

St. Anthony Medical Center Emergency Medical Services System



Basic Life Support Treatment Protocols

**St. Anthony Medical Center
Emergency Medical Services System**

**Basic Life Support
Standing Medical Orders**

Introduction

These protocols are to be followed by all Basic Life Support Providers of the St. Anthony Medical Center EMS System. Deviations from these orders can be made only by the Medical Director, or designee. Providers should use these orders when treatment needs to be initiated prior to contact with the receiving facility. These protocols should be used in the event that communication cannot be established or communication is disrupted or lost between the responding medics and the receiving facility. Every effort should be made to contact the receiving facility over cellular phone, IHERN, or landline phone. These protocols are also to be used in disaster situations, when immediate action to preserve life and limb supersedes the need to directly communicate with the receiving facility.

Due to geographic and regional considerations, some providers may include or exclude certain interventions, as indicated in this document.

**Stevan A. Vuckovic, D.O., FACOEP, FACEP
EMS Medical Director**

**Daniel M. Netluch, M.D., FACEP
Administrative Director- Emergency Services**

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St. Anthony Medical Center Emergency Medical Services System



Supplemental Information

Code 2
RADIO PROTOCOL

Outline for Radio Report
(Transmitting as few words as possible)

1. Name and unit number of provider.
2. Requested destination, closest hospital, and ETA.
3. Age, Sex, and approximate weight of patient.
4. Chief complaint, to include signs and symptoms, and degree of distress.
5. Level of Consciousness and orientation.
6. Clinical Condition: Focused and Detailed patient assessment findings.
7. History of present injury or illness.
8. SAMPLE History findings.
9. Treatment rendered and response.

Trauma Patient

1. Name and unit number of provider
2. Age, sex, and mechanism of injury.
3. Chief complaint, to include signs and symptoms, and degree of distress.
4. Level of Consciousness and orientation.
5. Focused and detailed patient assessment findings.
6. SAMPLE History findings.
7. Treatment rendered and response.
8. Destination and ETA.

Mass Casualty Incident

1. Name and unit number of provider.
2. Approximate number of victims and approximate triage levels.
3. Mechanism of illness or injury.
4. Report of any potential hazards.
5. Medical communications should utilize IHERN unless otherwise specified.

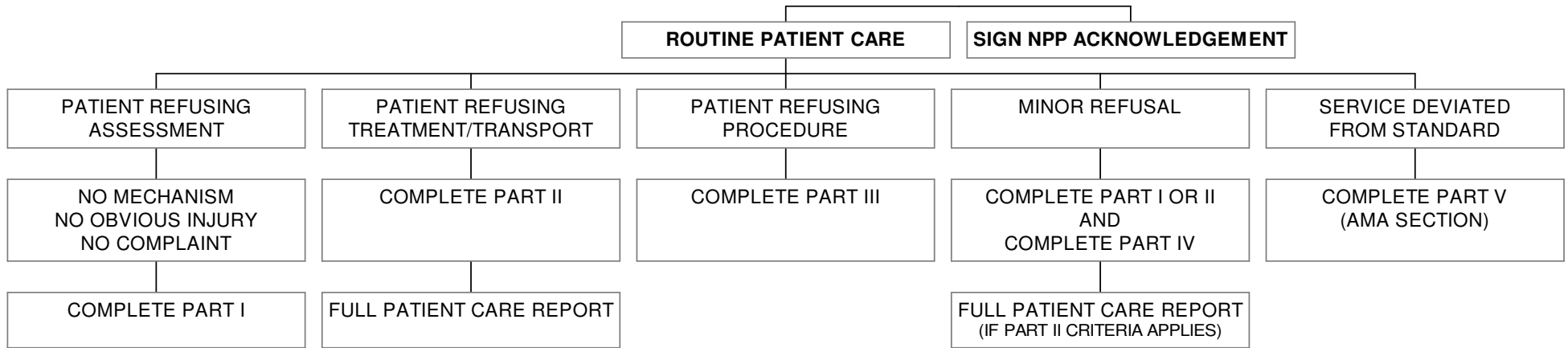
Code 3

ACCELERATED TRANSPORT

Certain conditions require treatment within minutes. These situations occur when a problem is discovered in the Initial Assessment (Primary Survey) that cannot be rapidly resolved by field interventions. Only airway and spinal immobilization should be managed prior to transport. Further efforts at stabilization should be performed enroute to the receiving facility and should not delay transport.

If circumstances demand hospital care for patient stability, rapid transport is indicated. Each case will be unique and compelling reasons must be documented. Notify receiving hospital of the situation so that preparations can be made. Primary resuscitative measures must be initiated.

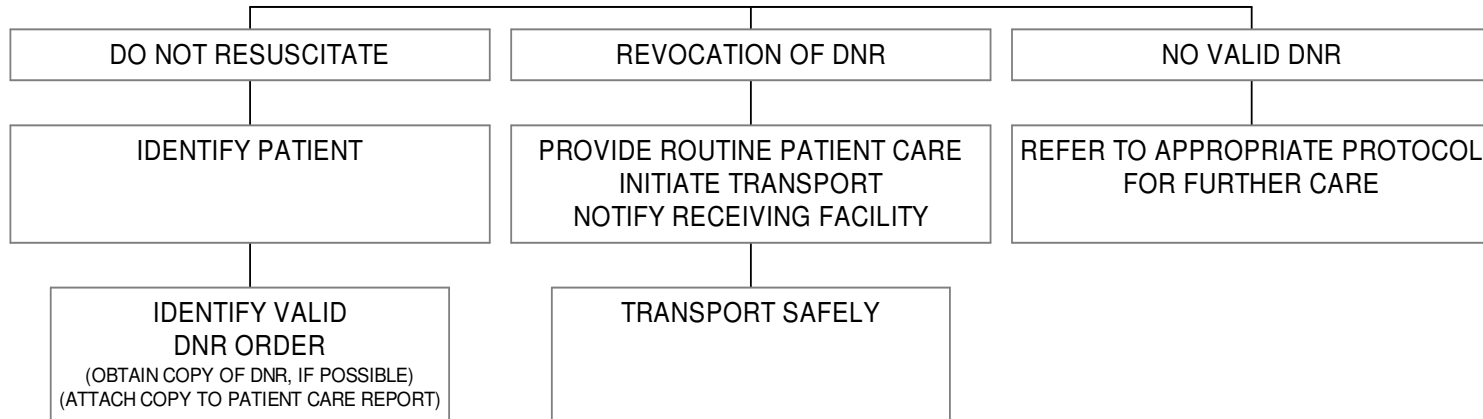
Code 4
REFUSAL OF SERVICES



1. Document situation in all cases of refusal and contact medical control for assistance.
2. List the presence or absence of factors that enable refusal.
3. Document notification of potential consequences of their refusal.
4. Document receipt of "Policy of Privacy Practices" form.
5. Obtain the required signatures.
6. Obtain witness signature. (Family, friend, police, or EMS personnel)

Code 5

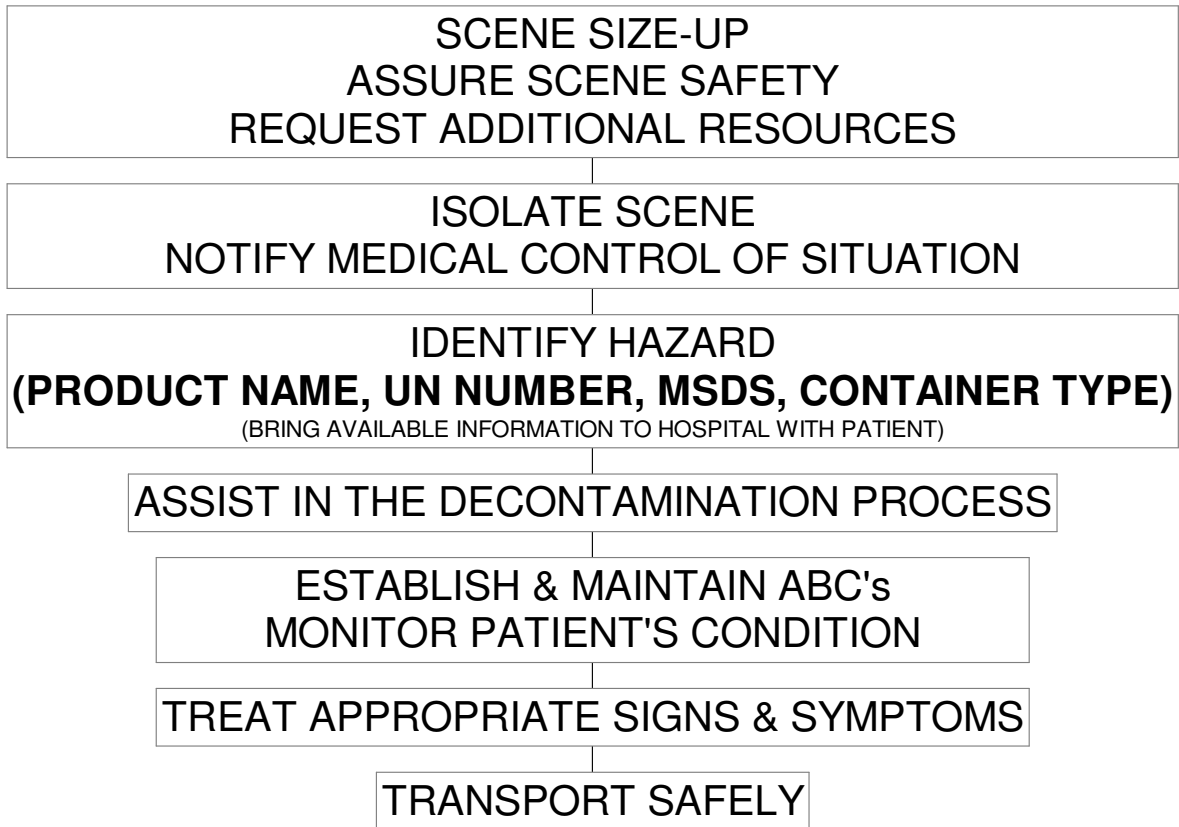
HONORING DO NOT RESUSCITATE ORDERS



- Cause of action prescribed by a physician to withhold resuscitation measures on a victim of cardiopulmonary arrest.
- Pre-hospital personnel must make a reasonable attempt to verify the identification of the patient named in a valid DNR Order.
- Patient should be a resident of a long-term care facility; hospice patient; home care patient; or inter-hospital transfer patient.
 - A living Will **CANNOT** be accepted nor recognized by EMS Providers.
 - Should contain the following information:
 - Patient's Name
 - Name and signature of attending physician
 - Effective Date
 - The words "Do Not Resuscitate"
 - Evidence of consent (any of the following): patient's signature, legal healthcare decision maker.
- Notify Medical Control that you are honoring a DNR Order in the field.
- The patient, physician who signed the DNR Order, or the consenting party to the DNR Order can verbally or physically destroy the DNR Order.
- Provide comfort care and compassion for the patient.
- Treat acute airway obstruction, even if airway support is required.
- Treat problems not specifically listed (i.e. Instant Glucose for hypoglycemia).

Code 6

HAZARDOUS MATERIALS RESPONSE



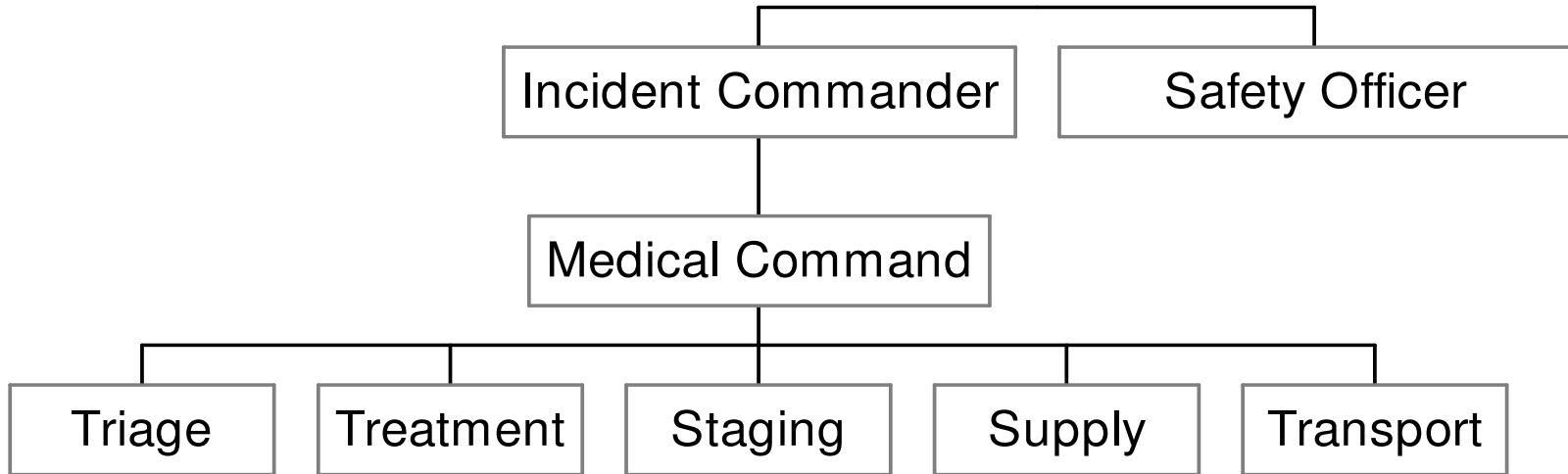
Poison Control Center
(800) 222-1222

Code 7

MASS CASUALTY INCIDENT RESPONSE PROCEDURE

Medical responses to incidents where the number of victims or potential victims out number the Emergency Service Personnel, pose special problems for any EMS System. Therefore, in response to such incidents, the Incident Management System (IMS), as outlined by SARA, OSHA, and NFPA 1500 and 1561 Standards, will be instituted.

Medical Command is responsible for assessing the scene for the number and severity of casualties. This information is to be communicated to the receiving facility, prior to the initiation of transportation.

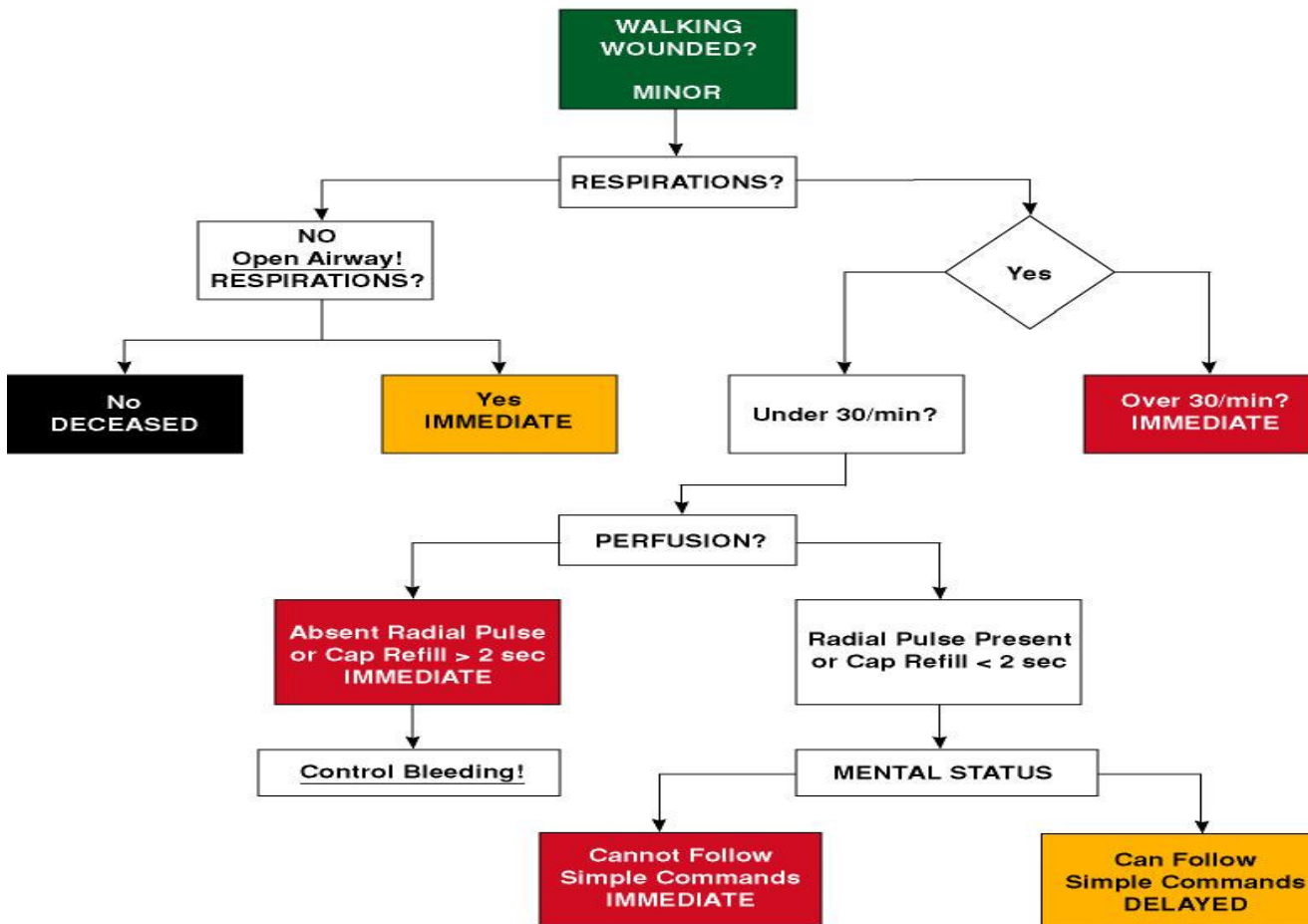


Code 8

STANDARD TRIAGE SYSTEM

The use of a Universal Triage System will help maintain the continuity of care and control of every victim, injured or uninjured. Every victim will be placed into one of four triage categories based upon the S.T.A.R.T. Triage System.

