EMS REGION XI CHICAGO

BLS/EMT-B

STANDING MEDICAL ORDERS

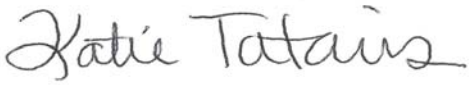
REGION XI - CHICAGO EMS SYSTEM
BLS STANDING MEDICAL ORDERS

These Standing Medical Orders (SMOs) have been developed and approved through a collaborative process involving the four EMS Systems of EMS/Trauma Region XI.

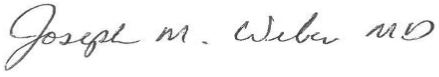
The following SMOs are to be utilized as the pre-hospital medical treatment guidelines by the system's EMT-B. It is understood that deviations from the SMOs may be necessary in the interest of assuring that a patient is transported to an appropriate medical facility rather than receive no care at all.

Eddie Markul, M.D.
EMS Medical Director
Advocate Illinois Masonic Medical Center
Chicago, IL

Kenneth Pearlman, M.D.
EMS Medical Director
Northwestern Memorial Hospital
Chicago, IL



Katie Tataris, M.D., MPH
EMS Medical Director
University of Chicago Medical Center
Chicago, IL



Joseph Weber, M.D.
EMS Medical Director
John H. Stroger, Jr. Hospital of Cook County
Chicago, IL

Written : 12/00
Reviewed: 3/00; 6/02; 2/03; 3/09; 5/11; 5/12; 4/13; 11/14; 2/15; 10/15
Revised: 3/00; 2/03; 3/09; 5/11; 5/12; 8/13; 11/14; 2/15; 10/15

BLS STANDING MEDICAL ORDERS

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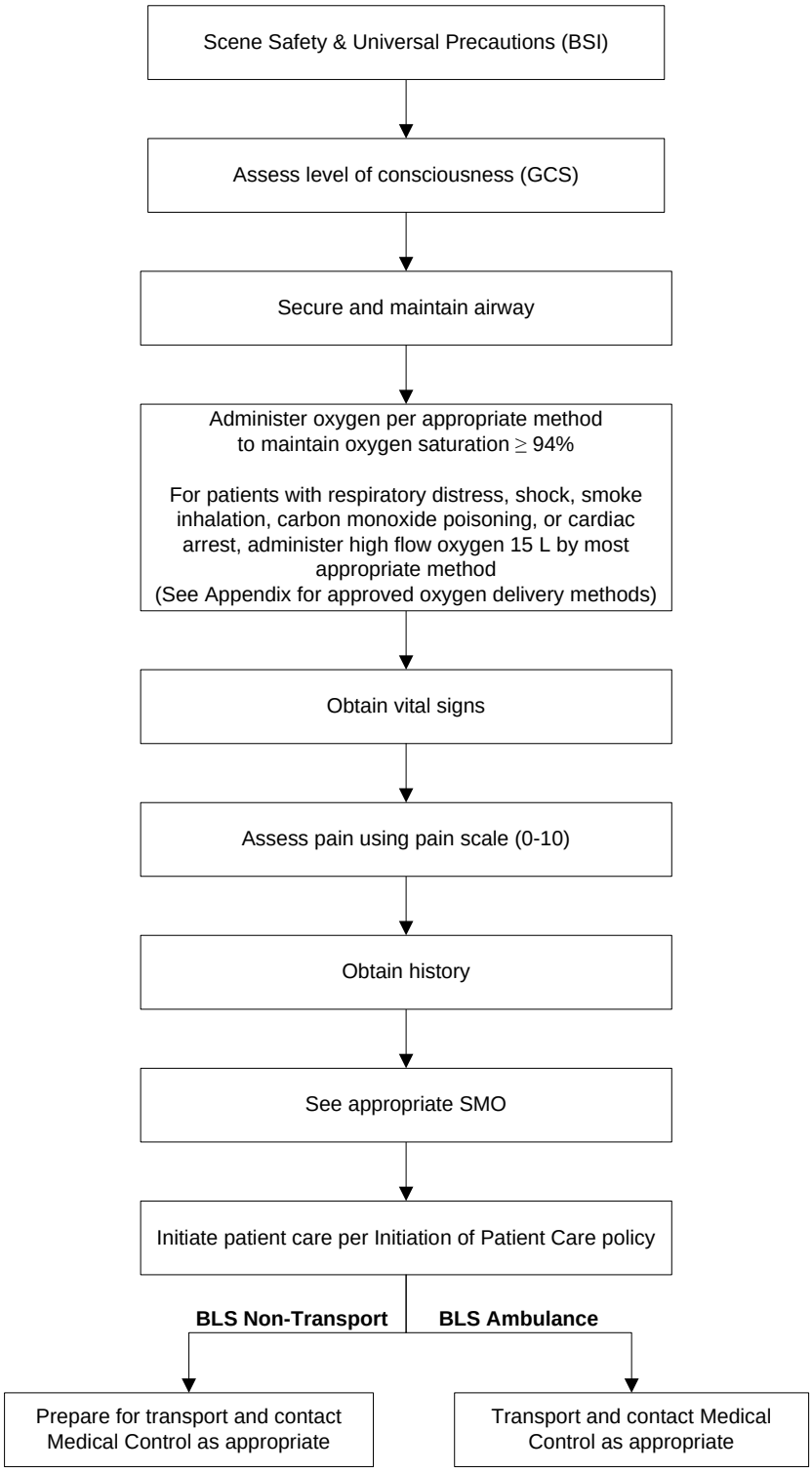
GENERAL

Routine Medical Care (RMC) A-1

ROUTINE MEDICAL CARE (RMC) - BLS



Written: 12/99
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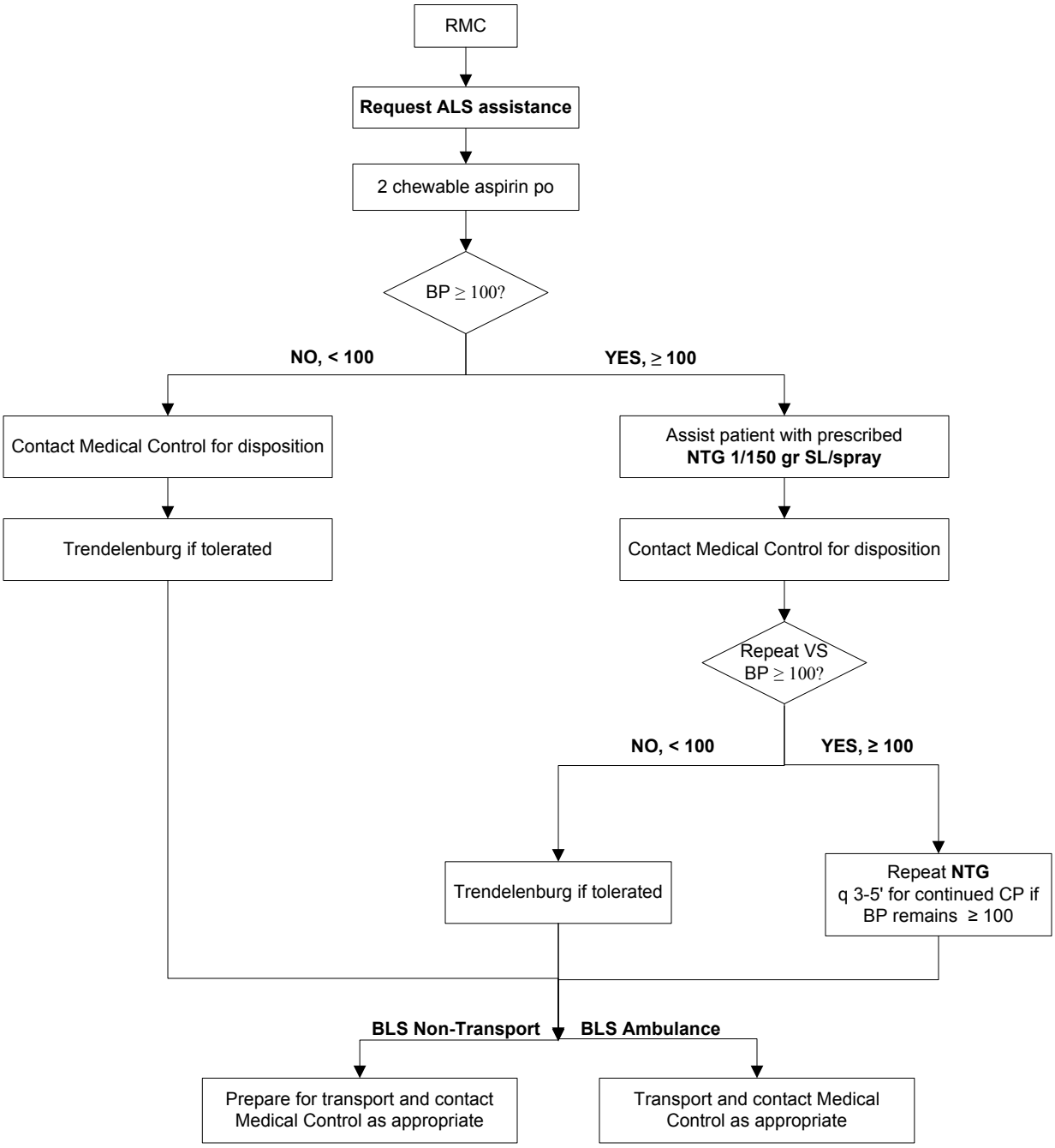
IDPH Approval: 3/5/10; 2/25/16
Implementation: CFD BLS 5/00; Other 8/00; 1/1/11; 3/1/16

CARDIAC

CARDIAC CHEST PAIN - BLS



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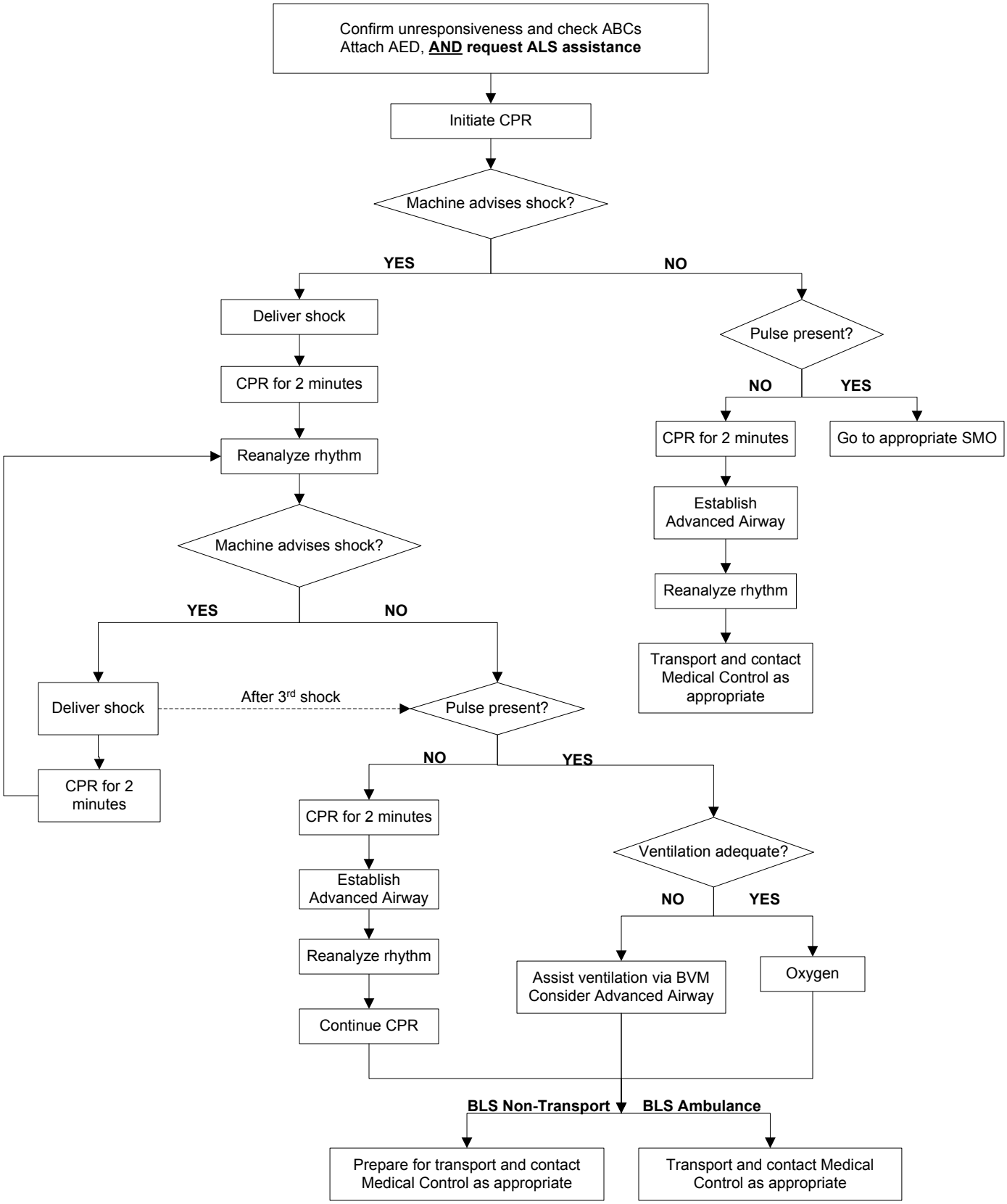
IDPH Approval: 3/5/10
Implementation: CFD BLS 5/00; Other 8/00; 1/1/11

CARDIAC ARREST - BLS



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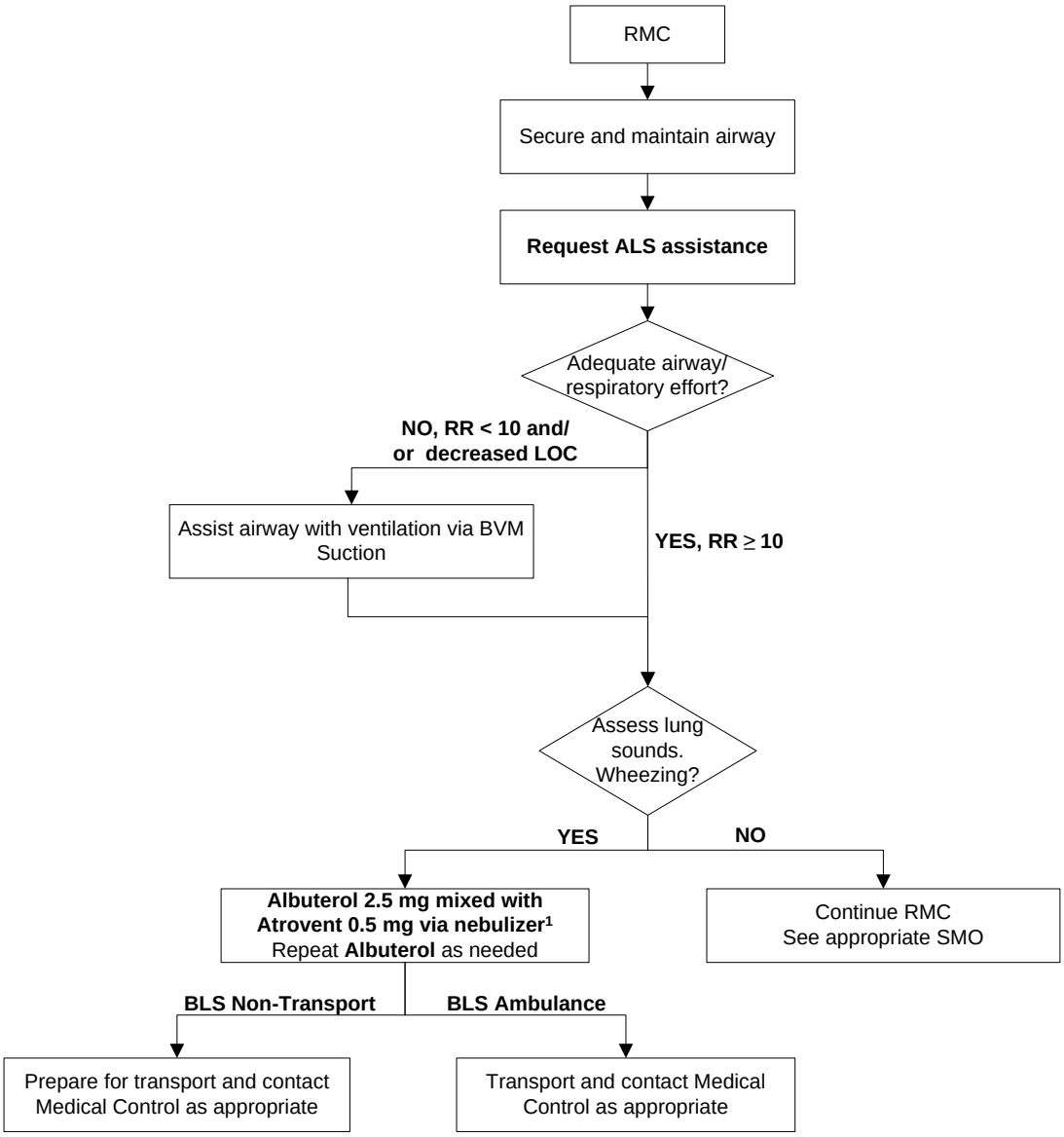
MDC Approval: 1/00; 3/00; 4/7/09; 6/7/11
IDPH Approval: 9/04; 3/5/10; 9/29/11
Implementation: CFD BLS 5/00; Other 8/00; 1/1/05; 1/11/11; 4/1/12

RESPIRATORY

RESPIRATORY DISTRESS - BLS



1 – If available

NOTE: Complete lack of breath sounds may indicate severe bronchoconstriction

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Reviewed: 3/00; 12/01; 3/09; 6/11
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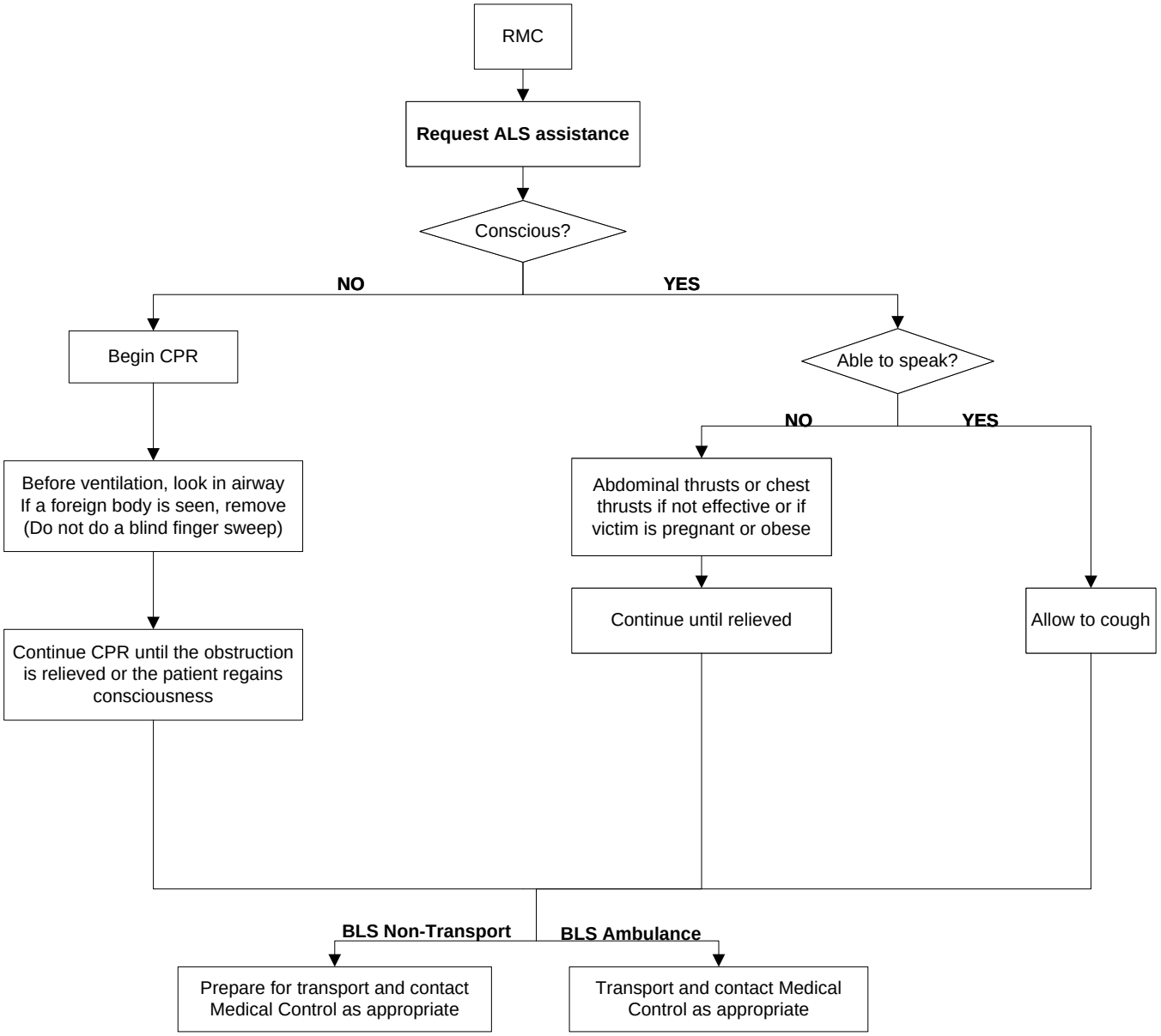
IDPH Approval: 5/02; 3/5/10; 9/29/11
Implementation: CFD BLS 5/00; Other 8/00; 1/1/03; 1/1/11; 4/1/12

RESPIRATORY OBSTRUCTION - BLS



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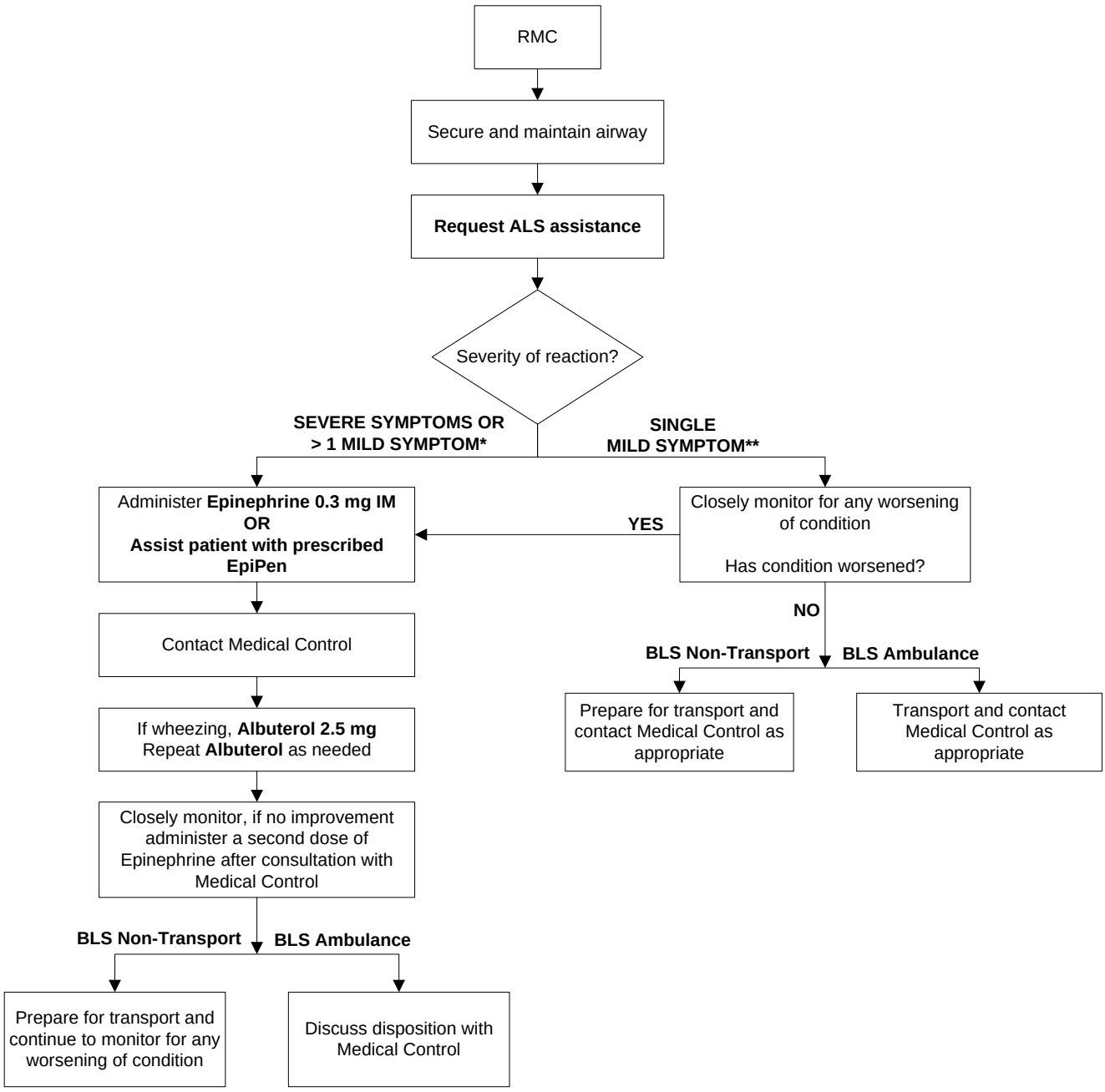
MDC Approval: 1/00; 3/00; 4/7/09; 5/30/12; 10/5/15
IDPH Approval: 3/5/10; 1/31/13; 2/25/16
Implementation: CFD BLS 5/00; Other 8/00; 1/1/11; 2/1/13; 3/1/16

ALLERGIC REACTION and/or ANAPHYLAXIS - BLS



***Severe symptoms of an allergic reaction may include any combination of the following:**

RESPIRATORY – Shortness of breath, wheezing, repetitive coughing
CARDIOVASCULAR – Pale, cyanotic, low blood pressure, dizzy
THROAT – Tightness, hoarse, trouble breathing/swallowing
MOUTH – Swelling of the tongue and/or lips
SKIN- Diffuse hives or redness
GI – Repetitive vomiting, severe diarrhea
NEURO – Anxiety, confusion, sense of doom

****Mild symptoms of an allergic reaction may include any combination of the following:**

NOSE – Itchy/runny nose, sneezing
MOUTH – Itching
SKIN- Few hives, mild itching
GI – Mild nausea/discomfort

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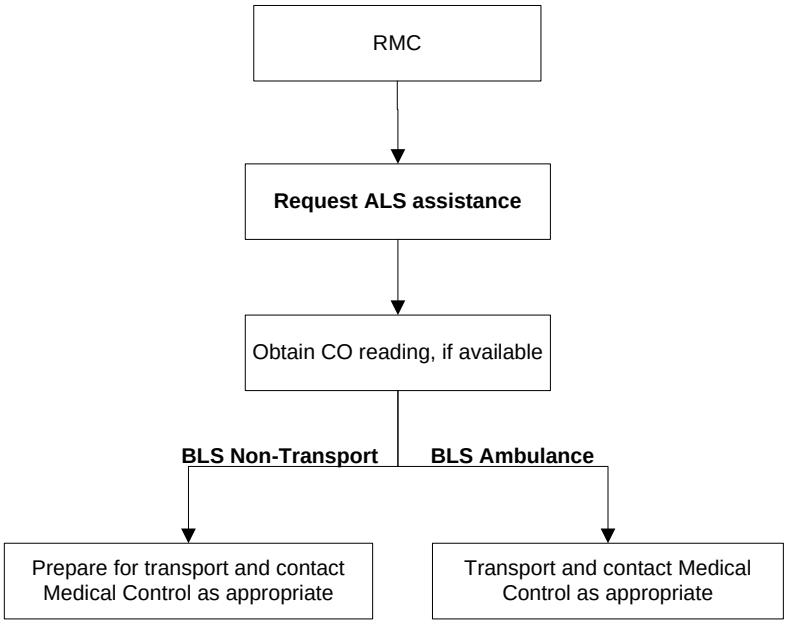
IDPH Approval: 3/5/10; 1/28/14; 1/12/17
Implementation: 1/1/11; 6/1/14; 4/1/17

