



Airway Obstruction

Approval: Troy M. Falck, MD – Medical Director

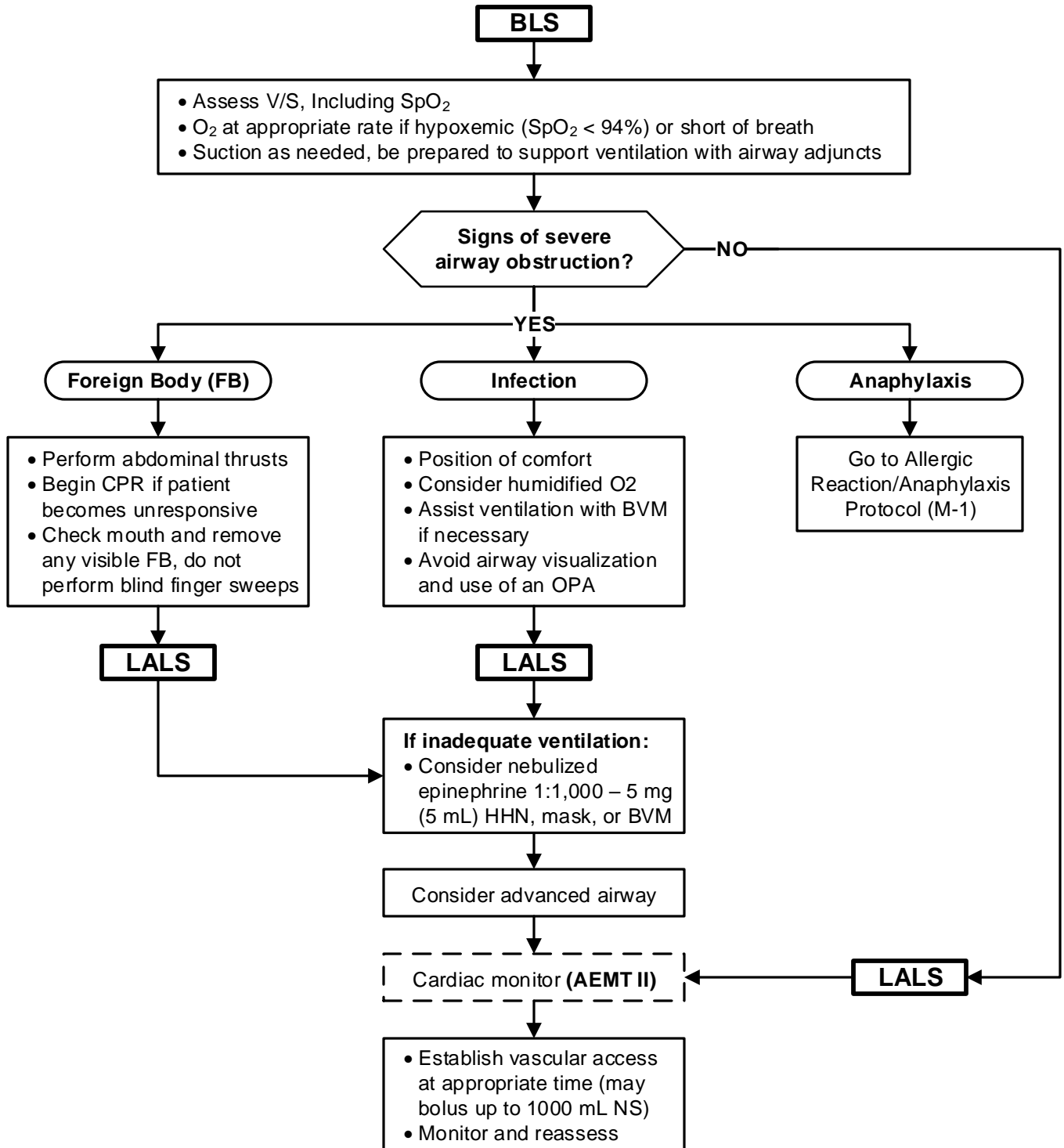
Effective: 12/01/2018

Approval: Victoria Pinette – Executive Director

Next Review: 07/2021

• **Signs of severe airway obstruction:**

- Poor air exchange
- Cyanosis
- Increased breathing difficulty
- Inability to speak/breathe
- Silent cough



