATMENT:

- a) Consider possible scene and patient contamination and follow agency safety procedures.
- b) Note which chemical agent caused the burn and obtain the MSDS for that chemical (if possible).
- c) The patient's clothing should be completely removed to prevent continued exposure and the patient decontaminated **prior to** being placed in the ambulance for transport.
- d) **Dry chemical powder** should be brushed off before applying water.
- e) Irrigate the patient with Sterile Water if and only if the MSDS indicates use of water will not cause an adverse reaction. Body parts should be flushed for at least 1-2 minutes. Do not use Sterile Saline on chemical burns.
- f) Irrigate burns to the eye with Sterile Water for at least 20 minutes. Alkaline burns should receive continuous irrigation throughout transport.

Pediatric Burn Protocol

BLS Care

BLS Care should be directed at conducting a thorough patient assessment, initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock and preparing the patient for or providing transport.

1. Includes all components of *EMR Care*.
2. Initiate ILS/ALS intercept and transport as soon as possible.
3. **Contact Medical Control** as soon as possible.

ILS/ALS Care

ILS/ALS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, stabilizing the patient's perfusion and preparing for or providing patient transport.

1. Includes all components of *EMR Care*.
2. Be prepared to intubate if necessary.
3. **IV Fluid Therapy:** 20mL/kg fluid bolus of 0.9% Normal Saline, may repeat once.
4. Transport and **Contact Medical Control** as soon as possible.
Morphine Sulfate: 0.1mg/kg IV/IM to reduce the patient's anxiety and severity of pain.
5. If the patient is allergic to Morphine or if Morphine is not effective:
Fentanyl: 1mcg/kg IV/IM over 2 minutes for pain.
Fentanyl 2mcg/kg IN.
7. **Midazolam (Versed):** 0.1mg/kg IV over 1 minute May repeat Midazolam.

OR

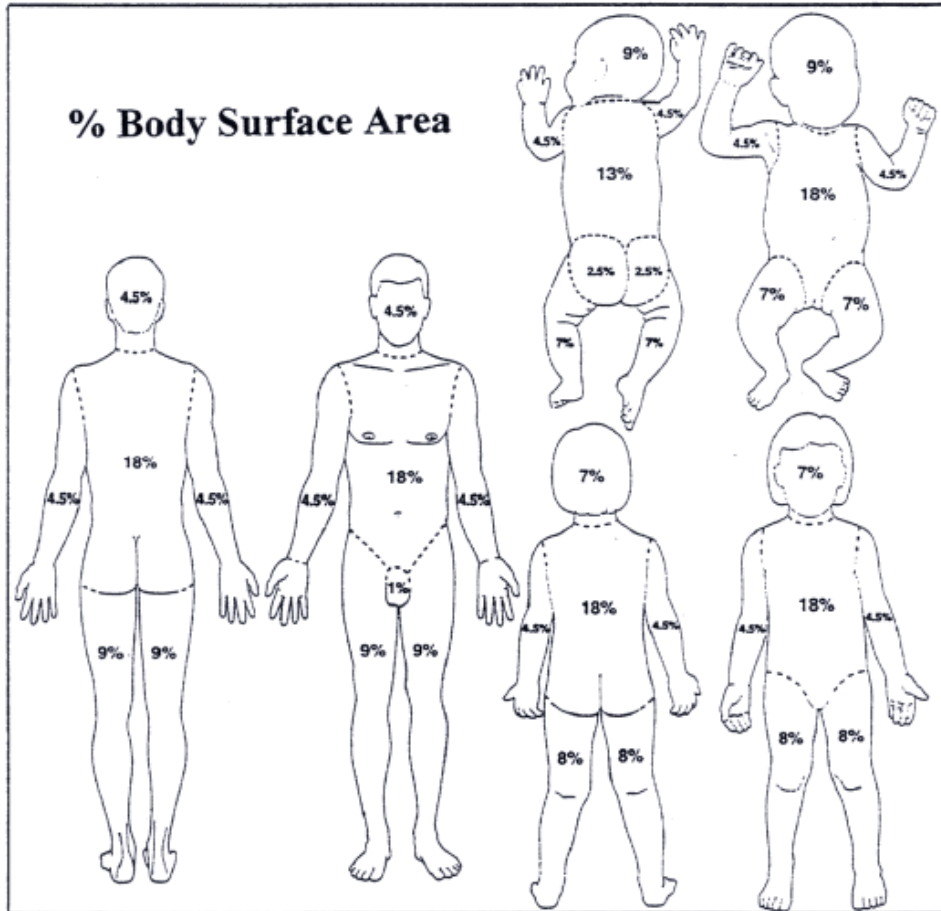
Midazolam (Versed): 0.2mg/kg IM.