SUSPECTED CARBON MONOXIDE POISONING - BLS



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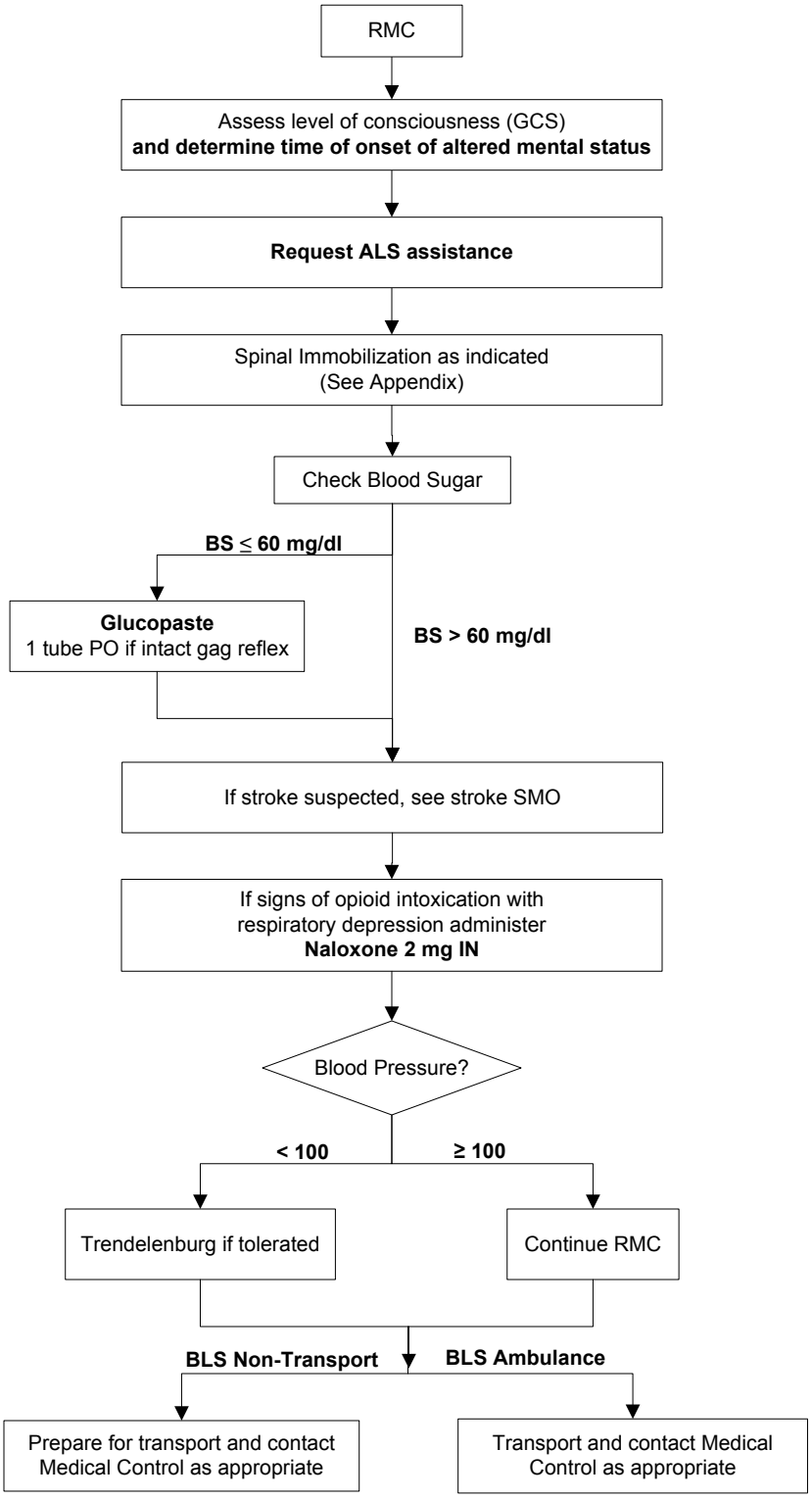
MDC Approval: 4/7/09; 6/7/11; 10/6/15
IDPH Approval: 3/5/10; 9/29/11; 2/25/16
Implementation: 1/1/11; 4/1/12; 3/1/16

MEDICAL

ALTERED MENTAL STATUS - BLS



Written: 1/09 Replaces Decreased Level of Consciousness SMO
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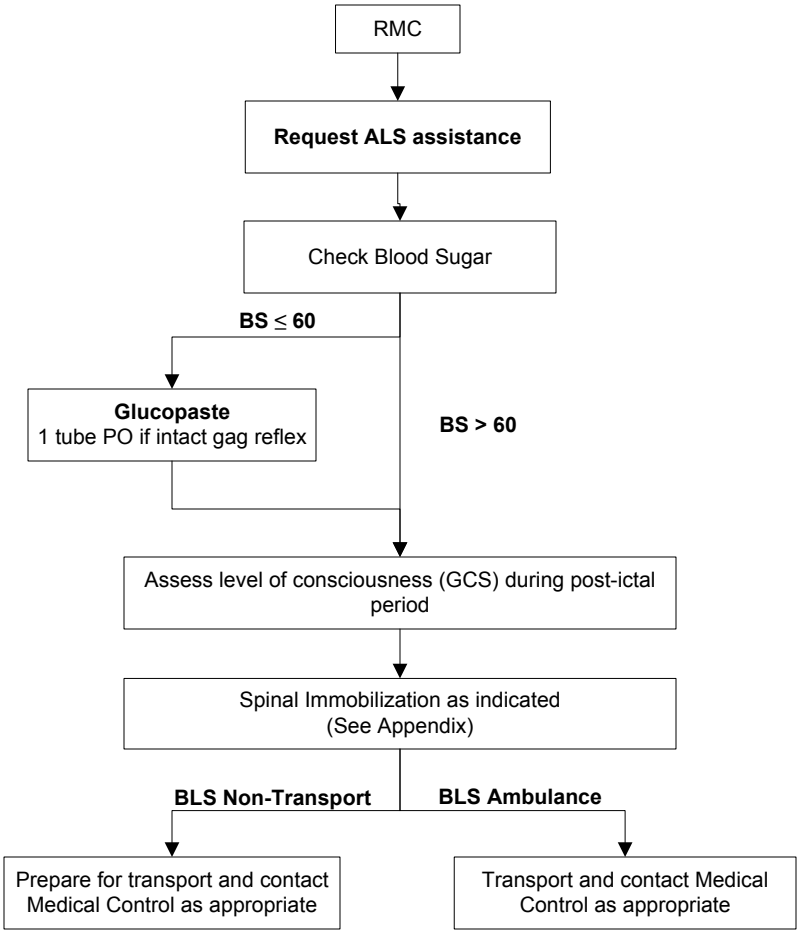
MDC Approval: 4/7/09; 6/1/10; 6/7/16
IDPH Approval: 3/5/10; 11/24/10; 8/11/16
Implementation: 1/1/11; 3/1/11; 10/17/16

SEIZURES - BLS



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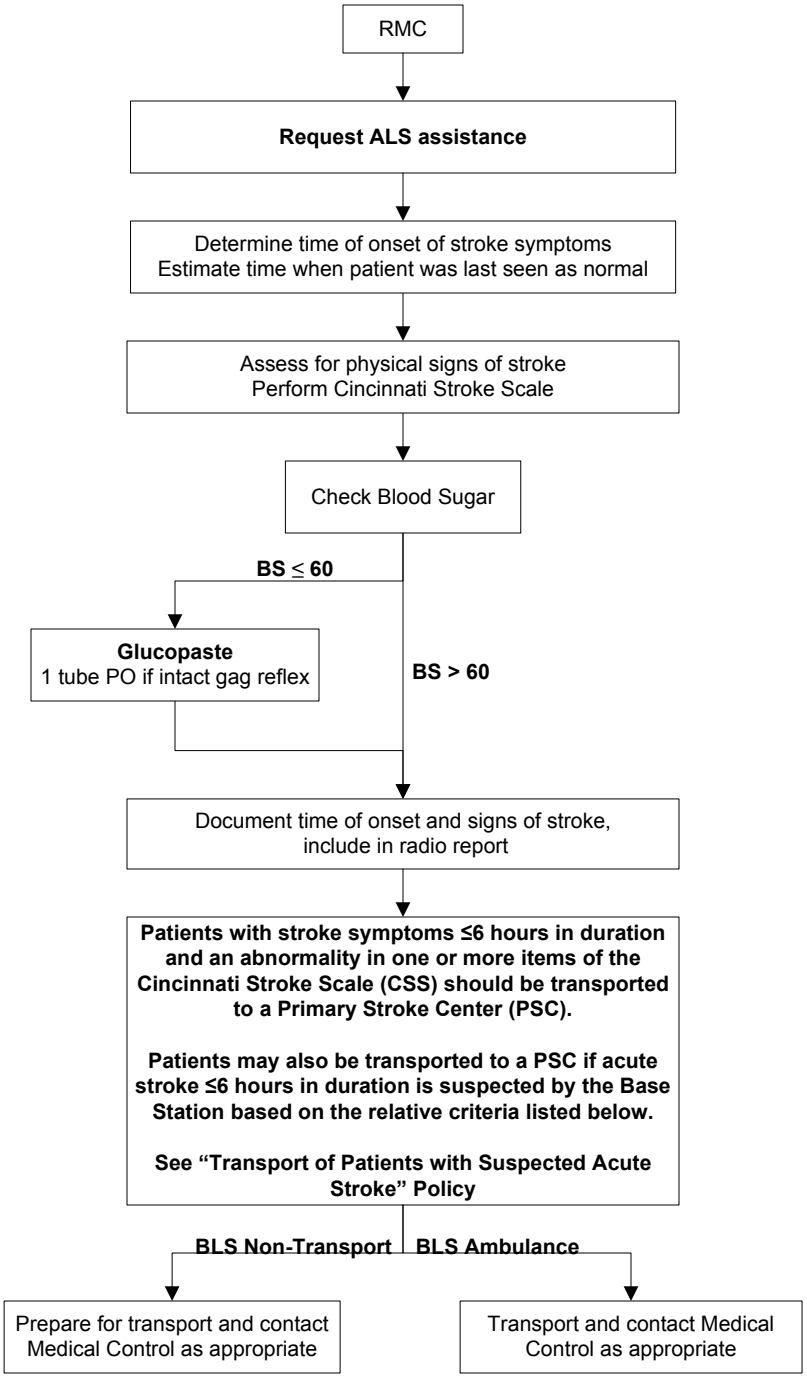
Implementation: CFD BLS 5/00; Other 8/00; 1/1/11

SUSPECTED ACUTE STROKE - BLS



Relative Criteria

Patients with a negative or unattainable CSS may be transported to a PSC if acute stroke ≤6 hours in duration is suspected by the Base Station based on any of the following:

- Sudden and persistent alteration of consciousness
- Sudden onset severe headache (especially in association with vomiting +/- systolic BP >200)
- Severe and sudden loss of balance

Cincinnati Stroke Scale (CSS) (for responsive patient):

1. **Facial droop** – have patient show teeth or smile
   Abnormal = one side does not move as the other
2. **Arm Drift** – have patient close eyes and hold arms out for 10 seconds with palms up
   Abnormal = one arm does not move or drifts down
3. **Abnormal speech** – have patient say, "You can't teach an old dog new tricks"
   Abnormal = patient slurs words, uses wrong words or is unable to speak

Positive CSS = One or more of the above items are abnormal

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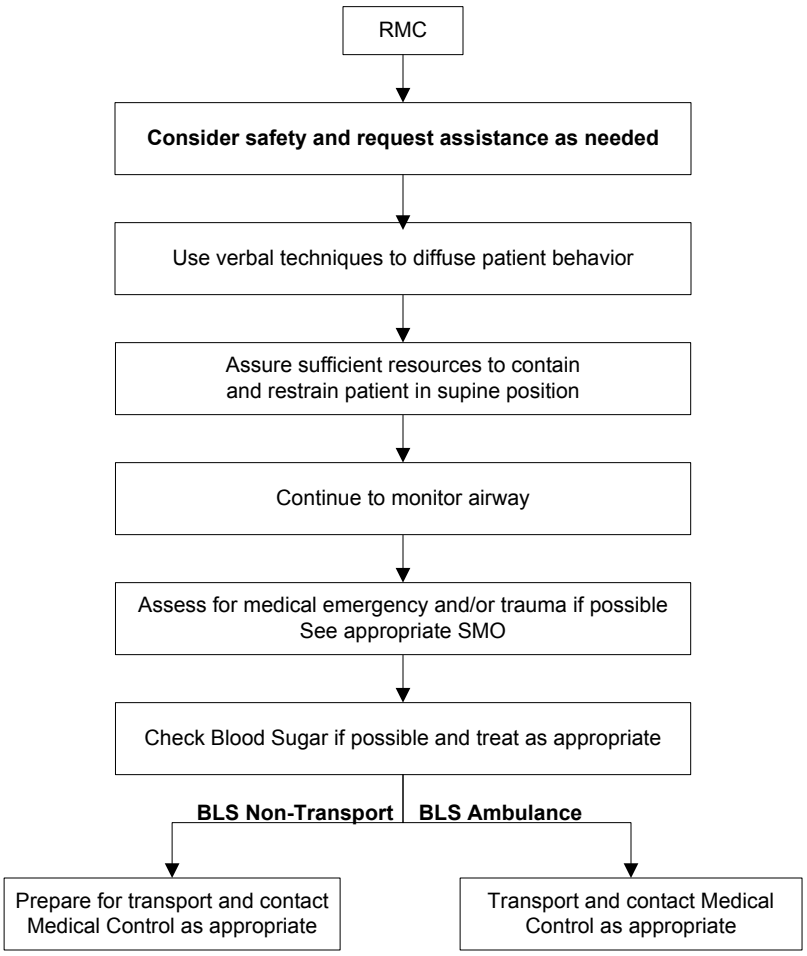
Implementation: 1/1/03; 1/1/11; 3/1/11

BEHAVIORAL EMERGENCY - BLS



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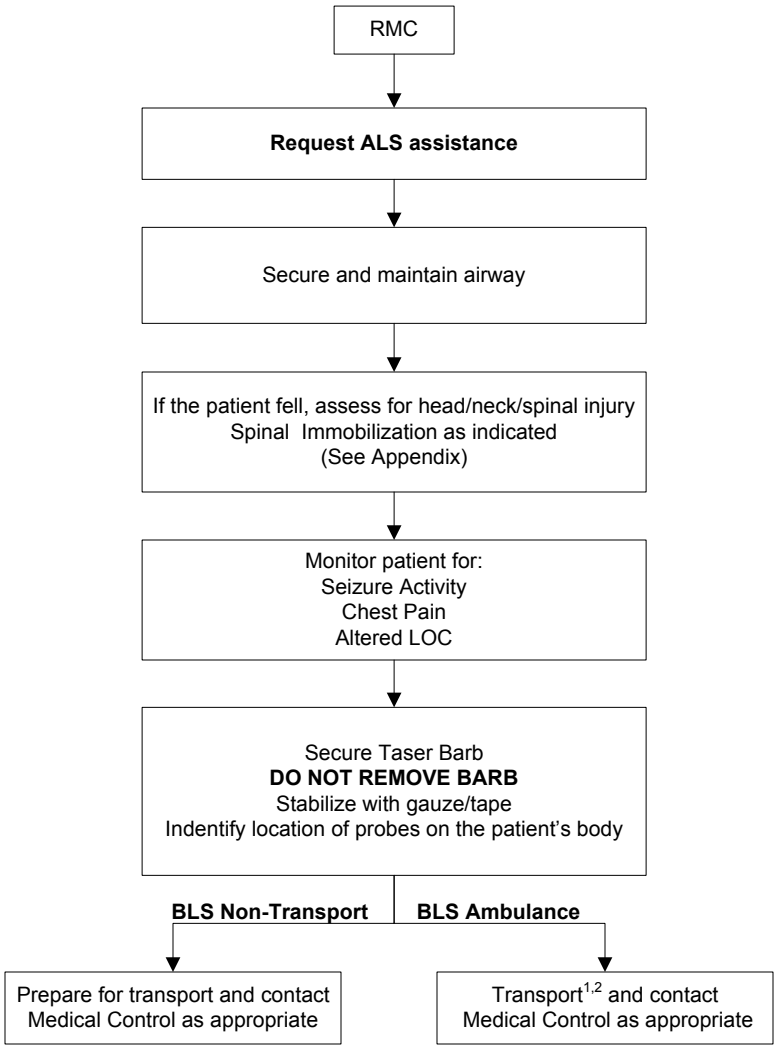
Revised: 3/09
MDC Approval: 4/7/09
IDPH Approval: 3/5/10
Implementation: 1/1/11

TASER / ELECTRICAL WEAPON DEVICE EXPOSURE – BLS

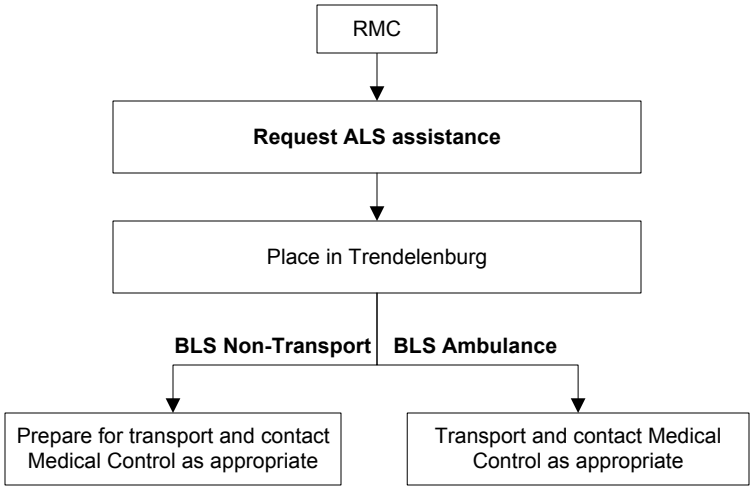
Note: This protocol is to be used for patients who have been subdued by the use of any conductive electrical weapon device (e.g. TASER)



1 – Patient will be transported to the closest comprehensive Emergency Department.
2 – Patients who are in police custody must be accompanied to the hospital by appropriate law enforcement personnel.

Written: 2/09
Reviewed: 3/09; 5/11; 10/15
Revised: 3/09; 10/15
MDC Approval: 4/7/09; 11/17/15
IDPH Approval: 3/5/10; 2/25/16
Implementation: 1/1/11; 3/1/16

NON-CARDIOGENIC / NON-TRAUMATIC SHOCK - BLS



Written: 1/09
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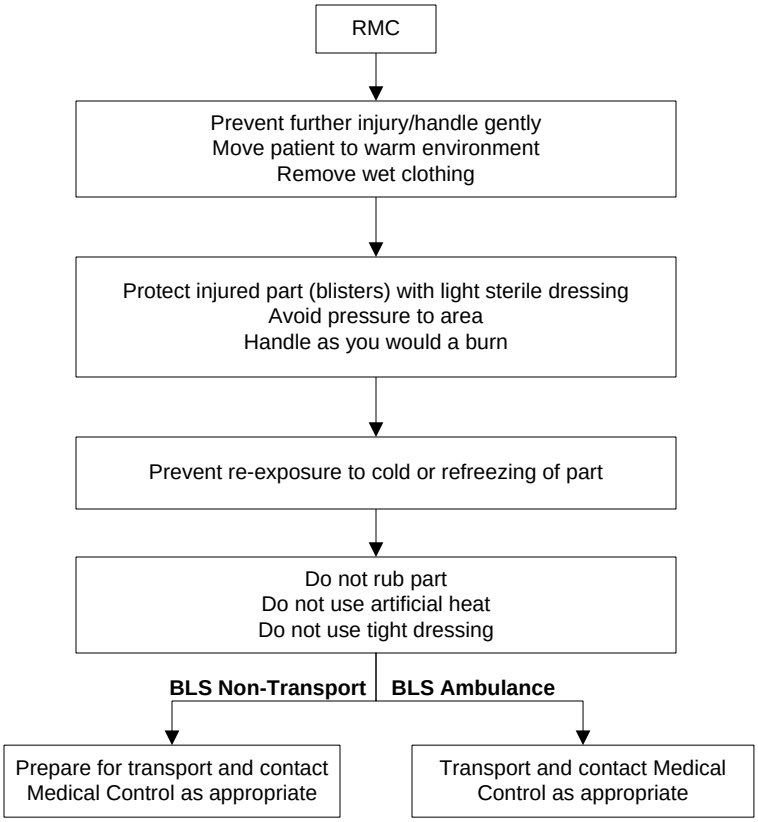
Revised: 3/09; 10/15
MDC Approval: 4/7/09; 10/6/15
IDPH Approval: 3/5/10; 2/25/16
Implementation: 1/1/11; 3/1/16

ENVIRONMENTAL

FROSTBITE - BLS



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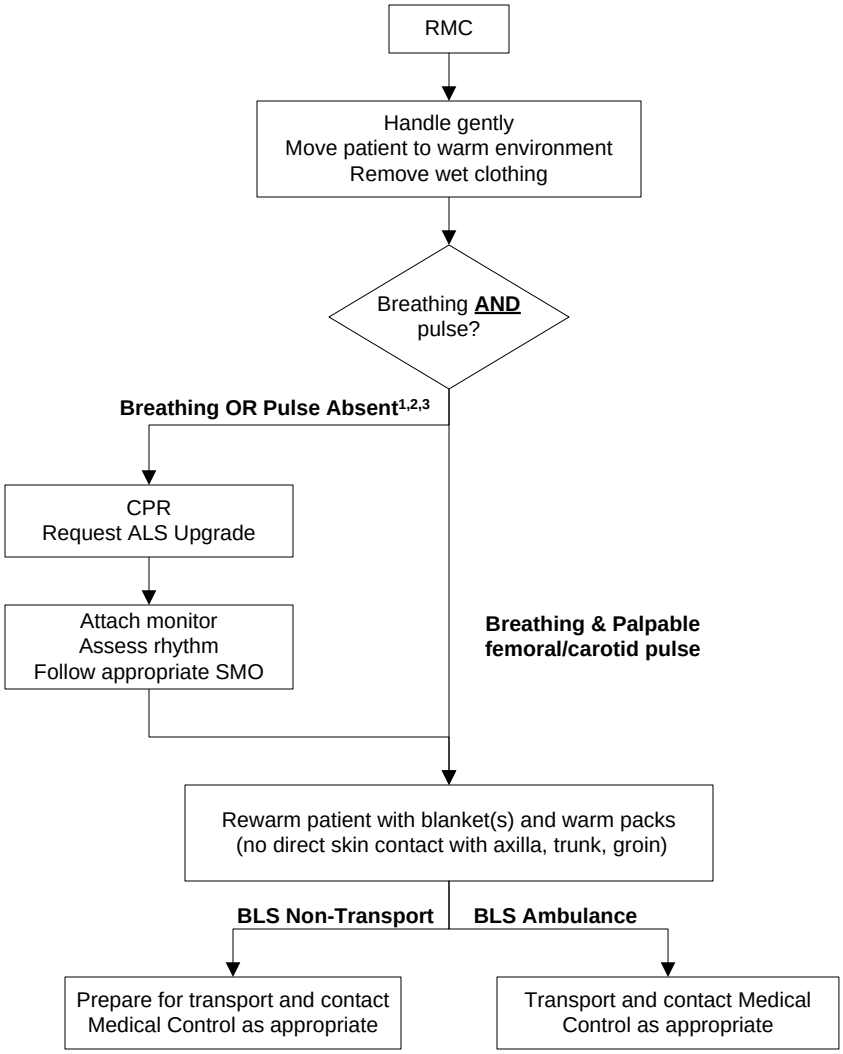
MDC Approval: 1/00; 3/00; 4/7/09
IDPH Approval: 3/5/10
Implementation: CFD BLS 5/00; Other 8/00; 1/1/11

HYPOTHERMIA - BLS



1 - May present with altered sensorium or unconscious. Heart more susceptible to dysrhythmias. May have apnea, dusky or cyanotic appearance, fixed and dilated pupils; may appear without signs of life.
2 – An individual in a frozen state is not considered salvageable.
3 – The suspected hypothermic patient shall never be declared dead in the field.

Written: 12/99
Reviewed: 3/00; 3/09; 5/11
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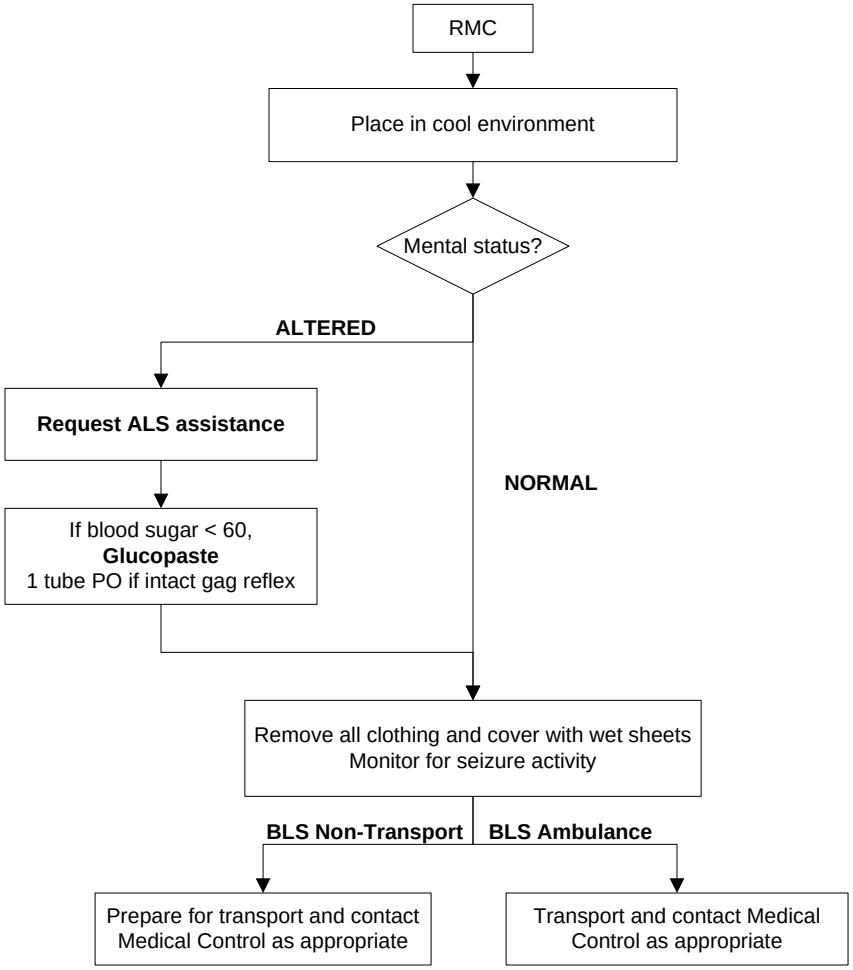
IDPH Approval: 3/5/10; 9/29/11
Implementation: CFD BLS 5/00; Other 8/00; 1/1/11; 4/1/12

HEAT ILLNESS - BLS



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MDC Approval: 1/00; 3/00; 4/7/09
IDPH Approval: 3/5/10
Implementation: CFD BLS 5/00; Other 8/00; 1/1/11

BURNS - BLS

RMC

Assess singed facial hair, hoarseness, wheezing, cough or stridor

Airway compromise?