START TRIAGE SYSTEM



Code 9

STANDARD PRECAUTIONS

Task or Activity	Gloves	Gown	Mask	Protective Eyewear
Assessing Patient	YES	NO	NO	NO
Assessing Vital Signs	YES	NO	NO	NO
Assessing Diagnostic Signs				
Bleeding Control (Minimal Bleeding)	YES	NO	NO	NO
Bleeding Control (Major Bleeding)	YES	YES	YES	YES
Emergency Childbirth	YES	YES	YES	YES
Blood Draw	YES	NO	NO	NO
Blood Glucose Check				
IV Access	YES	NO	NO	NO
Giving Medication Injections				
Oral/Nasal Suctioning	YES	YES	YES	YES
Inserting Basic Airway Adjunct CombiTube				
LMA Insertion	YES	NO	YES	YES
Inserting Advanced Airway Adjunct Endotracheal Intubation	YES	NO	YES	YES
Cleaning Ambulance	YES	NO	NO	NO

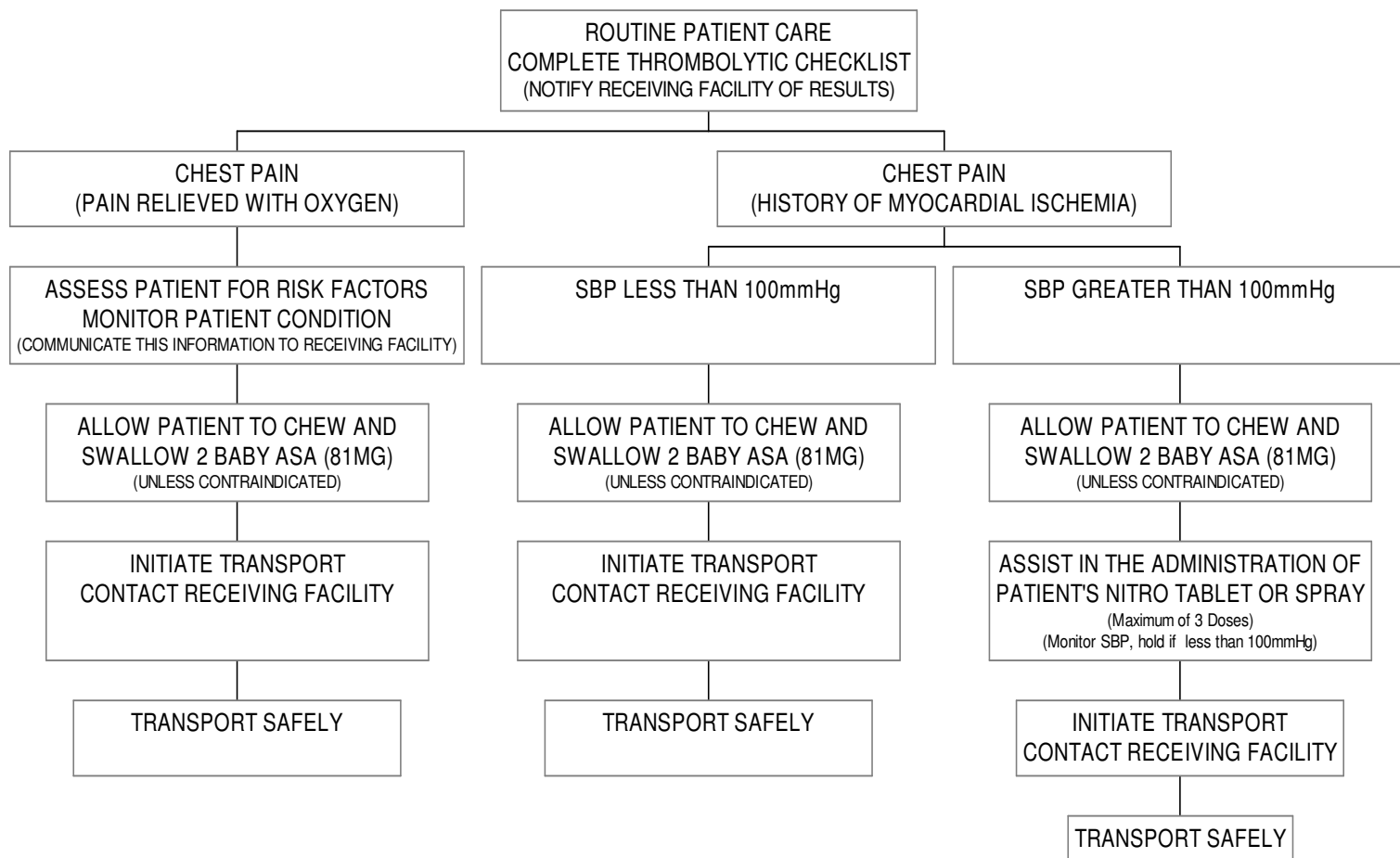
St. Anthony Medical Center Emergency Medical Services System



Adult Medical Patient Care Protocol

Code 10

SUSPECTED CARDIAC PATIENT



THROMBOLYTIC CHECKLIST

Clinical Presentation

- Chest Pain
- Unrelieved with Nitro
- Last > 30 minutes

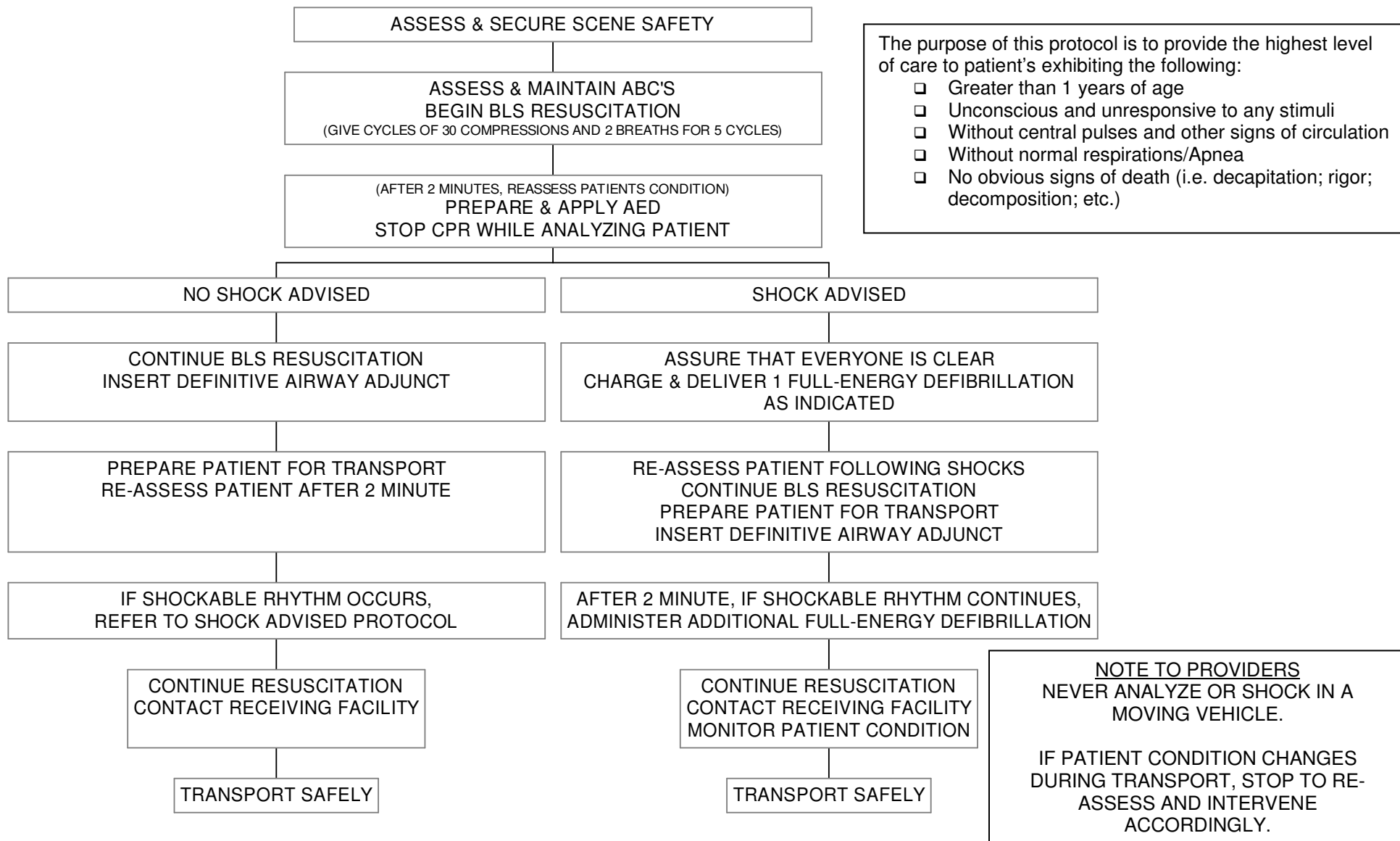
Contraindications

- History of Stroke or TIA
- Active Internal Bleeding
- History of Bleeding Disorder
- Uncontrolled Hypertension
- Intracranial/Spinal surgery
- History of CA; AVM; or aneurysm
- History of trauma or surgery within 2 weeks
- Pregnancy
- Anticoagulant use
- Blood Thinners (Call MC)
- Suspected aortic dissection
- Suspected Pericarditis

CONTRAINDICATIONS TO ASA ADMINISTRATION INCLUDE ASA ALLERGY AND ACTIVE BLEEDING

Code 11

CARDIAC ARREST-DEFIBRILLATION PROTOCOL



The purpose of this protocol is to provide the highest level of care to patient's exhibiting the following:

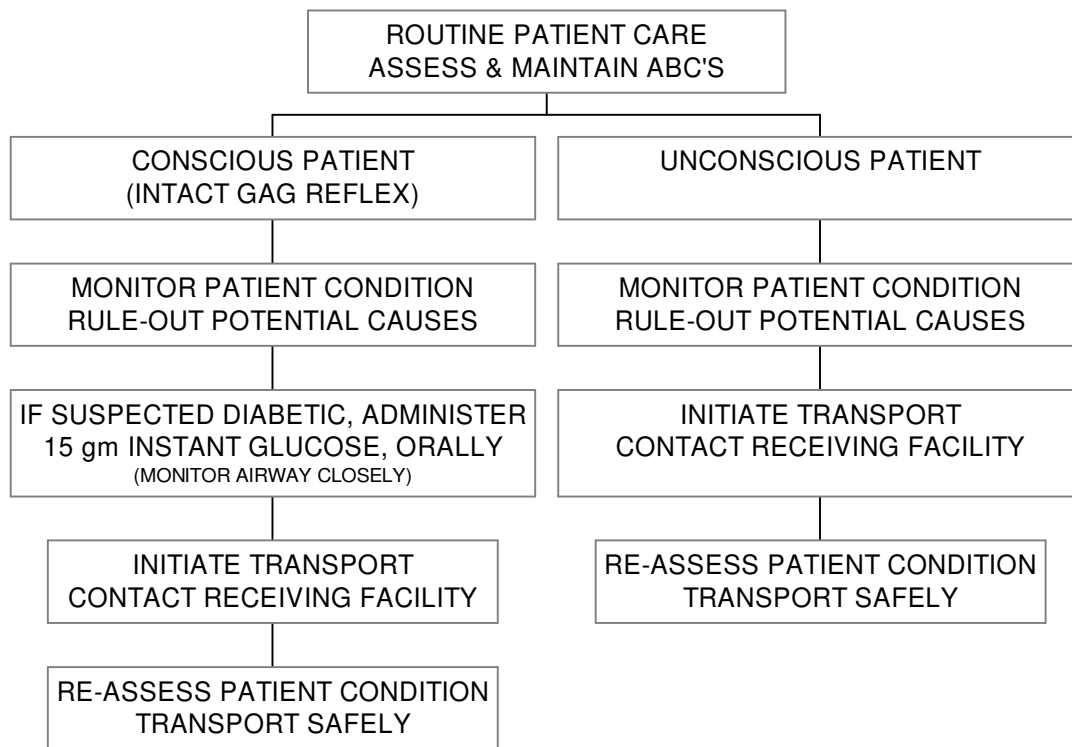
- Greater than 1 years of age
- Unconscious and unresponsive to any stimuli
- Without central pulses and other signs of circulation
- Without normal respirations/Apnea
- No obvious signs of death (i.e. decapitation; rigor; decomposition; etc.)

NOTE TO PROVIDERS
NEVER ANALYZE OR SHOCK IN A MOVING VEHICLE.

IF PATIENT CONDITION CHANGES DURING TRANSPORT, STOP TO RE-ASSESS AND INTERVENE ACCORDINGLY.

Code 12

ALTERED LEVEL OF CONSCIOUSNESS



- Identify Possible Causes**
- A = Alcohol; Acidosis**
 - E = Endocrine Emergencies**
 - I = Insulin**
 - O = Over Dose**
 - U = Uremia**

 - T = Trauma; Tumor**
 - I = Infection**
 - P = Psychiatric Emergencies**
 - S = Stroke; Sepsis**

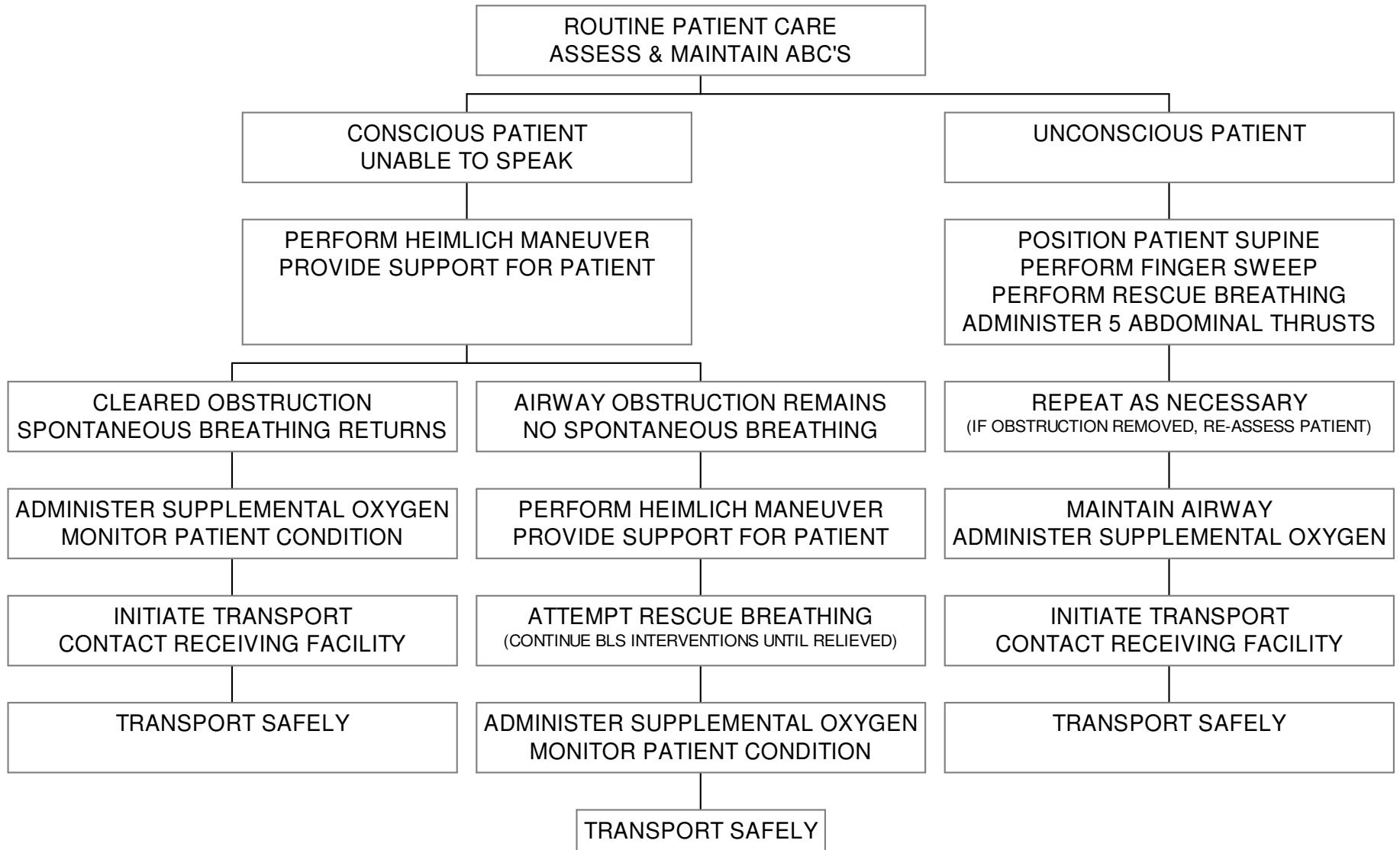
Other Causes & Management

Overdose: Obtain information on suspected agent.
Support ABC's
Contact Poison Control

