

Signs & Symptoms:

Altered LOC, agitation, cool, pale, diaphoretic, or warm, dry & flushed. Constricted pupils, tachycardia, shortness of breath, slurred speech, depression, suicidal intentions or thoughts.

Obtain and Document:

Patient weight, time of ingestion, medication/substance(s) ingested, amount ingested, any alcohol, etc. Transport the ingested substance/medication bottles/containers plus any vomitus with the patient to the emergency department.

Routine Transport Orders-Pediatric**Pediatric Airway****Pediatric IV/IO****Cardiac Monitor**Consider **CO**

Contact Poison Control for information as needed.

POISON CONTROL
1-800-222-1222

General

EMT

AEMT

Paramedic

Tricyclic ingestion**Sodium Bicarbonate 8.4%**

1 mEq/kg IVP, IO

Observe for seizure activity and cardiac dysrhythmias

Opiates

Respiratory Depression

Naloxone (Narcan)0.1 mg/kg IVP, IO,
0.2 mg/kg IN**Maximum 2 mg**

Administer Narcan in lowest dose as needed to maintain adequate respirations

Perform scene size-up and ensure crew safety. Be careful of potential violent situation and be aware of biohazards.

Routine Transport Orders-Pediatric

Pediatric Airway Protocol

Pediatric IV/IO

Cardiac Monitor

Blood Glucose

Contact Poison Control for information as needed.

POISON CONTROL
1-800-222-1222

General

EMT

AEMT

Paramedic

Dextrose 10% (D10) IVP, IO

5 ml/kg

Maximum 100 ml

Until patient awake &/or glucose
60 mg/dl

< 60 mg/dl

Make every effort to **contact Poison Control** if you feel that the patient does not need to be transported. Note the instructions of Poison Control on the run sheet.

Naloxone (Narcan)

0.1 mg/kg IVP, IO, 0.2 mg/kg IN

Maximum 2 mg

EMT may administer via IN only

Narcan 0.2 mg/kg IN Max. 2 mg

Respiratory depression?

Administer Narcan in lowest dose as needed to maintain adequate respirations

2 Indications:

1. Suspected Cyanide Poisoning
2. **Smoke Inhalation** with 3 criteria met.
 - a. Confined space smoke exposure
 - b. Altered LOC
 - c. Nasal/oral sooting or burns or Suspected Cyanide Poisoning

