

REGION I EMERGENCY MEDICAL SERVICES

Emergency Medical Responder Standing Medical Orders

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STANDING MEDICAL ORDERS
EMR**

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Emergency Medical Responder Standing Medical Orders General Guidelines

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SMO: Body Substance Exposure

Overview: Body substance exposure is a significant risk for pre-hospital care providers. This SMO serves as a guideline for exposure reporting in EMS Region 1. For specific information, review the receiving hospital specific procedure for reporting, treatment and follow-up care.

INFORMATION NEEDED

- Date and time of exposure
- Host patient
- Type of exposure
- BSI used by pre-hospital provider

OBJECTIVE FINDINGS

- A significant exposure is blood or body fluids on or in non-intact skin
- A non-significant exposure would be identified as blood or body fluids on in-tact skin or clothes, or BSI equipment

RECOMMENDATIONS

- Each hospital has specific procedures for the pre-hospital exposure. Consult with the ED nurse Manager for specific response to reporting, treatment and follow-up care.
- If a pre-hospital provider, (EMT, Fireman, Police Officer, etc), has a significant exposure, (e.g. blood or body fluid on non-intact skin, contact with mucous membranes or a needle stick), they should respond to the emergency department who is receiving the patient. The person who has the exposure should notify the charge nurse of the receiving hospital emergency department and advise that a potential significant exposure has occurred.
- The appropriate hospital, system and department incident reports must be completed. Some departments require additional notification paperwork be completed. Once the appropriate forms are completed, they will be turned into the receiving hospitals Emergency Department Charge Nurse and appropriate agency / department officer.
- An EMS system form must be completed and returned to the resource hospital of the agency involved (e.g., an exposure happens to an EMT on XYZ department in Anywhere. A form must be filled out for Anywhere Hospital, XYZ department and the EMS Resource Hospital of XYZ department)
- The appropriate person in the receiving hospitals emergency department will evaluate the exposure to determine if a significant exposure has occurred.

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RECOMMENDATIONS (continued)

- ___ If a significant exposure has occurred or is suspected the receiving hospitals Emergency Department Charge Nurse or appropriate designee will implement the hospital specific response procedure. This procedure will include but not be limited to baseline blood test on the EMS provider and host patient, interview and counseling of risks to EMS provider, follow-up information and / or referral which may or may not include prophylaxis.
- ___ The response action will be documented on the incident report forms and forwarded to the EMS provider, receiving facility infection control provider, providers department officer (if applicable), and the providers EMS System Resource Hospital.
- ___ Follow-up notification of test results is the responsibility of the receiving hospital infectious disease provider. The EMS Systems Coordinator will follow up within 48 hours of receipt of incident report to clarify procedure has been accomplished and notification and follow-up has occurred.
- ___ If the exposure is identified as non-significant the EMS provider will be advised of same and no further testing will be accomplished. The EMS provider will be counseled on proper use of BSI in the pre-hospital environment.
- ___ The non-significant exposure will be documented on the incident report and forwarded to the chain of command of the provider and the EMS Resource Hospital System Coordinator.

Documentation of adherence to SMO

Complete and accurate information regarding:

- Exposure type
- Host patient
- EMS provider
- Receiving hospital
- Description of event
- Results and follow-up care and notification
- It is imperative that the EMS provider who has a potential exposure report to the receiving hospital's emergency department at the time of exposure. Delay in reporting could result in hospital and staffs inability to attain host blood for testing and effectively provide counseling, intervention or follow-up. The provider should initiate this as soon as possible. Follow any additional agency specific policies and/or procedures.
- The best response to an exposure is not to have one. Use proper BSI precautions in every patient encounter.
- If there are questions regarding BSI precautions, vaccinations, or proper reporting contact the local hospital, host agency / Department Chief or EMS Officer or the EMS Systems Coordinator at the EMS Resource Hospital.

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PROCEDURE: Body Substance Isolation (Universal Precautions)

Overview: Body substance isolation should be used for all patient contacts if the pre-hospital provider may be exposed to blood or other body fluids.

INFORMATION NEEDED

- Assume all patients are carriers of infectious / contagious disease
- If specific contagion is identified respond with appropriate BSI protection (e.g. TB appropriate fitted mask with filtration system, gown, and gloves)
- If disease etiology dictates, mask and cover patient appropriate to minimize exposure
- Review patient chart for specifics to contagion
- Make sure annual testing and prophylaxis is accomplished
- Make sure proper testing and BSI equipment is available for use prior to patient response

Use BSI:

- Potential respiratory contagion in a closed ambulance environment
- Potential contagion from blood and body fluids during a trauma patient response
- Potential contagion during an invasive skill (e.g. needle stick)

RECOMMENDATIONS

- Gloves should be worn when handling blood, body fluids, mucous membranes, non-intact skin, and body tissues. Double glove if necessary.
- New gloves should be worn for each patient contact. Hands must be washed (wet or dry wash) after glove removals and between patient contacts.
- If splash of blood or body fluid is anticipated, a full face shield or goggles and facemask should be worn
- If emergency ventilatory support is necessary. A resuscitation mask with one-way valve and filter or bag valve mask should be used.
- Do not recap needles. Promptly place sharps in a designated puncture resistance, protected lid container.
- Place all soiled linen in a properly marked laundry bag before sending in to laundry or leaving at hospital.
- Do not launder contaminated clothes with regular laundry. Wash separately then rinse washer with at least a 1:10 bleach solution.
- Use a solution of 1 part bleach to 10 parts water (or equivalent solution) to clean equipment, clean spills, and decontaminate walls, floors, and other objects soiled with blood or body fluids.

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RECOMMENDATIONS (continued)

- If pre-hospital provider has a skin break (cut, abrasion, dermatitis, etc) use gloves and clothing to protect from exposure with blood or body fluids
- Keep vaccinations current and have proper annual testing
- Significant exposure to and possible contamination from blood or body fluids should be reported immediately (ask receiving hospital for Exposure Report Form)
- Patients should be asked if they are allergic to latex. Non-latex equipment should be used on all patients that have latex allergies.

Documentation of adherence to SMO

- BSI used
- Documentation of situation in which potential exposure or exposure occurred
- Nature of contagion
- Person or agency exposure reported to and additional information regarding origination of transfer, number of people potential exposed, duration of exposure and receiving facility.

PRECAUTIONS AND COMMENTS

- Make sure that proper BSI equipment is available prior to patient encounter
- Since there is no reliable, immediate means to identify infected patients, pre-hospital care providers should be equally cautious when caring for all patients.

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SMO: Firearm Concealed Carry Act

Overview: Illinois has implemented the Firearm Concealed Carry Act allowing registered individuals to possess a concealed firearm on a daily or routine basis. This SMO will be a common sense guide for the EMS provider in dealing with the firearm during patient care procedures. While it is not an exhaustive list of possible situations, it will give guidance during most situations.

Information Needed:

Consider that the safest place for the firearm in any of these situations is in the accompanying holster. EMS providers will now need to ask if the patient is armed before making the decision to start an evaluation. It may be necessary to remind the patient that State law prohibits firearms on a hospital campus. When approaching a scene where the patient may be carrying a concealed handgun, several scenarios are possible and should be handled in one of the following manners:

1. The patient is at their private residence. Ask or assist the patient in removing the firearm and holster as one unit and leave it at the residence in their previously designated location (ideal situation).
2. If law enforcement is at the scene during situations such as a traffic accident or public encounter, have the officer secure and take custody of the firearm.
 - a. If the patient is unable to remove the holstered firearm due to significant mechanism of injury and a full body assessment is needed, cut the holster straps and remove the holstered firearm from the patient as a unit and give to law enforcement.
 - b. If the holster is contaminated with blood or bodily fluid, have the officer don gloves before touching the holstered firearm. Provide a plastic or biohazard bag if necessary.
 - c. If the patient has an altered level of consciousness and is unable to comply with the request to remove the holstered firearm, safely remove the holstered firearm by whatever means necessary (cut holster straps, unbuckle straps, etc.) and give to law enforcement when available, or have the officer assist with safe removal of the firearm. Belligerent, combative, or uncooperative patients that are known to have a firearm should not be approached until law enforcement arrives or the scene is otherwise made safe.
3. If law enforcement are not on scenes to take custody of the firearm, place the holstered firearm in the lockable firearm transport (see IDPH recommendation).
4. If the hospital has a secure location, such as a gun safe currently used by law enforcement, place the firearm, holstered if possible, in the gun safe and notify law enforcement or a qualified hospital security agent.
5. Make arrangements for law enforcement to meet the ambulance at the hospital and take custody upon arrival in the ambulance bay or parking area.
6. Women may carry the firearm in a purse rather than a holster. The safest approach is to leave the firearm in the purse, turning it and the contents over to law enforcement to secure the firearm. The purse can be returned to the patient once the firearm is removed and secure.

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7. If the patient has the firearm in a pocket without a holster, use extreme caution in retrieving it from the clothing, handling it only by the handle. Never attempt to unload the firearm or handle the trigger area. Avoid trying to manipulate or change the safety on a firearm. Have one crew member place the gun in a safe or secure location in the home or lockable firearm transport box in the ambulance until law enforcement arrives.
8. If the patient is to be transported by helicopter from the scene or a rendezvous point, leave the firearm with first arriving law enforcement or notify local law enforcement of the situation. Do not send the firearm in the helicopter.
9. It may be considered a refusal of care if a patient will not remove or relinquish their firearm. Contact Medical Control for any situation of this type.

PRECAUTIONS AND COMMENTS

- If the EMS provider feels threatened or that the scene is unsafe, then follow standard policies and procedures for scene safety.
- EMS providers should never attempt to unload a firearm, regardless of their experience with it.
- Providers should make arrangements with state, county, and local law enforcement to assist with these situations.
- Relinquish firearm only to law enforcement, security personnel, or other qualified person.
- At no time should patient care be compromised in a safe situation due to there being a firearm. This includes transporting to the hospital where law enforcement can rendezvous with EMS to take custody of the firearm.
- Receiving hospitals should allow an ambulance on the premises with a secured firearm to facilitate optimal patient outcomes, as long as arrangements are pending for law enforcement to take custody of the firearm.
- A chain of custody form may be necessary to reduce the potential of losing the firearm or ammunition while patient care is being administered. Consult local authorities or your hospital for such a form.

Medical Control Contact Criteria

__ Contact Medical Control whenever a question exists as to the best treatment course for the patient

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SMO: Do Not Resuscitate (DNR), POLST, Advanced Directive

Overview: IDPH EMS Region 1 Medical Directors have adopted the Illinois Department of Public Health (IDPH) “Uniform Do-Not-Resuscitate (DNR) Advanced Directive” as mandated by (210 ILCS 50/) Emergency Medical Services Act.

This SMO is intended to honor a physician’s order that reflects an individual’s wishes about receiving cardiopulmonary resuscitation (CPR). It allows an individual, in consultation with their health-care professional, to make advanced decisions about CPR, in the event the individual’s breathing and/or heartbeat stops. When the patient has a valid DNR form, EMS personnel will not institute “Cardiopulmonary Resuscitation”. This has been defined by IDPH as various medical procedures, such as chest compressions, electrical shocks, and insertion of a breathing tube, used in an attempt to restart the patient’s heart and/or breathing.

The implementation of this SMO references subsection (d) of Section 65 of the Health Care Surrogate Act, 755 ILCS 40/65, provides;

“A health care professional or health care provider may presume, in the absence of knowledge to the contrary, that a completed Department of Public Health Uniform DNR Order or a copy of that form is a valid DNR Order. A health care professional or health care provider, or an employee of a health care professional or health care provider, who in good faith complies with a do-not-resuscitate order made in accordance with this Act is not, as a result of that compliance, subject to any criminal or civil liability, except for willful and wanton misconduct, and may not be found to have committed an act of unprofessional conduct.”

“DNR” or Do Not Resuscitate does not allow for the withholding routine treatment from a patient who has a pulse and respiration.

The sections below explain what is on the form, however, situations where hospice patients call 911 generally need to be transported.

Information Needed

- Completed patient assessment.
- Completed IDPH or Medical Control approved POLST/ Advanced Directive form

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SMO: Do Not Resuscitate (DNR), Practitioner Order for Life-Sustaining Treatment (POLST),
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Objective Findings

- ___ Patient assessment to determine if the patient is presenting with:
- Full Cardiopulmonary Arrest
 - *Cessation of heartbeat and respirations
 - Pre-arrest Emergency
 - *breathing is labored or stopped
 - *heartbeat is still present
- ___ Completed IDPH approved POLST/ Advanced Directive form

Advance Directives

IDPH POLST form	Practitioner Orders for Life Sustaining Treatment; provides guidance during life-threatening emergencies. Must be followed by all healthcare providers
Power of Attorney for Healthcare	Names agent: rarely contains directions for authorized practitioner
Mental Health Treatment Declaration	Directions + Agent (for authorized practitioner)
Living Will	Directions for authorized practitioner (NOT EMS)

1. A valid, completed POLST form or previous DNR order does not expire. A new form voids past ones; follow instructions on most recent form. EMS is not responsible for seeking out other forms- work with form that is presented as truthful.
2. Original form NOT necessary- all copies of a valid form are also valid; form color does not matter.
3. SECTION A Cardiopulmonary Resuscitation: (no pulse and not breathing)
 - a. If "Attempt Resuscitation" box is checked, start full resuscitation per SMO. Full treatment (section B) should be selected.
 - b. If "Do Not Attempt Resuscitation/ DNR" box is checked; do not begin CPR.
4. SECTION B explains extent/intensity of treatment for persons found with a pulse and/or breathing.
 - a. Full Treatment: Primary goal of sustaining life by medically indicated means. In addition to treatment described in selected treatment and comfort-focused treatment, use of intubation, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated.
 - b. Selective Treatment: Primary goal of treating medical conditions with selected medical measures. In addition to treatment described in Comfort-focused Treatment, use medical treatment, IV fluids and IV medications as medically appropriate, and consistent with patient preference. Do not intubate. May consider less invasive airway support (CPAP/BiPAP). Transfer to hospital if indicated.

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- c. Comfort-Focused Treatment: Primary goal of maximizing comfort. Relieve pain and suffering through use of medications by EMS approved routes as needed; use oxygen, suction, manual treatment of airway obstruction. Do not use treatments listed in Full and Selected Treatment unless consistent with comfort goal. Contact transporting agency only if comfort needs cannot be met in current location.
5. COMPONENTS OF A VALID POLST form/ DNR order: Region I recognizes an appropriately executed IDPHPOLST form and/or any other written document that has not been revoked; containing at least the following elements:
 - a. Patient Name
 - b. Resuscitation order (Section A)
 - c. Date
 - d. 3 Signatures
 - i. Patient or Legal Representative Signature
 - ii. Witness Signature
 - iii. Authorized Practitioner Name & Signature (Physician, licensed resident (2nd year or higher), APN, PA)
6. If POLST or DNR form is valid: follow orders on form. If form is missing or inappropriately executed, contact Medical Control for guidance.
7. A patient, POA, or Surrogate that consented to the form may revoke it at any time. A POA or Surrogate should not overturn decisions made, documented, and signed by the patient.
8. If resuscitation begun prior to from presentation, follow form instructions after order validity is confirmed.
9. If orders disputed or questionable contact Medical Control and explain the situation, follow orders received.

Power of Attorney for Healthcare (POA)/ Living Wills:

If someone presents themselves as having POA to direct medical care for a patient and/or a Living Will is presented follow these procedures:

1. Contact Medical Control; explain situation and follow orders received.
2. Living Wills alone may not be honored by EMS personnel
3. If a Power of Attorney for healthcare document is presented by the agent, confirm that the document is in effect and covers the current situation
 - a. If yes, the agent may consent to or refuse general medical treatment for the patient.
 - b. A POA cannot rescind a DNR order consented to by the patient.
 - c. A POA may rescind a DNR order for which they or another surrogate provided consent.
 - d. If there is any doubt, continue treatment, contact medical control, explain the situation, and follow orders received.
4. Bring any documents received to the hospital.

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Hospice Patients not in cardiac/respiratory arrest:



1. If patient is registered in a hospice program and has a POLST form completed, follow patient wishes as specified in Box B.
2. Consult with hospice representatives if on scene re: other care options.
3. Contact Medical Control; communicate patient's status; POLST selection; hospice recommendations; presence of written treatment plans and/or valid DNR orders. Follow Medical Control orders.
4. If hospice enrollment is confirmed but a POLST form is not on scene, contact Medical Control. A DNR order should be assumed in these situations; seek Medical Control approval to withhold resuscitation if cardiorespiratory arrest occurs.

Documentation of adherence to SMO

- Documentation of the patient assessment and condition
- Documentation of valid POLST/DNR form
- Document any issues or concerns with the call
- Document all contact with Medical Control
- Document whom the patient/ deceased has been transferred to


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HIPAA PERMITS DISCLOSURE OF POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT			
 State of Illinois Illinois Department of Public Health		IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM	
For patients, use of this form is completely voluntary. Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition, new orders may need to be written.		Patient Last Name	Patient First Name
		MI	
		Date of Birth (mm/dd/yy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F
		Address (street/city/state/ZIP code)	
A	CARDIOPULMONARY RESUSCITATION (CPR) If patient has no pulse and is not breathing.		
Check One	<input type="checkbox"/> Attempt Resuscitation/CPR <input type="checkbox"/> Do Not Attempt Resuscitation/DNR (Selecting CPR means Full Treatment in Section B is selected)		
<i>When not in cardiopulmonary arrest, follow orders B and C.</i>			
B	MEDICAL INTERVENTIONS If patient is found with a pulse and/or is breathing.		
Check One (optional)	<input type="checkbox"/> Full Treatment: Primary goal of sustaining life by medically indicated means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. <i>Transfer to hospital and/or intensive care unit if indicated.</i> <input type="checkbox"/> Selective Treatment: Primary goal of treating medical conditions with selected medical measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). <i>Transfer to hospital, if indicated. Generally avoid the intensive care unit.</i> <input type="checkbox"/> Comfort-Focused Treatment: Primary goal of maximizing comfort. Relieve pain and suffering through the use of medication by any route as needed; use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Request transfer to hospital only if comfort needs cannot be met in current location. Optional Additional Orders _____		
C	MEDICALLY ADMINISTERED NUTRITION (If medically indicated) Offer food by mouth, if feasible and as desired.		
Check One (optional)	<input type="checkbox"/> Long-term medically administered nutrition, including feeding tubes. Additional Instructions (e.g., length of trial period) _____ <input type="checkbox"/> Trial period of medically administered nutrition, including feeding tubes. _____ <input type="checkbox"/> No medically administered means of nutrition, including feeding tubes. _____		
D	DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)		
		<input type="checkbox"/> Patient	<input type="checkbox"/> Agent under health care power of attorney
		<input type="checkbox"/> Parent of minor	<input type="checkbox"/> Health care surrogate decision maker (See Page 2 for priority list)
Signature of Patient or Legal Representative			
Signature (required)		Name (print)	Date
Signature of Witness to Consent (Witness required for a valid form)			
I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.			
Signature (required)		Name (print)	Date
E	Signature of Authorized Practitioner (physician, licensed resident (second year or higher), advanced practice nurse or physician assistant)		
My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient's medical condition and preferences.			
Print Authorized Practitioner Name (required)		Phone	
Authorized Practitioner Signature (required)		Date (required)	
		 Page 1	
Form Revision Date - April 2016 (Prior form versions are also valid.)			
SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED • COPY ON ANY COLOR OF PAPER IS ACCEPTABLE • 2016			

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HIPAA PERMITS DISCLOSURE OF POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT										
THIS SIDE FOR INFORMATIONAL PURPOSES ONLY										
Patient Last Name	Patient First Name	MI								
<p>Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.</p>										
Advance Directive Information										
I also have the following advance directives (OPTIONAL)										
<input type="checkbox"/> Health Care Power of Attorney <input type="checkbox"/> Living Will Declaration <input type="checkbox"/> Mental Health Treatment Preference Declaration										
Contact Person Name	Contact Phone Number									
Health Care Professional Information										
Preparer Name	Phone Number									
Preparer Title	Date Prepared									
<p>Completing the IDPH POLST Form</p> <ul style="list-style-type: none"> • The completion of a POLST form is always voluntary, cannot be mandated and may be changed at any time. • A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC. • Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy. • Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms. 										
<p>Reviewing a POLST Form</p> <p>This POLST form should be reviewed periodically and if:</p> <ul style="list-style-type: none"> • The patient is transferred from one care setting or care level to another, or • or there is a substantial change in the patient's health status, or • or the patient's treatment preferences change, or • or the patient's primary care professional changes. 										
<p>Voiding or revoking a POLST Form</p> <ul style="list-style-type: none"> • A patient with capacity can void or revoke the form, and/or request alternative treatment. • Changing, modifying or revising a POLST form requires completion of a new POLST form. • Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid. Beneath the written "VOID" write in the date of change and re-sign. • If included in an electronic medical record, follow all voiding procedures of facility. 										
<p>Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order</p> <table border="0"> <tr> <td>1. Patient's guardian of person</td> <td>5. Adult sibling</td> </tr> <tr> <td>2. Patient's spouse or partner of a registered civil union</td> <td>6. Adult grandchild</td> </tr> <tr> <td>3. Adult child</td> <td>7. A close friend of the patient</td> </tr> <tr> <td>4. Parent</td> <td>8. The patient's guardian of the estate</td> </tr> </table>			1. Patient's guardian of person	5. Adult sibling	2. Patient's spouse or partner of a registered civil union	6. Adult grandchild	3. Adult child	7. A close friend of the patient	4. Parent	8. The patient's guardian of the estate
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4. Parent	8. The patient's guardian of the estate									
<p>For more information, visit the IDPH Statement of Illinois law at http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives</p>										
<p>HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT</p>										
<p>ICCI 16-425</p>		 Page 2								
<p>SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED • COPY ON ANY COLOR OF PAPER IS ACCEPTABLE • 2016</p>										

Original SMO Date: 02/07 SMO: Do Not Resuscitate (DNR), Practitioner Order for Life-Sustaining Treatment (POLST),
 Reviewed: 05/09; 03/10; 06/17; 09/19; 06/20 Advanced Directive
 Last Revision: 03/10; 06/17 Page 6 of 6

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Current Version: 2020.1
 Issued: 07/20
 EMS/ Region 1 SMO

**REGION I EMERGENCY MEDICAL SERVICES
STANDING MEDICAL ORDERS
EMR**

SMO: Notification of Coroner

Overview: Certain patient death situations require notification of a Coroner for investigation into that death. Deaths that occur in EMS Region 1 will be reported to the coroner of the county affected. There should be no transport of a deceased patient across county boundaries.