Head Injury: Full Spinal Immobilization
Support ABC's

Code 13

AIRWAY OBSTRUCTION



Code 14

RESPIRATORY DISTRESS, FAILURE, OR ARREST

DIFFERENTIAL DIAGNOSIS CRITERIA

RESPIRATORY DISTRESS

- ❑ INCREASED RATE
- ❑ ACCESSORY MUSCLE USAGE
- ❑ MENTAL STATUS CHANGES
- ❑ CHANGE IN SKIN CHARACTERISTICS

RESPIRATORY FAILURE

- ❑ RESPIRATORY FATIGUE
- ❑ DECREASED RATE
- ❑ UNCONSCIOUSNESS
- ❑ POOR PERFUSION

RESPIRATORY ARREST

- ❑ UNCONSCIOUSNESS
- ❑ IRREGULAR/ABSENT RESPIRATIONS
- ❑ CARDIOPULMONARY ARREST

ROUTINE PATIENT CARE
ASSESS & MAINTAIN ABC'S

CONSCIOUS PATIENT
UNABLE TO SPEAK

UNCONSCIOUS PATIENT

ASSIST POSITIVE PRESSURE VENTILATION (PPV)
INSERT ORAL OR NASAL AIRWAY

ASSIST POSITIVE PRESSURE VENTILATION (PPV)
INSERT ORAL OR NASAL AIRWAY

RE-ASSESS & MAINTAIN ABC'S
MONITOR PATIENT CONDITION

INITIATE TRANSPORT
CONTACT RECEIVING FACILITY

INITIATE TRANSPORT
CONTACT RECEIVING FACILITY

INSERT DEFINITIVE AIRWAY
(LMA/ CombiTube)

TRANSPORT SAFELY

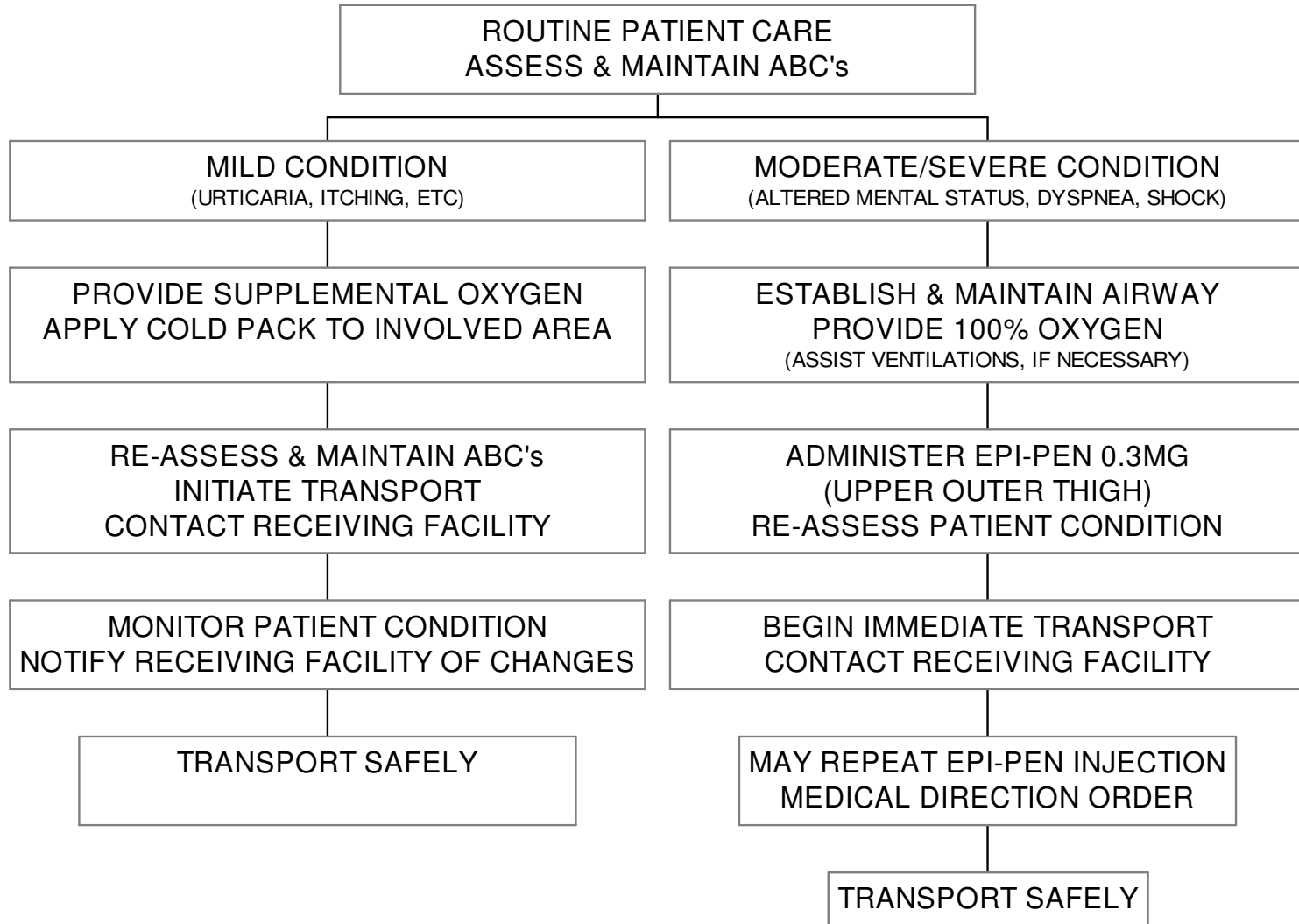
TRANSPORT SAFELY

REACTIVE AIRWAY DISEASE

- ❑ OBTAIN SUPPLEMENTAL OXYGEN
- ❑ OBTAIN AND ASSIST IN THE ADMINISTRATION OF THE PATIENT'S METERED DOSE INHALER

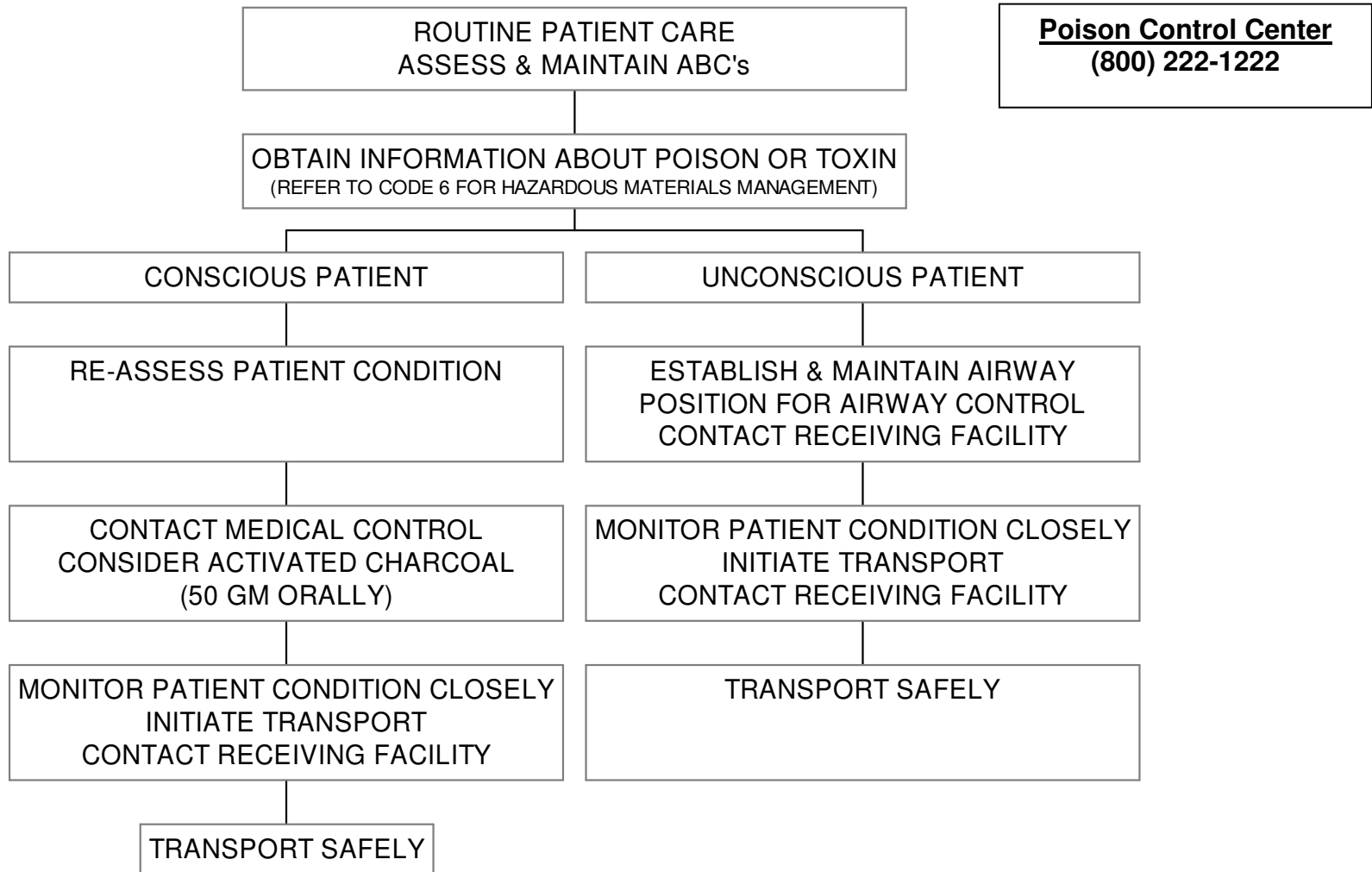
Code 15

ANAPHYLACTIC SHOCK



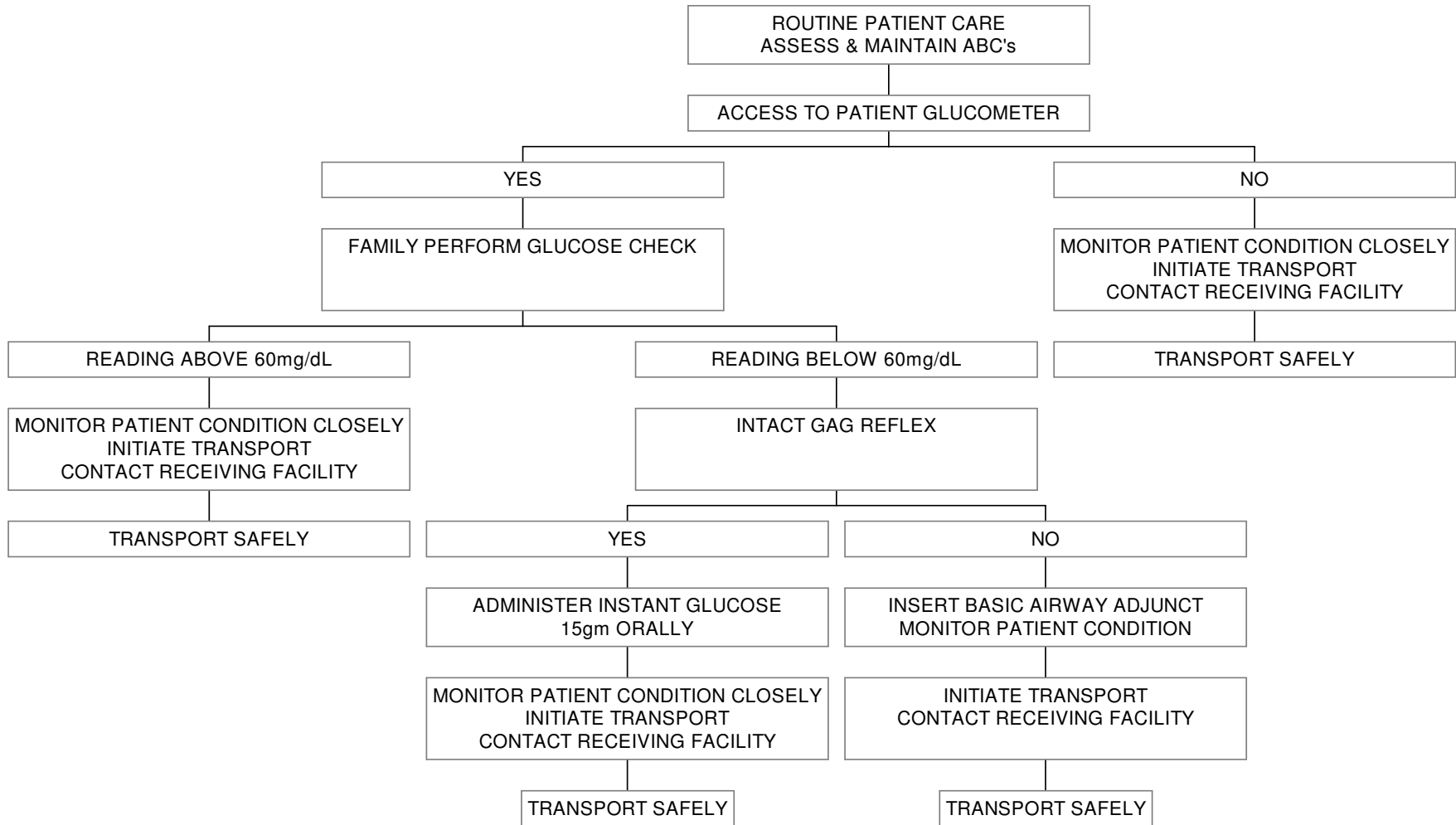
Code 16

POISONING/TOXIC EXPOSURE



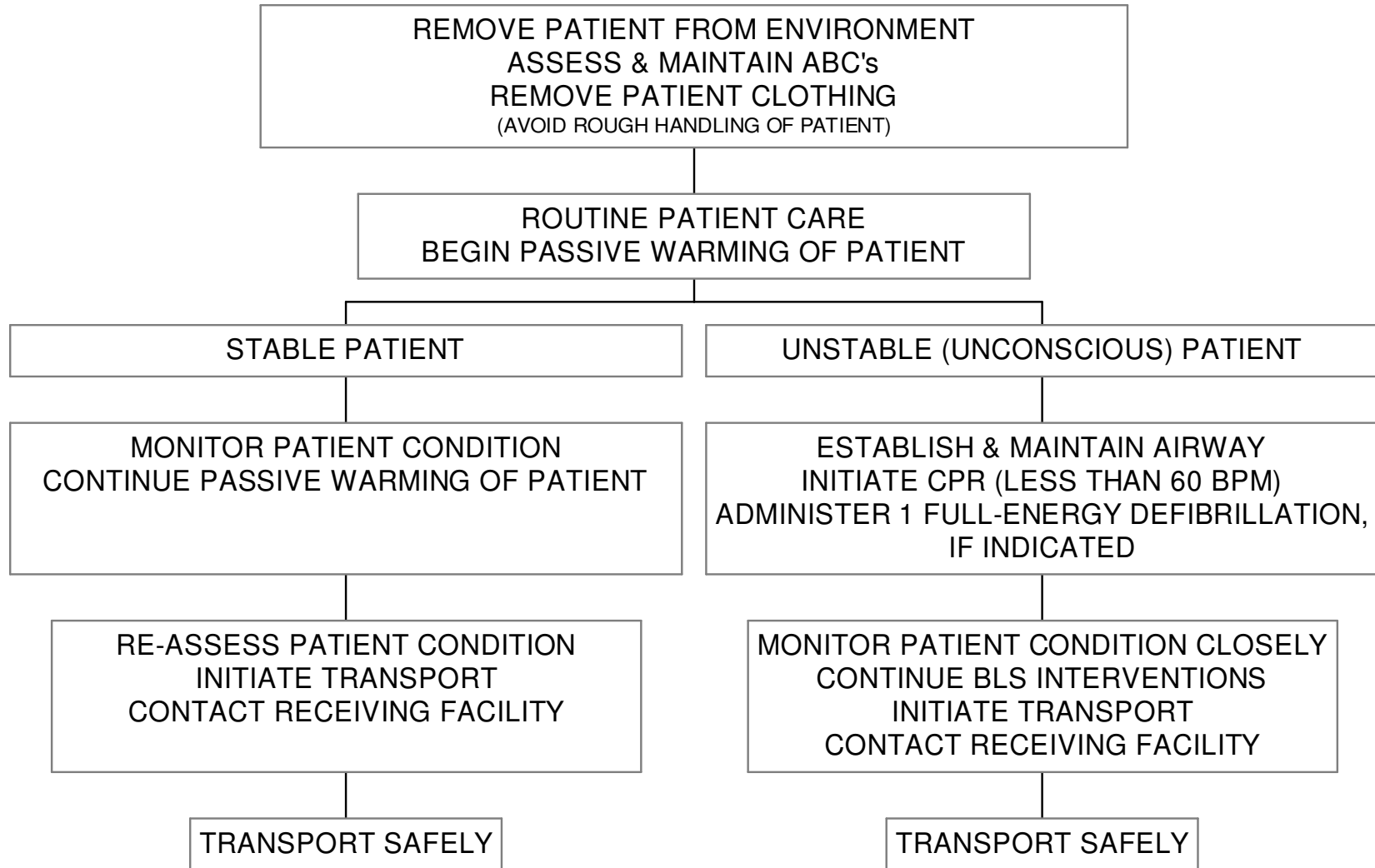
Code 17

DIABETIC EMERGENCIES (KNOWN DIABETIC PATIENT)



