Universal Patient Care Guideline

Scene Safe? — Yes

- Bring all necessary equipment to patient
- Demonstrate professionalism and courtesy
- Mass assembly consider WMD
- Utilize appropriate PPE

No

- Call for help and Additional Resources
- Stage Until Scene is Safe

Consider Airborne or Droplet if indicated

Initial Assessment
BLS Maneuvers
Initiate Oxygen if indicated

Adult Assessment Procedure

Pediatric Assessment Procedure
Use Length-Based Measuring Tape

Blood Pressure
Palpated Pulse Rate Respiratory Rate
12 Lead Acquisition
ECG Acquisition
Temperature
Pain Scale

B	Oxygen Saturation > 94% Capnography, 35-45 mmHg if available Glucometry
I	ECG Interpretation 12 Lead Interpretation

Trauma Patient

Evaluate Mechanism of Injury (MOI) and Consider Spinal Immobilization if Indicated

Significant MOI
- Primary and Secondary Trauma Assessment
- Obtain Vitals Signs
- Obtain SAMPLE
- Exit To Appropriate Guideline

No Significant MOI
- Primary and Secondary Trauma Assessment
- Focused Assessment on Specific Injury

Medical Patient

Mental Status Exam

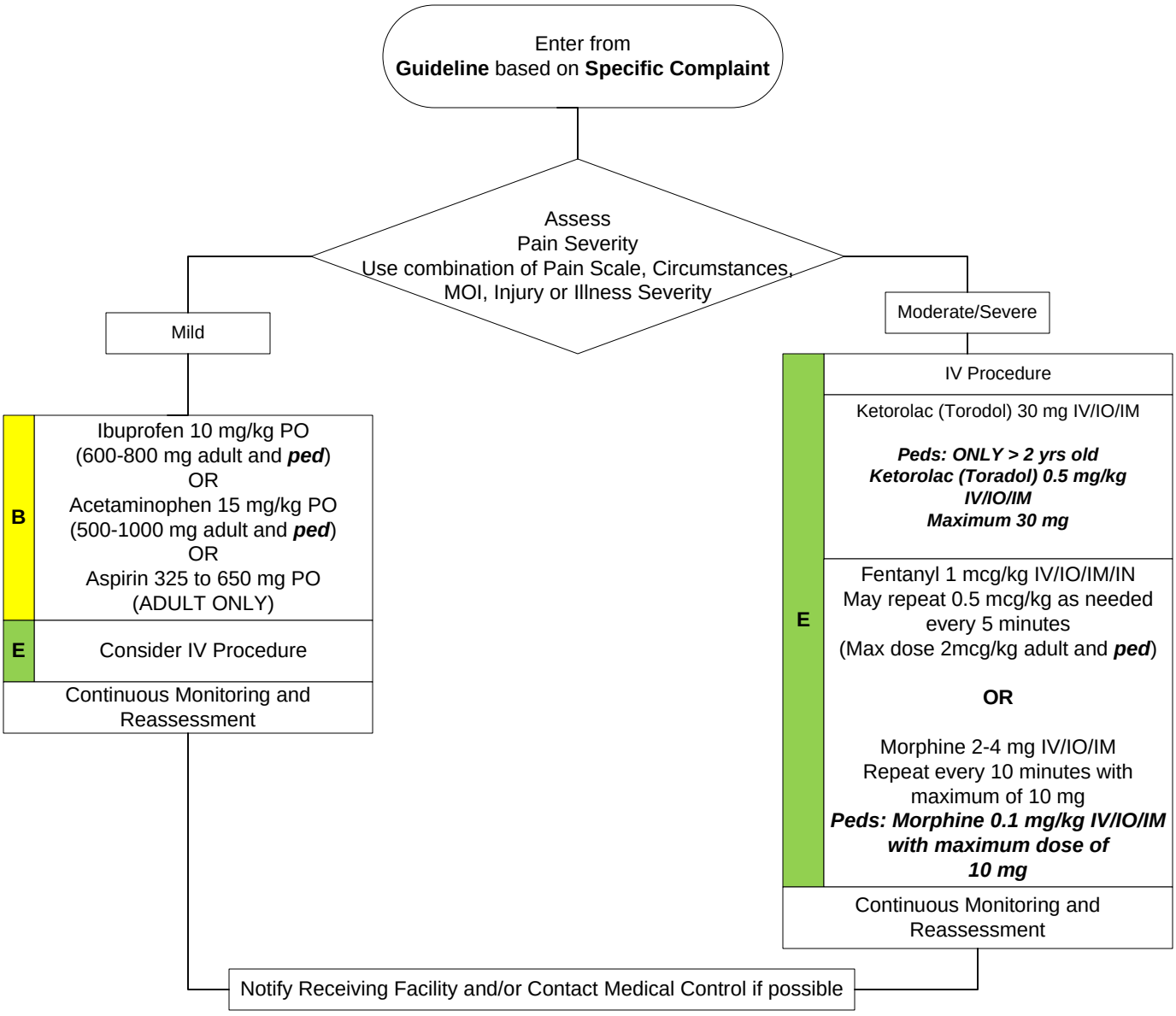
Unresponsive
- Primary and Secondary Assessment
- Obtain history of present illness from available sources/scene survey
- Obtain SAMPLE
- Exit To Appropriate Guideline

