Lowndes County Fire Rescue



Medical and Trauma Protocols

Effective	

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GENERAL INFORMATION

Purpose

The purpose of this document is to provide guidelines regarding permissible and appropriate emergency medical services procedures and treatment modalities which may be rendered by personnel to a patient in the out-of-hospital environment.

Professional Judgment

Since each medical emergency must be dealt with on an individual basis and appropriate care determined accordingly, professional judgment is mandatory in determining treatment within the parameters of these guidelines.

Authority

The authority for implementing these guidelines for care of pre-hospital patients is found in state law OCGA 31-11-60.1 (b) and (c), OCGA 31-11-50 (b), and the Rules of the Department of Public Health Chapter 511-9-2.

It is the responsibility of each medic to be familiar with the laws, rules and regulations, and guidelines and adhere to them. Even an order by a physician does not justify procedures not in accordance with laws, rules and regulations.

BODY SUBSTANCE ISOLATION

Body Substance Isolation should be used for all patient contacts if the health care provider may be exposed to blood, or other body fluids. Body Substance Isolation assumes that all patients are carriers of infectious contagious diseases.

General recommendations

- Gloves should be worn when handling blood, body fluids, mucous membranes, nonintact skin, and body tissues. New gloves should be worn for each patient contact. Hands must be washed after glove removal.
- ♦ If a splash of blood or body fluid is anticipated, a full-face shield or goggles and a facemask should be worn.
- If emergency ventilatory support is necessary, a resuscitation mask should be used.
- ♦ Do not recap needles. Promptly place disposable sharps in a designated puncture resistant container.
- Place all soiled linen in a clear, plastic bag before sending it to the laundry.
- Use a solution of 1-part household bleach to 100 parts water to clean equipment, clean up spills, and decontaminate walls and other objects soiled with blood or body fluids.
- If your skin has a break, cut, abrasion, or dermatitis, use gloves and avoid any contact with blood or body fluids.
- Be vaccinated against Hepatitis B.
- Exposure to and possible contamination from blood or body fluids should be reported.

Since there is no reliable, immediate means to identify infected patients, pre-hospital care providers should be equally cautious when caring for all patients.

ROUTINE MEDICAL CARE

Have equipment brought to the patient. This includes AED, oxygen, suction (if available), advanced airway equipment and the capability for communications.

The following procedures will be performed on all nontraumatic medical emergencies.

Assess patient, including vital signs, as often as the situation warrants

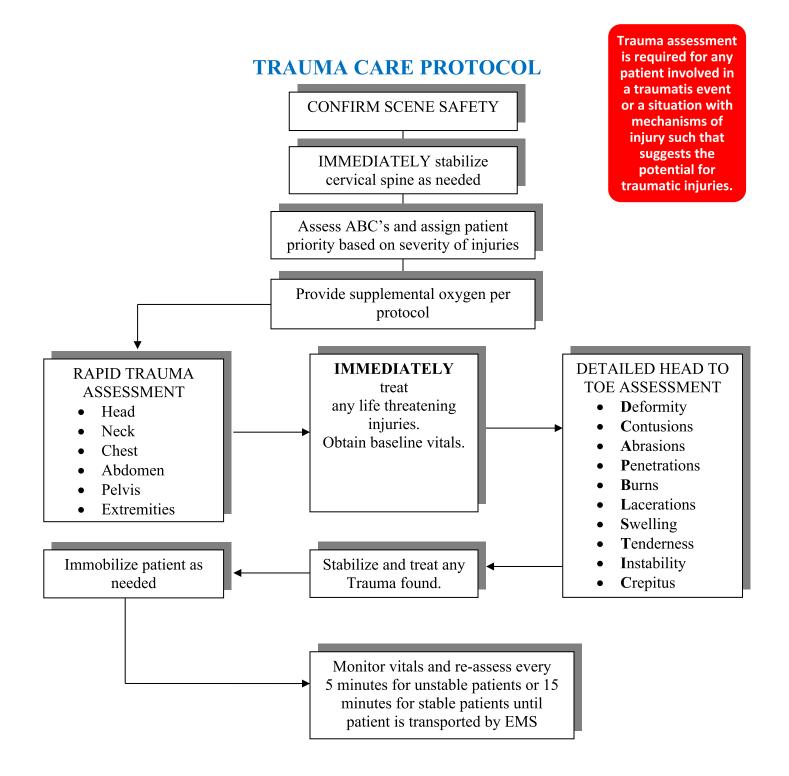
Perform airway management, ventilatory assistance, and oxygen therapy as indicated by patient's clinical condition or presentation.

Monitor patient and determine treatment pathway

Multiple Patient Procedures

If a potential multi-casualty incident (MCI) exists, contact Dispatch and have EMS and law enforcement notified as soon as possible. (See Procedures Protocols Page 22)

The Medical Control Physician is authorized to make all protocols standing orders during the MCI.



AIRWAY MANAGEMENT

Manually open the airway

Insert oropharyngeal / nasopharyngeal airway (Procedure Protocols Page 32 and 33)

Ventilate patient with bag-valve-mask and 100% oxygen

Airway
Management is
required for any
patient exhibiting
signs of respiratory
compromise
involving inability
to maintain and
manage their own
airway.

OXYGEN THERAPY

Provide ventilatory assistance as needed

Determine and document patient's respiratory status prior to and after treatment.

For all patients with severe respiratory distress administer oxygen via Non-Rebreather at 10 LPM

If patient will not tolerate Non-Rebreather, oxygen may be administered via Nasal Cannula at 6LPM

For patients with non-distressed respiratory effort, administer oxygen as needed via nasal cannula at 2-4 LPM

FOR PATIENTS WITH SEVERE HEAD TRAUMA, ACUTE CORONARY SYNDROME OR INDICATORS OF ACUTE MYOCARDIAL INFARCTION:

- High flow oxygen has proven to have vasoconstricting properties and may be contraindicated in the above patients.
 - Target Pulse Oximetry in the range of 94%.
- **DO NOT** withhold high-flow oxygen if patient is in respiratory distress.

ALL patients
exhibiting
respiratory
distress or
significant medical
or traumatic
complaints should
receive oxygen
therapy.

ABDOMINAL PAIN

Routine medical care

Treat any immediately life threatening symptoms first (hypotension, shock)

Obtain initial vital signs. If vital signs indicate patient is in shock, IMMEDIATELY treat per SHOCK protocol while continuing steps of ABDOMINAL PAIN protocol.

Sharp or dull pain in stomach area "popping" sensation in abdomen cramping nausea/vomiting tenderness on palpation bruising to abdominal area

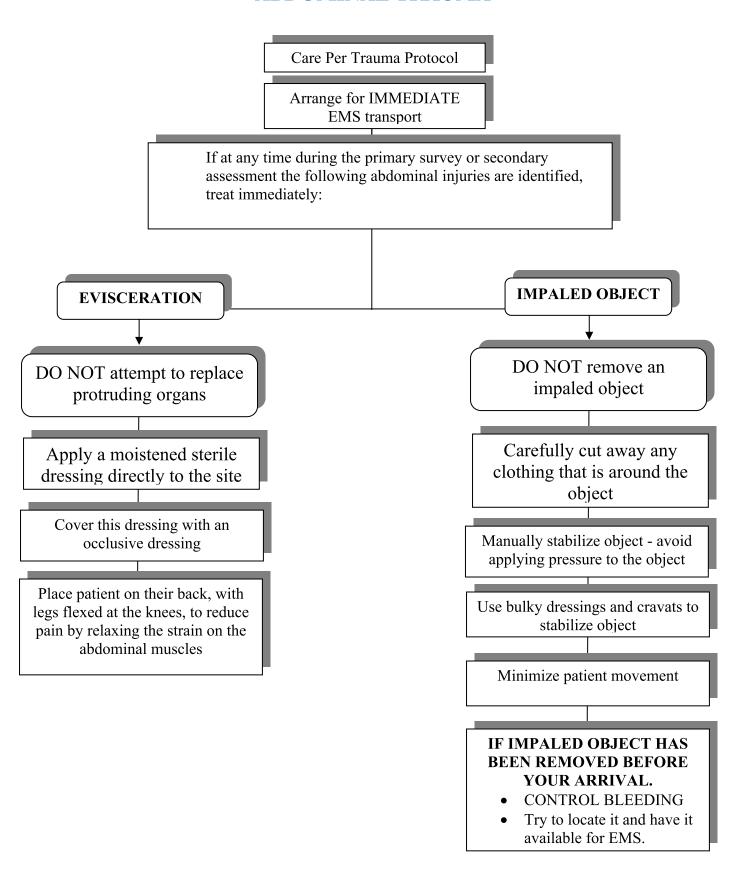
INITIAL TREATMENT

- Establish airway and maintain as indicated.
- Administer high concentration oxygen.
- DO NOT give the patient anything by mouth.
- Allow the patient to assume a position of comfort.