Coroner Notification:

- Out of hospital deaths that are not transported to the hospital

Resuscitation is not indicated in the following situations:

- The patient has been declared dead by a coroner or patient's physician
- Patient has a valid DNR/POLST order
- Obvious signs of death

Obvious signs of death include:

ALL of the following:

- Unresponsive
- Apnea
- Pulseless
- Fixed dilated pupils

AND at least one of the following:

- Rigor mortis without profound hypothermia
- Decomposition
- Decapitation
- Incineration
- Profound dependent lividity
- Skin deterioration or decomposition
- Trauma to the head, neck or chest inconsistent with life
- Blunt trauma with no signs of life
- Penetrating trauma with no signs of life on arrival

Original SMO Date: 07/04
Reviewed: 06/17; 09/19; 06/20
Last Revision: 06/17

SMO: Notification of the Coroner

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EMS/ Region 1 SMO

PROCEDURE:

- Confirm signs of death, note time
- Notify Coroner
- EMS should remain on scene until relieved by coroner or law enforcement

Documentation of adherence to SMO

- Document time of pronouncement/decision to not initiate treatment
- Document all hand-offs and/or transfer of custody of the body

Medical Control Contact Criteria

- Contact Medical Control for any questions regarding this SMO

PRECAUTIONS AND COMMENTS

- Do not transport patient who is dead at scene unless otherwise directed by the coroner

**REGION I EMERGENCY MEDICAL SERVICES
STANDING MEDICAL ORDERS
EMR**

SMO: Pain Assessment and Management

Overview: Pain is the most frequent reason people seek healthcare. Pain is an individual and unique experience, changing not only from person to person, but from minute to minute. Fear and anxiety associated with injury and illness are intensified by the presence of pain. Pain management is a desired goal of treatment. Pain relief can decrease patient anxiety and provide for comfort. Care must be taken to ensure that the treatment of pain does not result in masking of important symptoms or result in deterioration of the patient.

Conditions:

1. Chest Pain due to acute coronary syndrome – [See Chest Pain in EMR Medical Guidelines](#)
2. Multisystem trauma – refer to [Routine Trauma Care](#) or [EMR Trauma Emergencies Guidelines](#)
3. Severe burns – refer to [Adult Burns](#) or [Pediatric Burns SMO](#)
4. Significant orthopedic trauma – [EMR Trauma Emergencies Guidelines](#)
5. Abdominal Pain

INFORMATION NEEDED

- Patient Age
- Pertinent Medical History
- Pain Assessment: One of the best pain assessment techniques for gathering and recording information is by the use of the mnemonic **O-P-Q-R-S-T**:
 - **Onset** – when did the pain start?
 - **Provokes** - what brings on the pain?
 - **Quality** - what does it feel like?
 - **Region / Radiation** where is it? Where does it go?
 - **Severity** - how bad is it? (Rated on a consistently used scale) (1-10 grading scale)
 - **Timing** - when did it start/end? How long does it last? How long have you had it?

OBJECTIVE FINDINGS

- General appearance
- Mental status (AVPU), skin condition, perfusion status
- Respiratory rate, rhythm and pattern and work of breathing (patient positioning such as tripod)
- Hemodynamic state Blood Pressure, perfusion status

Original SMO Date: 07/04
Reviewed: 06/17; 09/19; 06/20
Last Revision: 06/17

SMO: Pain Assessment and Management

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EMS/ Region1 SMO

TREATMENT

- Perform patient assessment and record vital signs, level of consciousness and oxygen saturation.
- Reassure and comfort patient.
- Provide care based on other SMOs related to the patient's presenting complaint.
- Place the patient in position of comfort. If risk of spine injury, institute spinal restrictions.
- Coach the patients breathing – calm, deep inhalations and slow relaxed exhalations.
- Distract patient or encourage them to focus on something other than their injury or pain.

Documentation of adherence to SMO

- Patient's presenting signs and symptoms, including vital signs, level of consciousness and oxygen saturation. Oxygen administration
- Indication for SMO use
- Documentation of measures utilized to make patient more comfortable i.e. reassurance, position of comfort etc.
- Repeat assessment and vital signs as indicated.
- Changes from baseline, if any, that occur during treatment or transport

Medical Control Contact Criteria

- Contact Medical Control whenever a question exists as to the best treatment course for the patient

**REGION I EMERGENCY MEDICAL SERVICES
STANDING MEDICAL ORDERS
EMR**

SMO: Physician/ RN on Scene

Overview: When EMT's have established patient contact, "a caregiver/patient" relationship has been established between the patient and EMSMD or designee. If a physician in on-scene they MAY assume responsibility for this patient if the following criteria are satisfied and documented:

- Physician can show a State of Illinois Medical license
- Physician also produces a picture ID
- Physician agrees to accompany patient to the hospital in the transporting vehicle

If any of these criteria are not met and the physician on scene insists on taking control of the situation, contact Medical Control for physician-to-physician communication. The EMT should employ the following as guidelines in interacting with a physician on the scene:

PHYSICIAN ON SCENE

___ Contact the resource hospital as soon as possible. All treatment should be reported over the radio for purposes of documentation.

___ When, after consultation with the EMSMD or designee, it is determined that the physician's orders may be harmful to the patient, the EMT will:

- Explain to the physician on-scene the recognized deviation from SOPs and/or policies and procedures.
- Immediately put the physician at the scene in contact with Medical Control.
- The EMSMD or designee will explain system SOPs and policies and procedures and attempt to reach consensus on patient care. Patient management by the licensed physician to provide supervision and direction throughout the pre-hospital care and transport process will continue until responsibility for care of the patient can be turned over directly to a physician on duty at hospital emergency department.
- In cases where disagreements cannot be resolved, the EMSMD or designee will assume responsibility for patient care.

___ In cases where the patient's personal physician is physically present, Medical Control should respect the previously established doctor/patient relationship as long as acceptable medical care is being provided.

Original SMO Date: 07/04
Reviewed: 06/17; 09/19; 06/20
Last Revision: 06/17

SMO: Physician/RN On Scene

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EMS/ Region1 SMO

RN or NON-AGENCY EMS PROVIDER ON SCENE

- An RN or non-agency EMS provider on scene may assist to the level of First Aid. If additional skill are needed (e.g. IV initiation) Medical Control **MUST** be contacted for permission to utilize this person in an expanded role.
- An RN or non-agency EMS provider on scene must provide proof of State of Illinois licensure and a picture ID.
- He/she must agree to follow the directions of the EMSMD or his/her designee.

Documentation of adherence to SMO

- Notification of Medical Control as outlined above.
- Any deviation from SMO as discussed with Medical Control.
- Documentation of name, State of Illinois license number, and picture ID produced as outlined above.

Medical Control Contact Criteria

- Immediately upon scene physician's request to assume responsibility at the scene.
- If any question exists as to best treatment option for the patient.

PRECAUTIONS AND COMMENTS

- The "caregiver/patient" relationship has been established between the patient and EMSMD when the EMT establishes patient contact.
- EMT's act under medical direction of Medical Control for the management of the patient.
- On-scene physician, RN, or non-agency EMS Provider involvement should be established with caution and with close Region 1 Medical Control guidance.

Original SMO Date: 07/04
 Reviewed: 06/17; 09/19; 06/20
 Last Revision: 06/17

SMO: Physician/RN On Scene

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 EMS/ Region1 SMO

EMS REGION 1

SMO: Physician/RN on Scene Page 3 of 3

ON-SITE PHYSICIAN RESPONSIBILITY ACKNOWLEDGMENT

Thank you for your offer of assistance. Be advised the attending EMS Region 1 personnel are operating under the authority of Illinois law. No physician or other person may intercede in patient care without the EMS Region 1 Medical Director, or his or her appropriate designee, relinquishing responsibility of the scene or otherwise giving approval in accordance with EMS Region 1 SMOs.

IF YOU ARE A PHYSICIAN AND DESIRE TO ACCEPT RESPONSIBILITY FOR AND DIRECTION OF THE CARE OF THE PATIENT(S) AT THE SCENE:

1. You **MUST** show your medical license wallet card to the EMT and state your specialty.
2. You **MUST** accompany any patient whose care you direct to the medical facility in the ambulance or other attending medical vehicle.
3. Your direction of a case **MUST** be approved by the EMS Region 1 Medical Director or his or her appropriate designee.

Please print except for your signature:

I, _____ M.D. / D.O., assume full responsibility for the pre-hospital direction of medical care of the patient(s) identified below during this ambulance call, and I will accompany the patient(s) to the medical facility. I understand that the Region 1 EMS Medical Director, or his or her appropriate designee, retains the right to resume responsibility for the medical care of such patient(s) at his or her discretion in accordance with Region 1 EMS SMOs at any time, and that the care of the patient(s) will be relinquished to the appropriate Region 1 personnel upon arrival at the medical facility.

Patient Identification (*please initial and provide information as appropriate*):

_____ All patients at the scene, **OR**

_____ The following patients: _____

Physician Signature (M.D. / D.O.)

_____/_____/_____
Date

Thank you for your interest.

Region 1 EMS Personnel to complete: Date ____/____/____ Run Identification _____ EMT Initials _____
--

White: Chart
 Yellow: EMS Office
 Pink: Provider
 Gold: Physician

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**REGION I EMERGENCY MEDICAL SERVICES
STANDING MEDICAL ORDERS
EMR**

SMO: Refusal of Medical Care or Transport

Overview: Generally an Emergency Medical Responder will not execute patient refusals. This SMO is provided to be informational regarding the refusal process. In the event that there is not a higher level of care present and the patient insists on refusing transport the EMR should follow this SMO as closely as possible and contact Medical Control for any high-risk refusals.

This SMO relates to those cases in which EMS has been called and the patient/patients refuse to give their consent for assessment and/or treatment and/or transport and highlights the following:

- An adult patient with decision-making capacity has the right to refuse medical treatment. An adult patient with decision-making capacity, for the purpose of this SMO, is defined as:
 - Oriented to person, place, time, and event
 - No suspicion of being under the influence of drugs or alcohol
- An adult patient cannot refuse emergency treatment if that patient has decreased level of consciousness or, in EMS personnel's judgment, cannot make competent decisions related to their emergency care.
- A patient is considered high risk for signing a refusal under the following circumstances:
 - Concern with decision-making capacity
 - A minor with no legal guardian available
 - Suspected high risk medical conditions, such as:
 - Chest pain
 - Syncope
 - Altered Mental Status
 - Stroke/TIA
 - Abnormal vital signs
 - EMS provider impression
- All patients who refuse care must be encouraged to sign a [Region One Prehospital Refusal](#) form (or a form mandated by the agency's EMS MD).

OBJECTIVE FINDINGS

- Adult patient is conscious and competent
- Patient injuries
- Vital signs
- SAMPLE history

Original SMO Date: 07/04
Reviewed: 02/06; 06/17; 09/19; 06/20
Last Revision: 02/06; 06/17

SMO: Refusal of Medical Care or Transport

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Current Version: 2020.1
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EMS/ Region1 SMO

Refusal of Treatment by Competent Adult Patients

- __ Patients have the right to refuse treatment and/or transport
- __ The patient will be informed of the risk of refusal and possibility of deterioration of medical condition, up to and including death
- __ Attempt to assess vital signs and SAMPLE history if possible
- __ For high risk refusals, as defined above:
 - Consider contacting Medical Control
 - Attempt to leave patient in care of a responsible party
 - Provide post refusal instructions as indicated
 - Inform patient to call back if conditions changes or decision to refuse treatment is reconsidered
- __ Once the allowed assessment is performed, and the patient persists in refusing care and/or transport, the patient will be asked to sign the [Region One Prehospital Refusal](#) form (or a form mandated by the agency's EMS MD). The refusal form must also be signed by the EMT and by one other witness (preferably law enforcement or family) if available.

Multiple Victims Refusal of Consent for Treatment

- __ To ensure the efficient use of resources, if an incident is declared an MVI or Disaster by the on scene commander, a reasonable/ common sense approach should be used and provider safety must be considered. If mechanism of the incident indicates the potential for victims or the Incident Commander has declared an MVI or Disaster, and the patients are refusing treatment, the [Region One Multiple Victim Release Form](#) may be completed in lieu of individual Patient Refusal Form.
- __ One EMS Run Report must be completed and a copy of the Multiple Victim Release form must be attached to the Run Report.

Minor in Need of Emergency Care who Refuses Treatment

- __ All reasonable attempts should be made to release a minor to a legal guardian. If a legal guardian cannot be located document attempts made to contact.
 - Minor may be turned over to local police or juvenile authority, or
 - Minor may be released if legal guardian is contacted by phone and consent for release is given. Document phone call, name of guardian, and witness.
- __ If the need for emergency care exists or if the behavior of the patient suggests a lack of capacity to make a refusal in a valid manner continue to render care, up to and including transport.

Post-Treatment Refusals

This section applies to when treatment has been given by EMS and the patient considers their condition improved to the point that they refuse transport, such as:

- Hypoglycemic patient
- Overdose patient
- Asthma/respiratory
- Chest pain
- Syncope
- Pain control

Original SMO Date: 07/04
 Reviewed: 02/06; 06/17; 09/19; 06/20
 Last Revision: 02/06; 06/17

SMO: Refusal of Medical Care or Transport

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 EMS/ Region1 SMO

Important points to discuss with patient before obtaining refusal:

- EMS evaluation and/or treatment is not a substitute for medical evaluation and treatment by a doctor. EMS will advise the patient to see a doctor or go to a hospital. The patient will be given the [Discharge Instruction Form](#). EMS will circle the appropriate potential diagnosis with the patient and document this discussion on the refusal form.
- If patient's condition was discussed with Medical Control on scene, inform them that this also does not substitute for medical evaluation.
- Patient's condition may be worse than originally evaluated. Without treatment, patient's condition or problem could become worse.
- If patient changes their mind or condition becomes worse, patient should be made aware that they may call 911 and EMS will respond as always.

Medical Control Contact Criteria

- ___ Contact Medical Control whenever a question exists as to the best treatment course for the patient
- ___ Issues regarding decision-making capacity of patients should be managed directly with Medical Control
- ___ Contact Medical Control if there is a question regarding need for evaluation/ treatment (based on mechanism of injury, etc.)

PRECAUTIONS AND COMMENTS

- Important points to discuss with patient before obtaining refusal:
 - EMS evaluation and/or treatment is not a substitute for medical evaluation and treatment by a doctor. EMS will advise the patient to see a doctor or go to a hospital. If patient's condition was discussed with Medical Control on scene, inform them that this also does not substitute for medical evaluation.
 - Patient's condition may be worse than originally evaluated. Without treatment, patient's condition or problem could become worse.
 - If patient changes their mind or condition becomes worse, patient should be made aware that they may call 911 and EMS will respond as always.
- FOR MINORS: Instruct the patient's legal guardian that in this situation, they are acting on behalf of the patient and they understand the above information regarding refusal of treatment or transport, and accept responsibility for the patient.
- Certain injuries, illnesses, ingestions, or injected substances can alter behavior and create a situation whereby the capacity to make a valid judgment by the patient no longer exists. It is better to treat and prevent any further harm to the patient who may not be able to judge his/her own condition.
- The State of Illinois permits [Emancipated Minors](#) to be treated as adults and therefore allows them to make the decision regarding consent for treatment or refusal of services.

Original SMO Date: 07/04
 Reviewed: 02/06; 06/17; 09/19; 06/20
 Last Revision: 02/06; 06/17

SMO: Refusal of Medical Care or Transport

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 EMS/ Region1 SMO

Region 1 Refusal Form

Region One Prehospital Refusal

Date: ___/___/___ Location of Call: _____ Type of Call: _____
Time: _____ Dispatched: _____ Enroute: _____ Arrived: _____ Completed: _____
Agency: _____ Unit #: _____ Call #: _____

Patient Information

Name: _____ Guardian Name: _____
Address: _____ City: _____ State: _____ Zip: _____
D.O.B.: ___/___/___ Age: _____ Gender: [] Male [] Female

Assessment of Patient

Medical Hx: _____ Allergies: _____
Medications: _____
BP: ___/___ Pulse: _____ Resp.: _____ Skin: _____ Pupils: R-___/L-___ [] Refused V/S

Check appropriate response: Draw an "X" through the most appropriate box - Y is yes and N is no
Is the patient oriented to: Person [Y] [N] Place [Y] [N] Time [Y] [N] Situation [Y] [N]
Suspicion of intoxication? [Y] [N]
Medical Control Contacted? [Y] [N] M.D. / ECRN Name: _____

Patient left in care of: _____ Phone Number: (____) _____

Release from Medical Responsibility

I, _____ hereby release the Hospital, EMS System and it's physicians, nurses and employees and the EMS Service and it's EMTs of any responsibility and liability for the worsening of my condition. I acknowledge that I have been informed of the risks and I voluntarily assume all responsibilities in making this decision.

- Adult Patient or Guardian initial next to the box(es) with the most appropriate statement(s)
[] I do not consider myself to be injured or ill and do not wish to receive medical services, treatment, or transport.
[] I have been advised to seek first aid or medical treatment, which I am refusing.
[] I have received emergency medical treatment and am now refusing further care or transport to a medical facility.
[] I have received emergency medical treatment and am consenting to transport to a medical facility but, I am refusing the following: _____
[] I am refusing transport to the nearest hospital.
[] I am requesting transport to _____ Hospital. I have been informed that this facility lies outside the responding agency's territorial range of transport. I am refusing transport to a hospital within this territorial range.

RISKS

All refusals of treatment have the inherent risks of threatening the health, medical safety and possible survival of the patient. All transfers have the inherent risks of traffic delays, accidents during transports, inclement weather, rough terrain, and the limitations of equipment and personnel present in the vehicle, all of which may be the potential threat to the health, medical safety and possible survival of the patient. Transfers to a more distant hospital may increase these risks. The following risks have been explained to the patient, the patient's guardian and/or power of attorney for healthcare.

- [] Deterioration of Medical Condition, up to and including death
[] Deterioration of Medical Condition of Pregnant and/or unborn Child/Delivery
[] I have received a "Refusal / Discharge Instruction" form.

Printed name of patient / person authorized to consent for patient X Signature of patient / person authorized to consent for patient Date
Printed name of witness X Signature of witness Date

Comments: _____

X Signature of Crewmember #1/License # X Signature of Crewmember #2/License #
SHMS-7782 11/2017 White: Agency Copy Yellow: EMS Copy Pink: Patient Copy

Region 1 Discharge Instructions

Refusal / Discharge Instructions

UNIVERSAL INSTRUCTIONS:

- YOU HAVE NOT RECEIVED A COMPLETE MEDICAL EVALUATION. SEE A PHYSICIAN AS SOON AS POSSIBLE.
- IF AT ANY TIME AFTER YOU HAVE TAKEN ANY MEDICATION, YOU HAVE TROUBLE BREATHING, START WHEEZING, GET HIVES OR A RASH, OR HAVE ANY UNEXPECTED REACTION, CALL 911 IMMEDIATELY.
- IF YOUR SYMPTOMS WORSEN AT ANY TIME, YOU SHOULD SEE YOUR DOCTOR, GO TO THE EMERGENCY DEPARTMENT OR CALL 911.

ABDOMINAL PAIN:

- Abdominal pain is also called belly pain. Many illnesses can cause abdominal pain and it is very difficult for EMS to identify the cause.
- Take your temperature every 4 hours.

Call or see a physician, go to the emergency department, or call 911 immediately if:

- Your pain gets worse or is now only in 1 area
- You vomit (throw up) blood or find blood in your bowel movement
- You become dizzy or faint
- Your abdomen becomes distended or swollen
- You have a temperature over 100° F
- You have trouble passing urine
- You have trouble breathing

BACK PAIN:

- Apply heat to the painful area to help relieve pain. You may use a warm heating pad, whirlpool bath, or warm, moist towels for 10 to 20 minutes every hour.
 - Stay in bed as much as possible the first 24 hours.
 - Begin normal activities when you can do them without causing pain.
 - When picking things up, bend at the hips and knees. Never bend from the waist only.
- #### Call or see a physician, go to the emergency department, or call 911 immediately if:
- You have shooting pains into your buttocks, groin, legs, or arms or the pain increases.
 - You have trouble urinating or lose control of your stools or urine.
 - You have numbness or weakness in your legs, feet, arms, or hands.

FEVER:

- Always take medications as directed. Tylenol and Ibuprofen can be taken at the same time.
 - If you are taking antibiotics, take them until they are gone, not until you are feeling better.
 - Drink extra liquids (1 glass of water, soft drink or Gatorade per hour of fever for an adult)
 - If the temperature is above 103° F, it can be brought down by a sponge bath with room temperature water. Do not use cold water, a fan, or an alcohol bath.
 - Temperature should be taken every 4 hours.
- #### Call or see a physician, go to the emergency department, or call 911 immediately if:
- Temperature is greater than 101° F for 24 hours
 - A child becomes less active or alert.
 - The Temperature does not come down with Acetaminophen (Tylenol) or Ibuprofen with the appropriate dose.

HEAD INJURY:

- Immediately after a blow to the head, nausea, and vomiting may occur.
- Individuals who have sustained a head injury must be checked, and if necessary awakened, every 2 hours for the first 24 hours.
- Ice may be placed on the injured area to decrease pain and swelling.
- Only drink clear liquids such as juices, soft drinks, or water the first 12 hours after injury.
- Acetaminophen (Tylenol) or Ibuprofen only may be used for pain.

Call or see a physician, go to the emergency department, or call 911 immediately if:

- The injured person has persistent vomiting, is not able to be awakened, has trouble walking or using an arm or leg, has a seizure, develops unequal pupils, has a clear or bloody fluid coming from the ears or nose, or has strange behavior.

INSECT BITE/STING:

- A bite or sting typically is a red lump which may have a hole in the center. You may have pain, swelling and a rash. Severe stings may cause a headache and an upset stomach (vomiting).
 - Some individuals will have an allergic reaction to a bite or sting. Difficulty breathing or chest pain is an emergency requiring medical care.
 - Elevation of the injured area and ice (applied to the area 10 to 20 minutes each hour) will decrease pain and swelling.
 - Diphenhydramine (Benadryl) may be used as directed to control itching and hives.
- #### Call or see a physician, go to the emergency department, or call 911 immediately if:
- You develop any chest pain or difficulty breathing.
 - The area becomes red, warm, tender, and swollen beyond the area of the bite or sting.
 - You develop a temperature above 101° F.