- **Handtevy system should be used.**

Critical Thinking Elements

- *****WaterJel® may be used for THERMAL BURNS (after the burn has been irrigated according to protocol) if it is available.**
- **BurnJel® contains Lidocaine and may NOT be used in the EMS System.**
- **Treat other symptoms or trauma per the appropriate protocol.**
- **IV access should not be obtained through burned tissue unless no other site is available.**
- **Closely monitor the patient's response to IV fluids and assess for pulmonary edema.**
- **Closely monitor the patient's airway – have BVM, suction and/or intubation equipment readily available.**
- **Do not delay transport of a “Load and Go” trauma patient to care for burns.**
- **For chemical/powder burns, be aware of inhalation hazards and closely monitor for changes in respiratory status.**

Pediatric Burn Protocol



Palm of hand (including fingers) of infant or child = 1% of the total body surface

Pediatric Heat-Related Emergencies Protocol

Heat-related emergencies can often be seen in the pediatric population involved in intense sporting activities. When the body loses the ability to cool itself off, the body will retain heat, elevating core body temperature. If the core body temperature rises above normal, physiological consequences can develop. These can range from muscle cramps up to loss of consciousness and death. The treatment of hyperthermic injuries is basic if caught early.

EMR

EMR Care should be focused on assessing the situation and initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. Move the patient to a cool environment. Remove clothing as necessary to make the patient comfortable. Cold packs may be utilized for the neck (posterior), armpits, groin and along the thorax. Do not cool the patient to a temperature that will cause them to shiver.
3. **Oxygen:** 10-15 L/min via non-rebreather mask or 4-6 L/min via nasal cannula if the patient cannot tolerate a mask. Be prepared to support the patient's respirations with BVM if necessary.

BLS Care

BLS Care should be directed at conducting a thorough patient assessment, initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock and preparing the patient for or providing transport.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. Move the patient to a cool environment. Remove clothing as necessary to make the patient comfortable. Cold packs may be utilized for the neck (posterior), armpits, groin and along the thorax. Do not cool the patient to a temperature that will cause them to shiver.
3. **Oxygen:** 10-15 L/min via non-rebreather mask or 4-6 L/min via nasal cannula if the patient cannot tolerate a mask. Be prepared to support the patient's respirations with BVM if necessary.

Pediatric Heat-Related Emergencies Protocol

BLS Care (continued)

4. Treat other symptoms per the appropriate protocol.
5. Initiate ILS/ALS intercept if needed and transport as soon as possible.

ILS/ALS Care

ILS/ALS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, stabilizing the patient's perfusion and preparing for or providing patient transport.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
 2. Move the patient to a cool environment. Remove clothing as necessary to make the patient comfortable. Cold packs may be utilized for the neck (posterior), armpits, groin and along the thorax. Do not cool the patient to a temperature that will cause them to shiver.
 3. **Oxygen:** 10-15 L/min via non-rebreather mask or 4-6 L/min via nasal cannula if the patient cannot tolerate a mask. Be prepared to support the patient's respirations with BVM if necessary.
 4. **IV Fluid Therapy:** 20mL/kg fluid bolus of 0.9% Normal Saline if the patient is hypotensive. May repeat bolus once.
 5. Treat other symptoms per the appropriate protocol.
 6. Transport as soon as possible.
- **Handtevy system should be used.**

Heat Disorders

Heat (Muscle) Cramps – Heat cramps are muscle cramps caused by overexertion and dehydration in the presence of high temperatures. Signs & symptoms include: *Normal or slightly elevated body temperature; generalized weakness; dizziness; warm, moist skin and cramps in the fingers, arms, legs or abdominal muscles.*

Heat Exhaustion – Heat exhaustion is an acute reaction to heat exposure and the most common heat-related illness a prehospital provider will encounter. Signs & symptoms include: *Increased body temperature; generalized weakness; cool, diaphoretic skin; rapid, shallow breathing; weak pulse; diarrhea; anxiety; headache and possible loss of consciousness .*

Heatstroke – Heatstroke occurs when the body's hypothalamic temperature regulation is lost. Cell death and damage to the brain, liver and kidneys can occur. Signs & symptoms include: *Cessation of sweating; very high core body temperature; hot, usually dry skin; deep, rapid, shallow respirations (which later slow); rapid, full pulse (which later slows); hypotension; confusion, disorientation or unconsciousness and possible seizures.*

Fever (Pyrexia) – A fever is the elevation of the body temperature above the normal temperature >100.4 degrees. Fever is sometimes difficult to differentiate from heatstroke; however, there is usually a history of infection or illness with a fever.

