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These protocols and procedures are to be used as Emergency Medical Responder guidelines for operation during the medical and or trauma care of a person that require medical direction. They are also intended to be guidelines to ensure that personnel are trained in proper pre-hospital patient care.

Procedures are not considered rigid rules, but rather established standards against which Emergency Medical Responder care practice can be measured.

Treatment protocols are specific orders directing the actions pertaining to techniques and/or medications used by Emergency Medical Responder personnel who are required to practice under direct supervision of a physician and under their respective EMS Medical Control authority.

Treatment protocols may and should be initiated without prior direct Medical Control contact, especially when the patient’s condition and/or situation is life threatening. As soon as the condition and/or situation permits, the patient should be transported to the emergency department via company policy or local 911 emergency service.

These protocols assume that the Emergency Medical Responder has a thorough working knowledge and current completion card in Basic Life Support (BLS) by the American Heart Association or American Red Cross. Accordingly, BLS procedures are not discussed at length in these protocols.

The Protocols may be used as an educational device before, during and after a run, as a general education tool for squads and responders.

Although not identical, these protocols and procedures are derived from the State of Ohio EMS guidelines. Please note that items in this manual are subject to continuous review for the sake of providing members with the most current emergency medical information. Updates to this material may be frequent to maintain a current standard of care to benefit both the patient and the provider of emergency medical care. The cover page of this manual indicates when the most current version was printed. Please replace older versions with newly updated material as soon as it is issued. Once updated, older versions are to be considered obsolete and are to be discarded to help eliminate confusion.
INTRODUCTION

MEDICAL CONTROL GENERAL GUIDELINES

1. The patient history should not be obtained at the expense of the patient. Life-threatening problems detected during the primary assessment must be treated first.

2. Cardiac arrest due to trauma is not treated by medical cardiac arrest protocols. Trauma patients should be transported promptly with CPR, control of hemorrhage, cervical spine immobilization, and other indicated procedures attempted en route.

3. When transferring lower level pre-hospital care to a higher level of prehospital care, a thorough consult should be performed between caregivers describing initial patient presentation and care rendered to the point of transfer.

4. If the patient’s condition does not seem to fit a protocol or protocols, contact Medical Control for guidance.

5. All trauma patients with a mechanism or history for multiple system trauma should be transported as soon as possible. The scene time should be 10 minutes or less.

6. Medical patients will be transported in the most efficient manner possible considering the medical condition. Justification for scene times greater than 20 minutes should be documented.

7. The state of Ohio, Division of EMS, specifies minimum Emergency Medical Responder equipment. The Medical Director may also make specific recommendations for equipment choices.

8. These protocols are the written Medical Direction and Standing Orders of the Medical Director and authorize the activities of the Emergency Medical Responder until such time as these Standing Orders are overridden / supplemented by:
   a. Radio / telephone contact with the Emergency Department for direct “on-line” medical direction / orders.
   b. The arrival on the scene of a person with a higher level of EMS certification. This person must provide proof and state / accept responsibility for the care delivered to that patient.
   c. The arrival of local EMS to take over care and transport of the patient.

9. Vital signs should be obtained and recorded every 5 minutes for unstable or critical patients, if possible.
INTRODUCTION

PHYSICIAN INTERVENER GUIDELINES

1. When a non-medical-control physician offers assistance to EMS or the patient is being attended by a physician with whom they do not have an ongoing patient relationship, EMS personnel must contact On-line Medical Control and the physician must be approved by On-line Medical Control.

2. When the patient is being attended by a physician with whom they have an ongoing patient relationship, EMS personnel may follow orders given by the physician if the orders conform to current EMS guidelines, and if the physician signs the PCR. Notify Medical Control at the earliest opportunity. Any deviation from local EMS protocols requires the physician to accompany the patient to the hospital.

3. EMS personnel may accept orders from the patient’s physician over the phone with the approval of Medical Control. The paramedic should obtain the specific order and the physician’s phone number for relay to Medical Control so that Medical Control can discuss any concerns with the physician directly.
INTRODUCTION

MEDICAL CONTROL GENERAL GUIDELINES

All algorithms are color coded to denote procedures, which may be performed by the Emergency Medical Responder. To perform procedure color-coded red, Medical Control must be contacted for permission. Higher levels of certification will perform lower level evaluations and procedures when interpreting the algorithms.