RESPIRATORY DISTRESS:

- Respiratory Distress is also known as shortness of breath or difficulty breathing.
 - Causes of Respiratory Distress include reactions to pollen, dust, animals, molds, foods, drugs, infections, smoke, and respiratory conditions such as Asthma and COPD. If possible avoid any causes which produce respiratory distress.
 - If you have seen a physician for this problem, take all medication as directed.
- #### Call or see a physician, go to the emergency department, or call 911 immediately if:
- Temperature is greater than 101° F.
 - The cough, wheezing, or breathing difficulty becomes worse or does not improve even when taking medications.
 - You have Chest Pain.
 - Sputum (spit) changes from clear to yellow, green, grey, or becomes bloody.
 - You are not able to perform normal activities.

EXTREMITY INJURY:

- Extremity Injuries may consist of cuts, scrapes, bruises, sprains, or broken bones (fractures).
 - Apply ice to the injury for 15 to 20 minutes each hour for the first 1 to 2 days.
 - Elevate the extremity above the heart as possible for the first 48 hours to decrease pain and swelling.
 - Use the extremity as pain allows.
- #### Call or see a physician, go to the emergency department, or call 911 immediately if:
- Temperature is greater than 101° F.
 - The bruising, swelling, or pain gets worse despite the treatment listed above.
 - Any problems listed on the Wound Care instructions are noted.
 - You are unable to move the extremity or if numbness or tingling is noted.
 - You are not improved in 24 to 48 hours or you are not normal in 7 to 10 days.

VOMITING/DIARRHEA:

- Vomiting (throwing up) can be caused by many things. It is common in children, but should be watched closely.
 - Diarrhea is most often caused by either a food reaction or infection.
 - Dehydration is the most serious problem associated with vomiting or diarrhea.
 - Drink clear liquids such as water, apple juice, soft drinks, or Gatorade for the first 12 hours or until things improve. Adults should drink 8 to 12 glasses of fluids per day with diarrhea. Children should drink 1 cup of fluid for each loose bowel movement.
- #### Call or see a physician, go to the emergency department, or call 911 immediately if:
- Temperature is greater than 101° F.
 - Vomiting or Diarrhea lasts longer than 24 hours, gets worse, or blood is noted.
 - You cannot keep fluids down or no urination is noted in 8 hours.


WOUND CARE:

- Wounds include cuts, scrapes, bites, abrasions, or puncture wounds.
 - If the wound begins to bleed, apply pressure over the wound with a clean bandage and elevate the wound above the heart for 5 to 10 minutes.
 - Unless instructed otherwise, clean the wound twice daily with soapy water, and keep the wound dry. It is safe to take a shower but do not place the wound in bath or dish water.
 - See a physician for a tetanus shot if it has been 10 years or more since your last one.
- #### Call or see a physician, go to the emergency department, or call 911 immediately if:
- See the Extremity Injury instructions.
 - Temperature is greater than 101° F.
 - Bruising, swelling, or pain gets worse or bleeding is not controlled as directed above.
 - Any signs of infection, such as redness, drainage of yellow fluid or pus, red streaks extending from the wound, or a bad smell is noted.

Refusal / Discharge Instructions

UNIVERSAL INSTRUCTIONS:

- YOU HAVE NOT RECEIVED A COMPLETE MEDICAL EVALUATION. SEE A PHYSICIAN AS SOON AS POSSIBLE.
- IF AT ANY TIME AFTER YOU HAVE TAKEN ANY MEDICATION, YOU HAVE TROUBLE BREATHING, START WHEEZING, GET HIVES OR A RASH, OR HAVE ANY UNEXPECTED REACTION, CALL 911 IMMEDIATELY.
- IF YOUR SYMPTOMS WORSEN AT ANY TIME, YOU SHOULD SEE YOUR DOCTOR, GO TO THE EMERGENCY DEPARTMENT OR CALL 911.

<p>Chest Pain:</p> <ul style="list-style-type: none"> • There are many causes of chest pain. • Some of the causes include: heart problems, heartburn, esophagus disorders, pneumonia, pleurisy, pulmonary embolism, panic attacks or inflammation in your chest. • Some of these problems can be serious and life threatening. • Chest Pain should be evaluated by a physician. <p>Call or see a physician, go to the emergency department, or call 911 immediately if:</p> <ul style="list-style-type: none"> • If increase in pain or pressure in chest. • Sweating • Unexplained weakness, dizziness, lightheadedness • Shortness of breath • Nausea or vomiting • Fast or irregular heart beat 	<p>Syncope - Fainting :</p> <ul style="list-style-type: none"> • Fainting is a temporary loss of consciousness. • There are many causes for fainting. • Fainting usually occurs when your blood pressure drops suddenly and a decrease in blood flow to the brain results. • Some of the causes include: heart problems, drop in blood sugar, certain medication, emotional distress, standing up too quickly, heat or dehydration. • Syncope/Fainting should be evaluated by a physician. <p>Call or see a physician, go to the emergency department, or call 911 immediately if:</p> <ul style="list-style-type: none"> • Unexplained weakness, dizziness, lightheadedness continues. • Shortness of breath • Nausea or vomiting • Pain or pressure in the chest • Fast or irregular heart beat 	<p>Hypertension – High Blood Pressure:</p> <ul style="list-style-type: none"> • High blood pressure is a common condition that may cause health problems, such as heart disease. • You can have high blood pressure for years without any symptom. • Uncontrolled high blood pressure increases your risk of serious health problems including heart attack and stroke. • High blood pressure is generally defined as a pressure over 140/90. • Have your blood pressure checked regularly and see a physician if it is high. <p>Call or see a physician, go to the emergency department, or call 911 immediately if:</p> <ul style="list-style-type: none"> • You have other symptoms such as headache, dizziness, shortness of breath, chest pain or nosebleeds.
<p>Low Blood Sugar:</p> <ul style="list-style-type: none"> • Causes of low blood sugar: too little food, too much insulin or diabetes pills and/or more active than usual. • The onset is often sudden. • Some Symptoms include: shaky, sweating, fast heartbeat, blurry vision, headache, irritable, weakness or fatigue. • If you feel like your blood sugar is low, check your blood glucose. If you can't check your glucose, treat anyway. • Treat by eating glucose tablets, candies, fruit juice or regular soda pop. • Check blood glucose again. • Eat something in addition to the sugar. Eat something with protein and/or carbohydrate to last longer. <p>Call or see a physician, go to the emergency department, or call 911 immediately if:</p> <ul style="list-style-type: none"> • If symptoms do not improve or stop. 	<p>High Blood Sugar:</p> <ul style="list-style-type: none"> • Causes of high blood sugar: too much food, too little insulin or diabetes pills, illness or stress. • The onset often starts slowly. • Some Symptoms include: extreme thirst, need to urinate often, dry skin, hungry, drowsy, slow healing of wounds. • Check blood glucose. • If your blood glucose is higher than your goal and you don't know why call your healthcare provider. <p>Call or see a physician, go to the emergency department, or call 911 immediately if:</p> <ul style="list-style-type: none"> • If symptoms do not improve or stop. 	<p>Unsafe Situation:</p> <ul style="list-style-type: none"> • Are you currently in a relationship / situation where you feel unsafe or threatened? <p>Information about shelter and alternatives is available 24 hours a day by contacting the Domestic Violence Hotline at:</p> <ul style="list-style-type: none"> • Illinois hotline 877-863-6338 • National hotline 800-799-7233 / TTY 800-787-3224 • http://www.ilcadv.org/
<p>Narcan:</p> <ul style="list-style-type: none"> • You have received Narcan for an apparent Narcotic overdose. You were unconscious and breathing was compromised. Narcan was administered to save your life. • We strongly recommend that you go to the hospital for additional medical care. The Narcan may wear off before the Narcotic is out of your system. If that happen you could die • We cannot take you against your will. • We recommend that you do not do any more drugs or alcohol. 	 <p style="font-size: 1.2em; margin: 5px 0;">Local Phone Numbers</p>	<p>Refusing against EMS advice:</p> <p>Patients that have apparent decision making capacities have the right to refuse. We recommend the following:</p> <ul style="list-style-type: none"> • You seek medical care. • You stay with a responsible adult who will observe you and call 911 if needed. • Please call 911 or seek medical attention if you change your mind.

Region One Multiple Patient Prehospital Refusal Form

Date: ___/___/___ Location of Call: _____

Time: Dispatched: _____ Enroute: _____ Arrived: _____ Completed: _____

Agency: _____ Unit #: _____ Call #: _____

Type of Incident: _____

Medical Control Contacted? M.D. / ECRN Name: _____

RELEASE FROM RISKS OF MEDICAL RESPONSIBILITY

I, *listed below*, hereby release the Hospital, EMS System and its physicians, nurses, and employees and the EMS agency and its' Personal of any responsibility and liability for the worsening of medical condition of multiple victims involved in this incident. I acknowledge that I have been informed of the risks and I voluntarily assume all responsibility. I acknowledge that all refusals carry the inherent risks of deterioration of medical condition up to and including death.

Print Name	Signature	DOB
-------------------	------------------	------------

1. _____

Address _____

2. _____

Address _____

3. _____

Address _____

4. _____

Address _____

5. _____

Address _____

6. _____

Address _____

7. _____

Address _____

Signature of EMS crew #1

Signature of EMS crew #2

If School Bus Accident, signature of authorized school designee: _____

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**REGION 1 EMERGENCY MEDICAL ORDERS
STANDING MEDICAL ORDERS
EMR**

PROCEDURE: Restraints

Overview: Patients will only be restrained if clinically necessary. The use of restraints is only utilized if the patient is violent and may cause harm to themselves or others. Physical restraints are a last resort in caring for the emotionally disturbed patient. Never apply physical restraints for punitive reasons, or in a manner that restricts breathing and circulation, or in places that restrict access for monitoring the patient.

PROCEDURE

- __ Scene size-up:
 - Assess the patient and surrounds for potential weapons.
 - When dealing with an agitated and combative patient consider law enforcement to help gain control of the situation.
 - If scene is unsafe, back out and call law enforcement.
- __ Utilize verbal de-escalation methods whenever possible. Consider physical restraints a last resort when verbal control is ineffective.
- __ To safely restrain a patient use a minimum of 4 people, if possible.
- __ Once restrained, place patient in semi-fowlers or recovery position to maximize breathing
- __ Assess and address any medical conditions after the patient is safely restrained.
- __ If law enforcement restrains a patient with handcuffs, an officer with a key must accompany the patient during transport (law enforcement may follow in their vehicle).

Documentation of adherence to SMO

- __ Behavior noted as evidence that the patient is at risk of self-harm or harm to others
- __ Type of restraint used and if partial or full restraints were used
- __ Constant observation of patient while restraints in place
- __ Neurovascular status check noted every 10 minutes while restraints in place
- __ If handcuffs are used by a law enforcement officer, officer that has the key to the handcuffs must accompany the patient (may be in his/her own vehicle)
- __ Time medical control was contacted

Original SMO Date: 07/04
Reviewed: 02/06; 06/17; 09/19; 06/20
Last Revision: 02/06; 06/17

Procedure: Restraints

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Current Version: 2020.1
Issued: 07/20
EMS/ Region1 SMO

PRECAUTIONS AND COMMENTS

- At no point should EMS personnel place themselves in danger. Additional manpower should be requested as needed.
- In emergency situations, an EMR may initiate application of restraints in the absence of an order from Medical Control.
- Explain the procedure to the patient (and the family) if possible. The team leader should be the one communicating with the patient.
- If attempts at verbally calming the patient have failed and the decision is made to use restraints, do not waste time bargaining with the patient.
- Remember to remove any equipment from your person which can be used as a weapon against you (i.e. trauma shears).
- Approach the patient, keeping the team leader near the head to continue communications and at least one person on each side.
- Always keep the patient informed of why the restraints are being used.
- Soft, disposable restraints are preferred for EMS use.
- No hog-tying or hobble restraints allowed. No “sandwiching” with long boards or scoop stretchers.

**REGION I EMERGENCY MEDICAL SERVICES
STANDING MEDICAL ORDERS
EMR**

SMO: Spinal Restriction

Overview: Spinal restriction should be considered on patients that have experienced a mechanism of injury. The purpose of this SMO is to give guidance on which patients should receive spinal restriction and how to accomplish this spinal restriction.

Indication

__ Any patient that experiences a mechanism of injury that creates the potential for a spine injury

OBJECTIVE FINDINGS

__ Mental Status

__ Neuro Assessment – LOC, pupils, and the ability to move and feel extremities

Selective Spinal Restriction

__ If any of the following is present or a spine injury is suspected then perform spinal restriction:

- Any focal deficits noted in the neuro exam.
- Patient age 65 or greater or less than 5 with a mechanism of injury.
- Alteration in mental status.
- Evidence of intoxication.
- Evidence of intoxication may include: GCS less than 15, slurred speech, dilated pupils, flushed skin, unsteady gate, irregular behavior or presence of paraphernalia.
- Inability of patient to communicate.
- Distraction injury: any painful injury that may distract the patient from the pain of a spinal injury.
- Examples of distracting injuries: long bone fractures, rib fractures, pelvic fractures, abdominal pain, large contusion, avulsion to the face or scalp, partial thickness burns greater than 10% TBSA or full thickness burns or any significantly painful injury.
- Tenderness, swelling or deformity noted when the spine is palpated.
- Pain to Range of Motion (ROM)
- ROM should not be assessed if any one of the above is present.
- To assess ROM have patient touch chin to chest, look up, and turn head from side to side. If any pain is noted stop this assessment.

__ If none of the above is present, spinal restriction is not required

Original SMO Date: 03/16
Reviewed: 06/17; 09/19; 06/20
Last Revision: 06/17

SMO: Spinal Restriction

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EMS/ Region1 SMO

Spinal Restriction Techniques**Assessment**

- Assess motor and sensory function before and after spinal restriction and regularly during transport.
- Consider the use of SpO₂ to monitor respiratory function

Ambulatory patients

- Alert cooperative patients may be allowed to self-limit movement but a cervical collar is and should be recommended
- Apply appropriate sized cervical collar. If the cervical collar does not fit then, use alternate mode of stabilization.
- Instruct patient to sit on the cot. Secure the patient in position of comfort. Limit the movement of the neck during this process.

Non- ambulatory patients

- Extricate patient as needed by the safest method available while limiting flexion, extension, rotation and distraction of the spine.
- Tools such as pull sheets, scoop stretchers, KED, vacuum splints and backboards may be used.
- Place the patient in the best position suited to protect the airway while applying appropriate spinal restriction.
- If patient is transported on a hard device apply adequate padding

Penetration trauma patients without spinal pain or neuro deficits do not need spinal restriction.

Pediatric patients

- Pediatric patients may not understand why they are being separated from their parent / guardian and are being placed in spinal restriction. Fighting with the pediatric patient may cause more harm to their spine. Consider leaving the child in their uncompromised car seat with added padding. If parent / guardian are available have them be involved in the child's care. This may alleviate the need to force the patient into spinal restriction.
- If child has been removed from the vehicle / car seat consider the use of pediatric restriction devices (or adult restriction with additional padding). If this causes increased agitation, movement and potential harm to the child consider placing the child in a car seat and pad to restrict movement.
- During transport every effort should be made to safely restrain the pediatric patient.

__ Following is a list of acceptable methods / tools to achieve spinal restriction. This list is arranged from the least invasive to the most invasive.

- Fowler's, semi-fowlers or supine positioning on cot with correctly sized cervical collar.
- Supine position with vacuum splint from head to toe.
- For pediatric patients, uncompromised child car seat with appropriate padding.
- Supine position on scoop stretcher, secured with straps and appropriate padding including head blocks.
- KED (vest type extrication device)
- Supine position on long backboard, secured with straps and appropriate padding including head blocks

Documentation of adherence to SMO

- __ Mechanism of injury
- __ Neuro Assessment
- __ Spinal precaution completed
- __ Assessment findings before and after patient packaging

Medical Control Contact Criteria

- __ Contact Medical Control whenever a question exists as to the best treatment course for the patient

PRECAUTIONS AND COMMENTS

- Spinal precaution for at-risk patients is paramount. This is true whether or not a backboard is utilized. Minimal patient movement and the patient's security to stretcher and /or backboard are necessary.
- Backboards should be used judiciously where the possible benefits outweigh the risks. Long backboards can cause discomfort and agitation in a patient, but the concerns and benefits of spinal restriction should take prevalence.
- In the event a patient is placed on a restriction device for extrication or before the arrival of the transporting unit a decision may be made by transporting unit whether the patient should be left on a restriction device for transport using guideline noted in this SMO.

Original SMO Date: 03/16
 Reviewed: 06/17; 09/19; 06/20
 Last Revision: 06/17

SMO: Spinal Restriction

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 EMS/ Region1 SMO

**REGION I EMERGENCY MEDICAL SERVICES
STANDING MEDICAL ORDERS
EMR**

SMO: Transfer of Responsibility of Patient Care

Overview: Patients entrust the medical community to care for them to the highest level possible. To that end, this policy is to delineate proper transfer of responsibility of patient care.

INFORMATION NEEDED

- Level of care patient is currently receiving
- Level of care to which patient is being transferred

TRANSFER OF RESPONSIBILITY FOR PATIENT CARE

Transfer of patient care to another prehospital care provider (in a situation other than a disaster or triage situation):

- When the care of a patient is going to be transferred to another prehospital care provider, the EMR crew shall remain with the patient until the second care provider arrives and accepts responsibility for the care of the patient.
- Written or verbal acceptance of responsibility for the patient should be obtained.
- The second provider shall not accept responsibility for the patient until the report is given. When care of patient is transferred to another prehospital provider, that provider must be of at least an equal, if not higher, degree of training (e.g., BLS crew must transfer to at least another BLS ambulance; care of the ALS patient may not be transferred to a BLS crew).

Documentation of adherence to SMO

- Document to whom the patient is being transferred to include level of licensure.

Medical Control Contact Criteria

- Contact Medical Control whenever a question exists as to the best treatment course to the patient.

PRECAUTIONS AND COMMENTS

- Abandonment is defined as terminating medical care without legal excuse or turning care over to personnel who do not have training and expertise appropriate for the medical needs of the patient.

Original SMO Date: 07/04
Reviewed: 06/17; 09/19; 06/20
Last Revision: 06/17

SMO: Transfer of Responsibility of Patient Care

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EMS/ Region1 SMO

REGION I EMERGENCY MEDICAL SERVICES

Medical and Trauma Emergencies For Emergency Medical Responders

SMO	Section
Airway Management - Adult	Adult Medical
EMR Medical Emergencies	Adult Medical
Routine Medical Care	Adult Medical
BDLS/ADLSTriage Method	Trauma
EMR Trauma Emergencies	Trauma
Routine Trauma Care	Trauma
Triage Categorization of Patients	Trauma

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**REGION I EMERGENCY MEDICAL SERVICES
STANDING MEDICAL ORDERS
EMR**

SMO: Airway Management - Adult

Overview: Managing a patient's airway may be necessitated due to upper or lower airway obstruction, inadequate ventilation, impairment of the respiratory muscles, ventilation-perfusion mismatching, diffusion abnormalities, or impairment of the nervous system. Dyspnea often is associated with hypoxia.

INFORMATION NEEDED

- Scene survey
- Chief complaint
- History of foreign body airway obstruction, respiratory distress, etc. (see [Primary Survey](#))
- Medical History (see [Secondary Survey](#))

OBJECTIVE FINDINGS

- Mental status (AVPU)
- Airway patency (head-tilt chin lift OR modified jaw thrust for unconscious patient or if C-spine trauma is a possibility)
- Oxygenation and Circulatory status (pulse oximetry, vital signs)

TREATMENT

- Assess airway patency utilizing adjuncts as indicated
- Oxygen as indicated for patient condition. Maintain SpO₂ levels in the 94% to 99% if possible.
 - Nasal cannula (2-6 L/min) for awake, oriented, stable patients without evidence of hypoperfusion
 - High flow via nonrebreather mask (10-15 L/min)
 - Assist ventilations with BVM and 100% oxygen if indicated.
- Manage Foreign Body Airway Obstruction per American Heart Association standards
- Assess airway patency utilizing adjuncts as indicated
 - BVM/Pocket Mask
 - OPA
 - NPA
 - System approved Supraglottic Airway (per manufacturers guidelines)

Original SMO Date: 07/04
Reviewed: 06/17; 09/19; 06/20
Last Revision: 09/19

SMO: Airway Management

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TREATMENT (continued)

__ Confirm advanced airways and document with the following:

- Auscultation
- Absence of gastric sounds
- Bi-lateral chest rise

Documentation of adherence to SMO

- __ Indications for airway management
 __ Methods utilized
 __ Confirmation details
 __ Patient condition reassessed

Medical Control Contact Criteria

__ Contact Medical Control whenever a question exists as to the best treatment course for the patient

PRECAUTIONS AND COMMENTS

- Utilize BLS methods for maintaining airway patency and good ventilations and reassess patient's oxygenation and ventilatory status BEFORE utilizing supraglottic airway methods, particularly in pediatric patients. Benefits of intubation not demonstrated well in pediatrics.

REGION I EMERGENCY MEDICAL SERVICES STANDING MEDICAL ORDERS EMR

SMO: Routine Medical Care

Overview: A routine medical assessment needs to be completed on all medical patients to identify and immediately correct life-threatening problems. This protocol is intended to provide the E.M.S. Provider with guidelines to treat a medical patient as effectively and soon as possible.

INFORMATION NEEDED

- Perform scene size-up and triage
- Identify and control hazards
- Move patient emergently if necessary
- Contact Medical Control with any questions or concerns

Perform the following measures as applicable:

1. [Body Substance Isolation \(Universal Precautions\)](#)
2. Stabilize spine if indicated and maintain manual control until relieved.
3. Perform a brief assessment of the patient's responsiveness.
4. Evaluate airway, breathing and circulation.
5. If the patient is unconscious, pulseless and not breathing implement [Cardiopulmonary Arrest SMO](#)
6. As necessary: open airway manually, suction, and use airway adjuncts as indicated. Airway adjuncts include oropharyngeal, nasopharyngeal and any system approved supraglottic airways.
7. If patient is having difficulty, position patient in a semi-sitting position (if no spinal precautions needed).
 - Position the patient in the recovery position, or other comfortable position as indicated.
8. Administer O2 as indicated: If pulse oximeter is available assess O2 saturation
 - N.R.B. mask at 100% O2 (12-15 L/ min)
 - Nasal cannula (2-6 L/ min)
 - if indicated, assist breathing with appropriate device and 100% O2
9. Patients with altered mental status: If blood glucose monitoring equipment is available check patient blood sugar levels.
10. Loosen tight clothing.
11. Protect the patient's privacy as much as possible.
12. Look for Medic Alert Tags.
13. Reassure the patient and explain what you are doing.
14. Obtain patient's medical history and the history of the emergency event as soon as possible.
15. Use the [S.A.M.P.L.E.](#) process to organize history.
16. Give a complete and accurate report to the arriving EMS transporting unit.