Acute Nausea & Vomiting Protocol

Acute nausea and vomiting may occur from a variety of illness including, but not limited to:

- Adverse medication effects

An attempt at determining potential causes of isolated nausea or vomiting must be made in order to identify potential life threatening conditions.

EMR

EMR Care should be focused on assessing the situation and initiating routine patient care to assure that the patient has a patent airway, is breathing and has a per fusing pulse as well as beginning treatment for shock.

1. Render initial care in accordance with the *Universal Patient Care Protocol*.
2. Place the patient in an upright or lateral recumbent position as tolerated.
3. Monitor airway status in vomiting patients as aspiration may occur. Reposition the patient as necessary to maintain a patent airway.
4. **Oxygen:** 15 L/min via non-rebreather mask or 6 L/min via nasal cannula if the patient cannot tolerate a mask. **Note:** Oxygen by mask may trap secretions and compromise the airway if the patient is actively vomiting.
5. Perform **blood glucose level test**.
6. **Oral Glucose:** 15g PO if the patient's blood sugar is < 60mg/dL, the patient is alert to verbal stimuli, is able to sit in an upright position, has good airway control and has an intact gag reflex.
7. Perform a 2nd **blood glucose level test** to re-evaluate blood sugar 5 minutes after administration of Oral Glucose. If blood sugar remains <60mg/dL, administer a 2nd dose of Oral Glucose (15g).

Acute Nausea & Vomiting Protocol

BLS Care

BLS Care should be directed at conducting a thorough patient assessment, initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock & preparing the patient for or providing transport.

1. Render initial care in accordance with the *Universal Patient Care Protocol*.
2. Place the patient in an upright or lateral recumbent position as tolerated.
3. Monitor airway status in vomiting patients as aspiration may occur. Reposition the patient as necessary to maintain a patent airway.
4. **Oxygen:** 15 L/min via non-rebreather mask or 6 L/min via nasal cannula if the patient cannot tolerate a mask. **Note:** Oxygen by mask may trap secretions and compromise the airway if the patient is actively vomiting
5. Perform **blood glucose level test**.
6. Initiate ILS/ALS intercept if needed and transport as soon as possible.

ILS/ALS

ILS/ALS Care should be directed at continuing or establishing a more advanced level of care, identifying potential serious conditions, stabilizing airway and circulation where appropriate and providing pharmacological relief from symptoms of nausea and vomiting.

1. Render initial care in accordance with the *Universal Patient Care Protocol*.
 2. Place the patient in an upright or lateral recumbent position as tolerated.
 3. Monitor airway status in vomiting patients as aspiration may occur. Reposition the patient as necessary to maintain a patent airway.
 4. **Oxygen:** 15 L/min via non-rebreather mask or 6 L/min via nasal cannula if the patient cannot tolerate a mask. **Note:** Oxygen by mask may trap secretions and compromise the airway if the patient is actively vomitin
- **Handtevy system should be used.**

Acute Nausea & Vomiting Protocol

ILS/ALS Care

5. Ondansetron

[8-15 kg]

Dose: 2 mg PO x1;

Alt: 0.15 mg/kg IV x1

[16-30 kg]

Dose: 4 mg PO x1;

Alt: 0.15 mg/kg IV x1

[>31 kg]

Dose: 4 mg/dose PO

Alt: 0.15 mg/kg IV x1

6. **IV Fluid Therapy:** 20mL/kg fluid bolus if the needed.
7. Perform **blood glucose level test**.
8. **Administer D10W 5mL/kg. Max dose of 250mL.**
9. .GLUCAGON 0.1mg/kg IM if no IV/IO is established and patient is symptomatic
10. Blood sugar 60-250mg/dl maintain blood sugar and use appropriate protocol
11. **Blood sugar greater than 250mg/dl. Dehydration with no evidence of CHF/fluid overload. LACTATED RINGERS BOLUS 20ml/kg. Repeat as needed to maintain age appropriate blood pressure max 60ml/kg**
12. Initiate transport as soon as possible.
13. Contact the receiving hospital as soon as possible.
 - **Handtevy system should be used.**

Critical Thinking Elements

- Avoid use of Zofran in patients with congenital long QT syndrome as these patients are at particular risk for Torsades de Pointes

Pediatric Hypothermia Protocol

Hypothermia in children is common at any time of the year. Children dissipate heat faster than adults due to their body mass compared to the surface area of skin. EMS providers must suspect an onset of hypothermia in all cold environmental emergencies, child neglect and trauma. Rapid identification and treatment of hypothermia can have a significant effect on the outcome of the pediatric patient.