YES

Secure airway
Consider advanced airway
Request ALS assistance

NO

Remove clothing
Clothing should be cut, not pulled off
Smoldering clothing should be extinguished with water
Remove all accessories and jewelry
Do not attempt to cool patient

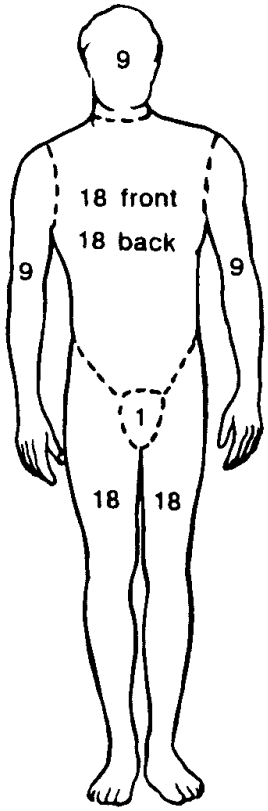
Estimate BSA

Cover with dry dressings or sheet

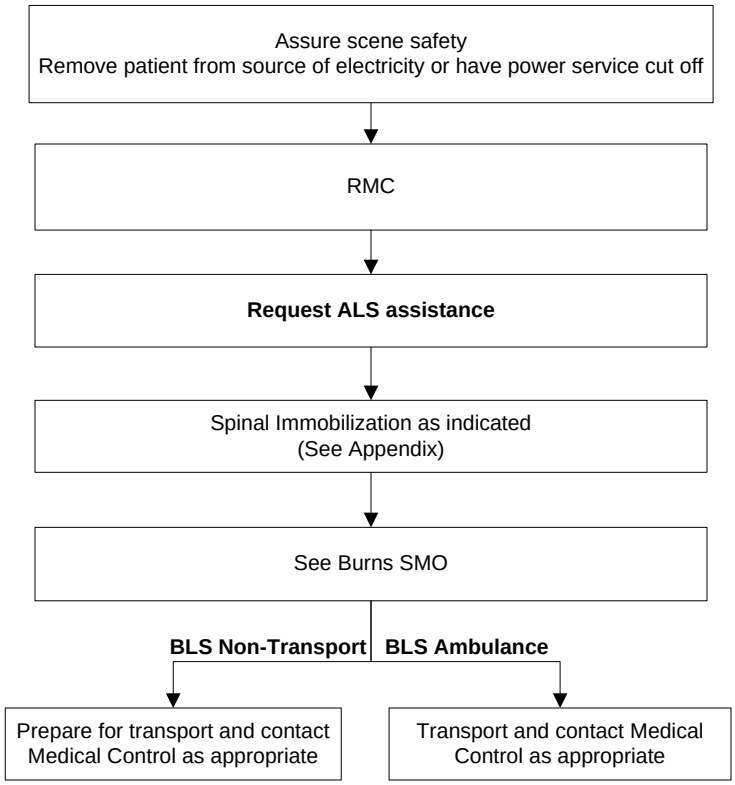
BLS Non-Transport **BLS Ambulance**

Prepare for transport and contact Medical Control as appropriate

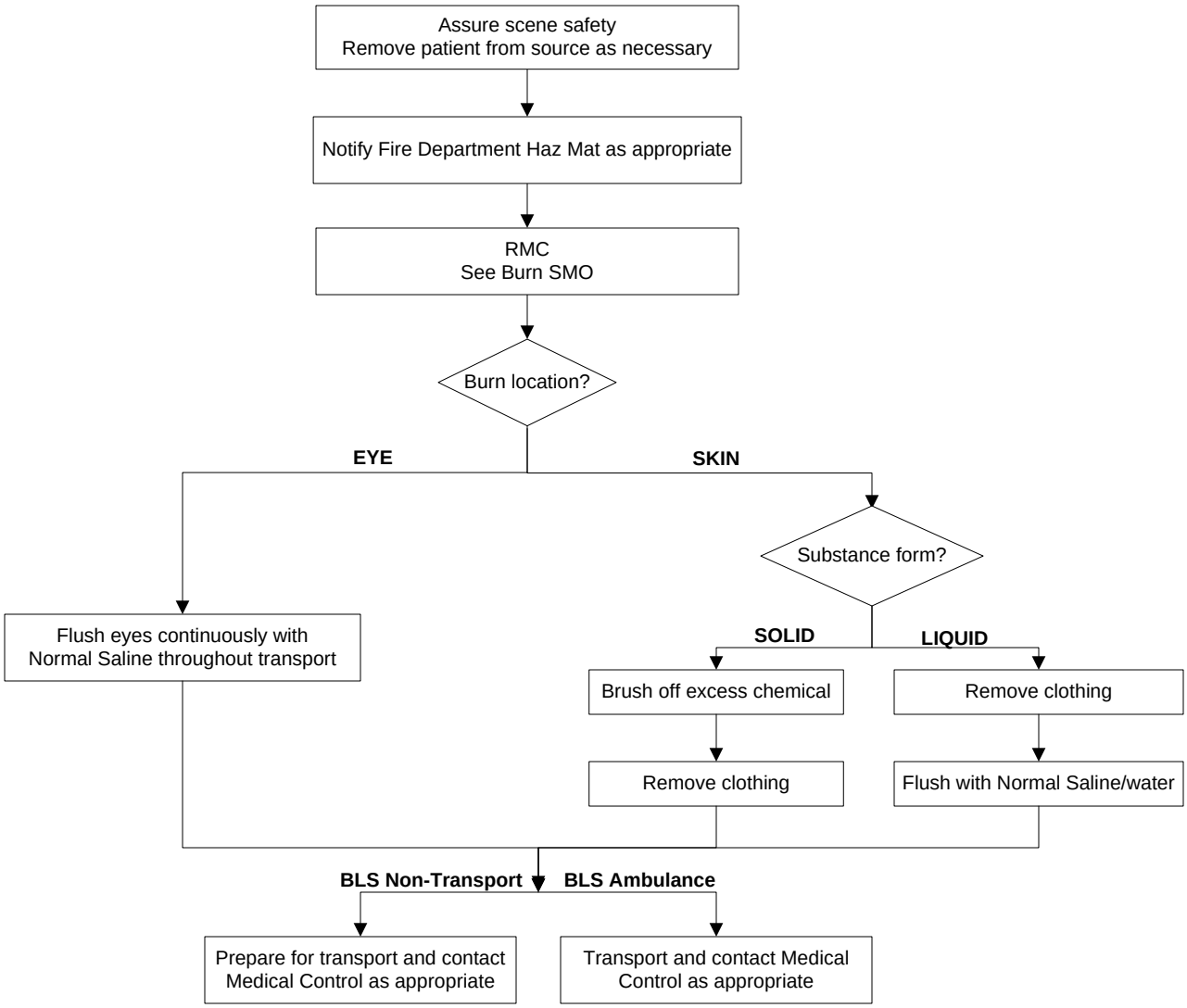
Transport and contact Medical Control as appropriate



ELECTRICAL BURNS - BLS



CHEMICAL BURNS - BLS



*** All efforts should be made to decontaminate the patient prior to transport, as appropriate per HazMat team.**

Written: 12/99
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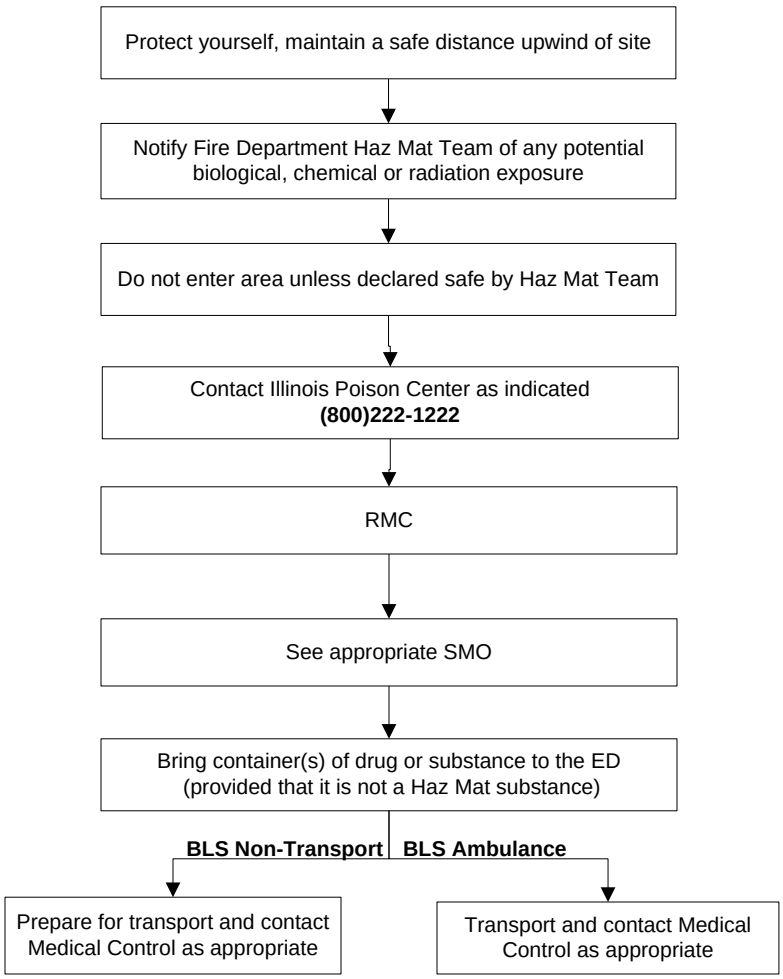
Implementation: CFD BLS 5/00; Other 8/00; 1/1/11; 4/1/12

HAZ MAT / TOXIC EXPOSURE - BLS



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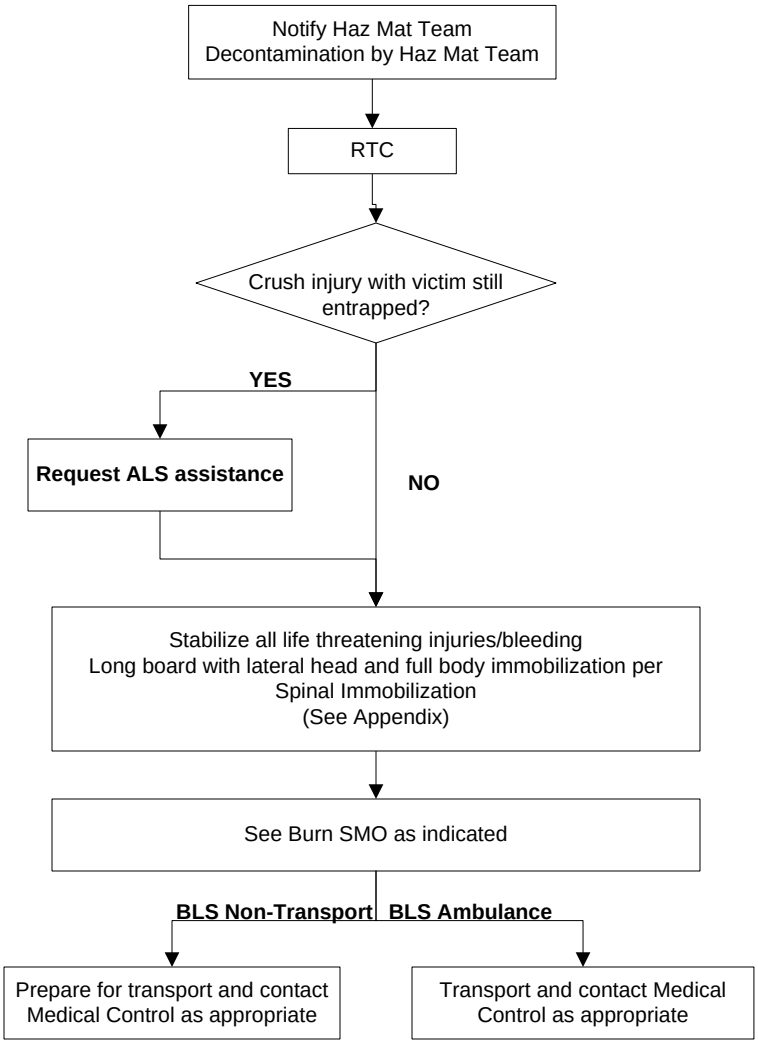
IDPH Approval: 3/5/10; 9/29/11
Implementation: CFD BLS 5/00; Other 8/00; 1/1/11; 4/1/12

HAZARDOUS EVENTS / NUCLEAR/BLAST INJURIES - BLS



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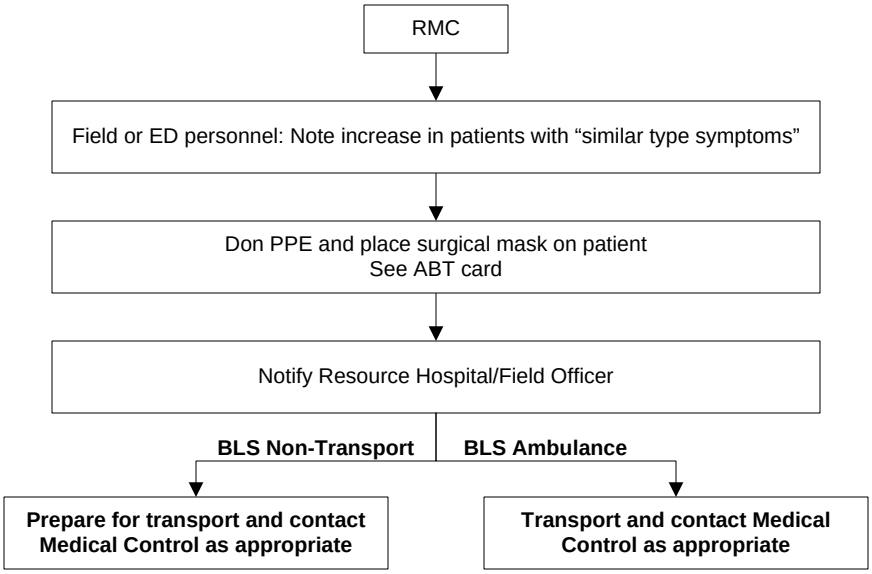
HAZARDOUS EVENTS / SUSPECTED BIOLOGICAL - BLS



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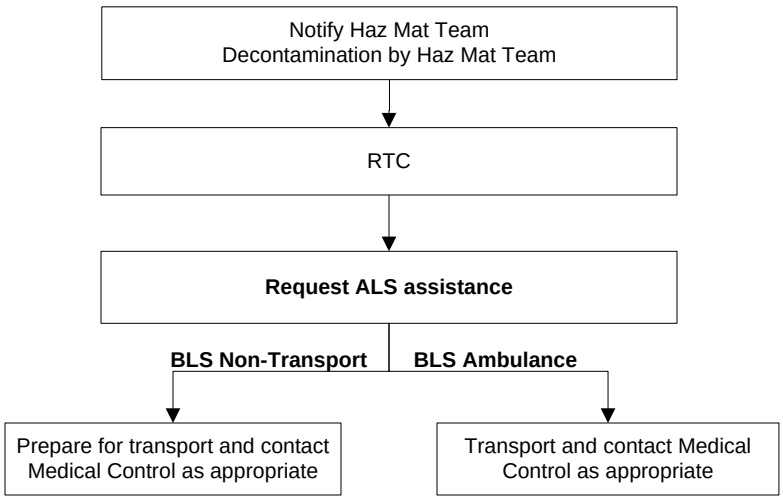
HAZARDOUS EVENTS / CHEMICAL - BLS



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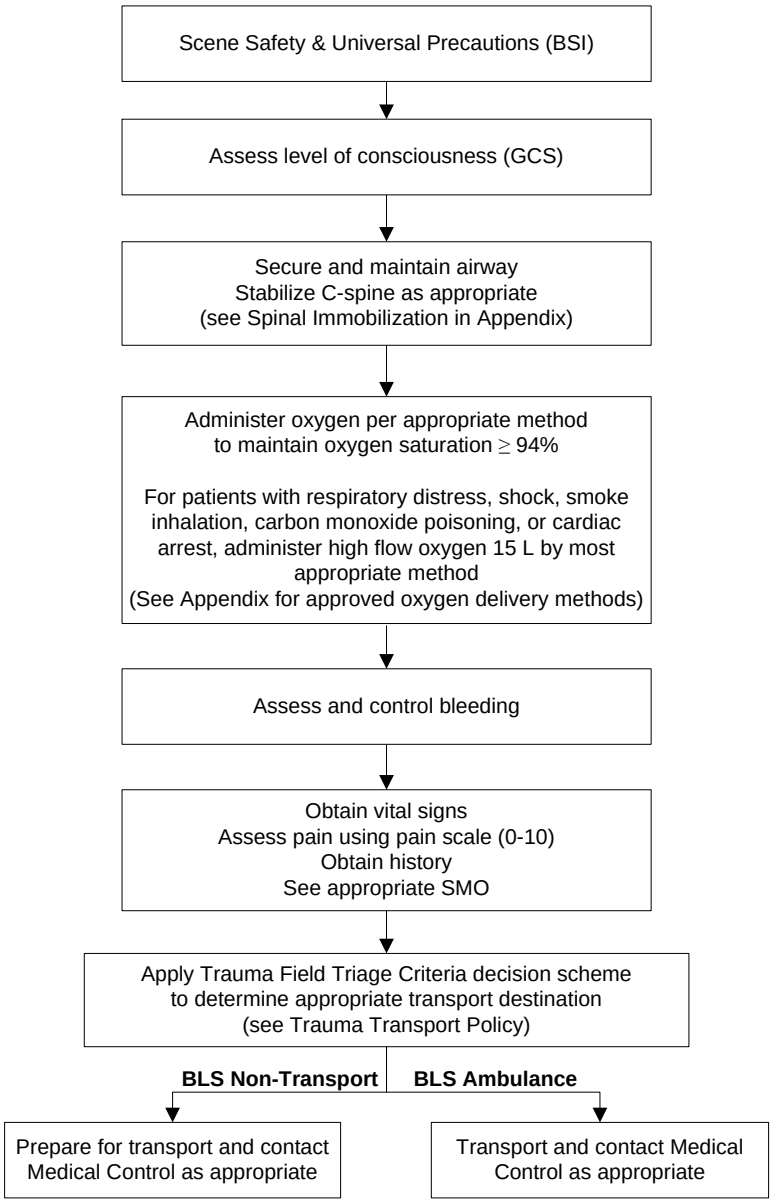
IDPH Approval: 3/5/10; 9/29/11
Implementation: 1/1/11; 4/1/12

TRAUMA

ROUTINE TRAUMA CARE (RTC) - BLS



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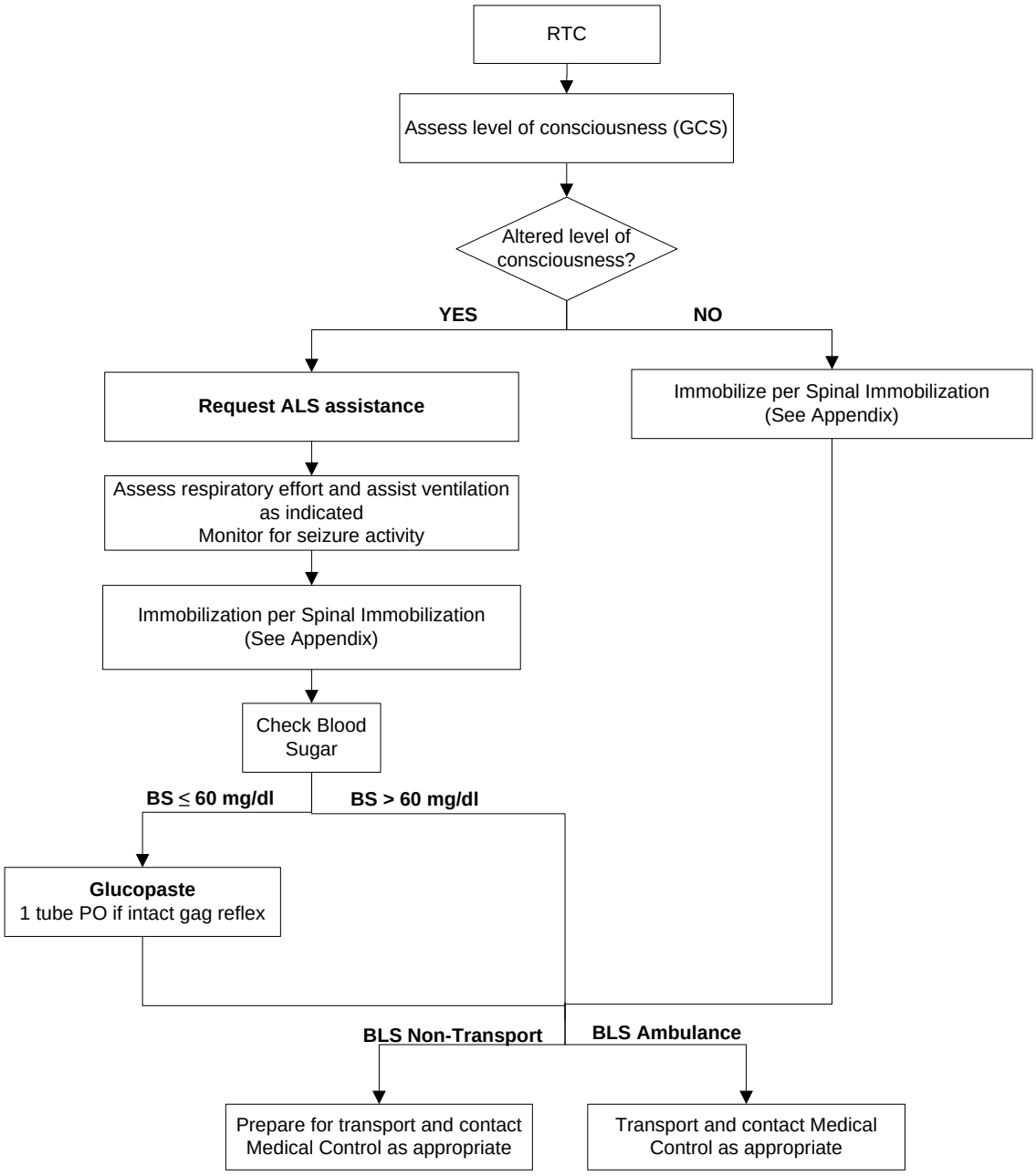
Revised: 3/00; 3/09; 5/11; 10/15
MDC Approval: 1/00; 3/00; 4/7/09; 6/7/11; 10/6/15
IDPH Approval: 3/5/10; 9/29/11; 2/25/16
Implementation: CFD BLS 5/00; Other 8/00; 1/1/11; 4/1/12; 3/1/16

HEAD TRAUMA - BLS



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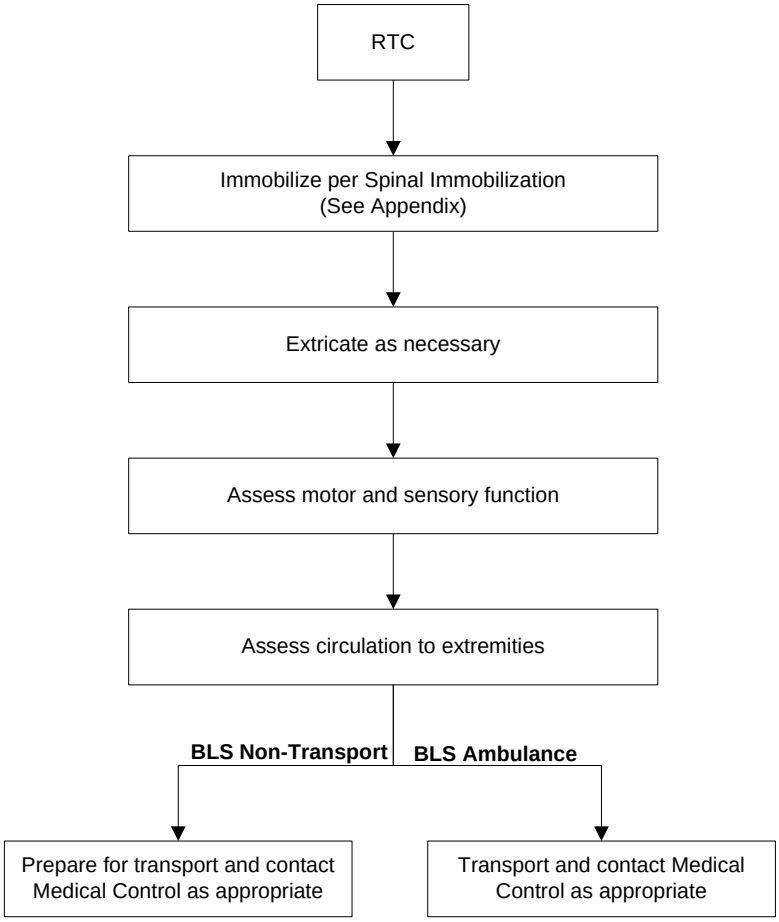
IDPH Approval: 3/5/10; 2/26/16
Implementation: 1/1/11; 3/1/16

SPINAL TRAUMA - BLS



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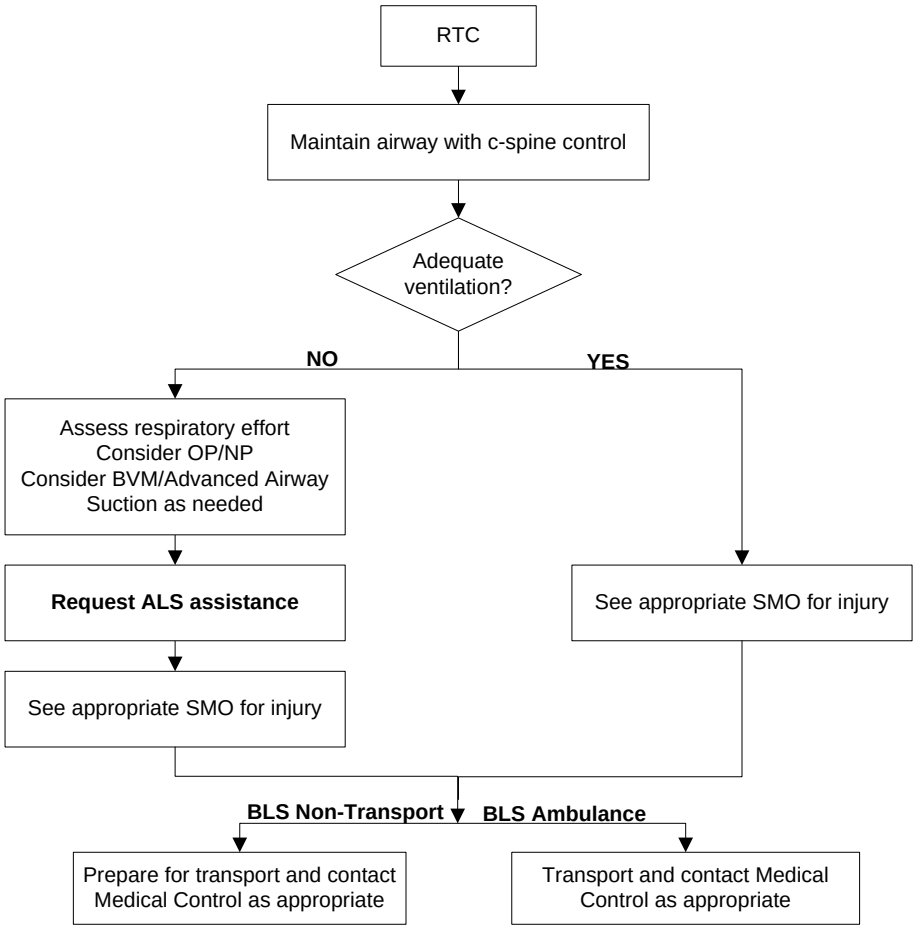
IDPH Approval: 3/5/10
Implementation: CFD BLS 5/00; Other 8/00; 1/1/11