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Pain Management

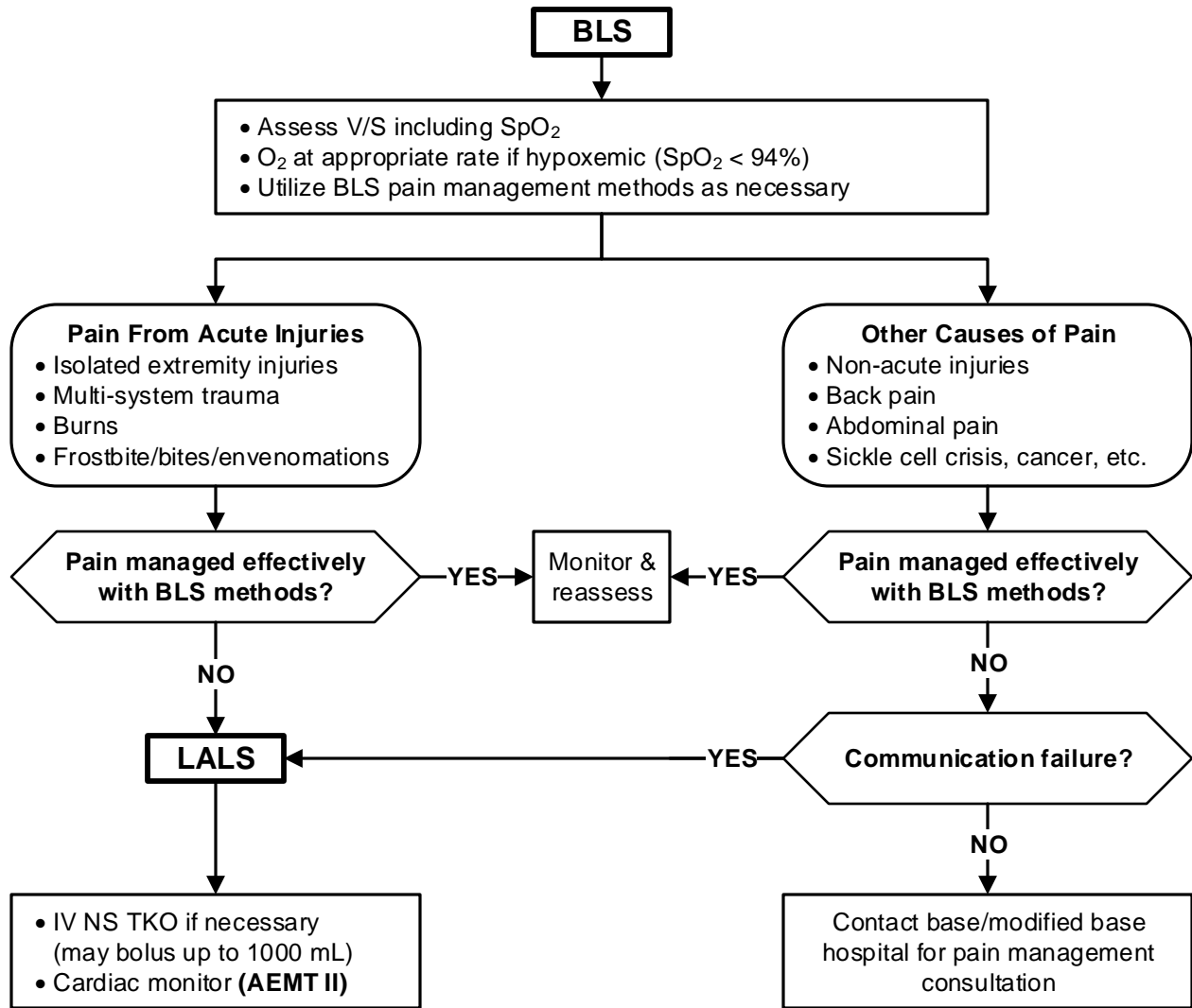
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- Whenever feasible, behavioral measurement of pain should be used in conjunction with self-report. Interpretation of pain behaviors and decision-making regarding treatment of pain requires consideration of the context in which the pain behaviors are observed.
- Not all painful conditions require LALS (AEMT II) intervention. BLS pain management methods (splinting, positioning, compression, ice, verbal assurance, etc.) are effective in managing pain and may be sufficient for certain pts.
- Multiple factors must be considered in determining the most appropriate analgesic(s) to administer for pain management (medication availability & contraindications, clinical impression, pt. history, etc.).
- Continuous cardiac and SpO₂ monitoring are required for all pts receiving analgesics.
- Medication doses, pt. response and reason for administration shall be adequately documented in the PCR.