The protocol format is for quick reference and does not detail patient assessment, interpretation or interventions. EMS personnel are accountable for all patient care and documentation to their level of training.

<table>
<thead>
<tr>
<th>COLOR CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WHITE</strong></td>
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<tr>
<td><strong>GRAY</strong></td>
</tr>
<tr>
<td><strong>GREEN</strong></td>
</tr>
<tr>
<td><strong>RED</strong></td>
</tr>
</tbody>
</table>
INTRODUCTION
UNIVERSAL PATIENT CARE PROTOCOL

ASSURE TRANSPORT CAPABLE EMS RESOURCES HAVE BEEN SUMMONED

PATIENT ASSESSMENT
Assess the patient’s level of consciousness
If unresponsive – assess for a pulse

NO PULSE - BEGIN CPR
Open Airway with a head tilt chin lift
Insert and Oropharyngeal Airway if available

HAS PULSE - CHECK AIRWAY
Is the airway open and patient?

HAS AIRWAY – CHECK BREATHING
Is the Patient Breathing?

Provide rescue breathing with a BVM or pocket mask at 10 – 12 bpm

DETERMINE CHIEF COMPLAINT
OBTAIN VITAL SIGNS
Respirations, Heart Rate, Blood Pressure

Administer Supplemental Oxygen via NRB or NC

O – Onset
P – Provocation
Q – Quality
R – Radiation / Region
S – Severity (1 to 10 scale)

OBTAIN “SAMPLE” HISTORY
S – Signs and Symptoms
A – Allergies
M – Medications patient is currently taking
P – Past Medical History
L – Last Oral Intake (time and what)
E – Events leading to the Problem

REFER TO AND TREAT PER APPROPRIATE PROTOCOL AS REQUIRED

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS
RESPIRATORY EMERGENCIES
MEDICAL EMERGENCIES

FOLLOW
UNIVERSAL PATIENT CARE PROTOCOL

Place Patient in a Position of Comfort

Assess ABC’s
Respiratory Rate, Effort, Adequacy

Administer Supplemental Oxygen via 10 – 15 lpm via NRB or BVM

Never withhold O2 from patients in respiratory distress
If respiratory rate <8 or >40 assist with BVM

ASTHMA / COPD
Allow patient to use their metered dose inhaler or breathing treatments
IF AVAILABLE

ALLERGIC REACTION / ANAPHYLAXIS

IF SEVERE REACTION
Facial swelling
Difficulty Breathing
Stridor
Low BP
ADMINISTER EPINEPHRINE AUTO INJECTOR (EPI-PEN)

Remove patient from allergen if possible
Remove stinger with a rigid card
Apply ice to swollen areas

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS
CHEST PAIN
MEDICAL EMERGENCIES

FOLLOW
UNIVERSAL PATIENT CARE PROTOCOL

Place Patient in a position of comfort
If Hypotensive (Low Blood Pressure)
Lay patient as flat as possible

**DO NOT ALLOW**
Patient to take Nitroglycerin if they have a systolic Blood Pressure <100

Administer Supplemental Oxygen
via NC or NRB
Never withhold O2 from patients in respiratory distress

Reassess Vital every 5 minutes

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS
STROKE
MEDICAL EMERGENCIES

FOLLOW UNIVERSAL PATIENT CARE PROTOCOL

ASSESS ABC’s
If Patient is having trouble speaking, pay close attention to their ability to control their own airway

HAVE SUCTION AVAILABLE
Consider positioning patient on their side

Administer Supplemental Oxygen via NC or NRB
Never withhold O2 from patients in respiratory distress
If Respiratory Rate <8 or >24 Assist with BVM

DETERMINE THE TIME THE PATIENT WAS LAST SEEN NORMAL
This will be time zero
Report time last seen normal to EMS

DETERMINE IF THE PATIENT HAS ANY NEUROLOGIC DEFICITS
(Paralysis, Speech Problems, Headache, etc.)