Original SMO Date: 07/04
Reviewed: 02/06; 06/17; 09/19; 06/20
Last Revision: 02/06; 06/17

SMO: Routine Medical Care

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REGION I EMERGENCY MEDICAL SERVICES STANDING MEDICAL ORDERS EMR

SMO: Medical Emergencies

Overview: Emergency Medical Responder shall utilize the following guidelines for medical emergency care situations.

Allergic Reactions: Mild or Moderate Reaction

Overview: Allergic reactions can vary in severity from a mild reaction consisting of hives and rash to a severe generalized allergic reaction termed anaphylaxis resulting in cardiovascular and respiratory collapse. Common causes of allergic reactions include: bee/wasp stings, penicillin or other drug allergies and seafood or nuts. Exposures can occur from ingestion, inhalation, injection or absorption through skin or mucous membranes. This SMO is intended to help the EMS responder assess and treat the spectrum of allergic reactions. Common assessment findings include exposure to common allergens (bee stings, drugs, nuts, seafood, medications), prior allergic reactions, wheezing, stridor, respiratory distress, itching, hives, rash, nausea, weakness, anxiety

1. [Routine Medical Care](#)
2. Remove etiologic agent if possible or relocate patient
3. Oxygen as indicated

Allergic Reactions: Severe Reaction / Anaphylaxis

1. [Routine Medical Care](#)
2. To be categorized as a severe allergic reaction / anaphylaxis patient will have one or more of the following:
 - __ Altered mental status
 - __ Hypotension (SBP < 90 and evidence of hypoperfusion)
 - __ Bronchospasm (difficulty breathing / wheezing)
 - __ Swelling of the face and/or airway
3. Administer **Epinephrine Autoinjector**
 - **Epi JR. 0.15mg** for children weighing 33 pounds (15 kg) to 66 pounds (30kg)
 - **Epi 0.3mg** for patients greater than 66 pounds (30kg)
 - Consult Medical Control for children less than 33 pounds

Original SMO Date: 07/04
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Last Revision: 09/19

SMO: Medical Emergencies

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Altered Mental Status

Overview: The term *altered mental status* describes a change from the “normal” mental state. The term *level of consciousness* indicates a patient’s state of awareness. Check surroundings for syringes, blood glucose monitoring supplies, insulin, etc. Be alert to changes in mental status and symptoms such as headache, seizures, confusion, trauma, etc. Obtain medical history: psychiatric and medical problems, medications, and allergies.

1. [Routine Medical Care](#)
2. Protect the patient’s airway. Watch for vomiting and have suction available.
3. Protect patient’s c-spine.
4. If equipment available, determine blood glucose level – normal range 60-120mg/dL
 - Blood glucose < 80 with signs and symptom of hypoglycemia:
 - **Oral Glucose** if patient is alert with intact gag reflex
5. **Naloxone (Narcan) 2mg** intranasal, for suspected opiate overdose with respiratory depression consisting of respirations < 12 and or very shallow respirations and/or signs of shock

Behavioral

Overview: “Normal” behavior is generally considered to be adaptive behavior that is accepted by society. This idea is also defined by society when the behavior:

- Deviates from society’s norms and expectations
- Interferes with well-being and ability to function
- Is harmful to the individual or group

A behavior emergency can be defined as a change in mood or behavior that cannot be tolerated by the involved person or others and requires intervention.

1. Scene size-up. If scene unsafe, elicit police assistance before patient contact.
2. [Routine Medical Care](#) or [Routine Trauma Care](#)
3. Identify yourself clearly
4. Approach patient in a calm and professional manner. Talk to patient alone—request bystanders to wait in another area. Show concern for family members as well. Allow patient to verbalize his problem in his own words. Reassure patient that help is available.
5. Get patient’s permission to do your assessment before touching patient
6. NEVER leave patient alone.

Bites, Stings and Envenomation

Overview: An insect, animal or human bite or sting frequently is a combination of puncture, laceration, avulsion and crush injuries. Complications are common—all patients who have been bitten/ stung should seek physician evaluation. Try to find out the type of animal or insect, time of exposure and history of previous exposures, allergic reactions, and any known specific allergen.

[Routine Medical Care](#)

__ See [Allergic Reaction Mild/Moderate](#) or [Allergic Reaction Severe](#) as needed

__ If patient is hypotensive, treat for [Shock](#)

__ Scrape off any remaining stinger or tentacles

__ Clean the affected area with saline, cover with sterile dressing

__ Do not perform any of the following:

- Tourniquets or constricting bands above or below the site
- Incision and / or suction
- Application of cold for snake or spider bites

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Last Revision: 09/19

SMO: Medical Emergencies

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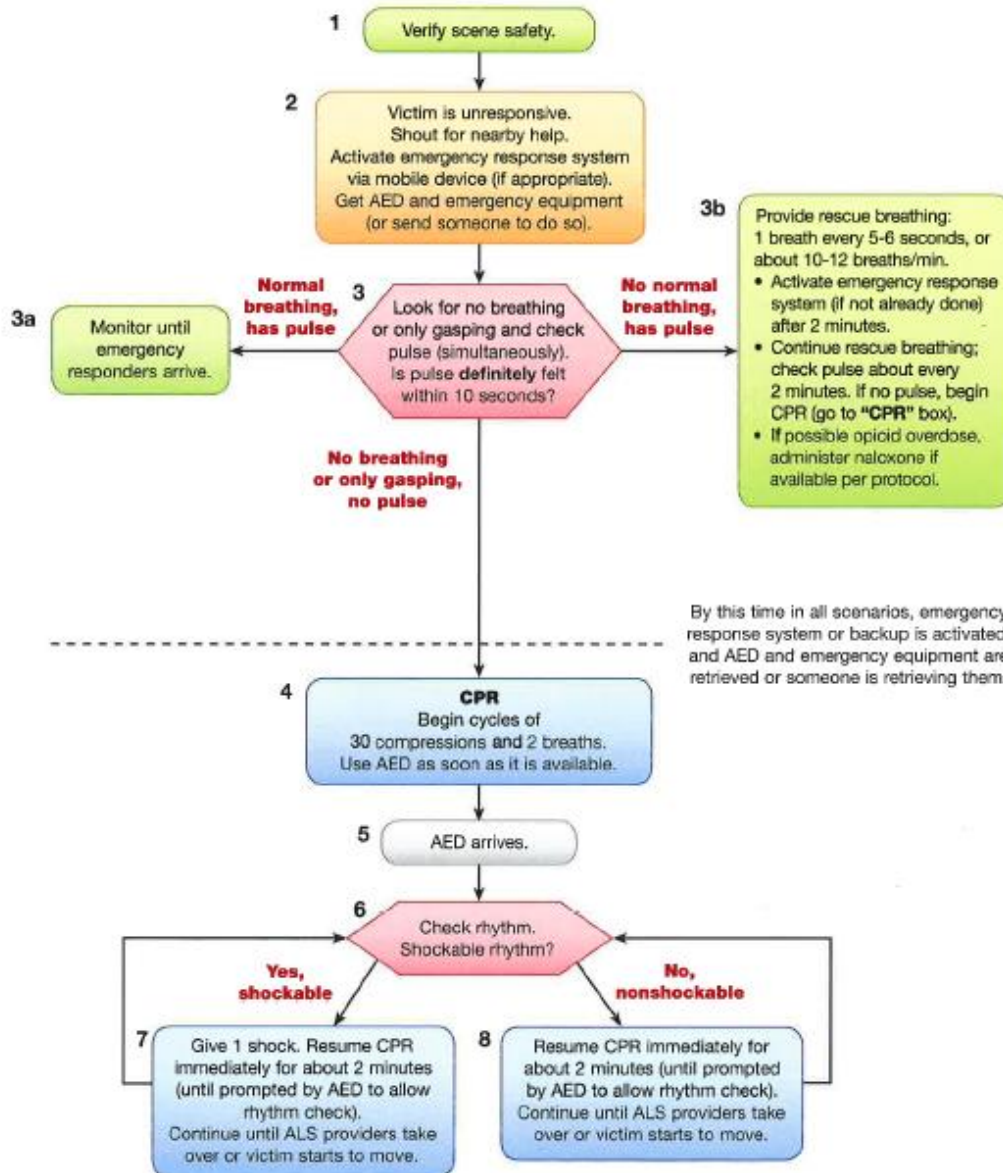
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Cardiac Arrest Algorithm

Per AHA Guidelines 2015

**BLS Healthcare Provider
Adult Cardiac Arrest Algorithm—2015 Update**



© 2015 American Heart Association

Figure 4. BLS Healthcare Provider Adult Cardiac Arrest Algorithm.

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Reviewed: 02/06; 06/17; 09/19; 06/20	
Last Revision: 09/19	Page 3 of 6

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Chest Pain of Suspected Cardiac Origin

Overview: Patients with acute non-traumatic chest pain are among the most challenging patients cared for in EMS. They may appear seriously ill or completely well and yet remain at significant risk of sudden death or acute myocardial infarction. Sorting out which patient is experiencing chest pain of cardiac origin represents a tremendous challenge. This SMO should be utilized whenever cardiac chest pain is suspected. Whenever there is question as to whether or not you should utilize this SMO, contact medical control for further guidance.

1. [Routine Medical Care](#)
2. Administer O₂ as indicated
3. Low Dose- **ASA 81 mg X FOUR tablets** chew and swallow
4. If at any time patient becomes unconscious and pulseless, begin [Cardiac Arrest SMO](#)

Environmental Emergencies

(Hyperthermia)

Overview: Heat illness results from one of two basic causes:

- Normal mechanisms that regulate the body's thermostat are overwhelmed by environmental conditions such as heat stress or increased exercise in moderate to extreme environmental conditions.
- Failure of the body's regulatory mechanisms especially in older adults, young children, babies and ill or debilitated patients.

1. [Routine Medical Care](#)
2. Remove the patient from the hot environment.
3. Begin cooling measures with cool water and fanning.

(Hypothermia)

Overview: Core body temperature less than 95 ° F [35° C] can result from a decrease in heat production, an increase in heat loss, or a combination of the two factors. Most common cause is exposure to extreme environmental conditions. Classified as Mild (CBT of 96.8° F to a CBT of 93.2° F [36-34° C]), Moderate (CBT of 86° F [30°C]), and Severe (CBT of < 86.0° F [<30°C]).

1. [Routine Medical Care](#)
2. Handle the patient very gently
3. Remove the patient from the cold environment
4. Cut away any wet clothing
5. Conserve body heat with blankets
6. Do NOT add external warming measures
7. Assess pulse for 30- 45 seconds
8. If the use of the AED is warranted do not shock the patient more than 3 times

Obstructed Airway

1. [Routine Medical Care](#)
2. Remove the airway obstruction if able to visualize.
3. Suction the airway as needed.
4. If the airway is still obstructed use American Heart or Red Cross obstructed airway procedures.

Original SMO Date: 07/04

Reviewed: 02/06; 06/17; 09/19; 06/20

Last Revision: 09/19

SMO: Medical Emergencies

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EMS/ Region1 SMO

Poisoning and Overdose

Overview: Poisoning and Overdose can take several forms and patients may range from mildly ill to very critical. This SMO is intended to guide EMS Responders in providing care for these patients. Variances in condition occur due to amount of substance involved, time of incident, type of substance involved, and whether it is an overdose or actual poison.

1. [Routine Medical Care](#)
2. Attempt to identify the substances and method of ingestion.
3. Collect bottles, pills, syringes, M.S.D.S. papers or other items that may help identify the substance.
4. For patient suspected of overdosing on narcotics or unknown substances
 - Ensure ABC's, oxygenation, ventilation
 - **Naloxone (Narcan) 2mg** intranasal for altered mental status with severe respiratory depression or arrest; signs and symptoms of shock; or hypoventilation

Respiratory Distress with Acute Bronchospasm (Wheezing)

Overview: Respiratory distress with acute bronchospasm can be seen in patients as a result of many causes including asthma, COPD, bronchitis, and allergic reaction. Treatment must be concentrated on airway patency and ventilation.

1. [Routine Medical Care](#)
2. Administer O₂ as indicated
3. If available, administer **Albuterol Neb** or assist with patients' prescribed medication / inhalers

Seizure

Overview: A seizure is a temporary, abnormal electrical activity of the brain that results in a loss of consciousness, loss of organized muscle tone, and presence of convulsions. The patient will usually regain consciousness within 1 to 3 minutes followed by a period of confusion and fatigue (post-ictal state).

Multiple seizures in a brief time span or seizures lasting more than 5 minutes may constitute status epilepticus and require EMS intervention to stop the seizure. Causes of seizures include: epilepsy, stroke, head trauma, hypoglycemia, hypoxia, infection, a rapid change in core body temperature (e.g. febrile seizures), eclampsia, alcohol withdrawal, and overdose.

1. [Routine Medical Care](#)
2. Protect the patient from injury during the seizure. Take special care to protect the patient's head and airway (watch for vomiting and have suction available).
3. Administer O₂.

Stroke

Overview: Stroke, also known as cerebrovascular accident (CVA), is a sudden interruption in blood flow to the brain that results in neurological deficit. This interruption can be caused by ischemia (blockage) or hemorrhage (bleeding). It is the third leading cause of death in the United States and frequently leaves its survivors severely debilitated.

1. [Routine Medical Care](#)
2. [Perform FAST Exam](#)
3. Protect airway, suction as necessary. Seizure and vomiting
4. Administer O₂ as indicated
5. Maintain head and neck in neutral alignment. Do NOT flex the neck.
6. If BP > 90 mmHg, elevate head of bed to 30°
7. If altered sensorium, seizure, or focal neurological deficit, obtain and record blood sugar level.
 - If blood sugar < 80 administer **Oral Glucose** if patient is alert with intact gag reflex
8. Monitor and record neurological status and any changes.
9. Protect paralyzed limbs from injury.
10. Whenever possible, the EMR should establish the last known well time.

FAST EXAM

FACIAL DROOP: Ask the person to smile and/or show their teeth

_____ **Normal:** Both sides of the face are equal, there is no droop noted to one side

_____ **ABNORMAL:** One side the mouth or face is drooping, drooling or does not look the same

ARM DRIFT: Ask the person to hold both arms out in front of them for the count of 10

_____ **Normal:** Both arms move equally

_____ **ABNORMAL:** One arm drifts down or does not move at all, the other is normal

SPEECH: Have the person say a sentence (example: You can't teach an old dog new tricks.)

_____ **Normal:** Sentence sounds normal, no slurring words and person uses correct words

_____ **ABNORMAL:** Patient unable to speak (mute), words are slurred, incorrect words used

TIME: If the time of **Last Known Well** is **GREATER** than **8 hours**, then a stroke alert is **NOT** paged because the patient is outside of acute window.

If any of the above questions is scored abnormal, the chances are high that a stroke may be occurring.

REGION I EMERGENCY MEDICAL SERVICES STANDING MEDICAL ORDERS EMR

SMO: Routine Trauma Care

Overview: A trauma assessment needs to be completed on all trauma patients to identify and immediately correct life-threatening problems in accordance with PHTLS and ITLS guidelines. Scene times should be kept to a minimum and the patient should be promptly transported to the trauma center. Emergency Medical Responders shall utilize the following guidelines for trauma emergency care situations. Contact Medical Control whenever a question exists as to the best treatment course for the patient.

Perform the following measures as necessary:

1. Scene Assessment (Scene Size-up)

- Assess scene safety and situation
- Apply Personal Protection Equipment
- Identify mechanism of injury and any special extrication needs
- Call for additional resources
- Minimal disturbance of crime scene should be considered

2. Assessment

- Assess airway patency utilizing adjuncts as indicated (OPA, NPA and any System approved supraglottic airway). Secure the airway with [Spinal Restriction](#).
- Spinal restriction as indicated
- Assess breathing, apply oxygen as indicated:
 - Oxygen via nasal cannula (2-6 L/min) for awake, oriented, stable patients without evidence of hypoperfusion or mental status changes.
 - High-flow via non-rebreather mask (10-15 L/min) if indicated. Assist ventilations with BVM and 100% oxygen if indicated
 - Clear and maintain airway with [Spinal Restriction](#) as indicated
 - Airway management as indicated
- Chest Trauma:
 - For open chest wounds utilize occlusive dressings
- Immediately control external bleeding. Refer to [Bleeding Guidelines](#)
- Follow Shock / Internal Bleeding guidelines if SBP < 90 mm Hg for patient management
- Assess disability: [AVPU](#), [pupils and Glasgow Coma Scale](#), and PMS.
- If altered mental status, check blood sugar.

Original SMO Date: 07/04
Reviewed: 02/06; 06/17; 09/19; 06/20
Last Revision: 02/06; 06/17

SMO: Routine Trauma Care

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Assessment (continued):

- Remove clothing to expose injuries. Cover patient with a blanket to avoid hypothermia.
- Obtain SAMPLE history.
- Reassess airway patency and maintain good ventilation.
- Reassess ABC's including patient's color.
- Perform [Secondary Assessment](#)
- For head trauma elevate head approximately 15-30 degrees.
- Splint fractures and bandage wounds, control bleeding. Re-check PMS.
- Reassess critical patients frequently

REGION I EMERGENCY MEDICAL SERVICES STANDING MEDICAL ORDERS EMR

SMO: Trauma Emergencies

Overview: The EMR shall utilize the following guidelines for trauma emergency care situations.

Abuse: Geriatric/Spouse

1. Scene safety, notify law enforcement if necessary
2. [Routine Trauma Care](#) or [Routine Medical Care](#) as appropriate
3. Treat injuries as appropriate
4. Should patient refuse care, resource assistance information should be provided
 - Domestic Violence Hotline (**1-800-799-7233**)
 - Elder Abuse (persons 60 years of age or older) **1-800-252-8966**
 - Nursing Home Abuse – **1-800-252-4343**
 - Adult Protective Services – **1-866-800-1409**
5. Attempt to preserve evidence if needed

Amputations

1. [Routine Trauma Care](#)
2. Control bleeding
3. Place body part in plastic bag. Place plastic bag containing body part in a larger bag or container and place in container with ice/ water.
4. Use caution to not freeze body part.

Bleeding

1. [Routine Trauma Care](#)
2. For external bleeding use direct pressure, if direct pressure is not effective a tourniquet should be considered.
3. Direct pressure is the primary method of controlling most external bleeding and should be used as soon as possible.
4. Tourniquets:
 - Consider tourniquets when direct pressure does not control breathing
 - Tourniquets may not be practical on proximal extremity locations
 - Cut away clothing
 - Tighten per manufacturers' instructions until hemorrhage stops
 - Secure tourniquets per manufacturers' recommendations
 - Note time of tourniquets application and provide this information to receiving care provider. Do not remove any tourniquet without authorization from Medical Control.
 - If one tourniquet is not sufficient to control bleeding consider a second tourniquet proximal to the first

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SMO: Trauma Emergencies

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5. Wound Packing:

- Consider wound packing for life threatening bleed from a penetrating injury to the buttock, pelvis (pelvic girdle), axilla (armpit), or neck. Also, consider for penetrating injuries to extremity with significant bleeding that cannot be controlled with direct pressure or tourniquets.
- Wound packing is contraindicated for the chest, back, head, abdomen, and dialysis graft bleeding.
- Wound packing procedure:
 - Attempt to control bleeding with direct pressure.
 - Cut away clothing at wound site.
 - Have wound packing supplies on hand – use a roll of plain gauze.
 - Carefully remove any obvious foreign object from the wound (splintered wood, etc.)
 - Apply direct pressure just proximal to the wound to reduce bleeding. With one finger of the other hand push the end of the gauze as deeply into the wound as possible. Continue to feed the gauze deep into the wound in small increments. Do not attempt to feed a large amount of gauze all at once.
 - Continue to pack gauze deeply and tightly in order to apply direct pressure over the source of the bleed. When the packing reaches the level of the skin apply any remaining gauze over the wound to help apply pressure.
 - Hold direct pressure over the wound for at least ten minutes. Do not release this pressure to “check” for bleeding.
 - If possible, wrap with gauze to maintain pressure.
 - Note: this is a very painful procedure, provide [Pain Management](#) per SMO.

6. Treat for shock.

Bones and Muscles

1. [Routine Trauma Care](#)
2. Control external bleeding with direct pressure. If direct pressure is unsuccessful, consider a tourniquet to control bleeding
3. Manual stabilization - support the joint above and below the injury.
4. Cover open wounds with sterile dressing.
5. Pad to prevent pressure and discomfort.
6. Use caution to not replace protruding bones.
7. Reassess pulses as needed
8. Assess treat for shock

Burns

1. [Routine Trauma Care](#)
2. The first priority is to stop the burning process by removing the patient from the source of the burn or eliminate the source
 - a. Thermal burns
 - 1) Continuously monitor the airway. Examine the mouth and nose for signs of respiratory burns.
 - 2) Remove clothing and jewelry from the affected site.
 - 3) Cover the burn with dry sterile dressing.
 - 4) Protect patient from hypothermia
 - 5) Treat for shock
 - b. Chemical burns
 - 1) [Body Substance Isolation](#)
 - 2) Remove clothing and jewelry
 - 3) For dry chemicals brush off all visible chemical prior to beginning the water flush.
 - 4) The site should be flushed with copious amounts of water for 20 minutes.
 - c. Electrical burns
 - 1) Scene safety
 - 2) Treat entrance and exit wounds as thermal burns.
 - 3) Spinal restriction is indicated with serious electrical burns.
 - 4) If the patient is pulseless refer to [Cardiac Arrest SMO](#).

Chest Injuries

1. [Routine Trauma Care](#)
2. If an open wound is present (sucking chest wound), cover the wound with a 3-sided, occlusive dressing. If the patient develops increased difficulty breathing or cyanosis, temporarily release the dressing.