EMR

EMR should be focused on assessing the situation and initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. Handle the patient as **gently** as possible.
3. Create a warm environment for the patient. Remove wet or frozen clothing and cover the patient with warm blankets. Prevent re-exposure to cold. Warm packs may be utilized for the neck (posterior), armpits, groin and along the thorax.
4. **Oxygen:** 10-15 L/min via non-rebreather mask or 4-6 L/min via nasal cannula if the patient cannot tolerate a mask. Be prepared to support the patient's respirations with BVM if necessary.
5. Do not rub frostbitten or frozen body parts. Protect injured parts (e.g. blisters) with light, sterile dressings and avoid pressure to the area.

BLS Care

BLS Care should be directed at conducting a thorough patient assessment, initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock and preparing the patient for or providing transport.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. Handle the patient as **gently** as possible.
3. Create a warm environment for the patient. Remove wet or frozen clothing and cover the patient with warm blankets. Prevent re-exposure to cold. Warm packs may be utilized for the neck (posterior), armpits, groin and along the thorax.
4. **Oxygen:** 10-15 L/min via non-rebreather mask or 4-6 L/min via nasal cannula if the patient cannot tolerate a mask. Be prepared to support the patient's respirations with BVM if necessary.

Pediatric Hypothermia Protocol

BLS Care (continued)

5. Do not rub frostbitten or frozen body parts. Protect injured parts (e.g. blisters) with light, sterile dressings and avoid pressure to the area.
6. Treat other symptoms per the appropriate protocol.
7. Initiate ILS/ALS intercept if needed and transport as soon as possible.

ILS/ALS Care

ILS/ALS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, stabilizing the patient's perfusion and preparing for or providing patient transport.

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
 2. Handle the patient as **gently** as possible.
 3. Create a warm environment for the patient. Remove wet or frozen clothing and cover the patient with warm blankets. Prevent re-exposure to cold. Warm packs may be utilized for the neck (posterior), armpits, groin and along the thorax.
 4. **Oxygen:** 10-15 L/min via non-rebreather mask or 4-6 L/min via nasal cannula if the patient cannot tolerate a mask. Be prepared to support the patient's respirations with BVM if necessary.
 5. **IV Fluid Therapy:** 20mL/kg fluid bolus of **warmed** 0.9% Normal Saline.
 6. Do not rub frostbitten or frozen body parts. Protect injured parts (e.g. blisters) with light, sterile dressings and avoid pressure to the area.
 7. Treat other symptoms per the appropriate protocol.
 8. Transport as soon as possible.
- **Handtevy system should be used.**

Critical Thinking Elements

- **Do not thaw frozen parts in the field if there is a chance of refreezing. Protect frostbitten areas from refreezing.**
- **Patients with hypothermia should be considered at high risk for ventricular fibrillation. It is imperative that these patients be handled gently and not re-warmed aggressively.**
- **The presence of delirium, bradycardia, hypotension and/or cyanosis is usually indicative of severe hypothermia (core body temperature of < 90 degrees Fahrenheit).**

Pediatric Drowning Protocol

Drowning remains one of the top five causes of pediatric death each year. EMS efforts need to focus on airway control and hypothermia management. Complications may arise from the fluid the child has drowned in. Remember – children can drown in as little as two inches of fluid. Children not only drown in rivers or pools but also mop buckets and bathtubs.

EMR

EMR should be focused on assessing the situation and initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock.

1. Render initial care in accordance with the *Routine Patient Care Protocol* and *Routine Trauma Care Protocol*.
2. Make sure the scene is safe. Use appropriate personnel and equipment for rescue.
3. Establish and maintain spinal immobilization.
4. **Oxygen:** 15 L/min via non-rebreather mask or 6 L/min via nasal cannula if the patient cannot tolerate a mask. Be prepared to clear the airway and support the patient's respirations with BVM if necessary.
5. Initiate **CPR** if indicated.
6. Treat respiratory and/or cardiac symptoms per the appropriate protocol.

BLS Care

BLS Care should be directed at conducting a thorough patient assessment, initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock and preparing the patient for or providing transport.

1. Includes all components of *EMR Care*.
2. Initiate ILS/ALS intercept and transport as soon as possible.
3. **Contact Medical Control** as soon as possible.

Pediatric Drowning Protocol

ILS/ALS Care

ILS/ALS Care should be directed at continuing or establishing care, conducting a thorough patient assessment, stabilizing the patient's perfusion and preparing for or providing patient transport.