TRAUMA AIRWAY - BLS



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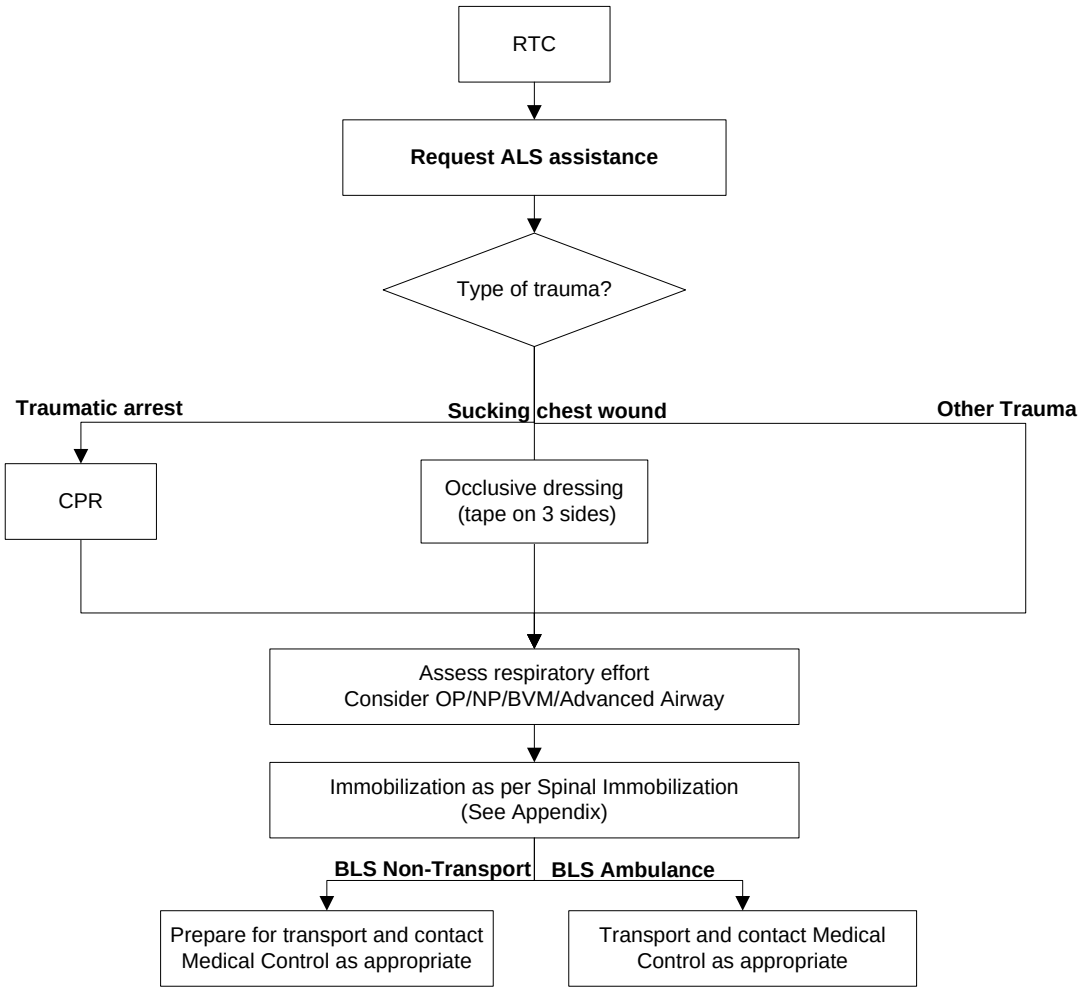
Revised: 3/09; 5/11
MDC Approval: 4/7/09; 6/7/11
IDPH Approval: 3/5/10; 9/29/11
Implementation: 1/1/11; 4/1/12

CHEST TRAUMA - BLS



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Revised: 3/09; 5/11
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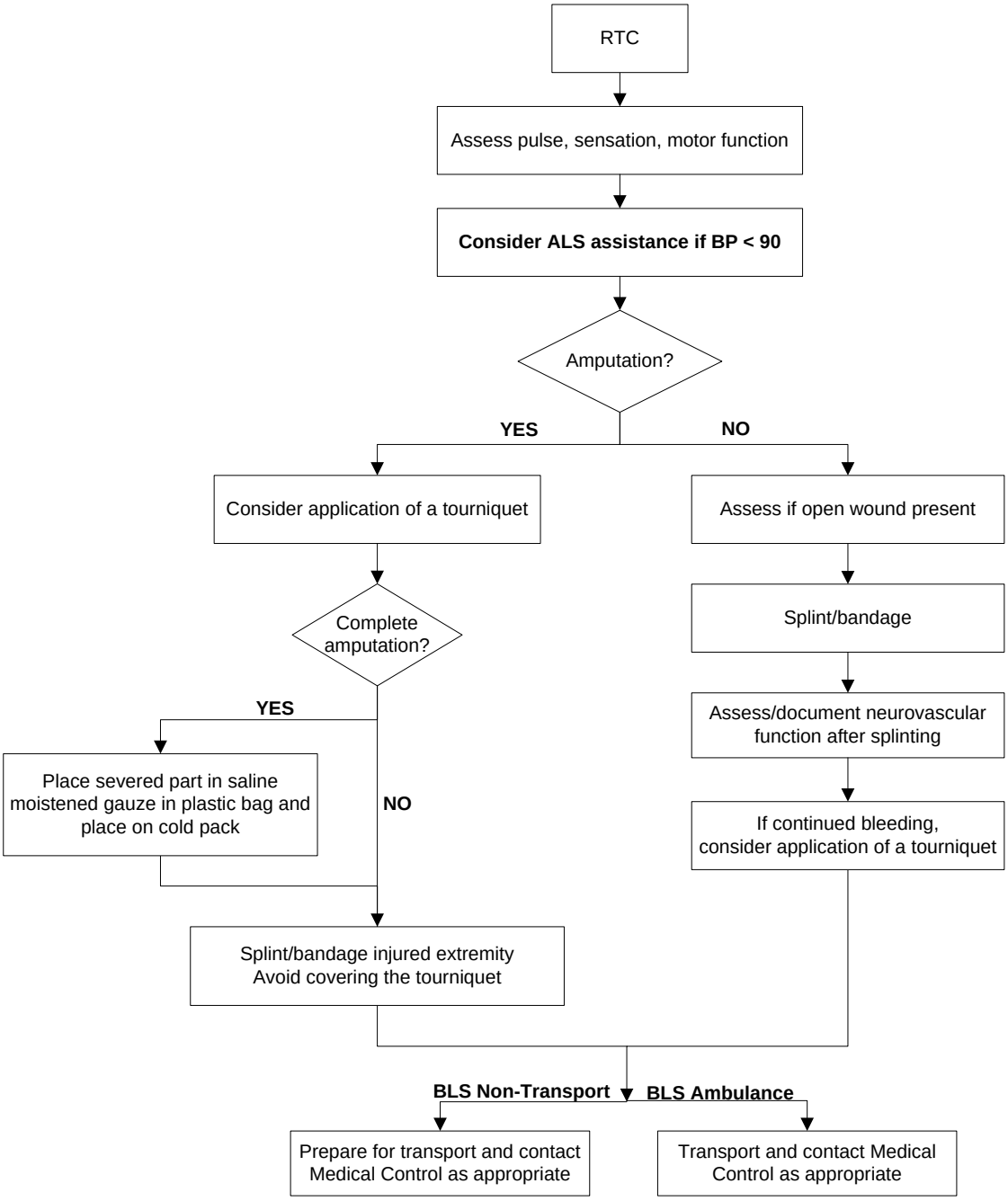
IDPH Approval: 3/5/10; 9/29/11
Implementation: 1/1/11; 4/1/12

EXTREMITY TRAUMA - BLS



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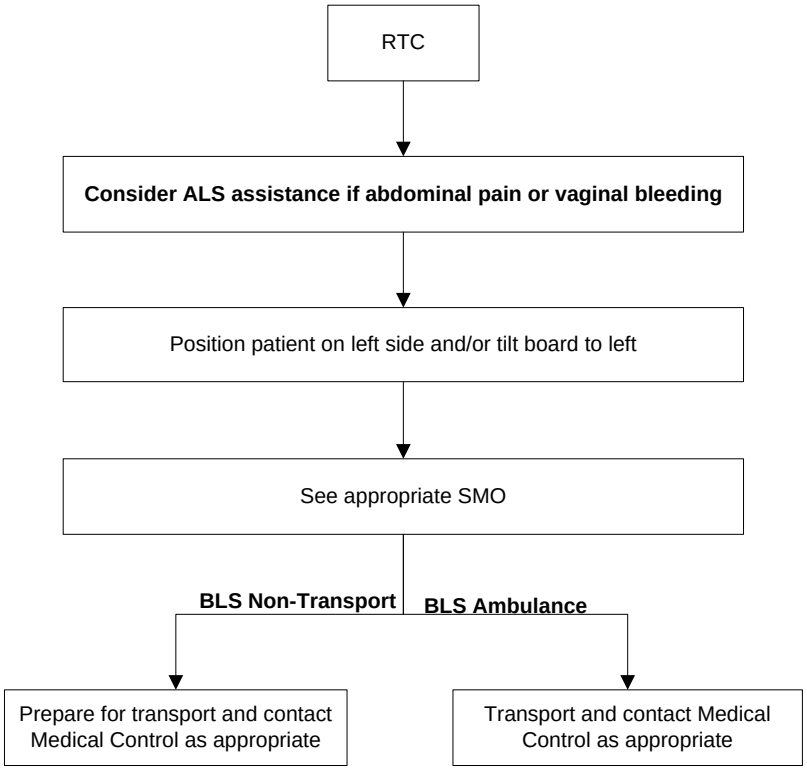
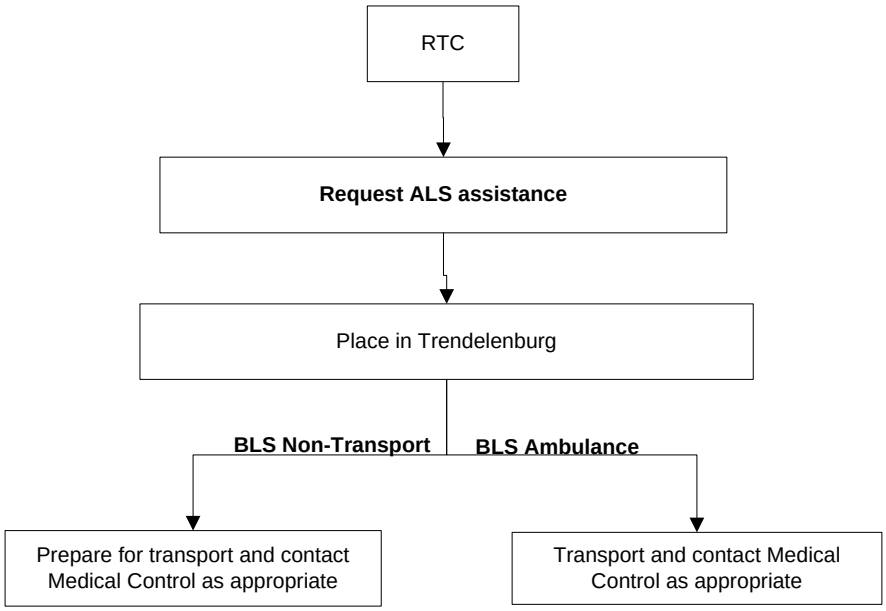
MDC Approval: 1/00; 3/00; 4/7/09; 6/7/11; 9/3/13
IDPH Approval: 3/5/10; 9/29/11; 9/30/13
Implementation: CFD BLS 5/00; Other 8/00; 1/1/11; 4/1/12; 10/1/13

TRAUMA IN PREGNANCY - BLS



Written: 1/09
Reviewed: 3/09; 5/11
Revised: 3/09
MDC Approval: 4/7/09
IDPH Approval: 3/5/10
Implementation: 1/1/11

TRAUMATIC HEMORRHAGIC SHOCK - BLS



Written: 1/09
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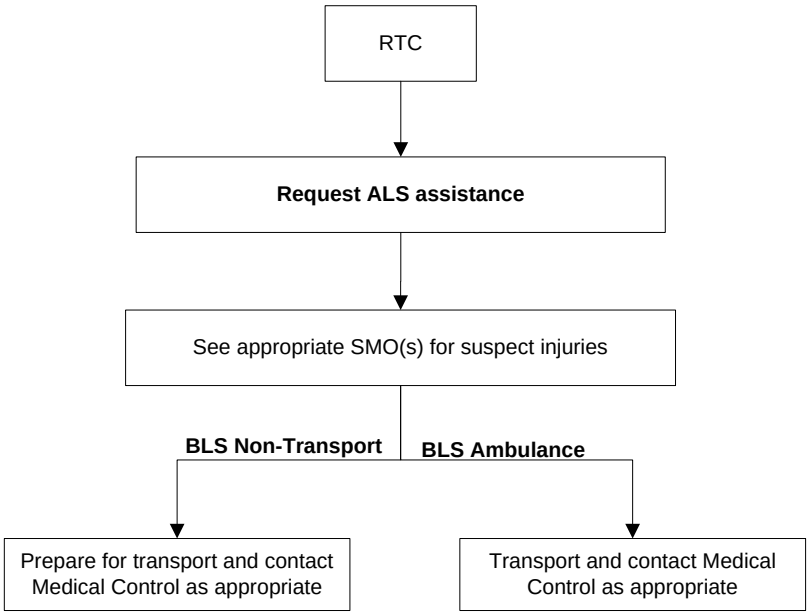
IDPH Approval: 3/5/10; 2/25/16
Implementation: 1/1/11; 3/1/16

TRAUMATIC ARREST - BLS



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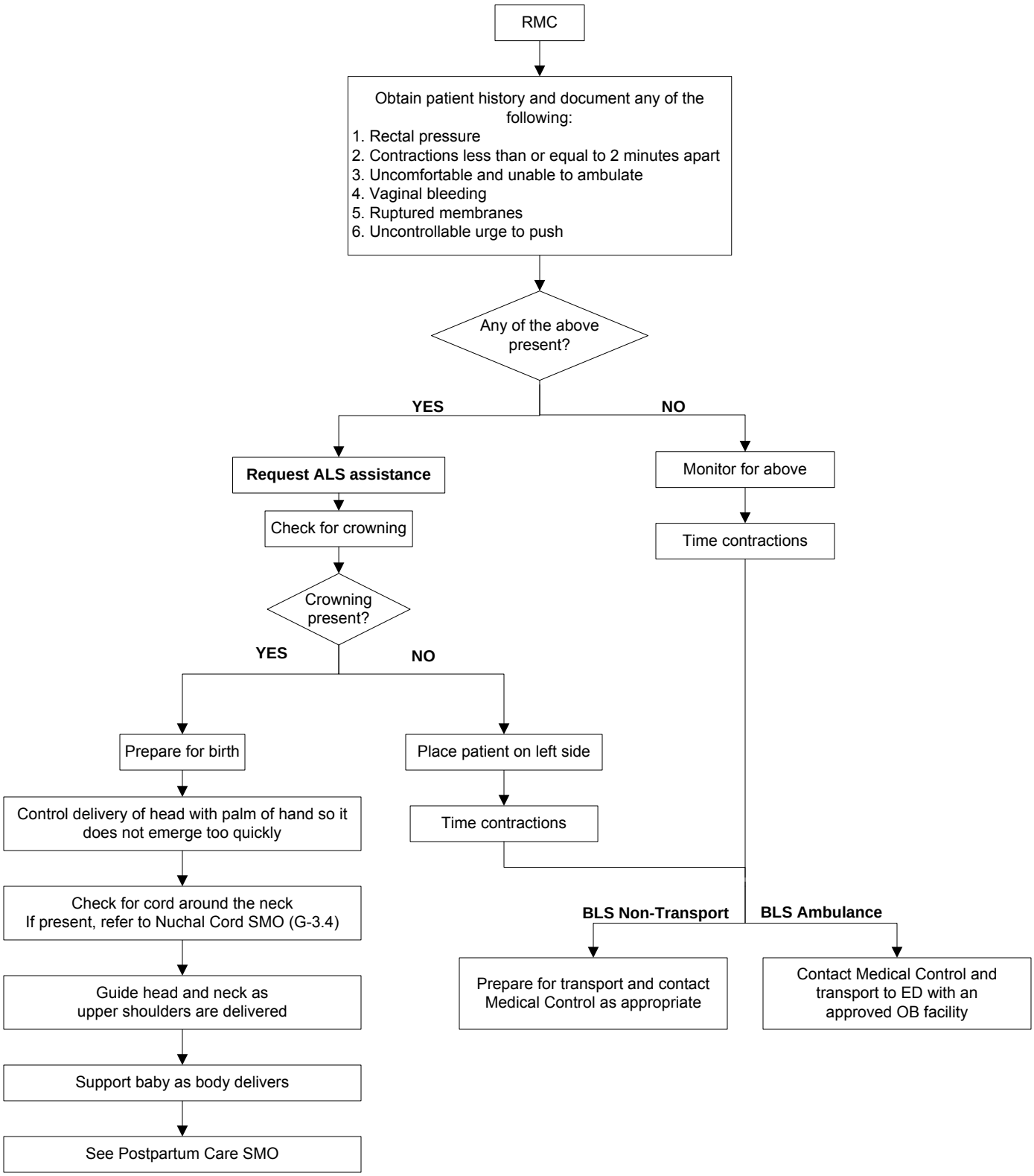
IDPH Approval: 3/5/10; 2/25/16
Implementation: 1/1/11; 3/1/16

OBSTETRICS

EMERGENCY CHILDBIRTH - BLS



Written: 12/99
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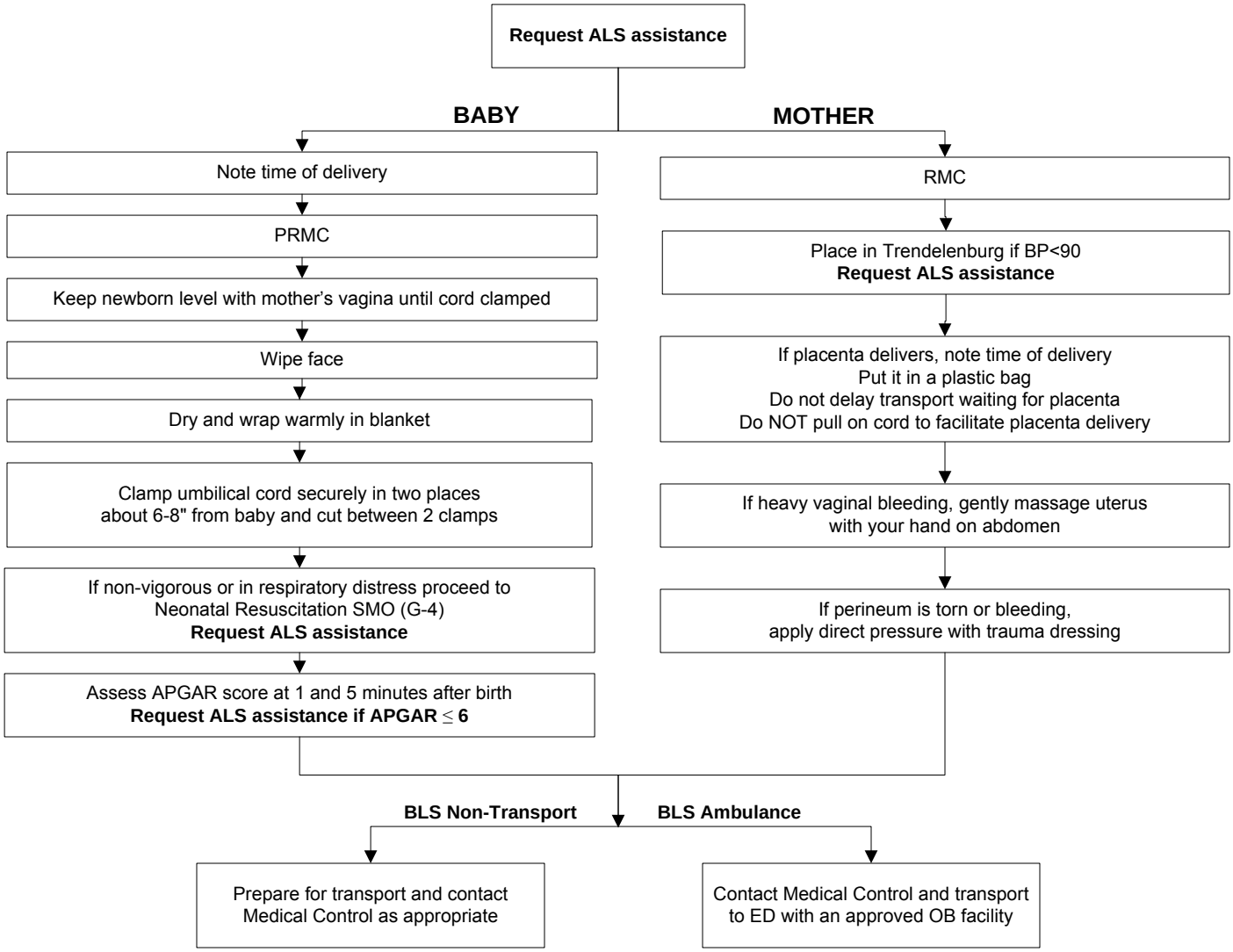
MDC Approval: 1/00; 3/00; 4/7/09; 6/7/11; 10/6/15
IDPH Approval: 3/5/10; 9/29/11; 2/25/16
Implementation: CFD BLS 5/00; Other 8/00; 1/1/11; 4/1/12; 3/1/16

POSTPARTUM CARE - BLS



APGAR SCORING

	0	1	2	1 Min	5 Min
A=Appearance (color)	Blue, pale	Blue hands and feet	Entirely pink	_____	_____
P=Pulse (heart rate)	Absent	<100/min	≥100/min	_____	_____
G=Grimace (reflex irritability)	No response	Grimace	Cough or sneeze	_____	_____
A=Activity (muscle tone)	Limp	Some flexion of extremities	Active motion	_____	_____
R=Respiratory effort	Absent	Weak cry, hypoventilation	Good, strong cry	_____	_____
			TOTALS =		

Written: 12/99
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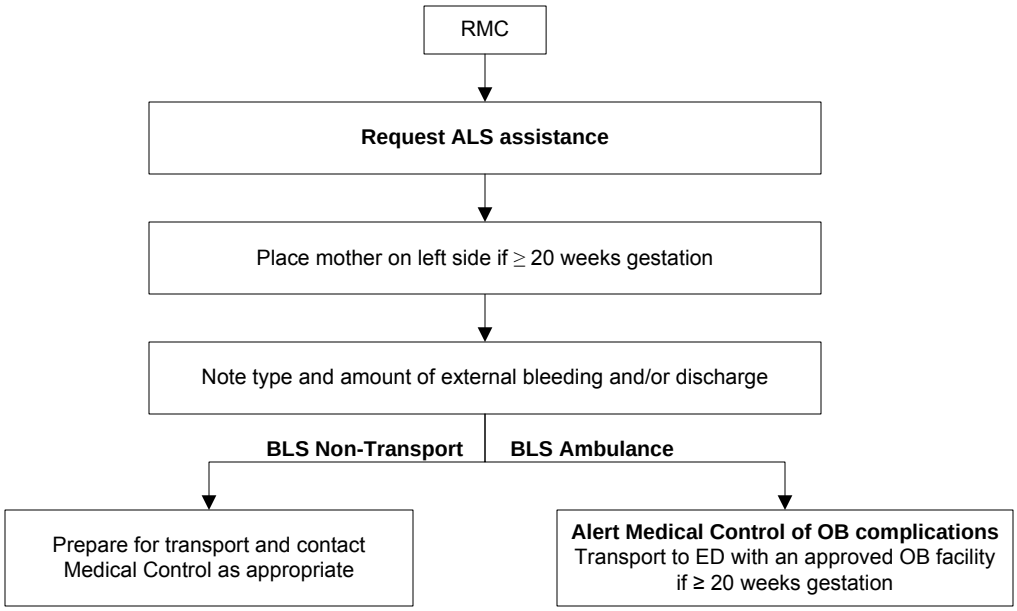
Implementation: CFD BLS 5/00; Other 8/00; 1/1/11; 4/1/12; 3/1/16

OBSTETRICAL COMPLICATIONS - BLS

BLEEDING IN PREGNANCY



Written: 1/09
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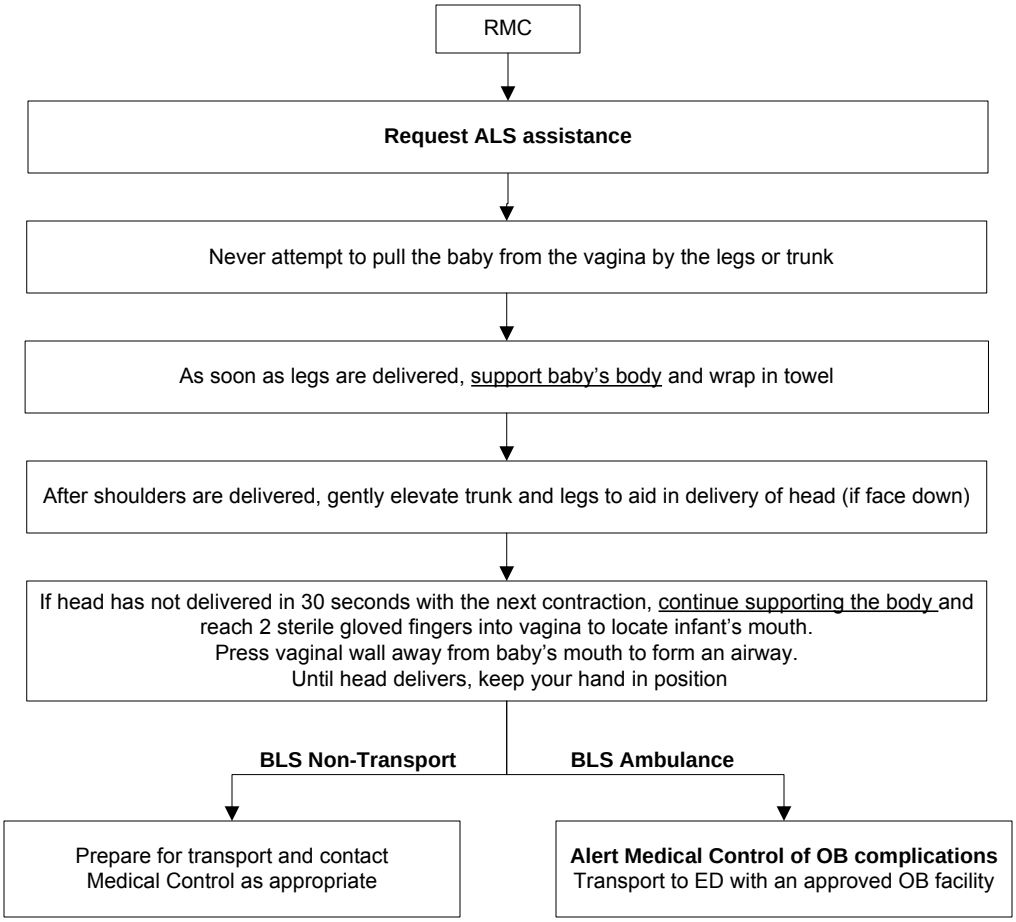
Implementation: 1/1/11