Perform a focused history

- Ask the patient to describe the pain:
 - What were they doing when the pain started?
 - What makes it better or worse?
 - O What does it feel like?
 - Where is the pain? Does it move anywhere?
 - o How bad is it? (refer to pain scale)
 - o Is it constant or does it come and go?
- Has the patient ever had the pain before?
- When did the patient last eat? What was it?
- When was their last bowel movement? Was there blood or black material in it?
- Have they vomited? Was there any blood or coffee ground material present?
- What other symptoms are present? (fever, chest pain, nausea, trouble breathing)
- Is there any history of trauma?
- If the patient is female:
 - o Determine when last menstrual period was.
 - Have menstrual periods been regular?
 - o Has there been any vaginal bleeding or discharge?
 - o Is there the possibility of pregnancy?
- Is there any other relevant past medical history?
- Has the patient had any abdominal surgeries?

ABDOMINAL TRAUMA

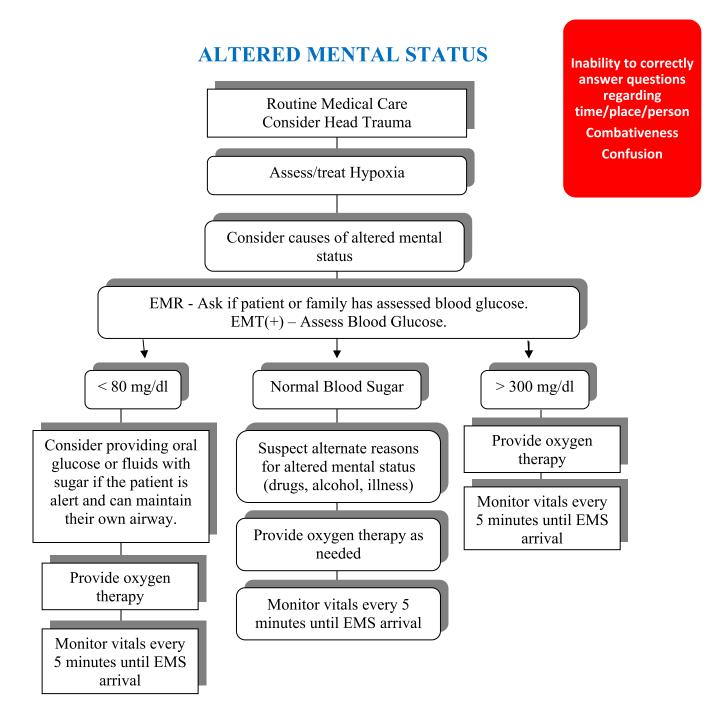


AIRWAY OBSTRUCTION

Follow accepted AHA BLS Protocols for obstructed airway

If unsuccessful, continue efforts to include considerations for CPR and await transport

Inability to speak
Peripheral Cyanosis
Wheezing or
Stridorous
respirations
Anxiety
Confusion



ANAPHYLAXIS

Stable Hemodynamics (SBP > 100) with minor or moderate skin manifestations (itching, rash, blotches, hives, urticaria), and **no respiratory compromise.**

Pronounced skin rash, itching, blotches, hives and/or urticaria
Peripheral Cyanosis
Wheezing or
Stridorous
respirations
Anxiety

Confusion

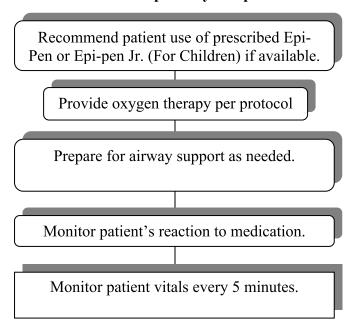
STABLE PATIENT

Routine Medical Care Assess BP and respiratory status

Be alert for LOC changes and ANY signs of respiratory compromise.

UNSTABLE PATIENT

SBP < 100 with significant skin manifestations itching, rash, blotches, hives, urticaria and respiratory compromise.



ANIMAL BITE

Routine Medical / Trauma Care

CONTROL ANY BLEEDING IMMEDIATELY.

Treat any open bites per HEMMORHAGE and OPEN WOUND protocol.

Treat any closed bites per SOFT TISSUE INJURY protocol.

Puncture wounds
Bleeding at site
Swelling
Contusions
LATE SIGNS
Warmth / fever at site
Severe swelling
Continued pain

Purulent discharge

QUESTIONS TO ASK

- 1. When where and how was the patient bitten?
- 2. What type of animal was it?
- 3. Location of the animal at this time?
- 4. Vaccination status of the animal.

STEPS TO COMPLETE

- 1. Notify Dispatch as soon as possible.
- 2. Notify Battalion Chief as soon as possible.
- 3. Notify Animal Control as soon as possible

PATIENT INFORMATION

1. Inquire as to last Tetanus immunization or booster. Advise of need for Tetanus booster or immunization.

BLISTERS

Routine medical care

DO NOT rupture unbroken blisters

Apply a sterile dressing and protect the area from further contamination

If blister is already broken, treat per OPEN WOUND protocol

If the patient has blisters that lie deep in the palm of the hand or in the sole of the foot, warn them about attempting to care for it themselves. These are potentially serious burns.

Recommend evaluation and treatment at medical facility.

Offer EMS transport

Redness or discoloration Pain at site Moist and mottledskin Visible pustule

BURNS

Exposure to heat, chemicals or electricity
Reddened, blotchy or charred skin
Blisters

Stop the Burning

Remove clothing, jewelry from affected area Routine Medical Care

Assess evidence of burns to upper airway, upper airway compromise, critical body surface burns or electrical burns.

ALL burns greater than 10% body surface area, electrical burns, chemical burns and burns involving the airway, hands, feet or genitalia must be *IMMEDIATELY* transported

via EMS. Thermal Electrical Chemical Airway Management Confirm patient is Consider hazmat Protocol (Pg. 8) disconnected from risk electricity source Arrange EMS transport Attempt to identify for 1ST degree burns > the chemical Suspect 15% BSA or 2nd degree spinal injury Burns > 5% BSA Flush with copious amounts of water Follow protocol for Arrange EMS transport unless contraindicated treatment of for ALL 3rd degree thermal burns burns Stop burning process. All electrical burn Follow protocol for

patients MUST be

transported via

EMS for possible cardiac issues

Cover burn(s) with

sterile burn dressing

Remove any clothing

EXCEPT any that is

stuck to burn.

Burn assessment methods can be found on Pg. 37 of the procedure protocols.

treatment of

thermal burns

Arrange EMS transport for ALL 3rd degree burns Monitor vitals every 15 minutes for stable patients and every 5 minutes for unstable patients until EMS arrival.

CARDIAC ARREST

ALL PATIENTS

No pulses
Apnea
No signs
of life

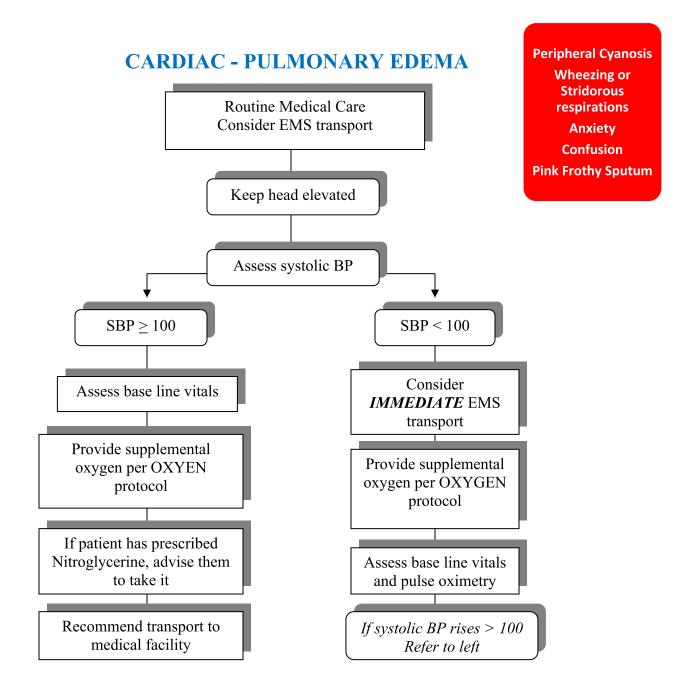
CPR per recommended AHA guidelines for age.

