GD-097-PHS-EMS

TRIAGE, TREATMENT AND TRANSPORT GUIDELINES

As recommended by the

Bureau of Emergency Medical Services & Trauma System

Arizona Department of Health Services

April 2011
[Revised June 2012]

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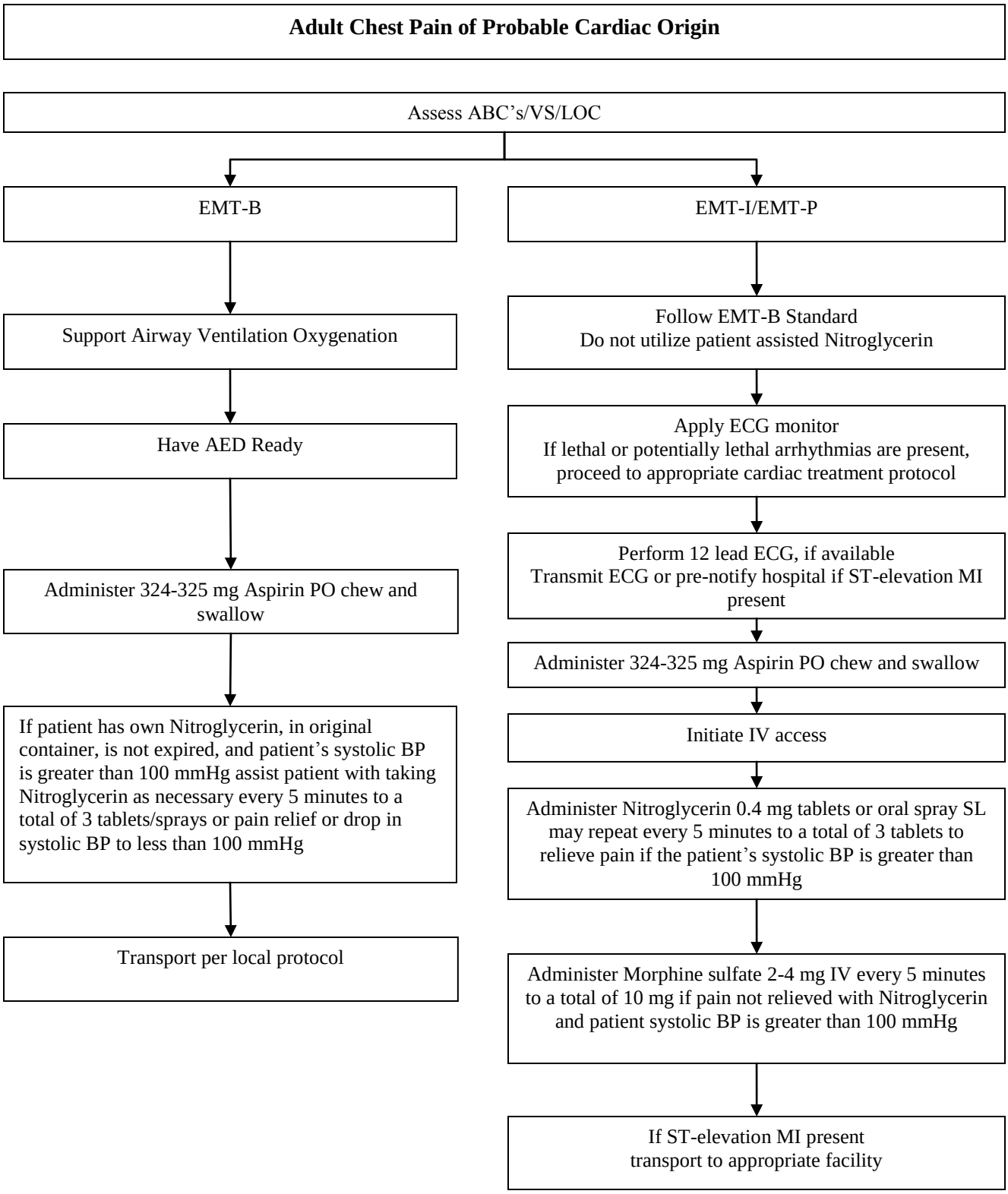
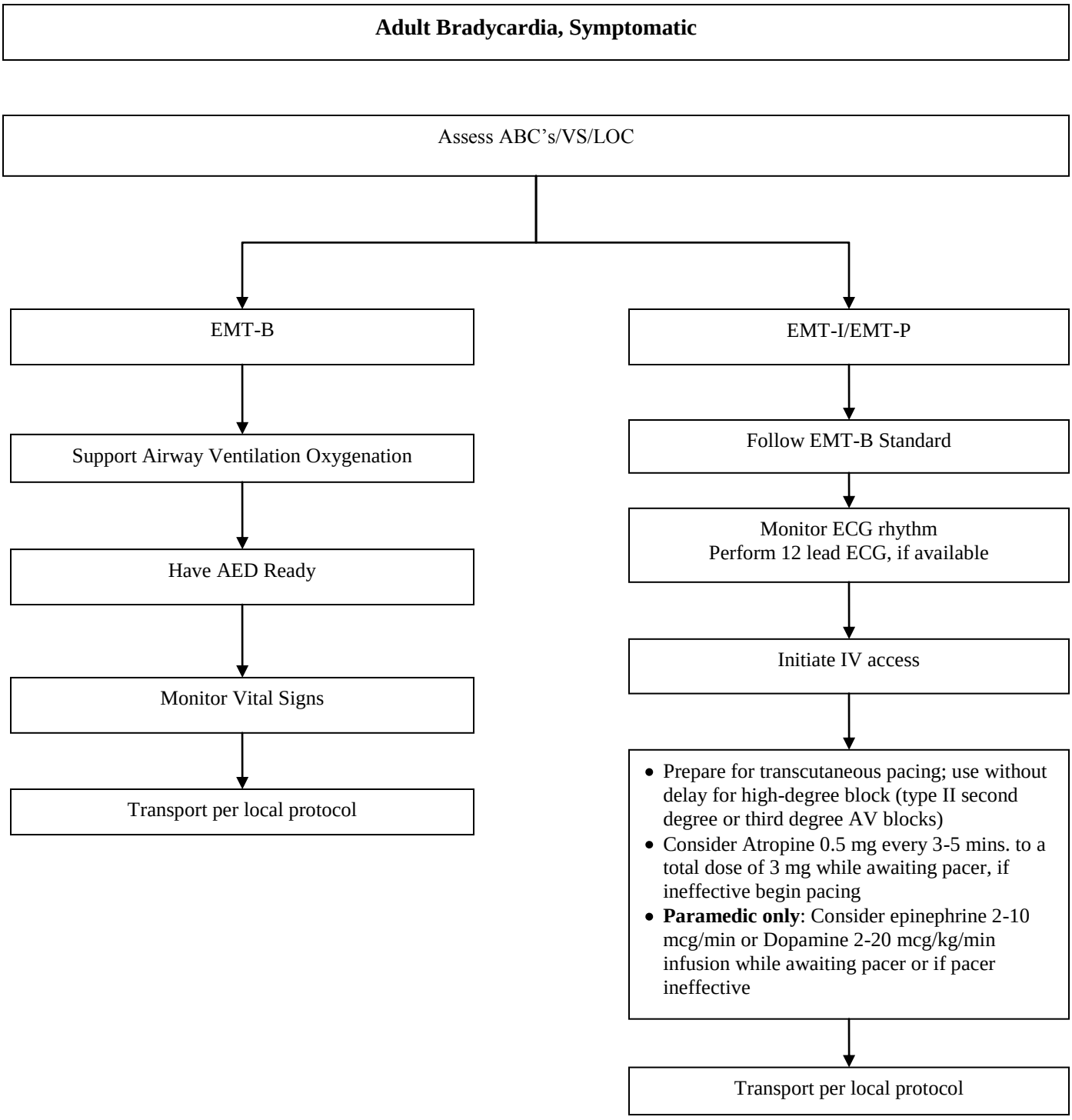
DISCLAIMER

These protocols are designed to be a resource document for use by Medical Direction Authorities responsible for the administrative, organizational and on-line medical direction of pre-hospital EMS personnel. It is specifically recognized that regional variations from the guidelines contained within are not only acceptable, but also appropriate, depending on the individual circumstances of the involved areas and organizations.

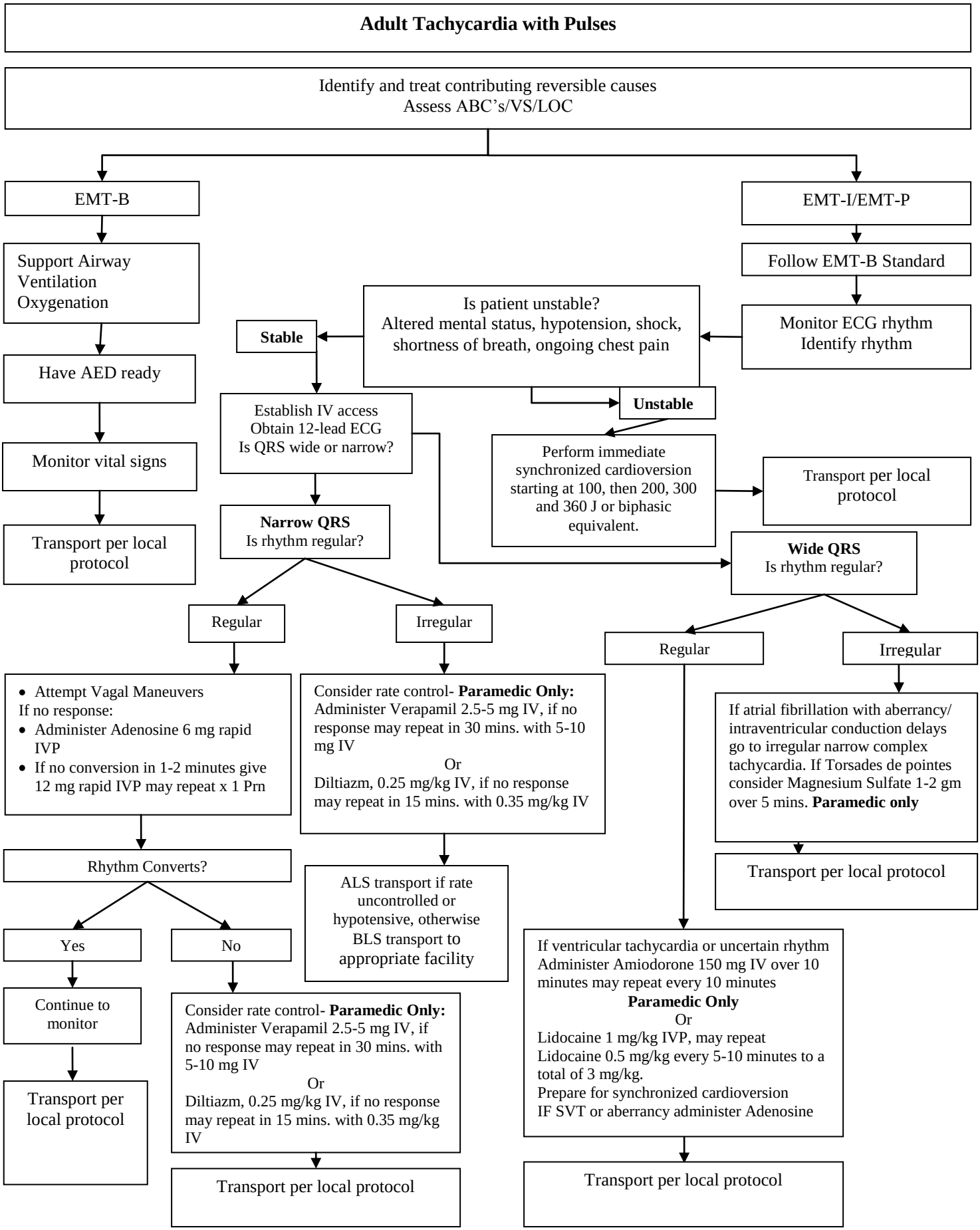
By Statute and Rule, all advanced life support pre-hospital EMS personnel shall have administrative and on-line medical direction. These guidelines are not meant to act as a substitute, proxy or alternative to that medical direction. Any conflict between these guidelines and the individual EMS provider's medical direction shall default to the Administrative or on-line medical direction.

These protocols are set forth guidelines deemed by the Bureau of EMS and Trauma System to be within the acceptable standard of medical care. It is specifically recognized that there are acceptable regional variations from these procedures and protocols, which may also satisfy the standard of care. This manual does NOT define, limit, expand, or otherwise purport to establish the legal standard of care.

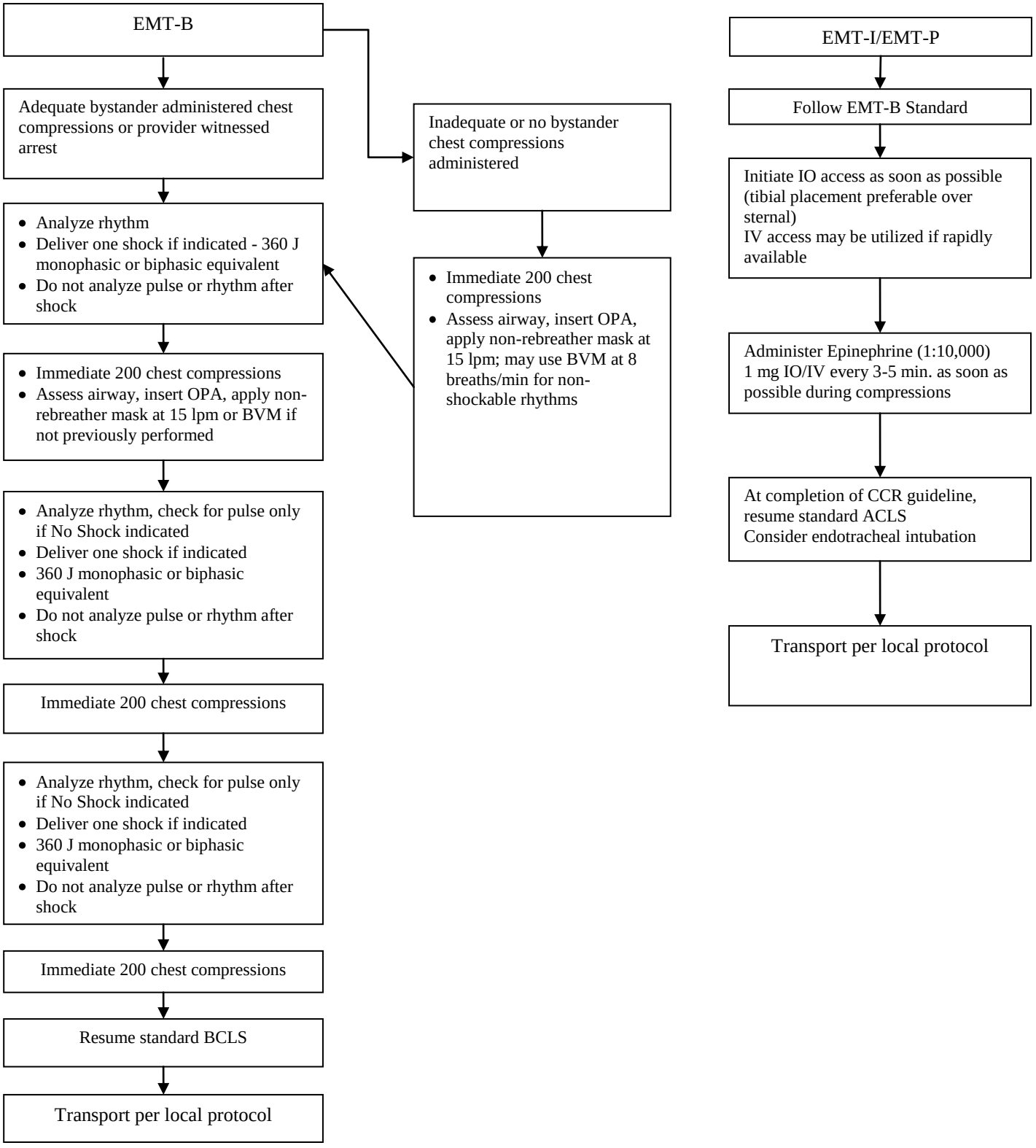

Adult Chest Pain of Probable Cardiac Origin
Assess ABC's/VS/LOC
EMT-B
Support Airway Ventilation Oxygenation
Have AED Ready
Administer 324-325 mg Aspirin PO chew and swallow
If patient has own Nitroglycerin, in original container, is not expired, and patient's systolic BP is greater than 100 mmHg assist patient with taking Nitroglycerin as necessary every 5 minutes to a total of 3 tablets/sprays or pain relief or drop in systolic BP to less than 100 mmHg
Transport per local protocol
EMT-I/EMT-P
Follow EMT-B Standard
Do not utilize patient assisted Nitroglycerin
Apply ECG monitor
If lethal or potentially lethal arrhythmias are present, proceed to appropriate cardiac treatment protocol
Perform 12 lead ECG, if available
Transmit ECG or pre-notify hospital if ST-elevation MI present
Administer 324-325 mg Aspirin PO chew and swallow
Initiate IV access
Administer Nitroglycerin 0.4 mg tablets or oral spray SL may repeat every 5 minutes to a total of 3 tablets to relieve pain if the patient's systolic BP is greater than 100 mmHg
Administer Morphine sulfate 2-4 mg IV every 5 minutes to a total of 10 mg if pain not relieved with Nitroglycerin and patient systolic BP is greater than 100 mmHg
If ST-elevation MI present
transport to appropriate facility


Adult Bradycardia, Symptomatic
Assess ABC's/VS/LOC
EMT-B
Support Airway Ventilation Oxygenation
Have AED Ready
Monitor Vital Signs
Transport per local protocol
EMT-I/EMT-P
Follow EMT-B Standard
Monitor ECG rhythm
Perform 12 lead ECG, if available
Initiate IV access
Prepare for transcutaneous pacing; use without delay for high-degree block (type II second degree or third degree AV blocks)
Consider Atropine 0.5 mg every 3-5 mins. to a total dose of 3 mg while awaiting pacer, if ineffective begin pacing
Paramedic only: Consider epinephrine 2-10 mcg/min or Dopamine 2-20 mcg/kg/min infusion while awaiting pacer or if pacer ineffective
Transport per local protocol