OBSTETRICAL COMPLICATIONS - BLS

BREECH BIRTH



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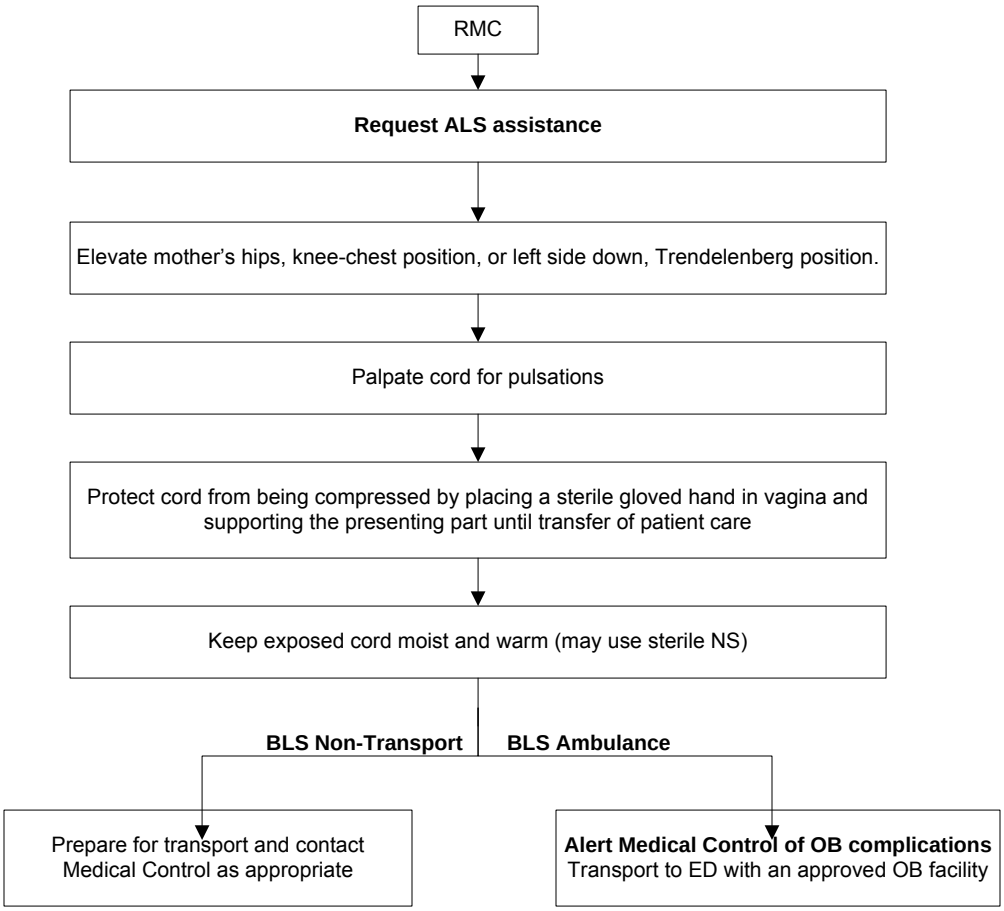
MDC Approval: 1/00; 3/00; 4/7/09; 10/6/15
IDPH Approval: 3/5/10; 2/25/16
Implementation: CFD BLS 5/00; Other 8/00; 1/1/11; 3/1/16

OBSTETRICAL COMPLICATIONS - BLS

PROLAPSED CORD



Written: 12/99
Reviewed: 3/00; 3/09; 5/11; 10/15
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MDC Approval: 1/00; 3/00; 4/7/09; 6/7/11; 10/6/15
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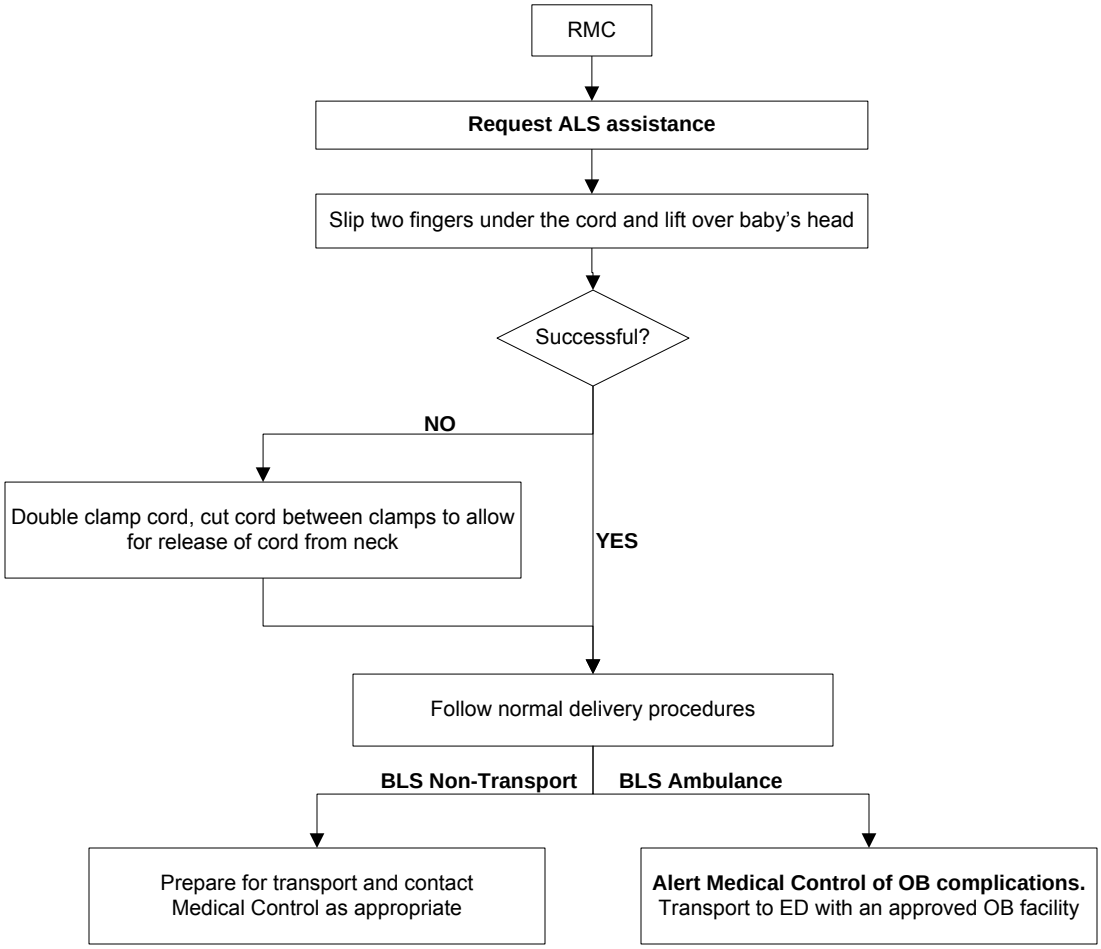
Implementation: CFD BLS 5/00; Other 8/00; 1/1/11; 4/1/12; 3/1/16

OBSTETRICAL COMPLICATIONS - BLS

NUCHAL CORD



Written: 12/99
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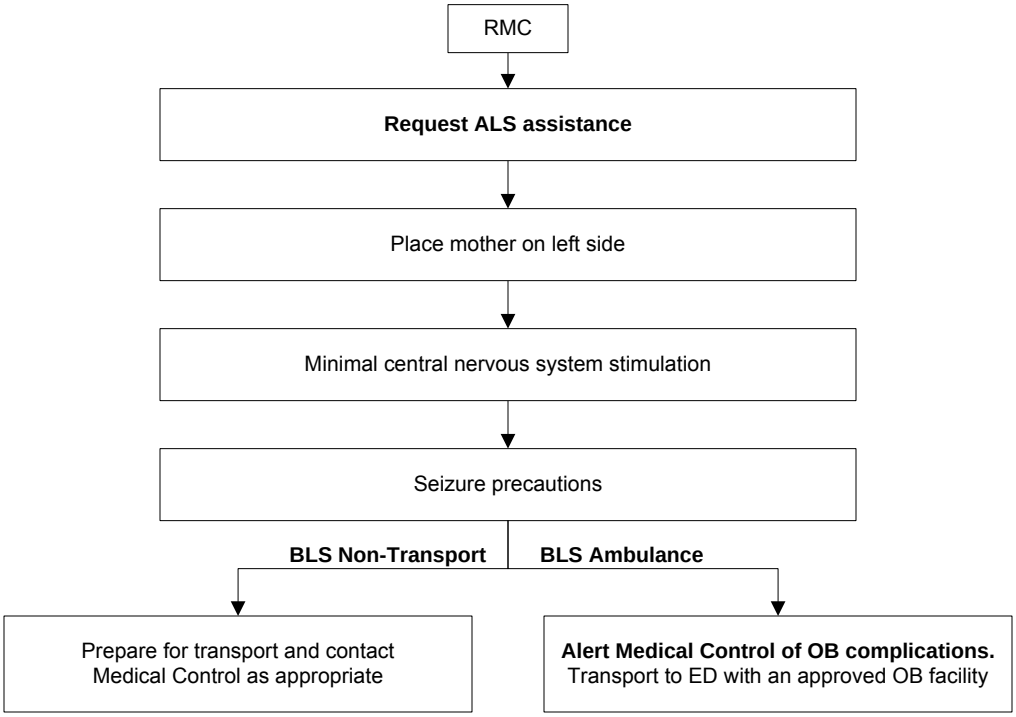
MDC Approval: 1/00; 3/00; 4/7/09; 10/6/15
IDPH Approval: 3/5/10; 2/25/16
Implementation: CFD BLS 5/00; Other 8/00; 1/1/11; 3/1/16

OBSTETRICAL COMPLICATIONS - BLS

PRE-ECLAMPSIA OR TOXEMIA (ECLAMPSIA)



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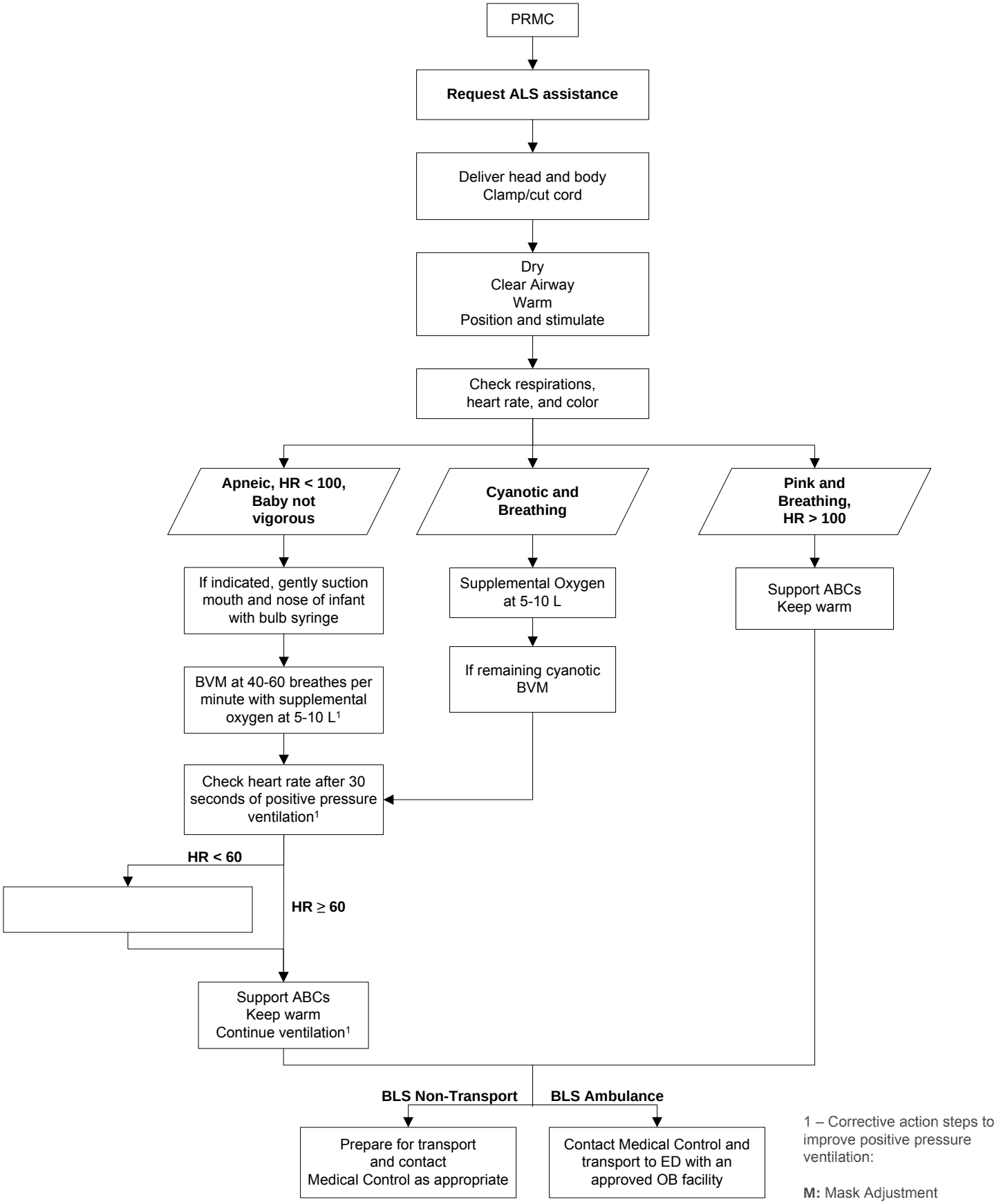
Implementation: 1/1/11

NEONATAL RESUSCITATION - BLS



1 – Corrective action steps to improve positive pressure ventilation:

M: Mask Adjustment
R: Reposition Airway
S: Suction Mouth & Nose
O: Open Mouth
P: Pressure Increase
A: Airway Alternative

Written: 12/08
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IDPH Approval: 3/5/10; 9/29/11; 2/25/16
Implementation: 1/1/11; 4/1/12; 3/1/16

PEDIATRICS

PEDIATRIC INITIAL ASSESSMENT - BLS

I. SCENE SIZE-UP

A. Protect from body substance through isolation (glasses, gloves, gown and mask).

B. Assess the scene for safety and take appropriate steps.

C. Determine the mechanism of injury/nature of illness.

1. Note the number of patients.

2. Initiate Mass Casualty Plan, if necessary.
   a. Call for additional personnel and equipment.
   b. Begin triage.

3. Assess for any indication of abuse or neglect of the patient (See policy “Reporting Abused and/or Neglected Patients”)

II. INITIAL ASSESSMENT OF PEDIATRIC PATIENT

A. Assess general impression of child and environment with initial assessment of wellness and general appearance (conduct from a distance). Complete assessment while protecting the cervical spine, if necessary.

1. Determine nature of illness or mechanism of injury.

2. Is child in a life threatening condition? Treat immediately.

3. Obtain SAMPLE history and identify any caregivers at scene.

B. Assess child's mental status.

1. Identify yourself and your purpose using age appropriate terms.

2. Initially approach child in non-threatening manner, on their level when appropriate. Initiate touch in a non-threatening manner, before examining child when appropriate.

3. Evaluate child's mental status utilizing Pediatric Coma Scale.

C. Assess airway

1. Responsive Child

PEDIATRIC INITIAL ASSESSMENT (cont.)

a. If child is talking or crying, then assess for adequacy of breathing.
b. If child is not talking or crying, open airway using modified jaw thrust maneuver.

2. Unresponsive Child

a. Open the airway using modified jaw thrust maneuver.
b. Consider use of oral airway.

D. Assess Breathing

1. Non-breathing child

a. Maintain open airway and assist breathing utilizing ventilatory adjuncts and oxygen at the appropriate rate.
b. Suction if necessary.
c. Pulse oximeter

2. Breathing child

a. Look for rise and fall of chest and feel for rate and depth of breathing.
b. Look for use of accessory muscles, nasal flaring, grunting and retractions.
c. Determine adequacy of breathing for age (either too fast or too slow).
d. If breathing is inadequate, assist breathing utilizing ventilatory adjuncts and oxygen at the appropriate rate.
e. Suction if necessary.
f. Pulse oximeter (if indicated)

PEDIATRIC VITAL SIGNS

Weight in kg = (2 x age in years) + 10

Age	**Pulse**	**Systolic Blood Pressure**	**Respiratory Rate**
Neonate (0-30 days)	100-180	> 60	30-60
Infant (31 days - < 1yr)	100-160	> 60	30-60
Toddler (1 yr - < 3 yrs)	90-150	> 70	24-40
Pre-School (3 yrs - < 5 yrs)	80-140	> 75	22-34
School Age (5 yrs – 12 yrs)	70-120	> 80	18-30
Adolescent (> 12 yrs)	60-100	> 90	12-16

PEDIATRIC INITIAL ASSESSMENT (cont.)

E. Assess Circulation

INDICATORS OF HYPOPERFUSION IN CHILDREN

- Cyanosis despite administration of oxygen
- Truncal pallor/cyanosis and coolness
- Hypotension (late sign)
- Bradycardia (ominous sign)
- Weak, thready, or absent peripheral pulses
- No palpable blood pressure
- Decreasing level of consciousness

1. Check brachial or femoral pulse for rate and quality.

2. If none found, check for carotid pulse. If pulseless, start CPR and see appropriate SMO.

3. Assess capillary refill.

4. Assess skin condition.

5. Assess and control severe bleeding.

F. Identify priority pediatric patients for immediate transport and initiate interventions as per SMOs.

G. Repeat initial assessment.

1. Every 15 minutes in a stable child.

2. Every 5 minutes in an unstable child.

3. Repeat before beginning detailed physical examination.

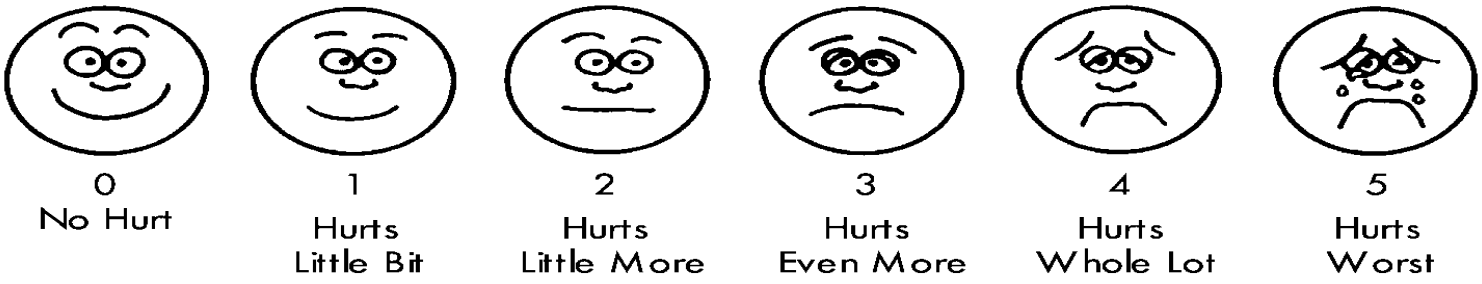
H. Initiate measures to prevent heat loss to keep the child from becoming hypothermic.

I. For children with special healthcare needs (CSHN), refer as needed to child's emergency care plan. Understanding the child's baseline will assist in determining the significance of altered physical findings.

PEDIATRIC INITIAL ASSESSMENT (cont.)

PEDIATRIC GLASGOW COMA SCALE (PGCS)				
	> 1 Year		**< 1 Year**	**Score**
EYE OPENING	Spontaneously		Spontaneously	4
	To verbal command		To shout	3
	To pain		To pain	2
	No response		No response	1
MOTOR RESPONSE	Obeys		Spontaneous	6
	Localizes pain		Localizes pain	5
	Flexion-withdrawal		Flexion-withdrawal	4
	Flexion-abnormal (decorticate rigidity)		Flexion-abnormal (decorticate rigidity)	3
	Extension (decerebrate rigidity)		Extension (decerebrate rigidity)	2
	No response		No response	1
	> 5 years	**2-5 Years**	**0-23 Months**	
VERBAL RESPONSE	Oriented	Appropriate words/phrases	Smiles/coos appropriately	5
	Disoriented/confused	Inappropriate words	Cries and is consolable	4
	Inappropriate words	Persistent cries and screams	Persistent inappropriate crying and/or screaming	3
	Incomprehensible sounds	Grunts	Grunts, agitated, and restless	2
	No response	No response	No response	1
TOTAL PEDIATRIC GLASGOW COMA SCORE:				**(3-15)**

PEDIATRIC PAIN SCALE



Written: 12/99
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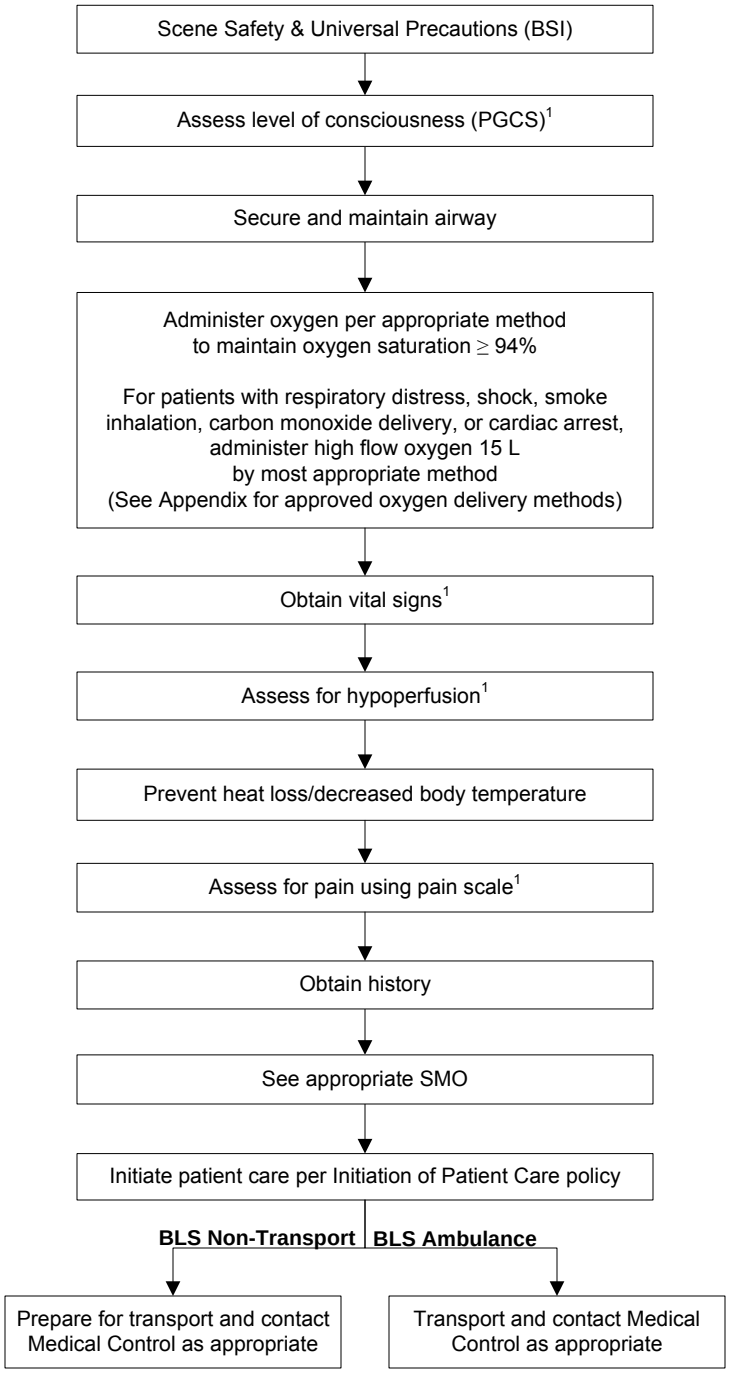
MDC Approval: 1/00; 3/00; 4/7/09; 10/6/15
IDPH Approval: 5/02; 7/9/09; 2/25/16
Implementation: CFD BLS 5/00; Other 8/00; 1/1/10; 3/1/16

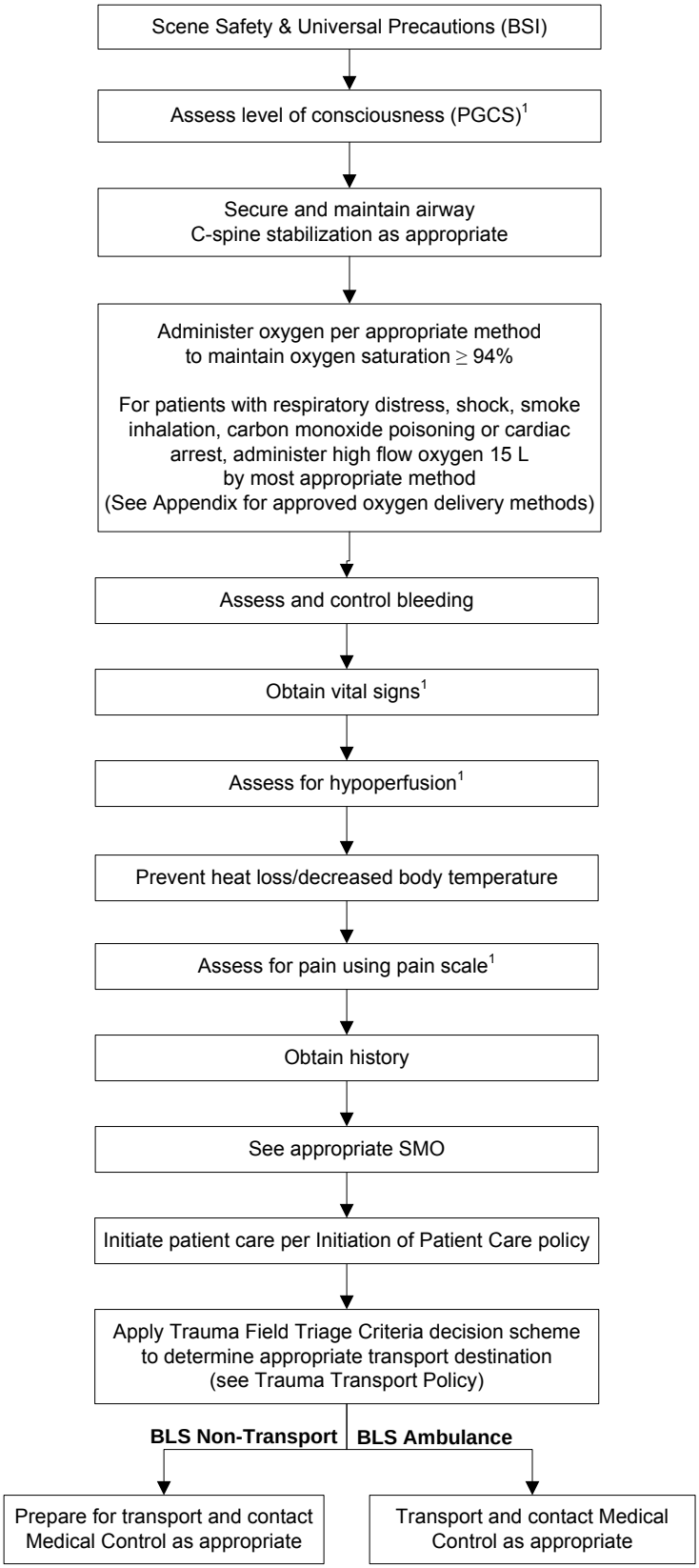
PEDIATRIC ROUTINE MEDICAL CARE (PRMC) - PEDIATRIC - BLS
(Age Newborn – 15 yrs.)



1 – See Pediatric Initial Assessment

Written: 1/09
Reviewed: 3/09; 5/11; 2/16
Revised: 3/09; 2/16
MDC Approval: 4/7/09; 2/16/16
IDPH Approval: 3/5/10; 2/25/16
Implementation: 1/1/11; 3/1/16

PEDIATRIC ROUTINE TRAUMA CARE (PRTC) - PEDIATRIC - BLS
(Age Newborn – 15 yrs.)