IMMEDIATELY arrange for EMS transport

Utilize Automated External Defibrillator as soon as possible.

Consider use of airway adjuncts.

Prepare patient to expedite EMS transport.

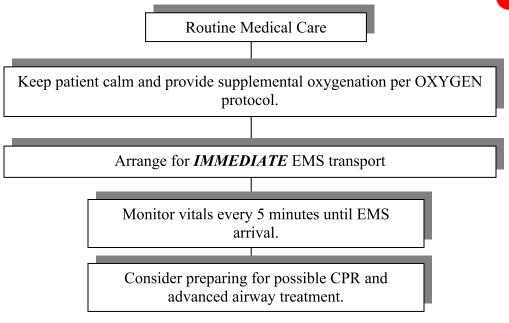


Nitroglycerine is contraindicated in patients who have taken Erectile Dysfunction medication within 24 hours.

CARDIAC - SYMPTOMATIC BRADYCARDIA

Symptomatic bradycardia is defined as a pulse rate < 60 with a systolic BP < 100, with serious signs and symptoms including chest pain, SOB, altered mental status, signs of CHF or hypoperfusion.

Pulse rate < 60 with a systolic BP < 100 Chest pain Shortnes of breath Altered mental status Signs of CHF or hypoperfusion



CARDIAC – ACUTE CORONARY SYNDROME

(ACS)

(Suspected Cardiac Chest Pain)

Crushing or dull Chest pain or numbness that may or may not radiate down left arm or into mid-clavicular area

Shortnes of breath
Altered mental status



Obtain baseline vitals and history

Suggest IMMEDIATE transport to hospital via EMS

If $SBP \ge 100$

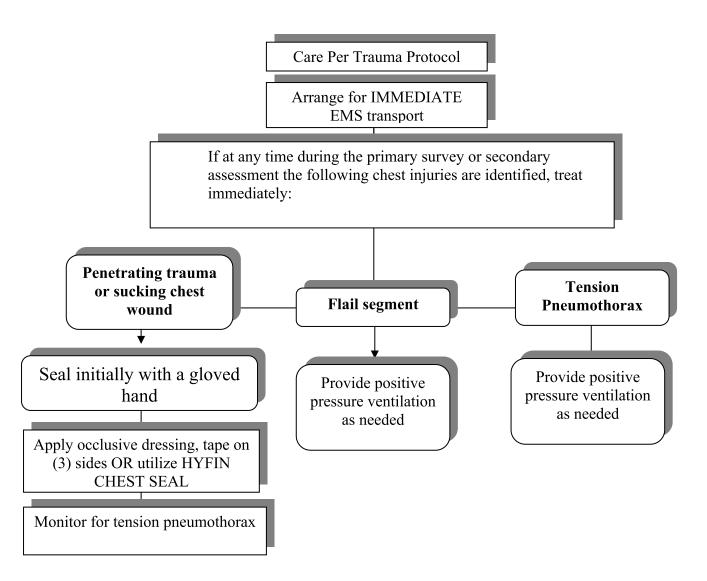
and patient has prescribed
Nitroglycerine, recommend that
they take it per prescribed
directions.

Provide supplemental oxygen per OXYGEN protocol.

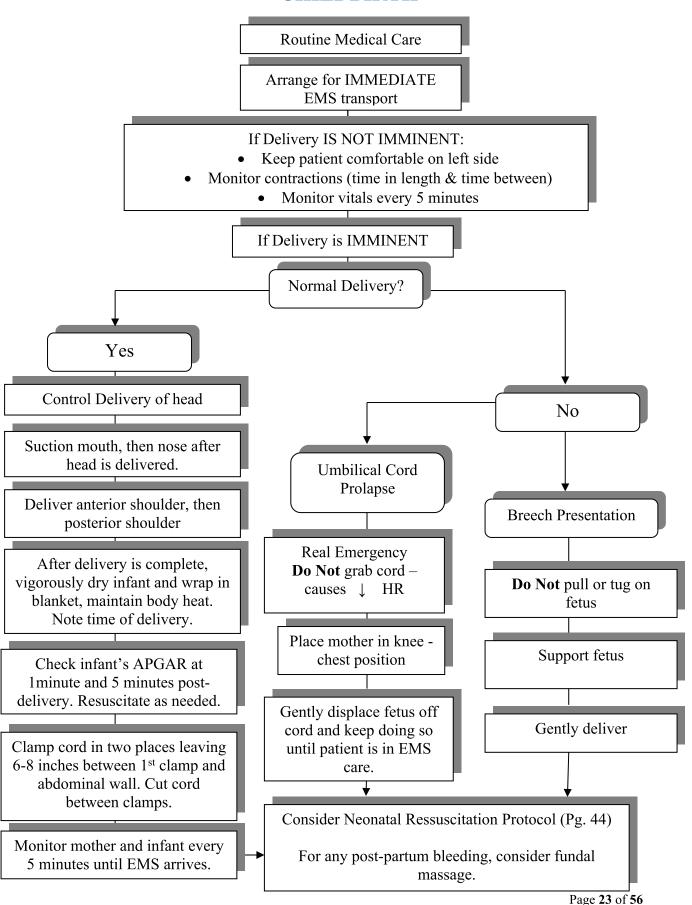
If chest pain persists and SBP > 100, Nitroglycerine may be repeated up to a total of 3 times

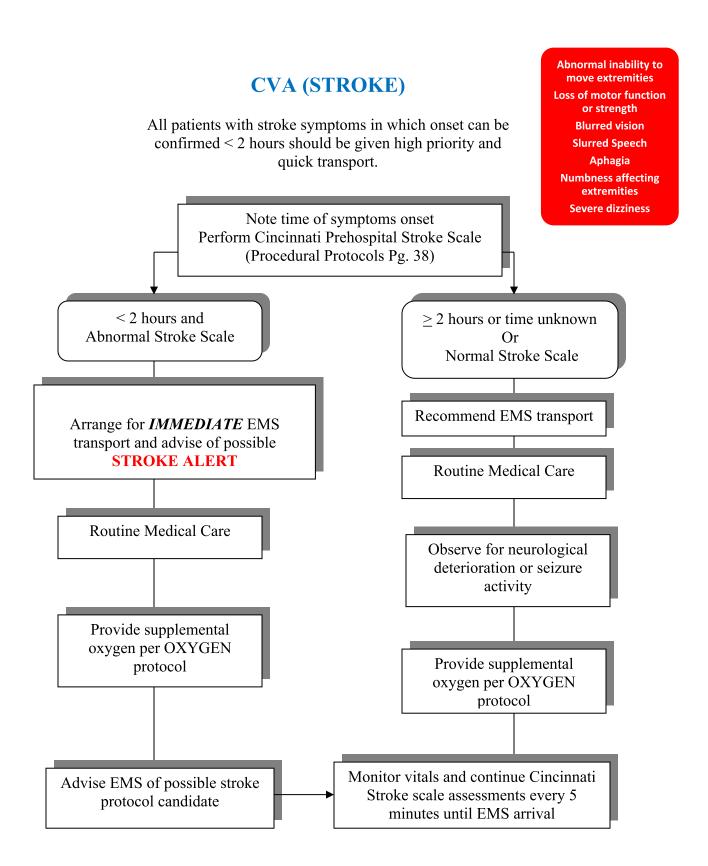
Monitor vitals every 5 minutes until EMS arrival.