Child Abuse and Neglect

1. [Routine Trauma Care](#)
2. If you suspect abuse or neglect do not confront the parents. EMS's role is one of patient treatment and transporting the child.
3. Manage the scene in order to preserve evidence.
4. Insure that an EMS team member has notified medical control or other appropriate agency. EMS responders are mandatory reporters.
 - a. Remain objective during reporting procedures.
 - b. For DCFS call 1-800-25ABUSE (1-800-252-2873)

Drowning and Near Drowning

1. [Routine Trauma Care](#)
2. Keep the victim warm. If hypothermia is suspected, handle patient very gently. Remove wet clothing and apply warm blanket.

NOTE: Because of possible serious delayed reactions, all near drowning patients should be evaluated in the Emergency Department even if they appear to be uninjured at the scene.

Eviscerations

1. [Routine Trauma Care](#)
2. Do not attempt to replace protruding organs.
3. Cover with thick, sterile, moist dressings.

Impaled Object

1. [Routine Trauma Care](#)
2. Do not remove object unless interferes with airway control.
3. Manually stabilize object with use of bulky dressings.
4. Control bleeding.

Injuries to the Brain and Skull

1. [Routine Trauma Care](#)
2. Maintain ABC's.
3. [Spinal Restriction](#)
4. Monitor mental status
5. Control bleeding.

Shock/ Internal Bleeding

1. [Routine Trauma Care](#)
2. Maintain the patient's body position as flat.
3. Keep patient warm.

SIDS (Sudden Infant Death Syndrome)

1. SIDS cannot be predicted or prevented.
2. Start infant CPR
3. Remain compassionate to all involved. Do not make any statements that they could construe as untruthful or appear to be assigning blame.

**REGION I EMERGENCY MEDICAL SERVICES
STANDING MEDICAL ORDERS
EMR**

SMO: Triage Categorization of Patients

Overview: This protocol is to be used when EMS providers are faced with a situation where NEEDS EXCEED RESOURCES. This can occur when number or intensity of care needed by victims exceed the care that can be provided with the present resources. Needs may exceed resources with just a few patients or you may encounter situations with ample resources where multiple patient's needs can be met easily. This policy should be instituted any time needs exceed resources on scene. In order to maintain proficiency in triaging patients, the region I EMS Medical Directors will require patient triage to occur any time the number of victims on scene exceed 5 patients. (Mandatory for > 5 victims but may be instituted for less)

Several steps should occur when encountering a situation where needs exceed resources. First, early recruitment of additional help must be attempted. Second, care must be prioritized to provide the greatest good to the most patients. As additional resources become available, i.e. additional caregivers or equipment on site, the treatment priorities should be adjusted to expand care to those who were initially triaged to a delayed or expectant category.

Early and concise communication from the field to medical control is vitally important. Once you have an initial assessment of approximate numbers of victims, severity and types of injuries/illnesses i.e. triage category (number of reds, yellows, greens and blacks), contact medical control with this information. Be sure to specify which information is "known" versus "estimates or guesstimates." As more precise information is available frequent updates of medical control need to occur.

Region I has adopted the START Triage method as described below. In a disaster situation, one may be working with other providers that utilize different triage systems. It may be helpful to be familiar with some of the more common systems. The United States Military uses a standardized triage category system that is taught in the Basic Disaster Life Support Course. The BDLS Triage System assists in the triage of large numbers of casualties. It is designed to sort large numbers of casualties that are in close proximity to each other. It is presented at the end of this protocol.

Original SMO Date: 07/04
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Last Revision: 06/17

SMO: Triage Categorization
START Triage Method
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START TRIAGE

__ Triage is used to sort patients and resources when the demand for emergency medical services exceeds the immediate capability to deliver that service. The goal of triage is to deliver the most care to the greatest number of patients, and to deliver care to those patients who will benefit most.

__ Triage officers are designated according to the district or county [Mass Casualty plan](#). Illinois EMS Region 1 Trauma Plan utilizes the **S.T.A.R.T.** triage plan. Casualties are sorted according to the START triage method and tagged:

- **RED:** Immediate, life threatening
- **YELLOW:** Delayed treatment. These patients are the next priority after patients in the RED category have been treated and/or transported.
- **GREEN:** Designates the “walking wounded” or patients with minor injuries.
- **BLACK:** Dead, no resuscitation indicated. In mass casualty situations, resuscitation of fatally injured patients may take care away from those who would have a much greater chance of survival. In these situations, no resuscitations should be initiated. Of course, if there is sufficient personnel and equipment, normal protocols for caring for these patients should apply.

OBJECTIVE FINDINGS

__ **S.T.A.R.T. TRIAGE:** (Simple Triage and Rapid Transport)

In START triage the patient is assessed quickly for the following signs. Once a patient has a value, which would place him in the RED category, tag him and move on. For the initial triage all patients who can walk are considered GREEN.

GUIDELINES (SEE FLOWCHART)

__ Step 1 - Clear the scene of any walking wounded

__ Step 2 - Assess ventilation in the remaining patients

No respiratory effort after opening patient’s airway- BLACK

Respirations above 30 - RED

Respirations below 30 - continued assessment

__ Step 3 - Assess perfusion

No radial pulse - RED

Radial pulse present - continued assessment

__ Step 4 - Assess neurological status

Unconscious or altered level of consciousness - RED

__ Once the BLACKS, GREENS, and REDS have been designated by the above physical findings - all remaining patients are designated as YELLOW (delayed).

__ Once the patients have been moved into the various treatment areas immediate re-triage should be accomplished. All BLACK category patients should be confirmed as resources are available.

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SMO: Triage Categorization
START Triage Method
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Documentation of adherence to SMO

- Assessment, reassessment and vital signs documented (identified color system)
- Treatment
- Patient destination
- Type of situation (chemical, trauma, etc)
- Decontamination needed.

PRECAUTIONS AND COMMENTS

- Keep **ALL** patient communication concise to keep radio time to a minimum
- Reassess and re-triage patients as indicated
- Trauma patients pose a significant risk for exposing pre-hospital personnel at the scene to blood and body fluids. Barrier precautions should be in place before arrival at the scene and BSI should be observed at all times
- Scene Safety is paramount.
- Minimal disturbance of crime scene should be considered.

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START Triage Method
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REGION I EMERGENCY MEDICAL SERVICES

Obstetrical Emergencies For Emergency Medical Responders

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Normal Delivery

- Assist with delivery
- Sterile technique
- Control and guide delivery of baby's head. After the head delivers, use bulb syringe to suction the infant's mouth first, then nares. This is critical if meconium is present, because aspiration causes significant lung injury.
- Check for nuchal cord – slide over head if possible. If tight, clamp and cut, unwind, and deliver baby quickly
- Proceed to control and guide delivery of the body
- Suction mouth first, then nares
- Clamp and cut cord – clamps should be placed at approximately 6 inches and 9 inches from baby, then cut between clamps
- Dry and wrap infant for warmth (especially the head); if possible, place with mother for shared body heat
- Note time of delivery
- Assess infant's status using [APGAR score](#) at 1 and 5 minutes post-delivery (see Precautions and Comments)
- Evaluate mother post-delivery for evidence of shock due to excessive

Pre-partum Hemorrhage – near term

- Assume placenta previa (painless bleeding) or abruption placenta (sharp pain)
- Check for crowning but DO NOT attempt vaginal exam
- Treat for shock
- Do not pack the vagina with any material to stop bleeding. An externally placed dressing or pad should be used to absorb flow

Post-partum Hemorrhage

- Fundal massage
- Immediate transport to nearest hospital
- Do not pack the vagina with any material to stop bleeding. An externally placed dressing or pad should be used to absorb flow

Breech Delivery

- Assist with delivery, if able
- Provide airway with gloved hand for baby if needed
- If unable to deliver, left lateral Trendelenburg position and rapid transport

Prolapsed Cord

- Left lateral Trendelenburg position, elevate hips, if possible or knee-chest position
- If cord is present, manually displace presenting part off cord and maintain displacement
- Rapid transport

Original SMO Date: 11/07

SMO: Obstetric Emergency: Childbirth/Pre-Partum Hemorrhage/Post-Partum Hemorrhage

Reviewed: 05/12; 12/12; 07/13; 06/17; 09/19; 06/20

Last Revision: 05/12; 12/12; 06/17

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PRECAUTIONS AND COMMENTS

- Spontaneous abortion of fetus (>20 weeks) gestational age should be considered a neonatal resuscitation. See [Neonatal Resuscitation SMO](#).
- Consider ruptured ectopic pregnancy in a woman of childbearing age with signs of shock.

BLOOD LOSS ESTIMATION GUIDE

250 ml = 1 cup or clot mass size of an orange

355 ml = 12 oz soda can

500 ml = 2 cups or clot mass size of a softball

Floor spill

500 ml = 20 inches diameter

1000 ml = 30 inches diameter

1500 ml = 40 inches diameter

APGAR SCORE:

Appearance (skin color)	0=Body and extremities blue, pale	1=Body pink, extremities blue	2=Completely pink
Pulse	0=Absent	1=Less than 100/min	2=100/min and above
Grimace (Irritability)	0=No response	1=Grimace	2=Cough, sneeze, cry
Activity (Muscle tone)	0=Limp	1=Some flexion of the extremities	2=Active motion
Respirations	0=Absent	1=Slow and irregular	2=Strong cry

Original SMO Date: 11/07

SMO: Obstetric Emergency: Childbirth/Pre-Partum Hemorrhage/Post-Partum Hemorrhage

Reviewed: 05/12; 12/12; 07/13; 06/17; 09/19; 06/20

Last Revision: 05/12; 12/12; 06/17

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REGION I EMERGENCY MEDICAL SERVICES

Pediatric Emergencies For Emergency Medical Responders

SMO	Category
Pediatric Airway Management	Pediatric
Pediatric Medical Emergencies	Pediatric
Pediatric Neonatal Resuscitation	Pediatric
Pediatric Trauma Emergencies	Pediatric
Routine Pediatric Care	Pediatric

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**REGION 1 EMERGENCY MEDICAL SERVICES
STANDING MEDICAL ORDERS
EMR**

SMO: Routine Pediatric Care

Overview: Pediatric patients account for about 10% or less of EMS emergency responses. Caring for these patients presents unique challenges related to size, physical and intellectual maturation, and diseases specific to neonates, infants, and children. It is important to maintain and improve knowledge and clinical skills for these patients through continuing education programs and clinical applications specific to this age group.

The importance of assessing and maintaining AIRWAY, BREATHING, & CIRCULATION (A-B-C) in the pediatric patient cannot be overemphasized.

INFORMATION NEEDED

- Patient age and weight
- Scene assessment
- Primary assessment
- Nature of illness/mechanism of injury
- Focused history/physical Assessment
- Ongoing assessment

General Approach to the Pediatric Patient

Assessments and interventions must be tailored to each child in terms of age, size, and development. Providers must be familiar with assessment algorithms for medical emergencies, assessment mnemonics such as DCAP-BTLS for trauma emergencies.

Consider the following when performing a pediatric patient assessment:

- Smile if appropriate to the situation
- Keep voice at an even quiet tone
- Speak slowly using simple, age appropriate terms
- Use toys or penlight as distracters
- Keep small children with their caregiver(s), allowing the caregiver to hold the child and assist with the assessment if necessary. Child must be properly restrained during transport.
- Kneel down to the level of the child if possible

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SMO: Routine Pediatric Care

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General Approach to Pediatric Patient (continued)

- Make as many of the following observations as possible prior to touching the child as physical contact may upset the child
 - Level of consciousness
 - General appearance, age appropriate behavior, malnourished or well-nourished appearance, purposeful eye movement, general mood, playing, using a pacifier or bottle
 - Obvious respiratory distress or extreme pain
 - Position of the child: upright, tripod, recumbent, semi-fowlers
 - Muscle tone: good vs. flaccid
 - Movement: spontaneous, purposeful, symmetrical
 - Skin color
 - Life-threatening injuries
- It may be necessary to interview an adolescent without a caregiver present to obtain accurate information about drug use, alcohol use, LMP, sexual activity, or abuse

AIRWAY

- Self-maintained
- Maintainable with positioning or assistance: held tilt/chin lift, jaw thrust, tripod, high fowlers
- Maintainable with adjuncts
- Maintainable with suction
- Most pediatric patients can be successfully ventilated using BVM
- BVM, supraglottic are preferred airways for pediatric patients

BREATHING

- Rate - compare to normal for age. Rate greater than 60/min is critical in all ages
- Rhythm: regular; irregular; patterned, Cheyne-stokes, agonal, biots, Kussmaul
- Quality: work of breath; use of accessory muscles, head bobbing, see-saw breathing, retractions, nasal flaring
- Auscultate respiratory sounds for absence, presence, snoring, stridor, crackles, gurgling, wheezing, grunting
- Pulse oximetry
- Administer oxygen of O₂ sat <94 and/or other signs of respiratory compromise
- **Blow by**
- **Nasal cannula**
- **Non-rebreather**
- **BVM**

CIRCULATION

- Heart rate – compare to normal for age.
- Central/truncal pulses (apical, femoral, carotid) – strong, weak, absent
- Peripheral pulses – present/absent, strong, weak, thready
- Skin/mucous membrane color
- Skin temperature – hot, warm, cool
- Blood pressure – use appropriate sized cuff
- Use the Pediatric Trauma Score for B/P determination if appropriate cuff is unavailable or capillary refill time (children under age 3)
- Hydration status – infant anterior fontanel status, mucous membranes, skin turgor, tears, urine output history

DISABILITY

- Use AVPU to assess responsiveness.
- Assess pupil response
- Assess distal neurologic status – numbness or tingling

EXPOSURE

- Assess for hypo/hyperthermia
- Check for significant bleeding
- Check for petechiae or purpura (purple discolorations that do not blanch with skin pressure)
- Be aware of signs of child abuse and, if present, report to authorities

Documentation of adherence to SMO

Primary Assessment

___ Patient weight

Original SMO Date: 07/04
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SMO: Routine Pediatric Care

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Medical Control Contact Criteria

__ Contact Medical Control if any questions arise regarding the best treatment options for the patient

PRECAUTIONS AND COMMENTS

Considerations for Children with Special Healthcare Needs (CSHN)

- Refer to child's emergency care plan formulated by their medical providers, if available.
- Understanding the child's baseline will assist in determining the significance of altered physical findings. Parents/caregivers are the best source of information on: medications, baseline vitals, functional/normal mentation, likely medical complications, equipment operation and troubleshooting, emergency procedures.
- It may be helpful to use the DOPE mnemonic to assess problems with ventilation equipment or long-term catheters for feeding tubes. DOPE stands for:
 - D – Dislodged tube
 - O – Obstructed tube
 - P – Pneumothorax
 - E – Equipment failure
- Assess in a systematic and thorough manner, regardless of underlying conditions. Use parents/caregivers as medical resources.
- Be prepared for differences in airway anatomy, physical development, cognitive development, surgical alterations, or mechanical adjuncts. Common home therapies include: respiratory support, nutritional therapy, intravenous therapy, urinary catheterization, dialysis, biotelemetry, ostomy care, orthotic devices, communication or mobility devices, or hospice care.
- Communicate with the child in an age appropriate manner. Maintain communication with and remain sensitive to the parents/caregivers and child.
- The most common emergency encountered with the pediatric patient is respiratory related and so familiarity with respiratory emergency interventions/adjuncts/treatment is appropriate.

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SMO: Routine Pediatric Care

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Pediatric Glasgow Coma Scale***Eye Opening:***

- 4-Spontaneous
- 3-To Verbal Stimuli
- 2-To Painful Stimuli
- 1-None

Verbal Response:

- 5-Oriented/Infant coos or babbles
- 4-Confused/Infant has irritable cry
- 3-Inappropriate words/Infant cries in pain
- 2-Incomprehensible sounds/Infant moans in pain
- 1-No Response

Motor Response:

- 6-Obeys/Infant moves spontaneously or purposefully
- 5-Localizes pain/Infant withdraws to touch
- 4-Withdraws to pain
- 3-Flexion (decorticate posturing)
- 2-Extension (decerebrate posturing)
- 1-No response

NORMAL VITAL SIGNS***Respiratory Rates***

Age	Breaths/min
Infant (< 1 year)	30 – 60
Toddler (1-3 years)	24 – 40
Preschool (4-5 years)	22 – 34
School age (6-12 years)	18 – 30
Adolescent (13-18 years)	12 – 16

Heart rates

Age	Awake Pulse/min	Mean	Sleeping Pulse/min
Newborn-3 months	85-205	140	80-160
3 months-2 years	100-190	130	75-160
2-10 years	60-140	80	60-90
> 10 years	60-100	75	50-90

Blood pressure

Age	Systolic		Diastolic	
	Female	Male	Female	Male
1 day	60-76	60-74	31-45	30-44
4 days	67-83	68-84	37-53	35-53
1 month	73-91	74-94	36-56	37-55
3 months	78-100	81-103	44-64	45-65
6 months	82-102	87-105	46-66	48-68
1 year	68-104	67-103	22-60	20-58
2 years	71-105	70-106	27-65	25-63
7 years	79-113	79-115	39-77	38-78
Adolescent (15 years)	93-127	95-131	47-85	45-85

Original SMO Date: 07/04
 Reviewed: 02/06; 06/17; 09/19; 06/20
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SMO: Routine Pediatric Care

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DEGREE OF DEHYDRATION ASSESSMENT

Clinical Parameters	Mild	Moderate	Severe
Body weight loss			
Infant	5% (50 ml/kg)	10% (100 ml/kg)	15% (150 ml/kg)
Child	3% (30 ml/kg)	6% (60 ml/kg)	9% (90 ml/kg)
Fontanelle	Flat or depressed	Depressed	Significant depression
Mucous Membranes	Dry	Very dry	Parched
Skin Perfusion	Warm / normal color	Cool extremities / pale	Cold extremities
Heart Rate	Mild tachycardia	Moderate tachycardia	Extreme tachycardia
Peripheral Pulse	Normal	Diminished	Absent
Blood Pressure	Normal	Normal	< 70 + 2x age in years
Sensorium	Normal-irritable	Irritable-lethargic	Unresponsive

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 Last Revision: 02/06; 06/17

SMO: Routine Pediatric Care

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**REGION I EMERGENCY MEDICAL SERVICES
STANDING MEDICAL ORDERS
EMR**

SMO: Pediatric Airway Management

Overview: Respiratory arrest is the common reason for codes. Bradycardia is often the result of hypoxia. This makes optimizing a pediatric patient's oxygenation and ventilation of primary importance. Fortunately, most pediatric patients are able to be successfully BVM ventilated. Utilization of pediatric supraglottic airways are preferred airway adjuncts.

INFORMATION NEEDED

- Scene survey
- Chief complaint
- History of foreign body airway obstruction, respiratory distress, etc. (see [Primary Patient Assessment SMO](#))
- Medical History (see [Secondary Patient Assessment SMO](#))

OBJECTIVE FINDINGS

- Mental status (AVPU)
- Airway patency (head-tilt chin lift OR modified jaw thrust for unconscious patient or if C-spine trauma is a possibility)
- Oxygenation and Circulatory status (pulse oximetry, vital signs)

TREATMENT

- [Routine Pediatric Care](#)
- Manage Foreign Body Airway Obstruction per American Heart Association standards
- Assess airway patency utilizing adjuncts as indicated
 - BVM/ Pocket Mask
 - OPA
 - NPA
 - Per EMS System approval supraglottic airway per manufacturer's instructions
- Confirm advanced airways and document:
 - Auscultation
 - Absence of gastric sounds
 - Chest rise

Original SMO Date: 06/17
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Last Revision: 09/19

SMO: Pediatric Airway Management

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Current Version: 2020.1
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EMS/ Region1 SMO

Documentation of adherence to SMO

- Indications for airway management
- Methods utilized
- Confirmation for advanced airway
- Patient condition reassessed

Medical Control Contact Criteria

- Contact Medical Control whenever a question exists as to the best treatment course for the patient

PRECAUTIONS AND COMMENTS

- Utilize basic methods for maintaining airway patency and good ventilations and reassess patient's oxygenation and ventilatory status BEFORE utilizing advanced airway methods.

Original SMO Date: 06/17

Reviewed: 06/17; 09/19; 06/20

Last Revision: 09/19

SMO: Pediatric Airway Management

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Current Version: 2020.1
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 EMS/ Region1 SMO

REGION I EMERGENCY MEDICAL SERVICES STANDING MEDICAL ORDERS EMR

SMO: Pediatric Medical Emergencies

Overview: Emergency Medical Responder shall utilize the following guidelines for medical emergency care situations.

Allergic Reactions: Mild or Moderate Reaction

Overview: Allergic reactions can vary in severity from a mild reaction consisting of hives and rash to a severe generalized allergic reaction termed anaphylaxis resulting in cardiovascular and respiratory collapse. Common causes of allergic reactions include: bee/wasp stings, penicillin or other drug allergies and seafood or nuts. Exposures can occur from ingestion, inhalation, injection or absorption through skin or mucous membranes. This SMO is intended to help the EMS responder assess and treat the spectrum of allergic reactions. Common assessment findings include exposure to common allergens (bee stings, drugs, nuts, seafood, medications), prior allergic reactions, wheezing, stridor, respiratory distress, itching, hives, rash, nausea, weakness, anxiety

1. [Routine Pediatric Care](#)
2. Remove etiologic agent if possible or relocate patient
3. Oxygen as needed

Allergic Reactions: Severe Reaction / Anaphylaxis

1. [Routine Pediatric Care](#)
2. To be categorized as a severe allergic reaction / anaphylaxis patient will have one or more of the following:
 - __ Altered mental status
 - __ Hypotension (SBP < 90 and evidence of hypoperfusion)
 - __ Bronchospasm (difficulty breathing / wheezing)
 - __ Swelling of the face and/or airway
3. Administer **Epinephrine Autoinjector**
 - **Epi JR. 0.15mg** for children weighing 33 pounds (15 kg) to 66 pounds (30kg)
 - **Epi 0.3mg** for patients greater than 66 pounds (30kg)
 - Consult Medical Control for children less than 33 pounds or if there is a question regarding medication administration

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SMO: Pediatric Medical Emergencies

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Altered Mental Status

Overview: The term *altered mental status* describes a change from the “normal” mental state. The term *level of consciousness* indicates a patient’s state of awareness. Check surroundings for syringes, blood glucose monitoring supplies, insulin, etc. Be alert to changes in mental status and symptoms such as headache, seizures, confusion, trauma, etc. Obtain medical history: psychiatric and medical problems, medications, and allergies.

Performing a neurologic examination on an infant or child is more difficult than examining an adult. Pediatric patients often cannot or will not cooperate with the examiner. Parents and guardians can confirm whether the infant or child’s reaction to verbal or tactile stimuli is baseline or changed.