1 – See Pediatric Initial Assessment

Written: 12/99
Reviewed: 3/09; 5/11; 10/15
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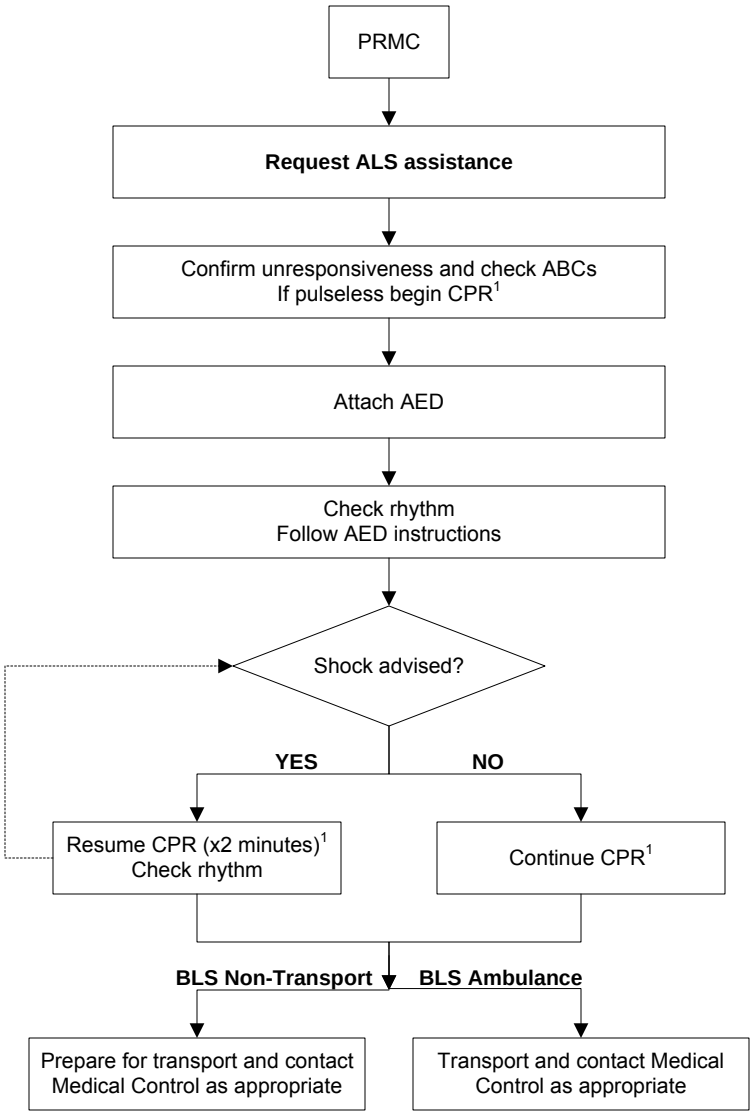
MDC Approval: 1/00; 4/7/09; 10/5/15
IDPH Approval: 3/5/10; 2/25/16
Implementation: CFD BLS 5/00; Other 8/00; 1/1/11; 3/1/16

CARDIOPULMONARY ARREST - PEDIATRIC - BLS



1 – Pediatric CPR rates: 1 rescuer = 30 compressions: 2 ventilations
2 rescuers = 15 compressions: 2 ventilations

Written: 3/00
Reviewed: 3/09; 5/11; 10/15
Revised: 3/09; 5/11; 10/15
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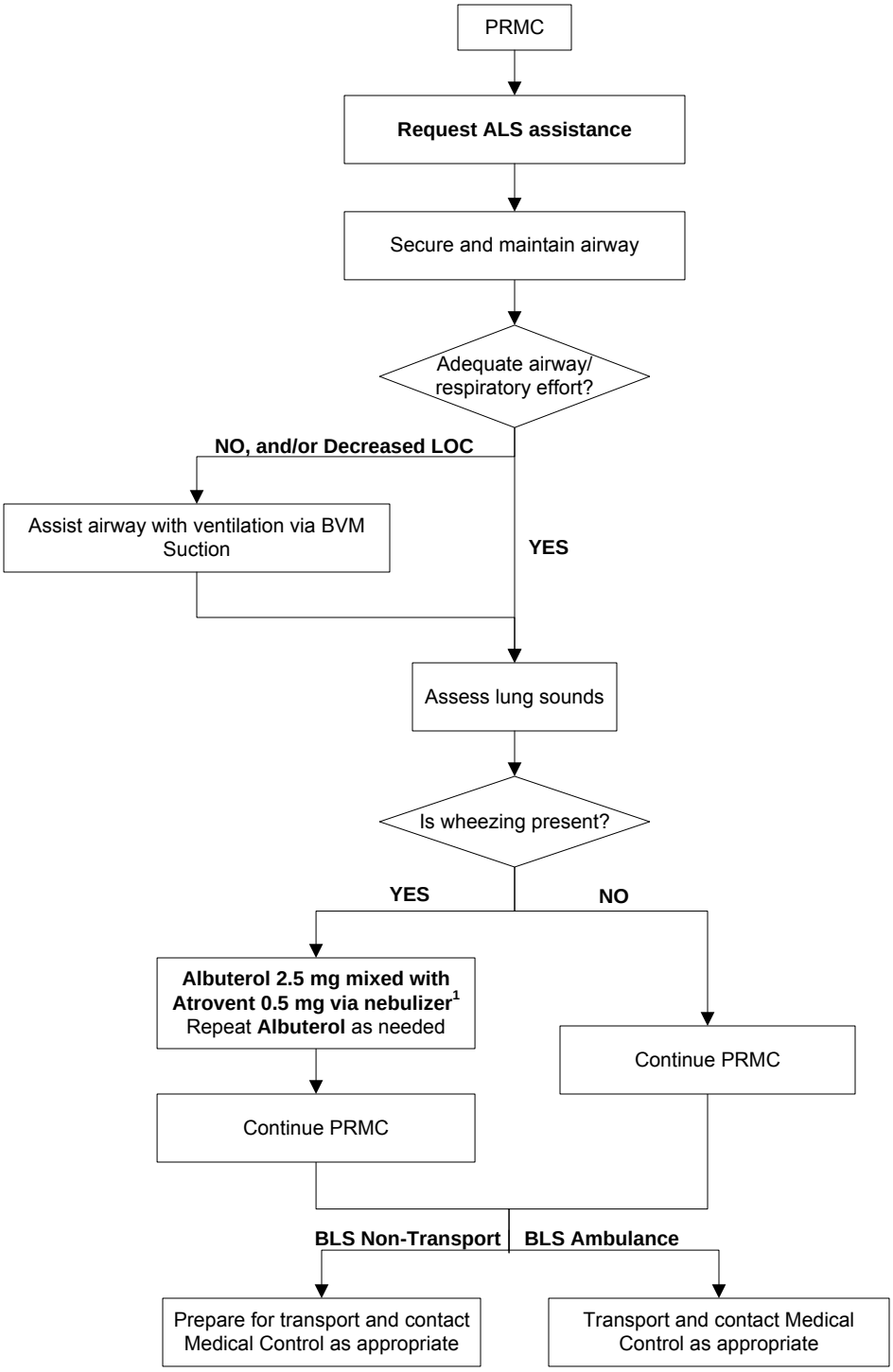
IDPH Approval: 3/5/10; 9/29/11; 2/25/16
Implementation: CFD BLS 5/00; Other 8/00; 10/2/02; 1/1/11; 4/1/12; 3/1/16

RESPIRATORY DISTRESS - PEDIATRIC - BLS



1 – If available

NOTE: If patient has an established tracheostomy, see Tracheostomy with Respiratory Distress SMO

NOTE: Complete lack of breath sounds may indicate severe bronchoconstriction

Written: 2/09
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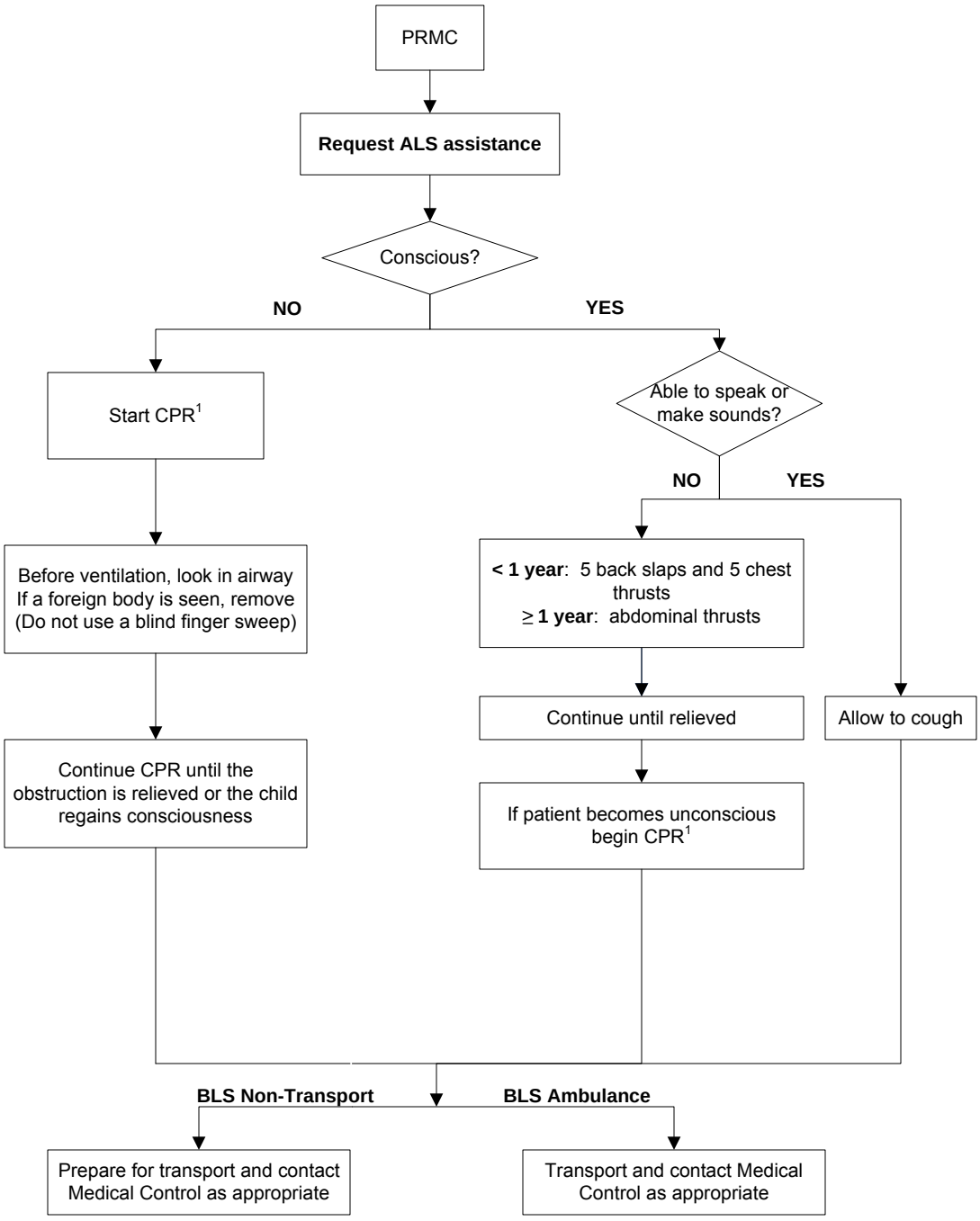
Implementation: 1/1/11; 4/1/12; 3/1/16

RESPIRATORY OBSTRUCTION - PEDIATRIC - BLS



1 – Pediatric CPR rates: 1 rescuer = 30 compressions: 2 ventilations
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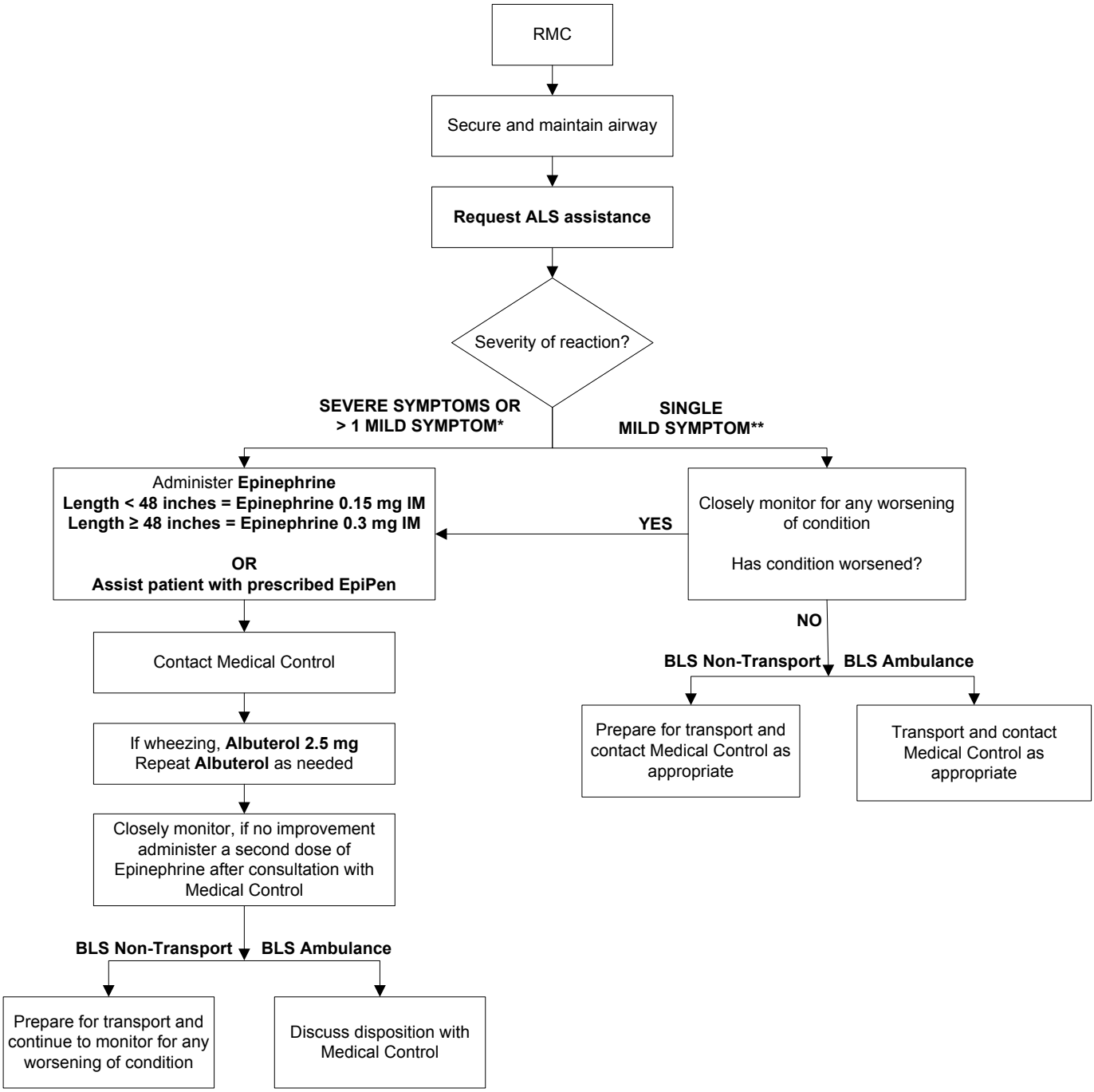
IDPH Approval: 3/5/10; 9/29/11; 1/31/13; 2/25/16
Implementation: CFD BLS 5/00; Other 8/00; 1/1/11; 4/1/12; 2/1/13; 3/1/16

ALLERGIC REACTION and/or ANAPHYLAXIS - PEDIATRIC - BLS



***Severe symptoms of an allergic reaction may include any combination of the following:**

RESPIRATORY – Shortness of breath, wheezing, repetitive coughing
CARDIOVASCULAR – Pale, cyanotic, low blood pressure, dizzy
THROAT – Tightness, hoarse, trouble breathing/swallowing
MOUTH – Swelling of the tongue and/or lips
SKIN- Diffuse hives or redness
GI – Repetitive vomiting, severe diarrhea
NEURO – Anxiety, confusion, sense of doom

****Mild symptoms of an allergic reaction may include any combination of the following:**

NOSE – Itchy/runny nose, sneezing
MOUTH – Itching
SKIN- Few hives, mild itching
GI – Mild nausea/discomfort

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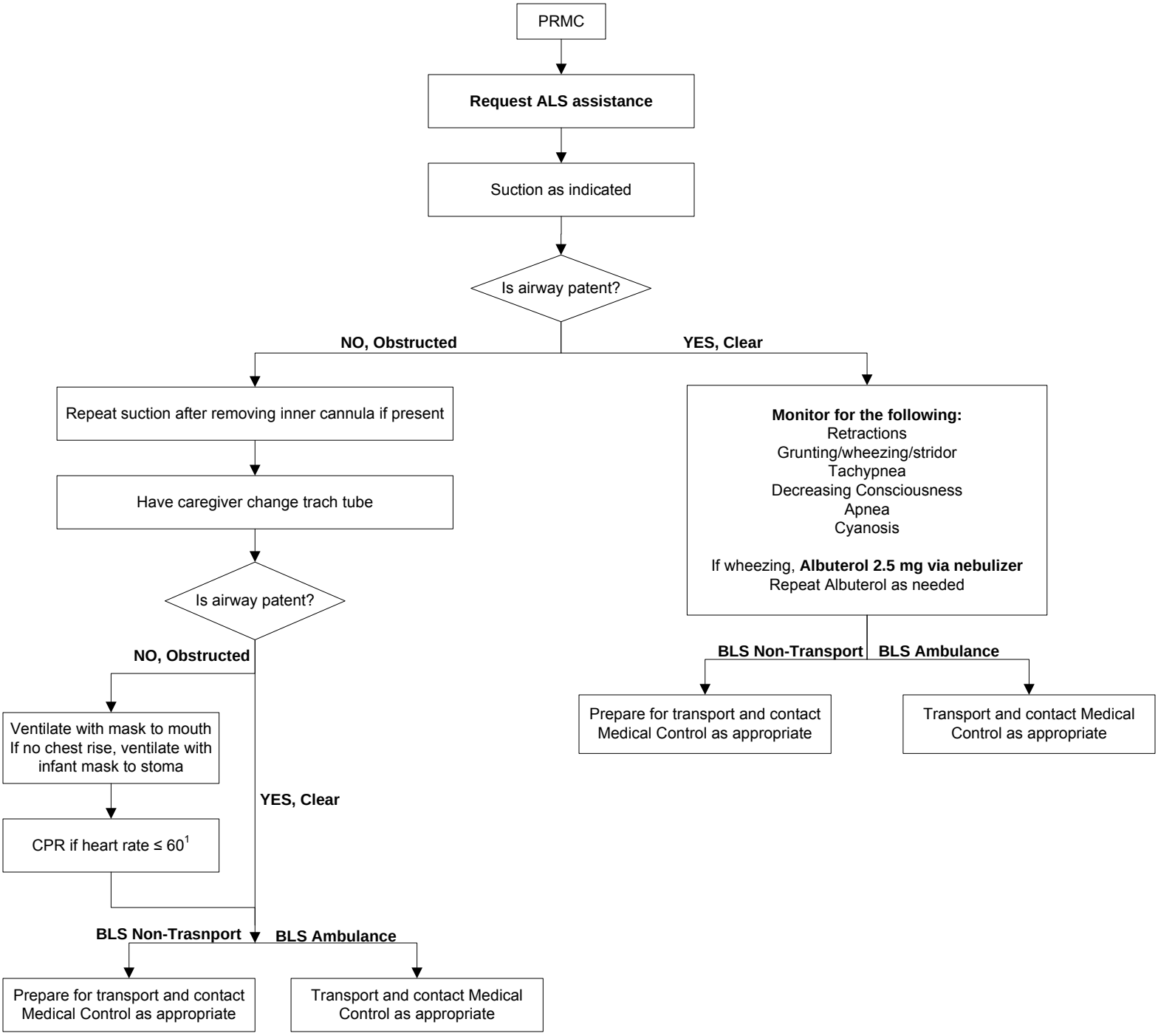
IDPH Approval: 3/5/10; 1/28/14; 1/12/17
Implementation: 1/1/11; 6/1/14; 4/1/17

TRACHEOSTOMY WITH RESPIRATORY DISTRESS - PEDIATRIC - BLS



1 – Pediatric CPR rates: 1 rescuer = 30 compressions: 2 ventilations
2 rescuers = 15 compressions: 2 ventilations

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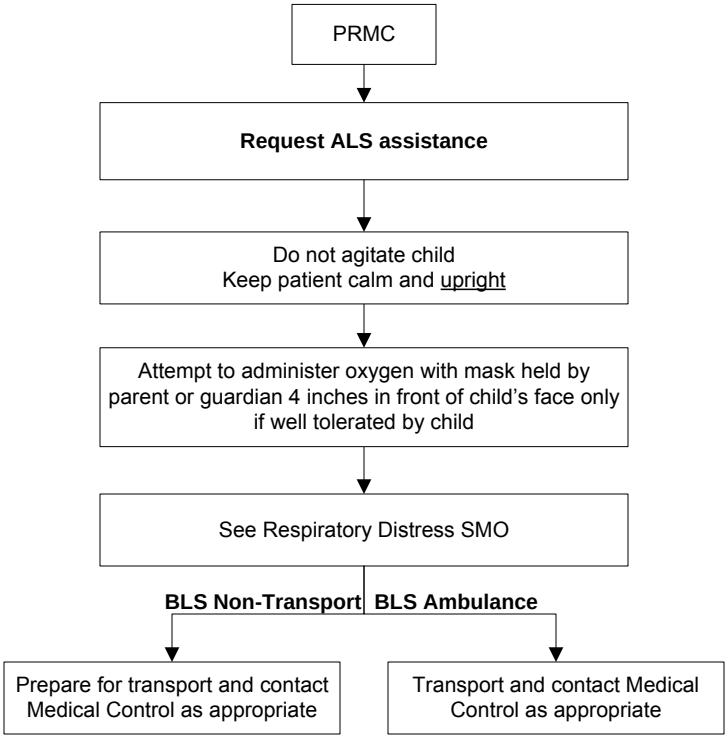
IDPH Approval: 3/5/10; 9/29/11; 2/25/16
Implementation: 1/1/11; 4/1/12; 3/1/16

SUSPECTED CROUP OR EPIGLOTTITIS - PEDIATRIC - BLS



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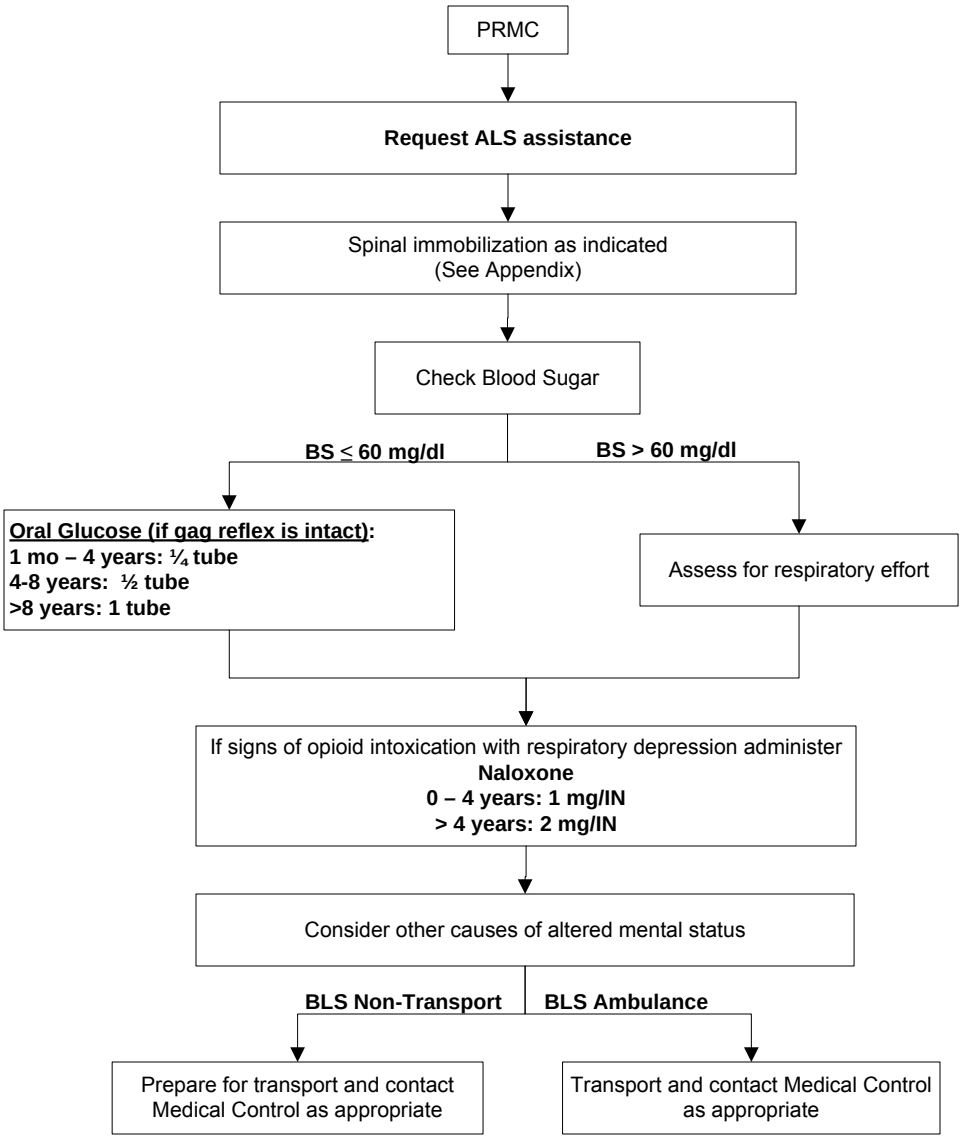
MDC Approval: 1/00 3/00; 4/7/09; 10/5/15
IDPH Approval: 3/5/10; 2/25/16
Implementation: CFD BLS 5/00; Other 8/00; 1/1/11; 3/1/16

ALTERED MENTAL STATUS - PEDIATRIC - BLS

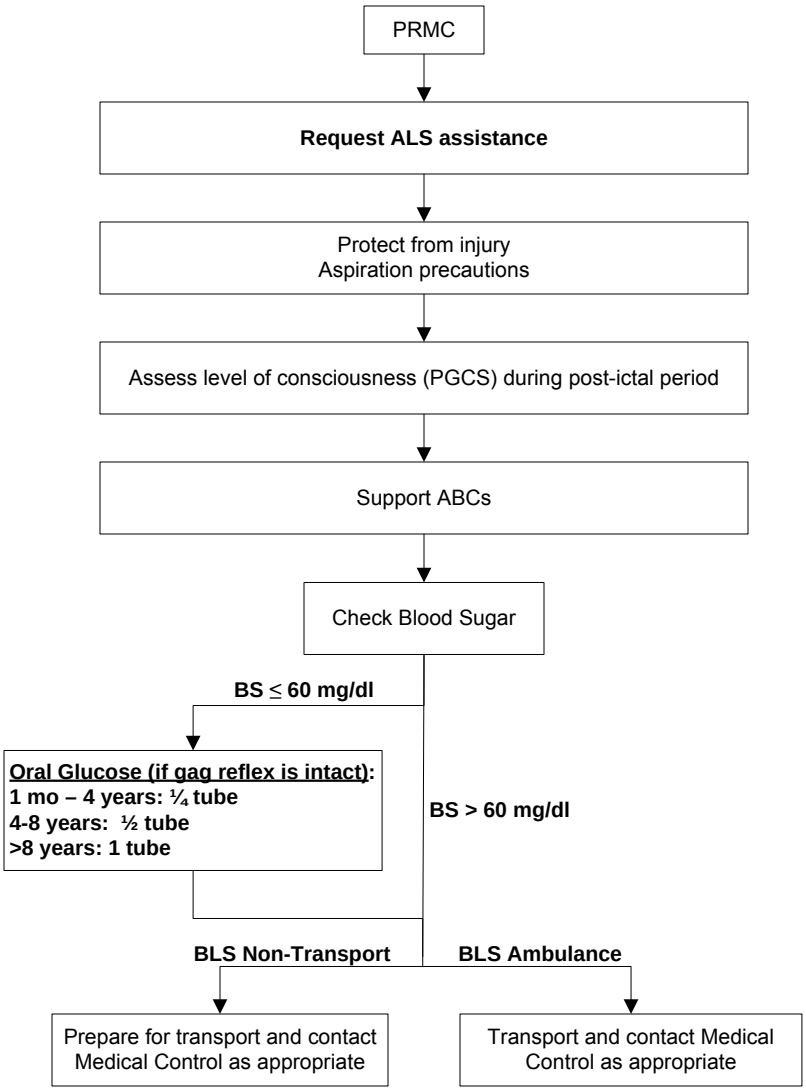


Special Considerations:
Consider causes:

A Alcohol, abuse
E Epilepsy, electrolytes, encephalopathy
I Insulin
O Opiates, overdose
U Uremia
T Trauma, temperature
I Infection, intussusception, inborn errors
P Psychogenic
P Poison
S Shock, seizures, stroke, space-occupying lesion, subarachnoid hemorrhage, shunt