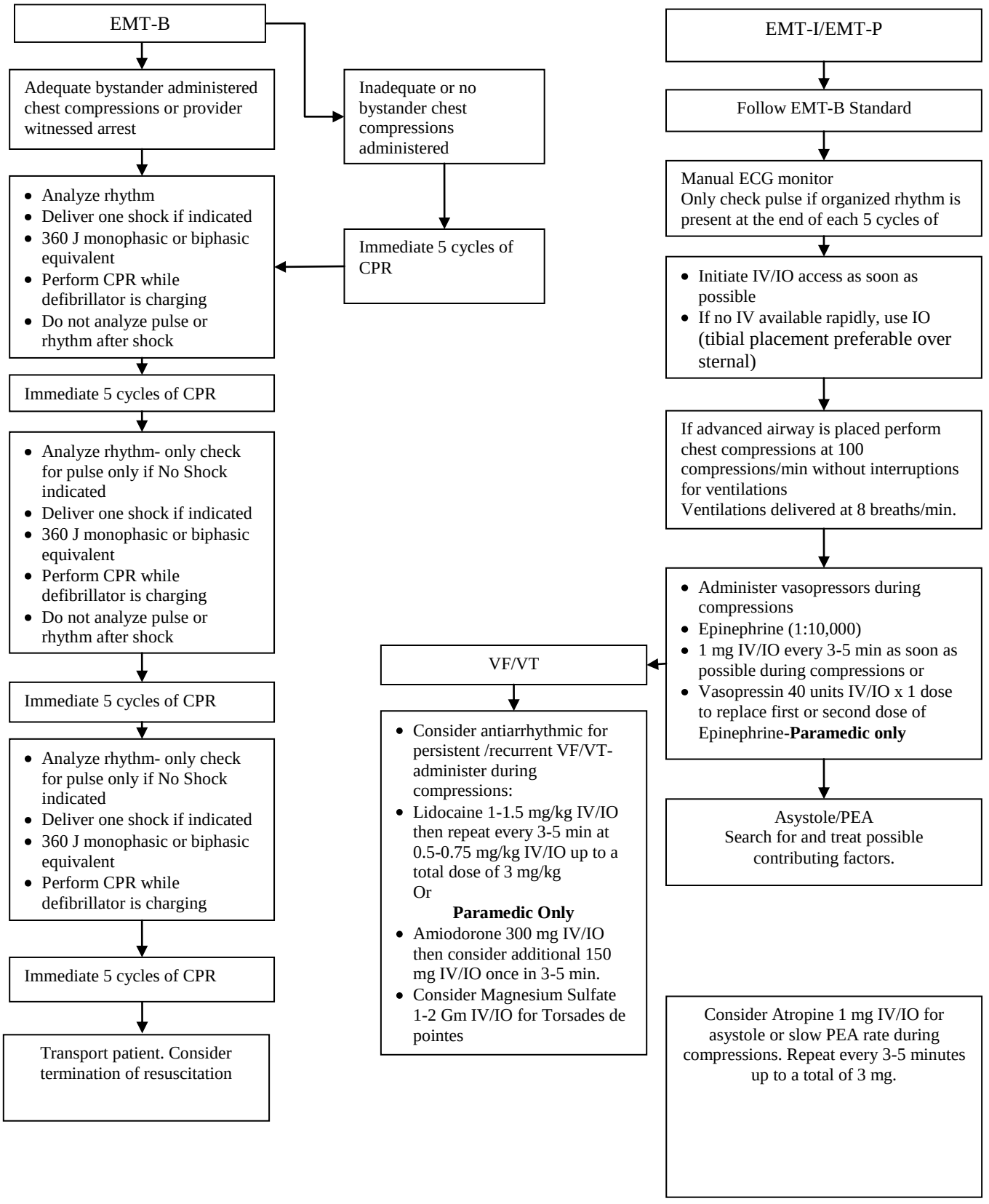
Adult Tachycardia with Pulses



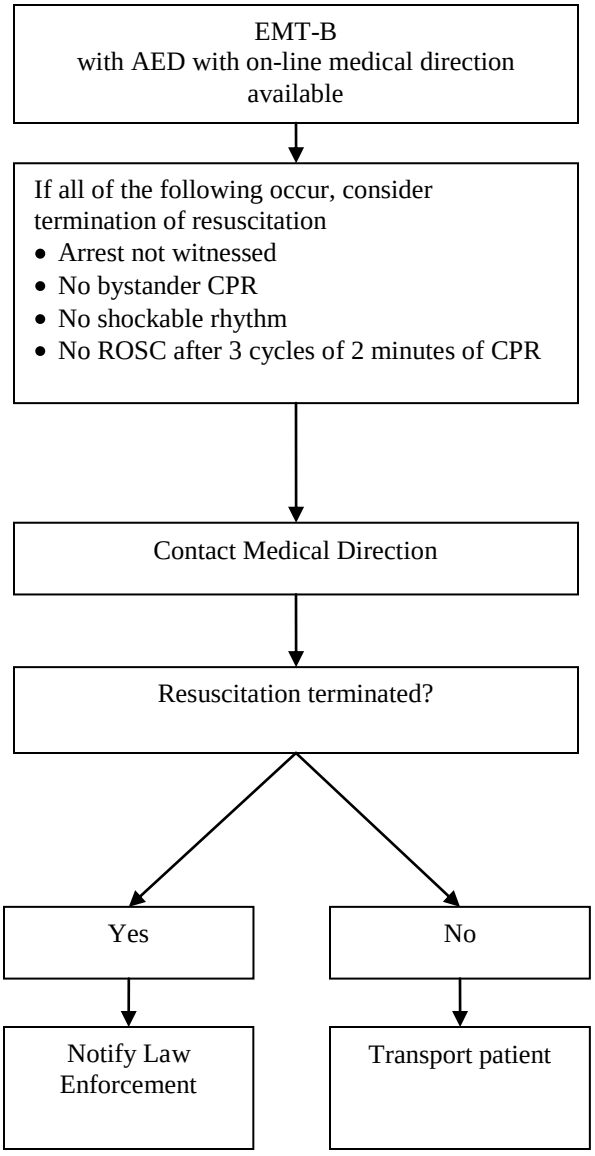
Adult Pulseless Arrest-Cardiocerebral Resuscitation

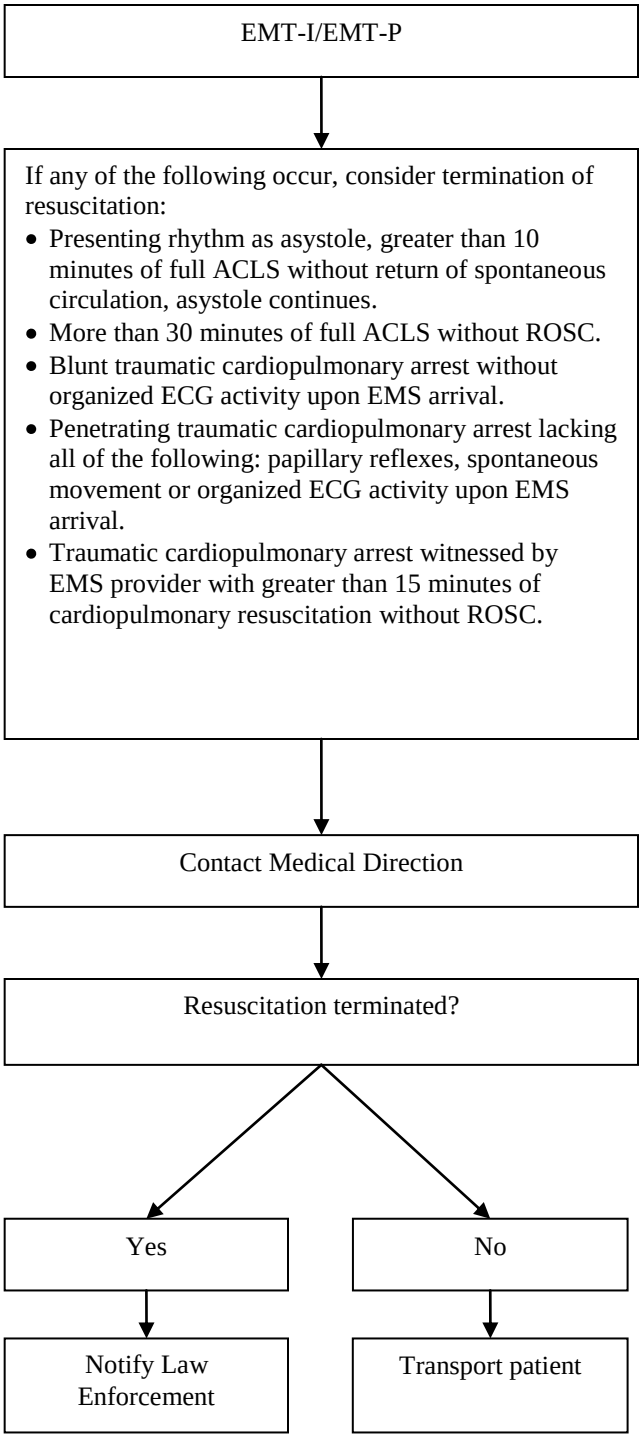


Adult Pulseless Arrest

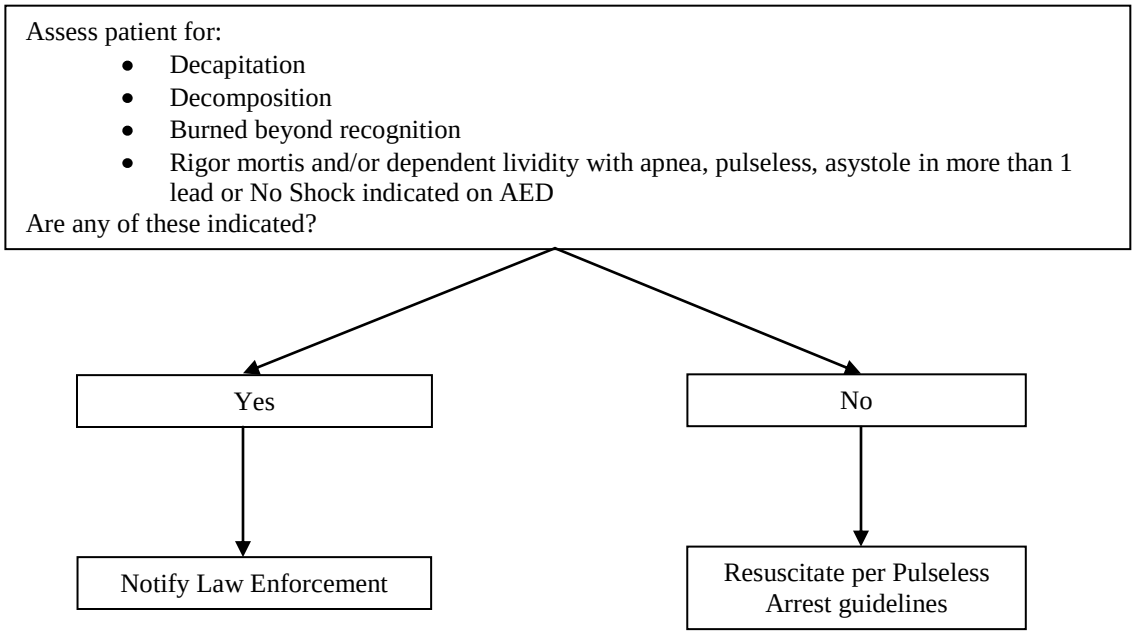


Adult Termination of Resuscitation Efforts
[Environmental Hypothermia not Present]