CHEST TRAUMA



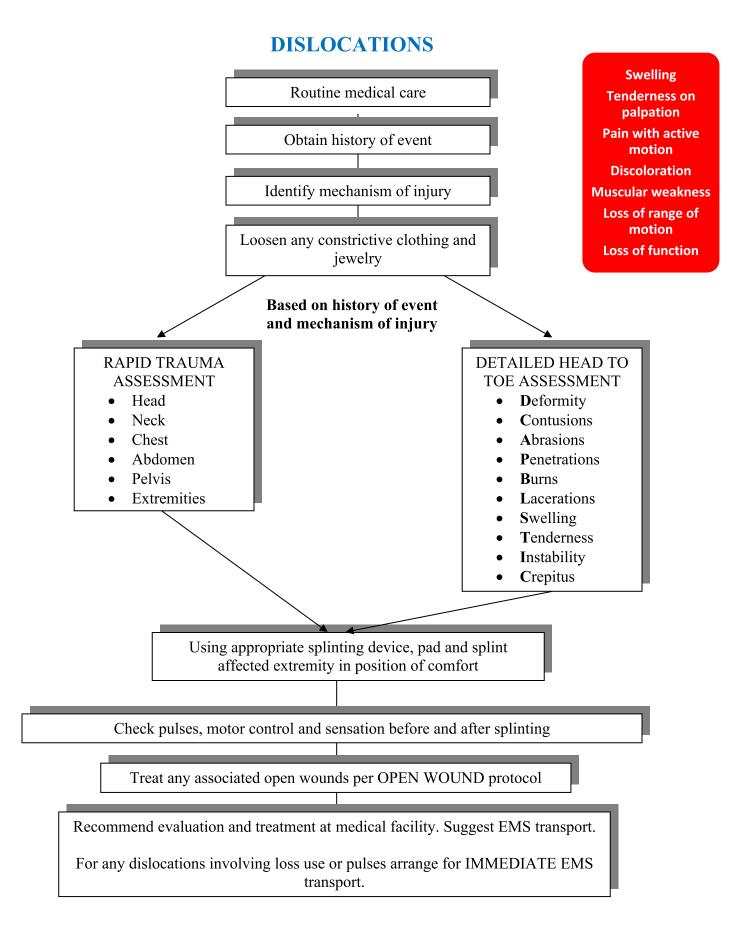
CHILDBIRTH

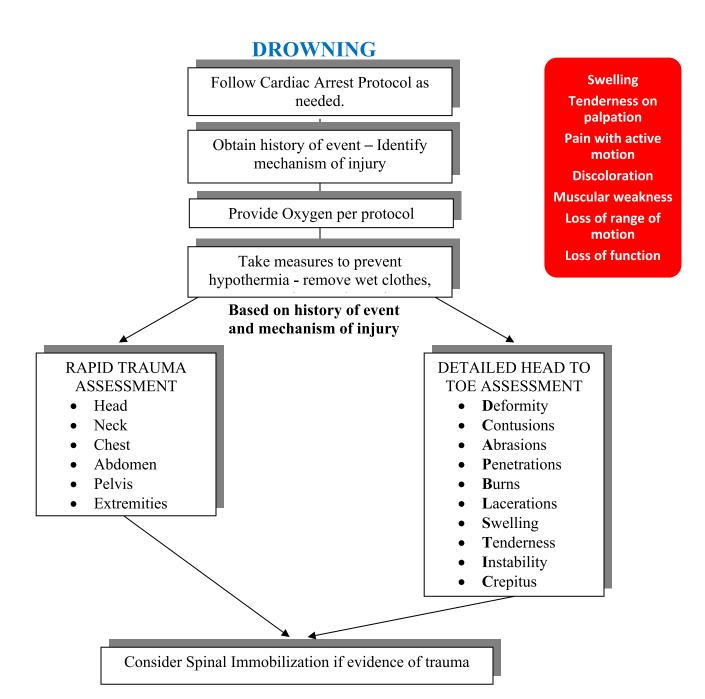




Bring witness or family member to answer questions relating to the patients past medical history.

Transport with head elevated at 45° when patient condition will tolerate.





EPISTAXIS (NOSE BLEED)

Hypertension
Direct trauma
Past History

Routine Medical / Trauma Care

Place patient in sitting position, leaning forward if possible. If not possible, place patient in semi-fowlers position

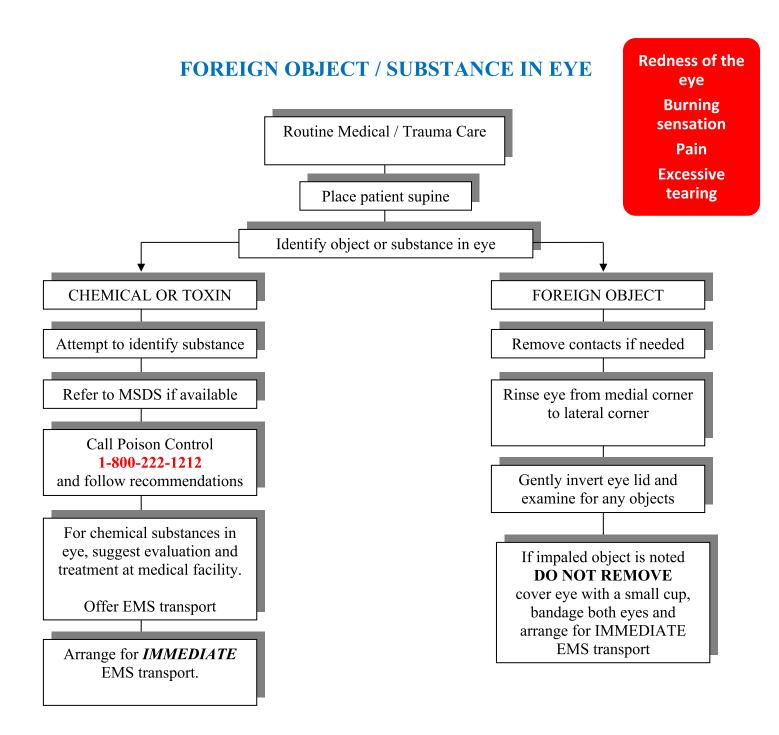
Apply direct pressure to affected nare by pressing it toward bridge of nose. (Pinch Nose)

Apply indirect ice or cold pack to nose and face.

Obtain baseline vitals and history.

For all nosebleeds that persist for longer than 15 minutes or for diastolic BP > 90 mm/hg, suggest patient seek evaluation and treatment at medical facility. Offer EMS transport.

Monitor vitals every 15 minutes until EMS arrival



• If efforts are not successful, suspect corneal abrasion or laceration.

FRACTURES Pain on palpation or Routine medical care movement Pale or flushed skin at site Obtain history of event **Delayed CRT Numbness or tingling** of extremity Identify mechanism of injury Feeling or pressure at site **Diminished or absent** Loosen any constrictive clothing and pulses jewelry **Based on history of event** and mechanism of injury **DETAILED HEAD TO** RAPID TRAUMA ASSESSMENT TOE ASSESSMENT Head **D**eformity **C**ontusions Neck Chest **A**brasions Abdomen **P**enetrations **Pelvis B**urns **Extremities** Lacerations Swelling **T**enderness Instability Crepitus Using appropriate splinting device, pad and splint affected extremity in position of comfort Check pulses, motor control and sensation before and after splinting Treat any associated open wounds per OPEN WOUND protocol. DO NOT attempt to reinsert exposed bones. Cover with moistened trauma dressing. Recommend evaluation and treatment at medical facility. Suggest EMS transport. For any fractures involving exposed bone, loss of use or pulses arrange for

IMMEDIATE EMS transport. DO NOT ATTEMPT TO MANIPULATE TO PUT BONE BACK IN!

FROSTBITE

Routine Medical / Trauma Care

Remove patient from exposure

Attempt to determine initial time of exposure.

Remove any wet or constrictive garments from the affected site.

DO NOT attempt to re-warm in the field.

Cover any thawed parts with a loosely applied, dry sterile dressing.

Recommend transport to medical facility for evaluation.