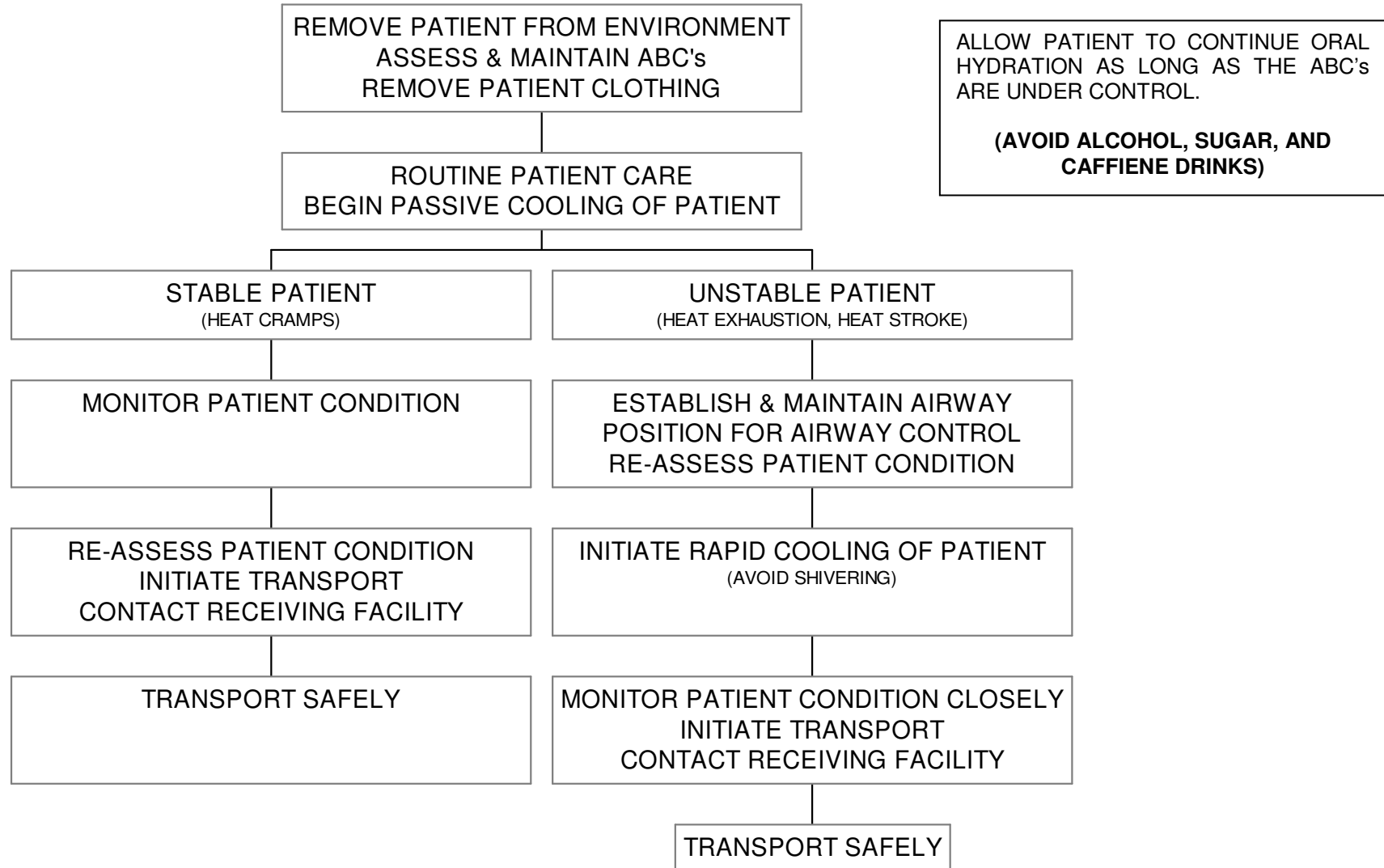
Code 18

COLD RELATED EMERGENCIES



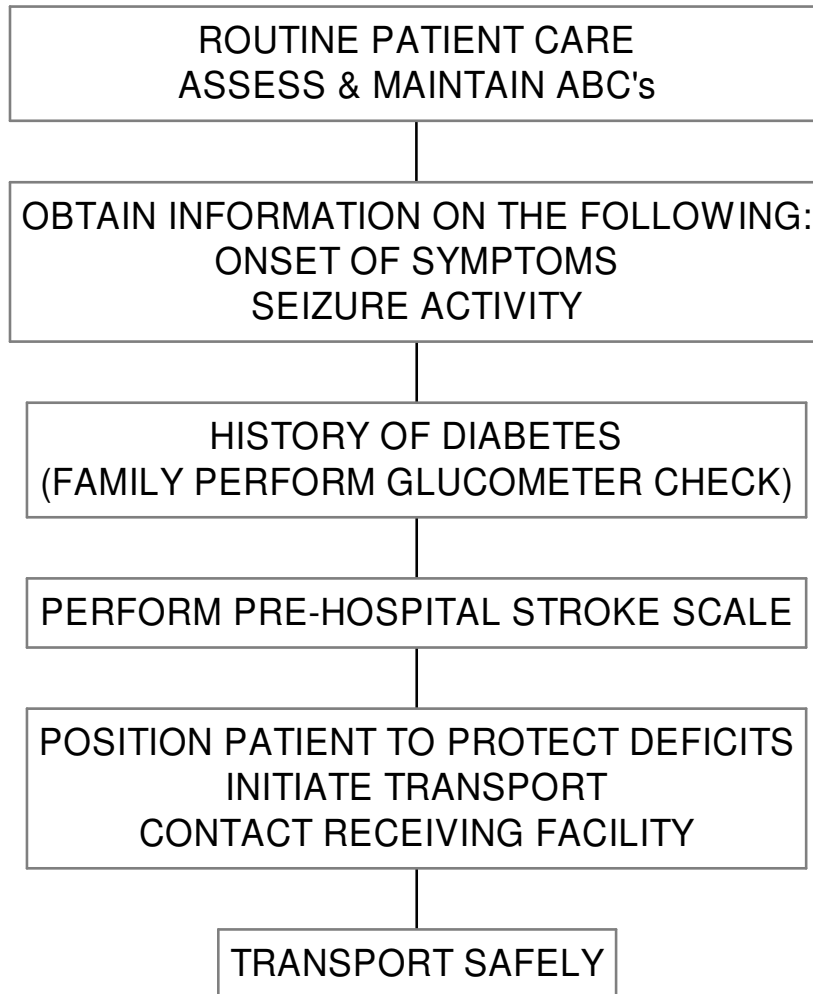
Code 19

HEAT RELATED EMERGENCIES



Code 20

STROKE "BRAIN ATTACK"



PRE-HOSPITAL STROKE SCALE

- FACIAL DROOP** (Ask patient to show teeth or smile)
Normal-Both sides of the face move equally well.
Abnormal-One side doesn't move equally well.
- ARM DRIFT/GRIP STRENGTH** (Ask the patient to squeeze your fingers or hold both arms outstretched and hold)
- SPEECH** (Ask the patient to recite a short sentence)

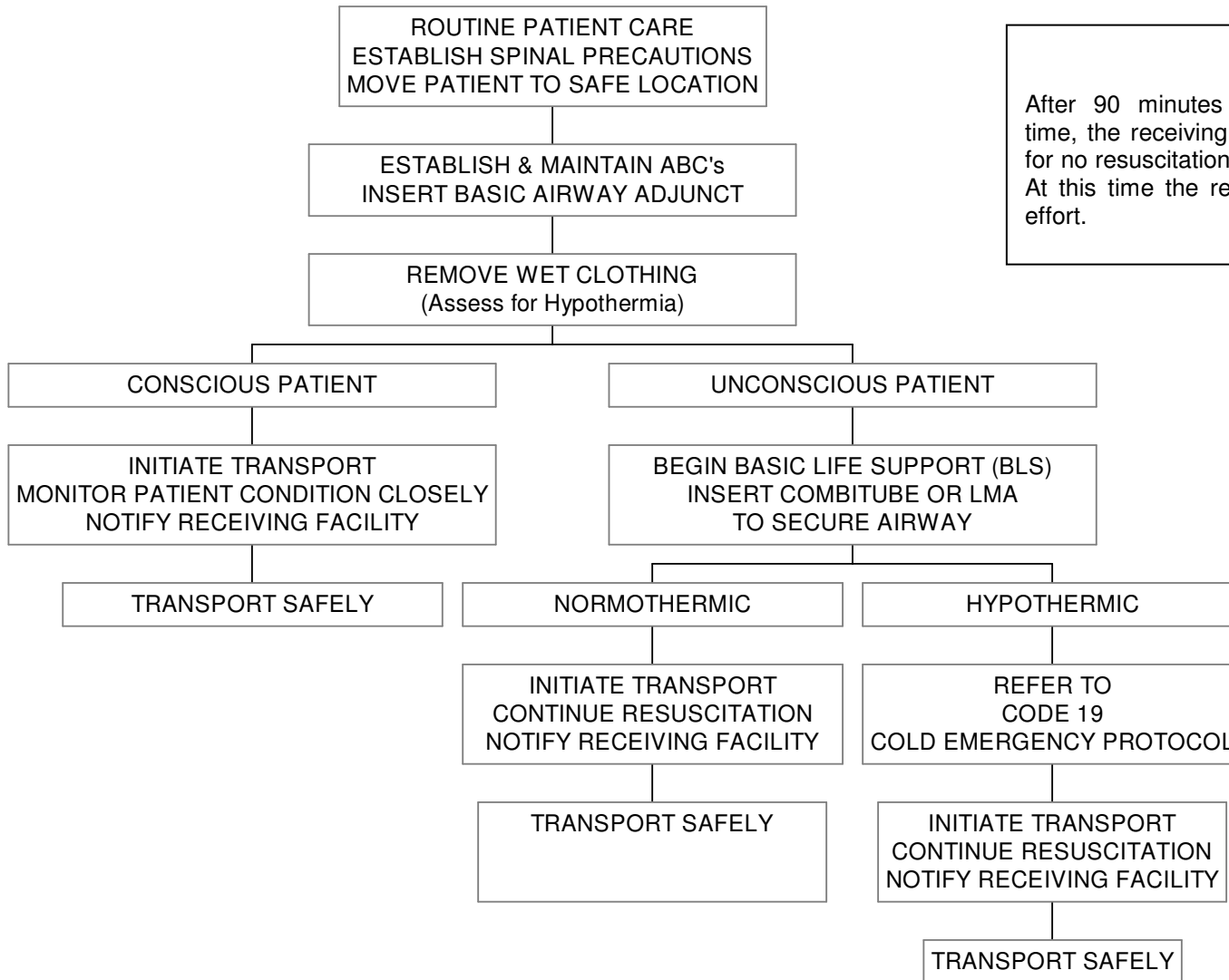
THROMBOLYTIC CHECKLIST

Contraindications

- History of Stroke or TIA
- Active Internal Bleeding
- History of Bleeding Disorder
- Uncontrolled Hypertension
- Intracranial/Spinal surgery
- History of CA; AVM; or aneurysm
- History of trauma or surgery within 2 weeks
- Pregnancy
- Previous Thrombolytic use
- Anticoagulant use
- Suspected aortic dissection
- Suspected Pericarditis

Code 21

SUBMERSION INJURY



NOTE

After 90 minutes of documented submersion time, the receiving hospital should be contacted for no resuscitation efforts on recovery of patient. At this time the rescue will become a recovery effort.

Code 22

PSYCHOLOGICAL EMERGENCIES

I. Purpose/Definition

Given the magnitude of the problems of abuse and violence in society, early detection of domestic violence victims, appropriate legal and social services referrals and the delivery of timely medical care are essential.

Domestic violence is a pattern of coercive behavior engaged in by someone who is or who was in an intimate relationship with the recipient. These behaviors may include: repeated battering, psychological abuse, sexual assault or social isolation such as restricted access to money, friends, transportation, health care, or employment. Typically, the victims are female, but it must be recognized that males can be victims of abuse as well.

II. Domestic Violence Indicators

While sometimes the specific history of abuse is offered, many times the victim of abuse, (either out of fear or because of the coercive nature of the relationship or out of the desire to protect the abuser) will not volunteer a true history but instead ascribe injuries to another cause. Therefore, an appropriate review must be undertaken with respect to patients presenting with injuries:

- That does not seem to correspond with the explanation offered.
- That is of varying stages of healing.
- That has the contour of objects commonly used to inflict injury (i.e. hand, belt, rope, teeth, cigarette).
- During pregnancy.

Other Factors:

- Partner accompanies patient and answers all questions directed to patient.
- Patient reluctant to speak in front of partner.
- Denial or minimalization of injury by partner or patient.
- Intensive, irrational jealousy or possessiveness expressed by partner.

Physical injuries commonly associated with domestic violence:

- Central injuries, specifically to the face, head, neck, chest, breasts, abdomen, or genitalia.
- Contusions, lacerations, abrasions, stab wounds, burns, human bites, and fractures.
- Complaints of acute or chronic pain without tissue injury.
- Signs of sexual assault.
- Injuries or vaginal bleeding during pregnancy, spontaneous or threatened miscarriage.
- Multiple injuries in different stages of healing.

Direct impact of domestic violence on pregnancy may include:

- Abdominal trauma leading to abruption, pre-term labor, and delivery.
- Fetal fractures.
- Ruptured maternal liver, spleen, or uterus.
- Antepartum hemorrhage.
- Exacerbation of chronic illness.

III. Approaches for Interviewing the Patient

The goals of the physical examination are to identify injuries requiring further medical intervention and to make observations and collect evidence that may corroborate the patient's report of abuse. A thorough physical examination is essential to uncover hidden injuries or compensated trauma. If the patient reports sexual assault, the sexual assault protocol should be followed:

- ❑ Always interview the patient in a private place, away from anyone accompanying them to the ED. Questioning the patient in front of the batterer may place the patient and any children in danger.
- ❑ You may be the first person or medical professional to acknowledge the abuse. It is important that you convey your concerns about what has happened to the patient, to the Emergency Department physician or nurse.
- ❑ When interviewing, do not ask patient if they were battered or abused (many battered persons do not consider themselves in this light). Instead, you can ask the patient:
 - “Have you had a fight with someone?”
 - “Did anyone hurt you?”
 - “Many times we have seen these types of injuries in patients who are hurt by someone else, did someone hurt you?”
 - “I am concerned that someone may be hurting you or scaring you, can you tell me what happened?”
- ❑ Most battered persons feel very shamed and humiliated about what has happened to them. It is important that you repeatedly reinforce that no one deserves to be hurt, no matter what they may or may not have done.
- ❑ Questions or attitudes not to ask or express:
 - “What keeps you with a person like that?”
 - “Do you get something out of violence?”
 - “What did you do at the moment that caused them to hit you?”
 - What could you have done to avoid or defuse the situation?”

IV. Care of Patient:

- ❑ Treat obvious injuries, provide support, and transport safely.
- ❑ Report your suspicions and findings to the Emergency Department physician or nurse. Document on your patient care report of this notification.
- ❑ If patient is not transported, make the appropriate referrals through law enforcement and document in you patient care report.