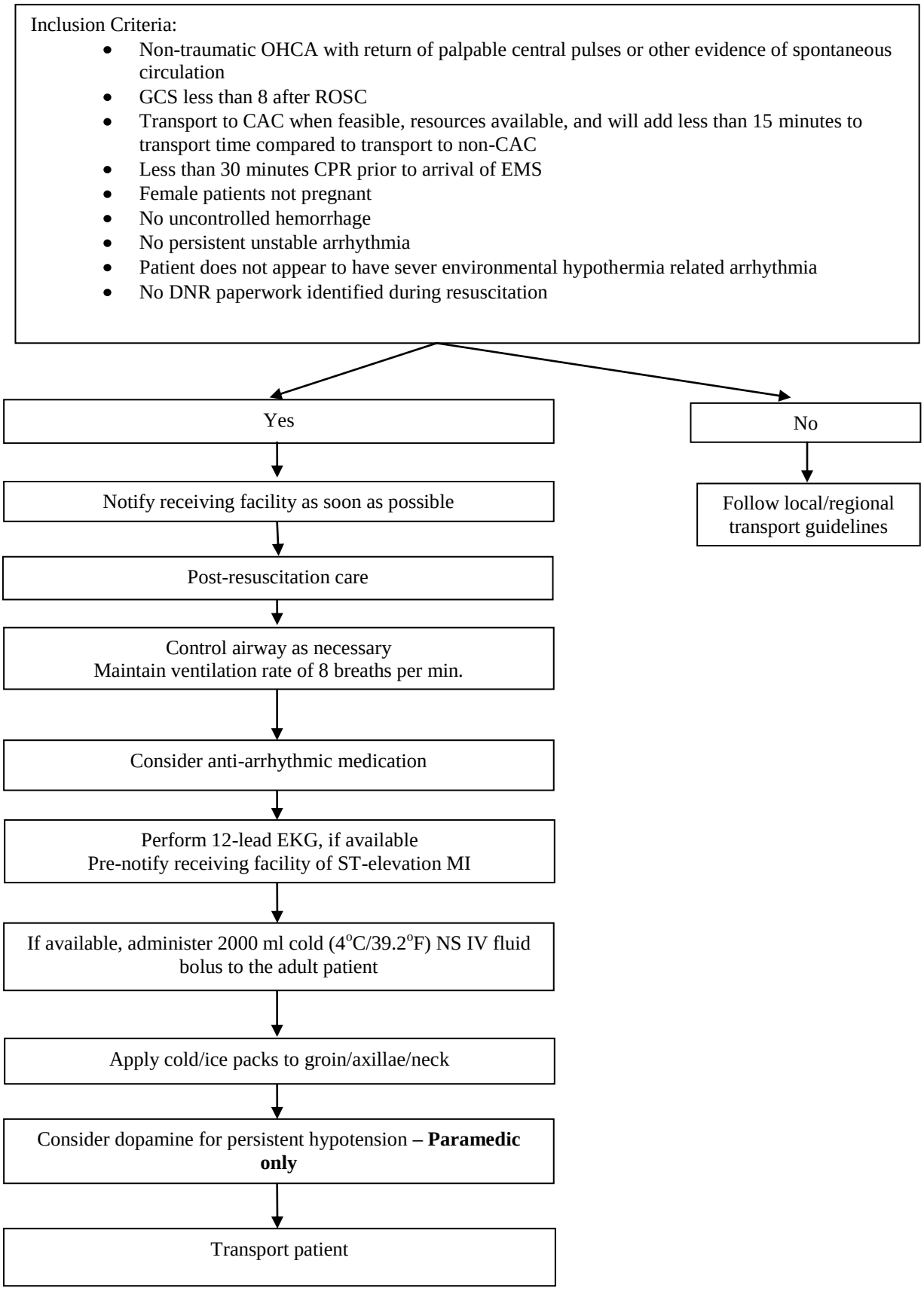




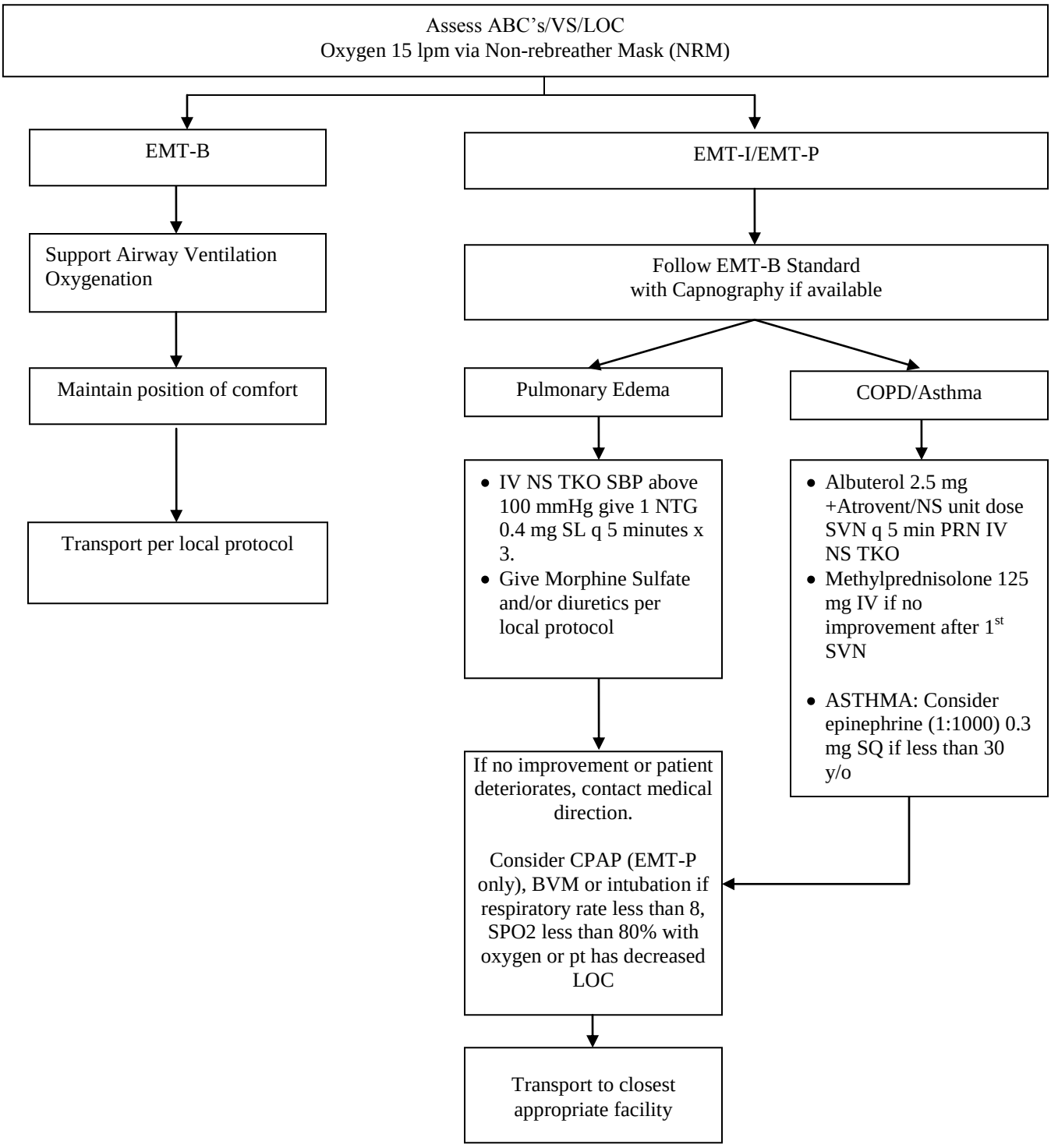
Adult Dead On-Scene



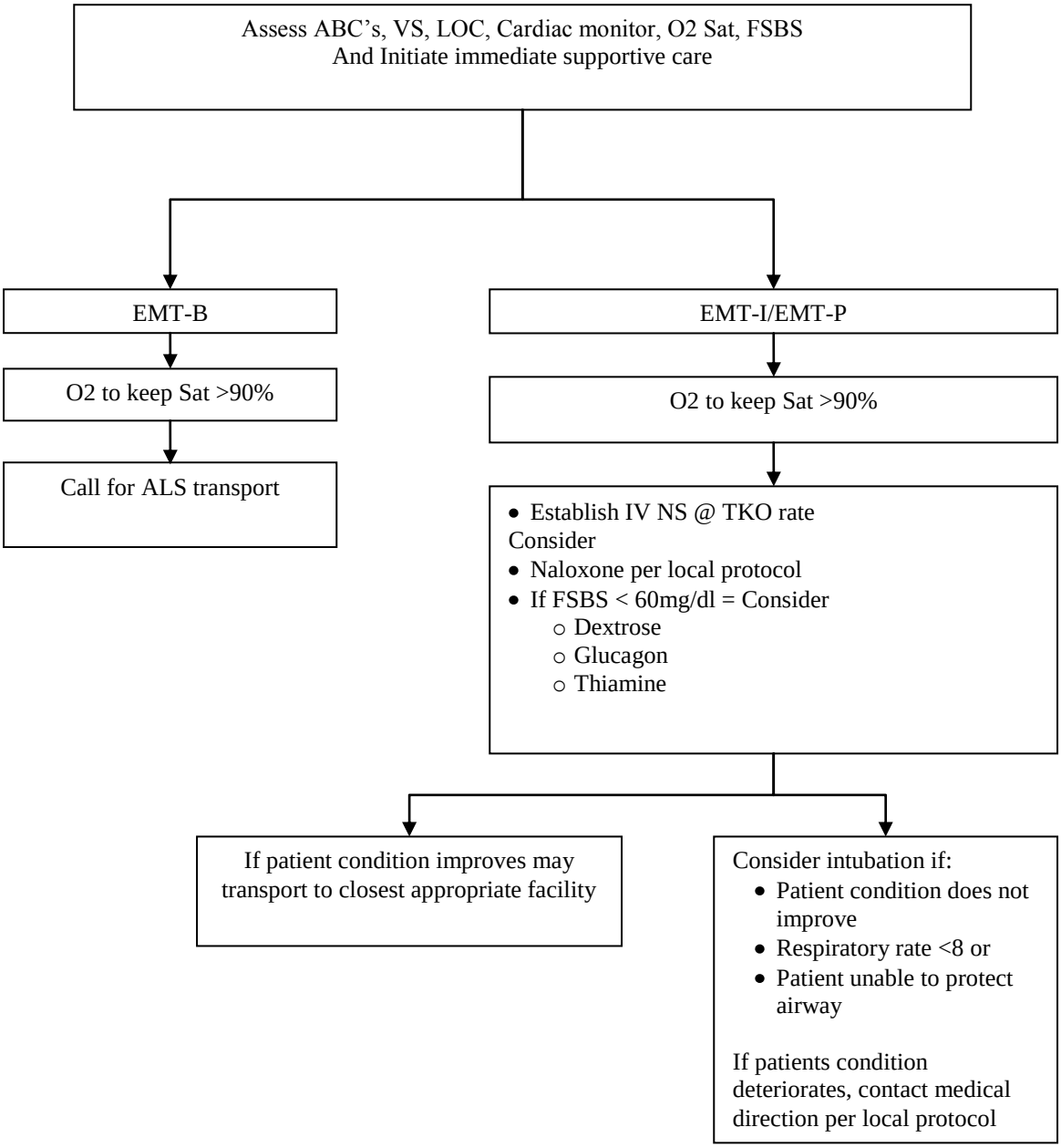
Adult Transport to Designated Cardiac Arrest Center/Cardiac Arrest Post-Resuscitation



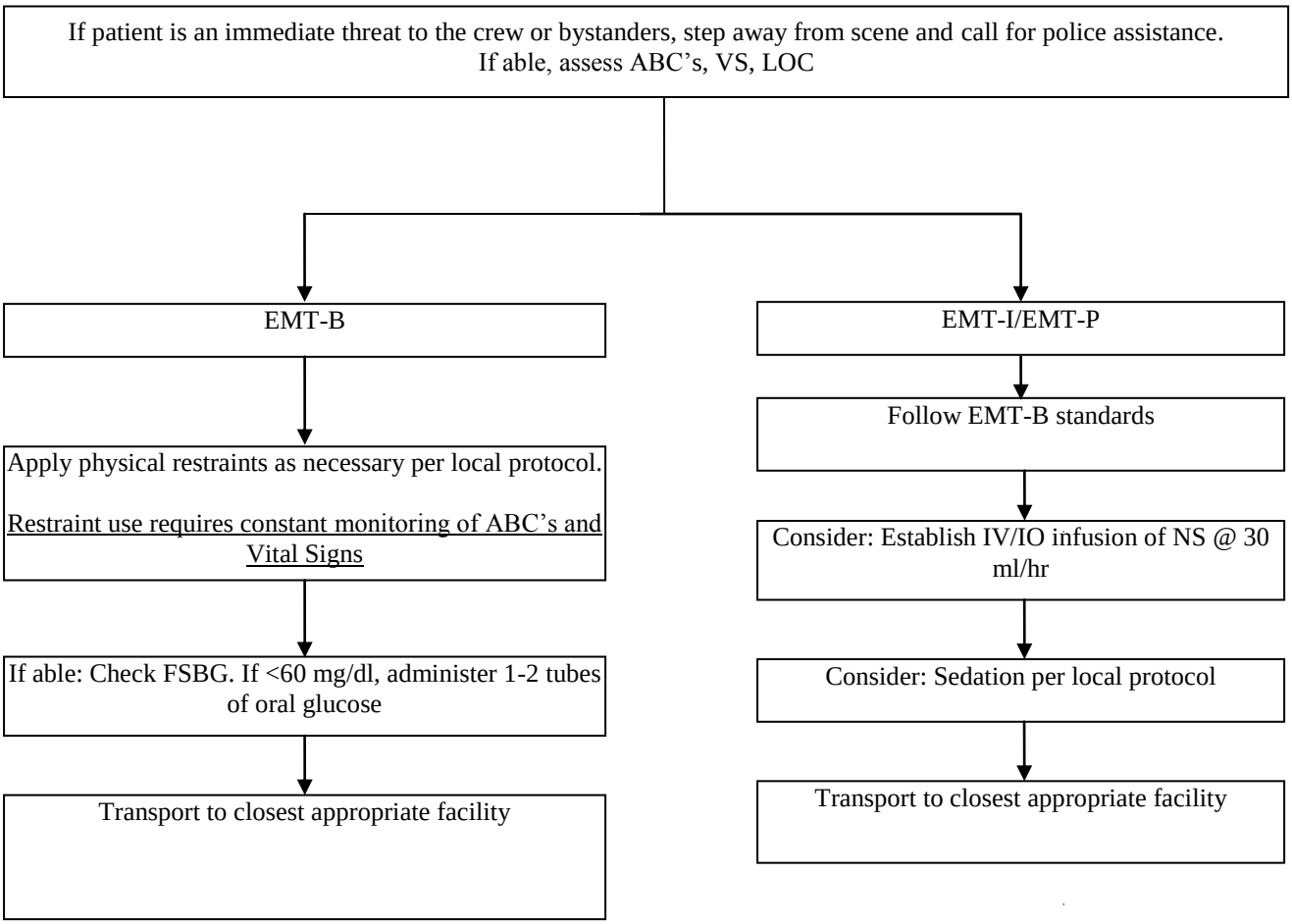
Adult Respiratory Difficulty



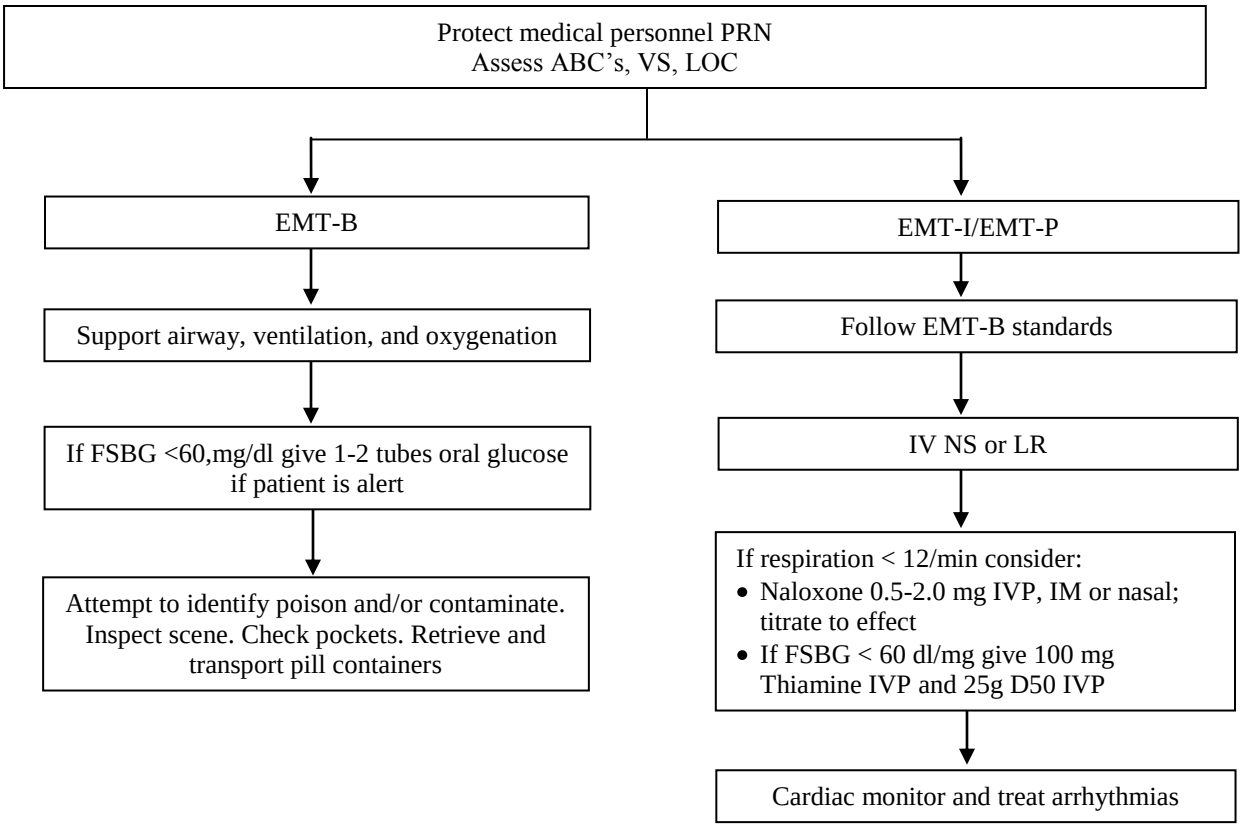
Adult Unconscious/Unresponsive
[Non-Traumatic Adult ≥ 15 Y/O]



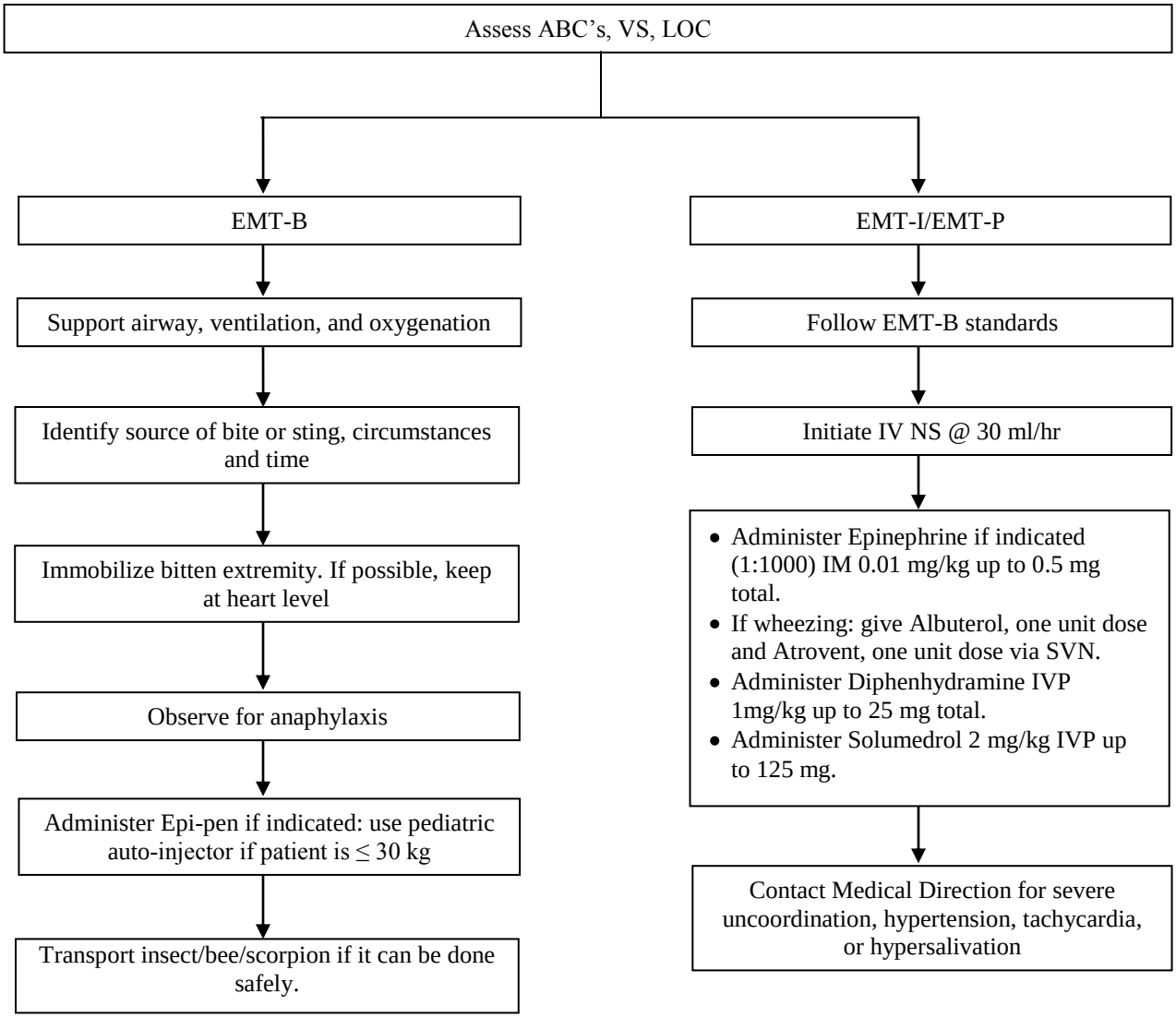
Adult Behavioral Emergency – Violent or Combative Patient