Responsive
- Chief Complaint Obtain SAMPLE
- Primary and Secondary Assessment
- Focused Assessment on specific complaint
- Obtain Vital Signs
- Exit To Appropriate Guideline

Transfer patient hand off includes patient information, personal property and summary of care and response to care

General Guidelines

Pain Control



PEARLS

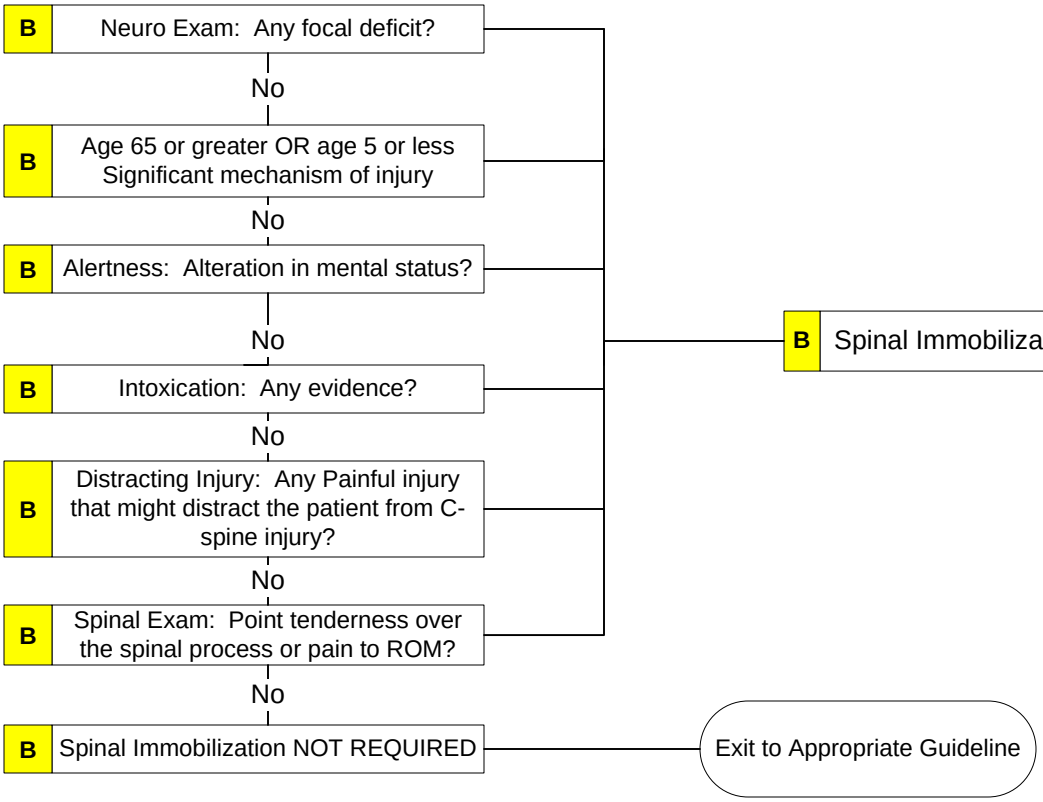
* Pain severity (0-10) is a vital sign to be recorded before and after PO, IV, IO, IM or IN medication delivery and at patient hand off.
* Both arms of the treatment may be used in concert. For patients in Moderate pain for instance, you may use the combination of an oral medication and parenteral if no contraindication are present.
* Do NOT administer any PO medication for patients who may need surgical intervention such as open fractures or fracture deformities, headaches or abdominal pain.
* Ketorolac (Toradol) and Ibuprofen should not be used in patients with known renal disease or renal trans-plant, in patients who have know drug allergies to NSAID's, with active bleeding, headaches, abdominal pain, stomach ulcers or in patients who may need surgical intervention such as open fractures or fracture deformities.
* **Do NOT** administer Acetaminophen to patients with a history of liver disease.