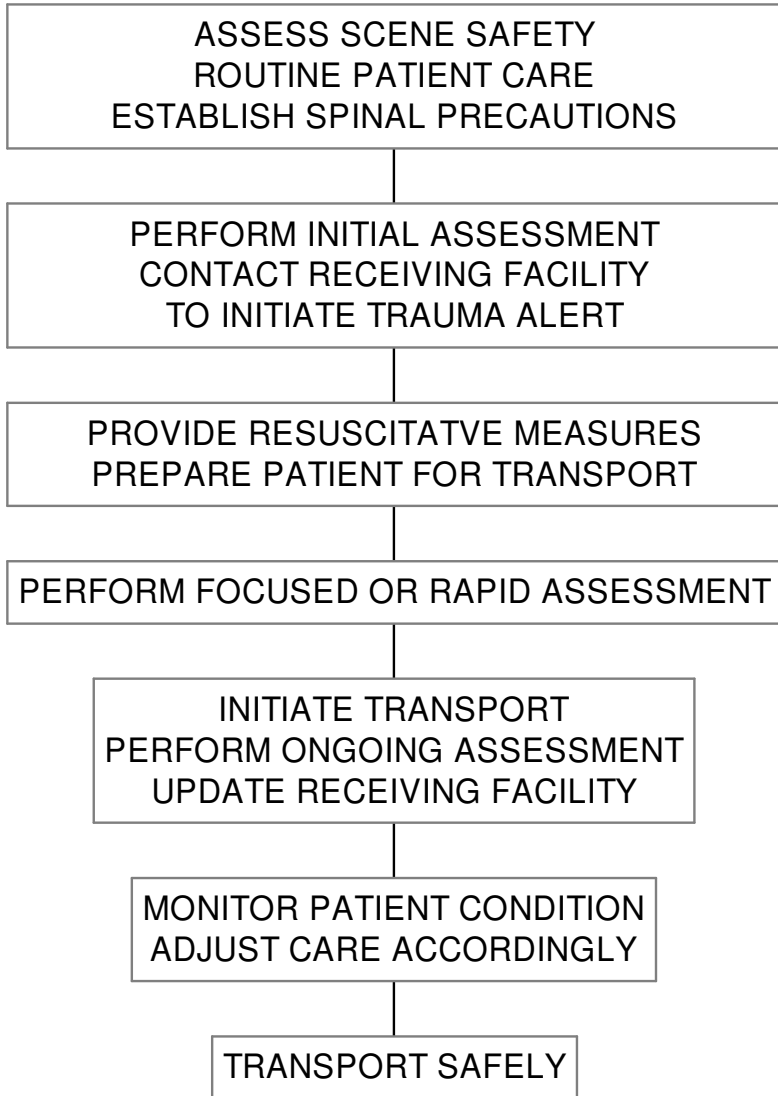
St. Anthony Medical Center Emergency Medical Services System



Trauma Patient Care Protocols

Code 30

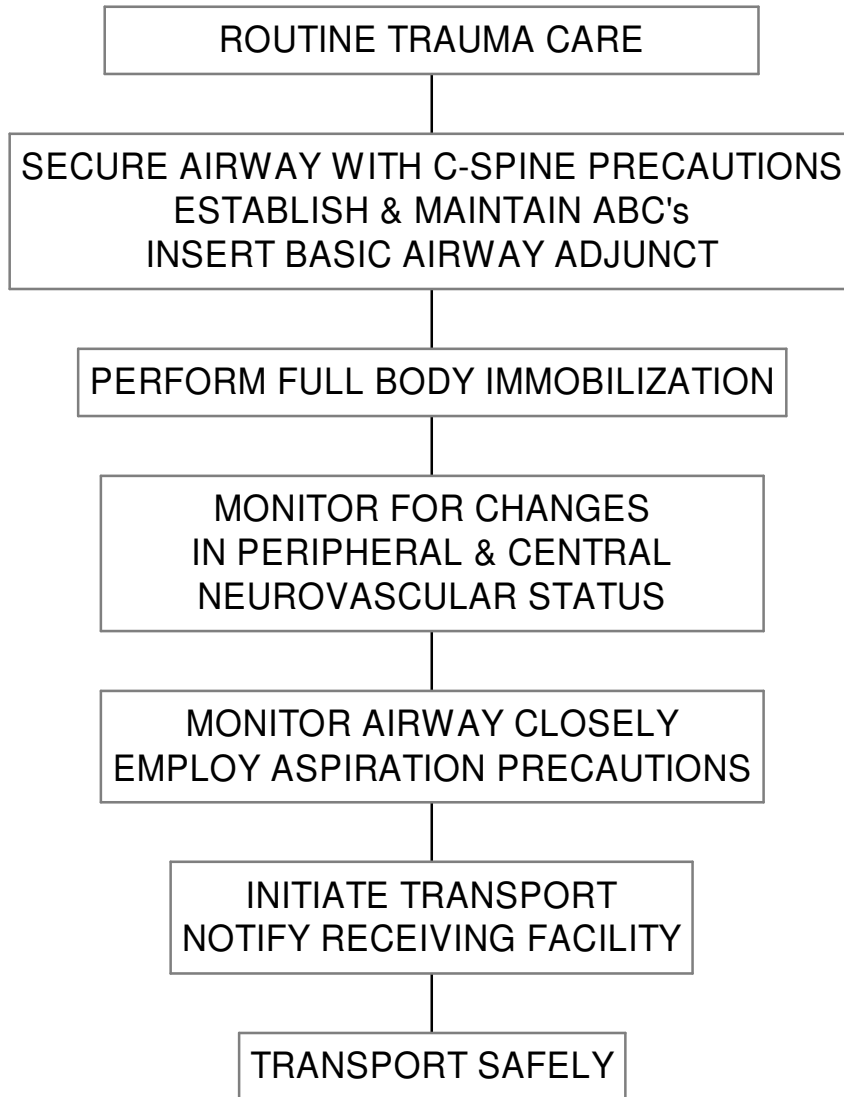
ROUTINE TRAUMA CARE



- AIRWAY**
 - Secure with C-Spine precautions
 - Remove foreign body airway obstructions
 - Provide 100% supplemental oxygen
- BREATHING**
 - Assess rate, depth, effort, and adequacy
 - Identify deficits in respiratory mechanism
 - Inspect, palpate, auscultate, and percuss chest
- CIRCULATION**
 - Control external hemorrhage
 - Monitor central and peripheral circulation
 - Assess capillary refill
- DISABILITY**
 - Assess and monitor mental status
 - Assess and monitor distal neurovascular status
 - Assess and monitor pupillary responses
- EXPOSE**
 - Expose injuries to examine completely
 - Assess posterior aspect of patient prior to immobilization

- INITIATE TRAUMA ALERT FOR THE FOLLOWING MECHANISMS OF INJURY:**
- Ejection from vehicle
 - Death of occupant in same vehicle compartment
 - Adult falls greater than 20 feet
 - Pediatric falls greater than three times the height of the patient
 - Pregnant patient of greater than 24 weeks gestation

Code 31
SUSPECTED SPINAL CORD INJURY



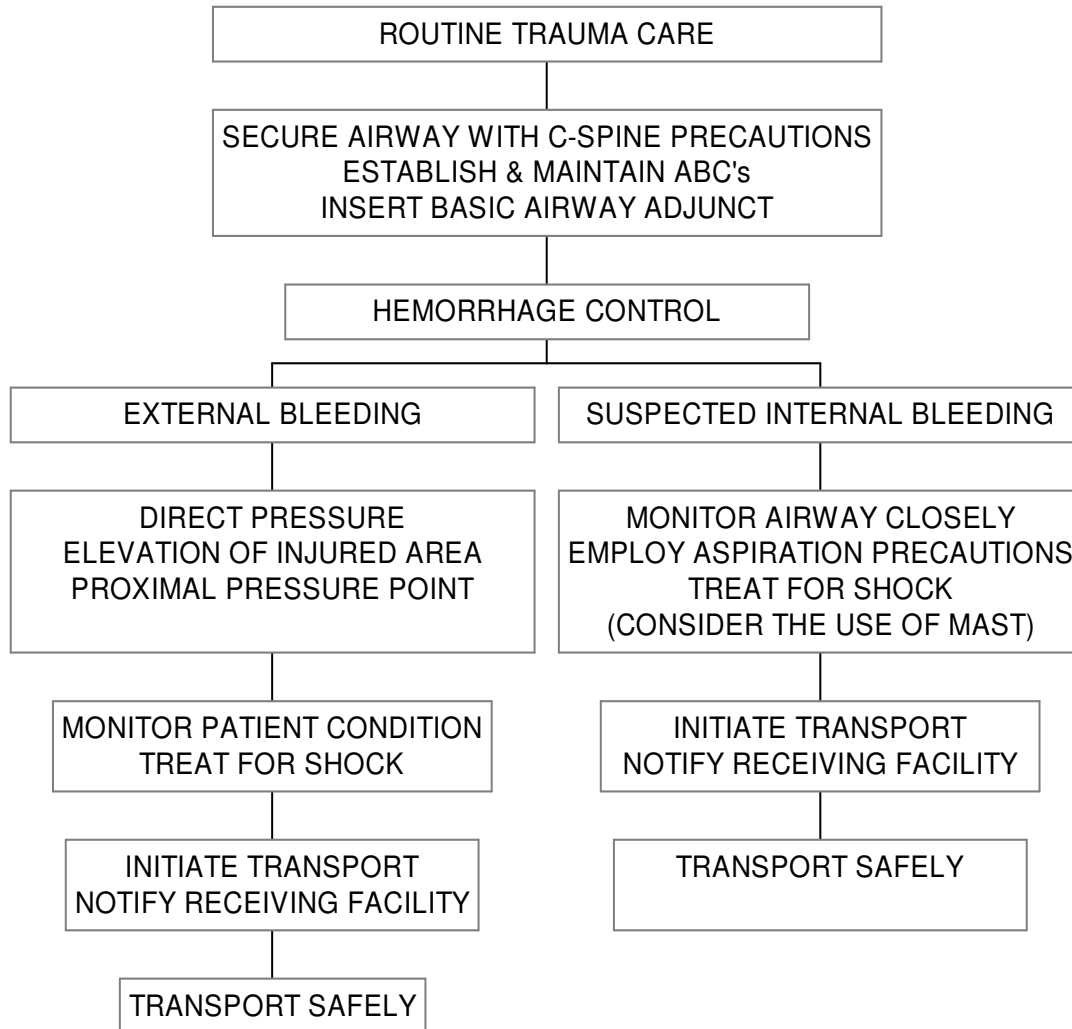
NOTE TO PRE-HOSPITAL PROVIDERS

Suspect spinal injuries in all patients with:

- Any head or facial trauma.
- Altered mental status.
- Suspected deceleration injuries.
- Complaints of neck or back pain.
- Physical findings suggestive of neck or back injury
- Significant Mechanism of Injury

Code 32

HEMORRHAGIC SHOCK



The use of PASG/MAST Garments in hypotensive patients is controversial. Researchers do agree that inflation of PASG/MAST will raise blood pressure by moving blood from the periphery to the core of the body. However, in bleeding above the diaphragm, this may increase blood loss and further compromise the patient's condition.

BTLS and PHTLS Standards have suggested the following indications for the use of PASG/MAST:

- Neurogenic Shock**
(No thoracic bleeding)
- Hemorrhagic Shock**
(No head or thoracic bleeding)
- Pelvic Fractures**
(No thoracic bleeding)
- Lower Extremity Fractures**
(Load and Go Situations)

Contraindications

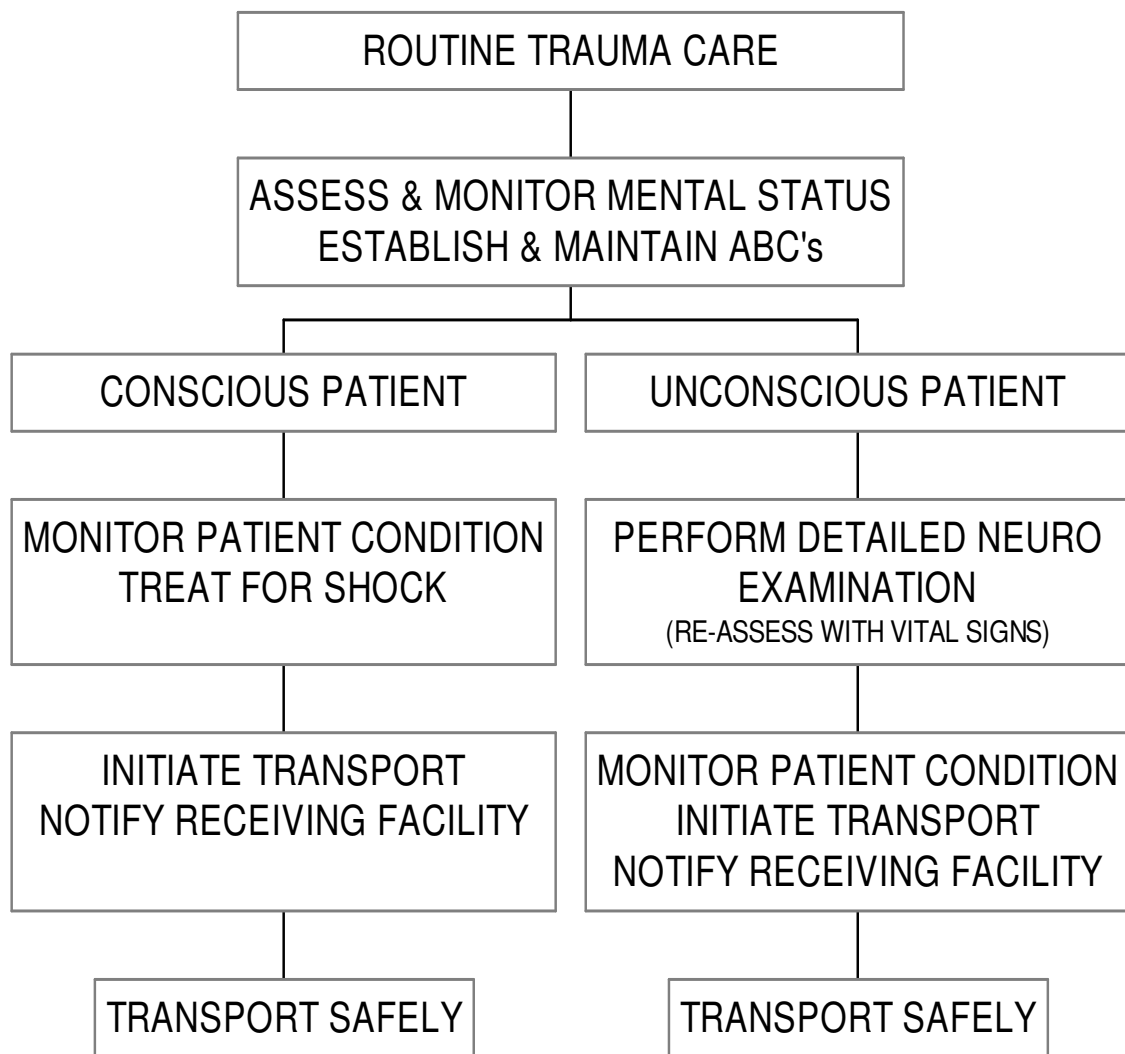
- Acute Pulmonary Edema
- Cardiogenic Shock
- Thoracic Injuries

Relative Contraindications

- Impaled Objects
- Isolated Head Injuries
- Advanced Pregnancy

Code 33

HEAD TRAUMA/UNCONSCIOUS PATIENT



GLASGOW COMA SCALE

EYE OPENING

SPONTANEOUS	4
TO VERBAL COMMAND	3
TO PAIN	2
NO RESPONSE	1

VERBAL RESPONSE

ORIENTED AND CONVERSES	5
DISORIENTED AND CONVERSES	4
INAPPROPRIATE WORDS	3
INCOMPREHENSIBLE SOUNDS	2
NO RESPONSE	1

MOTOR RESPONSE

OBEYS VERBAL COMMANDS	6
LOCALIZES PAIN	5
WITHDRAWS FROM PAIN (FLEXION)	4
ABNORMAL FLEXION FROM PAIN	3
EXTENSION FROM PAIN	2
NO RESPONSE	1

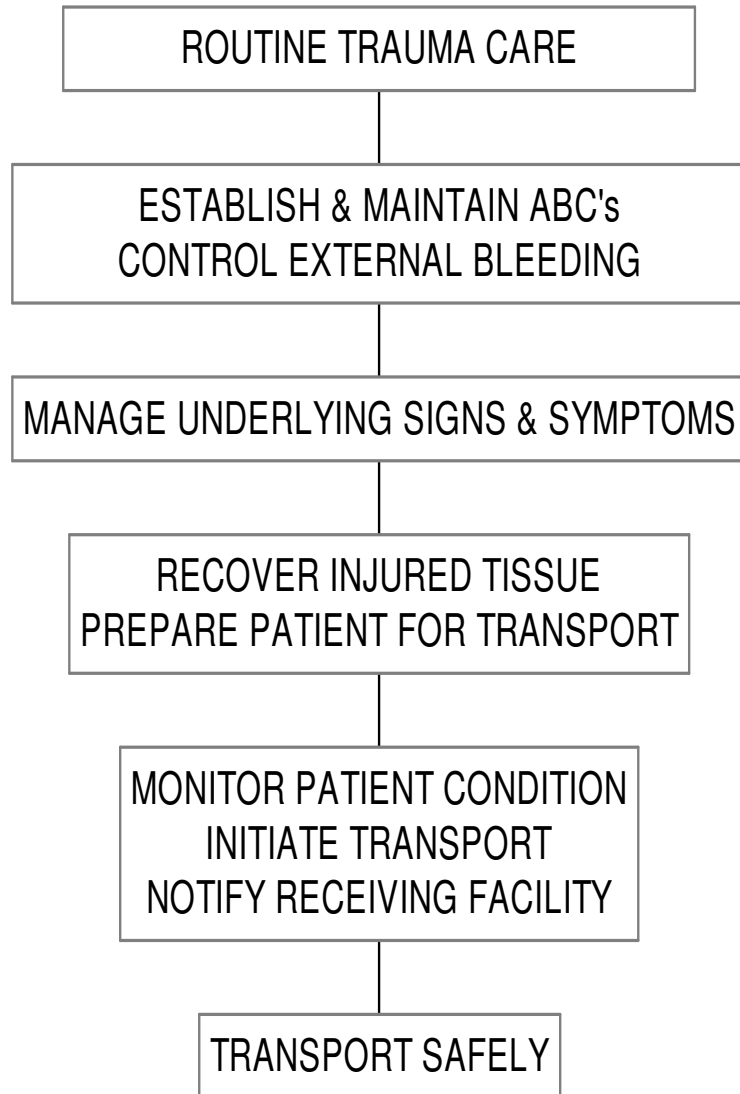
AVPU Scale

A	Alert
V	Verbal
P	Painful
U	Unresponsive

Consider insertion of airway adjunct (Oral; nasal; CombiTube; LMA), if unconsciousness persists.