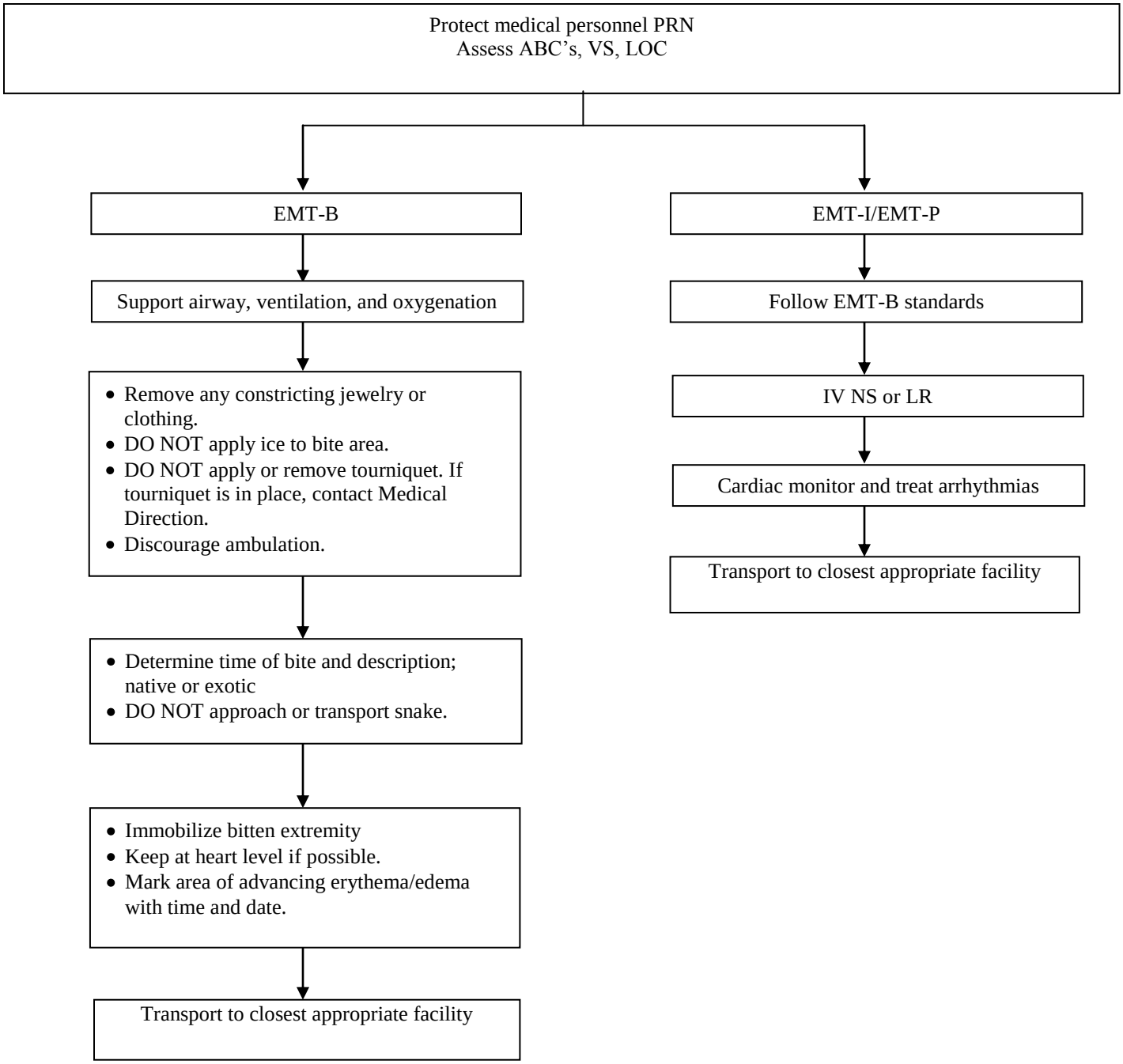
Poison Ingestion/Inhalation



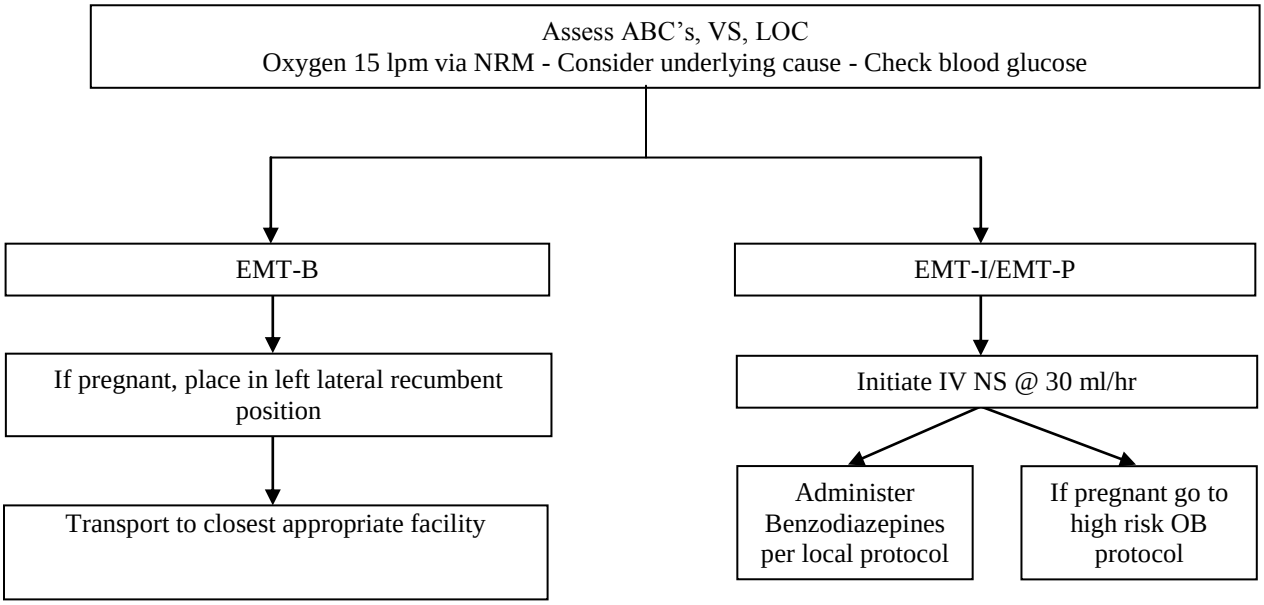
Adult Poison - Bites and Stings

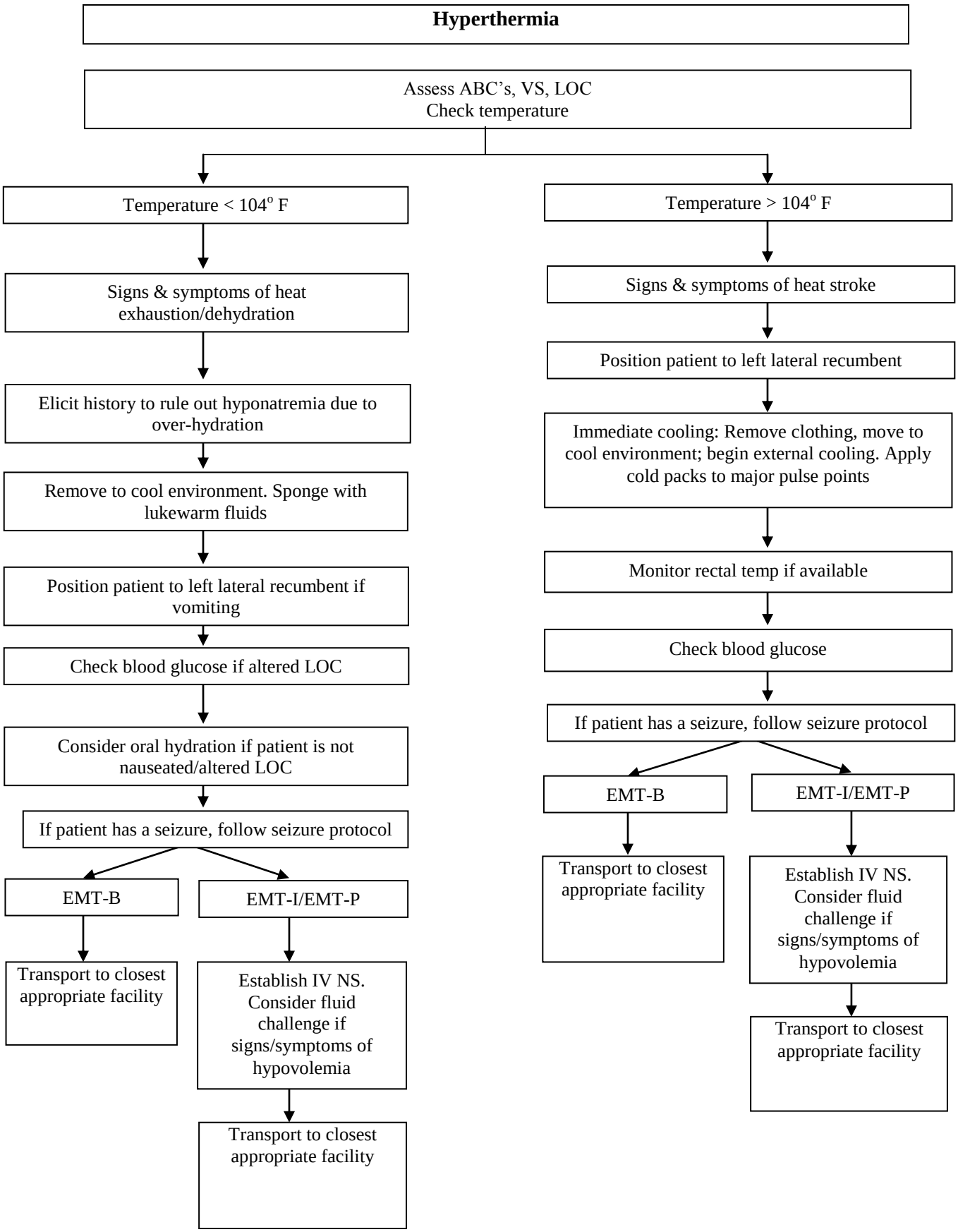


Poison – Snakebite

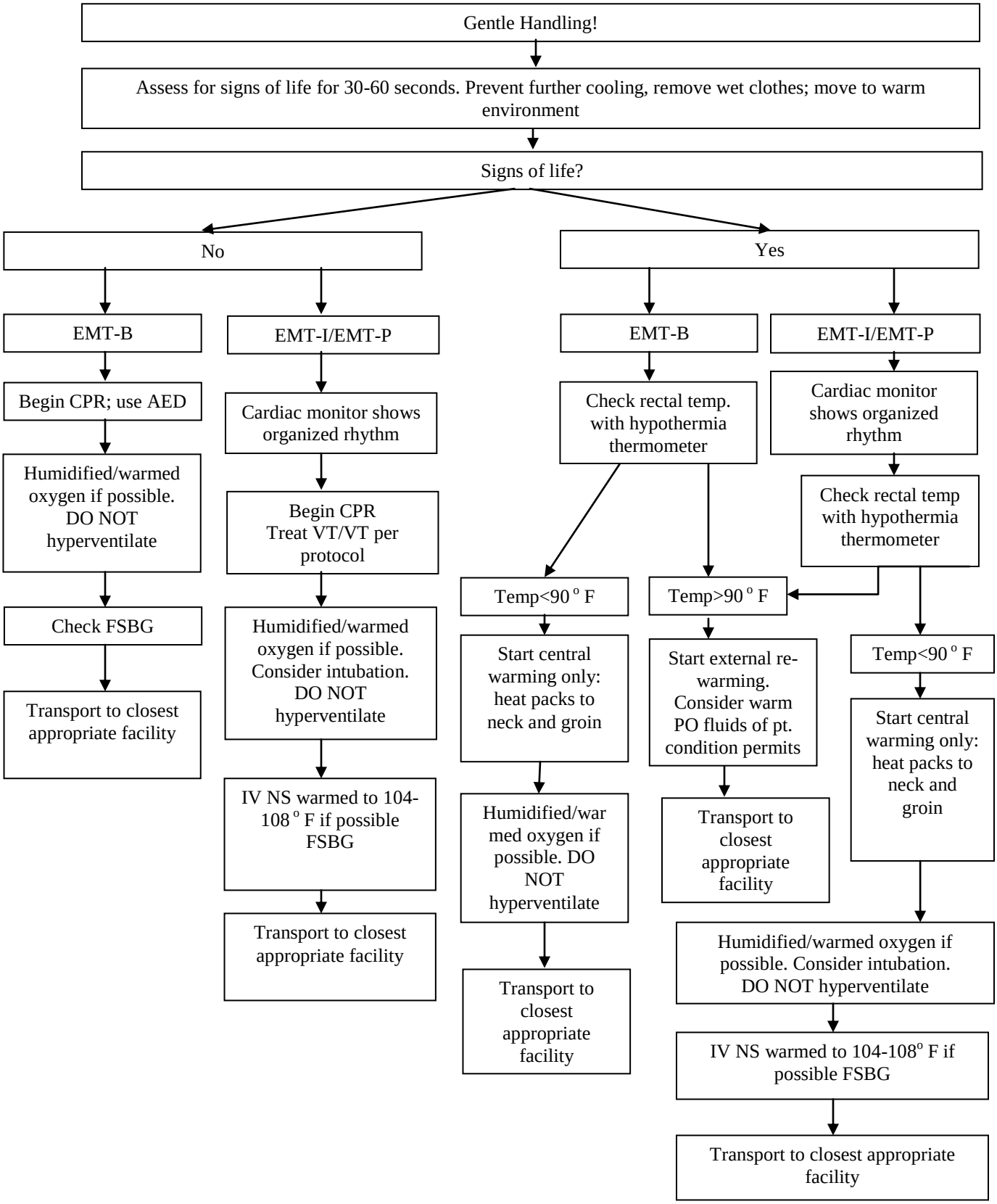


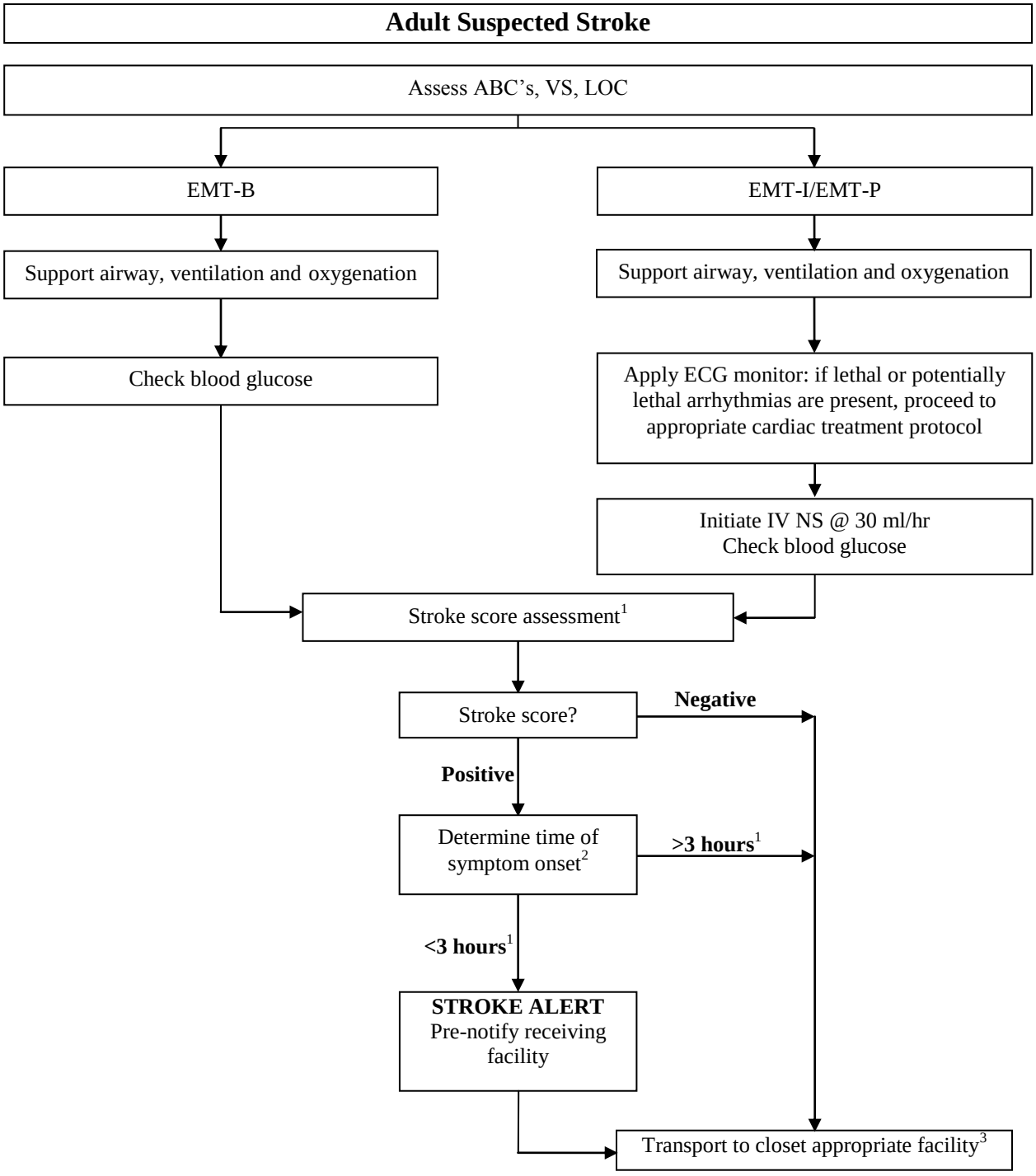
Adult Seizures




Hyperthermia
Assess ABC's, VS, LOC
Check temperature
Temperature < 104° F
Signs & symptoms of heat exhaustion/dehydration
Elicit history to rule out hyponatremia due to over-hydration
Remove to cool environment. Sponge with lukewarm fluids
Position patient to left lateral recumbent if vomiting
Check blood glucose if altered LOC
Consider oral hydration if patient is not nauseated/altered LOC
If patient has a seizure, follow seizure protocol
EMT-B
EMT-I/EMT-P
Transport to closest appropriate facility
Establish IV NS. Consider fluid challenge if signs/symptoms of hypovolemia
Transport to closest appropriate facility
Temperature > 104° F
Signs & symptoms of heat stroke
Position patient to left lateral recumbent
Immediate cooling: Remove clothing, move to cool environment; begin external cooling. Apply cold packs to major pulse points
Monitor rectal temp if available
Check blood glucose
If patient has a seizure, follow seizure protocol
EMT-B
EMT-I/EMT-P
Transport to closest appropriate facility
Establish IV NS. Consider fluid challenge if signs/symptoms of hypovolemia
Transport to closest appropriate facility