1. Includes all components of *BLS*.
 2. Transport as soon as possible.
 3. **Contact Medical Control** as soon as possible.
 4. **The patient should be monitored closely on a cardiac monitor for the development of arrhythmias.**
- **Handtevy system should be used.**

Suspected Child Maltreatment –Abuse Protocol

Illinois state law mandates that EMS providers report any suspicious acts of suspected maltreatment. There is no profile of the “typical” family in which abuse is taking place. Maltreatment of children affects all socio-economic classes. As EMS professionals, we need to be aware of the warning signs, treat the injuries of the child and report accordingly.

EMR, BLS Care, ILS Care, ALS Care

1. Consider scene safety issues:
 - a) If the offender is present and interferes with transportation of the patient, or is influencing the patient’s acceptance of medical care, contact law enforcement and Medical Control for consultation on the appropriate action to take.
 - b) If the parent/guardian refuses to allow transportation of the child, contact law enforcement and Medical Control for consultation on the appropriate action to take.
2. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
3. Treat obvious injuries or illnesses.
4. After the scene is safe, assess the environment for factors that may affect patient outcome:
 - a) Environmental
 - b) Interaction with parents/guardians
 - c) Discrepancies in the history of events
 - d) Injury patterns inconsistent with history of events or anticipated motor skills based on the child’s growth and development stage.
 - e) Signs of intentional injury or emotional harm.
5. Transport regardless of extent of injuries.
6. **Upon arrival at the ED, notify the receiving physician or nurse of the suspected maltreatment/abuse. Remember – healthcare workers (including EMS) are mandated by Illinois state law to report cases of suspected abuse or neglect to the Department of Children and Family Services (DCFS) by calling 1-800-252-2873.**
7. Thoroughly document the child’s history & physical exam findings.

Critical Thinking Elements

- **Do not make accusations on the PCR. Document objective physical findings, not opinion.**
- **A copy of the *Manual for Mandated Reporters* can be downloaded at www.state.il.us/dcf.**
- **Willful failure to report suspected incidents of child abuse/neglect is a misdemeanor (1st violation) or a class 4 felony (2nd or subsequent violations).**
- **Reports must be confirmed in writing to the local investigation unit within 48 hours of the Hotline call.**

Sudden Infant Death Syndrome (SIDS) Protocol

Sudden Infant Death Syndrome (SIDS) and the death of a child are among the most difficult patient care experiences for the prehospital professional. SIDS is the leading cause of infant mortality in the United States and the causes are not known.

The death of a child is a horrible event and creates difficult emotional issues for the caregivers as well as for the prehospital professional. The infant may be in the care of a parent/caregiver or babysitter at the time of death and may not be at home. Absence of one or both parents may complicate field management and interactions at the scene (PEPP 2001).

EMR, BLS Care, ILS Care & ALS

1. Render initial care in accordance with the *Routine Pediatric Care Protocol*.
2. **If obvious signs of biological death are present** (*pulseless, apneic, cold skin, frothy/blood tinged fluid in the mouth, lividity, dark red mottling on the body, rigor mortis*):
 - a) Confirm absence of breathing and pulse.
 - b) Confirm asystole in two (2) or more leads.
 - c) **Contact Medical Control** and follow procedures for death at scene.
 - d) Provide for the needs of the family:
 - Have at least one prehospital professional stay with the family until a support network is established.
 - Contact support personnel:
 - ❖ Clergy
 - ❖ Other family members
 - ❖ Friends
 - ❖ Professional counselors
3. Consider the possibility of child maltreatment:
 - a) Refer to *Suspected Child Maltreatment Protocol*.
 - b) Obtain past medical history and the history of events.
 - Refrain from asking judgmental or leading questions.
 - Do not place blame or accusations.
4. Consider CISM for prehospital personnel.

Sudden Infant Death Syndrome (SIDS) Protocol

Critical Thinking Elements

- **The decision of staying on scene or transporting a dead infant to the ED is a difficult one. Consider these factors:**
 - a) **Could this be a crime scene?**
 - b) **Am I giving false hope to the family?**
- **The prehospital caregiver cannot determine the true cause of death in an infant. Therefore, do not rush to judgment. Treat every caregiver as a grieving parent regardless of the situation.**
- **There are nearly 3000 SIDS cases per year in the United States:**
 - a) **90-95% of SIDS cases are < 6 months old.**
 - b) **5% of SIDS cases are actually due to child neglect.**
 - c) **SIDS cases occur more frequently in males & during the winter months.**