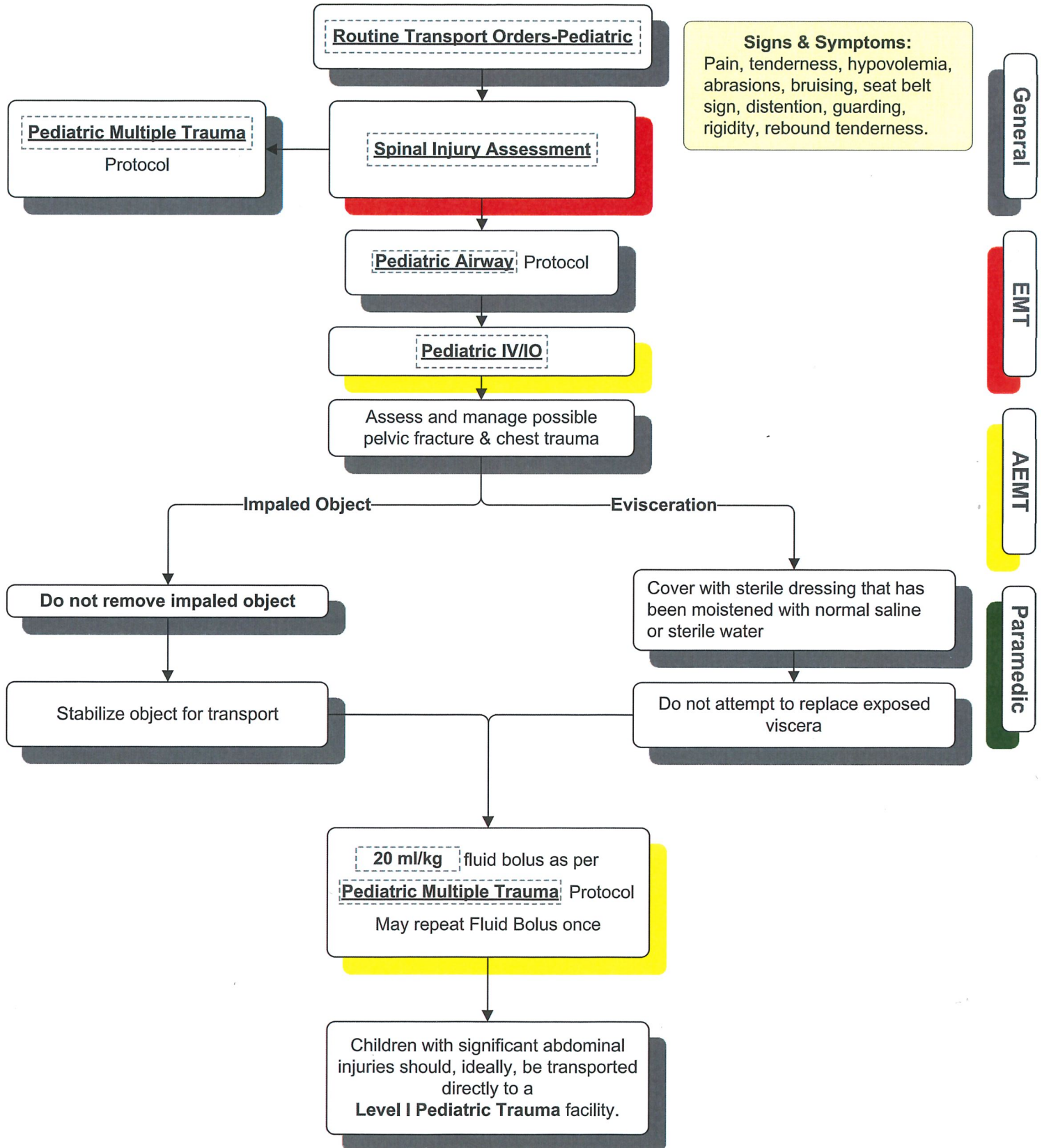
Smoke Inhalation / CO Poisoning

Cyanide toxicity, closed space fire, smoke inhalation with decreased LOC and inadequate response to oxygen therapy?

Carboxyhemoglobin Monitor

Appropriate Protocol

Hypotension, Seizures,
Ventricular dysrhythmias,
or Mental status changes?



Isolated extremity trauma can be treated with focus and care. Be sure to check and document Pulse, Motor, And Sensory values prior to and after splinting. However, in unstable multiple trauma situations, extremity immobilization can be completed in a more rudimentary way in order to save scene times and attend to more life threatening injuries.

If other injuries,

Pediatric Multiple Trauma

Protocol

Routine Transport Orders-Pediatric

Wound Care

Pediatric IV/IO

20 ml/kg

0.9 NS bolus if
hypovolemic shock present

Pediatric Pain Management Protocol

Assess injured extremity for color,
pulses, sensation, movement,
temperature, and bleeding.

Amputation?

Remove gross contamination

**Wrap part in sterile dressing
moistened with 0.9 NS**

**Place wrapped amputated tissue in
plastic bag on ice, avoid direct contact
between ice and tissue**

Children with significant abdominal injuries
should, ideally, be transported directly to a
Level I Pediatric Trauma facility.

General

EMT

AEMT

Paramedic

Burns many times are not life-threatening, but cause a significant amount of pain. Some types of burns are flame, scalds, steam, electrical, flash, tar and chemical burns. Consider transporting patient to burn center.

Routine Transport Orders-Pediatric

Pediatric Airway Protocol

Burns can be thermal, or chemical. Types of burns are First degree (red and painful), Second degree (Skin blisters) and Third degree (Necrosis). Use the Lund and Browder to estimate body surface percentage affected.

Signs of other injuries:

Pediatric Multiple Trauma

Protocol

Remove rings, bracelets, and any other constricting items

Thermal

Chemical

If burn < 10% body surface area (Lund-Browder)
Cool down the wound with Normal Saline

Cover burn area with dry dressings. May cover body part with wet dressings if burn is limited to small area (<10%BSA)
Consider transport for patients with burns involving the hands, face and genitalia (critical burns).