Hypothermia

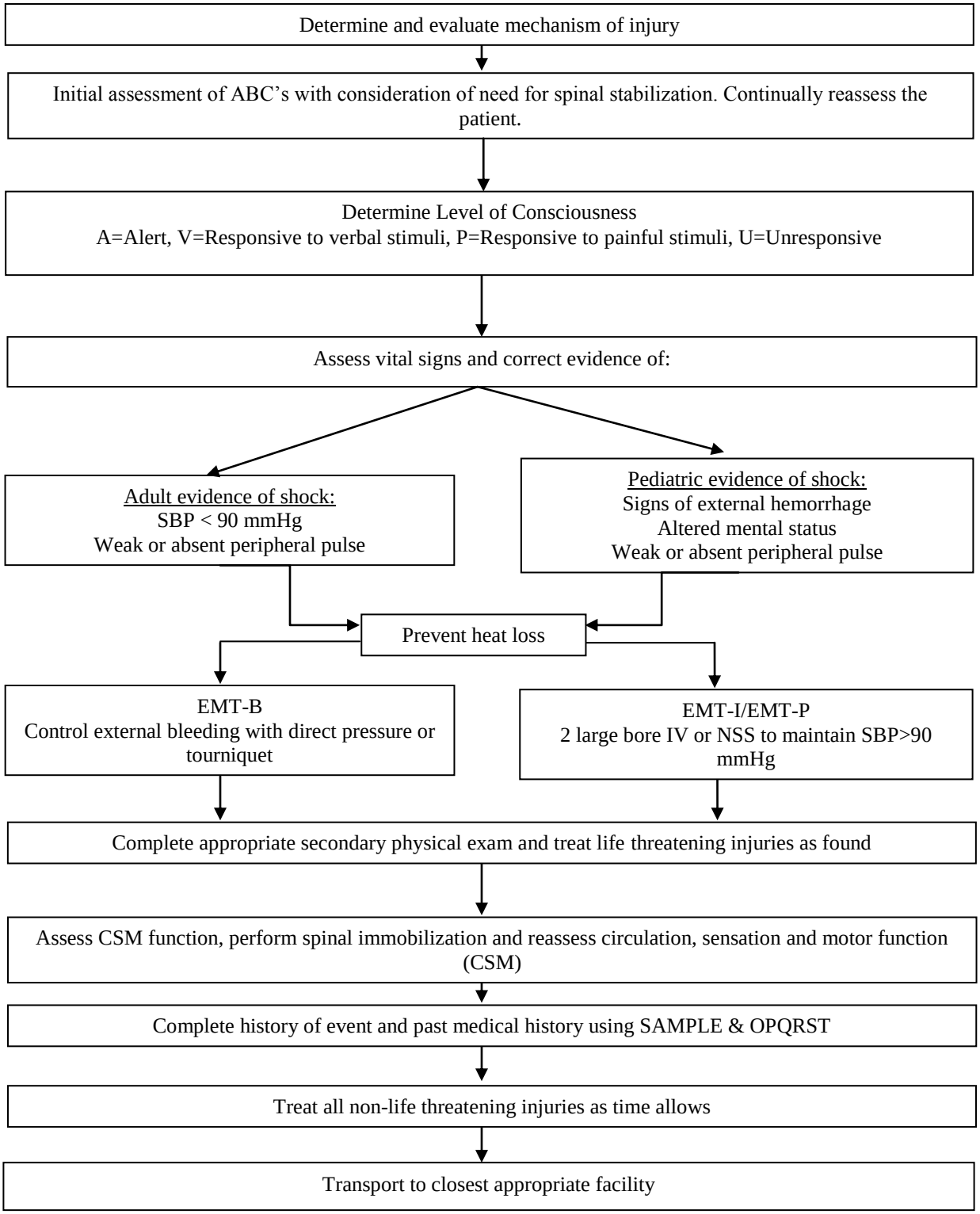




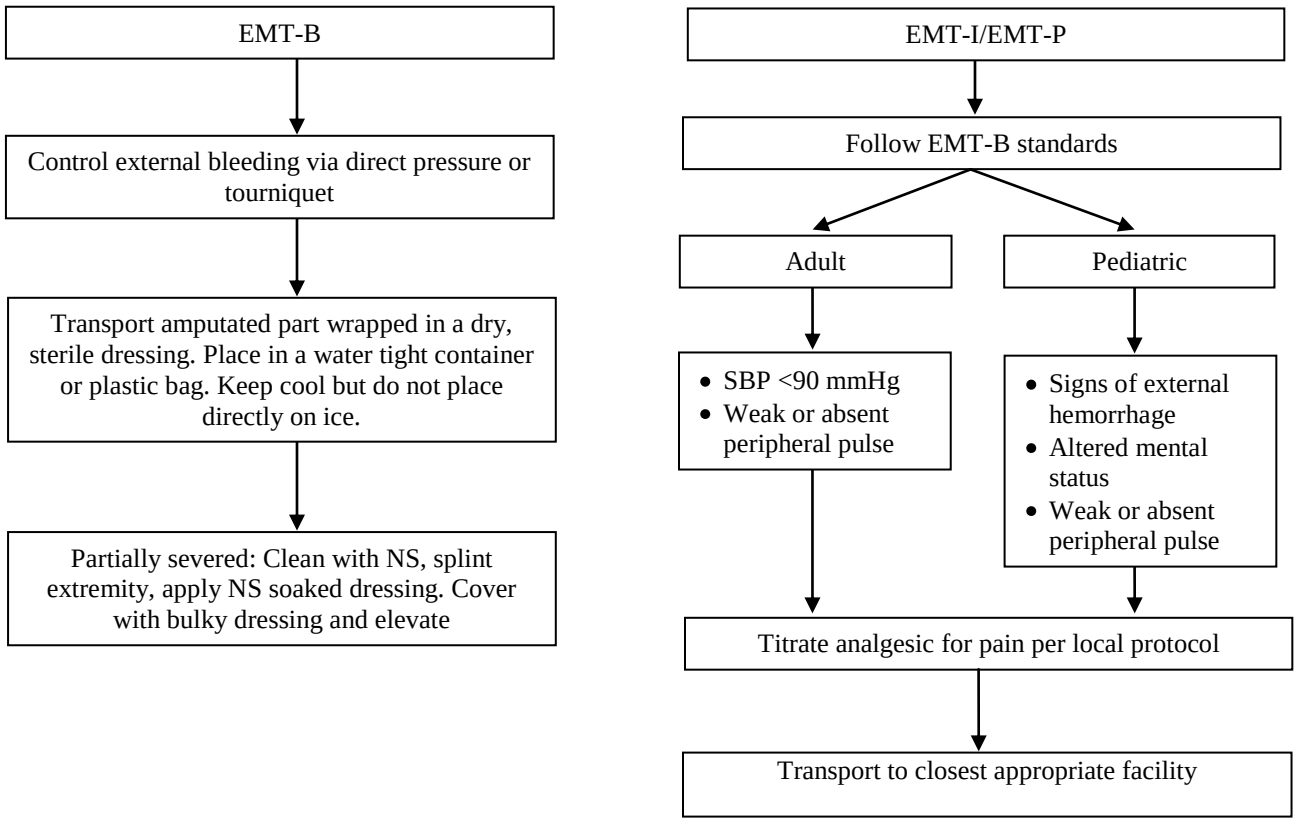
[1]method determined by regional medical guidelines
[2]last normal if time of onset unknown
[3]as determined by local medical direction

Revised 6/2012

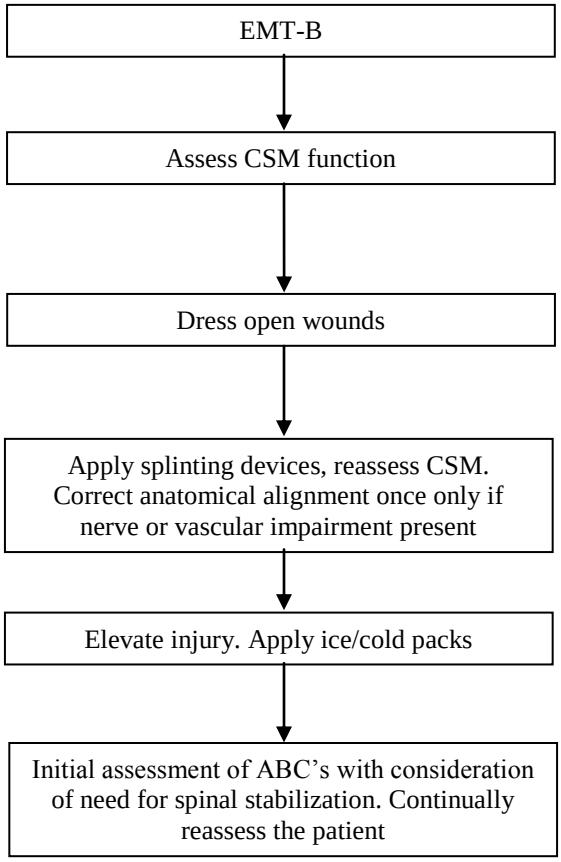
Trauma - General Management

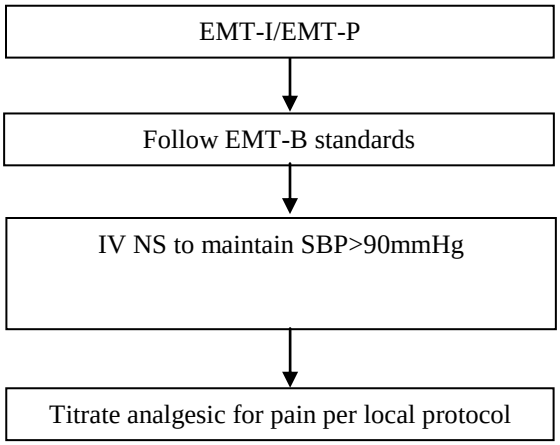


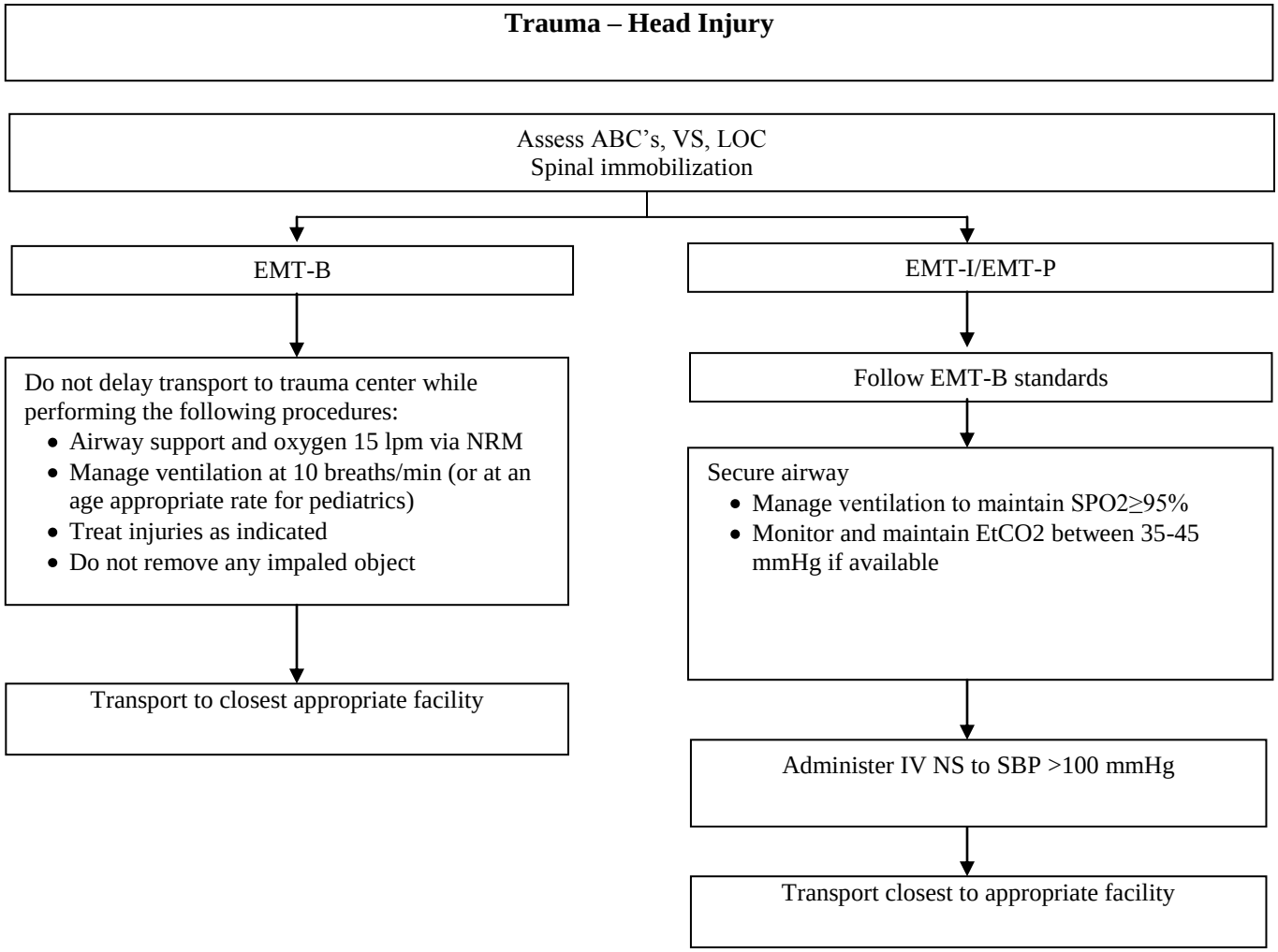
Trauma - Amputated Parts



Trauma - Extremity Fractures, Dislocation and Sprains






Trauma – Head Injury
Assess ABC's, VS, LOC
Spinal immobilization
EMT-B
EMT-I/EMT-P
Do not delay transport to trauma center while performing the following procedures:
Airway support and oxygen 15 lpm via NRM
Manage ventilation at 10 breaths/min (or at an age appropriate rate for pediatrics)
Treat injuries as indicated
Do not remove any impaled object
Transport to closest appropriate facility
Follow EMT-B standards
Secure airway
Manage ventilation to maintain SPO2≥95%
Monitor and maintain EtCO2 between 35-45 mmHg if available
Administer IV NS to SBP >100 mmHg
Transport closest to appropriate facility

Spinal Immobilization Protocol

l. PURPOSE

To provide a field decision scheme for determining the need for spinal immobilization of injured patients.

II. PROCEDURE

Conduct a neurovascular assessment. Follow the outline below to determine the need for immobilization.

BLUNT TRAUMA		**PENETRATING TRAUMA TO HEAD, NECK OR TORSO**	
IMMOBILIZE *if any of the following criteria are present:* • Spinal pain or tenderness • Neurological deficit or complaint • Anatomic deformity of spine • Concerning mechanism of injury * • Presence of alcohol/drugs • Distracting • injury **	CONSIDER NOT IMMOBILIZING *Patient must meet the following criteria:* • No spine pain or tenderness • No neurological deficit or complaint • No anatomic deformity of spine • No concerning mechanism of injury * • Absence of evident impairment from alcohol/drugs • No obvious distracting injury **	IMMOBILIZE *if any of the following criteria are present:* • Neurological deficit or complaint	CONSIDER NOT IMMOBILIZING • No neurological deficit or complaint

III. SPECIAL CONSIDERATIONS

*****Any mechanism that produces a violent impact to the head, neck, torso, or pelvis (e.g., assault, entrapment in structural collapse, etc.), or incidents producing sudden acceleration, deceleration, or lateral bending forces to the neck or torso.

** Any injury that may have the potential to impair the patient's ability to appreciate other injuries.

In the event that initiation of standard spinal immobilization is judged impractical or likely to cause more potential harm than benefit, use modified immobilization technique and contact medical direction as needed.

If decisional capacity is confirmed, defer immobilization and proceed with standard care. If patient lacks decisional capacity consult with medical direction. In patients refusing immobilization in whom decisional capacity is questionable, perform and document a cognitive screen.

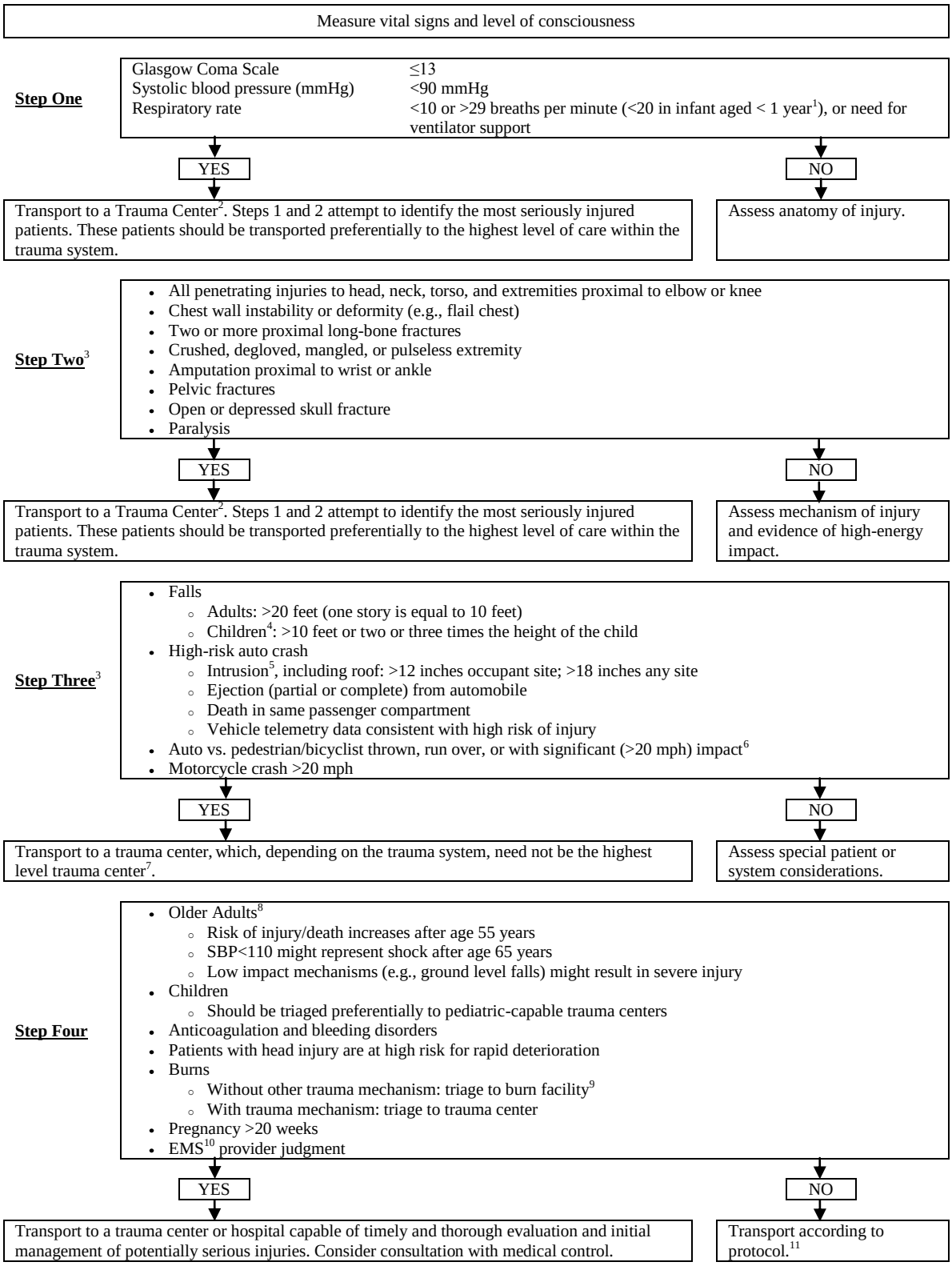
"USE CLINCIAL JUDGEMENT. IF IN DOUBT, IMMOBILIZE"

Added to TTTG: 6/2012

Arizona Guidelines for Field Triage of Injured Patients

(Regional modifications are permissible)

FIELD TRIAGE DECISION SCHEME



WHEN IN DOUBT, TRANSPORT TO A TRAUMA CENTER

FIELD TRIAGE SCHEME FOOTNOTES
[1] The upper limit of respiratory rate in infants is >29 breaths per minute to maintain a higher level of over-triage for infants.
[2] Trauma centers are designated Level I-IV. A Level I center has the greatest amount of resources and personnel for care of the injured patient and provides regional leadership in education, research, and prevention programs. A Level II facility offers similar resources to a Level I facility, possible differing only in continuous availability of certain subspecialties or sufficient prevention, education, and research activities for Level I designation; Level II facilities are not required to be resident or fellow education centers. A Level III center is capable of assessment, resuscitation, and emergency surgery, with severely injured patients being transferred to a Level I or II facility. A Level IV trauma center is capable of providing 24-hour physician coverage, resuscitation, and stabilization to injured patients before transfer to a facility that provides a higher level of trauma care.
[3] Any injury noted in Step Two or Step Three triggers a "YES" response.
[4] Age <15 years.
[5] Intrusion refers to interior compartment intrusion, as opposed to deformation which refers to exterior damage.
[6] Includes pedestrians or bicyclists thrown or run over by a motor vehicle or those with estimated impact >20 mph with a motor vehicle.
[7] Local or regional protocols should be used to determine the most appropriate level of trauma center; appropriate center need not be Level I.
[8] Age >55 years.
[9] Patients with both burns and concomitant trauma for whom the burn injury poses the greatest risk for morbidity and mortality should be transferred to a burn center. If the non-burn trauma presents a greater immediate risk, the patient may be stabilized in a trauma center and then transferred to a burn center.
[10] Emergency medical services.
[11] Patients who do not meet any of the triage criteria in Steps One through Four should be transported to the most appropriate medical facility as outlined in local EMS protocols.

Revised: 6/2012

Arizona Ground and Air Ambulance Mode of Transport Guidelines

The decision for mode of transport for both field and inter-facility patients is based on the premise that the time to definitive care and quality of care are critical to achieving optimal outcomes. Factors of distance, injury/illness, road conditions, weather, and traffic patterns should be considered when choosing between air or ground transport. The skill level of the transport team(s) involved should also be considered.