Spinal Immobilization

Entry from appropriate Guideline
Circumstances warrant spinal immobilization consideration

Default is ALWAYS Immobilize

Any doubt; immobilize



Exit to Appropriate Guideline

PEARLS

* Significant mechanism includes high-energy events such as ejection, high falls, and abrupt deceleration crashes and may indicate the need for spinal immobilization in the absence of symptoms.
* Consider immobilization in any patient with arthritis, cancer, dialysis or other underlying spinal or bone disease.
* The decision to NOT implement spinal immobilization in a patient is the responsibility of the patient attendant solely.
* In the very young and the very old, a normal exam may not be sufficient to rule out spinal injury.
* The acronym “NSAIDS” should be used to remember the steps in this guideline:

N – Neurologic exam. Look for focal deficits such as tingling, reduced strength, or numbness in an extremity.
S – Significant mechanism or extremes of age.
A – Alertness. Is patient oriented to person, place, time and event? Any change of alertness with incident?
I – Intoxication. Is there any indication that the person is intoxicated, impaired decision making ability?
D – Distracting Injury. Is there any other injury producing significant pain in the patient? Any injury which the patient seems to focus on and rate 6 or greater on the pain scale is likely distracting.
S – Spinal exam. Look for point tenderness in any spinal process or spinal process tenderness with range of motion. Each of the 7 cervical spinal processes must be palpated during the exam.

Continuous Compression CPR (CC-CPR); Adult

Contraindications:

Children < 8
Know/suspected overdose
Respiratory cause of arrest
Hypothermia
Near Drowning
Traumatic Arrest

Cardiac Arrest

200 Chest Compressions
Insert OPA, apply Non-rebreather mask at 100%

E IV/IO Procedure
I Epinephrine 1 mg, 1:10,000 IV/IO

Rhythm analysis: Single shock at highest joule setting and without pulse check

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Endotracheal Intubation/King Airway while NOT interrupting compressions