Pediatric IV/IO

Pediatric Pain Management Protocol

Smoke inhalation / CO Poisoning?

Pediatric Toxic Overdose

For sedation Consider

Midazolam (Versed)

0.1 mg/kg IVP, IO, IN

Maximum 2 mg per dose

for sedation due to significant 2nd and 3rd degree burns.

Eye involvement?
Continuous Normal Saline flush in affected eye

Remove clothing or expose area

Flush area with water or Normal Saline for 10 - 15 minutes

Carboxyhemoglobin Monitor

Children with significant abdominal injuries should, ideally, be transported directly to a **Level I Pediatric Trauma** facility.

General

EMT

AEMT

Paramedic

Injury Signs & Symptoms**Tension Pneumothorax-**

Severe respiratory distress, hypotension, tachycardia, decreased level of consciousness (LOC), cyanosis, absent breath sounds on affected side, distended external jugular veins

Open Pneumothorax-Respiratory distress, sucking wound

Hemothorax-Profound hypovolemic shock, decreased LOC, pallor, flat external jugular veins, respiratory distress

Flail segment-Severe respiratory distress, unequal chest movement, cyanosis, decreased LOC

Routine Transport Orders-Pediatric**Pediatric Airway** Protocol

Oxygen should be administered to maintain SpO₂ >94%

Spinal Injury Assessment

Vital Signs / Perfusion

Do not remove any impaled or foreign object. Stabilize impaled object for transport. Carefully assess for and treat a life-threatening thoracic injury.

If evidence of other injuries?

Pediatric Multiple Trauma

Protocol

General

EMT

AEMT

Paramedic

Abnormal

Normal

Rapid Transport

Focused history and physical exam

Transport

Evaluate chest for the following injuries

Tension pneumothorax
Hemothorax
Flail segment
Open pneumothorax

Open Pneumothorax
Nonporous dressing with pressure vent

Signs & Symptoms of Hypovolemic Shock

Normal Saline Bolus

20 ml/kg

Repeat as needed

Reassess **Pediatric Airway** Protocol

Tension pneumothorax?

Needle Decompression

Children presenting with significant chest trauma should, ideally, be transported directly to a **Level I Pediatric Trauma** facility.

If injuries are inconsistent with the history, abuse should be suspected.

Routine Transport Orders-Pediatric

Spinal Injury Assessment

If indicated

Treat per appropriate protocol

Remove the child from the scene as soon as possible. Avoid pressing for detailed history of the event.

If patient's condition allows, do not leave until Police arrive. EMS should report even if taken to hospital.

Law enforcement should be called to the scene if the parents or other caregiver refuse transport after it has been deemed necessary by the Medic crew.

Report and carefully document ALL suspected cases of child abuse. Documentation should include size, shape, color, degree of healing, and location of each injury.

If indicated

Pediatric IV/IO

(If indicated)

Pediatric Airway Protocol

Identify individual county resources for child protective services.

These children should be transported to hospital if at all possible. If the child is unstable due to injury, transport to the closest appropriate hospital.

Child abuse should be suspected when any of the following exist:

History is inconsistent with the extent of injury or developmental age.
The injury reflects an outline of an object or mode of infliction.
There is a delay in seeking medical attention.
There are other unexplained injuries in various stages of healing.
The explanation seems vague or confused.

Children's Services

should be notified on all cases of suspected abuse. See:

Phone Numbers

Child abuse should be suspected when any of the following exist:

