



Airway Obstruction

Approval: Troy M. Falck, MD – Medical Director

Effective: 12/01/2021

Approval: Victoria Pinette – Executive Director

Next Review: 09/2024

• Signs of severe airway obstruction:

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

BLS

- Assess V/S, Including SpO₂
- O₂ at appropriate rate if hypoxemic (SpO₂ <94%) or short of breath
- Suction as needed, be prepared to support ventilation with airway adjuncts

Signs of severe airway obstruction?

NO

Foreign Body (FB)

Infection

Anaphylaxis

- Perform abdominal thrusts
- Begin CPR if pt becomes unresponsive
- Check mouth & remove any visible FB, do not perform blind finger sweeps

- Position of comfort
- Consider humidified O₂
- Assist ventilation with BVM if necessary
- Avoid airway visualization and use of an OPA

Go to Allergic Reaction/Anaphylaxis Protocol (M-1)

LALS

LALS

- If inadequate ventilation:**
- Consider nebulized epinephrine 1:1,000 – 5 mg (5 mL) HHN, mask, or BVM
 - Consider advanced airway

- Cardiac monitor (**AEMT II**)
- Establish vascular access at appropriate time (may bolus up to 1000 mL NS)
- Monitor & reassess

LALS

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Pain Management

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General Pain Management Principles

- Pain management shall be adequately addressed/documentated for all pts with a report of pain.
- EMS treatment should be directed at reducing pain to a tolerable level - pts may not experience complete pain relief.

BLS

- Assess V/S including pain scale & SpO₂
- O₂ at appropriate rate if SpO₂ <94% or short of breath
- Place pt in position of comfort, immobilize, splint & apply ice/cold packs as appropriate

Pain From Acute Injuries

- Burns, frostbite, extremity injuries, multi-system trauma, etc.

Other Causes of Pain

- Back pain, abdominal pain, sickle cell crisis, cancer, etc.

Pain managed effectively?

YES

Monitor & reassess

Pain managed effectively?

YES

NO

NO

LALS

- Contact base/modified base hospital for pain management consultation
- May proceed to LALS treatment in the event of communication failure

- IV NS TKO if necessary (may bolus up to 1000 mL)
- Continuous cardiac monitoring (AEMT II)

Morphine (AEMT II)

- 2 - 5 mg slow IV/IO (over 1 min) or IM
- May repeat every 5 mins as necessary (max cumulative: 20 mg)

Severe pain from acute isolated extremity injuries (including hip & shoulder), not adequately relieved by other pain management methods/analgesics

Midazolam (AEMT II)

- 1 mg slow IV/IO
- May repeat x 1 in 5 mins (max cumulative: 2 mg)

Morphine & Midazolam Contraindications

- SBP <100
- SpO₂ <94% or RR <12
- ALOC or suspected TBI

Midazolam Administration Notes

- Use extreme caution when administering morphine & midazolam to the same pt; this results in a deeper level of sedation with an increased risk for airway & respiratory compromise
- Midazolam doses shall be administered a minimum of 5 mins following administration of a morphine dose

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Suspected Stroke

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Cincinnati Prehospital Stroke Scale (CPSS)

| Component | Normal Result | Abnormal Result |
|---|---|---|
| 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 & 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 | Pt 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 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 mins)

LALS

- Consider advanced airway if GCS ≤8 or need for airway protection
- Cardiac monitor, consider 12-lead EKG (**AEMT II**) - do not delay transport
- Obtain blood draw if requested by stroke receiving center
- IV/IO 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 SpO₂ <94% or short of breath
- 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 mins, 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 mins after delivery
- Clamp & cut umbilical cord
 - Delay clamping cord for 2 mins 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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Pediatric Pain Management

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