Reassess Vital every 5 minutes

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS

Did Patient Fall during this episode?
Are they Injured?
Consider Spinal Immobilization
ALTERED MENTAL STATUS

MEDICAL EMERGENCIES

FOLLOW
UNIVERSAL PATIENT CARE PROTOCOL

ASSESS ABC’s
Pay close attention to their ability to control their own airway

HAVE SUCTION AVAILABLE
Consider positioning patient on their side

If Hypotensive (Low Blood Pressure)
Lay patient as flat as possible IF NO AIRWAY OR BREATHING COMPROMISE

Administer Supplemental Oxygen via NC or NRB
Never withhold O2 from patients in respiratory distress
If Respiratory Rate <8 or >24 Assist with BVM

DIABETIC PATIENT
If patient has their own glucose meter allow them to check their glucose levels
If patient is conscious and able to swallow Allow patient to have food or beverages containing sugar

Consider Causes
Head Injury
Overdose
Stroke
Hypoxia
(Report Findings to EMS)

IF OPIATE OVERDOSE SUSPECTED
Administer NALOXONE (NARCAN)
One whole syringe, half of dose up each nostril using atomizer tip

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS
ABDOMINAL PAIN
MEDICAL EMERGENCIES

FOLLOW
UNIVERSAL PATIENT CARE PROTOCOL

ASSESS ABC’s
Pay close attention to their ability to control their own airway

HAVE SUCTION AVAILABLE
Consider positioning patient on their side

If Hypotensive (Low Blood Pressure)
Lay patient as flat as possible IF NO AIRWAY COMPROMISE

Administer Supplemental Oxygen
via NC or NRB
Never withhold O2 from patients in respiratory distress
If Respiratory Rate <8 or >24 Assist with BVM

Focused Exam of the Abdomen
Assess all 4 quadrants for pain on palpation, distension, or rigidity
Last Oral Intake?
Any Vomiting or Diarrhea?
Is the pain sharp or dull?

Reassess Vital every 5 minutes

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS
POISONING / OVERDOSE

MEDICAL EMERGENCIES

FOLLOW
UNIVERSAL PATIENT CARE PROTOCOL

ASSESS ABC’s
Pay close attention to their ability to control their own airway

HAVE SUCTION AVAILABLE
Consider positioning patient on their side

If Hypotensive (Low Blood Pressure)
Lay patient as flat as possible
IF NO AIRWAY OR BREATHING COMPROMISE

Administer Supplemental Oxygen via NC or NRB
Never withhold O2 from patients in respiratory distress
If Respiratory Rate <8 or >24 Assist with BVM

POISONING

ATTEMPT TO DETERMINE
What was the exposure?
How much was the exposure?
How long ago was the exposure?
Reassess Vital every 5 minutes

OVERDOSE

ATTEMPT TO DETERMINE
Was the overdose intentional?
What was taken?
How much was taken?
How long ago was it taken?

IF OPIATE OVERDOSE SUSPECTED
Administer NALOXONE (NARCAN)
One whole syringe, half of dose up each nostril using atomizer tip
Reassess Vital every 5 minutes

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS
ENVIROMENTAL EMERGENCIES
MEDICAL EMERGENCIES

FOLLOW
UNIVERSAL PATIENT CARE PROTOCOL

ASSESS ABC’s
Pay close attention to their ability to control their own airway
HAVE SUCTION AVAILABLE
Consider positioning patient on their side

If Hypotensive (Low Blood Pressure)
Lay patient as flat as possible
IF NO AIRWAY OR BREATHING COMPROMISE

Administer Supplemental Oxygen
via NC or NRB
Never withhold O2 from patients in respiratory distress
If Respiratory Rate <8 or >24 Assist with BVM

HYPOTHERMIA
Move Patient to a warm environment
Remove wet clothing
Begin to warm the patient slowly
Reassess Vital every 5 minutes
Be alert to bradycardia (slow heartrate)

HYPERTERMIA
Remove patient from the warm environment
Begin cooling with tepid water
If the patient is hot to touch and has an altered mental status
Begin rapid cooling with ice in the groin and axilla

CONTACT MEDICAL CONTROL AS NECESSARY
TRANSPORT VIA EMS
**BEHAVIORAL EMERGENCIES**

**MEDICAL EMERGENCIES**

1. **IS THE SCENE SAFE?**
   - Your safety is the top priority
   - CALL LAW ENFORCEMENT TO THE SCENE IF NEEDED

2. **FOLLOW UNIVERSAL PATIENT CARE PROTOCOL**
   - Avoid upsetting the patient any further
   - Do not make judgments about the patient’s situation
   - Assess if patient is competent to make his own decisions as they pertain to medical care and transport

3. **CONSIDER CAUSES**
   - Behavioral emergency could have a medical cause.
   - Hypoxia, Hypoglycemia, Head Trauma, Overdose, Stroke

4. **IF COOPERITIVE**
   - Administer Supplemental Oxygen via NC or NRB
   - Never withhold O2 from patients in respiratory distress
   - If Respiratory Rate <8 or >24 Assist with BVM

5. **CONTACT MEDICAL CONTROL AS NECESSARY**

6. **TRANSPORT VIA EMS**
Determine if there is time for transport or whether delivery is imminent. Signs of imminent delivery include contractions 1-2 minutes apart, lasting 30-45 seconds, bulging membranes, or the presence of crowning.