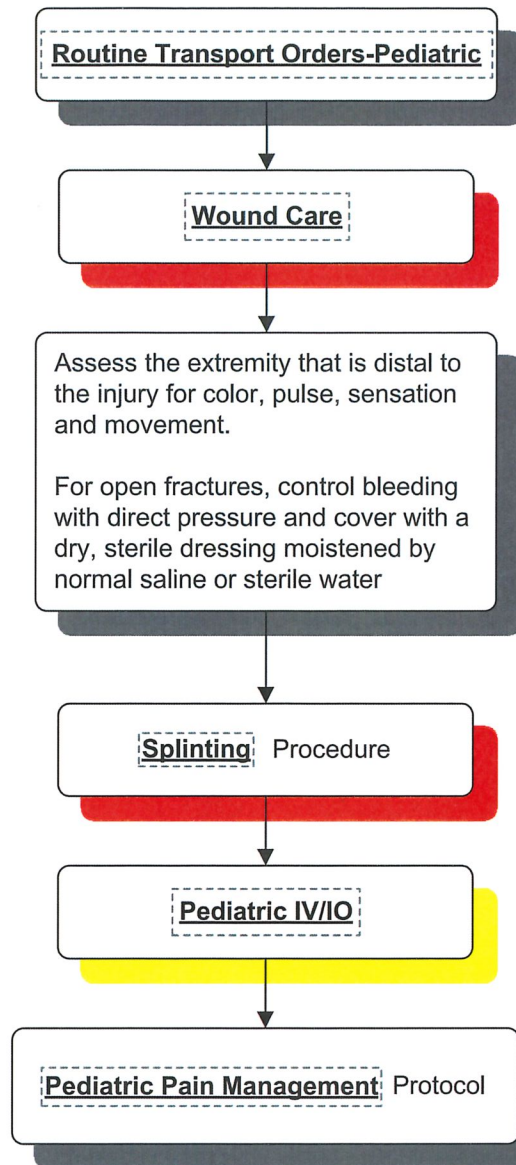
- History is inconsistent with the extent of injury or developmental age.
- The injury reflects an outline of an object or mode of infliction.
- There is a delay in seeking medical attention.
- There are other unexplained injuries in various stages of healing.
- The explanation seems vague or confused.

General

EMT

AEMT

Paramedic



Isolated extremity trauma can be treated with focus and care. Be sure to check and document Pulse, Motor, And Sensory values prior to and after splinting. However, in unstable multiple trauma situations, extremity immobilization can be completed in a more rudimentary way in order to save scene times and to attend more life threatening injuries.

General

EMT

AEMT

Paramedic

Children are more likely to experience head injuries, because their heads are proportionally larger, and heavier, in comparison to the rest of their bodies.

Younger children frequently fall and injure their face, because of being clumsy when they first start walking. Older children suffer dental injuries from bike and skateboard accidents. Spinal injuries are not as common in children, but because of their larger head, are vulnerable to c-spine injury.

Routine Transport Orders-Pediatric

Isolated head trauma?

Yes

Pediatric Airway Protocol

If necessary

Spinal Injury Assessment

Pediatric IV/IO

Do not restrict fluids in a patient who is hypotensive or has shock signs and symptoms

Indications for transport include loss of consciousness, change in state of consciousness, profuse vomiting, children under 2 years of age with large hematomas, gait disturbances, seizures, and pupillary changes.

See: Pediatric Seizures

Monitor and reassess

Children with significant abdominal injuries should, ideally, be transported directly to a **Level I Pediatric Trauma** facility.

Pediatric Multiple Trauma
Protocol

General

EMT

AEMT

Paramedic

Perform a trauma assessment. Expose patient. Attempt to keep scene time to a minimum. Treat life threatening injuries as priority. **REMEMBER**, shock in children is primarily recognized by:

TACHYCARDIA - anxiety, restlessness

POOR PERIPHERAL PERFUSION (cool, clammy skin with slow capillary refill, weak pulses)

If no improvement or vital signs deteriorate, repeat bolus as necessary. Inform hospital of responses to treatment and re-communicate any change.

If patient seizing,
See: **Pediatric Seizures**

Routine Transport Orders-Pediatric

Pediatric Airway Protocol

Spinal Injury Assessment

Pediatric IV/IO

NS Fluid Bolus

20 ml/kg

If blood pressure is less than expected or shock symptoms present

Cardiac Monitor

Assess for tension pneumothorax or flail chest. Evaluate for neurological deficit. Do not restrict fluids in a child that has an inadequate BP or shock symptoms.

Pediatric Pain Management Protocol

For fractures, burns, etc.

For Sedation Consider

Midazolam (Versed)

0.1 mg/kg IVP, IO, IN

Maximum 2 mg per dose

See:

Mucosal Atomizer Device (MAD)

for IN dose

May repeat in 10 minutes For sedation with severe burns or fractures.

General

EMT

AEMT

Paramedic