Local and regional analysis of mode of transport decisions should be part of the normal, on-going quality improvement process. Mode of transport discussion should be incorporated into on-going pre-hospital and hospital educational opportunities. Although the examples provided below are not intended to cover all potential circumstances, consider the following assumptions:

- Air ambulance transport may be quicker.
- There are no weather or road issues that would make air transport preferable to ground transport or ground transport preferable to air transport.
- Patients in cardiac arrest and receiving CPR should never be transported by air ambulance.

Transports from one hospital to another for a higher level of care typically fall into one of two broad types: Those in which a quicker form of transport may make a difference in treatment/outcome; and, those in which a quicker form of transport may not make a difference in treatment/outcome. As a general rule, the potential benefit to the patient should outweigh the risk associated with Air Ambulance transport.

MODE OF TRANSPORT EXAMPLES (examples not intended to cover all potential circumstances)	
Quicker Form of Transport May Make a Difference in Outcome	Quicker Form of Transport May Not Make a Difference in Outcome
Patient with a suspected aortic injury as seen on chest X-ray or CT scan.	Patient with 2 broken ribs, no pneumothorax and who is breathing fine.
Patient with an open book pelvic fracture.	Patient with a minor pelvic fracture and hemodynamically stable.
Patient with stab wound to the abdomen near the upper right quadrant.	Patient with gun-shot wound to the thigh with excellent pulses, no expanding thigh, and no significant on-going blood loss.
Patient with a gunshot wound to the thigh with decreased pulses.	Stab wound to the arm with decreased sensation but normal pulses, no "tightness", and no significant on-going blood loss.
Patient with Glasgow Coma Scale (GCS) less than 12 and the GCS is decreasing.	Patient with a concussion and normal CT scan of the brain; or if no CT, then a GCS of 15.
Patient with a time-sensitive illness (such as STEMI, stroke, sepsis, burn victims, etc.) that would benefit from proven intervention or treatment that is only **available** at the specific receiving institution.	Patients with medical conditions that are not eligible for or will not receive time sensitive interventions.
Geriatric, pediatric or peri-natal patients with unexplained and worsening illness.	Special populations whose vital signs are stable and indications for acute changes are unlikely.

When considering air transport, the amount of time saved should be significant enough to allow a potentially beneficial intervention to take place at the receiving facility. Time considerations should take into account arranging for air transport, patient packaging, transport to the aircraft and transport for the patient from the helipad or airport to the receiving facility. The referring physician should collaborate with the receiving physician (this is not limited to transfers initiated in the ED), and transport service providers to determine the appropriate mode of transport based on the patient's condition, best practices, and the above mentioned factors.

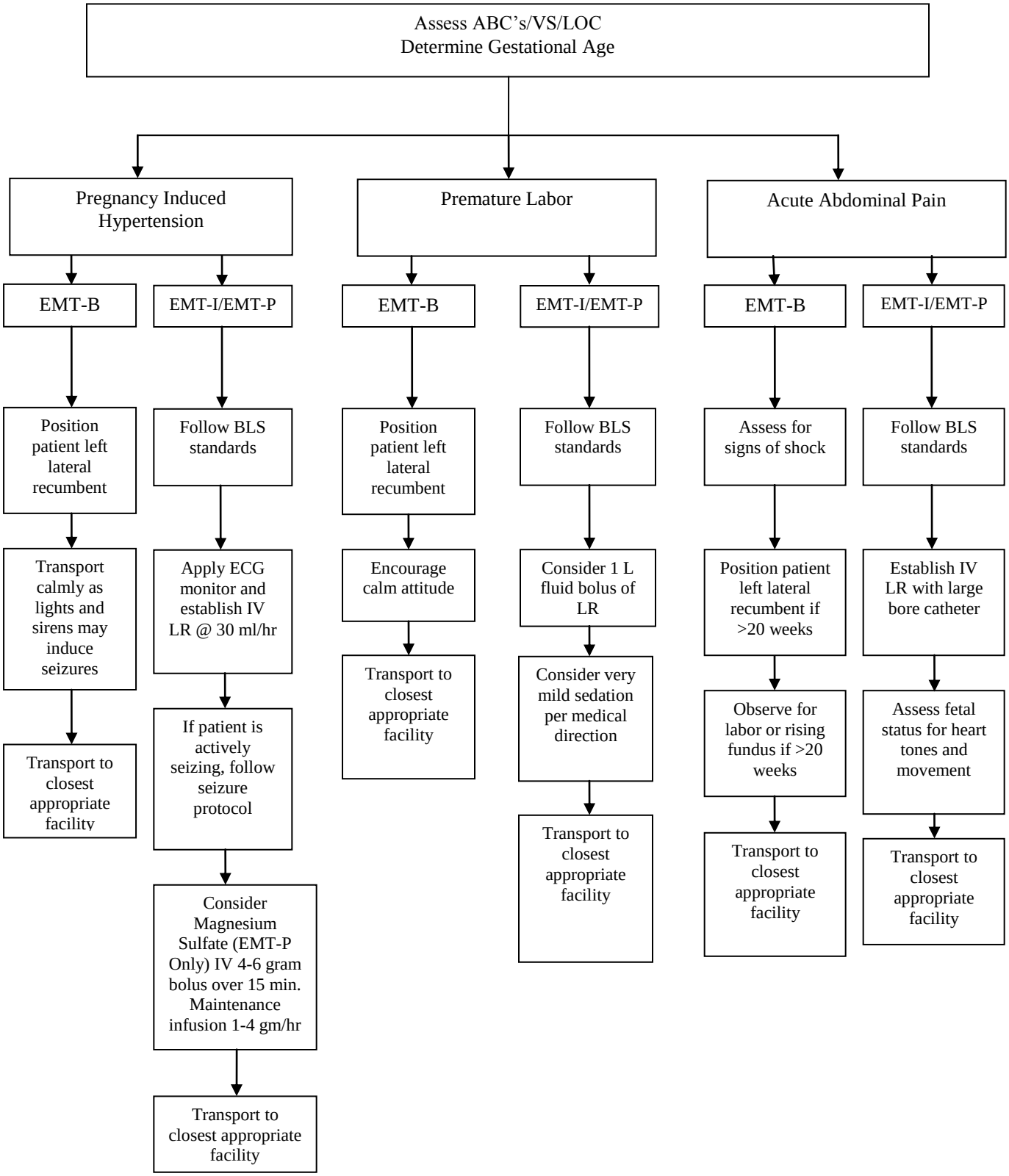
References:

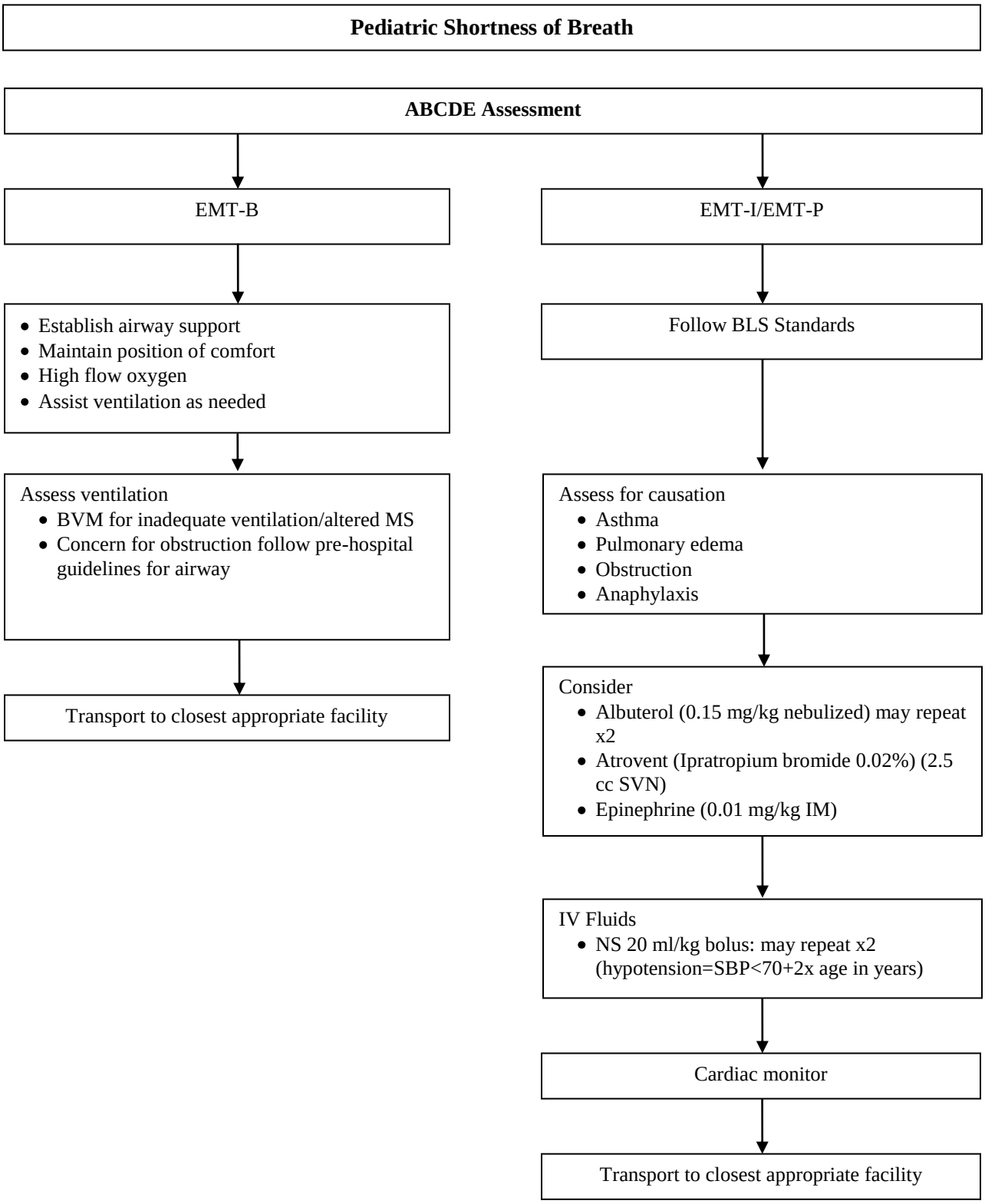
American College of Emergency Physicians. 2011. Appropriate utilization of air medical transport in the out-of-hospital setting (http://www.acep.org/Content.aspx?id=29116)

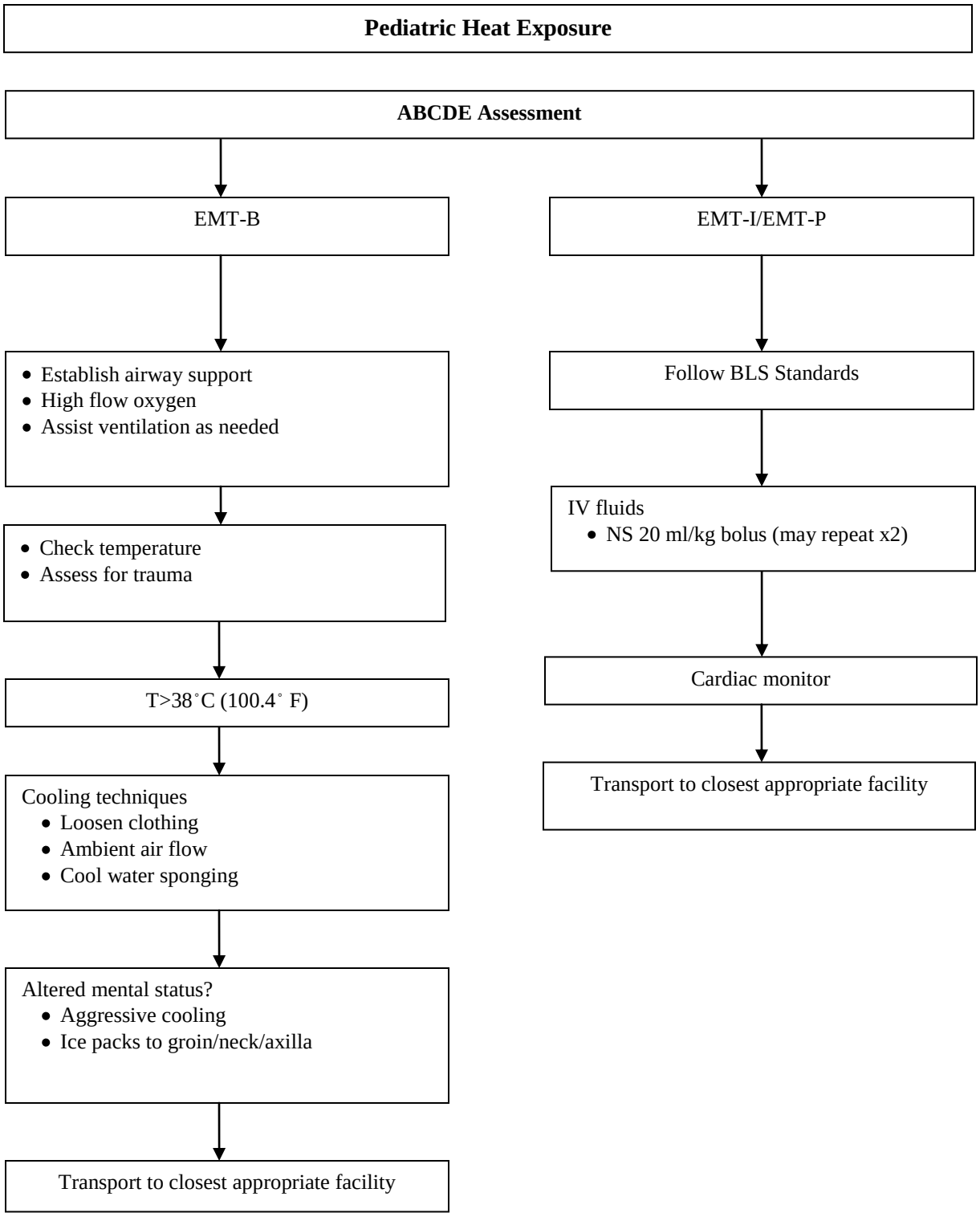
National Association of EMS Physicians. Guidelines for air medical dispatch. Prehospital emergency care. April/June 2003. Volume 7, number 2 (http://www.naemsp.org/pdf/AirMedicalDispatch.pdf)

Added to TTTG: 6/2012

Adult High Risk OB (HROB)




Pediatric Shortness of Breath
ABCDE Assessment
EMT-B
EMT-I/EMT-P
• Establish airway support
• Maintain position of comfort
• High flow oxygen
• Assist ventilation as needed
Follow BLS Standards
Assess ventilation
• BVM for inadequate ventilation/altered MS
• Concern for obstruction follow pre-hospital guidelines for airway
Assess for causation
• Asthma
• Pulmonary edema
• Obstruction
• Anaphylaxis
Consider
• Albuterol (0.15 mg/kg nebulized) may repeat x2
• Atrovent (Ipratropium bromide 0.02%) (2.5 cc SVN)
• Epinephrine (0.01 mg/kg IM)
IV Fluids
• NS 20 ml/kg bolus: may repeat x2 (hypotension=SBP<70+2x age in years)
Cardiac monitor
Transport to closest appropriate facility
Transport to closest appropriate facility


Pediatric Heat Exposure
ABCDE Assessment
EMT-B
EMT-I/EMT-P
• Establish airway support
• High flow oxygen
• Assist ventilation as needed
Follow BLS Standards
• Check temperature
• Assess for trauma
IV fluids
• NS 20 ml/kg bolus (may repeat x2)
T>38˚C (100.4˚ F)
Cardiac monitor
Cooling techniques
• Loosen clothing
• Ambient air flow
• Cool water sponging
Transport to closest appropriate facility
Altered mental status?
• Aggressive cooling
• Ice packs to groin/neck/axilla
Transport to closest appropriate facility

Pediatric *Anaphylaxis/**Allergic Reaction

ABCDE Assessment

EMT-B

Anaphylaxis (respiratory distress or shock)

- Maintain airway
- High flow oxygenation
- Assist ventilation as necessary
- Check glucose (treat if <40 mg/dl)

- Assist patient with or administer Epi-pen if available
- Assist patient with Albuterol inhaler if available

Transport to closest appropriate facility

EMT-I/EMT-P

Allergic reaction (no respiratory distress)

Follow BLS standards

Consider:

- Diphenhydramine 1mg/kg IV/IM up to 25 mg
- Methylprednisolone 2 mg/kg IV
- Albuterol SVNs prn
- Epinephrine 0.01 mg/kg up to 0.3 mg (0.01-0.03 ml/kg) of 1:1000

Transport to closest appropriate facility

Anaphylaxis (respiratory distress or shock)

Follow BLS standards

Apply monitor

Epinephrine SC or IM 1:1000 0.01 mg/kg up to 0.3 mg (0.01-0.03 ml/kg)

Establish IV/IO of NS

For hypotension, Epinephrine IV/IO infusion: 0.1 mcg - 1.0 mcg/kg/min

If signs & symptoms of hypoperfusion fluid bolus of 20 ml/kg. May repeat PRN.

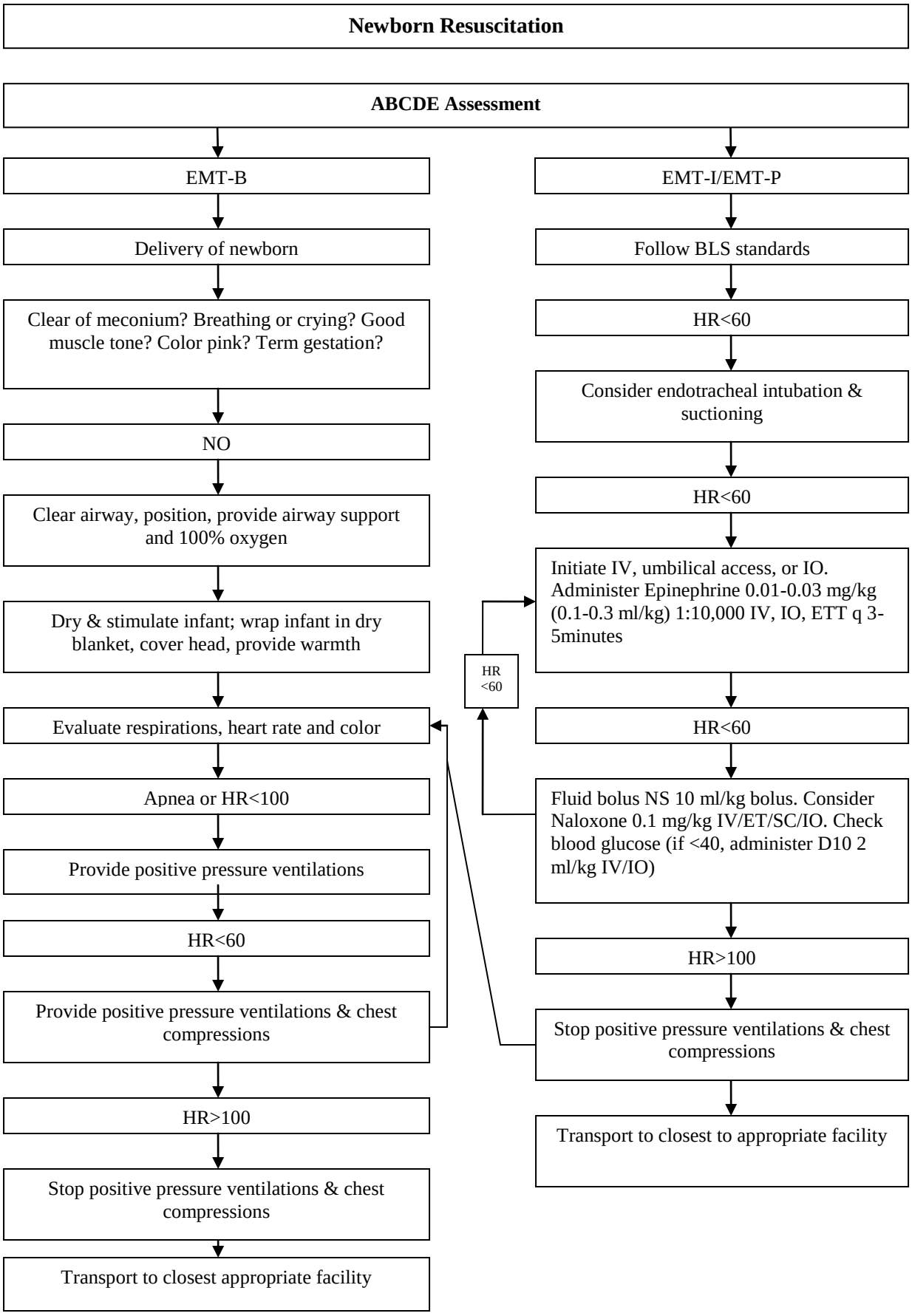
- BVN if respiratory failure or apnea
- SVN Albuterol 2.5 mg/3 ml NS via mask/mouth-piece/in-line if wheezing
- May repeat PRN

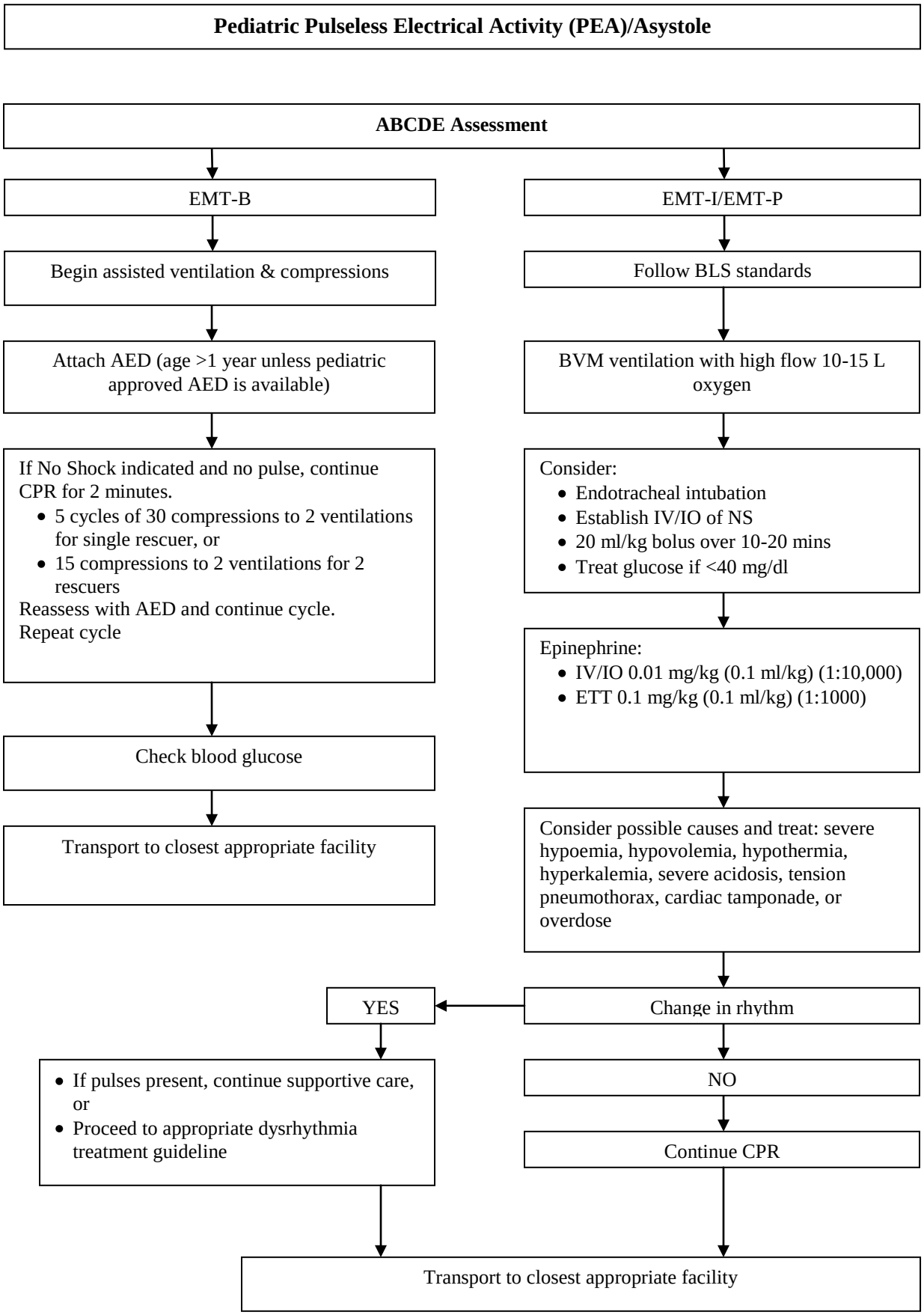
Diphenhydramine 1mg/kg IV/IM (max. 25 mg)

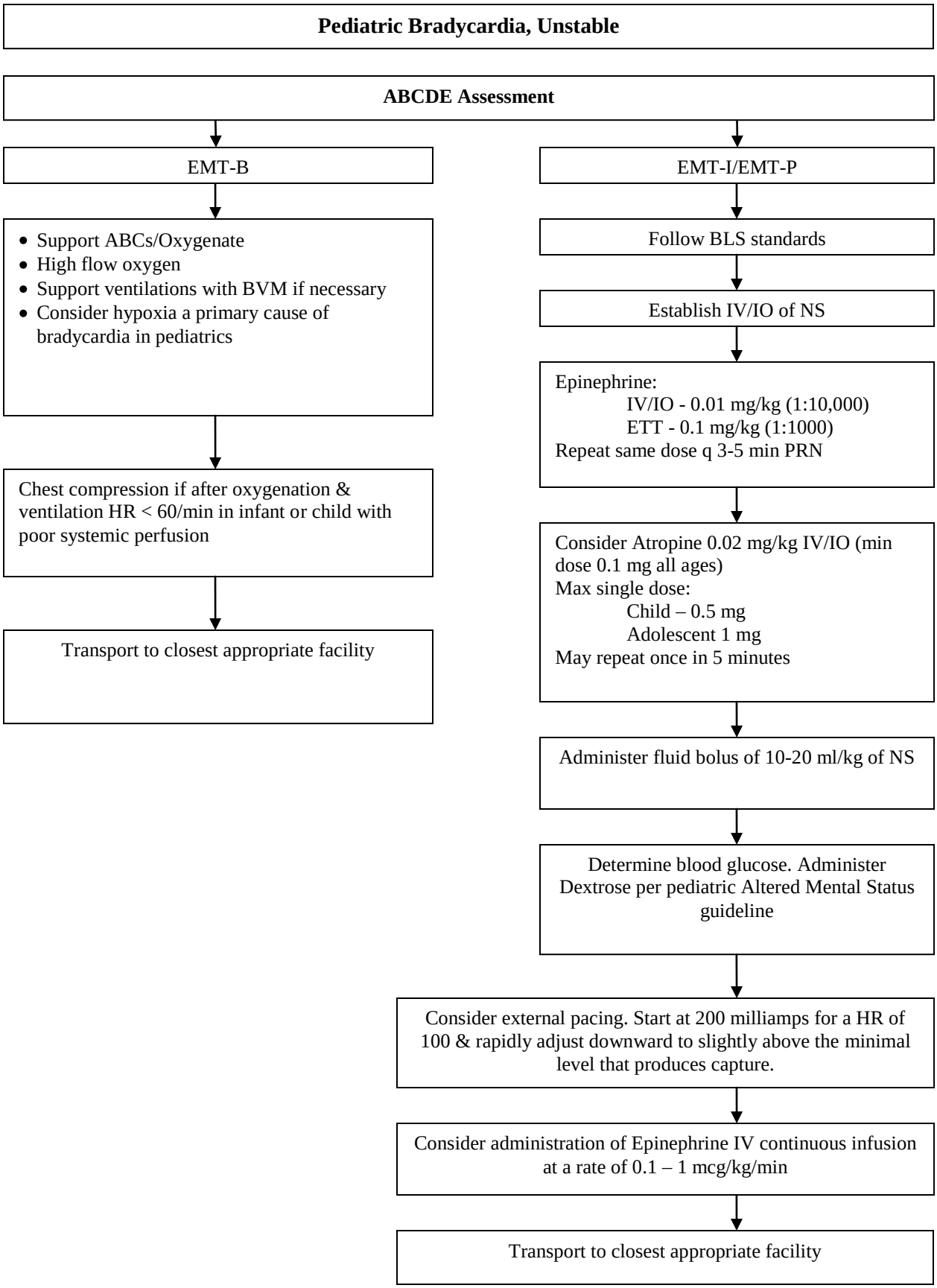
Consider Methylprednisolone 2 mg/kg IV

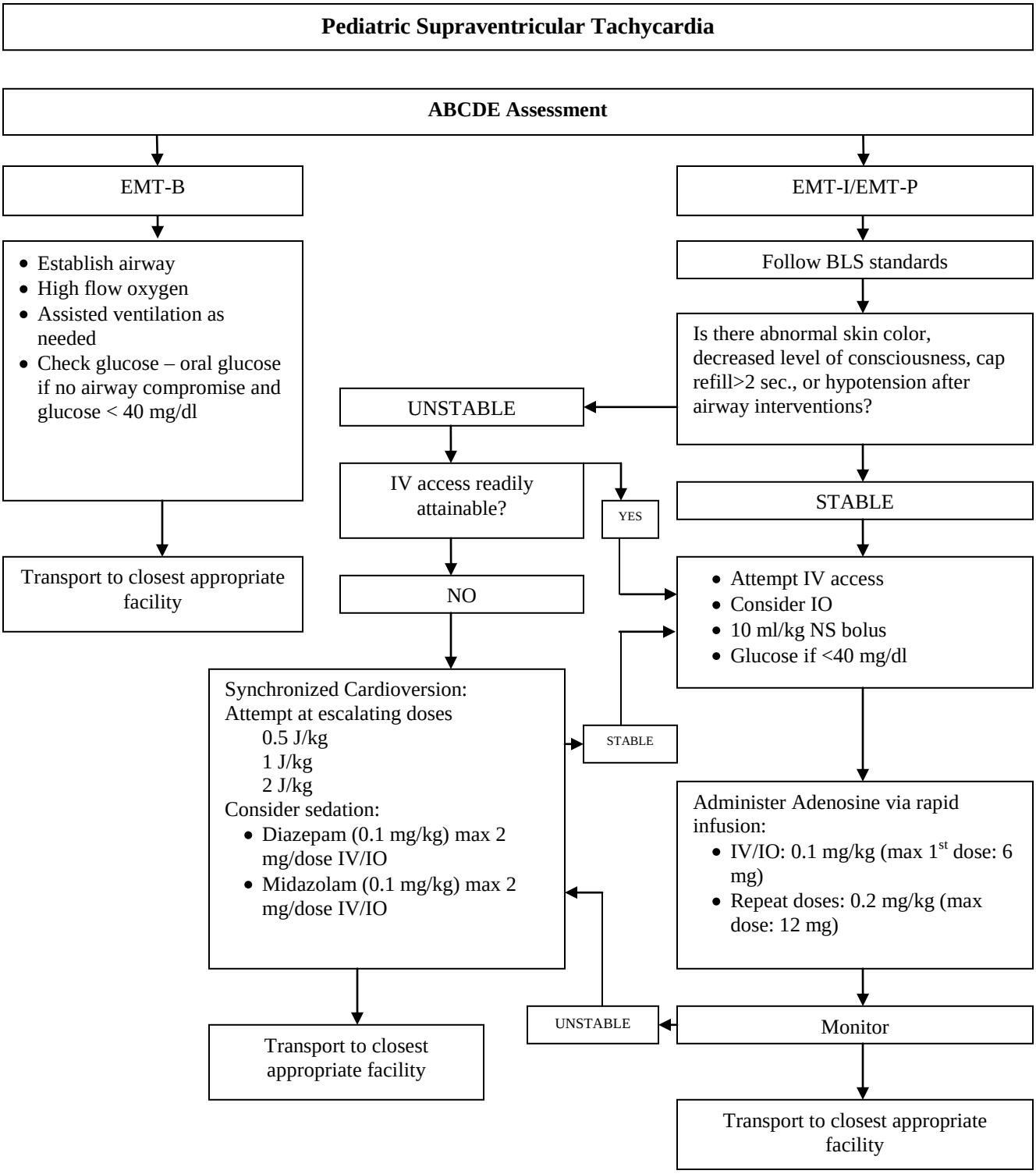
Transport to closest appropriate facility

*Anaphylaxis: stridor, bronchospasm, severe abdominal pain, respiratory distress, shock, edema of the lips/face/tongue
**Allergic reaction: itching, urticaria, nausea


Newborn Resuscitation
ABCDE Assessment
EMT-B
Delivery of newborn
Clear of meconium? Breathing or crying? Good muscle tone? Color pink? Term gestation?
NO
Clear airway, position, provide airway support and 100% oxygen
Dry & stimulate infant; wrap infant in dry blanket, cover head, provide warmth
Evaluate respirations, heart rate and color
Apnea or HR<100
Provide positive pressure ventilations
HR<60
Provide positive pressure ventilations & chest compressions
HR>100
Stop positive pressure ventilations & chest compressions
Transport to closest appropriate facility
EMT-I/EMT-P
Follow BLS standards
HR<60
Consider endotracheal intubation & suctioning
HR<60
Initiate IV, umbilical access, or IO. Administer Epinephrine 0.01-0.03 mg/kg (0.1-0.3 ml/kg) 1:10,000 IV, IO, ETT q 3-5minutes
HR<60
Fluid bolus NS 10 ml/kg bolus. Consider Naloxone 0.1 mg/kg IV/ET/SC/IO. Check blood glucose (if <40, administer D10 2 ml/kg IV/IO)
HR>100
Stop positive pressure ventilations & chest compressions
Transport to closest to appropriate facility
HR <60


Pediatric Pulseless Electrical Activity (PEA)/Asystole
ABCDE Assessment
EMT-B
Begin assisted ventilation & compressions
Attach AED (age >1 year unless pediatric approved AED is available)
If No Shock indicated and no pulse, continue CPR for 2 minutes.
5 cycles of 30 compressions to 2 ventilations for single rescuer, or
15 compressions to 2 ventilations for 2 rescuers
Reassess with AED and continue cycle.
Repeat cycle
Check blood glucose
Transport to closest appropriate facility
EMT-I/EMT-P
Follow BLS standards
BVM ventilation with high flow 10-15 L oxygen
Consider:
Endotracheal intubation
Establish IV/IO of NS
20 ml/kg bolus over 10-20 mins
Treat glucose if <40 mg/dl
Epinephrine:
IV/IO 0.01 mg/kg (0.1 ml/kg) (1:10,000)
ETT 0.1 mg/kg (0.1 ml/kg) (1:1000)
Consider possible causes and treat: severe hypoemia, hypovolemia, hypothermia, hyperkalemia, severe acidosis, tension pneumothorax, cardiac tamponade, or overdose
Change in rhythm
YES
If pulses present, continue supportive care, or
Proceed to appropriate dysrhythmia treatment guideline
NO
Continue CPR
Transport to closest appropriate facility


Pediatric Bradycardia, Unstable
ABCDE Assessment
EMT-B
EMT-I/EMT-P
• Support ABCs/Oxygenate
• High flow oxygen
• Support ventilations with BVM if necessary
• Consider hypoxia a primary cause of bradycardia in pediatrics
Chest compression if after oxygenation & ventilation HR < 60/min in infant or child with poor systemic perfusion
Transport to closest appropriate facility
Follow BLS standards
Establish IV/IO of NS
Epinephrine:
IV/IO - 0.01 mg/kg (1:10,000)
ETT - 0.1 mg/kg (1:1000)
Repeat same dose q 3-5 min PRN
Consider Atropine 0.02 mg/kg IV/IO (min dose 0.1 mg all ages)
Max single dose:
Child – 0.5 mg
Adolescent 1 mg
May repeat once in 5 minutes
Administer fluid bolus of 10-20 ml/kg of NS
Determine blood glucose. Administer Dextrose per pediatric Altered Mental Status guideline
Consider external pacing. Start at 200 milliamps for a HR of 100 & rapidly adjust downward to slightly above the minimal level that produces capture.
Consider administration of Epinephrine IV continuous infusion at a rate of 0.1 – 1 mcg/kg/min
Transport to closest appropriate facility



Monitor rate in children < 2 years is >220 BPM
Biphasic energy settings may be different

Pediatric Ventricular Fibrillation/Pulseless Ventricular Tachycardia

ABCDE Assessment

EMT-B

- Establish airway
- High flow oxygen
- Assisted ventilation as needed
- Start age-appropriate CPR
- Apply AED (age >1). Shock if advised
- Resume CPR immediately after shock for 2 minutes, then reassess. If No Shock advised, continue CPR and go to PEA/Asystole algorithm
- Check glucose – treat if < 40 mg/dl per hypoglycemia protocol

Transport to closest appropriate facility

EMT-I/EMT-P

Follow BLS standards

Perform complete sets of CPR
- 5 cycles of 30 compressions to 2 ventilations for single rescuer, or
- 15 compressions to 2 ventilations for 2 rescuers

Defibrillate once between each set of escalating doses:
2 J/kg
4 J/kg
4 J/kg

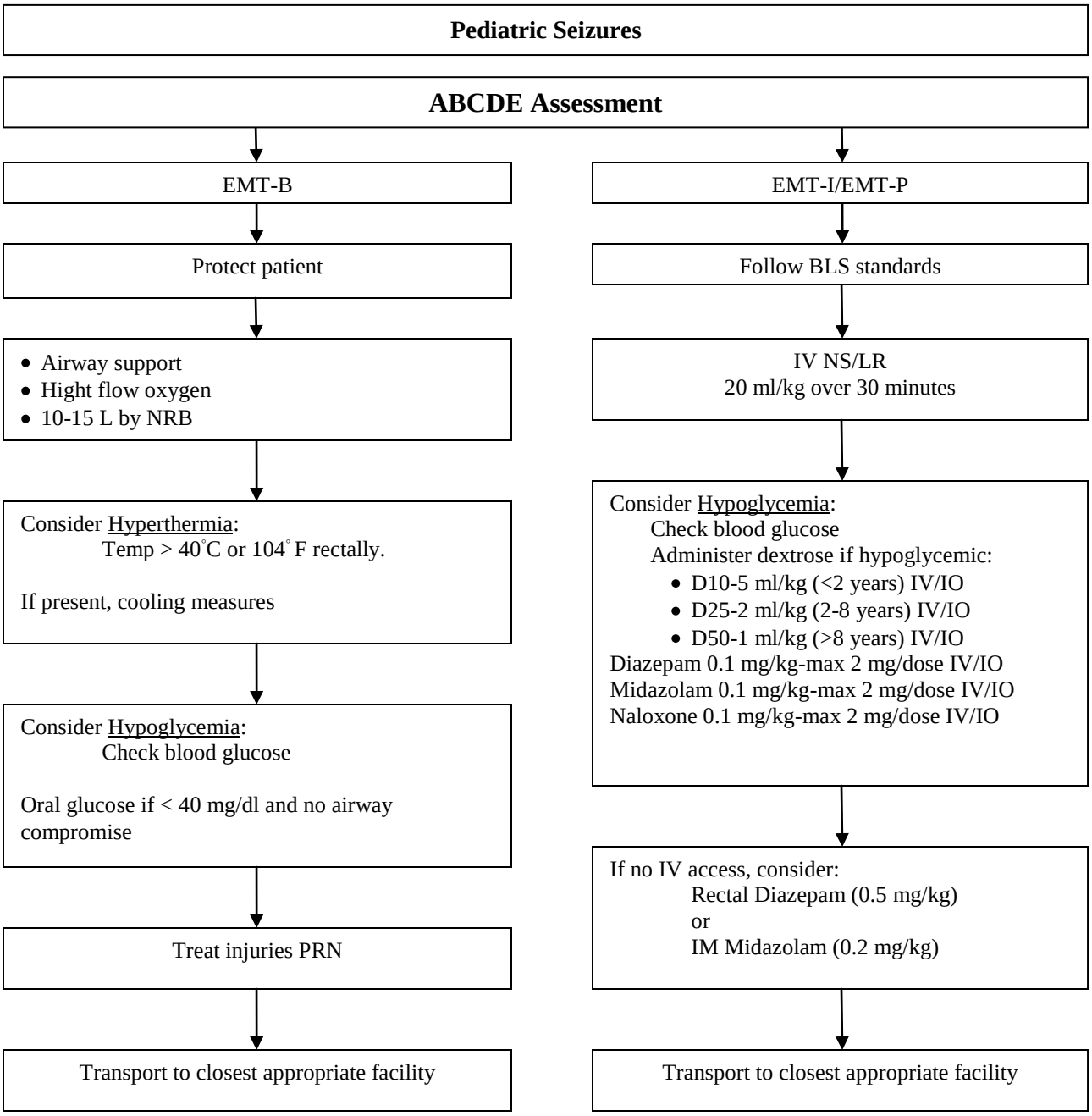
- Endotracheal intubation
- Establish IV/IO
- NS bolus 20 ml/kg over 10-20 minutes

Epinephrine:
IV/IO - 0.01 mg/kg (1:10,000)
ETT - 0.1 mg/kg (1:1000)
Repeat same dose q 3-5 min PRN

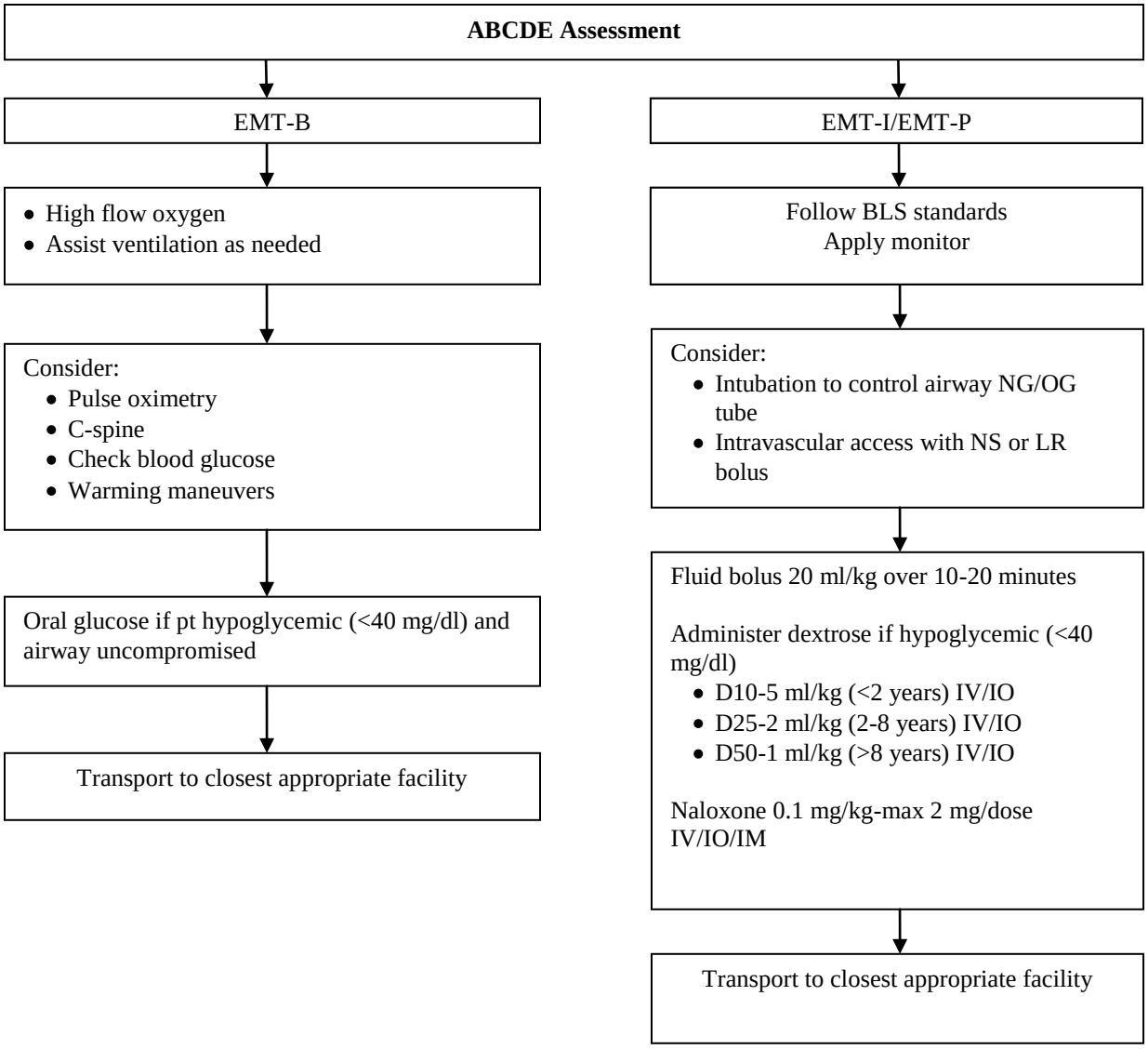
Continue defibrillation at 4 J/kg between each set of CPR cycles

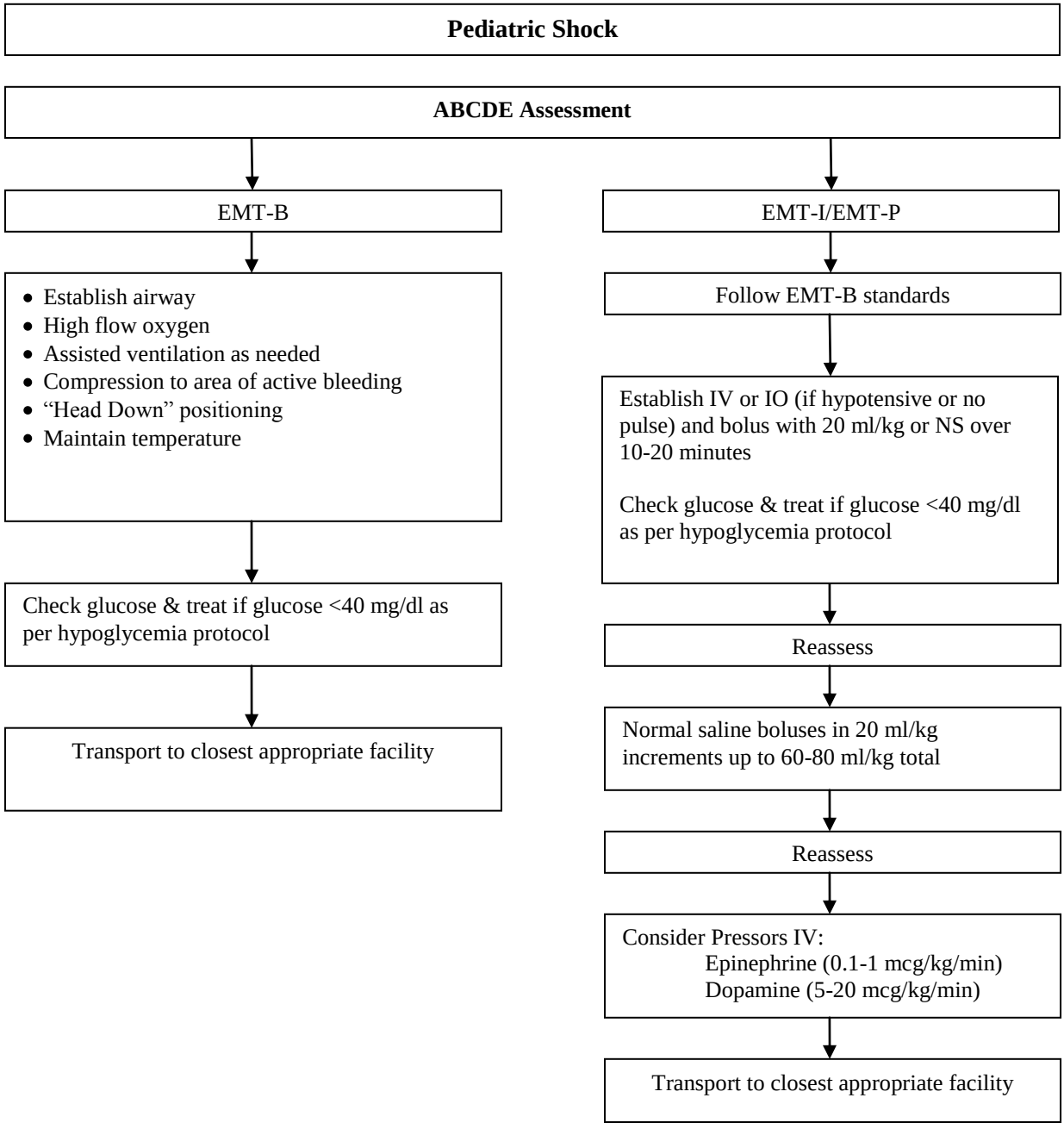
Consider Lidocaine
IV/IO 1 mg/kg; ETT 2 mg/kg
Or
Magnesium
IV/IO 25-50 mg/kg (for torsades de pointes or hypomagnesemia) max. 2 grams

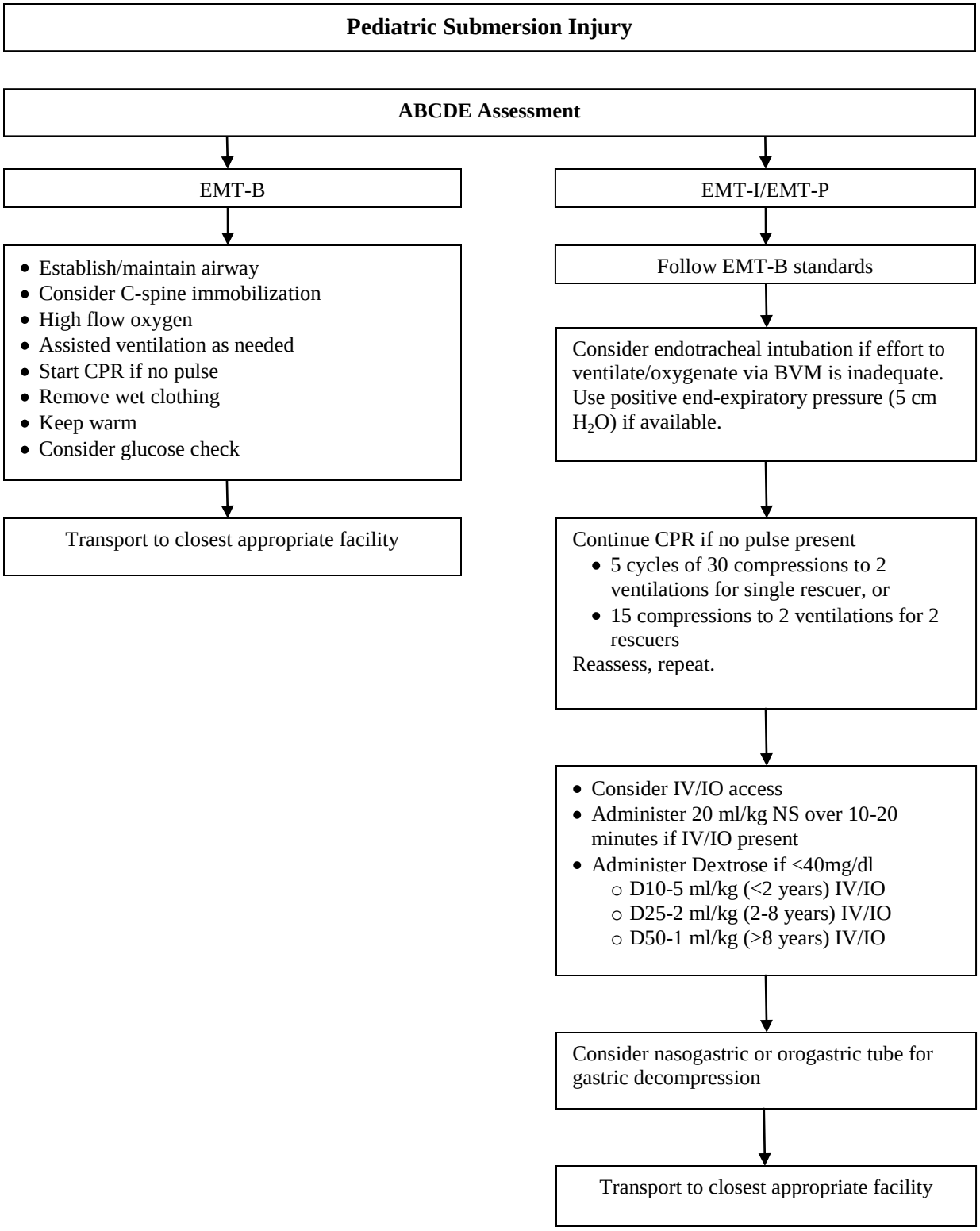
Transport to closest appropriate facility


Pediatric Seizures
ABCDE Assessment
EMT-B
Protect patient
Airway support
Hight flow oxygen
10-15 L by NRB
Consider Hyperthermia:
Temp > 40˚C or 104˚ F rectally.
If present, cooling measures
Consider Hypoglycemia:
Check blood glucose
Oral glucose if < 40 mg/dl and no airway compromise
Treat injuries PRN
Transport to closest appropriate facility
EMT-I/EMT-P
Follow BLS standards
IV NS/LR
20 ml/kg over 30 minutes
Consider Hypoglycemia:
Check blood glucose
Administer dextrose if hypoglycemic:
D10-5 ml/kg (<2 years) IV/IO
D25-2 ml/kg (2-8 years) IV/IO
D50-1 ml/kg (>8 years) IV/IO
Diazepam 0.1 mg/kg-max 2 mg/dose IV/IO
Midazolam 0.1 mg/kg-max 2 mg/dose IV/IO
Naloxone 0.1 mg/kg-max 2 mg/dose IV/IO
If no IV access, consider:
Rectal Diazepam (0.5 mg/kg)
or
IM Midazolam (0.2 mg/kg)
Transport to closest appropriate facility

Pediatric Altered Mental Status




Pediatric Shock
ABCDE Assessment
EMT-B
EMT-I/EMT-P
• Establish airway
• High flow oxygen
• Assisted ventilation as needed
• Compression to area of active bleeding
• "Head Down" positioning
• Maintain temperature
Check glucose & treat if glucose <40 mg/dl as per hypoglycemia protocol
Transport to closest appropriate facility
Follow EMT-B standards
Establish IV or IO (if hypotensive or no pulse) and bolus with 20 ml/kg or NS over 10-20 minutes
Check glucose & treat if glucose <40 mg/dl as per hypoglycemia protocol
Reassess
Normal saline boluses in 20 ml/kg increments up to 60-80 ml/kg total
Reassess
Consider Pressors IV:
Epinephrine (0.1-1 mcg/kg/min)
Dopamine (5-20 mcg/kg/min)
Transport to closest appropriate facility


Pediatric Submersion Injury
ABCDE Assessment
EMT-B
EMT-I/EMT-P
• Establish/maintain airway
• Consider C-spine immobilization
• High flow oxygen
• Assisted ventilation as needed
• Start CPR if no pulse
• Remove wet clothing
• Keep warm
• Consider glucose check
Follow EMT-B standards
Consider endotracheal intubation if effort to ventilate/oxygenate via BVM is inadequate. Use positive end-expiratory pressure (5 cm H_2O) if available.
Transport to closest appropriate facility
Continue CPR if no pulse present
• 5 cycles of 30 compressions to 2 ventilations for single rescuer, or
• 15 compressions to 2 ventilations for 2 rescuers
Reassess, repeat.
• Consider IV/IO access
• Administer 20 ml/kg NS over 10-20 minutes if IV/IO present
• Administer Dextrose if <40mg/dl
○ D10-5 ml/kg (<2 years) IV/IO
○ D25-2 ml/kg (2-8 years) IV/IO
○ D50-1 ml/kg (>8 years) IV/IO
Consider nasogastric or orogastric tube for gastric decompression
Transport to closest appropriate facility