Exit to Appropriate Cardiac Guideline

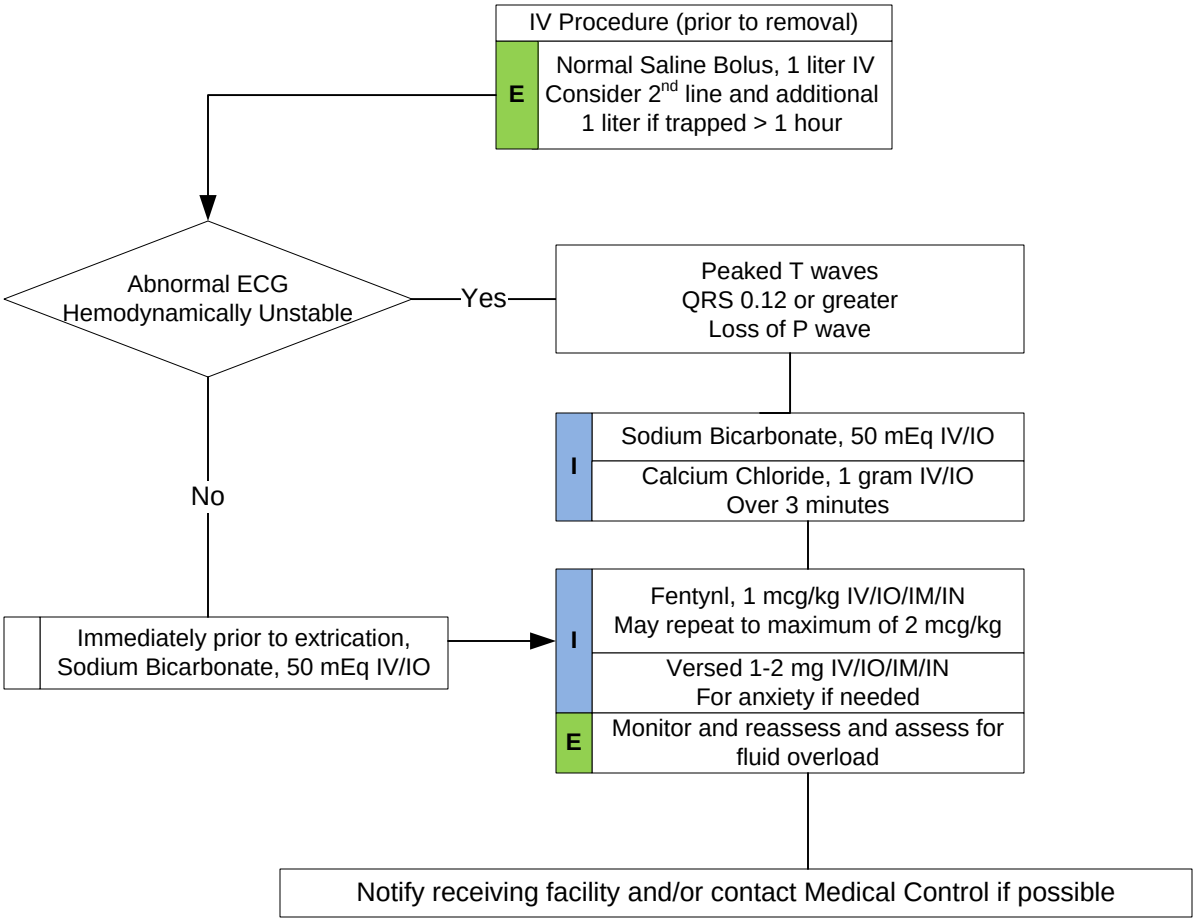
1. Follow manufacturer's recommendation for energy level.
2. Chest compressions at least 100/min., deep and complete recoil.
3. If potentially perfusing rhythm returns, continue with one more round of 200 compressions before pulse check.
4. ROSC, follow post-resuscitative care guideline.

Do NOT attempt ventilation/ intubation until after fourth set of 200 compressions

PEARLS
* Consider early IO placement if available and difficult IV anticipated.
* DO NOT HYPERVENTILATE: If advanced airway in place, ventilate 8-10 breaths per minute.
* Use a Team Focused Approach, assigning responders to predetermined tasks.
* Defibrillation energy should be at manufacturer's recommendation, maximum energy if unknown.

TERMINATION – If after 30 minutes of quality resuscitation effort and no Return of Spontaneous Circulation (ROSC) occurs, the team leader should inform the family of the situation and consider termination of resuscitation on the scene.

Crush Syndrome Trauma



PEARLS

* For patient's that have prolonged entrapment, contact Medical Control if possible, for additional treatment options.
* Scene safety is of paramount importance as typical scenes pose hazards to rescuers. Call for appropriate resources.
* Crush injury is very painful. Contact Medical Control if additional pain medication is needed.
* ECG changes with hyperkalemia include those in guideline, but may also be a "bizarre," wide complex.
* Patients may become hypothermic, even in warm environments.