Written: 6/04 Replaces Altered Level of Consciousness SMO
Reviewed: 3/09; 5/11; 10/15; 5/16
Revised: 3/09; 10/15; 5/16
MDC Approval: 4/7/09; 10/5/15; 6/7/16
IDPH Approval: 3/5/10; 2/25/16; 8/11/16
Implementation: 1/1/11; 3/1/16; 10/17/16

SEIZURES - PEDIATRIC - BLS



Written: 12/99
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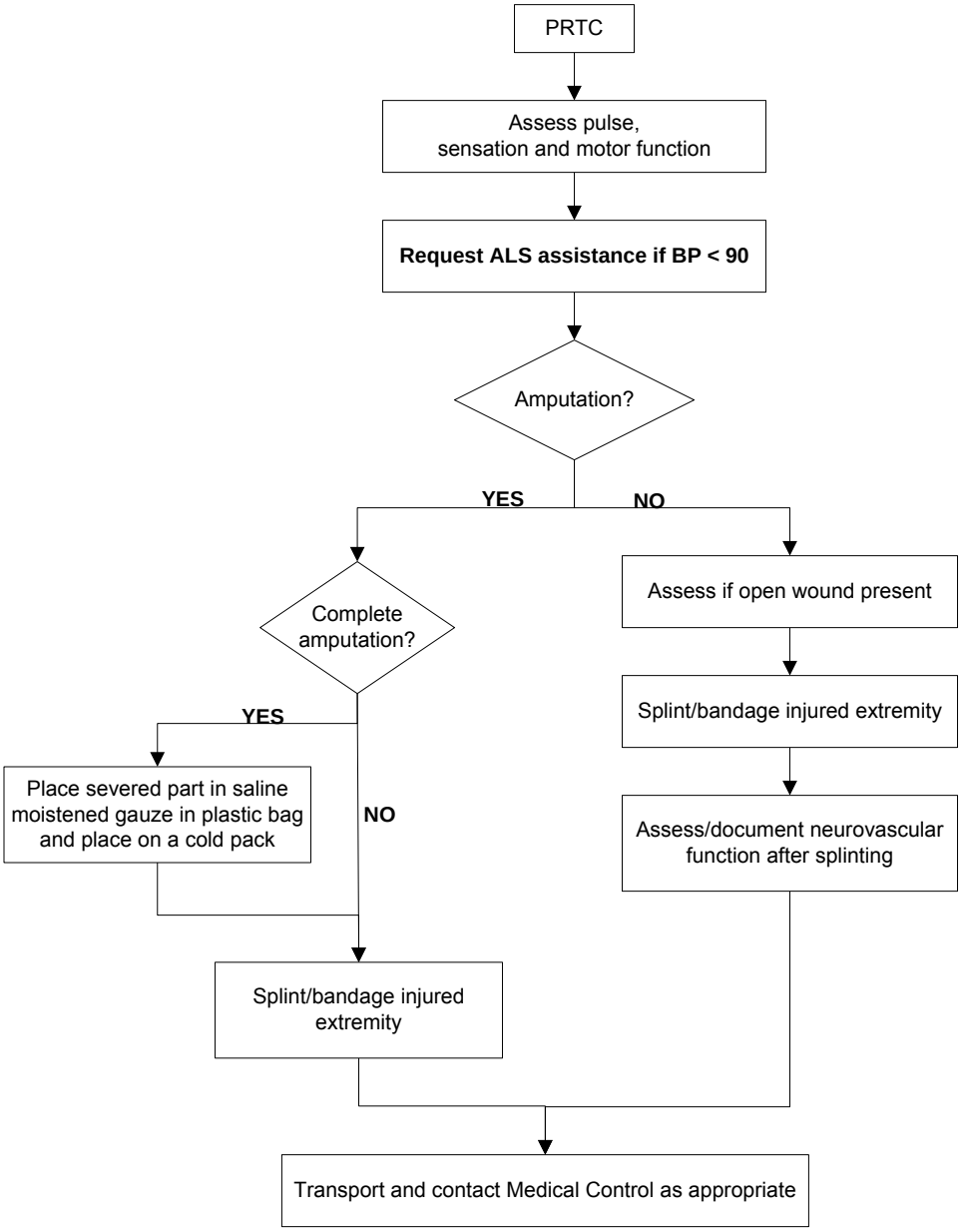
MDC Approval: 1/00; 3/00; 4/7/09; 10/5/15
IDPH Approval: 3/5/10; 2/25/16
Implementation: CFD BLS 5/00; Other 8/00; 1/1/11; 3/1/16

EXTREMITY TRAUMA - PEDIATRIC - BLS



Written: 5/04
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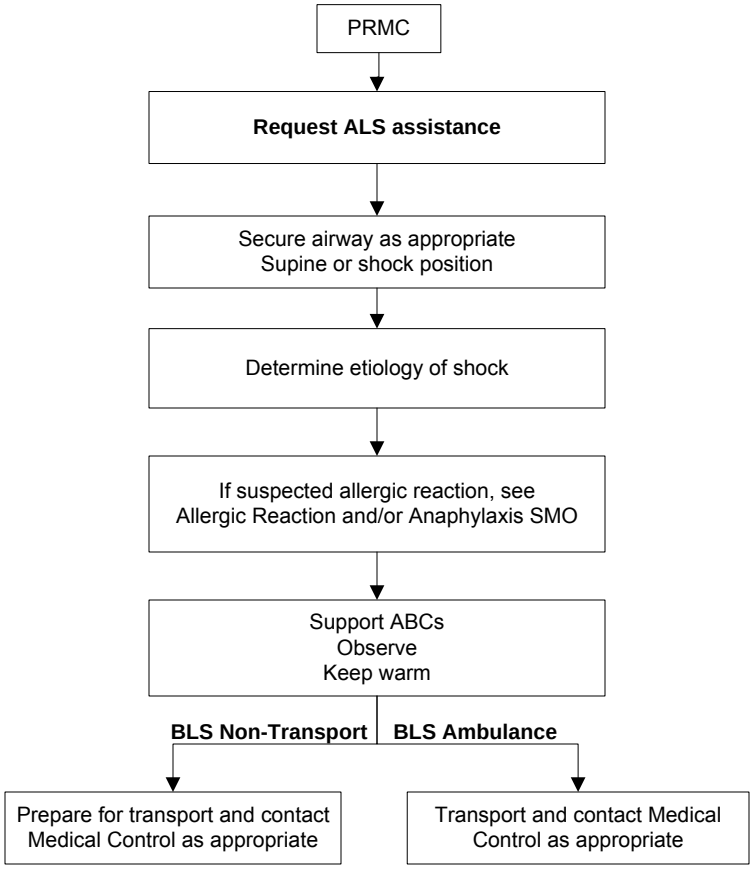
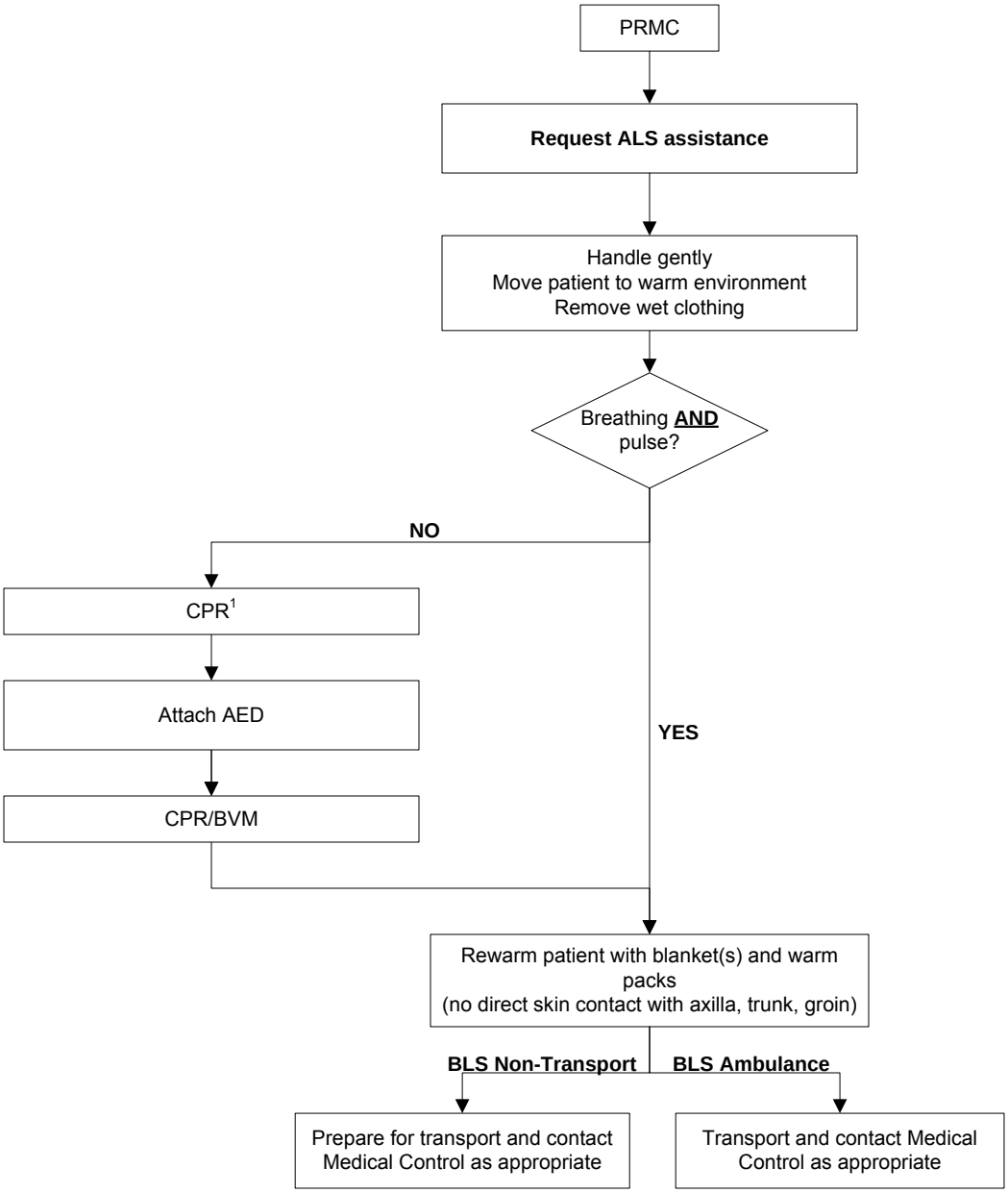
Revised: 9/09; 5/11
MDC Approval: 6/04; 6/7/11
IDPH Approval: 9/04; 3/5/10; 9/29/11
Implementation: 1/1/05; 1/1/11; 4/1/12

NON-TRAUMATIC SHOCK - PEDIATRIC - BLS



Written: 2/09
Reviewed: 3/09; 5/11
Revised: 3/09
MDC Approval: 4/7/09
IDPH Approval: 3/5/10
Implementation: 1/1/11

HYPOTHERMIA - PEDIATRIC - BLS

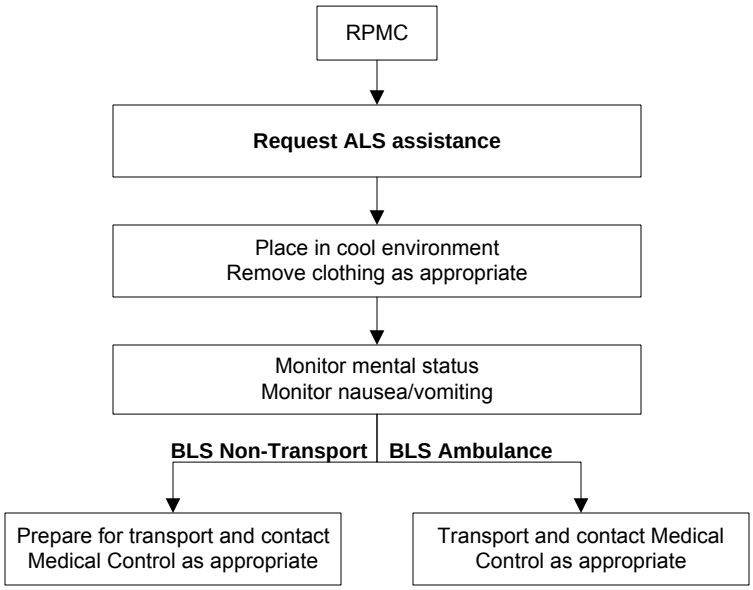


NOTES: **- May present with altered sensorium or as unconscious. Heart more susceptible to dysrhythmias. May have apnea, dusky or cyanotic appearance, fixed and dilated pupils; may appear without signs of life.**
- An individual in a frozen state is not considered salvageable.
- The suspected hypothermic patient shall never be declared dead in the field.

1 – Pediatric CPR rates: 1 rescuer = 30 compressions: 2 ventilations
2 rescuers = 15 compressions: 2 ventilations

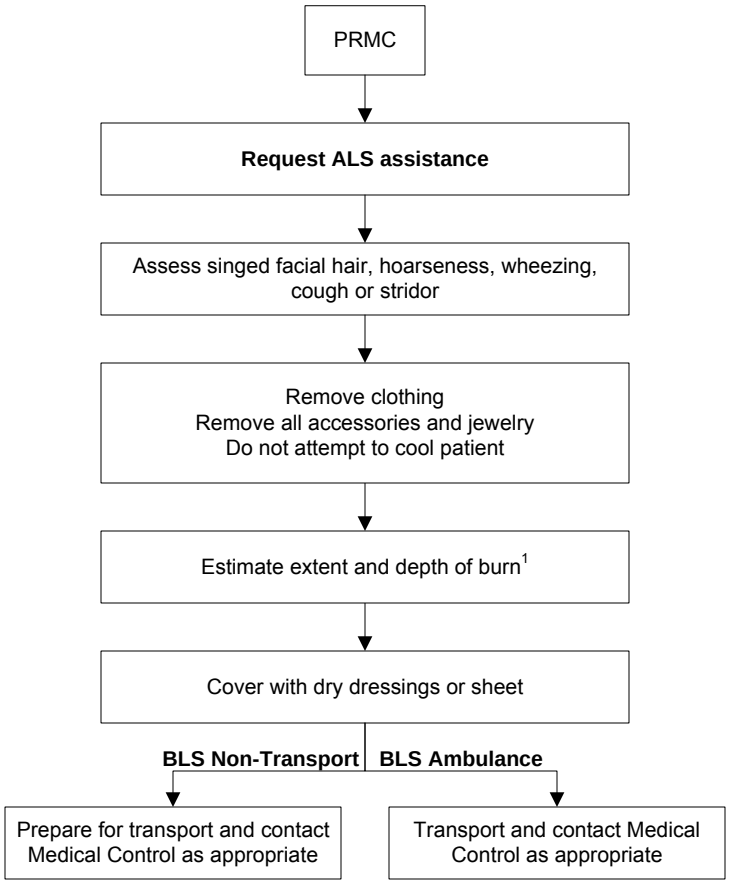
Written: 1/09
Reviewed: 3/09; 5/11; 10/15
Revised: 3/09; 5/11; 10/15
MDC Approval: 4/7/09; 6/7/11; 10/5/15
IDPH Approval: 3/5/10; 9/29/11; 2/25/16
Implementation: 1/1/11; 4/1/12; 3/1/16

HEAT ILLNESS - PEDIATRIC - BLS

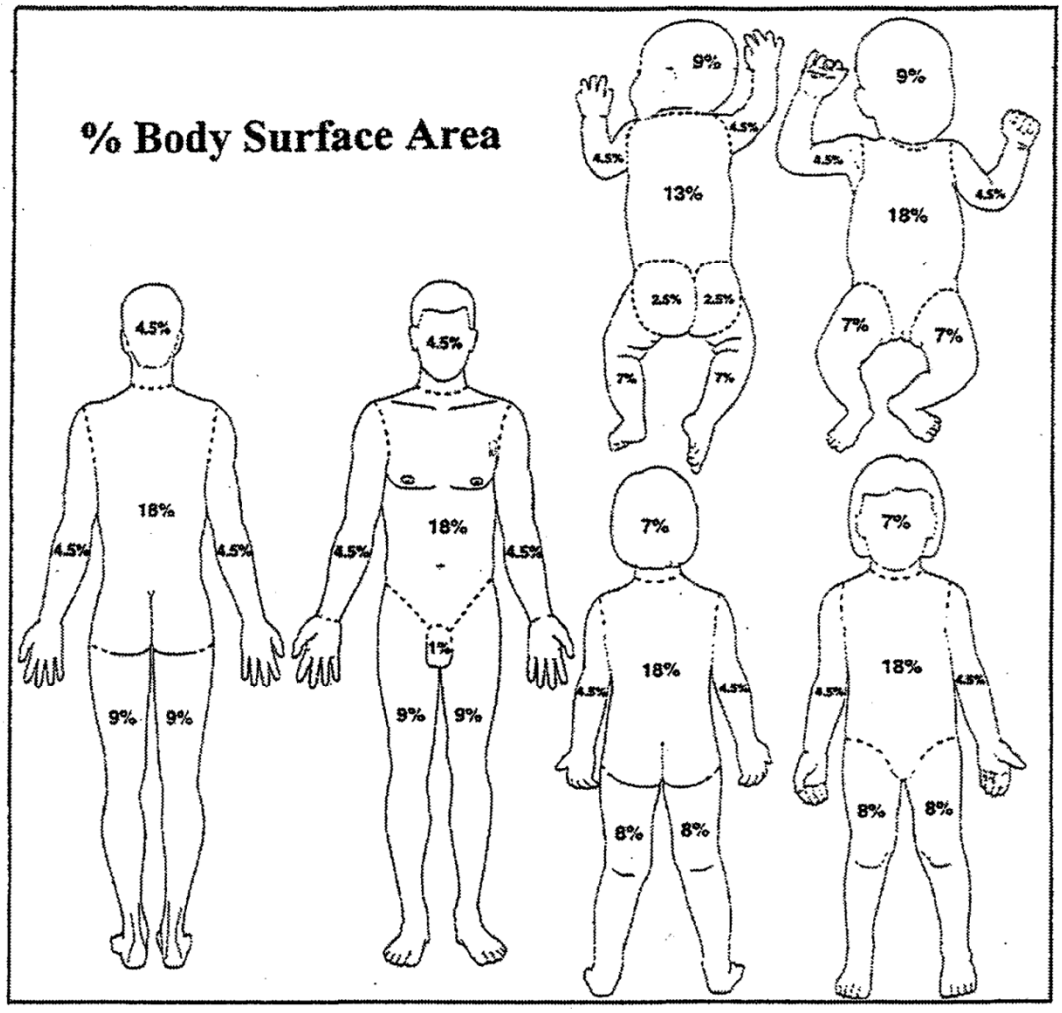


Written: 1/09
Reviewed: 3/09; 5/11
Revised: 3/09; 5/11
MDC Approval: 4/7/09
IDPH Approval: 3/5/10
Implementation: 1/1/11

BURNS - PEDIATRIC - BLS



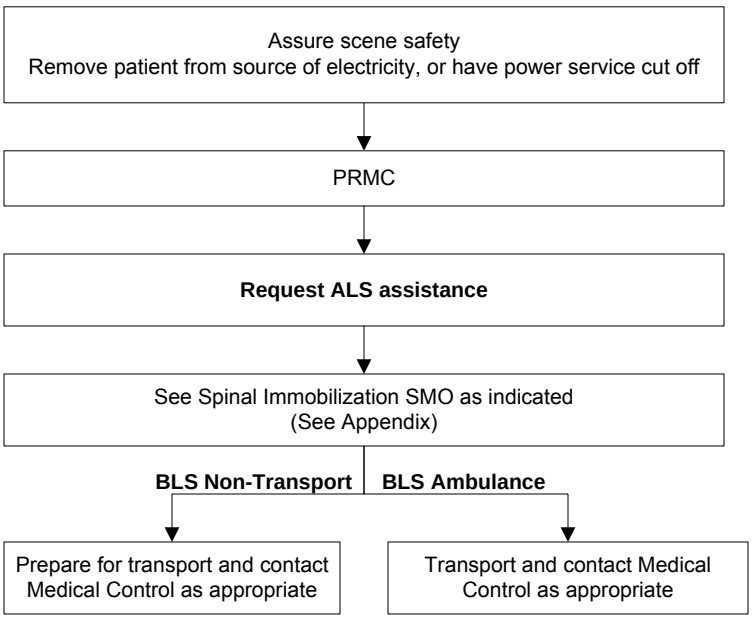
1 – See next page for Pediatric Burns % Body Surface Area



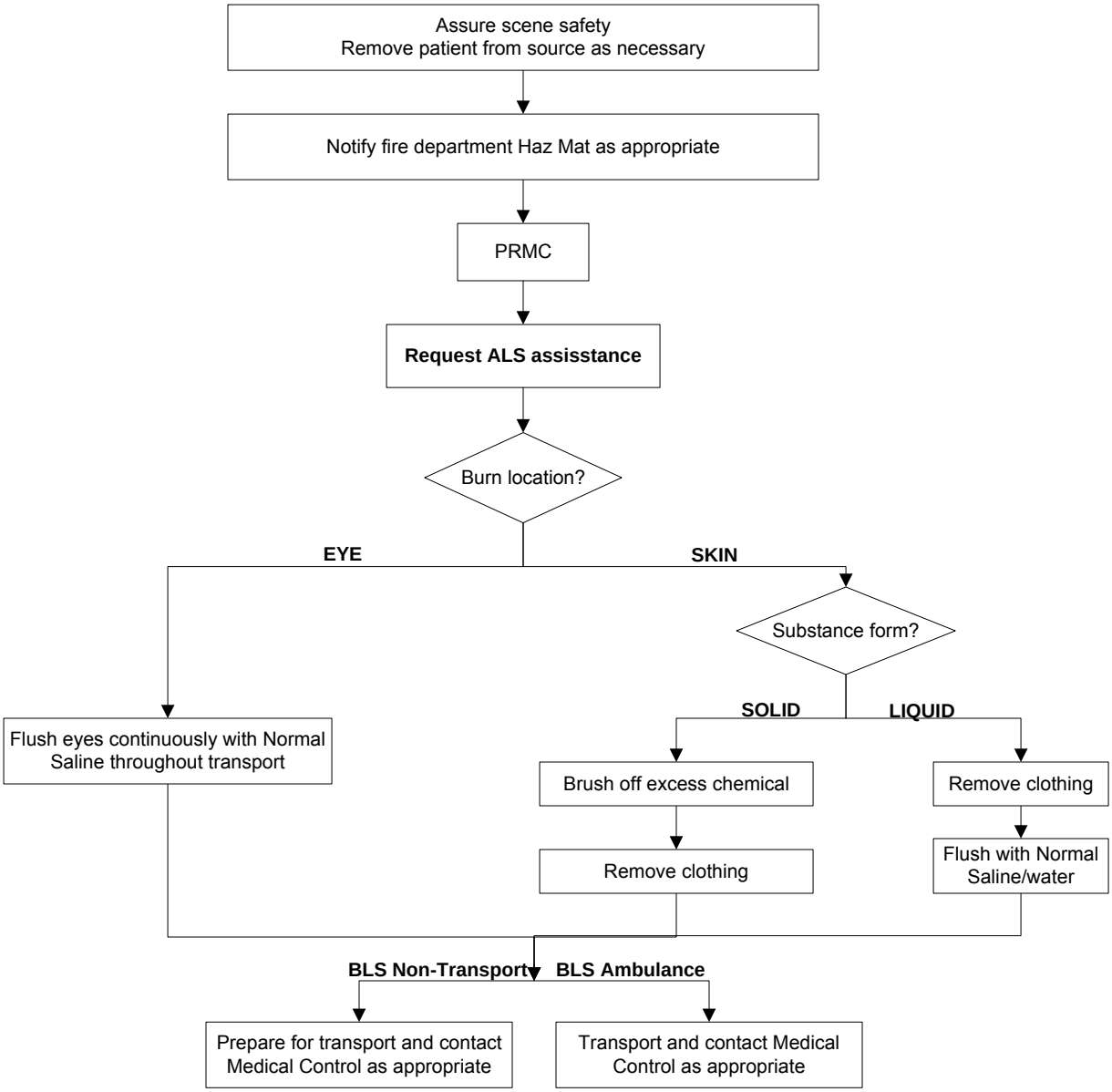
Palm of hand (including fingers) of infant or child = 1% of the total body surface

Any patient with a life threatening condition should be treated until stable at the nearest appropriate facility before being transferred to a burn center.