1. [Routine Pediatric Care](#)
2. Protect the patient’s airway. Watch for vomiting and have suction available.
3. Spinal Restrictions as indicated
4. Check blood glucose
5. Blood glucose level less than 80 mg/dl child or less than 40mg/dl newborn
 - Administer **Oral glucose** if patient is able to swallow, maintain their airway, and follow commands
6. Airway management as indicated
7. Consider **Naloxone** if suspected or possible overdose with respiratory depression, Administer **Naloxone** as indicated

Behavioral

Overview: “Normal” behavior is generally considered to be adaptive behavior that is accepted by society. This idea is also defined by society when the behavior:

- Deviates from society’s norms and expectations
- Interferes with well-being and ability to function
- Is harmful to the individual or group

A behavior emergency can be defined as a change in mood or behavior that cannot be tolerated by the involved person or others and requires intervention.

1. Scene size-up. If scene unsafe, elicit police assistance before patient contact.
2. [Routine Medical Care](#) or [Routine Trauma Care](#)
3. Identify yourself clearly
4. Approach patient in a calm and professional manner. Talk to patient alone—request bystanders to wait in another area. Show concern for family members as well. Allow patient to verbalize his problem in his own words. Reassure patient that help is available.
5. Get patient’s permission to do your assessment before touching patient

Bites, Stings and Envenomation

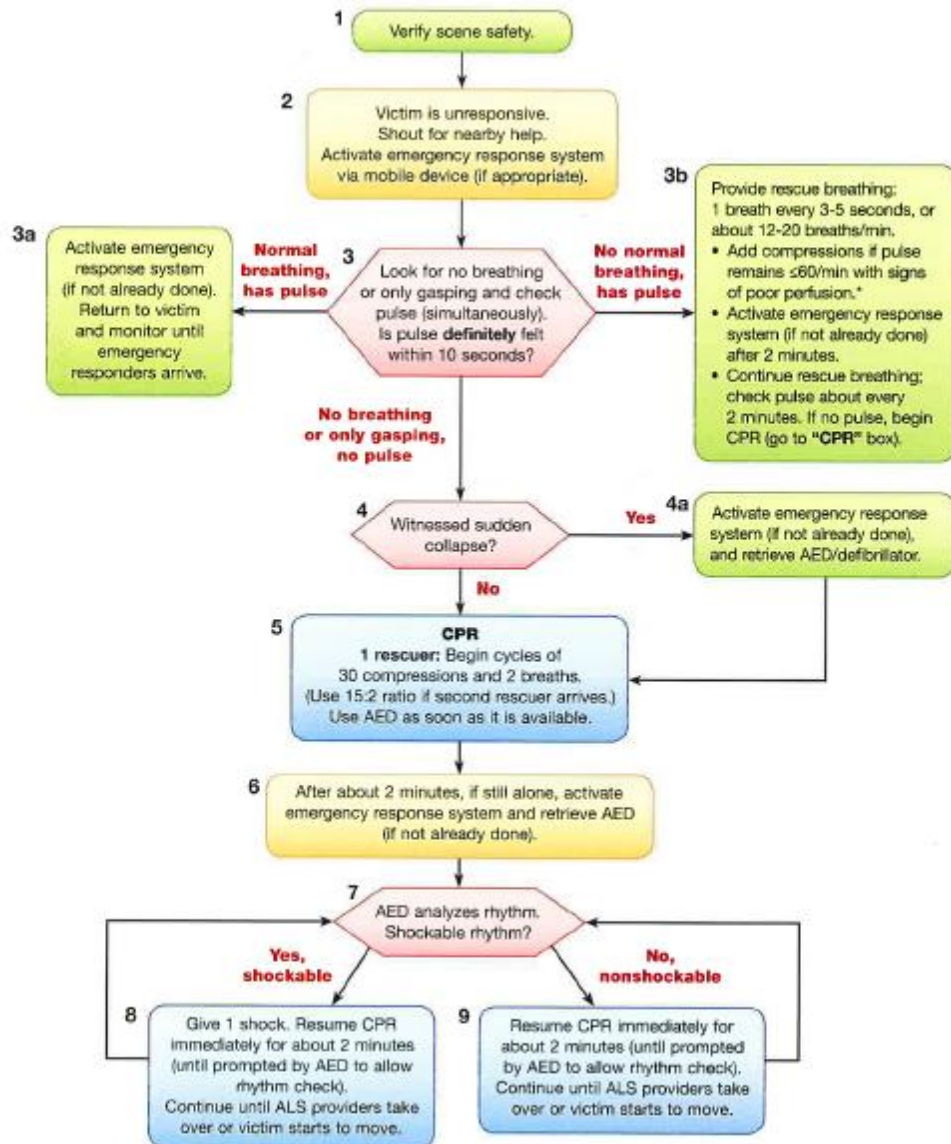
Overview: An insect, animal or human bite or sting frequently is a combination of puncture, laceration, avulsion and crush injuries. Complications are common—all patients who have been bitten/ stung should seek physician evaluation. Try to find out the type of animal or insect, time of exposure and history of previous exposures, allergic reactions, and any known specific allergen.

1. [Routine Pediatric Care](#)
2. See [Allergic Reaction Mild/Moderate](#) or [Allergic Reaction Severe](#) as needed
3. If patient is hypotensive, treat for shock
4. Scrape off any remaining stinger or tentacles
5. Clean the affected area with saline, cover with sterile dressing
6. Do not perform any of the following:
 - Tourniquets or constricting bands above or below the site
 - Incision and / or suction
 - Application of cold for snake or spider bites

Cardiac Arrest

Per American Heart Association 2015 guidelines

BLS Healthcare Provider Pediatric Cardiac Arrest Algorithm for the Single Rescuer—2015 Update



*Signs of poor perfusion may include cool extremities, decrease in responsiveness, weak pulses, pallor, mottling (patchy skin appearance), and cyanosis (turning blue).

© 2015 American Heart Association

Figure 28. BLS Healthcare Provider Pediatric Cardiac Arrest Algorithm for the Single Rescuer.

Environmental Emergencies

(Hyperthermia)

Overview: Heat illness results from one of two basic causes:

- Normal mechanisms that regulate the body's thermostat are overwhelmed by environmental conditions such as heat stress or increased exercise in moderate to extreme environmental conditions.
- Failure of the body's regulatory mechanisms especially in older adults, young children, babies and ill or debilitated patients.

1. [Routine Pediatric Care](#)

2. Remove the patient from the hot environment.
3. Begin cooling measures with cool water and fanning.

(Hypothermia)

Overview: Core body temperature less than 95 ° F [35° C] can result from a decrease in heat production, an increase in heat loss, or a combination of the two factors. Most common cause is exposure to extreme environmental conditions. Classified as Mild (CBT of 96.8° F to a CBT of 93.2° F [36-34° C]), Moderate (CBT of 86° F [30°C]), and Severe (CBT of < 86.0° F [<30°C]).

1. [Routine Pediatric Care](#)

2. Handle the patient very gently
3. Remove the patient from the cold environment
4. Cut away any wet clothing
5. Conserve body heat with blankets
6. Do NOT add external warming measures
7. Assess pulse for 30- 45 seconds
8. If the use of the AED is warranted do not shock the patient more than 3 times

Obstructed Airway

1. [Routine Pediatric Care](#)

2. Remove the airway obstruction if able to visualize.
3. Suction the airway as needed.
4. If the airway is still obstructed use American Heart or Red Cross obstructed airway procedures.

Poisoning and Overdose

Overview: Poisoning and Overdose can take several forms and patients may range from mildly ill to very critical. This SMO is intended to guide EMS Responders in providing care for these patients. Variances in condition occur due to amount of substance involved, time of incident, type of substance involved, and whether it is an overdose or actual poison. Caution must be used with all substances, including medications. When appropriate, utilize gloves and or masks to avoid exposing yourself.

1. [Routine Medical Care](#)
2. Attempt to identify the substances and method of ingestion.
3. Collect bottles, pills, syringes, M.S.D.S. papers or other items that may help identify the substance.
Use care to avoid direct contact with all substances, including medications (Universal Precautions).
4. For patient suspected of overdosing on narcotics or unknown substances
 - ___ Ensure ABC's, oxygenation, ventilation
 - ___ **Naloxone (Narcan) 2mg** intranasal for altered mental status with severe respiratory depression or arrest; signs and symptoms of shock; or hypoventilation

Respiratory Distress with Acute Bronchospasm (Wheezing)

Overview: Respiratory distress with acute bronchospasm can be seen in patients as a result of many causes including asthma, COPD, bronchitis, and allergic reaction. Treatment must be concentrated on airway patency and ventilation.

1. [Routine Medical Care](#)
2. Administer O₂ as indicated
3. If available, administer **Albuterol Neb** or assist with patients prescribed medication / inhalers

Seizure

Overview: A seizure is a temporary, abnormal electrical activity of the brain that results in a loss of consciousness, loss of organized muscle tone, and presence of convulsions. The patient will usually regain consciousness within 1 to 3 minutes followed by a period of confusion and fatigue (postictal state).

Multiple seizures in a brief time span or seizures lasting more than 5 minutes may constitute status epilepticus and require EMS intervention to stop the seizure. Causes of seizures include: epilepsy, stroke, head trauma, hypoglycemia, hypoxia, infection, a rapid change in core body temperature (e.g. febrile seizures), eclampsia, alcohol withdrawal, and overdose.

1. [Routine Medical Care](#)
2. Protect the patient from injury during the seizure. Take special care to protect the patient's head and airway (be prepared for vomiting and have suction available).
3. Administer O₂ and ventilate as indicated.

SIDS (Sudden Infant Death Syndrome)

1. SIDS cannot be predicted or prevented.
2. Start infant C.P.R.
3. Remain compassionate to all involved. Do not make any statements that they could construe as untruthful or appear to be assigning blame.

Original SMO Date: 07/04
Reviewed: 02/06; 06/17; 09/19; 06/20
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SMO: Pediatric Medical Emergencies

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**REGION I EMERGENCY MEDICAL SERVICES
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EMR**

SMO: Neonatal Resuscitation

Overview: Assessment, airway and infant body temperature cannot be over emphasized. The anatomical and physiological differences that are present in a newborn can cause severe problems if not recognized. All neonatal emergency patients should be transported to the hospital. Neonate is defined as less than 30 days old.

INFORMATION NEEDED

- Gestational age
- Infant is part of a multiple birth or NICU graduate
- Meconium stained during birth (See Meconium Staining section below)
- Mother use of drugs or alcohol
- Known infant history
- Presence of special need (e.g. apnea monitor, etc)
- If just born, time since birth

OBJECTIVE FINDINGS

- If just born 30 second cardiopulmonary assessment
 - Airway, breathing (respiratory rate, quality, work of breathing, presence of cry)
 - Circulation (skin color, temperature, pulses, capillary refill, mental status)
- If infant less than 30 days same arrest intervention as just born
- Airway interventions and keep baby warm

TREATMENT – MECONIUM STAINING NOTED

- As soon as head is delivered attempt to suction before baby starts to breath
- If thick meconium or secretion present and signs of respiratory distress thoroughly suction mouth, then nose

Original SMO Date: 07/04
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Last Revision: 06/17

SMO: Neonatal Resuscitation

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TREATMENT (NO MECONIUM STAINING NOTED)

- Assess patient, dry immediately if wet and stimulate
- Assess airway patency. Secure the airway.
- Suction mouth then nasopharynx.
- Cover head with stocking cap or equivalent
- Clamp and cut the cord if necessary
- Evaluate respirations. Assist with BVM ventilation with 40-60 breaths / min with 100% oxygen for severe respiratory depression; use mask with 100% oxygen for mild distress
- Check heart rate at base of umbilical cord or auscultate precordium as indicated. Further treatment depends on heart rate.
- If heart rate less than 60 bpm, continue assisted ventilations and begin chest compressions at 120 min
- If heart rate is 60-80 bpm then continue ventilations. If poor perfusion and no improvement after 30 seconds of ventilations with 100% oxygen, consider compressions at 120 min.
- If heart rate 80-100 bpm. Give 100% oxygen by BVM. Reassess heart rate after 15-30 seconds.
- If heart rate greater than 100 bpm, check skin color. If peripheral cyanosis give oxygen by mask.
- If unable to ventilate effectively with BVM consider supraglottic device.
- Confirm proper airway device placement and ventilate 30 times a minute with continued chest compressions.
- Continue to reassess respiratory rate and heart rate while enroute

Documentation of adherence to SMO

- 30-second cardiopulmonary assessment
- Administration of oxygen
- Document all cardiac interventions and response
- Medication administration
- Airway management

Medical Control Contact Criteria

- Contact Medical Control whenever a question exists as to the best treatment course for the patient
- Contact receiving hospital as soon as possible for a Neonatal Resuscitation patient

PRECAUTIONS AND COMMENTS

- Perform chest compressions on the neonate per American Heart Association guidelines

Original SMO Date: 07/04
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SMO: Neonatal Resuscitation

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 EMS/ Region1 SMO

REGION I EMERGENCY MEDICAL SERVICES STANDING MEDICAL ORDERS EMR

SMO: Pediatric Trauma Emergencies

Overview: The EMR shall utilize the following guidelines for trauma emergency care situations. Children have good compensatory mechanisms up to a point. When that point is reached they deteriorate very quickly. This SMO is intended to provide the EMS Provider with guidelines to treat a pediatric trauma patient as soon as possible.

Amputations

1. [Routine Trauma Care](#)
2. Control bleeding.
3. Place body part in plastic bag. Place plastic bag containing body part in a larger bag or container and place in container with ice/ water.
4. Use caution to not freeze body part.

Bleeding

1. [Routine Trauma Care](#)
2. For external bleeding use direct pressure, if direct pressure is not effective a tourniquet should be considered.
3. Direct pressure is the primary method of controlling most external bleeding and should be used as soon as possible.
4. Tourniquets:
 - Consider tourniquets when direct pressure does not control breathing
 - Tourniquets may not be practical on proximal extremity locations
 - Cut away clothing
 - Tighten per manufacturers' instructions until hemorrhage stops
 - Secure tourniquets per manufacturers' recommendations
 - Note time of tourniquets application and provide this information to receiving care provider. Do not remove any tourniquet without authorization from Medical Control.
 - If one tourniquet is not sufficient to control bleeding consider a second tourniquet proximal to the first
5. Wound Packing:
 - Consider wound packing for life threatening bleed from a penetrating injury to the buttock, pelvis (pelvic girdle), axilla (armpit), or neck. Also, consider for penetrating injuries to extremity with significant bleeding that cannot be controlled with direct pressure or tourniquets.
 - Wound packing is contraindicated for the chest, back, head, abdomen, and dialysis graft bleeding.
 - Wound packing procedure:
 - Attempt to control bleeding with direct pressure.
 - Cut away clothing at wound site.

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SMO: Pediatric Trauma Emergencies

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- Have wound packing supplies on hand – use a roll of plain gauze.
 - Carefully remove any obvious foreign object from the wound (splintered wood, etc.)
 - Apply direct pressure just proximal to the wound to reduce bleeding. With one finger of the other hand push the end of the gauze as deeply into the wound as possible. Continue to feed the gauze deep into the wound in small increments. Do not attempt to feed a large amount of gauze all at once.
 - Continue to pack gauze deeply and tightly in order to apply direct pressure over the source of the bleed. When the packing reaches the level of the skin apply any remaining gauze over the wound to help apply pressure.
 - Hold direct pressure over the wound for at least ten minutes. Do not release this pressure to “check” for bleeding.
 - If possible, wrap with gauze to maintain pressure.
 - Note: this is a very painful procedure, provide [Pain Management](#) per SMO.
6. Treat for shock.

Bones and Muscles

1. [Routine Trauma Care](#)
2. Control external bleeding with direct pressure. If direct pressure is unsuccessful, consider a tourniquet to control bleeding
3. Manual stabilization - support the joint above and below the injury.
4. Cover open wounds with sterile dressing.
5. Pad to prevent pressure and discomfort.
6. Use caution to not replace protruding bones.
7. Reassess pulses as needed
8. Assess treat for shock

Burns

1. [Routine Trauma Care](#)
2. The first priority is to stop the burning process by removing the patient from the source of the burn or eliminate the source
 - a. **Thermal burns**
 1. Monitor the airway. Examine the mouth and nose for signs of respiratory burns/ soot/singed nares.
 2. Remove clothing and jewelry from the affected site.
 3. Cover the burn with dry sterile dressing.
 4. Protect patient from hypothermia
 5. Treat for shock
 - b. **Chemical burns**
 1. [Body Substance Isolation](#)
 2. Remove clothing and jewelry
 3. For dry chemicals brush off all visible chemical prior to beginning the water flush.
 4. The site should be flushed with copious amounts of water for 20 minutes.
 - c. **Electrical burns**
 1. Scene safety
 2. Treat entrance and exit wounds as thermal burns.
 3. Spinal restriction is indicated with serious electrical burns.
 4. If the patient is pulseless refer to [Cardiac Arrest SMO](#).

Chest Injuries

1. [Routine Trauma Care](#)
2. If an open wound is present (sucking chest wound), cover the wound with a 3-sided, occlusive dressing. If the patient develops increased difficulty breathing or cyanosis, temporarily release the dressing.

Child Abuse and Neglect

1. [Routine Trauma Care](#)
2. If you suspect abuse or neglect do not confront the parents. EMS's role is one of patient treatment and transporting the child.
3. Manage the scene in order to preserve evidence.
4. Insure that an EMS team member has notified medical control or other appropriate agency. EMS responders are mandatory reporters.
 - a. Be objective during reporting procedures
 - b. For DCFS contact 1-800-25ABUSE (1-800-252-2873)

Drowning and Near Drowning

1. [Routine Trauma Care](#)
2. Keep the victim warm. If hypothermia is suspected, handle patient gently. Remove wet clothing and apply warm blanket.
NOTE: Because of possible serious delayed reactions, all near drowning patients should be evaluated in the Emergency Department even if they appear to be uninjured at the scene.
3. If pulseless start high quality CPR pre AHA guidelines
4. AED - treat per AHA guidelines
5. If other trauma is suspected refer to appropriate trauma SMO
6. BLS maneuvers to remove Foreign Body Airway Obstruction if indicated
7. Reassess basic methods to maintain airway patency and good ventilation

Eviscerations

1. [Routine Trauma Care](#)
2. Do not attempt to replace protruding organs.
3. Cover with thick, sterile, moist dressings.

Impaled Object

1. [Routine Trauma Care](#)
2. Do not remove object unless interferes with airway patency.
3. Manually stabilize object with use of bulky dressings.
4. Control bleeding.

Injuries to the Brain and Skull

1. [Routine Trauma Care](#)
2. Maintain ABC's.
3. [Spinal Restriction](#)
4. Monitor mental status
5. Control bleeding.

Shock/ Internal Bleeding

1. [Routine Pediatric Care](#) or [Routine Trauma Care](#)
2. Maintain the patient's body position as supine.
3. Keep patient warm.
4. Spinal Restriction as indicated
5. Control external bleeding
6. O₂ as indicated

REGION I EMERGENCY MEDICAL SERVICES

Appendices For Emergency Medical Responders

Appendix Item	
Adult/Pediatric Burn Reference Guide	Appendix
Glasgow Trauma Score/Revised Trauma Score	Appendix
Intranasal Medications/MAD Device	Appendix
Primary Patient Assessment	Appendix
Region 1 Abbreviations	Appendix
Secondary Patient Assessment	Appendix
Use of SMO's	Appendix

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**REGION I EMERGENCY MEDICAL SERVICES
STANDING MEDICAL ORDERS
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Appendix: Intranasal Medication - Mucosal Atomization Device (MAD)

Overview: In the absence of an established IV, intranasal is a rapid route offering high level of bio-availability of the medication being administered. The intranasal route can reduce the risk of needle sticks while delivering effective medication levels.

The rich vasculature of the nasal cavity provides a direct route into the bloodstream for medications that easily cross the mucous membranes. Due to this direct absorption into the bloodstream, rate and extent of absorption are relatively comparable to IV administration.

CONTRAINDICATIONS

- ___ Epistaxis (nosebleed)
- ___ Nasal Trauma
- ___ Nasal septal abnormalities
- ___ Nasal congestion / discharge

Medication that may be used Intranasal

___ **Naloxone**

PROCEDURE

- ___ Attach MAD tip to syringe
 - Intranasal doses are listed in the [Medication Administration Chart](#)
 - Do not exceed 0.5 – 1.0 ml per nostril
- ___ Remove air from syringe
- ___ Place MAD tip into nostril
- ___ Timing with respirations, depress the plunger rapidly when patient fully exhales and before inhalation
- ___ Evaluate the effectiveness of the medication, if desired effect has not been achieved, consider repeating and/or changing route of administration

Documentation of adherence to SMO

- ___ Dose and time of medication administered
- ___ Vitals before and after administration of medication

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Appendix: Intranasal Medication – Mucosal Atomization Device

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Medical Control Contact Criteria

__ Contact Medical Control whenever a question exists as to the best treatment course to the patient.

PRECAUTIONS AND COMMENTS

- Indication, contraindications, actions and side effects are the same when given intranasal as they would be if the medication were given IV /IM
- The *ideal* volume for intranasal administration is 0.2-0.3ml and the maximum recommended volume per nostril is 1ml. If dose is greater than 0.5ml, apply it in two separate doses allowing 5-10 minutes apart for each dose. The spacing allows the former dose to absorb.
- The MAD® atomizer has a dead space of 0.1ml, so particularly for doses less than 0.9ml be sure to take the dead space into account by adding 0.1ml to the final volume (i.e. volume of dose + 0.1ml)

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Appendix: Intranasal Medication – Mucosal Atomization Device

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**REGION I EMERGENCY MEDICAL SERVICES
STANDING MEDICAL ORDERS
EMR**

SMO: Region 1 Acceptable Abbreviations

A & O x 4	Alert, oriented person to date, time, place
Abd	Abdomen
ALS	Advanced life support
AM or a.m.	Between 12 midnight and 12 noon
AMA	Against Medical Advice
AMI or MI	Acute Myocardial Infarction
AMP	Ampule
Approx	Approximate or Approximately
ASHD	Arteriosclerotic Heart Disease
Assist or asst	Assistance
BBB	Bundle Branch Block
Bilat	Bilateral
BLS	Basic life support
BM	Bowel Movement
BOW	Bag of Waters
BP	Blood Pressure
CA	Cancer
CAD	Coronary Artery Disease
C-collar	Cervical Collar
CHF	Congestive heart failure
cm	Centimeter
CMS	Circulation, Motion, Sensation
CNS	Central nervous system
C/O	Complains of
COPD	Chronic Obstructive Pulmonary Disease
C-section or C-sect	Cesarean Section
CSF	Cerebral spinal fluid
C-spine	Cervical spine
CVA	Cerebrovascular accident
DC or dc	Discontinue
Dept	Department
Dx	Diagnosis
DTs	Delirium Tremens
D5W	5% Dextrose in water
ECG	Electrocardiogram
EDAP	Emergency Department Approved for Pediatrics
EDC	Expected date of confinement
ENT	Ears, Nose and Throat
ED	Emergency Department
ET	Endotracheal
ETOH	Alcohol
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Exam	Examination
Extr or EXT	Extremities
FB	Foreign Body
FHT	Fetal Heart Tones
Fib	Fibrillation
Fx	Fracture
GCS	Glasgow Coma Score
GI	Gastrointestinal
Gram	Gram
gr	Grain
gtt(s)	Drop(s)
GU	Genitourinary
H2O	Water
HEENT	Head, Eyes, Ears, Nose and Throat
HIV	Human Immunodeficiency Virus
H/O	History of
HPI	History of present illness
hr	Hour
HR	Heart rate
HTN	Hypertension
Hx	History
ILS	Intermediate Life Support
IM	Intramuscular
IN	Intranasal
IV	Intravenous
JVD	Jugular vein distention
K	Potassium
kg	Kilogram
Lt	Left
L or l	Liter
lb	Pound
LLQ	Left lower quadrant
LMP	Last menstrual period
LOC	Loss of consciousness
LR	Lactated ringers
LUQ	Left upper quadrant
mcg	micrograms
Med(s)	Medication(s)
mEq	Milliequivalent
mg	Milligrams
mL or ml	Milliliter
mod	Moderate
N & V or N/V	Nausea and vomiting
N/A or NA	Not applicable
NaHCO3	Sodium Bicarbonate
Neg	Negative
Neuro	Neurology / Nervous system
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NKA	No known allergies
NPO	Nothing by mouth
NRB mask	Non-rebreather mask
NS	Normal saline
NSR	Normal sinus rhythm
NTG	Nitroglycerin
O2	Oxygen
OB	Obstetric
OD	Overdose
P	Pulse
PAC	Premature atrial contraction
PASG	Pneumatic anti-shock garment
PAT	Paroxysmal atrial tachycardia
PE	Physical examination
PE	Pulmonary Embolism
PEDS	Pediatric
PERRL	Pupils equal, round and reactive to light
PMH	Past medical history
PJC	Premature junctional contraction
PM or p.m.	Between 12 noon and 12 midnight
PMS	Pulses Motor Sensation
PRN	As occasion requires / as needed
Pt	Patient
PVC	Premature ventricular contraction
q	Every
R or resp	Respiration
Rt	Right
Reg	Regular
RLQ	Right lower quadrant
RUQ	Right upper quadrant
Rx	Treatment, Take prescription
SL	Sublingual
SMO	Standing Medical Orders
SOB	Shortness of breath
Sub-Q or subq	Subcutaneous
Stat	Immediate
STD	Sexually transmitted disease
SVT	Supraventricular tachycardia
Temp	Temperature
TB	Tuberculosis
TKO	To keep open
URI	Upper respiratory infection
V-fib	Ventricular fibrillation
V-tach	Ventricular tachycardia
w/	With
w/o	Without
W/O	Wide open
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WNL	Within normal limits
wt	Weight
@	At
>	Greater than
<	Less than
ACLS	Advanced Cardiac Life Support
A/BDLS	Advanced/ Basic Disaster Life Support
AEIOUTIPS	Acidosis, alcohol; epilepsy; infection; overdose; uremia; tumor, trauma, toxin; insulin; psychosis, poison; stroke, seizure
AVPU	Alert, Verbal, Pain, Unresponsive
BTLS	Basic Trauma Life Support
DCAP-BTLS-IC	Deformities, Contusions, Abrasions, Penetrations or Punctures, Burns, Tenderness, Lacerations, Swelling, Instability, Crepitus
GEMS	Geriatrics Emergency Medical Services
Id-me	Immediate, Delayed, Minimal, Expectant
MASS	Move, Assess, Sort, Send
OPQRST	Onset, Provokes, Quality, Radiation, Severity, Time
PALS	Pediatric Advanced Life Support
PEPP	Pediatric Education Pre-hospital Provider
PHTLS	Pre-Hospital Trauma Life Support
SAMPLE	Signs & Symptoms, Allergies, Medications, Past medical history, Last oral intake, Events leading to incident
START	Simple Triage and Rapid Transport

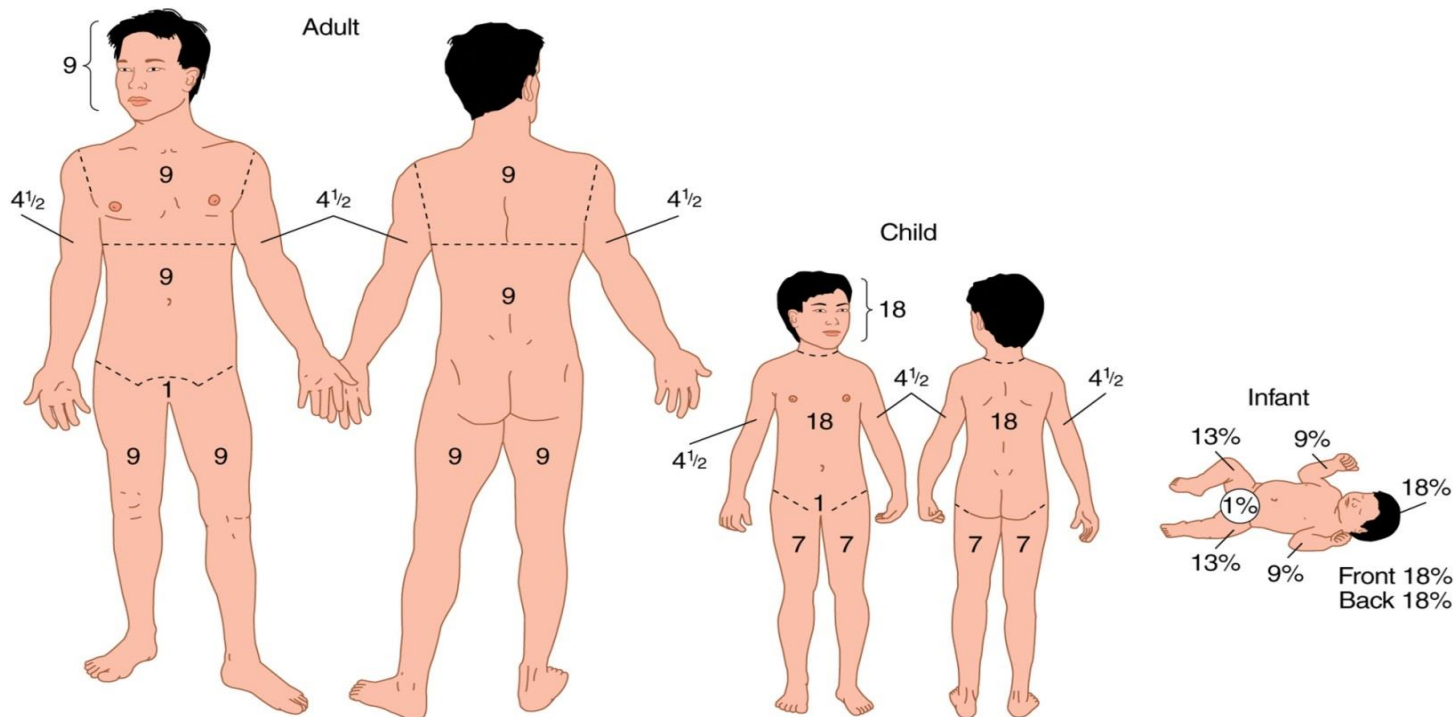
NOTE: Based on The Joint Commission National Patient Safety Goals, these acceptable abbreviations are to minimize confusion when using abbreviations. Commonly used abbreviations such as *MS, OU, OD, OS, cc* are not allowed to be utilized under Region 1 EMS Acceptable Medical Abbreviations.

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**REGION I EMERGENCY MEDICAL SERVICES
STANDING MEDICAL ORDERS
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APPENDIX: Adult/ Pediatric Burn Reference Guide

RULE OF NINES:



RULE OF PALMS: To measure the extent of irregular burns, the percentage of burned surface can be estimated by considering the palm of the patient's hand as equal to 1% of the total body surface and then estimating the TBSA burned in reference to the palm.

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**REGION I EMERGENCY MEDICAL SERVICES
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APPENDIX: Glasgow Coma Score/ Revised Trauma Score

ADULT GLASGOW COMA SCORE

AREAS OF RESPONSE		
EYE OPENING	Eyes open <i>Spontaneously</i>	4
	Eyes open in response to <i>Voice</i>	3
	Eyes open in response to <i>Pain</i>	2
	No eye opening response	1
VERBAL RESPONSE	<i>Oriented</i> (e.g., to person, place, time)	5
	<i>Confused</i> , speaks but is disoriented	4
	<i>Inappropriate</i> but comprehensible words	3
	<i>Incomprehensible</i> sounds but no words are spoken	2
	None	1
MOTOR RESPONSE	<i>Obeys Commands</i> to move	6
	<i>Localized Painful</i> stimuli	5
	<i>Withdraws</i> from painful stimulus	4
	<i>Flexion</i> , abnormal <i>decorticate</i> posturing	3
	<i>Extension</i> , abnormal <i>decerebrate</i> posturing	2
	No movement or posturing	1
TOTAL POSSIBLE SCORE		3 - 15
Severe Head Injury		≤ 8
Moderate Head Injury		9 - 12
Minor Head Injury		13 - 15

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ADULT TRAUMA SCORE

The Trauma Score is a numerical grading system for estimating the severity of injury. The score is composed of the Glasgow Coma Scale (reduced to approximately one-third value) and measurements of cardiopulmonary function. Each parameter is given a number (high for normal and low for impaired function). Severity of injury is estimated by summing the numbers. The lowest score is 0, and the highest score is 12.

RESPIRATORY RATE (spontaneous patient-initiated inspirations/ minute)	10 - 29 / minute	4
	greater than 29	3
	6 - 9 minutes	2
	1 - 5 / minute	1
	None	0
SYSTOLIC BLOOD PRESSURE	Greater than 89	4
	76 - 89 mm Hg	3
	50 - 75 mm Hg	2
	1 - 49 mm Hg	1
	No pulse	0
GLASGOW COMA SCALE (see above)	13 – 15	4
	9 – 12	3
	6 – 8	2
	4 – 5	1
	3	0
TOTAL POSSIBLE SCORE		0 – 12

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PEDIATRIC GLASGOW COMA SCORE

AREAS OF RESPONSE	>1 year	< 1 year		GCS
EYE OPENING	Spontaneously	Spontaneously		4
	To <i>Verbal Command</i>	To <i>Shout</i>		3
	To <i>Pain</i>	To <i>Pain</i>		2
	No eye opening response	No eye opening response		1
MOTOR RESPONSE	<i>Obeys Commands</i> to move	<i>Obeys Commands</i> to move		6
	<i>Localized Painful</i> stimuli	<i>Localized Painful</i> stimuli		5
	<i>Withdraws</i> from painful stimulus	<i>Flexion—normal</i>		4
	<i>Flexion</i> , abnormal <i>decorticate</i> posturing	<i>Flexion</i> , abnormal <i>decorticate</i> posturing		3
	<i>Extension</i> , abnormal <i>decerebrate</i> posturing	<i>Extension</i> , abnormal <i>decerebrate</i> posturing		2
	No movement or posturing	No movement or posturing		1
VERBAL RESPONSE	> 5 years	< 2 – 5 years	0 - 23 months	
	<i>Oriented</i> and converses	Appropriate words & phrases for age	Smiles, coos, cries appropriately	5
	<i>Disoriented</i> but converses	Inappropriate words	Cries	4
	<i>Inappropriate</i> words	Cries and/or screams	Inappropriate crying and/or screaming	3
	<i>Incomprehensible</i>	Grunts	Grunts	2
No response	No response	No response	1	
TOTAL POSSIBLE SCORE				3 - 15

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Pediatric Trauma Score

COMPONENT	VALUES		
	+2	+1	-1
Size	≥ 20 kg	10 – 20 kg	≤ 10 kg
Airway	Normal	Maintainable	Unable to maintain
CNS	Awake	Obtunded	Coma
Systolic BP	≥ 90 mm Hg	50 – 90 mm Hg	≤ 50 mm Hg
Open wound	None	Minor	Major
Skeletal Injuries	None	Closed fracture	Open or multiple fractures

Revised Trauma Score

Glasgow Coma Scale (GCS)	Systolic Blood Pressure (SBP)	Respiratory Rate (RR)	Coded Value
13-15	>89	10-29	4
9-12	76-89	>29	3
6-8	50-75	6-9	2
4-5	1-49	1-5	1
3	0	0	0

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AVPU

The mnemonic AVPU refers to the basic scale of consciousness and identifies the following levels of consciousness:

A – The patient is awake and alert. This does not necessarily mean that they are orientated to time and place or neurologically responding normally.

V – The patient is not fully awake, and will only respond to verbal commands or become roused after verbal stimuli.

P – The patient is difficult to rouse and will only respond to painful stimuli, such as nail bed pressure or trapezius pain.

U – The patient is completely unconscious and unable to be roused.

Sample History

S -Signs and symptoms

A- Allergies

M- Medications

P- Past medical history or pertinent history

L -Last oral intake

E- Events leading to incident

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REGION I EMERGENCY MEDICAL SERVICES STANDING MEDICAL ORDERS EMR

APPENDIX: Primary Patient Assessment

Overview: A Primary assessment needs to be completed on all patients to identify and immediately correct any life-threatening problems.

SCENE SIZE-UP/GLOBAL ASSESSMENT

- Recognize hazards, ensure safety of scene, and secure a safe area for treatment
- Apply appropriate universal body/substance isolation precautions
- Recognize hazards to patient and protect from further injury
- Identify number of patients and resources needed
- Call for EMS and /or law enforcement back-up if appropriate
- Initiate Incident Command Structure System (ICS), if appropriate
- Initiate Triage System, if appropriate
- Observe position of patient
- Determine mechanism of injury
- Plan strategy to protect evidence at potential crime scene

GENERAL IMPRESSION

- Check for life-threatening conditions
- AVPU (A=alert, V=responds to verbal stimuli, P=responds to painful stimuli, U=unresponsive)
- Determine chief complaint or mechanism of injury

AIRWAY (A)

- Ensure open airway
- Protect spine from unnecessary movement in patients at risk for spinal injury
- Ensuring airway patency supersedes spinal immobilization
- Look and listen for evidence of upper airway problems and potential obstructions
 - Vomitus
 - Bleeding
 - Loose or missing teeth
 - Dentures
 - Facial trauma
- Utilize any approved adjuncts as indicated to maintain airway

Original SMO Date: 07/04
Reviewed: 06/17; 09/19; 06/20
Last Revision: 06/17

Appendix: Primary Patient Assessment

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BREATHING (B)

- Look, listen, and feel assessing ventilation and oxygenation
- Expose chest and observe chest wall movement if necessary
- Determine approximate rate, depth, and work of breathing
- Reassess mental status
- Obtain pulse oximetry reading if available
- Intervention for inadequate ventilation and/or oxygenation:
 - Pocket mask BVM
 - Supplementary oxygen
 - Appropriate airway adjunct (oropharyngeal/ nasal)
 - Advance airway management if indicated after bag-valve- mask ventilation

CIRCULATION (C)

- Check for pulse and begin CPR if necessary
Note: defibrillation should not be delayed for CPR; if defibrillator is present and operator is qualified, use it to check patient for a shockable rhythm
- Palpate radial pulse if appropriate: absence or presence; quality (strong/weak); rate (slow, normal, or fast); regularity
- Control life-threatening hemorrhage with direct pressure
- Assess skin for signs of hypoperfusion or hypoxia
- Reassess mental status for signs of hypoperfusion
- Treat hypoperfusion if appropriate

LEVEL OF CONSCIOUSNESS & DISABILITIES (D)

- Determine need for C-Spine stabilization
- Determine [GLASCOW COMA SCALE \(GCS\) SCORE](#) in Appendix

EXPOSE, EXAMINE & EVALUATE (E)

- In situations with suspected life-threatening trauma mechanism, a rapid head-to-toe assessment should be performed
- Expose head, trunk, and extremities
- Head to toe for DCAP-BTLS (see Note section of [Secondary Assessment SMO](#))
- Treat any newly discovered life-threatening wounds as appropriate
- Assist patient with medications if appropriate

Documentation of adherence to SMO

- Findings of primary assessment, for example: alert, oriented, and verbalizing; unresponsive to painful stimuli, airway maintained with oropharyngeal airway, qualities of pulses, GCS, mechanism of injury, pulse oximetry, etc
- Any deviation from assessment and explanation of why
- Interventions for critical situations

REGION I EMERGENCY MEDICAL SERVICES STANDING MEDICAL ORDERS EMR

APPENDIX: Secondary Patient Assessment

Overview: The Secondary assessment is the systematic assessment and complaint focused relevant physical examination of the patient. The secondary assessment may be done concurrently with the patient history and should be performed after:

- The Primary Assessment and initial treatment and stabilization of life-threatening airway, breathing and circulation difficulties
- Spinal restriction as needed
- A Rapid Trauma Assessment in the case of significant trauma
- Investigation of the chief complaint and associated complaints, signs or symptoms
- An initial set of vital signs—pulse, respirations, blood pressure
- Lung sounds
- Consider orthostatic vital signs when needed to assess volume status
- Pulse oximetry (if indicated)

Give initial treatment including oxygen, ventilation if indicated, hemorrhage control if needed, basic wound/fracture care

The above set of assessments/treatments is referred to in these SMOs as “Routine Medical Care” or “Routine Trauma Care”. This care should be provided to all patients regardless of presenting complaint. The purpose of the focused assessment is to identify problems, which, though not immediately life- or limb-threatening, could increase patient morbidity and mortality. Exposure of the patient for examination may be reduced or modified as indicated due to environmental factors.

HISTORY

- ___ Optimally should be obtained directly from the patient; if language, culture, age-related, disability barriers or patient condition interferes, consult family members, significant others, scene bystanders or first responders.
- ___ Check for advance directives, patient alert bracelets and prescription bottles as appropriate.
- ___ Be aware of patient’s environment and issues such as domestic violence, child or elder abuse or neglect
- ___ Allergies, Medications
- ___ Past medical history relevant to chief complaint. Examples are previous myocardial infarcts, hypertension, diabetes, substance abuse, seizure disorder and hospital of choice.
- ___ Have patient prioritize his/her chief complaint if complaining of multiple problems
- ___ Ascertain recent medical history -admissions to hospitals, reasons given, etc.
- ___ Pain questions if appropriate: OPQRST (O=onset, P=provoked, Q=quality, R=radiation, S=severity, T=time) plus location and factors that increase or decrease the pain severity
- ___ Mechanism of injury if appropriate
- ___ See “Information Needed” section of each SMO for history relevant to specific patient complaints.

Original SMO Date: 07/04
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Appendix: Secondary Patient Assessment

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HEAD AND FACE

- ___ Observe and palpate skull (anterior and posterior) and face for DCAP-BTLS
- ___ Check eyes for: equality and, responsiveness of pupils, movement and size of pupils, foreign bodies, discoloration, contact lenses, prosthetic eyes
- ___ Check nose and ears for: foreign bodies, fluid, and blood
- ___ Recheck mouth for potential airway obstructions (swelling, dentures, bleeding, loose or avulsed teeth, vomitus, malocclusion, absent gag reflex) and odors, altered voice or speech patterns, and evidence of dehydration

NECK

- ___ Observe and palpate for DCAP-BTLS, jugular vein distention, use of neck muscles for respiration, tracheal tugging, shift or deviation, stoma, and medical information medallions

CHEST

- ___ Observe and palpate for DCAP-BTLS, scars, implanted devices (AICD or pacemakers), medication patches, chest wall movement, asymmetry and accessory muscle use
- ___ Have patient take a deep breath if possible and observe and palpate for signs of discomfort, asymmetry and air leak from any wound

ABDOMEN

- ___ Observe and palpate for DCAP-BTLS, scars, diaphragmatic breathing and distention
- ___ Palpation should occur in all four quadrants taking special note of tenderness, masses and rigidity

PELVIS/GENITO-URINARY

- ___ Observe and palpate for DCAP-BTLS, asymmetry, sacral edema, and as indicated for incontinence, priapism, blood at urinary meatus, or presence of any other abnormalities
- ___ Palpate and gently compress lateral pelvic rims and symphysis pubis for tenderness, crepitus or instability
- ___ Palpate bilateral femoral pulses

SHOULDERS AND UPPER EXTREMITIES

- ___ Observe and palpate for DCAP-BTLS, asymmetry, skin color, capillary refill, edema, medical information bracelets, and equality of distal pulses
- ___ Assess sensory and motor function as indicated

LOWER EXTREMITIES

- ___ Observe and palpate for DCAP-BTLS, asymmetry, skin color, capillary refill, edema, and equality of distal pulses
- ___ Assess sensory and motor function as indicated

BACK

- ___ Observe and palpate for DCAP-BTLS, asymmetry, and sacral edema

Original SMO Date: 07/04
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 Last Revision: 06/17

Appendix: Secondary Patient Assessment

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Documentation of adherence to SMO

- Changes and trends observed in the field
- Pertinent negative findings, e.g. denies SOB with chest pain; no other findings of significant injury
- Findings from history/source of information is not from the patient
- Findings of assessment on your initial exam

Medical Control Contact Criteria

- Contact Medical Control whenever a question exists as to the best treatment course for the patient

PRECAUTIONS AND COMMENTS

- Observation and palpation can be done while gathering patient's history.
- A systematic approach will enable the rescuer to be rapid and thorough and not miss subtle findings that may become life-threatening.
- Minimize scene time on trauma patients.
- The Focused Assessment should ONLY be interrupted if the patient experiences airway, breathing or circulatory deterioration requiring immediate intervention. Complete the examination before treating the other identified problems.
- Reassess vital signs, particularly in critical or rapidly-changing patients. Changes and trends observed in the field are essential data to be documented and communicated to the receiving facility staff.
- **DCAP-BTLS**: A mnemonic that stands for:
 - D**eformity
 - C**ontusion/Creptitus
 - A**brasion
 - P**uncture
 - B**ruising/**B**leeding
 - T**enderness
 - L**aceration
 - S**welling

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Appendix: Secondary Patient Assessment

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 EMS/ Region1 SMO

**REGION I EMERGENCY MEDICAL SERVICES
STANDING MEDICAL ORDERS
EMR**

APPENDIX: Use of Standing Medical Orders (SMOs)

I. PURPOSE

- A. To develop a standard approach of pre-hospital patient care in EMS Region 1. The following patient care SMOs are established and approved by the EMS Region 1 Medical Directors for use by EMS Providers, Physicians and ECRN’s operating within Region 1.
- B. Region 1 assumes certain common steps in a practical approach and response to emergency situations. These Standing Medical Orders outline current methods that have been well rewarded in terms of survival statistics.
- C. The SMO dosages and treatments are written in compliance with the EMS Education Standards set forth by the US Department of Transportation (DOT), the American Heart Association and Illinois Emergency Medical Services Act. Dosing for all medications is listed in the Medication Administration Chart.
- D. The Standing Medical Orders will be utilized:
 - i. As a written standard of care to be followed by all members of EMS Region 1 in the pre-hospital care of the acutely ill or injured patient.
 - ii. In disaster situations where immediate action to preserve and save lives supersedes the need to communicate with hospital-based personnel, or where such communication is not required by the Disaster Procedure.

II. MEDICAL CONTROL

- A. Throughout these SMOs are boxes set aside with Medical Control Contact Criteria. These boxes are placed to draw particular attention to treatments/ questions in which Medical Control needs to be contacted; however, always contact Medical Control if any question arises regarding the best treatment options for the patient.

Medical Control Contact Criteria

III. GENERAL GUIDELINES

- Pre-hospital personnel will initiate Basic measures, as dictated by the patient assessment and scope of practice.
- Medication dosing is generally not present in the SMO's. Please refer to the medication chart for all dosing information. Medications will be in **bold blue** print in all SMO's for BLS, ILS, and ALS. Medications will be in **bold red** print for EMR.
- Pre-hospital personnel will utilize good clinical judgment and consider additional resources as needed.
- [Routine Medical Care](#), [Routine Trauma Care](#), and/or [Routine Trauma Care](#) should be provided to every patient as guided by assessment of the scene and the patient's condition.
- The Resource Hospital or Associate Hospital Physician or ECRN provides on-line Medical Control.
- Optional Scope practices will be identified in each EMS Systems specific SMOs.

IV. DEFINITIONS

Advanced Life Support (ALS) Services – an advanced level of pre-hospital and inter-hospital emergency care and non-emergency medical care that includes basic life support care, cardiac monitoring, cardiac defibrillation, electrocardiography, intravenous therapy, administration of medications, drugs and solutions, use of adjunctive medical devices, trauma care, and other authorized techniques and procedures as outlined in the Advanced Life Support National Curriculum of the United States Department of Transportation and any modifications to that curriculum specified in this Part. (Section 3.10 of the Act)

Alternate EMS Medical Director or Alternate EMSMD – the physician who is designated by the Resource Hospital to direct the ALS/ILS/BLS operations in the absence of the EMS Medical Director.

Ambulance – any publicly or privately owned vehicle that is specifically designed, constructed or modified and equipped for, and is intended to be used for, and is maintained or operated for, the emergency transportation of persons who are sick, injured, wounded or otherwise incapacitated or helpless, or the non-emergency medical transportation of persons who require the presence of medical personnel to monitor the individual's condition or medical apparatus being used on such an individual. (Section 3.85 of the Act)

Ambulance Service Provider or Ambulance Provider – any individual, group of individuals, corporation, partnership, association, trust, joint venture, unit of local government or other public or private ownership entity that owns and operates a business or service using one or more ambulances or EMS vehicles for the transportation of emergency patients.

Associate Hospital – a hospital participating in an approved EMS System in accordance with the EMS System Program Plan, fulfilling the same clinical and communications requirements as the Resource Hospital. This hospital has neither the primary responsibility for conducting training programs nor the responsibility for the overall operation of the EMS System program. The Associate Hospital must have a basic or comprehensive Emergency Department with 24-hour physician coverage. It must have a functioning Intensive Care Unit and/or a Cardiac Care Unit.

Basic Life Support (BLS) Services – a basic level of pre-hospital and inter-hospital emergency care and non-emergency medical care that includes airway management, cardiopulmonary resuscitation (CPR), control of shock and bleeding and splinting of fractures, as outlined in a Basic Life Support National Curriculum of the United States Department of Transportation and any modifications to that curriculum specified in this Part. (Section 3.10 of the Act)

Dysrhythmia – a variation from the normal electrical rate and sequences of cardiac activity, also including abnormalities of impulse formation and conduction.

Emergency – a medical condition of recent onset and severity that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that urgent or unscheduled medical care is required. (Section 3.5 of the Act)

Emergency Medical Services (EMS) System or System – an organization of hospitals, vehicle service providers and personnel approved by the Department in a specific geographic area, which coordinates and provides pre-hospital and inter-hospital emergency care and non-emergency medical transports at a BLS, ILS and/or ALS level pursuant to a System Program Plan submitted to and approved by the Department and pursuant to the EMS Regional Plan adopted for the EMS Region in which the System is located. (Section 3.20 of the Act)

Emergency Medical Technician – a person, who has successfully completed a course of instruction in basic life support as prescribed by the Department, is currently licensed by the Department in accordance with standards prescribed by the Act and this Part and practices within an EMS System. (Section 3.50 of the Act)

Emergency Medical Technician-Intermediate or EMT-I – a person, who has successfully completed a course of instruction in intermediate life support as prescribed by the Department, is currently licensed by the Department in accordance with standards prescribed by the Act and this Part and practices within an EMS System. (Section 3.50 of the Act)

EMS Medical Director or EMSMD – the physician, appointed by the Resource Hospital, who has the responsibility and authority for total management of the EMS System.

Emergency Medical Responder – a person who has successfully completed a course of instruction in emergency first response as prescribed by the Department, who provides first response services prior to the arrival of an ambulance or specialized emergency medical services vehicle, in accordance with the level of care established in the emergency first response course. (Section 3.60 of the Act)

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Intermediate Life Support (ILS) Services – an intermediate level of pre-hospital and inter-hospital emergency care and non-emergency medical care that includes basic life support care, plus intravenous cannulation and fluid therapy, invasive airway management, trauma care, and other authorized techniques and procedures as outlined in the Intermediate Life Support National Curriculum of the United States Department of Transportation and any modifications to that curriculum specified in this Part. (Section 3.10 of the Act)

Paramedic – a person who has successfully completed a course of instruction in advanced life support care as prescribed by the Department, is licensed by the Department in accordance with standards prescribed by the Act and this Part and practices within an Advanced Life Support EMS System. (Section 3.50 of the Act)

Pediatric Trauma Patient – trauma patient from birth to 17 years of age.

Pre-Hospital Care – those emergency medical services rendered to emergency patients for analytic, resuscitative, stabilizing, or preventive purposes, precedent to and during transportation of such patients to hospitals. (Section 3.10 of the Act)

Pre-Hospital Care Provider – a System Participant or any EMT-B, I, P, Ambulance, Ambulance Provider, EMS Vehicle, Associate Hospital, Participating Hospital, EMS System Coordinator, Associate Hospital EMS Coordinator, Associate Hospital EMS Medical Director, ECRN or Physician serving on an ambulance or giving voice orders over an EMS System and subject to suspension by the EMS Medical Director of that System in accordance with the policies of the EMS System Program Plan approved by the Department.

Sustained Hypotension – two systolic blood pressures of 90 mmHg five minutes apart or, in the case of a pediatric patient, two systolic blood pressures of 80 mmHg five minutes apart.

Trauma – any significant injury which involves single or multiple organ systems. (Section 3.5 of the Act)

Vehicle Service Provider – an entity licensed by the Department to provide emergency or non-emergency medical services in compliance with the Act and this Part and an operational plan approved by its EMS System(s), utilizing at least ambulances or specialized emergency medical service vehicles (SEMSV). (Section 3.85 of the Act)

(Source: Amended at 27 Ill. Reg. 13507, effective July 25, 2003)

V. AUTHORITY

- A. Illinois Department of Public Health Rules and Regulations, Subchapter f, Emergency Services and Highway Safety [\[Title 77 Index\]](#) 77 Ill. Adm. Code Part 515 Emergency Medical Services and Trauma Center Code

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REGION I EMERGENCY MEDICAL SERVICES

PREHOSPITAL FORMULARY For Emergency Medical Responders

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Reference: Jones and Bartlett Learning LLC, 2013 pp 1574-1628

IDPH Approval

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Reviewed: June, 2020

Pharmacology EMR Only

Adult Patients

GENERIC NAME	INDICATIONS	CONTRAINDICATIONS	Route	Dose
<u>Albuterol Sulfate</u>	Shortness of Breath with bronchoconstriction / wheezing, Allergic Reaction, Hyperkalemia	Caution in tachycardia patients with severe cardiac disease	Nebulizer with 8 lpm O ₂ , inline CPAP	2.5 mg (in 3 ml) may repeat if needed off-line
<u>Aspirin chewable tablets</u>	Chest Pain suggestive of ACS	Recent GI bleed, Allergy, Bleeding Disorders	PO Chewed	324 mg (4 - 81 mg) off-line
<u>Epi Auto-Injector (Adrenalin)</u>	Anaphylaxis/allergic reaction bronchoconstriction / wheezing refractory to neb	Caution in patients with severe cardiac disease	IM	0.3 mg off-line Anaphylaxis on-line allergic reaction
<u>Naloxone (Narcan)</u>	Opioid overdose with respiratory depression	Caution with narcotic-dependent patients who may experience withdrawal syndrome	MAD	2 mg (in 2 ml) MAD is preferred route 1/2 in each nare may repeat X 1 dose off-line
<u>Oral Glucose</u>	Hypoglycemia	Patient who is not able to follow commands	PO	15 grams off-line

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Pharmacology EMR Only

Pediatric Patients

GENERIC NAME	INDICATIONS	CONTRAINDICATIONS	Route	Dose
<u>Albuterol Sulfate</u>	Shortness of Breath with bronchoconstriction / wheezing, Allergic Reaction, Hyperkalemia	Caution in tachycardia patients with severe cardiac disease	Nebulizer with 8 lpm O2, inline CPAP	2.5 mg (in 3 ml) may repeat if needed off-line Full dose make not be appropriate / needed in smaller patients, monitor patient and discontinue if extreme tachycardia or patient improved and additional medication not required
<u>Aspirin chewable tablets</u>	NA not used in pediatric patients			NA not used in pediatric patients
<u>Epi Auto-Injector (Adrenalin)</u>	Anaphylaxis/ allergic reaction bronchoconstriction / wheezing refractory to neb	Caution in patients with severe cardiac disease	IM	Epi Jr. 0.15 for patient 15 to 30 Kg (33-66 pounds) Epi 0.3 for patient greater than 30 kg (66 pounds) under 15 kg (33 pounds) call Medical Control off-line Anaphylaxis on-line allergic reaction
<u>Naloxone (Narcan)</u>	Opioid overdose with respiratory depression	Caution with narcotic-dependent patients who may experience withdrawal syndrome	MAD	1 mg for patients 10-20 kg (22-44 pounds) 2 mg for patients over 20 kg (44 pounds) 1/2 in each nare May repeat X 1 dose off-line
<u>Oral Glucose</u>	Hypoglycemia	Patient who is not able to follow commands	PO	15 grams off-line

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FORMULARY – Albuterol Sulfate

Albuterol Sulfate	(Proventil, Ventolin)
Classification:	Bronchodilator
Actions:	Relaxes bronchial smooth muscle by stimulating beta ₂ receptors resulting in bronchodilation.
Indications:	<ul style="list-style-type: none"> • Acute asthma/emphysema • Allergic reactions • COPD/bronchitis • Bronchospasm • Known or suspected patients with hyperkalemia
Contraindications include but not limited to:	<ul style="list-style-type: none"> ○ Symptomatic tachycardia (>150 BPM) ○ Chest pressure ○ Prior hypersensitivity reaction to Albuterol
Adverse effects include but not limited to :	<ul style="list-style-type: none"> ➢ Tachycardia ➢ Hypertension ➢ Palpitations ➢ Dizziness ➢ Dysrhythmias ➢ Restlessness ➢ Nausea
Adult Administration:	Via nebulizer – 2.5 mg - repeat PRN until relief of symptoms
Packaging Information: (2.5 mg/3 ml) Ampule/Nebulizer	
Pediatric Administration:	Via nebulizer – up to 2.5 mg Call Medical Control for repeat dosing
Onset:	Within 5 minutes
Duration:	3-4 hours
Pregnancy Safety:	Category C
Precautions and Comments:	Monitor blood pressure and heart rate closely.
Pharmacology Chart	Use with caution in patients with: <ul style="list-style-type: none"> • Heart disease • Hypertension • Tachy-dysrhythmias • Patients being treated with MAO inhibitors and tricyclics may experience tachycardia and hypertension • Patients who are hypersensitive to sympathomimetics
Used in SMO: Adult Respiratory Distress Pediatric Respiratory Distress	

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FORMULARY – Aspirin

Aspirin	(ASA)
Classification:	Antiplatelet, Analgesic, Antipyretic, Anti-inflammatory
Actions:	Inhibition of platelet aggregation and platelet synthesis. Reduction of risk of death in patients with a history of myocardial infarction or unstable angina.
Indications:	Chest pain with suspected myocardial ischemia
Contraindications include but not limited to:	<ul style="list-style-type: none"> ○ Allergy to ASA/NSAID ○ Peptic ulcer disease ○ Hypersensitivity to salicylates
Adverse effects include but not limited to:	<ul style="list-style-type: none"> ➤ Nausea, GI upset ➤ Hepatotoxicity ➤ Occult blood loss ➤ Anaphylaxis
Adult Administration:	324 mg / 4 tablets
Packaging Information: (81 mg) Chewable Tablet	
Pediatric Administration:	Not recommended
Onset:	30-60 minutes
Duration:	4-6 hours
Pregnancy Safety:	Category D in the third trimester: use ONLY if benefit to mother justifies the risk to the fetus.
Precautions and Comments:	Patients who have already taken Aspirin today (such as 81 mg daily dose) can still be administered Aspirin.
Pharmacology Chart	
Used in SMO: Chest Pain of Suspected Cardiac Origin	Consider Aspirin early in the appropriate intervention as it has been shown to improve mortality.

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FORMULARY – Epinephrine Auto-Injector (Adrenalin)

Epinephrine Auto-injector	Adrenalin, Epinephrine Hydrochloride
Classification:	Sympathomimetic agent (Catecholamine)
Actions:	Acts directly on Alpha and Beta receptors of the SNS. Beta effect is more profound than Alpha effects. Effects include: <ul style="list-style-type: none"> • Increased heart rate (chronotropy) • Increased cardiac contractile force (inotropy) • Increased electrical activity within myocardium (dromotropy) • Increased systemic vascular resistance • Increased blood pressure • Increased bronchial smooth muscle dilation
Indications:	<ul style="list-style-type: none"> • Allergic Reaction <ul style="list-style-type: none"> ○ Shortness of breath (wheezing, hoarseness, other abnormal breath sounds) ○ Itching/hives that are severe and rapidly progressing ○ Oral swelling/laryngospasm/difficulty swallowing ○ Hypotension/unresponsiveness ○ Patients with an exposure to known allergen with progressively worsening symptoms (i.e., hives) • Severe Asthma
Contraindications:	<ul style="list-style-type: none"> ○ None when indicated
Adverse effects include but not limited to:	<ul style="list-style-type: none"> ➤ Hypertension-tachycardia ➤ Tremor, weakness ➤ Pallor, sweating, nausea, vomiting ➤ Nervousness, anxiety ➤ Increases myocardial oxygen demand and potentially increases myocardial ischemia
Adult Administration: Packaging Information: Epinephrine (0.3 mg/0.3 ml) auto-injector Epinephrine (0.15 mg/0.3 ml) auto-injector	Patients over 30 kg (66 pounds): Epinephrine Auto-Injector (Adult size) 0.3 mg (0.3 mL, 1:1 mL) IM – lateral high thigh is preferred. May repeat in 10 minutes if patient condition warrants.
Pediatric Administration:	Patient 15-30 kg (33-66 pounds): Epinephrine Auto-Injector (Pediatric size) 0.15 mg (0.3 mL, 1:2 mL) – lateral high thigh is preferred. May repeat in 10 minutes if patient condition warrants.
Onset:	5-10 minutes
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<p>Duration:</p>	<p style="text-align: right;"><i>Formulary: Epinephrine Auto-Injector Page 2 of 2</i></p> <p>20 minutes</p>
<p>Pregnancy Safety:</p>	<p>Category C</p>
<p>Precautions and Comments:</p> <p>Pharmacology Chart</p> <p>Used in SMO: Adult Anaphylaxis and Allergic Reaction Pediatric Anaphylaxis and Allergic Reaction</p>	<p>Use with caution in elderly or pregnant patients, but don't withhold if patient has serious signs or symptoms (i.e., airway compromise, severe SOB, profound hypotension)</p>
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FORMULARY – Naloxone Hydrochloride (Narcan)

Naloxone Hydrochloride	Narcan
Classification:	Opioid antagonist
Actions:	Reverses the effects of narcotics by competing for opiate receptor sites in the central nervous system.
Indications:	<ul style="list-style-type: none"> • Narcotic agonist <ul style="list-style-type: none"> - Morphine - Heroin - Hydromorphone - Methadone - Meperidine - Paregoric - Fentanyl - Oxycodone - Codeine • Narcotic agonist/antagonist <ul style="list-style-type: none"> - Butrophanol - Pentazocine - Nalbuphine • Decreased level of consciousness • Coma of unknown origin
Contraindications include but not limited to:	<ul style="list-style-type: none"> ○ Use caution with narcotic-dependent patients who may experience withdrawal syndrome ○ Avoid use in meperidine-induced seizures
Adverse effects include but not limited to:	<ul style="list-style-type: none"> ➤ Hypertension ➤ Tremors ➤ Nausea/vomiting ➤ Dysrhythmias ➤ Diaphoresis ➤ Withdrawal (opiates) ➤ Flash pulmonary edema
Adult Administration:	See Pharmacology Chart
Pediatric Administration:	See Pharmacology Chart
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Onset:	Within 2 minutes
Duration:	20-30 minutes
Pregnancy Safety:	Category B
Precautions and Comments:	<p>Check and remove any transdermal systemic opioid patch.</p> <p>The goal of Naloxone administration is to improve respiratory drive, not to return the patient to their full mental capacity.</p> <p>High dose/rapid reversal of narcotic effects may lead to combative behavior, possible severe withdrawal, and other adverse drug reactions. Consider other causes/potency of opiate agonist when evaluating need for repeat dosing.</p> <p>Observe for: seizures, hypertension, chest pain, and/or severe headache.</p>
<p>Pharmacology Chart</p> <p>Used in SMO: Adult Altered Mental Status Intranasal Medication/MAD Device Pediatric Altered Mental Status Pediatric Poisoning and Overdose Poisoning and Overdose Adult</p>	

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FORMULARY – Oral Glucose

Oral Glucose	
Classification:	Monosaccharide carbohydrate
Actions:	After absorption from GI tract, glucose is distributed in the tissues and provides a rapid increase in circulating blood sugar.
Indications:	Suspected or known hypoglycemia
Contraindications:	Patient who is not able to follow commands
Adverse effects include but not limited to:	<ul style="list-style-type: none"> • Nausea/vomiting • Aspiration • Hyperglycemia
Adult Administration:	<p>15 GM/37.5 GM tube</p> <p>Alternative: Glucose tablets – 15-20 GM PO. Recheck blood sugar in 15 minutes. If BS still below 80 mg/dL and/or exhibiting signs/symptoms of hypoglycemia another 15-20 GM may be administered.</p>
Pediatric Administration:	Up to 15 GM as tolerated
Onset:	5-10 minutes
Duration:	Variable
Pregnancy Safety:	Category A
Precautions and Comments:	<p>Not a substitute for IV dextrose in extreme cases of hypoglycemia (blood sugar <40) unless IV access is unobtainable.</p> <p>Alternative: Glucose tablets – tablets are not recommended for patients who cannot protect their airway or of an appropriate age to swallow a tablet.</p>
<p>Pharmacology Chart</p> <p>Used in SMO: Adult Altered Mental Status Pediatric Altered Mental Status Stroke</p>	

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FORMULARY – References – Key to FDA Use-In-Pregnancy Ratings

Key to FDA Use-In-Pregnancy Ratings

The Food and Drug Administration's Categories are based on the degree to which available information has ruled out risk to the fetus, balanced against the drug's potential to the patient. Ratings range from "A", for drugs that have been tested for teratogenicity under controlled conditions without showing evidence of damage to the fetus, to "D" and "X" for drugs that are teratogenic. The "D" rating is generally reserved for drugs with no safer alternatives. The "X" rating means there is absolutely no reason to risk using the drug in pregnancy.

Category	Interpretation
A	Controlled studies show no risk. Adequate, well-controlled studies in pregnant women have failed to demonstrate risk to the fetus.
B	No evidence of risk in humans. Either animal findings show risk, but human findings do not, or if no human studies have been done, animal findings are negative.
C	Risk cannot be ruled out. Human studies are lacking, and animal studies are either positive for fetal risk or lacking. However, potential benefits may justify the potential risk.
D	Positive evidence of risk. Investigational or post-marketing data show risk to the fetus. Nevertheless, potential benefits may outweigh the potential risk.
X	Contraindicated in pregnancy. Studies in animals or human, or investigational or post-marketing reports have shown fetal risk, which clearly outweighs any possible benefit to the patient.

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Review of Standing Medical Orders

Ongoing review of Region I EMS Standing Medical Orders is required to remain current with interventions known to be effective in prehospital care and should be the responsibility of each provider in Region I. It is expected that each provider maintain a functional knowledge of the Standing Medical Orders and apply them appropriately during all patient interactions.

Updates and new Standing Medical Orders are noted with either the “Original SMO Date” or “Last Revision” within each SMO. The most current version and implementation date of the entire document is noted in the footer on each page. Distribution and education regarding any updates remains the purview of each Region I EMS Resource Hospital.

The Standing Medical Orders have been developed and approved through a collaborative process involving the Medical Directors listed below:

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SMO: Review of Standing Medical Orders

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