See Page 2 for LALS Pain Management



Pain Management

LALS Pain Management

AEMT II ONLY

Pain Not Effectively Managed With BLS Interventions

Fentanyl (opioid)

- 25 – 50 mcg slow IV (over 1 minute) or IM/IN
- May repeat every 5 minutes (maximum cumulative dose = 200 mcg)

Morphine Sulfate (opioid)

- 2 – 5 mg slow IV (over 1 minute) or IM
- May repeat every 5 minutes (maximum cumulative dose = 20 mg)

- ① Do not administer opioids to pts with any of the following contraindications:
 - Systolic BP < 100
 - Hypoxia or RR < 12
 - ALOC or evidence of traumatic brain injury
- ① If administering fentanyl and morphine to the same pt., maximum cumulative dose = 100 mcg fentanyl and 10 mg morphine

Severe Pain From Acute Isolated Extremity Injuries (including hip and shoulder injuries)

Midazolam (if pain not effectively managed with opioids)

- 1 mg slow IV
- May repeat x 1 in 5 minutes (max = 2 mg)

- ① Do not administer midazolam to pts with any of the following contraindications:
 - Systolic BP < 100
 - Hypoxia or RR < 12
 - ALOC or evidence of traumatic brain injury
- ① Use caution when administering opioids and midazolam to the same pt.



Suspected Stroke

Approval: Troy M. Falck, MD – Medical Director

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Cincinnati Prehospital Stroke Scale (CPSS)

Test	Normal	Abnormal
Facial Droop (Ask pt. to show teeth or smile)	Both sides of face move equally	One side of face does not move as well as the other side
Arm Drift (Ask pt. to close eyes and hold both arms out with palms up)	Both arms move the same, or both arms do not move	One arm does not move, or one arm drifts down compared with the other
Speech (Ask pt. to say “you can’t teach an old dog new tricks”)	Pt. uses correct words with no slurring	Patient slurs words, uses the wrong words, or is unable to speak

BLS

- Assess V/S, including SpO₂
- O₂ at appropriate rate if hypoxemic (SpO₂ < 94%) or short of breath
- Perform CPSS assessment

Suspect stroke for either of the following:

- New onset symptoms with abnormal CPSS
- New onset altered state (GCS < 14) with unidentifiable etiology

If stroke suspected:

- Determine time of onset of symptoms (pt. last known normal)
 - When possible, obtain and relay to the receiving hospital the name/contact information of the individual(s) who can verify the time of onset of symptoms (pt. last known normal)
- Check blood glucose (if glucometer available)
- Transport as soon as possible (scene time should be ≤ 10 minutes)

LALS

- Consider advanced airway if GCS ≤ 8 or need for airway protection
- Cardiac monitor, consider 12 Lead (**AEMT II**) – do not delay transport
- Obtain blood draw if requested by stroke receiving center
- IV NS TKO (may bolus up to 1000 mL)

- Transport to closest appropriate hospital
- Contact base/modified base hospital for destination consultation if necessary

Are both the following present?

- Onset of symptoms ≤ 24 hrs (including wake-up stroke*)
- ≤ 45 minute transport time to a stroke receiving center

- Transport to closest stroke receiving center
- Advise of “Stroke Alert” & time pt. last known normal
- Provide pt. identifying information if requested by stroke receiving center

*Wake-up stroke definition: Pt. awakens with stroke symptoms that were not present prior to falling asleep

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Childbirth

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APGAR Score

	Sign/Score	0	1	2
A	Appearance	Blue/Pale	Peripheral cyanosis	Pink
P	Pulse Rate	None	<100	>100
G	Grimace	None	Grimace	Cries
A	Activity	Limp	Some motion	Active
R	Respiration	Absent	Slow/irregular	Good/strong cry

- Assess V/S, including SpO₂
- O₂ at appropriate rate if hypoxemic (SpO₂ < 94%)
- Estimate blood loss
- Consider vascular access at appropriate time (may bolus up to 1000 mL)

Presenting Part

Prolapsed Cord

Rapid transport & early hospital contact

Protect umbilical cord

- Place mother in knee-chest position
- Insert gloved hand into vagina & gently push presenting part off cord
- Cover exposed cord with wet saline dressing

Head

- Allow delivery**
- Dry/provide warmth
 - Assure open/clear airway
 - Refer to Neonatal Resuscitation Protocol (P-2) if necessary

Breech or Footling

Rapid transport & early hospital contact

- Avoid compression of cord by presenting part
- Allow delivery to progress until baby's waist appears
- Rotate baby to face down position (do not pull)
- If head does not deliver in 3 minutes, insert gloved hand into vagina to create an air passage for infant
- As mother bears down, sweep head out of vagina

After delivery

- Calculate Apgar Score at 1 & 5 minutes after delivery
- Clamp & cut umbilical cord
 - Delay clamping cord for 2 minutes for uncomplicated births not requiring resuscitation
 - Double clamp cord, cut with sterile scissors between clamps, 6" from baby
- Transport, do not wait for placenta delivery
- After delivery of placenta, gently massage fundus until firm

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Hemorrhage

Approval: Troy M. Falck, MD – Medical Director

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Approved Commercial Tourniquet Devices:

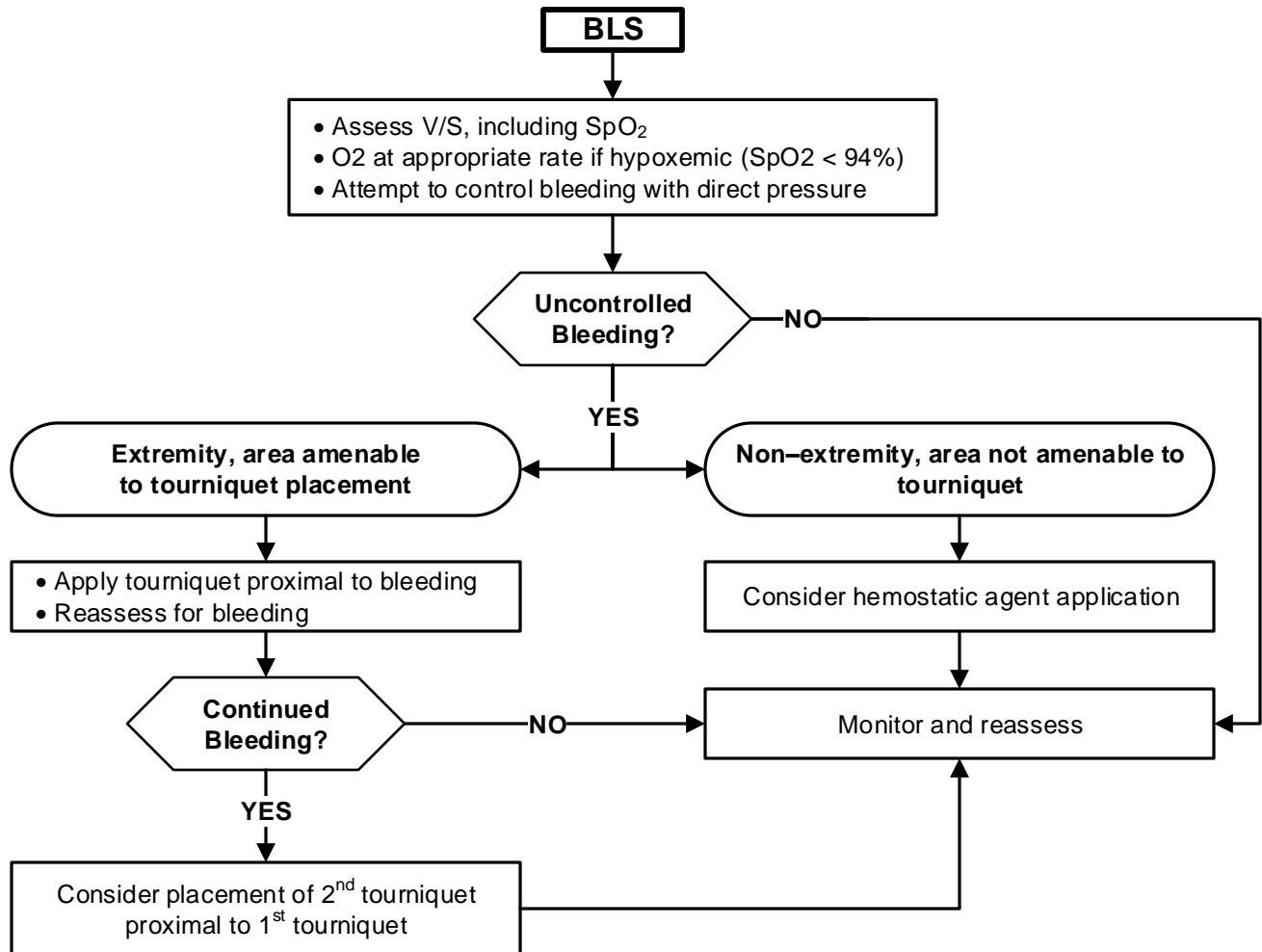
- Combat Application Tourniquet
- Emergency and Military Tourniquet
- Mechanical Advantage Tourniquet
- SAM XT Extremity Tourniquet
- Special Ops. Tactical Tourniquet
- RECON Medical Tourniquet

Tourniquet Utilization Notes:

- Tourniquets applied by lay rescuers or other responders shall be evaluated for appropriateness and may be adjusted or removed if necessary – improvised tourniquets should be removed by prehospital personnel
- If application is indicated and appropriate, a commercial tourniquet should not be loosened or removed by prehospital personnel unless time to definitive care will be greatly delayed (> 2 hours)

Approved Hemostatic Agents:

- QuikClot Emergency 4x4 and/or Combat Gauze Z-Fold
- HemCon ChitoGauze Pro Z-Fold



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Pediatric Pain Management

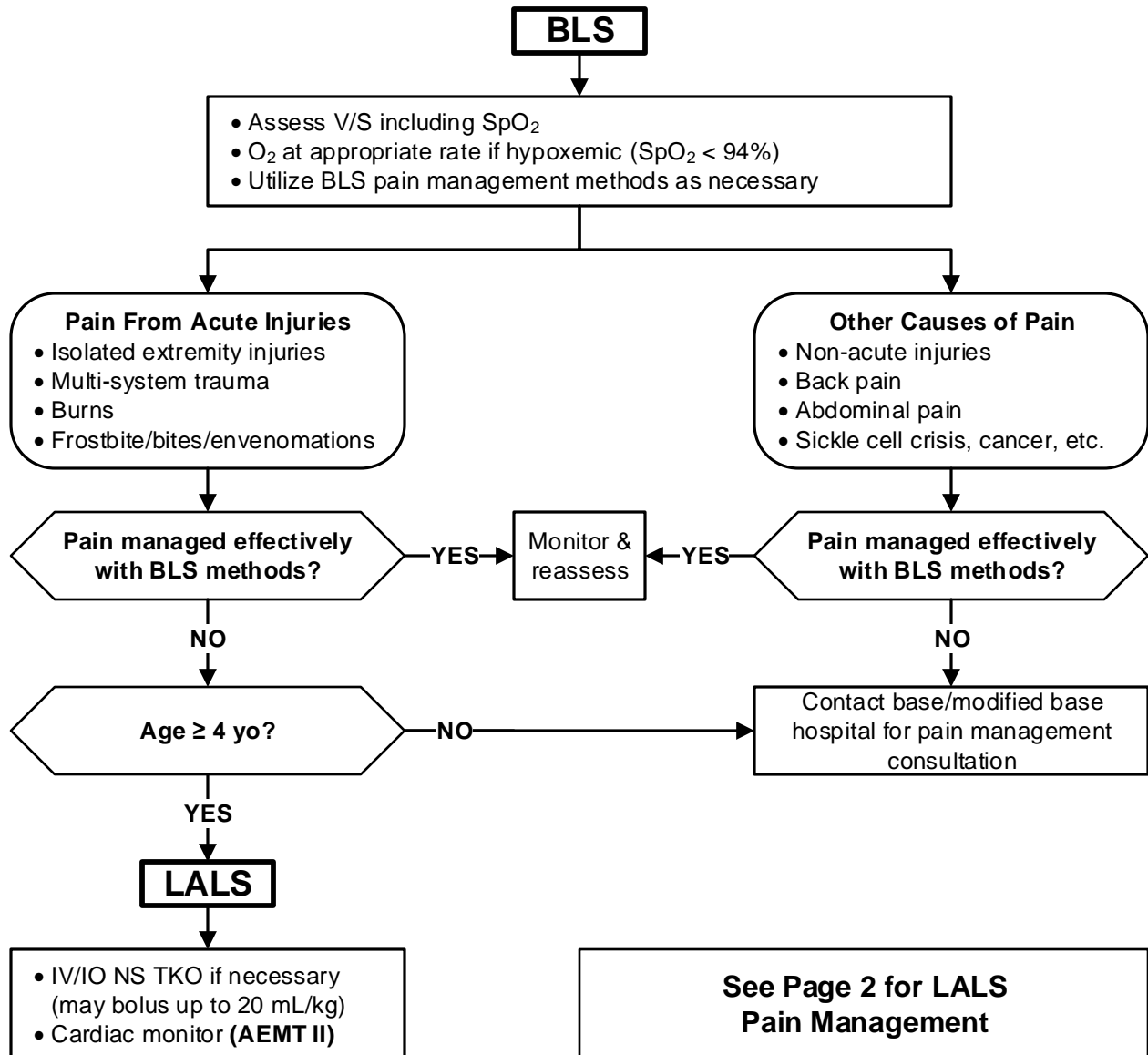
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Pediatric Pain Management

ALS Pain Management

AEMT II ONLY

Pain Not Effectively Managed With BLS Methods

Fentanyl (opioid)

- 1 mcg/kg slow IV/IO (over 1 minute) or IM/IN (maximum = 50 mcg)
- May repeat every 5 minutes (maximum = 4 doses)

Morphine Sulfate (opioid)

- 0.1 mg/kg slow IV/IO (over 1 minute) or IM (maximum = 5 mg)
- May repeat every 5 minutes (maximum = 4 doses)

- ① Do not administer opioids to pts with any of the following contraindications:
 - Systolic BP < 100
 - Hypoxia or RR < 12
 - ALOC or evidence of traumatic brain injury
- ① If administering fentanyl and morphine to the same pt., maximum cumulative dose = 4 total doses combined
- ① Use caution when administering opioids and midazolam to the same pt.