ELECTRICAL / LIGHTNING BURNS - PEDIATRIC - BLS



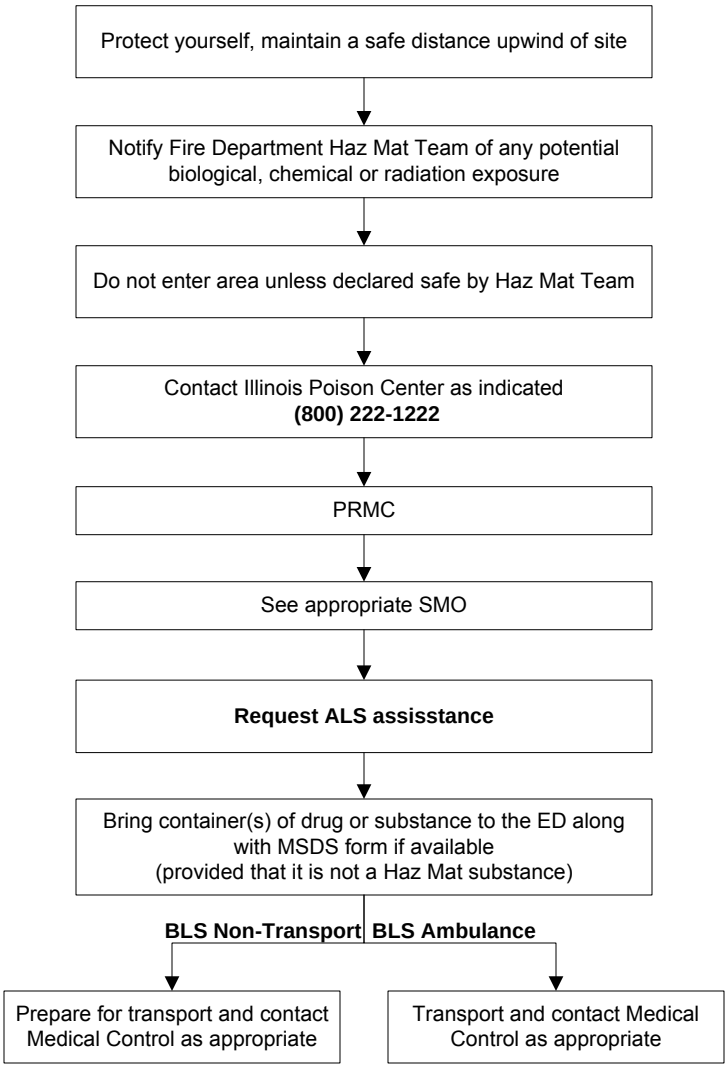
CHEMICAL BURNS - PEDIATRIC - BLS



*** All efforts should be made to decontaminate the patient prior to transport, as appropriate per HazMat team.**

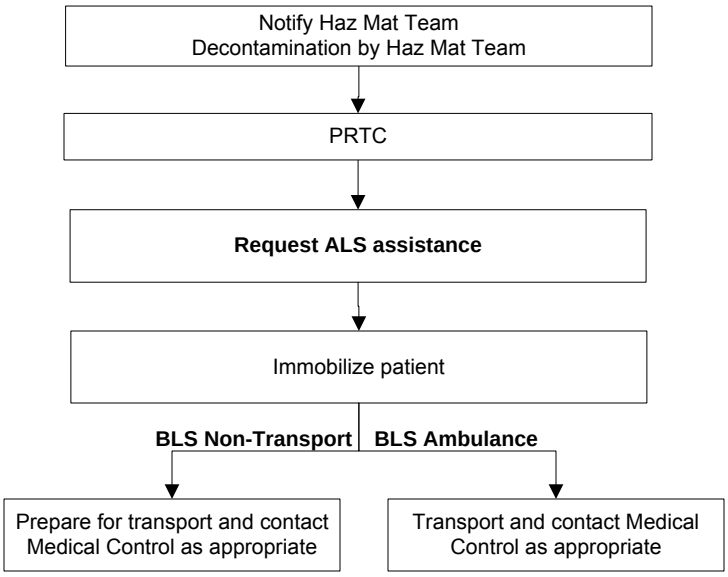
Written: 12/99
Reviewed: 3/00;3/09; 5/11; 10/15
Revised: 3/00; 3/09; 5/11; 10/15
MDC Approval: 1/00; 3/00; 4/7/09; 6/7/11; 10/5/15
IDPH Approval: 3/5/10; 9/29/11; 2/25/16
Implementation: CFD BLS 5/00; Other 8/00; 1/1/11; 4/1/12; 3/1/16

HAZ MAT / TOXIC EXPOSURE - PEDIATRIC - BLS



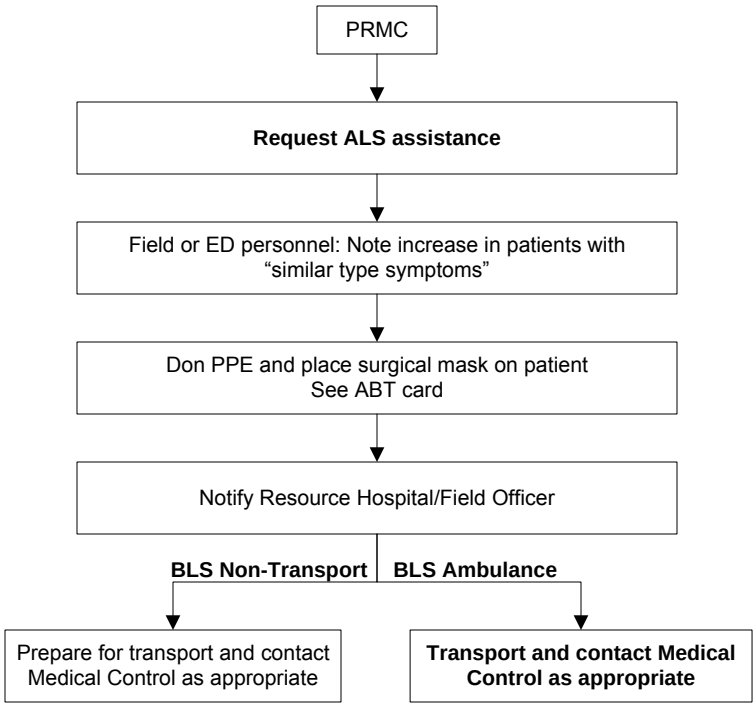
*** All efforts should be made to decontaminate the patient prior to transport, as appropriate per HazMat team.**

HAZARDOUS EVENTS / NUCLEAR/BLAST INJURIES - PEDIATRIC - BLS



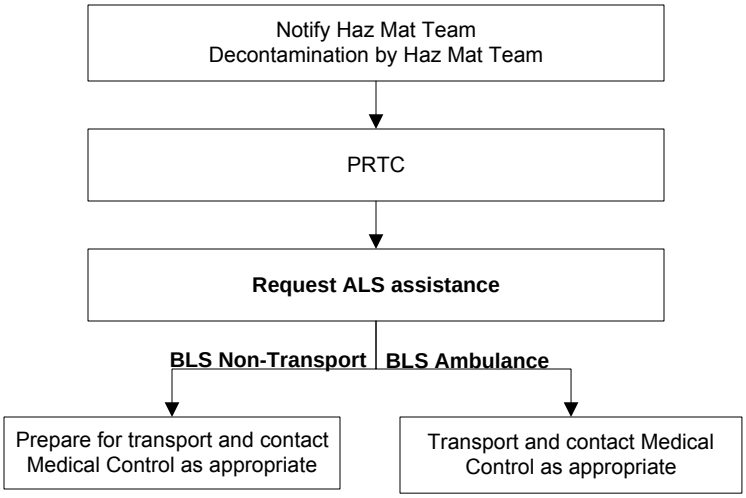
*** All efforts should be made to decontaminate the patient prior to transport, as appropriate per HazMat team.**

HAZARDOUS EVENTS / SUSPECTED BIOLOGICAL - PEDIATRIC - BLS



*** All efforts should be made to decontaminate the patient prior to transport, as appropriate per HazMat team.**

HAZARDOUS EVENTS / CHEMICALS and NERVE AGENTS - PEDIATRIC - BLS



*** All efforts should be made to decontaminate the patient prior to transport, as appropriate per HazMat team.**

Written: 1/09
Reviewed: 3/09; 5/11; 10/15
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MDC Approval: 4/7/09; 6/7/11; 10/5/15
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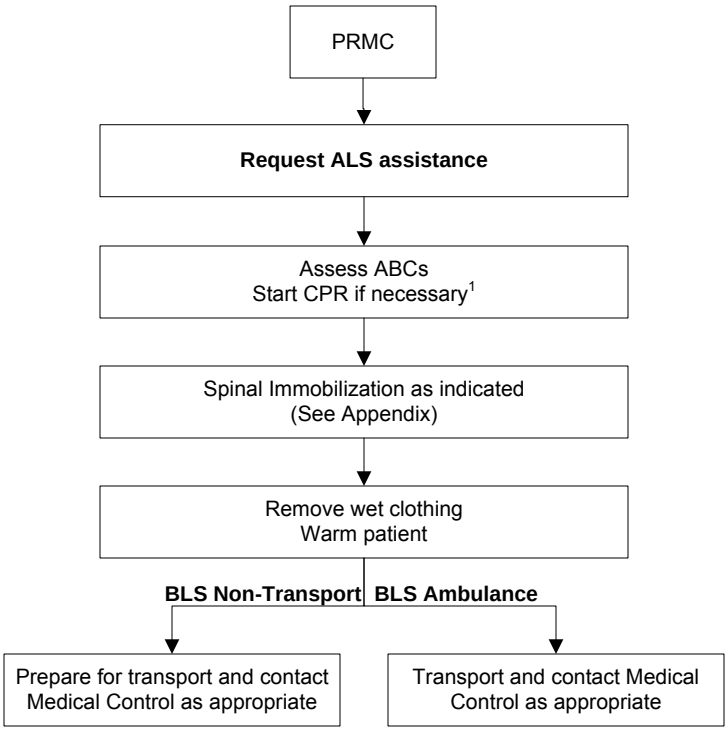
Implementation: 1/1/11; 4/1/12; 3/1/16

NEAR DROWNING - PEDIATRIC - BLS



1 – Pediatric CPR rates: 1 rescuer = 30 compressions: 2 ventilations
2 rescuers = 15 compressions: 2 ventilations

Written: 1/09
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Implementation: 1/1/11; 3/1/16

PEDIATRIC DRUG DOSING
DOSE REFERENCE GUIDE - BLS

DRUG	DOSE	MODE	INTERVAL/ RATE	DOSE PREP.
ALBUTEROL	2.5 mg	Nebulizer	X 1	2.5 mg/3 ml
ATROVENT	0.5 mg	Nebulizer	X 1	0.5 mg/3 ml
GLUCOSE, ORAL[1] (Age 1 month to 4 years)	¼ tube	PO	as indicated	25 gm/tube
GLUCOSE, ORAL (Age 4 to 8 years)	½ tube	PO	as indicated	25 gm/tube
GLUCOSE, ORAL (Age greater than 8 years)	1 tube	PO	as indicated	25 gm/tube
NALOXONE	1 mg: 0-4 years	IN	as indicated	2 mg/2 ml
NALOXONE	2 mg: > 4 years	IN	as indicated	2 mg/2 ml

1 - Oral Glucose is NOT to be used for patients less than 1 month old.

Written: 1/09
Reviewed: 3/09; 5/11; 5/16
Revised: 3/09; 5/11; 5/16
MDC Approval 4/7/09; 6/7/11
IDPH Approval: 7/9/09; 9/29/11
Implementation: 1/1/10; 4/1/12

APPENDIX

REGION XI APPROVED OXYGEN DELIVERY METHODS

Delivery Method	Flow Rate
Nasal Cannula	1 – 6L / min.
Non-rebreather Mask (NRB)	10 -15L / min.
Bag Valve Mask (BVM)	15L / min.
Endotracheal Intubation	15L / min.
King LT Supraglottic Airway	15L / min.
Blow-by (for children who do not tolerate a NRB)	10 – 15L / min.

Written: 2/16
Reviewed:
Revised:
MDC Approval: 2/16/16
IDPH Approval: 2/25/16
Implementation: 3/1/16

GLASGOW COMA SCALE (GCS)

TOTAL 3 to 15

EYES OPEN:	Spontaneously	4
	Verbal	3
	Pain	2
	None	1
BEST VERBAL:	Oriented	5
	Confused	4
	Inappropriate	3
	Incomprehensible	2
	None	1
BEST MOTOR:	Obeys	6
	Localizes	5
	Withdraws	4
	Abnormal Flexion	3
	Abnormal Extension	2
	None	1

Written: 1/09
Reviewed: 3/09; 5/11
Revised: 3/09
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IDPH Approval: 7/9/09
Implementation: 1/1/10

CINCINNATI STROKE SCALE

1) **Facial droop**: Have patient show teeth or smile
Abnormal: One side does not move as the other

2) **Arm drift:** Have patient close eyes and hold arms out for 10 seconds with palms up
Abnormal: One arm does not move or drifts down

3) **Abnormal speech:** Have patient say "You can't teach an old dog new tricks"
Abnormal: Patient slurs words, uses wrong words, or is unable to speak

Relative Criteria for Transport to a Primary Stroke Center (PSC)

Patients with a negative or unattainable CSS may be transported to a PSC if acute stroke ≤6 hours in duration is suspected by the Base Station based on any of the following:

- Sudden and persistent alteration of consciousness
- Sudden onset severe headache (especially in association with vomiting +/- systolic BP >200)
- Severe and sudden loss of balance

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Implementation: 1/1/10; 4/1/12

ADVANCED AIRWAY MANAGEMENT

KING LTS-D AIRWAY (SUPRAGLOTTIC AIRWAY) INTUBATION

INDICATIONS

- Airway management in a non-breathing person without a gag reflex
- Patient is over 4 feet in height.

CONTRAINDICATIONS

- Patients under 4 feet in height.
- Intact gag reflex.
- Patients with known esophageal disease
- Patients who have ingested caustic substances

EQUIPMENT

1. King LTS-D Airway
2. 14 Fr soft suction catheter
3. Lubricant
4. 60 cc syringe

PROCEDURE

1. Pre-oxygenate the patient.

2. Choose the correct size King LTS-D airway

    - **Size 3** fits **4-5 feet** in height **Yellow** connector.
    - **Size 4** fits **5-6 feet** in height **Red** connector.
    - **Size 5** fits **6+ feet** in height **Purple** connector.

3. Inspect the King LTS-D for visible damage prior to insertion.

4. Test cuff to ensure there are no leaks.

5. Apply a water-based lubricant to the beveled distal tip and posterior aspect of the tube. Avoid getting lubricant near the ventilatory openings.

6. Position patient's head. The ideal position for the King LTS-D insertion is "sniffing position". The angle of the King LTS-D does not allow for insertion at a neutral angle.

7. Hold the King LTS-D at the connector with the dominant hand. With the non-dominant hand, hold the mouth open and apply chin lift, unless contraindicated by C-spine precautions or patient position. Using a lateral approach, introduce tip into corner of mouth.

8. Advance the tip behind the base of the tongue while rotating tube back to midline so that the blue orientation line faces the chin of the patient.

9. Without exerting excessive force, advance the King LTS-D until base of connector is aligned with teeth or gums.

10. Inflate the cuffs with the minimum volume necessary to seal the airway. Inflation volumes are located the King LTS-D airway. Typical inflation volumes are as follows:

    - Size 3: 45-60 cc
    - Size 4: 60-80 cc
    - Size 5: 70-90 cc

11. Gently ventilate the patient using BVM. If initial ventilations meet resistance perform the following:

    - Slowly pull back on King LTS-D airway while gently ventilating.
    - When ventilations suddenly become easy and free flowing with corresponding chest wall rise maintain that level of insertion.

12. Confirm placement to ensure adequate ventilations by auscultation of lung sounds, observing adequate chest rise, and verification of end tidal CO2 waveform.

13. If necessary, add additional volume to cuff to maximize seal of the airway (within cuff size limits).

14. Secure King LTS-D airway to patient utilizing tape or appropriate commercial device.

15. Lubricate a 14 Fr. suction catheter prior to inserting into the King LTS-D's gastric access lumen.

16. Document the size of King LTS-D airway used and the depth of insertion at teeth or lips.

Note: The King LT airway does not protect the airway from aspiration like ET intubation does.

Written: 12/99
Reviewed: 3/00; 3/09; 5/11; 11/14
Revised: 3/00; 3/09; 11/14
MDC Approval: 1/00; 3/00; 4/7/09; 11/13/14
IDPH Approval: 7/9/09; 5/20/15
Implementation: CFD BLS 5/00; Other 8/00; 1/1/10; 6/1/15

CARDIAC ARREST MANAGEMENT
Incident Command for Cardiac Arrest (ICCA)

INDICATIONS

- Non-traumatic cardiac arrest

CODE TASKS

- Resuscitation must begin and continue where patient is encountered
- Provide high quality, uninterrupted chest compressions
- Provide early defibrillation
- Provide controlled ventilatory management during the resuscitation
- IV/IO access and ALS drug delivery
- End Tidal CO2 monitoring

EQUIPMENT

BLS:

1. Automated External Defibrillator
2. Bag Valve Mask
3. Supraglottic Airway (Combitube or King Airway)
4. Oxygen

ALS:

1. Lifepak 1000 monitor/defibrillator/pads (or private provider equivalent)
2. Lifepak 12/15 monitor/defibrillator/ETCO2/pads (or private provider equivalent)
3. Bag Valve Mask
4. Advanced airway equipment (supraglottic airway or endotracheal tube)
5. IV/IO equipment
6. ACLS drugs

PROCEDURE

1. Begin and continue resuscitation where the patient is encountered. **DO NOT MOVE THE PATIENT**. Call for an assist company (or as per private provider protocol). Patients should only be moved for scene safety concerns, not for provider convenience. Any delay in initiation of resuscitation will decrease the chance of survival.

2. Initiate high quality uninterrupted chest compressions. Harder-deeper-faster with rate 100-120 per minute. Use alternate providers to avoid fatigue. Chest compressions should only be interrupted to analyze rhythm and deliver defibrillation (< 10 seconds).

3. Attach cardiac monitor and assess rhythm. Defibrillate if ventricular fibrillation or pulseless ventricular tachycardia (or if AED advises). May initiate care with Lifepak 1000, however, upgrade to Lifepak 12/15 as soon as manpower allows.

4. Basic airway management with bag valve mask ventilation. Apply End Tidal CO2 to BVM. Monitor ETCO2 to assess quality of CPR. Goal ETCO2: > 12. If < 12 improve quality of chest compressions or switch compressors.

5. Continue 2 minute cycles of CPR and defibrillation until assist company arrives. Do not attempt IV/IO access or advanced airway management until at least three providers are on scene.

6. Code commander delegates tasks when assist company arrives.

7. IV/IO access and administration of drugs as per ALS SMOs B-3 and B-4. The proximal tibia is the preferred site for IO access during cardiac arrest resuscitation.

8. Place supraglottic airway (preferred advanced airway for patients in cardiac arrest). Endotracheal intubation may be performed as backup airway if unable to ventilate/oxygenate with supraglottic airway. Do not interrupt compressions during placement of an advanced airway.

9. Apply End Tidal CO2. Monitor waveform and number to assess:
    a. Correct advanced airway position and ventilation
    b. Quality of CPR
    c. Return of spontaneous circulation (ROSC)

10. Contact online medical control from the scene (before moving the patient) to discuss the following options:

    a. Termination of Resuscitative efforts (see policy….)
    b. Continue resuscitation on scene and recontact medical control
    c. ROSC achieved (consider therapeutic hypothermia see protocol …) and transport to closest STEMI center
    d. Ongoing resuscitation of patient without ROSC and transport to closest STEMI center versus closed comprehensive ED.

    Patients with ROSC or refractory Ventricular Fibrillation/Pulseless ventricular tachycardia should be transported to the closest STEMI-Receiving Center (SRC). Consider transport to a SRC for any patient with ongoing resuscitation.

MANDATORY DOCUMENTATION

1. “Cardiac Arrest” should be listed for paramedic impression for all non-traumatic cardiac arrest victims. Do not use “rule out” for any cardiac arrest impression.

2. All information from the first company on scene should be relayed to the transporting paramedics and included in both patient care records (assist company sheet and MRU).

3. All mandatory cardiac arrest questions in the MRU should be completed before record is closed.

4. End-Tidal CO2 number and waveform should be documented in the patient care record.

5. Lifepak 15 “Report>All” should be downloaded into the MRU computer once at hospital. This includes every monitor that was used during the code.

6. Lifepak 15 “Report>All” should additionally be uploaded to CodeSTAT.

ICCA ROLES AND RESPONSIBILITIES

Cardiac arrest is a shared ALS and BLS response. Successful resuscitation requires a coordinated effort. Upon arrival, resuscitation roles should be clearly delegated by the highest ranking medical member on scene, so that primary **code tasks** are carried out quickly and efficiently.

1. Code Commander

- Highest ranking medical member on scene
- Oversees all operations
- Responsible for timing of CPR cycles and defibrillation
- Requests additional manpower/resources
- Completes and/or delegates **code tasks**

2. Compressor-1

- Performs high quality uninterrupted chest compressions
- Assume compressor 2's role when relieved

3. Compressor-2

- Monitor's the effectiveness of compressor 1's compressions (monitors ETCO2 for compression quality feedback)
- Assists with seal during bag valve mask ventilation
- Relieves compressor 1 after 2 minutes or when compression quality decreases

4. Procedures

- Apply cardiac monitor/analyze rhythm
- Defibrillate
- Gain IV/IO access
- Administer medications as per ALS SMOs B-3 and B-4
- Basic and advanced airway management
- Apply and monitor End Tidal CO2

5. Logistics

- Oversee distribution of equipment
- Set up IV/IO equipment
- Assemble medications/assist with drug delivery
- Facilitates communication with online medical control
- Prepares for transport
- Relief for other tasks

6. Liaison/Safety

- Control the scene and provide for the safety of the resuscitation team
- Data collection/documentation: Patient demographics, medications, medical history, events
- Communicates and assists with family/bystanders

Written: 4/5/13
Reviewed: 10/15
Revised: 10/15
MDC Approval: 4/5/13; 10/5/15
IDPH Approval: 6/26/13; 2/25/16
Implementation: 1/6/14; 3/1/16

AUTOMATIC EXTERNAL DEFRIBILLATOR (AED)

INDICATIONS

- See appropriate SMO

CONTRAINDICATIONS

- Potential injury to rescuer

EQUIPMENT

1. Conduction jelly/defibrillation pads/saline pads
2. Monitor/defibrillator
3. Therapy pads

Written: 1/09
Reviewed: 3/09; 5/11
Revised: 3/09
MDC Approval: 4/7/09
IDPH Approval: 7/9/09
Implementation: 1/1/10

INTRA-NASAL DRUG ADMINISTRATION
Mucosal Atomization Device (MAD)

INDICATIONS

- Opioid Overdose – Naloxone (Adults & Pediatrics)

CONTRAINDICATIONS

- Nasal trauma

EQUIPMENT

1. Mucosal Atomizer Device (MAD)
2. Syringe

PROCEDURE

1. Draw up dose of medication into syringe
2. Expel air from syringe
3. Remove needle and attach MAD to syringe
4. Insert tip of MAD into nostril.
5. Rapidly administer medication (1ml max per nostril; recommend giving ½ the volume in each nostril)
6. Document the medication dose and patient response.

Written: 5/16
Reviewed: 5/16
Revised:
MDC Approval: 6/7/16
IDPH Approval: 8/11/16
Implementation: 10/17/16

EPINEPHRINE AUTO-INJECTOR (EpiPen)

INDICATIONS:

- Allergic Reactions

CONTRAINDICATIONS:

- None

MEDICATION:

- EpiPen Auto-Injector - Adult dose 0.3 mg of epinephrine
- EpiPen Jr Auto-Injector - Pediatric dose 0.15 mg of epinephrine
  Use an EpiPen 0.3 mg auto-injector for children over 25 kg (55 lb) and EpiPen Jr 0.15 mg auto-injector for children less than 25 kg (55 lb).

PROCEDURE

1. Obtain appropriate Epi-pen (adult dose 0.3 mg or pediatric dose 0.15 mg).

2. Make sure the medication is not discolored or expired.

3. Remove safety cap from auto-injector, if possible wipe patient's thigh with alcohol wipe. However, do not delay administration of the drug.

4. Place the tip of the auto-injector against the lateral part of the patient's thigh, midway between the waist and the knee.

5. Push injector firmly against the thigh until the injector activates, hold the injector in place until the medication is injected about 10 seconds.

6. Remove the injector from the patient's thigh and dispose of it in the proper biohazard container.

7. Reassess and record patient's vital signs after using the auto-injector.

8. Record the time and dose of injection on your patient care report.

REFERENCES:

- *Illinois EMSC Pediatric Allergic Reaction/Anaphylaxis BLS Care Guidelines.*
- *Brady Emergency Care 12th Edition*

Written: 10/2013
Reviewed:
Revised:
MDC Approval: 11/5/13
IDPH Approval: 1/28/14
Implementation: 6/1/14

TOURNIQUET APPLICATION

INDICATIONS

- Life threatening extremity hemorrhage that cannot be controlled by other means.

CONTRAINDICATIONS

- Non-extremity hemorrhage.
- Proximal extremity location where tourniquet application is not practical.

EQUIPMENT

System approved tourniquet

PROCEDURE

1. Visually inspect injured extremity and avoid placement of tourniquet over joint, angulated or open fracture, stab or gunshot wound sites.

2. Apply the tourniquet directly to skin, proximal to the wound, 2-3 inches above the wound or as high as you can go above the wound.

3. Secure tourniquet:

    - Pull the free running end of the self-adhering band *tight* and securely fasten the band back on itself (if applying to an arm wound). Do not adhere the band past the windlass rod.
    - If applying to a leg wound, the self adhering band must be routed through the friction adapter buckle and fastened back on itself. This will prevent it from loosening when twisting the windlass rod.

4. Twist the windlass rod until *bright red bleeding has stopped and the distal pulse is eliminated*.

5. Place the windlass rod inside the clip locking it in place. *Check for bleeding and distal pulse.* If bleeding is not controlled consider additional tightening or applying a second tourniquet side by side to the first tourniquet and reassess.

6. Secure the rod inside the clip with the strap.

7. Record time of tourniquet application.

8. Cover wound with appropriate sterile dressing and/or bandage. ***Do not cover tourniquet - the device must remain visible.***

9. Reassess and document absence of bleeding distal to tourniquet.

10. Remove any improvised tourniquets that might have been previously applied.

11. Prepare patient for transport and reassess effectiveness of the tourniquet every 10 minutes.

12. Ensure receiving hospital staff is aware of tourniquet placement and time tourniquet was applied.

MANDATORY DOCUMENTATION

- Location of injury and mechanism involved.
- Methods attempted to control bleeding and the time direct pressure was applied.
- Location of application of tourniquet
- Time of application of tourniquet
- Reassessment of tourniquet and its effectiveness
- Person at receiving hospital to whom use and location of the tourniquet is reported to

Written: 8/13
Reviewed: 9/13
Revised:
MDC Approval: 9/3/13
IDPH Approval: 9/30/13
Implementation: 10/1/13

SPINAL IMMOBILIZATION

INDICATIONS

- Traumatic head/neck/back pain - blunt and penetrating
- All patients with altered levels of consciousness who sustain trauma above the clavicles
- All patients with sensory or motor deficits following blunt or penetrating neck/back injury
- Significant mechanism of injury
- Patients demonstrating sensory or motor deficits should be considered for short board/KED extrication
- Consider patient exposed to electrical source (i.e. lightening, electrocution)

CONTRAINDICATIONS

- Caution should be used with impaled objects

EQUIPMENT

1. Hard cervical collar
2. Short board/KED
3. Long board with straps
4. Padding material
5. Lateral immobilization/padding

PROCEDURE

1. Secure scene and employ universal precautions

2. Stabilize head with hands and maintain in-line position

3. Apply appropriately sized collar

4. Move patient to long board, apply firm padding as needed to maintain full neutral spinal position. Head padding should be sufficient to limit lateral cervical movement

2. Secure/tape patient's torso and extremities to board. Infants in car seats should have application of an appropriate collar and lateral immobilization positioned in the car seat

3. Secure/tape head to padding and long board across forehead and collar

Written: 12/99
Reviewed: 3/00; 3/09; 5/11
Revised: 3/00; 3/09
MDC Approval: 1/00; 3/00; 4/7/09
IDPH Approval: 7/9/09
Implementation: CFD BLS 5/00; Other 8/00; 1/1/10

LATEX ALLERGIC PATIENTS

INDICATIONS

- Patients with known sensitivity to latex
- Patients with onset of respiratory or dermatological signs and symptoms once care is initiated

CONTRAINDICATIONS

- None

EQUIPMENT

LATEX FREE products for:

1. AIRWAY:
   a. Oral/Nasal airways
   b. Suction catheters
   c. BVM/masks
   d. O_2 tubing
   e. Endotracheal tubes
   f. Stylets

2. IV:
   a. Tourniquets
   b. Gloves
   c. Tape

When utilizing other medical equipment such as stethoscopes or blood pressure cuffs, provide a barrier between the patient and the device, for example Kerlix, 4 x 4's, cloth, etc.

PROCEDURE

1. Utilize latex free products whenever possible

2. If a patient experiences an onset of symptoms (i.e., respiratory and/or dermatological signs and symptoms) and routine, latex gloves have been utilized:
   a) DO NOT REMOVE GLOVES.
   b) PLACE LATEX FREE GLOVES OVER LATEX GLOVES, AS A SECOND PAIR.

3. MEDICATION ADMINISTRATION: Medication should not be drawn from a multi-dose vial, if possible. Medication drawn up in a syringe must be given immediately after withdrawing the medication.

4. BANDAGING: Secure bandaged sites with cloth or silk tape.

5. TREATMENT OF REACTION: See Allergic Reaction SMO for treatment of a latex reaction.

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ABBREVIATIONS/ACRONYMS

ABCs	Airway, Breathing, Circulation
ABT	Advanced Bioterrorism Triage
ALS	Advanced Life Support
BLS	Basic Life Support
BP	Blood Pressure
BSA	Body Surface Area
BS	Blood Sugar
BSI	Body Substance Isolation
BVM	Bag valve Mask
CO	Carbon monoxide
CP	Chest Pain
CPAP	Non-Invasive Pressure Support Ventilation
CPR	Cardiopulmonary Resuscitation
CRIC	Cricothyrotomy
CSHN	Children with Special Healthcare Needs
ECP	Emergency Communications Physician
ED	Emergency Department
EPI	Epinephrine
ET	Endotracheal Tube
ETOH	Alcohol
GCS	Glasgow Coma Scale
HR	Heart Rate
IM	Intramuscular
IN	Intranasal
IV	Intravenous
IVP	Intravenous Push
MAD	Mucosal Atomizer Device
NP	Nasopharyngeal
NRB	Non-rebreather Mask
NS	Normal Saline
NTG	Nitroglycerin
OB	Obstetrical
OP	Oropharyngeal
PGCS	Pediatric Glasgow Coma Scale
PO	By mouth
PPE	Personnel Protective Equipment
PR	Per Rectum
PRMC	Pediatric Routine Medical Care
PRTC	Pediatric Routine Trauma Care
PSC	Primary Stroke Center
RMC	Routine Medical Care
RR	Respiratory Rate
RTC	Routine Trauma Care
S/S	Signs and Symptoms
SBP	Systolic Blood Pressure
SL	Sublingual
SMO	Standing Medical Orders
SRC	STEMI Receiving Center
VS	Vital Signs

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