- Activate the EMS system to expedite transport.
- If delivery **IS NOT** imminent, prepare patient for incoming ambulance.
- If delivery **IS** imminent, prepare to assist with the delivery.

**FOLLOW UNIVERSAL PATIENT CARE PROTOCOL**

Administer Supplemental Oxygen NRB 10-15 LPM

Protect Mothers Privacy and close off area from onlookers

Observe Head Crowning
Prepare Patient for Delivery
Set-Up Equipment

Delivery of Head
Apply firm, gentle pressure with flat of hand to slow expulsion.
Allow head to rotate normally, check for cord around neck, and wipe face free of debris.
Suction mouth and nose with bulb syringe.

Delivery of Body
Place one palm over each ear with next contraction gently move downward until upper shoulder appears.
Then lift up gently to ease out lower shoulder Support the head and neck with one hand and buttocks with other.
**REMEMBER THE NEWBORN IS SLIPPERY**

Newborn and Cord
Keep newborn at level of vaginal opening. Keep warm and dry. After 10 seconds, clamp cord in two places with sterile equipment at least 6-8" from newborn. Cut between clamps.

Allow placenta to deliver itself but do not delay transport waiting. **DO NOT PULL ON CORD TO DELIVER PLACENTA.** Take placenta to hospital with patient.

**CONTACT MEDICAL CONTROL AS NECESSARY**

**TRANSPORT VIA EMS**
FOLLOW UNIVERSAL PATIENT CARE PROTOCOL

UNRESPONSIVE PATIENT
Feel for a carotid pulse
IF no Pulse BEGIN CPR at 30:2 Compression to Ventilation ratio
Send someone to get the AED

When AED arrives:
Turn on the AED and follow the prompts
Attach the pads to patient’s bare chest
(Continue chest compression while pads are being attached to the patient)
Plug in the pads connector
Clear patient so AED can analyze

If a shock is indicated:
Allow AED to charge
Clear everyone from touching the patient
Press the SHOCK button to deliver the shock
Immediately continue CPR

After 2 minutes the AED will prompt you to clear the patient so the AED can analyze the rhythm

If a shock is indicated:
Allow AED to charge
Clear everyone from touching the patient
Press the SHOCK button to deliver the shock
Immediately continue CPR and follow AED prompts

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS

RESPONSIVE PATIENT
FOLLOW APPROPRIATE PROTOCOL

If NO shock is advised
Immediately continue 2 minutes of CPR
Continue to follow AED prompts
If patient begins to breath or starts to move stop CPR and assess vitals
Emergency medical service personnel shall use the following criteria, consistent with their certification, to evaluate whether an injured person qualifies as an adult trauma victim or pediatric trauma victim, in conjunction with the definition of trauma according to the State of Ohio Trauma Triage Guidelines.

An **Adult Trauma Victim** is a person 16 years of age or older exhibiting one or more of the following physiologic or anatomic conditions:

### Physiologic conditions
- Glasgow Coma Scale < 13
- Loss of consciousness > 5 greater minutes
- Deterioration in level of consciousness at the scene or during transport
- Failure to localize to pain
- Respiratory rate < 10 or > 29
- Requires endotracheal intubation
- Requires relief of tension pneumothorax
- Pulse > 120 in combination with evidence of hemorrhagic shock
- Systolic blood pressure < 90, or absent radial pulse with carotid pulse present

### Anatomic conditions
- Penetrating trauma to the head, neck, or torso
- Significant, penetrating trauma to extremities proximal to the knee or elbow with evidence of neurovascular compromise
- Injuries to the head, neck, or torso where the following physical findings are present:
  - Visible crush injury
  - Abdominal tenderness, distention, or seatbelt sign
  - Pelvic fracture
  - Flail chest
- Injuries to the extremities where the following physical findings are present
  - Amputations proximal to the wrist or ankle
  - Visible crush injury
  - Fractures of two or more proximal long bones
  - Evidence of neurovascular compromise
- Signs or symptoms of spinal cord injury
- 2nd or 3rd Degree > 10% total BSA or other significant burns involving the face, feet, hands, genitalia, or airway