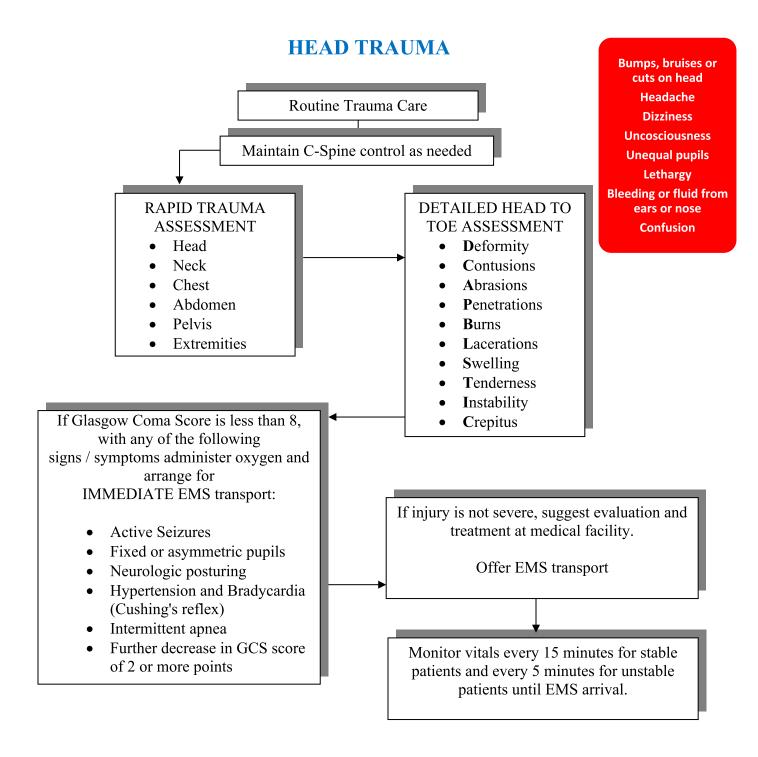
For any cases of major frostbite (loss of pulses, motor ability or control, apparent tissue death) arrange for *IMMEDIATE* EMS transport.

Monitor vitals every 15 minutes for stable patients and every 5 minutes for unstable patients until EMS arrival.

Reddened, blotchy or blackened appearance to affected area.

Loss of sensation to affected area.

Sloughing or blistering of skin in affected area.



HEAT EXHAUSTION

An abnormal condition characterized by weakness, vertigo, nausea, muscle cramps and possible syncope caused by depletion of body fluids and electrolytes resulting from prolonged exposure to elevated temperatures.

Weakness
Vertigo
Nausea
Muscle cramps
Possible syncope
Profuse sweating
Reddened skin
Rapid respirations
Rapid heart rate

Routine Medical Care

Move patient to cooler environment

Do focused assessment and physical exam. Establish baseline vitals to include temperature and pulse oximetry.

Sponge patient with room temperature water.
Avoid chilling the patient

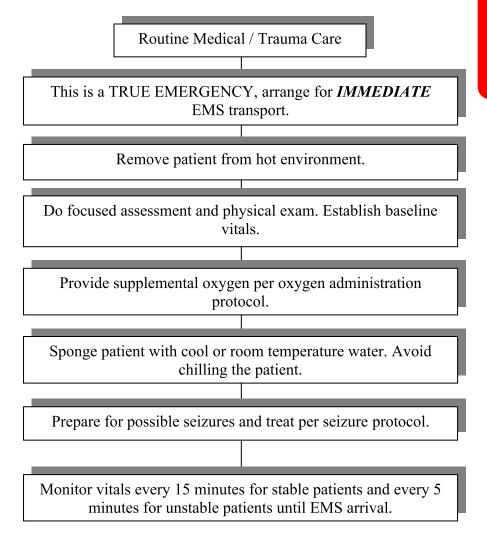
Recommend transport to medical facility for evaluation.

Provide supplemental oxygen according to oxygen administration protocol.

Monitor vitals every 15 minutes for stable patients and every 5 minutes for unstable patients until EMS arrival.

HEAT STROKE

A severe and sometimes fatal condition resulting from the failure of the temperature regulating capacity of the body caused by prolonged exposure to high temperatures. Weakness
Vertigo
Nausea
Muscle cramps
Possible syncope
No sweating
Reddened skin
Rapid respirations
Rapid heart rate
Weak pulses



HEMORRHAGE

Routine Medical / Trauma Care

Control any bleeding by applying direct pressure. (If Nosebleed, refer to *Nosebleed* protocol)

If direct pressure is not successful in controlling bleeding, apply tourniquet.

MINOR WOUND

- Clean area with soap & water
- Dress wound as appropriate
- Notify patient to check if their tetanus shot is current
- Apply additional dressings as needed.

SEVERE WOUND

- Administer supplemental oxygen per protocol
- Expose the wound and place direct pressure to the site
- Apply additional dressings as needed while continuing pressure. DO NOT remove saturated dressings
- If direct pressure is not successful in controlling bleeding, apply tourniquet.
- Immobilize site as needed with appropriate device

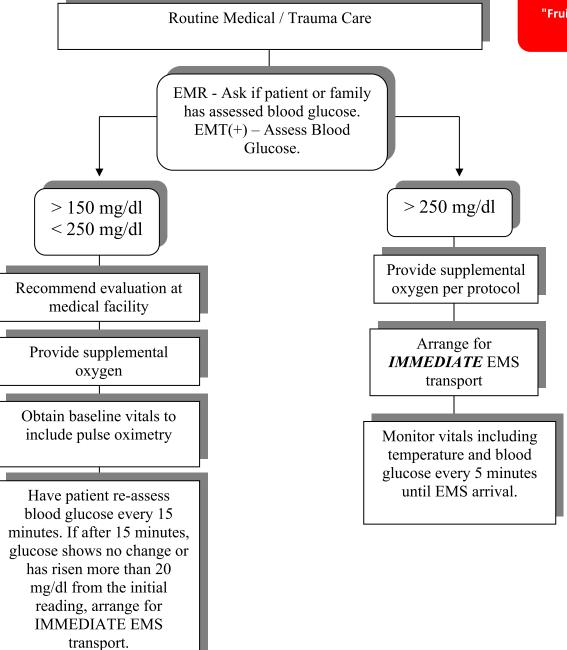
Obtain baseline vitals and history.

Monitor vitals every 15 minutes for stable patients and every 5 minutes for unstable patients until EMS arrival.

External bleeding
Oozing, flowing or spurting blood from wound

HYPERGLYCEMIA

Weakness
Vertigo
Nausea
Possible syncope
Profuse sweating
Confusion
"Fruity" odor on
breath



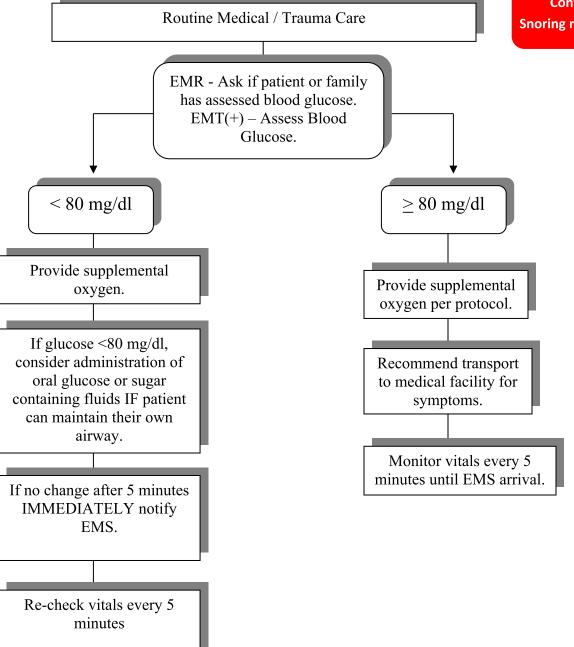
HYPERTENSION

Routine Medical Care Obtain baseline vitals and history Consider performing Cincinnati Stroke Scale (procedures Page 38) Identify possible causes Have patient rest in semi-fowler's position while monitoring. Provide oxygen therapy per protocol. For significant neurological deficits or diastolic BP>110 mm/hg arrange for IMMEDIATE EMS transport. Monitor vitals every 15 minutes for stable patients and every 5 minutes for unstable patients until EMS arrival. (Consider performing Cincinnati Stroke scale at each interval)

Diastolic pressure over 90mm/hg Nausea/Vomiting Confusion Blurred Vision Headache

HYPOGLYCEMIA

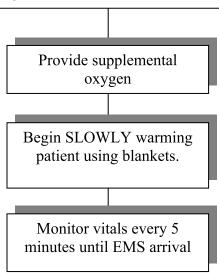
Weakness
Vertigo
Nausea
Possible syncope
Profuse sweating
Confusion
Snoring respirations



HYPOTHERMIA

Routine Medical / Trauma Care
Remove wet clothing, and protect patient from environment.
Handle patient gently, and avoid hyperventilating.
Arrange for *IMMEDIATE* EMS transport

Weakness
Vertigo
Nausea
Loss of coordination
Possible syncope
Profuse shivering
Cyanosis
Confusion



In cases of hypothermic cardiac arrest, continue CPR and airway treatments as normal with consideration for gentle handling and patient warming.

INSECT / BEE / WASP STINGS

Routine Medical / Trauma Care

MINOR REACTION

If stinger is present, gently remove it by scraping it away from site. DO NOT use tweezers or forceps to avoid squeezing

Wash area with soap and water

Apply ice to the area for 10 minutes.

the venom sac.

SIGNIFICANT REACTION

Treat per ANAPHYLAXIS protocol

Localized reaction at site of sting **Localized pain Redness Swelling Urticaria**

INTERNAL HEMORRHAGE

Routine Medical / Trauma Care

Identify mechanism of injury and choose to do a focused medical exam or rapid trauma assessment

Provide supplemental oxygen per protocol

MINOR

- Administer indirect ice or cold pack to area
- Apply compression bandage to area
- Elevate as necessary

SEVERE

- Administer supplemental oxygen per protocol
- Keep patient at rest
- Keep patient warm
- Treat for shock as needed

Obtain baseline vitals and history.

For all patients with diastolic BP < 100/60 mm/hg or with significant shock symptoms, arrange for *IMMEDIATE* EMS transport.

Monitor vitals every 5 minutes until EMS arrival

Vomiting or coughing up blood

Bruises on chest

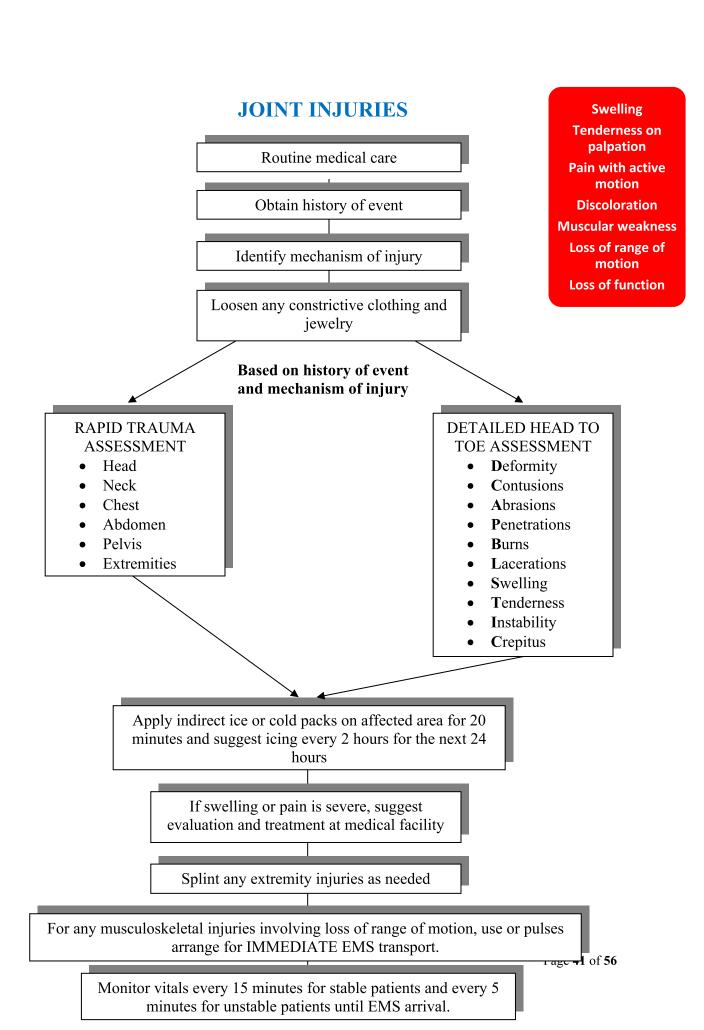
Bruised or swollen abdomen

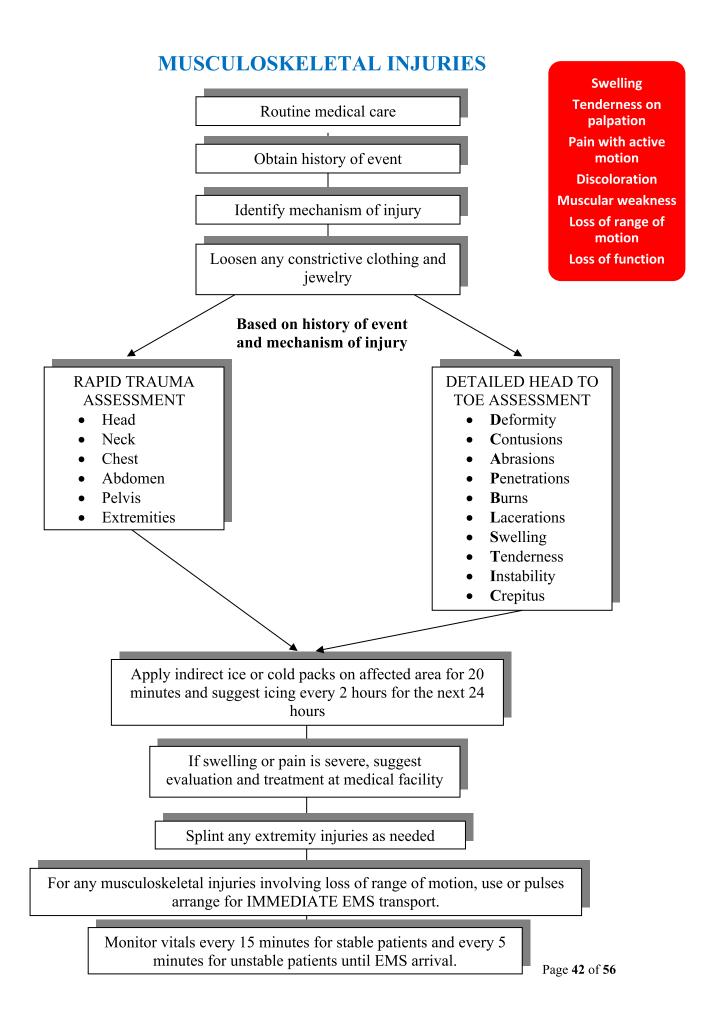
Abdominal tenderness, rigidity or spasms

Rectal or vaginal bleeding

Fractures

Signs of shock





NAUSEA / VOMITING

Gastric upset Emesis

Routine Medical Care Obtain baseline vitals Recommend electrolyte fluids such as Gatorade/Powerade or Pedialyte (for children) to combat dehydration Consider causes (cardiac, poisoning, motion sickness etc.) Obtain baseline vitals and history. If systolic BP is <100, assess and treat for shock. If symptoms have not subsided after 10 minutes, suggest patient seek evaluation and treatment at medical facility. If patient is exhibiting signs of shock, arrange for IMMEDIATE EMS transport. Monitor vitals every 15 minutes for stable patients and every 5 minutes for unstable patients until transported by

EMS.

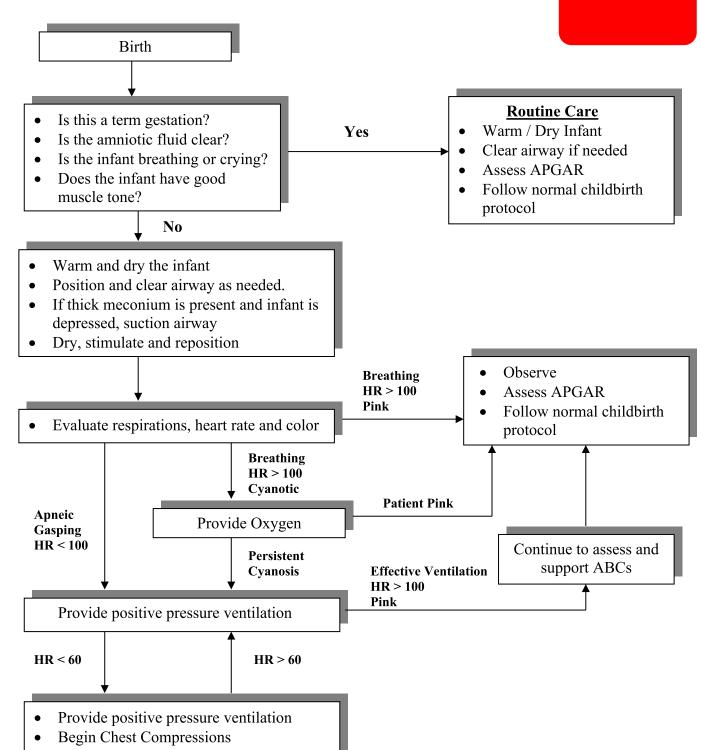
NEONATAL RESUCITATION

IMMEDIATELY ARRANGE FOR EMS TRANSPORT

30 SECONDS

30 SECONDS

Newly delivered infant



Abrasions OPEN WOUNDS Lacerations **Incisions Punctures** Routine Medical / Trauma Care **Avulsions Amputations** MINOR OPEN WOUNDS Do focused physical exam **Evisceration** Identify Mechanism of injury Obtain Baseline vital signs Assess bleeding and treat per HEMMORHAGE protocol SEVERE OPEN WOUNDS Refer to HEMMORHAGE protocol for bleeding control. **LACERATIONS ABRASIONS AVULSIONS EVISCERATION INCISIONS AMPUTATIONS** DO NOT attempt to **PUNCTURES** Refer to replace eviscerated Treat bleeding per **HEMMORHAGE** intestines or organs Apply bandage or **HEMMORHAGE** protocol dressing per protocol Contain eviscerated HEMMORAGE protocol entrails as best as DO NOT attempt to roll possible and cover with For gaping lacerations or back avulsed skin trauma pad moistened lacerations > 1/4 inch with sterile water or deep, stitches are DO NOT remove any saline. indicated hanging or still attached items. Splint as well as Cover eviscerated items If adjacent to any tendon possible. with emergency blanket or ligament, suggest or plastic sheet and evaluation & treatment at Place any amputated blanket to conserve body medical facility. items in sterile 4x4's then heat into a plastic bag then in DO NOT remove a second bag with ice and Continue to keep impaled objects. Stabilize water to be transported dressings moist in place and arrange for with patient. immediate transport Arrange for Arrange for **IMMEDIATE** EMS IMMEDIATE EMS transport Monitor vitals every 15 minutes for stable patients and every 5

minutes for unstable patients until EMS arrival.

POISONING / TOXINS / OVERDOSE

History is important. Whenever possible, determine the substance(s) involved and the quantity, time and route they were taken.

Indications:

- Poisoning by mouth
- Poisoning by injection
- Poisoning by absorption

Contraindications:

- Altered mental status
- Ingestion of acid or alkali substances
- Ingestion of hydrocarbons (petroleum)

Consult MSDS for substance information.
Contact Poison Control if substance is known
1-800-222-1222

Arrange for IMMEDIATE
EMS transport

Provide supplemental oxygen
per protocol

Monitor vitals every 5 minutes
until EMS arrival

Weakness
Vertigo
Nausea
Loss of
coordination
Possible syncope
Profuse shivering
Cyanosis
Confusion

S.L.U.D.G.E.

Salivation
Lacrimation
Urination
Defecation
Gastric Upset
Emesis

DOCUMENT

- Time Poison Control was called
- Person you spoke to
- Recommendations given

OVERDOSE CONSIDERAIONS

Consider specific antidote. If possible, see container label and contact Poison Control.

Rule Out Narcotic OD. Be aware of increasing use of home dermal pain control patches.

Suspected Narcotic OD — Refer to Altered Mental Status

Topical poisons - Brush away particulate matter before flushing with water.

Carbon Monoxide poisoning - Pulse Oximetry is unreliable.

Multiple victims in enclosure - consider environment and hazmat team.

RESPIRATORY ARREST

Apnea Unresponsiveness

CPR per recommended AHA guidelines for age and Routine Medical Care

IMMEDIATELY arrange for EMS transport

Simultaneously begin rescue breathing via approved device at:

ADULT: 1 breath every 5 seconds **CHILDREN**: 1 breath every 5 seconds **INFANTS**: 1 breath every 5 seconds

Consider use of airway adjunct

Be ready for any emesis or secretions

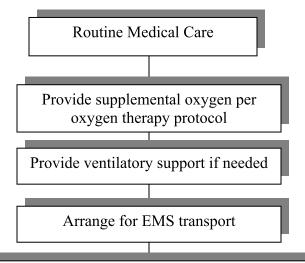
Prepare patient to expedite EMS transport.

If possible, attempt to obtain baseline vitals and monitor vitals every 5 minutes until EMS arrival

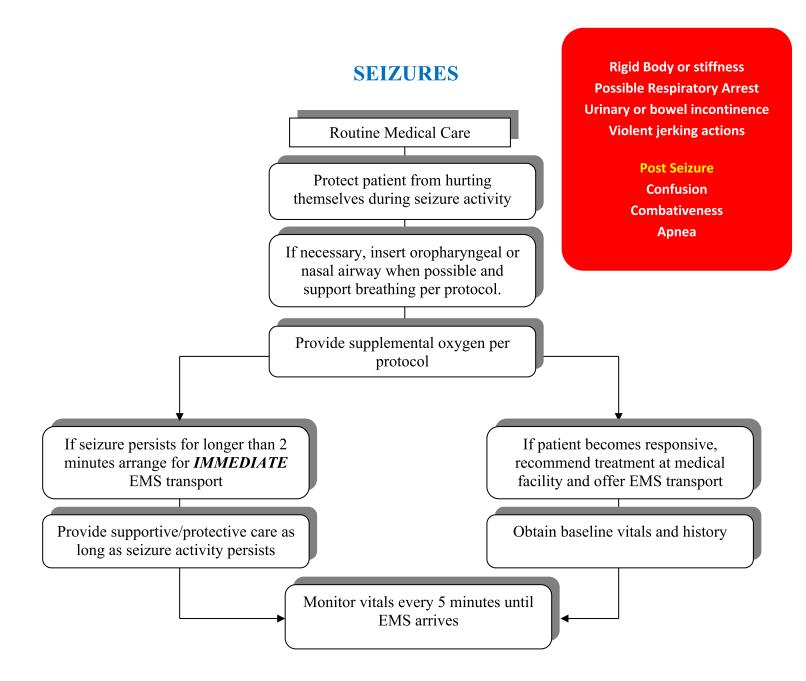
RESPIRATORY DISTRESS

Intervention for patients experiencing moderate to severe respiratory distress with wheezing presumed to be secondary to a reactive airway

Inability to speak
Peripheral Cyanosis
Wheezing or
Stridorous
respirations
Anxiety
Confusion



Monitor vitals every 15 minutes for stable patients and every 5 minutes for unstable patients until EMS arrival.



SHOCK

A state of inadequate tissue perfusion.

Provide supplemental oxygen per oxygen therapy protocol

RAPID TRAUMA
ASSESSMENT

• Head
• Neck
• Chest
• Abdomen

Restlessness
Anxiety
Progressive lethargy
Cool, clammy and pale
skin
Peripheral cyanosis
Excessive thirst
Nausea / Vomiting
Rapid shallow
respirations
Rapid, weak and/or
absent peripheral pulses
Dilated pupils
Decreased LOC
Low B/P

IMMEDIATELY arrange for EMS transport

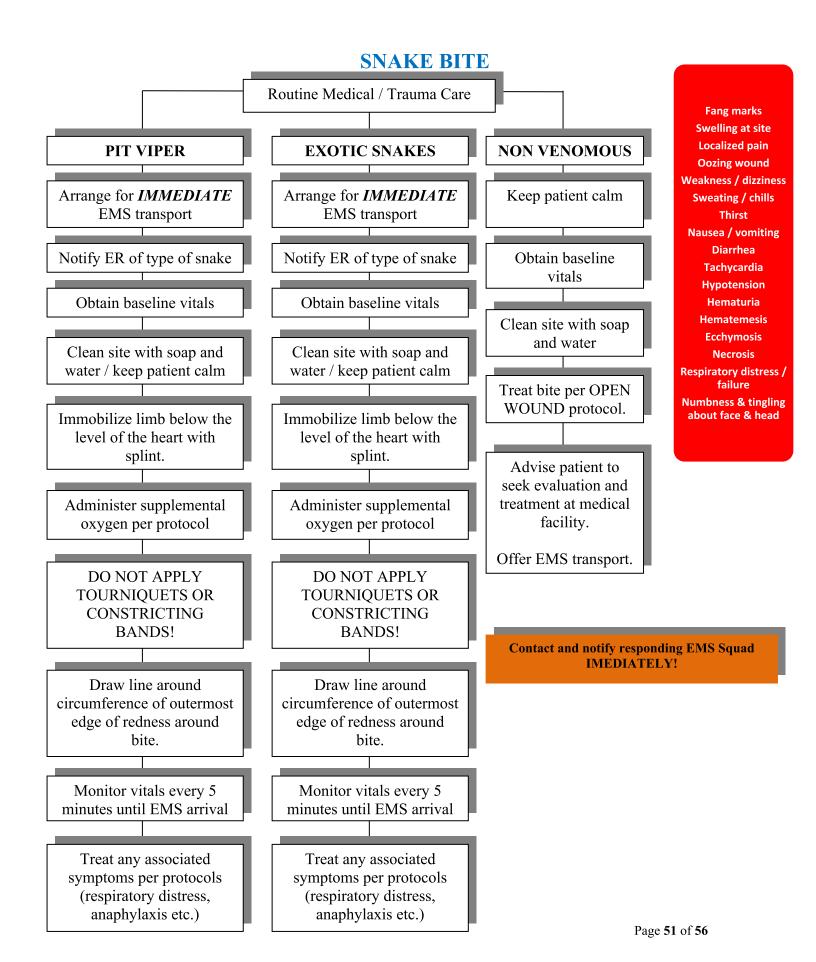
Pelvis Extremities

Obtain baseline vitals.

Perform detailed physical exam and history

Attempt to determine/isolate cause of symptoms

Monitor vitals every 5 minutes until patient is transported by EMS



SOFT-TISSUE INJURIES

Routine Medical / Trauma Care

MINOR CLOSED WOUNDS

- Do focused physical exam
- Identify Mechanism of injury
- Obtain Baseline vital signs
- Apply indirect ice or cold pack on affected area for 10 to 20 minutes.
- Suggest cold compress to area every 2 hours for the next 24 hours.

SEVERE CLOSED WOUNDS

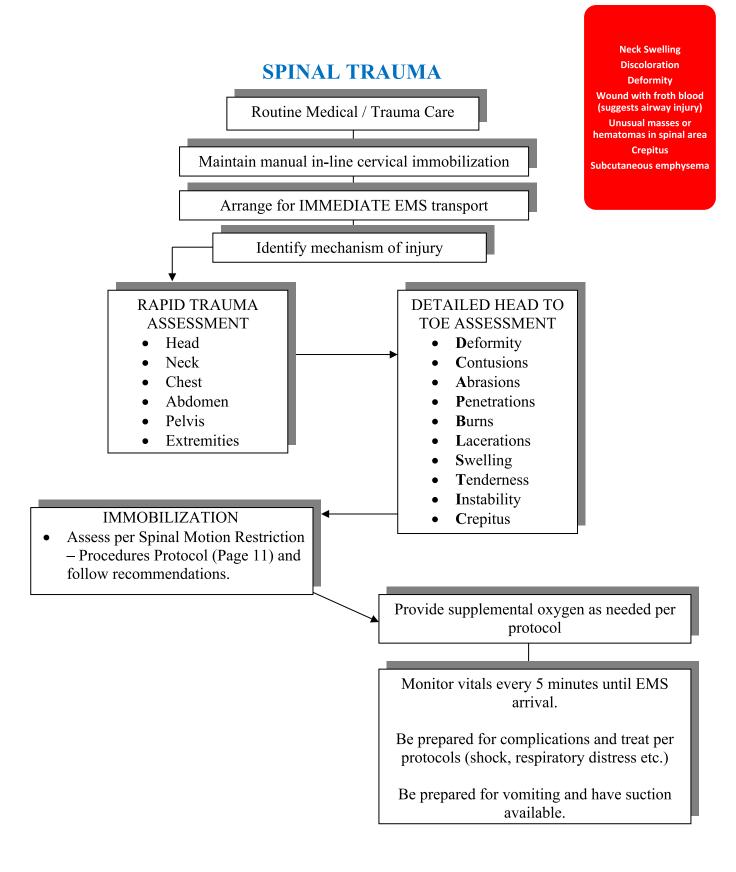
• Refer to INTERNAL HEMMORHAGE protocol

For all severe closed injuries or injuries with significant mechanism of injury arrange IMMEDIATE EMS transport.

Monitor vitals every 15 minutes for stable patients and every 5 minutes for unstable patients until EMS arrival.

Contusions
Hematomas
Crush
Injuries

SPIDER BITES Routine Medical / Trauma Care **BROWN RECLUSE BLACK WIDOW** Treat for severe Treat for severe **Localized pain** Small blister in the symptoms per symptoms per center of a white ring **Redness** (BULLSEYE) protocols protocols **Swelling** Localized pain **Progressive muscle** Redness spasma and cramping **Swelling** Recommend evaluation Recommend evaluation Nausea / Vomiting Tissue necrosis at site and treatment at a and treatment at a **Sweating** Chills medical facility medical facility Fever **Seizures** Nausea / Vomiting **Paralysis Joint Pain** Unresponsiveness Arrange for IMMEDIATE EMS transport for any patient exhibiting severe reaction. Monitor vitals every 15 minutes for stable patients and every 5 minutes for unstable patients until EMS arrival.



SPLINTING PROCEDURES

Splinting SHOULD NOT take priority over life threatening conditions.

Obvious fractures
Dislocations

Stabilize the injured limb manually.

Assess distal pulses, motor function and sensation. If pulses are absent, apply gentle in-line traction to the extremity to return the pulse.

Re-assess pulse, motor function and sensation after applying traction and every 5 minutes thereafter.

In some fractures, it may be necessary to splint them in the position they are found. In general, if pulses, motor function and sensation are intact, splint the extremity as it is found.

Splinting Recommendations

The following splints are recommended for the following situations. As every situation is different, splints may have to be improvised or adapted to achieve good immobilization.

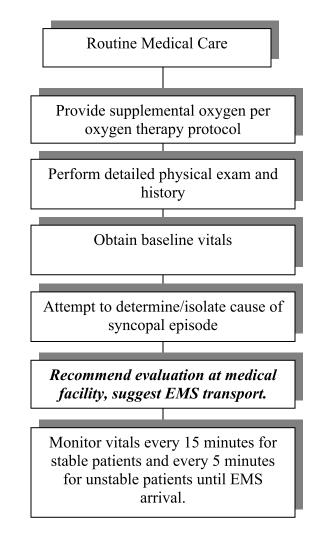
- Clavicle Sling and Swathe
- Radius / Ulna Arm board or SAM splint
- Tibia / Fibula Board splint or SAM splint
- Ankle Pillow wrap or SAM splint
- Any Joints Splint in position found with pillow wrap or SAM splints
- Hand In position of function, kling roll in palm with ACE wrap or SAM splint
- Hip Pillow wrap, inverted KED technique, LSB to facilitate movement
- Fingers Tong splint with tongue depressors or buddy taping

ALWAYS assess and document distal pulse, motor function and sensation before and after splinting.

SYNCOPE

A brief lapse in consciousness caused by transient cerebral hypoxia.

Palor
Dizziness
Numbness/tingling
in extremities
Nausea
Diaphoresis



If patient refuses EMS transport, advise them not to drive until evaluated by a physician and document recommendation.