Code 34

MUSCULOSKELETAL AND SOFT TISSUE INJURY



- Preparation of Body Part**
- ❑ Wrap part in moistened sterile gauze, sheet, or towel.
 - ❑ Place part in waterproof bag or container, seal, and label with patient name
 - ❑ **DO NOT** immerse in solution.
 - ❑ Place container in a second one filled with ice, cold water, or cold pack.

- R = REST INJURED SITE**
- I = ICE PACK APPLIED**
- C = COMPRESS AREA**
- E = ELEVATE INJURED SITE**

Code 35

BURN EMERGENCIES

May use saline to stop the burning process.

Cover all burned areas with dry sterile dressing.

REMOVE PATIENT FROM ENVIRONMENT
STOP THE BURING PROCESS
ROUTINE TRAUMA CARE

ESTABLISH & MAINTAIN ABC's
REMOVE CLOTHING AND JEWELRY

ASSESS EXTENT OF INJURY
TOTAL BODY SURFACE (TBS)
DEPTH OF INJURY
CRITICAL AREAS INVOLVED

THERMAL

CHEMICAL

ELECTRICAL

MONITOR ABC'S CLOSELY
ADMINISTER SUPPLEMENTAL OXYGEN
NOTIFY RECEIVING FACILITY
INITIATE TRANSPORT

MONITOR ABC'S CLOSELY
ADMINISTER SUPPLEMENTAL OXYGEN
ASSIST IN THE DECONTAMINATION PROCESS

MONITOR ABC'S CLOSELY
PERFORM BASIC LIFE SUPPORT, IF NEEDED
ESTABLISH & MAINTAIN SPINAL PRECAUTIONS
PERFORM DEFIBRILLATION, AS NEEDED

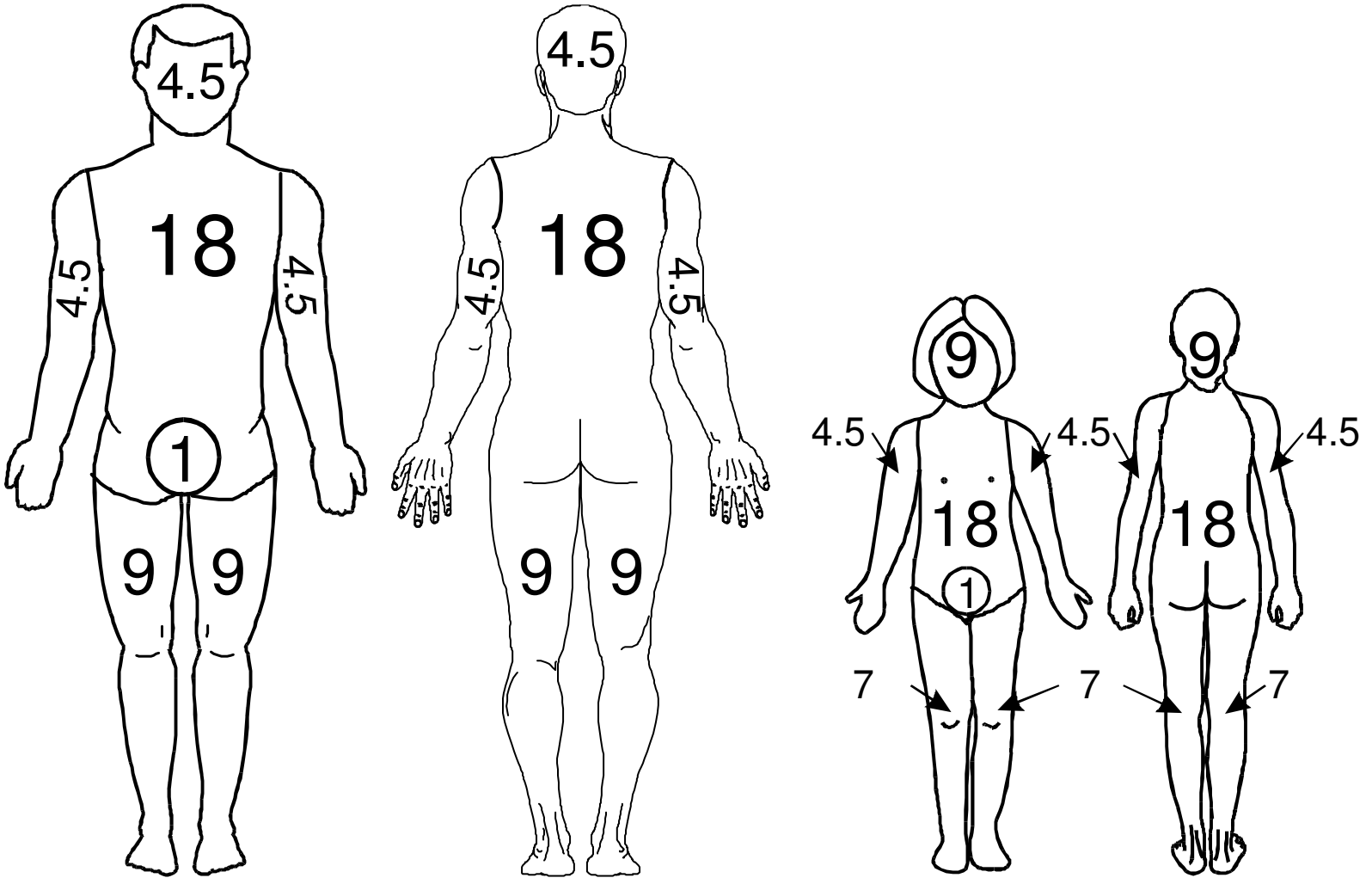
TRANSPORT SAFELY

MONITOR PATIENT CONDITION
NOTIFY RECEIVING FACILITY
INITIATE TRANSPORT

MONITOR PATIENT CONDITION
NOTIFY RECEIVING FACILITY
INITIATE TRANSPORT

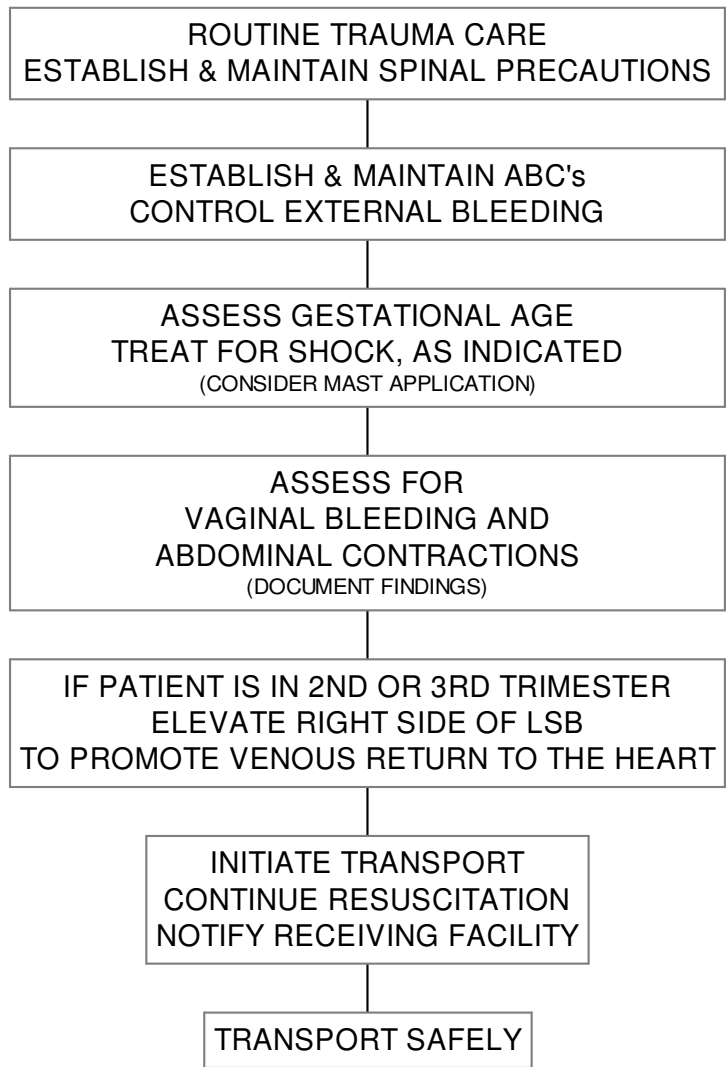
TRANSPORT SAFELY

TRANSPORT SAFELY



Code 36

TRAUMA IN PREGNANCY



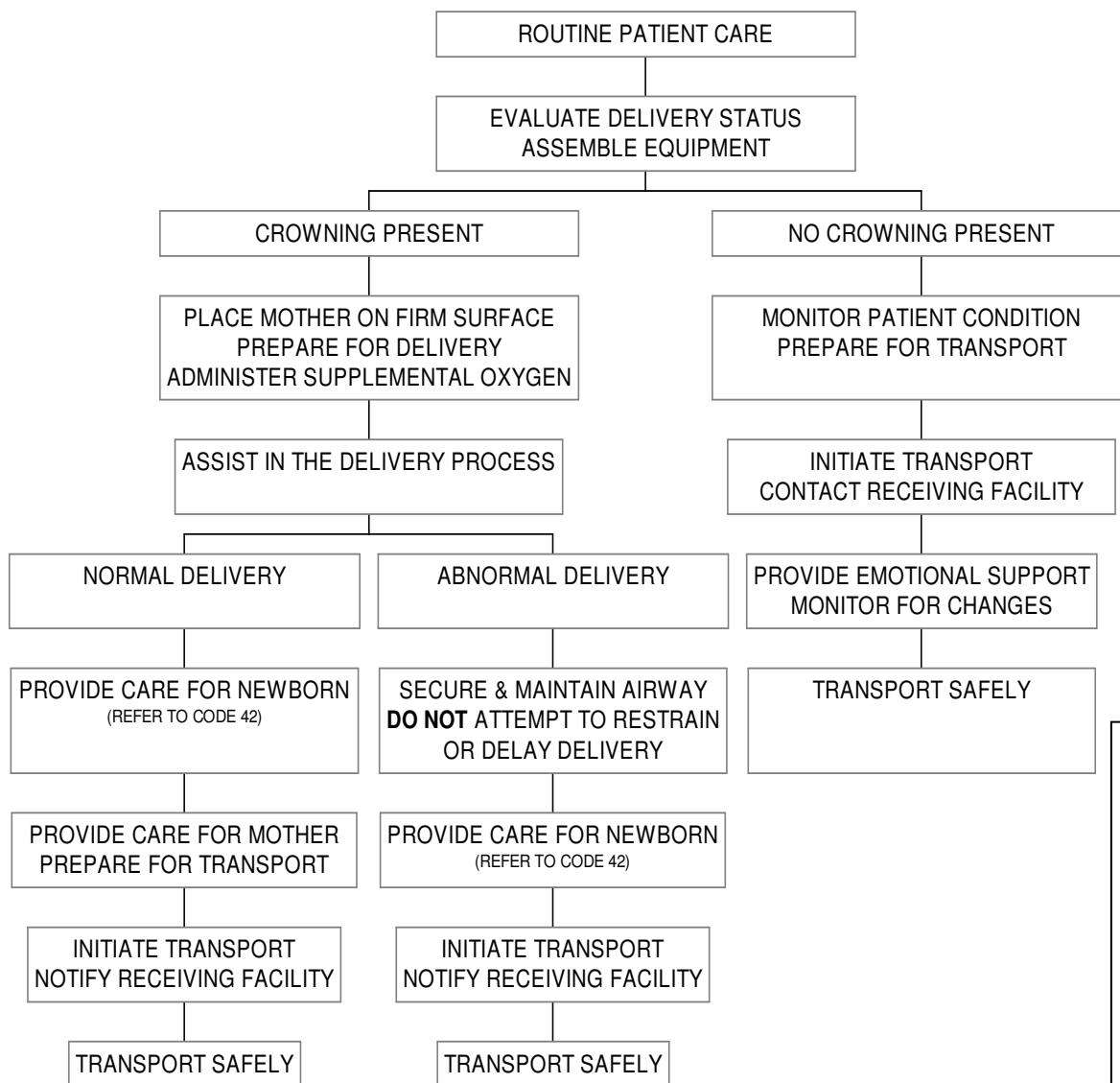
St. Anthony Medical Center Emergency Medical Services System



Obstetrical Patient Treatment Protocols

Code 40

EMERGENCY CHILDBIRTH



DOCUMENTED AT ONE AND FIVE MINUTES POST DELIVERY

	APGAR SCORE		
	0	1	2
Appearance	Blue/Pale	Body Pink Ext. Blue	All Pink
Pulse	Absent	<100/min	>100/min
Grimace	No Response	Grimace	Cough
Activity	Limp	Flexion	Very Active
Respirations	Absent	Slow	Good Cry

Code 41

MATERNAL CARE

ROUTINE PATIENT CARE
INITIATE TRANSPORT

ALLOW THE PLACENTA TO DELIVER ON ITS OWN
DO NOT DELAY TRANSPORT WAITING FOR IT TO DELIVER
(IF DELIVERED, COLLECT PLACENTA FOR HOSPITAL INSPECTIONS)

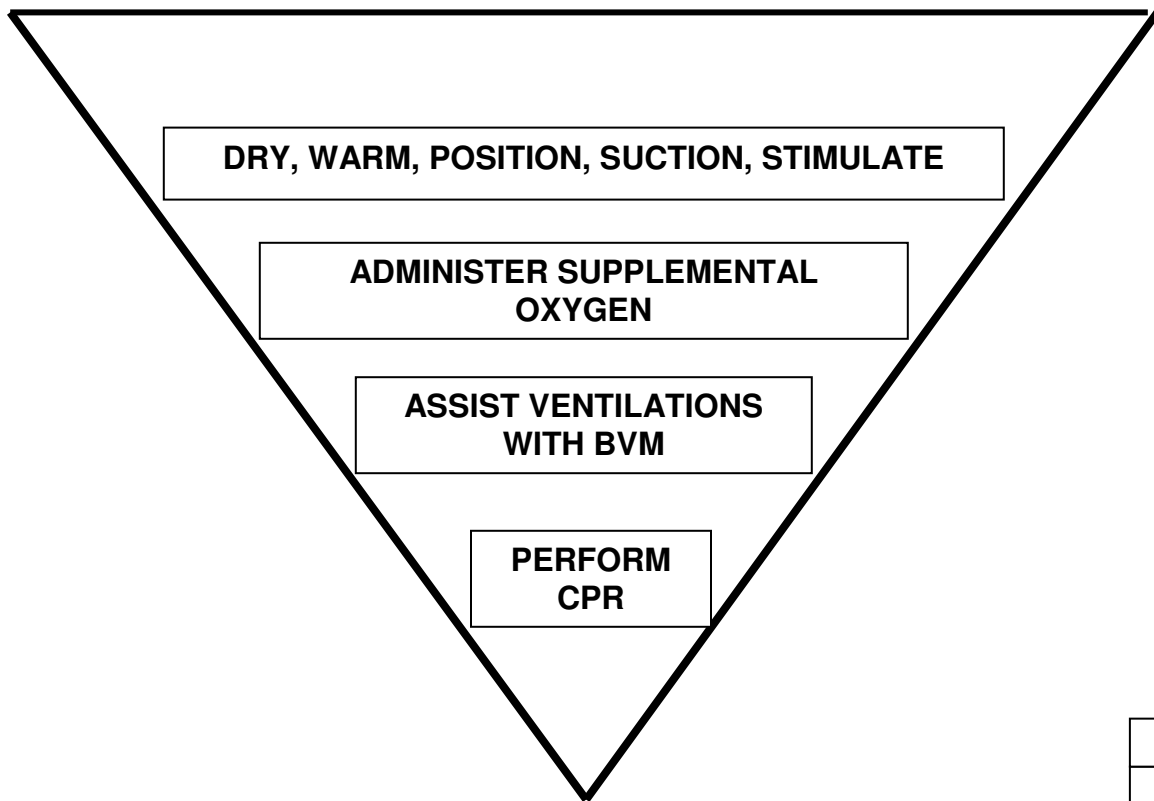
IF BLEEDING PERSISTS, PLACE STERILE SANITARY PAD
APPLY PRESSURE BY HAVING MOTHER PLACE LEGS TOGETHER
MASSAGE UTERUS, ALLOW MOTHER TO NURSE

PROVIDE EMOTIONAL SUPPORT
MONITOR FOR CHANGES
NOTIFY RECEIVING FACILITY

TRANSPORT SAFELY

Code 42

CARE FOR THE NEWBORN



- Suction mouth and then nose with bulb syringe. Monitor and repeat to maintain airway.
 - Quickly dry baby, and control heat loss.
 - Perform APGAR Score at one and five minutes post delivery.

 - Administer supplemental oxygen via blow-by method.
 - Monitor patient condition and respond as appropriate.

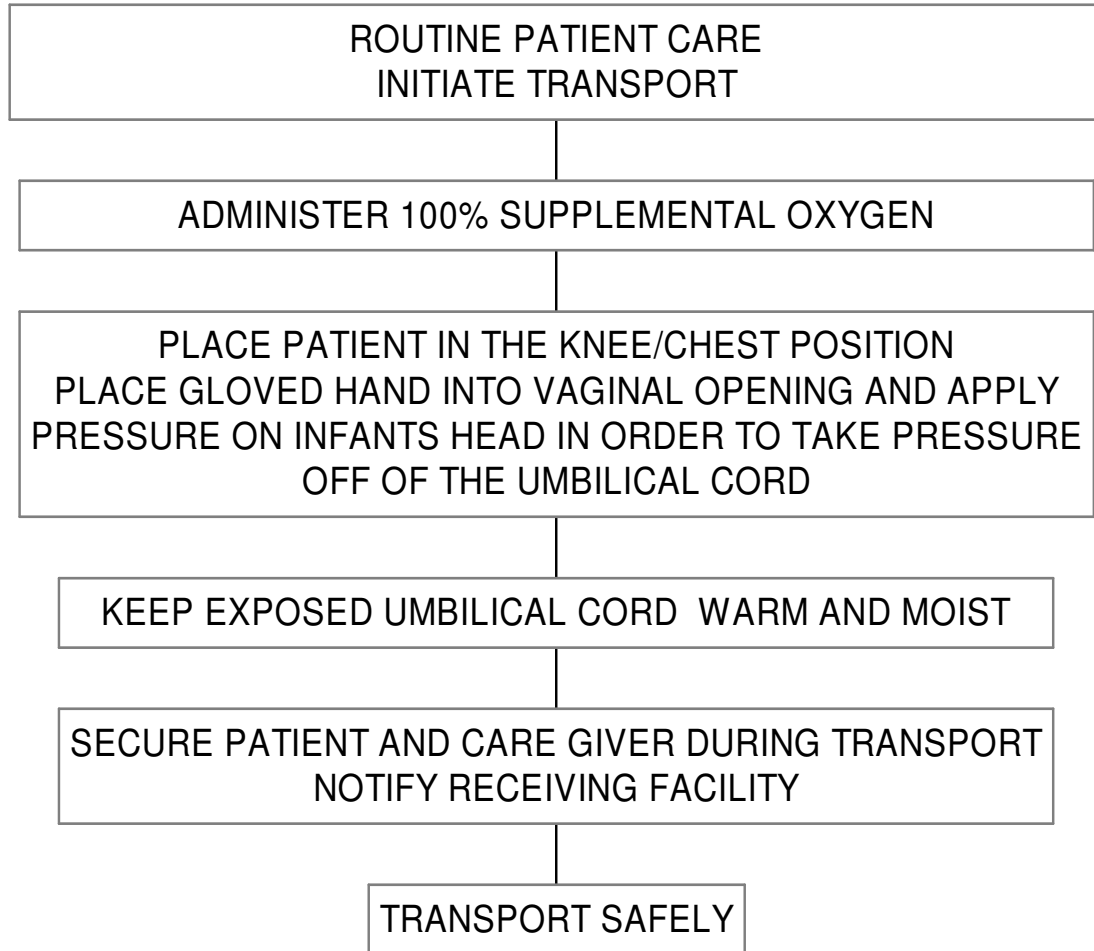
 - Initiate PPV if patient condition does not improve.
 - Consider insertion of airway adjunct.

 - Begin CPR if heart rate is below 60 BPM.
 - Constantly monitor patient condition.
- Communicate information to Receiving Facility during transport.**

Assess & document at one and five minutes, post delivery.

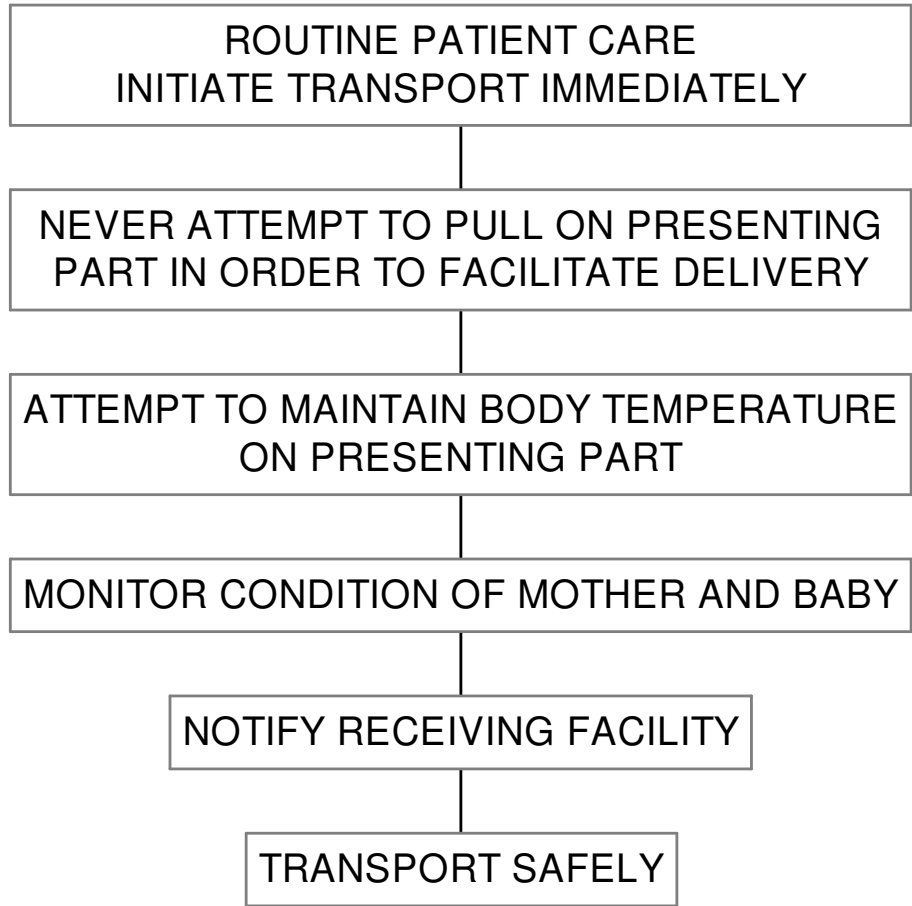
	<u>APGAR SCORE</u>		
	0	1	2
Appearance	Blue/Pale	Body Pink Ext. Blue	All Pink
Pulse	Absent	<100/min	>100/min
Grimace	No Response	Grimace	Cough
Activity	Limp	Flexion	Very Active
Respirations	Absent	Slow	Good Cry

Code 43
PROLAPSED CORD



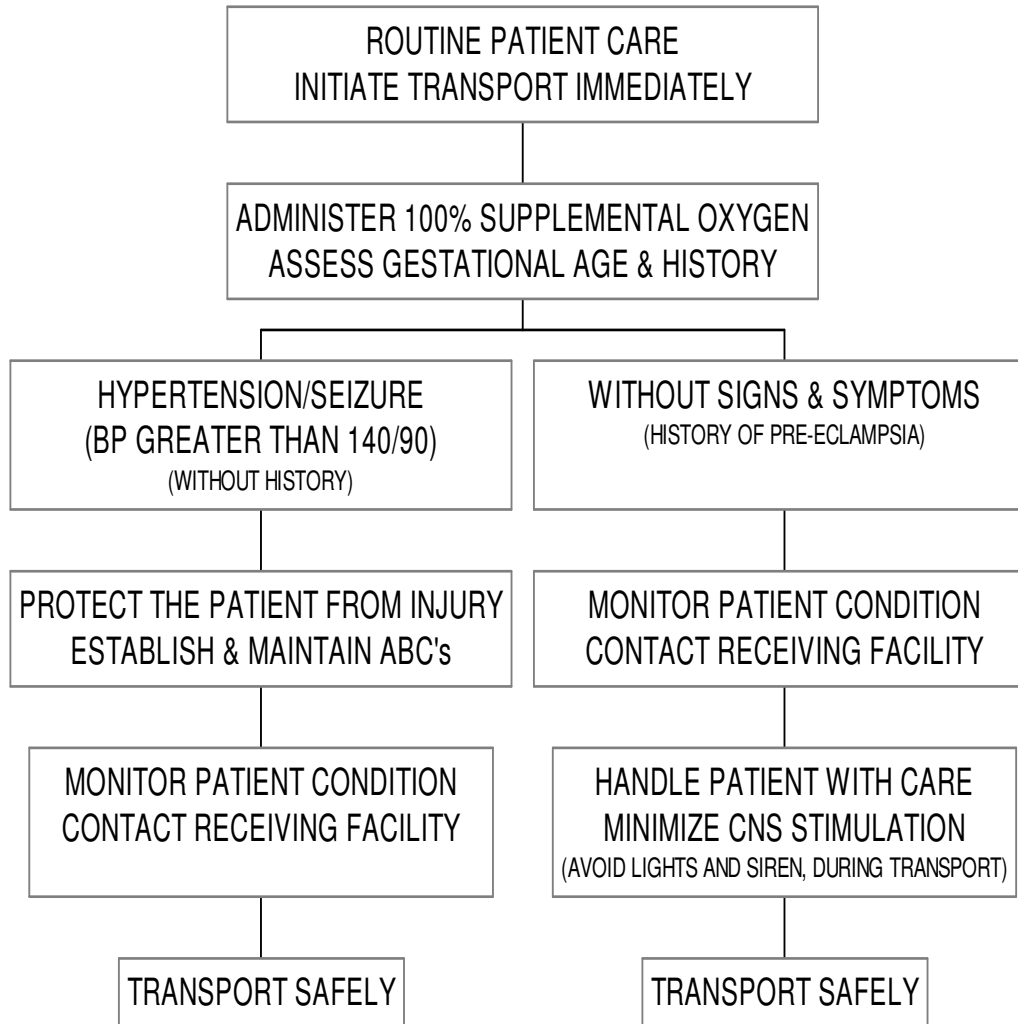
Code 44

BREECH PRESENTATION



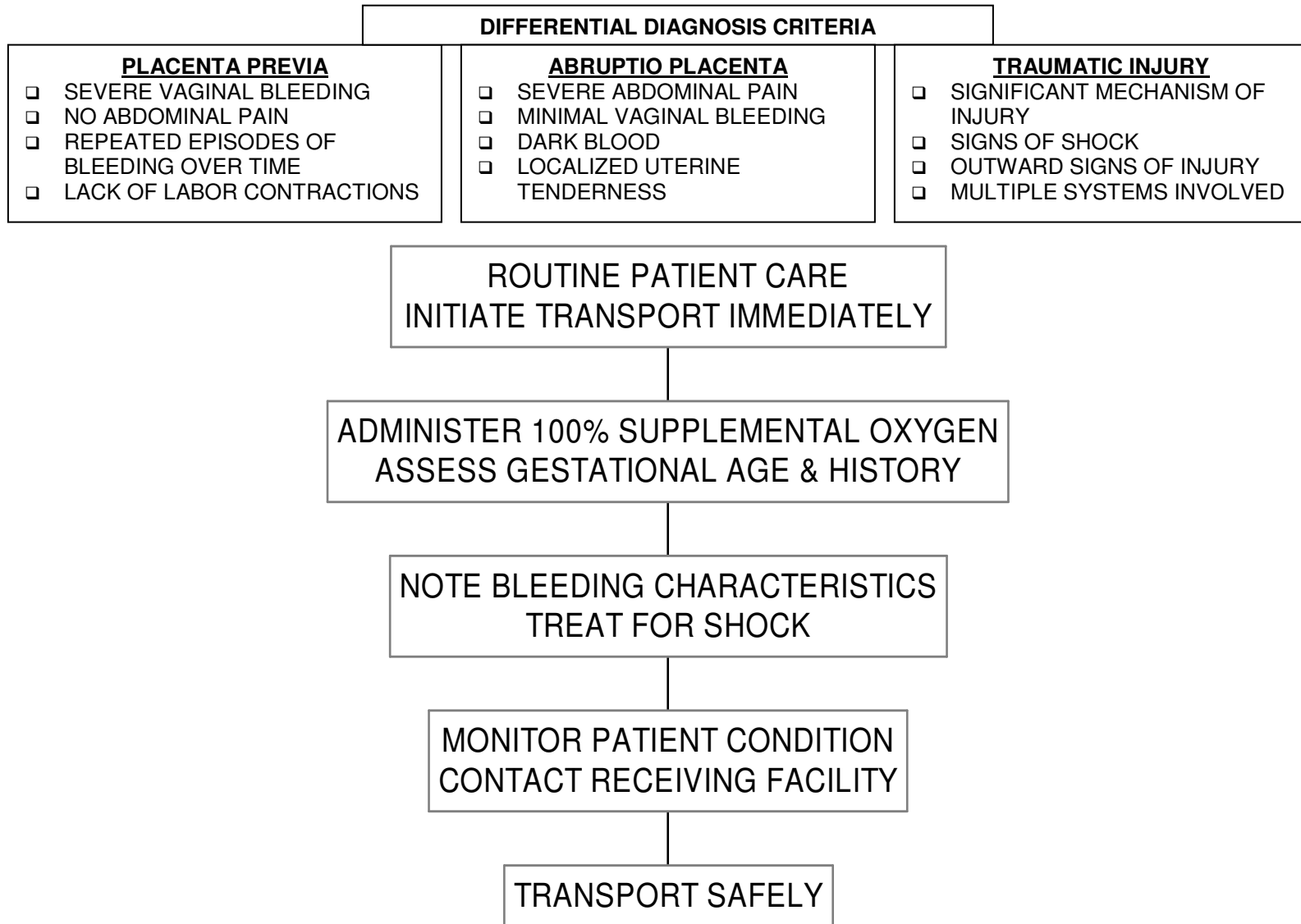
- Body Delivered but Head Not Delivering**
- ❑ After shoulders are delivered, gently elevate trunk and legs to aid delivery of head (if face down).
 - ❑ If head doesn't deliver within 30 seconds, insert two gloved fingers into the vaginal opening and apply gentle pressure to the mother's fundus. This is in an attempt to establish an artificial airway for the baby and must be maintained throughout transport to the hospital.

Code 45
PRE-ECLAMPSIA OR TOXEMIA



Code 46

THIRD TRIMESTER BLEEDING (PLACENTA PREVIA, ABRUPTIO PLACENTA, TRAUMA)

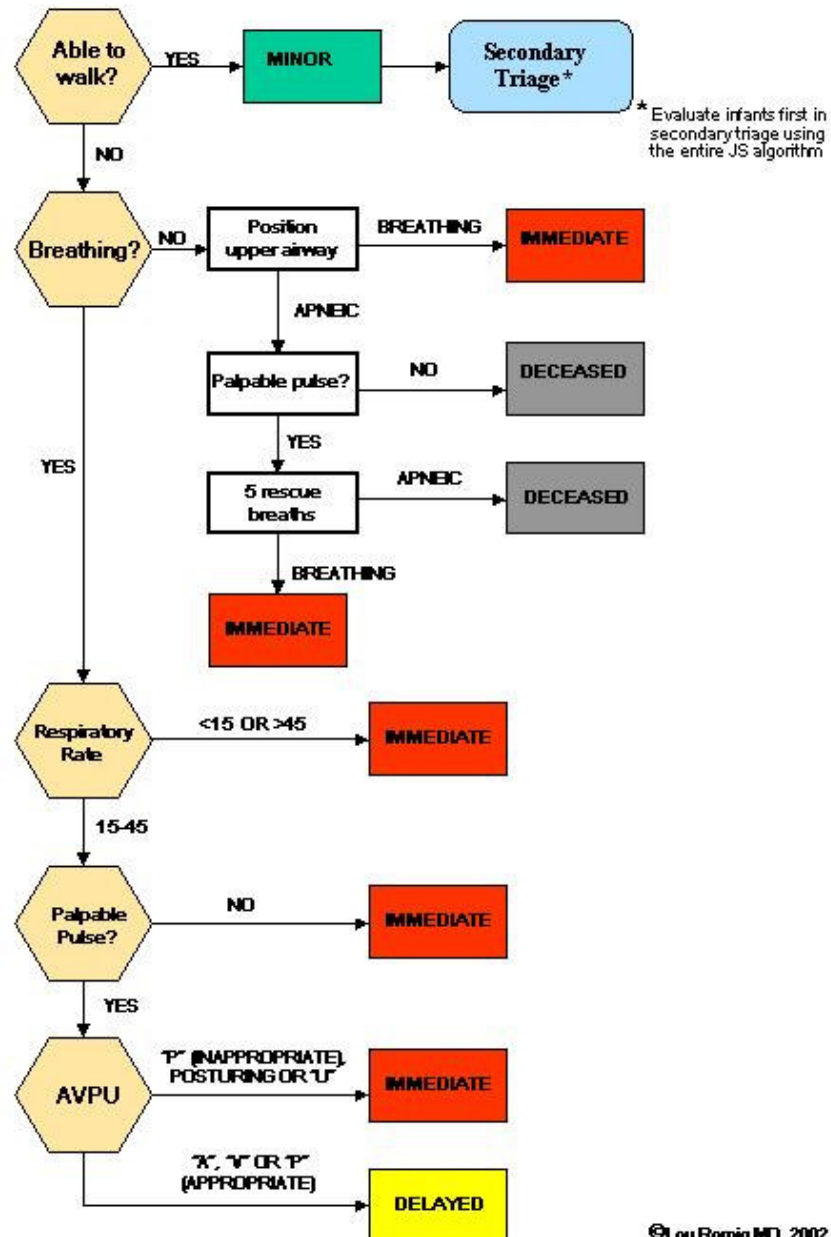


St. Anthony Medical Center Emergency Medical Services System



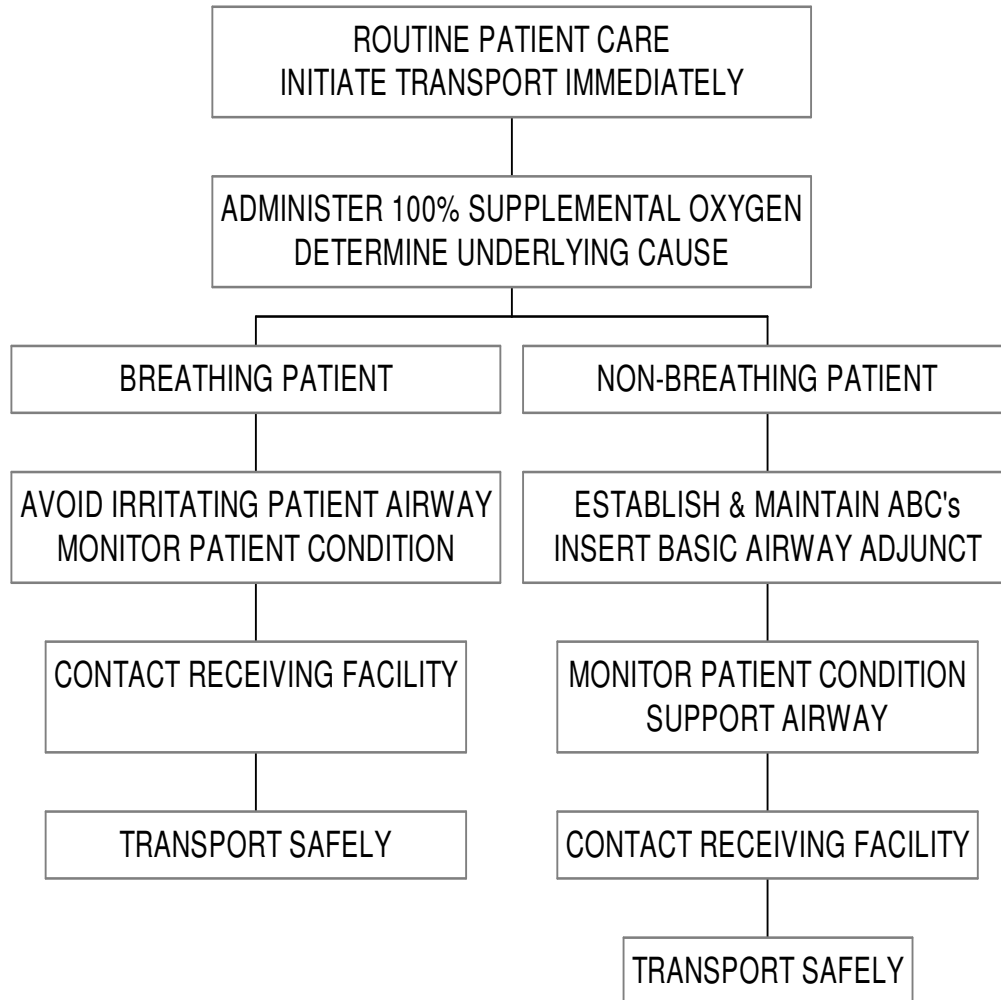
Pediatric Patient Treatment Protocols

JumpSTART Pediatric MCI Triage®



Code 50

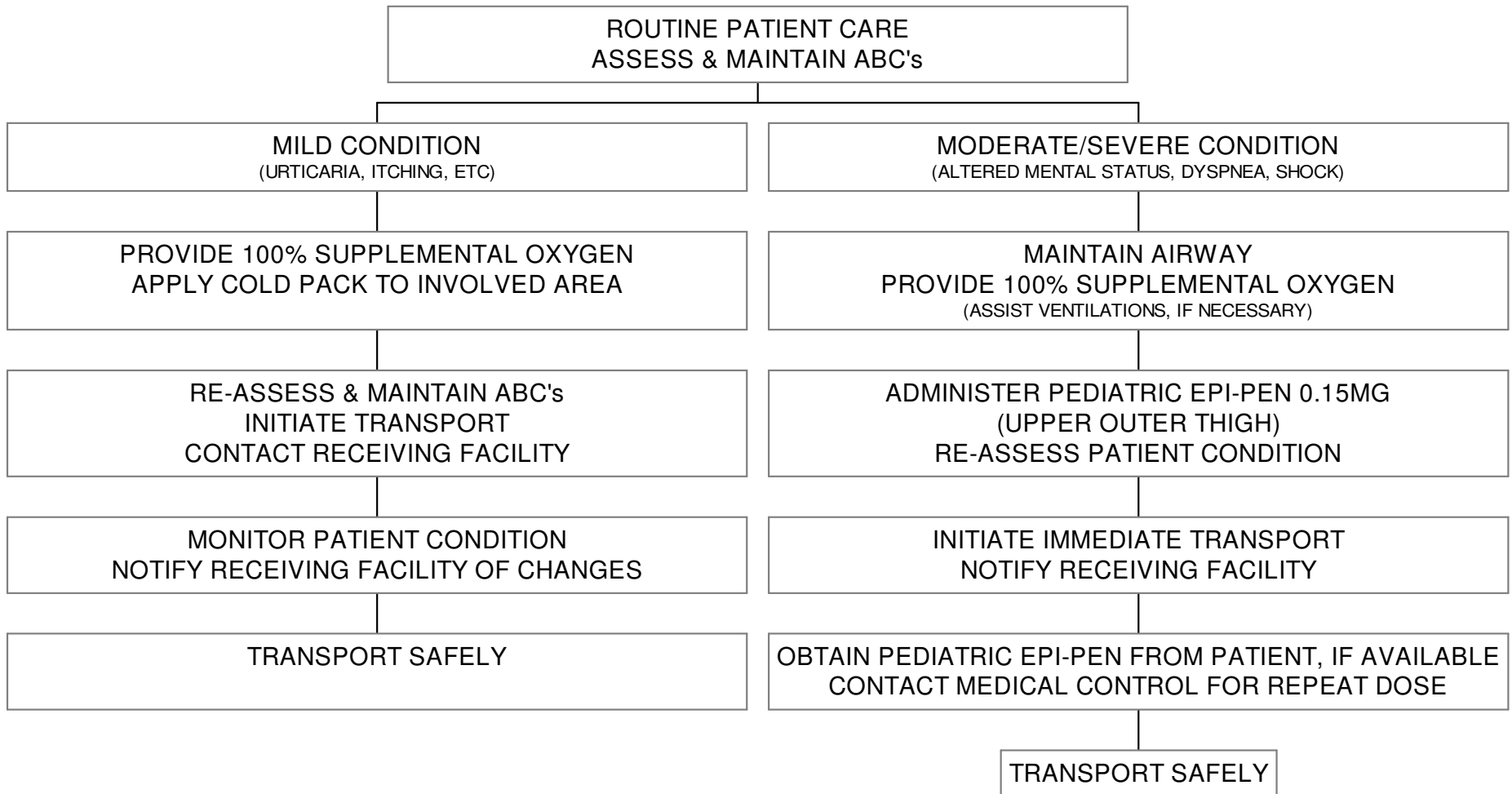
PEDIATRIC RESPIRATORY DISTRESS



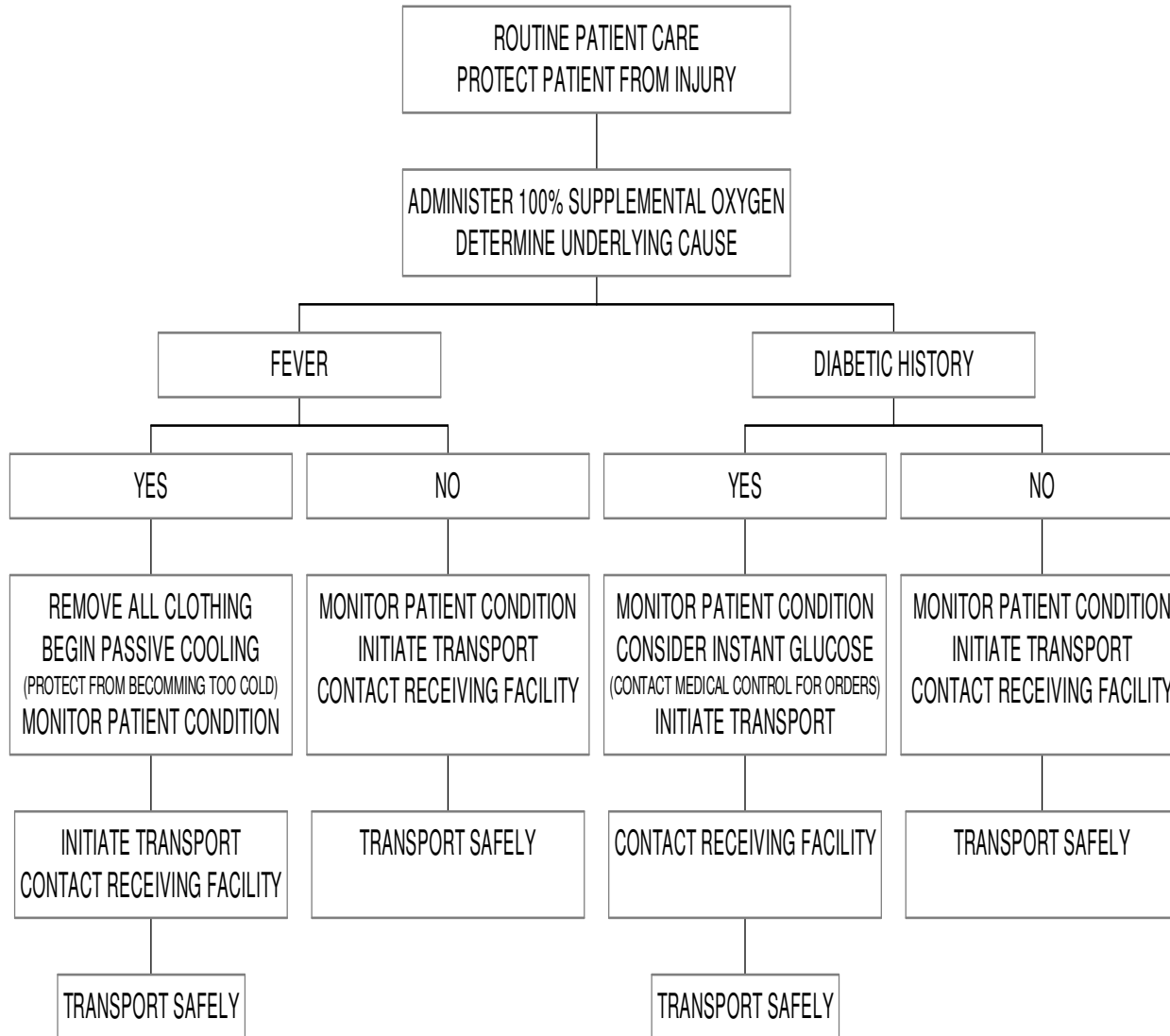
- CONSIDER POSSIBLE CAUSES**
- FOREIGN BODY OBSTRUCTION**
 - Heimlich Maneuver
 - REACTIVE AIRWAY DISEASE**
 - Assist with inhaler administration
 - ANAPHYLACTIC REACTION**
 - Administer Epi-Pen Injector

Code 51

PEDIATRIC ANAPHYLACTIC REACTION

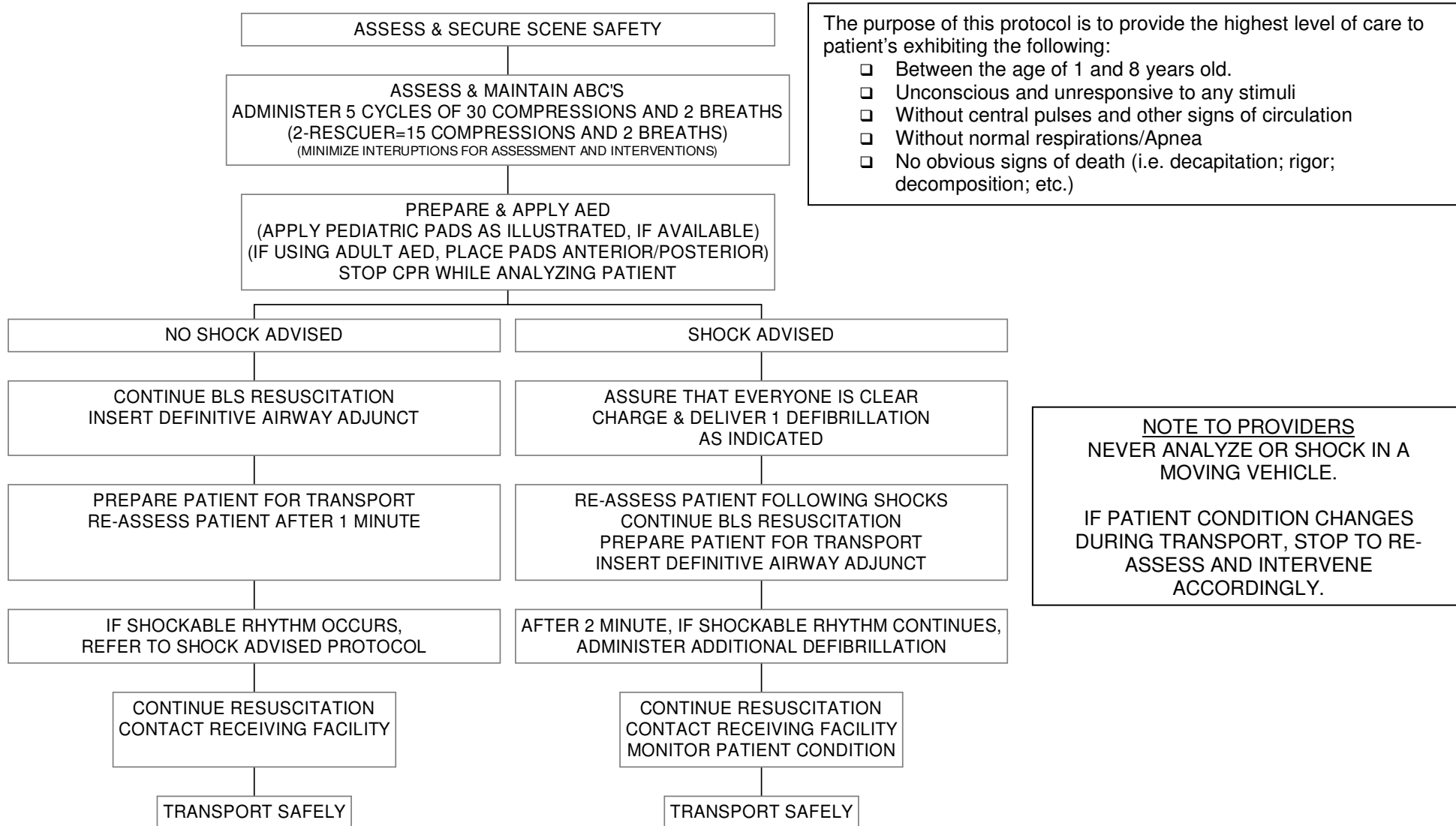


Code 52
PEDIATRIC SEIZURES



Code 53

PEDIATRIC CARDIAC ARREST-DEFIBRILLATION PROTOCOL



The purpose of this protocol is to provide the highest level of care to patient's exhibiting the following:

- Between the age of 1 and 8 years old.
- Unconscious and unresponsive to any stimuli
- Without central pulses and other signs of circulation
- Without normal respirations/Apnea
- No obvious signs of death (i.e. decapitation; rigor; decomposition; etc.)

NOTE TO PROVIDERS
NEVER ANALYZE OR SHOCK IN A MOVING VEHICLE.

IF PATIENT CONDITION CHANGES DURING TRANSPORT, STOP TO RE-ASSESS AND INTERVENE ACCORDINGLY.