### Field Trauma Triage Criteria: Mechanism of Injury (MOI) & Special Considerations

<table>
<thead>
<tr>
<th>Co-Morbid Diseases and Special Considerations:</th>
<th>Mechanisms of Injury (MOI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age &lt; 5 or &gt; 55</td>
<td>High speed MVC</td>
</tr>
<tr>
<td>Cardiac disease</td>
<td>Ejection from vehicle</td>
</tr>
<tr>
<td>Respiratory disease</td>
<td>Vehicle rollover</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Death in same passenger compartment</td>
</tr>
<tr>
<td>Immunosuppression</td>
<td>Extrication time &gt; 20 minutes</td>
</tr>
<tr>
<td>Morbid obesity</td>
<td>Falls greater than 20 feet</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Vehicle versus bicycle / pedestrian</td>
</tr>
<tr>
<td>Substance abuse/intoxication</td>
<td>Pedestrian thrown or run over</td>
</tr>
<tr>
<td>Liver disease</td>
<td>Motorcycle crash &gt; 20 mph with separation of rider from bike</td>
</tr>
<tr>
<td>Renal disease</td>
<td></td>
</tr>
<tr>
<td>Bleeding disorder/anticoagulation</td>
<td></td>
</tr>
</tbody>
</table>
Exceptions to Mandatory Transport to a Trauma Center:

Emergency medical service personnel shall transport a trauma victim directly to an adult or pediatric trauma center that is qualified to provide appropriate adult or pediatric care, unless one or more of the following exceptions apply:

- It is medically necessary to transport the victim to another hospital for initial assessment and stabilization before transfer to an adult or pediatric trauma center
- It is unsafe or medically inappropriate to transport the victim directly to an adult or pediatric trauma center due to adverse weather or ground conditions or excessive transport time
- Transporting the victim to an adult or pediatric trauma center would cause a shortage of local emergency medical service resources
- No appropriate adult or pediatric trauma center is able to receive and provide adult or pediatric trauma care to the trauma victim without undue delay
- Before transport of a patient begins, the patient requests to be taken to a particular hospital that is not a trauma center or, if the patient is less than eighteen years of age or is not able to communicate, such a request is made by an adult member of the patient’s family or a legal representative of the patient

<table>
<thead>
<tr>
<th>INFANT</th>
<th>Glasgow Coma Scale</th>
<th>ADULT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to age 4</td>
<td>Eye Opening</td>
<td>Age 4 to Adult</td>
</tr>
<tr>
<td>4</td>
<td>Spontaneously</td>
<td>Spontaneously 4</td>
</tr>
<tr>
<td>3</td>
<td>To speech</td>
<td>To command 3</td>
</tr>
<tr>
<td>2</td>
<td>To pain</td>
<td>To pain 2</td>
</tr>
<tr>
<td>___1</td>
<td>No response</td>
<td>No Response 1___</td>
</tr>
</tbody>
</table>

Best Verbal Response

<table>
<thead>
<tr>
<th>INFANT</th>
<th>Glasgow Coma Scale</th>
<th>ADULT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to age 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Coos, babbles</td>
<td>Oriented 5</td>
</tr>
<tr>
<td>4</td>
<td>Irritable cries</td>
<td>Confused 4</td>
</tr>
<tr>
<td>3</td>
<td>Cries to pain</td>
<td>Inappropriate words 3</td>
</tr>
<tr>
<td>2</td>
<td>Moans, grunts</td>
<td>Incomprehensible 2</td>
</tr>
<tr>
<td>___1</td>
<td>No response</td>
<td>No response 1___</td>
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</table>

Best Motor Response

<table>
<thead>
<tr>
<th>INFANT</th>
<th>Glasgow Coma Scale</th>
<th>ADULT</th>
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<tbody>
<tr>
<td>Birth to age 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Spontaneous</td>
<td>Obeys commands 6</td>
</tr>
<tr>
<td>5</td>
<td>Localizes pain</td>
<td>Localizes pain 5</td>
</tr>
<tr>
<td>4</td>
<td>Withdraws from pain</td>
<td>Withdraws from pain 4</td>
</tr>
<tr>
<td>3</td>
<td>Flexion (decorticate)</td>
<td>Flexion (decorticate) 3</td>
</tr>
<tr>
<td>2</td>
<td>Extension (decerebrate)</td>
<td>Extension (decerebrate) 2</td>
</tr>
<tr>
<td>___1</td>
<td>No response</td>
<td>No response 1___</td>
</tr>
<tr>
<td>___ = TOTAL</td>
<td>GCS ≤ 8? Intubate!</td>
<td>TOTAL = ___</td>
</tr>
</tbody>
</table>
TRAUMA GUIDELINES

TRAUMA

FOLLOW
UNIVERSAL PATIENT CARE PROTOCOL

ASSESS ABC’s
Pay close attention to their ability to control their own airway

HAVE SUCTION AVAILABLE
Consider positioning patient on their side

Control Bleeding, Apply Dressing

Consider Spinal Immobilization

Administer Supplemental Oxygen
via NC or NRB
Never withhold O2 from patients in respiratory distress
If Respiratory Rate <8 or >24 Assist with BVM

ONLY IF there are signs of cerebral herniation:
Blown pupils, bradycardia, posturing
High Flow O2 via BVM
14-16 Breath Per Min

Obtain Glasgow Score
Repeat every 5 minutes
Consider altered LOC protocol

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS

Be alert for Seizure activity
Protect Airway
Be Prepared to Suction
EYE INJURY
TRAUMA

FOLLOW
UNIVERSAL PATIENT CARE PROTOCOL

Remove Contact Lens
(If Applicable)

Do NOT remove penetrating objects,
stabilize in place

Flush debris from the eye with normal saline or sterile water

Cover soft tissue injuries with moist sterile dressings

Eye out; cover with moist sterile dressing

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS
CHEST TRAUMA

FOLLOW
UNIVERSAL PATIENT CARE PROTOCOL

ASSESS ABC’s
Pay close attention to their ability to control their own airway
HAVE SUCTION AVAILABLE

C-Spine Immobilization
Evidence of Trauma, Blunt or Penetrating
Abnormal breath sounds, inadequate respiratory rate, unequal symmetry, diminished chest excursion, cyanosis, flail segment, bruising
Use Jaw Thrust Airway Maneuver

Control bleeding cover wounds
If impaled object LEAVE OBJECT IN PLACE
Secure with bulky dressings

Administer Supplemental Oxygen via NC or NRB
Never withhold O2 from patients in respiratory distress
If Respiratory Rate < 8 or > 24 Assist with BVM

Constantly reassess for adequate breathing

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS
EXTREMITY / AMPUTATION TRAUMA

FOLLOW
UNIVERSAL PATIENT CARE PROTOCOL

ASSESS ABC’s
Pay close attention to their ability to control their own airway

HAVE SUCTION AVAILABLE
Consider positioning patient on their side

If Hypotensive (Low Blood Pressure)
Lay patient as flat as possible

IF NO AIRWAY COMPROMISE

POSSIBLE EXTREMITY FRACTURE
Remove rings, bracelets, and other constricting items on injured extremity if possible

Check for MSP’s (motor, sensory, pulse) distal to the fracture
Apply Ice to the extremity
Immobilize the extremity with a splint
Reassess for MSP’s (motor, sensory, pulse) distal to the fracture

CONTROL BLEEDING with gauze products
Severe spurting / spraying bleeding
APPLY TOURNAQUET

Amputation?
Clean amputated part with NS or sterile water
Wrap part in Sterile Dressing and place in plastic bag if able
Place that bag on Ice if available
No direct ice contact to tissue

CONTACT MEDICAL CONTROL AS NECESSARY
TRANSPORT VIA EMS
BURNS

TRAUMA

FOLLOW UNIVERSAL PATIENT CARE PROTOCOL

ASSESS ABC’s
Pay close attention to their ability to control their own airway

HAVE SUCTION AVAILABLE
Consider positioning patient on their side

If Hypotensive (Low Blood Pressure)
Lay patient as flat as possible
IF NO AIRWAY COMPROMISE

Remove rings, bracelets, and other constricting items

THERMAL BURNS
Remove clothing and / or expose area
If burn < 10% body surface area (using Rule of Nines)
Cool down wound with Water or Normal Saline

Cover burn with dry sterile sheet or dressings

CHEMICAL BURNS
Remove clothing and / or expose area
Flush area with Water or Normal Saline for 15 - 20 minutes

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS