Diabetic Emergencies

ABC'S
- secure as needed

OXYGEN
- as needed
- Nasal Cannula 1-6 lpm
- NRBM 15 lpm

ASSESSMENT
- vitals
- history
- physical
- medical alert tags
- other injuries/illnesses
- blood glucose level
- blood glucose level

SYMPTOMATIC?
- glucose < 60

LOC
- alert
- oriented

ORAL GLUCOSE

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

EMT-B

EMT-I

Paramedic

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

IV
- .9 % NAACL
- TKO

BG > 400 mg %
Titrate IV to a rate of 150 – 250 cc/hr

Pediatric Considerations
- 15 grams oral glucose as tolerated

- 1 gram/kg Dextrose IV

This form supersedes no other

KBEMS Form 30 063
090801
This form supersedes no other

KBEMS Form 30 065
090801
Hyperthermia

ABC’S
- secure as needed

OXYGEN
- as needed
- Nasal Cannula 1-6 lpm
- NRBM 15 lpm

ASSESSMENT
- vitals
- history
- physical
- Include skin temp., character and color
- O2 saturation
- Rate of onset

MOVE PATIENT
- cooler environment
- begin cooling if indicated

Symptomatic for Heat Stroke
- ice packs over groin and under armpits
- cool with wet towels or blankets

EMT-B

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

EMT-I

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

IV
- .9 % NACL
- Maintain B/P

Paramedic

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

ECG
- monitor

IV
- .9 % NACL
- Maintain B/P

See next page for specific treatment

This form supersedes no other

KBEMS Form 30 067
090801
Specific types of Heat Injury Management (in addition to the above)

**Heat Cramps**
- Replace fluids but try to avoid plain water (use sports drinks)
- Do not massage muscle cramps

**Heat Exhaustion**
- Fan & cool the pt. but avoid chilling
- Calm, quiet, and reassure pt.

**Heat Stroke**
- Rapid body cooling, move to cool environment, remove all possible clothing, rinse with cold water if possible or use whatever means are available (i.e.; ice packs) COOL RAPIDLY
- Transport to appropriate facility

This form supersedes no other
Hypothermia

ABC’S
- secure as needed

OXYGEN
- Nasal Cannula 1-6 lpm

ASSESSMENT
- vitals
- history
- physical
- Vitals may be much lower
- Monitor for full minute

EMT-B

EMT-I

Paramedic

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

IV
- LR or NS
- TKO

ECG
- monitor

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

IV
- LR or NS
- TKO

Precautions
- move patient to warm environment as soon as possible
- remove all wet clothing
  Protect the patient from further exposure
- handle patient with extreme care, rough handling can cause ventricular fibrillation
- high flow oxygen is contraindicated due to possibility causing ventricular fibrillation

See next page for localized injury

This form supersedes no other
Local Cooling and Frostbite

ABC’S
- secure as needed

OXYGEN
- as needed
- Nasal Cannula 1-6 lpm
- NRBM 15 lpm

ASSESSMENT
- vitals
- history
- physical

APPLY DRESSING
- Loose, light dressing
- Do not use tape or other circumferential bandages

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

- Remove items covering injured part(s)
- Protect injured area from pressure, trauma, friction
- Do not break blisters

Mild HYPOTHERMIA
Core temperature 93-97 degrees fahrenheit active external rewarming

Asses the pt. for presence or absence of pulse or respirations

Core Temp less than 97 degrees fahrenheit indicates hypothermia

Treat the pt. very gently. Rough handling can precipitate ventricular fibrillation.

Prevent further heat loss. Insulate from the ground, protect from the wind, eliminate evaporative heat loss by removing wet clothing or by covering pt. with vapor barrier (such as a plastic bag), cover the head & neck. Move the pt. to a warm environment.

Moderate HYPOTHERMIA
Core temperature 86-97 degrees fahrenheit active rewarming of truncal areas only

ABC’s
-secure as needed

Assesment

OXYGEN as needed
- Nasal Cannula 1-6 lpm
- Non Rebreather Mask 10-15 lpm

SEVERE HYPOTHERMIA
Core temperature less than 86 degrees fahrenheit
-Active internal rewarming
- warm IV fluids (109° F)
- warm, humid oxygen

- blood pressure
- respirations
- pulse
- pupils
- neuro function
- skin (core temperature)

If possible, oxygen & IV fluids should be heated. If possible, obtain core temperature.

This form supersedes no other

KBEMS Form 30 067A
090801
Chest Pain

ABC’S
- secure as needed

OXYGEN
- Nasal Cannula 1-6 lpm
- NRB 15 lpm

ASSESSMENT
- vitals
- history
- physical

- Note pt. allergies
- Does pt. take Nitro?
- Does pt. take Aspirin daily
- O2 Saturation
- Is the patient on ED medication?

EMT-B
TRANSPORT
- move to unit
- begin transport
- contact receiving facility

AED
- 3 lead
- obtain strip(s) for E.R.

EMT-I
TRANSPORT
- move to unit
- begin transport
- contact receiving facility

AED
- 3 lead
- obtain strip(s) for E.R.

Paramedic
ASPIRIN
- 325 mg P.O.
- chew tablets

NITRO
- B/P > 100 systolic
- 0.4 mg SL
- repeat X 2 every 5 min. if needed

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

ECG
- monitor

ACLS
- contact medical direction for approval
- initiate current ACLS Guidelines

- check allergy
- If pt. takes daily, check with provider

IV .9 % NACL

PARAMEDIC CONSIDERATIONS
- Atropine 0.5 mg IV bolus per ACLS Guidelines for bradycardia
- PEA per ACLS Guidelines for V-Fib, pulseless V-Tach, or Asystole
  Morphine Sulfate 1-3 mg every 3-5 mins titrated to effect or systolic BP less than 100mmHg

This form supersedes no other

KBEMS Form 30 069
090801
Abdominal Pain

ABC’S
- secure as needed

OXYGEN
- as needed
- Nasal Cannula 1-6 lpm
- NRBM 15 lpm

ASSESSMENT
- vitals
- history
- physical

SYMPTOMATIC?
- injury related pain

Yes

No

REFERENCE
- Refer to appropriate protocol

Yes

REFERENCE
- Refer to appropriate protocol

No

EMT-B
TRANSPORT
- move to unit
- begin transport
- contact receiving facility

EMT-I
TRANSPORT
- move to unit
- begin transport
- contact receiving facility

Paramedic
TRANSPORT
- move to unit
- begin transport
- contact receiving facility

Considerations
- Give nothing by mouth
- Be alert of vomiting
- Avoid analgesics
- Consider ectopic pregnancy for women of child bearing years

IV
- .9% NACL
- TKO

IV
- .9% NACL
- TKO

ECG
- Monitor

This form supersedes no other

KBEMS Form 30 071
090801
Respiratory Distress / Dyspnea

ABC'S
- secure as needed

OXYGEN
- Nasal Cannula 1-6 lpm
- NRBM 15 lpm
- BVM 15 lpm

ASSESSMENT
- vitals
- history
- physical

SYMPTOMATIC?
- severe resp. distress?

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

EMT-B
- move to unit
- begin transport
- contact receiving facility

EMT-I
- move to unit
- begin transport
- contact receiving facility

Paramedic
- move to unit
- begin transport
- contact receiving facility

CONSIDER
- 2.5 mg Albuterol Solution @ 10 – 15 lpm
- 0.5 mg Atrovent Solution @ 10 – 15 lpm

IV
- .9 % NACL
- TKO

COPD?
- Yes
- No

STATUS
- ASTHMATICUS
- No
- Yes

CONSIDER
- 2.5 mg Albuterol Solution @ 10 – 15 lpm
- 0.5 mg Atrovent Solution @ 10 – 15 lpm

IV
- .9 % NACL
- TKO

CONSIDER
- contact medical direction
- Epinephrine 0.3-0.5 mg 1:1000 SQ
- Epinephrine 0.3-0.5 mg 1:10,000 IV if hypotensive

Pediatric Considerations
- Epinephrine 0.1 mg 1:1000 SQ; repeat in 5 minutes not to exceed 0.5

This form supersedes no other

KBEMS Form 30 073
090801
Obstetrical Emergencies
Childbirth

ABC'S
- secure as needed

OXYGEN
- as needed
- Nasal Cannula 1-6 lpm
- NRBM 15 lpm

ASSESSMENT
- vitals
- history
- physical
- chronic illness
- # of pregnancies
- prenatal care?
- baby’s expected birth date
- last menstrual cycle
- time
- frequency
- duration
- strength
- bleeding
- prolapsed cord
- bulging or crowning
- presenting parts

MONITOR CONTRACTIONS

ASSESS PERINEAUM

IS BIRTH IMMINENT?
No
Yes

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

REMOVE UNWANTED Bystanders and PREPARE for DELIVERY

GO TO NEXT PAGE

Signs of Imminent Delivery
- effectual contractions which are less than 2 min. apart and lasting 30-60 sec.
- perineal bulging or crowning with contractions

Precautions
- even a small amount of blood during labor should be reported to medical facility
- elevation of B/P in the mother above 160/90 should be reported to the medical facility

This form supersedes no other

KBEMS Form 30 075
090801
Obstetrical Emergencies
Childbirth

EMT-B

EMT-I

Paramedic

IV
.9 % NACL
TKO

POSITION PATIENT
- supine with head and shoulders elevated above the level of her hips
- knees bent and spread her thighs

PREPARE AREA
- apply mask, gown and gloves
  - prep the vulva
  - apply sterile drapes

ASSIST IN DELIVERY
- hold gentle pressure against the baby’s head and support the perineal body as the head emerges to prevent an explosive birth
  - allow the body to rotate naturally
  - check the nuchal cord
- suction the nose and mouth immediately with bulb syringe
  - deliver the upper then lower shoulder
  - record exact time of birth

INFANT CARE
- clamp the umbilical cord with two clamps 2” apart and 8-10” from the infant
  - cut the cord between the clamps
- position the infant with a slight head down position and continue to suction airway
  - dry and stimulate the infant with towels
- obtain an APGAR score 1 min. post delivery
  - obtain cord sample (1 red, 1 purple)
- place the infant in a dry blanket and place with the mother

MOTHER CARE
- massage the fundus of the uterus following delivery
- examine the perineum for lacerations and dress appropriately
- delivery of the placenta should occur spontaneously

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

This form supersedes no other

KBEMS Form 30 075A
090801
Poisoning and Substance Abuse

SCENE SAFETY
- Identify source
- May need to move patient

ABC’S
- Secure as needed
- Be alert to vomiting

OXYGEN
- as needed
- Nasal Cannula 1-6 lpm
- NRBM 15 lpm

ASSESSMENT
- vitals
- history
- physical

ASSESSMENT
- LOC
- Pupils
- Duration of exposure
- Time elapsed since

TREATMENT
- Flood skin with H2O
- Remove contaminated clothing
- Contact Medical Control
- Treat per Medical Control

PORT of ENTRY
- Absorbed
- Inhaled
- Ingested / Injected

TREATMENT
- Estimate amount
- Bring container, if feasible
- Contact Medical Control
- Treat per Medical Control
- Do not induce vomiting unless directed

TREATMENT
- Move pt. to fresh air
- Contact Medical Control
- Treat per Medical Control

GO TO Next page

This Form supersedes no other
EMT-B

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

EMT-I

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

Paramedic

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

IV
 .9 % NACL
 TKO

ECG
- monitor

IV
 .9 % NACL
 TKO

EYE POISONING CONSIDERATIONS
- flood eye with lukewarm water continuously for 15 min. or more
  - have pt. blink during irrigation
  - Contact Medical Direction
  - Cover BOTH eyes with moist sterile dressing

Consider possible causes and treat cause
Hypovolemia
- Drug overdose such as tricyclics, digitalis
  - beta-blockers, calcium channel blockers
    - Hyperkalemia
    - Metabolic Acidosis
    - Respiratory Acidosis
    - Hypoxia
    - Cardiac Tamponade
    - Tension pneumothorax
    - Hypothermia
    - Massive pulmonary embolism
Seizures

ABC’S
- secure as needed

PROTECT PATIENT
- Protect from injury
- Do not use restraints
- Protect from onlookers and embarrassment as much as possible

OXYGEN
- Nasal Cannula 1-6 lpm
- NRBM 15 lpm

ASSESSMENT
- vitals
- history
- physical

EMT-B
TRANSPORT
- move to unit
- begin transport
- contact receiving facility

EMT-I
TRANSPORT
- move to unit
- begin transport
- contact receiving facility

PARAMEDIC and EMT-I
CONSIDERATIONS
- blood sugar < 60, treat per Diabetic Emergencies Protocol

IV
.9 % NACL TKO

ECG
- monitor

IV
.9 % NACL TKO

CONSIDERATIONS
- Transport pt. in a quiet, non-stimulating environment. Flashing lights and/or sirens may precipitate additional seizures.

PARAMEDIC
TRANSPORT
- move to unit
- begin transport
- contact receiving facility

Pts actively seizing administer Valium 5 – 10 mg IV or 1 – 5 of Vesed Versed 5 – 10 mg IM if no IV established

This form supersedes no other

KBEMS Form 30 079
090801
Cardiac Arrest – Code Blue

Overview

ABC’S
- secure as needed

OXYGEN
- BVM with 15 lpm

AED/ECG
- when available
- EMT-D and Paramedic personnel should follow appropriate dysrhythmia protocol

EMT-B
- move to unit
- begin transport
- contact receiving facility

EMT-I
- move to unit
- begin transport
- contact receiving facility

Paramedic
- move to unit
- begin transport
- contact receiving facility

TRANSPORT

IV
.9 % NACL
TKO

ACLS
- follow current ACLS guidelines with approved medications for specific algorithm

This form supersedes no other

KBEMS Form 30 081
090801
**RULE OF NINES**

**Adult**
- Head – 9%
- Anterior Torso – 18%
- Posterior Torso – 18%
- Arm – 9%
- Leg – 9%
- Neck – 1%

**Child**
- Head and Neck – 18%
- Anterior Torso – 18%
- Posterior Torso – 18%
- Arm – 9%
- Leg – 14%

**Burns**

**STOP BURNING PROCESS**
- remove victim from burning source
- remove necessary clothing
- do not remove stuck clothing

**ABC’S**
- secure as needed

**OXYGEN**
- as needed
- Nasal Cannula 1-6 lpm
- NRBM 15 lpm

**ASSESSMENT**
- vitals
- history
- physical
- Length of exposure
- Type of burn
- Med. Hx.
- O2 saturation
- % body surface burn (rule of nines)

**BURN CARE**
- refer to specific burn type and depth

**RULE OF NINES**

**Adult**
- Head – 9%
- Anterior Torso – 18%
- Posterior Torso – 18%
- Arm – 9%
- Leg – 9%
- Neck – 1%

**Child**
- Head and Neck – 18%
- Anterior Torso – 18%
- Posterior Torso – 18%
- Arm – 9%
- Leg – 14%

**Parkland Burn Formula:**
(wt. in kg) x (% BSA burn) x 4
1/2 total volume over 1st 8 hours post burn
1/2 total volume over remaining 16 hours post burn

**TRANSPORT**
- move to unit
- begin transport
- contact receiving facility

**EMT-B**

**EMT-I**

**PARAMEDIC**

**TRANSPORT**
- move to unit
- begin transport
- contact receiving facility

**IV**
- .9 % NAACL TKO

**ECG**
- monitor

**IV**
- .9 % NAACL TKO

*This form supersedes no other*

KBEMS Form 30 083
090801
**Burn Care**

**FLAME OR SCALDS**
- cool with saline soaks for 10 – 15 min. if your arrival time is less than 30 min. post burn
- cover with dry sterile sheets after the cooling process is complete
- DO NOT allow burn patient to become chilled or shiver

**TAR BURNS**
- cool with saline soaks for 10 – 15 min. if your arrival time is less than 30 min. post burn
- cover with dry sterile sheets
- DO NOT allow burn patient to become chilled or shiver

**ELECTRICAL BURNS**
- Take spinal precautions
- cover open wounds with dry sterile sheets
- assess for extremity fractures and entrance and exit wounds

**CHEMICAL**
- Flush with water for 20 min.
- phosphorus and lime burns are exceptions to water flush – brush off chemical

**CRITERIA FOR CRITICAL BURNS**
- Second degree > 30% BSA
- Third degree > 10% BSA
- Involve the face, hands, feet, or genitalia
- Involving the respiratory tract
- Associated with major soft tissue damage
- Associated with fractures
- Electrical burns
- HF acid burns

**DEPTH OF A BURN** - The depth of tissue damage due to burn is largely dependent on the temperature and duration of the thermal energy applied to the skin. Skin contact with heat caustic chemicals, radiation or electricity results in tissue destruction of variable degrees.

**PARTIAL THICKNESS BURNS** - First degree burns are superficial burns involving only the epidermis. The skin will be red and may be tender.

**SECOND DEGREE BURNS** - Involve the epidermis and part of the dermal layer. The skin will be red and blistered. Because sensory nerves are partially damaged, the patient will report extreme pain.

**FULL THICKNESS BURNS** - Third degree, full thickness burns destroy both layers of the skin. These burns will have a whitish or charred appearance and a tough, leathery feeling. Sensory nerves are destroyed in full thickness burns, therefore, all sensation is lost in the burned area.

**EXTENTS OF BURN** - Various methods are available to determine the extent of the burn surface. The "Rule of Nines" is the most universal guide to make an initial estimate.
**Stroke (CVA)**

**ABC’S**
- secure as needed

**OXYGEN**
- Nasal Cannula 1-6 lpm
- NRB 15 lpm

**ASSESSMENT**
- vitals
- history
- physical

- Airway control
- Blood pressure
- Pupils
- LOC
- Motor and sensory ability
- Facial expression

**SYMPTOMATIC?**
- decrease LOC
- decrease neurological function

- Yes

**POSSESSION PATIENT**
- affected side down
- position of comfort

**TRANSPORT**
- move to unit
- begin transport
- contact receiving facility

**EMT-B**
- move to unit
- begin transport
- contact receiving facility

**EMT-I**
- move to unit
- begin transport
- contact receiving facility

**Paramedic**
- move to unit
- begin transport
- contact receiving facility

**ECG**
- monitor

**IV**
- .9 % NACL TKO

**Paramedic Considerations**
- Contact medical direction for orders if systolic B/P > 100
- Approved Meds:
  - Clonidine p.o. 0.1, 0.2, 0.3mg
  - Labetalol 20mg IV over 2 minutes

This form supersedes no other
Pre-hospital Stroke Screen

Signs and Symptoms
- altered mental status
- impaired speech (aphasia or dysarthria)
- confusion/agitation
- uncoordinated movements/gait disturbance
- severe headache
- one-sided weakness (hemiparesis)
- one-sided paralysis (hypertension)
- hypertension
- lethargy/stupor/coma
- seizures
- vision disturbances
- unevenly dilated pupils

Have pt perform following activities

Have pt look up at you, smile, and show his/her teeth
Facial droop present  YES___  NO____

Have pt lift arms up and hold them out with eyes closed for ten seconds
Arm Drift       YES____      NO____

Have pt say "you can't teach an old dog new tricks".
Abnormal/slurring of speech     YES___      NO___

If yes to one or more treat pt per CVA algorhythm

This form supersedes no other
Chest Injuries - Trauma

ABC’S
- secure as needed

- Seal sucking chest wounds
- Stabilize flail segment

OXYGEN
- Nasal Cannula 1-6 lpm
- NRBM 15 lpm

- Mechanism of injury
- Lung sounds
- Tracheal deviation
- Subcutaneous emphysema
- Obvious deformity

ASSESSMENT
- vitals
- history
- physical

- Stabilize flail segment

IMPALED OBJECTS
- stabilize

SPINAL IMMOBILIZATION
- full spinal immobilization, as indicated by MOI

TRANSPORT
- move to unit
- begin transport immediately
- contact receiving facility

EMT-B

EMT-I

- LR or NS
- Maintain systolic B/P of 100

Paramedic

- Monitor

IV

ECG

TENSION PNEUMOTHORAX

- Unnecessary time should not be spent on the scene to stabilize chest injuries
- Open chest wounds should be dressed with occlusive dressing taped on all four sides, unless tension pneumothorax develops; release one corner

This form supersedes no other

KBEMS Form 30 087
090801
CHEST INJURIES S / S & TREATMENT

Simple Rib Fractures
1. Complete general management
2. Stabilize chest wall over sites of pain (patient's hand and arm is best method)

ADULT
Open Chest Wounds
1. Complete general management
2. Seal open wound on deepest exhalation
   use vaseline gauze
   monitor very closely for tension pneumothorax
   be prepared to release pressure if tension develops

Flail Chest
1. Complete general management
2. Stabilize chest wall with light sand bag or IV bag
3. Monitor closely for tension pneumothorax

Tension Pneumothorax
1. Complete general management
2. Decompress the chest with Nightingale Pneumothorax set
   s/s
   1. Mild to severe dyspnea
   2. Diminished or absent breath sounds
   3. Anxious/restless
   4. Tachypnea
   5. Tachycardia
   6. Distended neck veins
   7. Tracheal deviation away from the affected side
   8. Cyanosis (late)
   9. Hypotension
   10. Subcutaneous emphysema
   11. Hyperresonance to percussion on affected side

Hemothorax
1. Complete general management
2. Transport rapidly
   s/s
   1. Dyspnea
   2. Anxiety
   3. Restlessness
   4. Tachycardia
   5. Tachypnea
   6. Hypotension
   7. Diminished or absent breath sounds on affected side
   8. Dullness to percussion on the affected side.
   9. Neck veins may be flat or distended

Simple Pneumothorax
1. Complete general management
2. Transport rapidly
3. It should be noted that a simple pneumothorax will not always have Sub-Q subcutaneous emphysema and should be treated symptomatically and monitor breath sounds closely.

Traumatic Asphyxia
1. Complete general management
   s/s
   1. Deep violet color of the skin of the head and neck
   2. Bilateral subconjunctival petechial hemorrhages
   3. Facial edema
   4. Hematemesis
   5. Chest deformity
   6. Signs and symptoms of shock

Pericardial Tamponade
1. Complete general management
2. May include pericardial centisis
CHEST INJURIES S / S & TREATMENT

**ADULT**

**Myocardial Contusion**
1. Complete general management
2. When monitoring ECG, be especially observant for arrhythmias which may result from myocardial injury
   s/s:
1. Chest pain
2. Dyspnea
3. Arrhythmias
4. Bruising over chest
5. There may be tachycardia, irregular and/or weak pulse

**Traumatic Aortic Rupture**
1. Complete general management
   **Traumatic Aortic Rupture usually results from deceleration or blunt trauma. One third to one half of patients with an aortic rupture may have no signs of chest trauma.**
   s/s:
1. Upper-extremity hypertension with diminished lower-extremity pulses
2. Retrosternal or intrascapular pain
3. Dyspnea from tracheal compression and deviation
4. Stridor or hoarseness from compression of the recurrent laryngeal nerve

**Larynx / tracheobronchial Tree Injuries**
1. Complete general management
   Consider transtracheal jet insufflation
   Consider cricothyrotomy
   If unable to perform these procedures instruct the patient to breathe slowly. Slow breaths create less negative pressure on the walls of the trachea; thus ther is less chance the trachea will close completely.
2. Decompress tension pneumothorax as indicated
   **50% of deaths from these injuries occur within one hour**
   s/s:
1. Pneumothorax may develop into tension pneumothorax
2. Hemoptysis
3. Dyspnea
4. Subcutaneous emphysema
5. Cyanosis
8. Hamman's sign-crunching sound heard with each heart beat during auscultation of the heart

**Precautions:**
1. Unnecessary time should not be spent at the scene attempting to "stabilize" chest injuries when transport time is short
2. Do not be "blind" to the relative contraindication of the use of the PASG in injuries above the diaphragm. In certain instances, it may definitely be indicated and appropriate
3. Most major trauma to the chest requires your consideration to accompanying cervical and thoracic spine injury so extricate with C-collar and spine board.
4. In the smaller and rural communities, many major chest injuries will require inter-hospital transfer to the nearest facility with cardiopulmonary specialists following stabilization thus another reason to move efficiently and expeditiously on the scene
5. A hemothorax rarely causes tension and should not be evacuated in the field. It may be tamponading a vessel otherwise uncontrollable.

This form supersedes no other

KBEMS Form 30 087
090801
Abdominal Injuries – Trauma

ABC’S
- secure as needed

OXYGEN
- Nasal Cannula 1-6 lpm
- NRBM 15 lpm

ASSESSMENT
- vitals
- history
- physical
- Mechanism of injury
- Bowel sounds

TREAT FOR SHOCK
- Refer to shock protocol

SPINAL IMMOBILIZATION
- full immobilization if
- if indicated by MOI

EMT-B
TRANSPORT
- move to unit
- begin transport
- contact receiving facility

EMT-I
TRANSPORT
- move to unit
- begin transport
- contact receiving facility

Paramedic
TRANSPORT
- move to unit
- begin transport
- contact receiving facility

IV
.9 % NACL
Maintain systolic B/P of 100

ECG
- Monitor

IV
.9 % NACL
Maintain systolic B/P of 100

Considerations
- Treat associated injuries while enroute
- Suspect spinal injury with gunshot or long knife wounds
- Cover evisceration’s with moist sterile dressings
- Stabilize impaled objects before moving
  - Give nothing by mouth
  - Multiple IV lines to maintain B/P

This form supersedes no other
Head Injuries

ABC’S
- secure as needed

C-SPINE
- examine neck
- apply c-collar
- maintain manual stabilization

OXYGEN
- Nasal Cannula 1-6 lpm
- NRBM 15 lpm

ASSESSMENT
- vitals
- history
- physical

SPINAL IMMOBILIZATION
- full spinal immobilization

Considerations / Precautions
- KED for sitting patients
- Refer to shock protocol if indicated
- Monitor LOC and pupils frequently
- Vomiting is common with head and spinal injuries
- Avoid hyperventilating head injuries

- LOC
- Pupils
- Mechanism of injury
- Hematomas
- Lacerations
- Depressions
- Battle Signs (late sign)

EMT-B

EMT-I

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

IV
.9 % NACL
Maintain systolic B/P of 100

ECG
- Monitor

IV
.9 % NACL
Maintain systolic B/P of 100

This form supersedes no other
Spinal Trauma

ABC’S
- secure as needed

C-SPINE
- assess neck
- apply collar
- maintain manual stabilization

OXYGEN
- NRBM 15 lpm

SPINAL IMMOBILIZATION
- full spinal immobilization

ASSESSMENT
- vitals
- history
- physical

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

EMT-B
- Continue transport
- Secondary assessment

EMT-I
- IV .9 % NACL
- Maintain systolic B/P of 100

Paramedic
- IV .9 % NACL
- Maintain systolic B/P of 100
- ECG
- monitor
- Consider 125 – 250 mgs Solu Medrol

Considerations
- Treat life threatening injuries ASAP
- Provide additional management if transport allows

This form supersedes no other
**Multiple Systems Trauma**

- **ABC’S**
  - secure as needed

- **C-SPINE**
  - assess neck
  - apply collar
  - maintain manual stabilization

- **OXYGEN**
  - NRBM 15 lpm

- **SPINAL IMMOBILIZATION**
  - full spinal immobilization

- **ASSESSMENT**
  - vitals
  - history
  - physical
  - LOC
  - O2 saturation
  - Scene time < 10 min.

- **TRANSPORT**
  - move to unit
  - begin transport
  - contact receiving facility

- **EMT-B**
  - TRANSPORT
    - Continue transport
    - Secondary assessment

- **EMT-I**
  - **IV**
    - .9 % NACL
    - Maintain systolic B/P of 100

- **Paramedic**
  - **IV**
    - .9 % NACL
    - Maintain systolic B/P of 100

  - **ECG**
    - monitor

  - **TRANSPORT**
    - Secondary Assessment

**Considerations**
- Treat life threatening injuries ASAP
- Provide additional management if transport allows

This form supersedes no other
Orthopedic Injuries

ABC’S
- secure as needed

OXYGEN
- as needed
- Nasal Cannula 1-6 lpm
- NRBM 15 lpm

ASSESSMENT
- vitals
- history
- physical

- Treat other more serious injuries first
- Control severe bleeding/open wounds
- Assess neuro-vascular function
- Assess pulses

STABILIZE
- apply in-line traction
- immobilize site with appropriate splint
- apply ice when possible

ARE
- multiple fractures
- femur/pelvic fractures
- severe pain
- signs of shock

PRESENT?
- move to unit
- begin transport
- contact receiving facility

No

Yes

EMT-B

EMT-I

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

IV
.9 % NACL
TKO

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

IV
.9 % NACL
TKO

Consider analgesics

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

Paramedic
Orthopedic Injuries

Fracture Immobilization Procedure

- Angulated long bone fractures should be straightened.
- Injuries involving joints should be splinted in the position found unless there is neurovascular compromise. You may then attempt to straighten the extremity one time.
- Consider using MAST for multiple fractures involving the lower extremities.
- Immobilize the extremity before moving the patient whenever possible.
- Immobilize joints above and below the fracture site.
- Too much traction can distract fractures and compromise circulation. If neurovascular function is diminished or lost following application of traction, gently release traction until circulation is restored.

Care of Amputated Part

- Rinse part gently with normal saline to remove loose debris; do not scrub
- Wrap amputated part in gauze moistened with saline and transport with patient.
- Place wrapped part in plastic bag and seal with tape (do not immerse part in water/saline). Label with name, date and time.
- For long transport, wrap amputated part as listed above and keep cool. Place in cooler with cold pack or ice, but not in direct contact with ice.

Orthopedic Emergencies

- Open Fractures
  - Long bone fractures with joint dislocation.
- Fracture with neuro-vascular embarrassment that is irreversible in the field.
  - Fractures with large blood loss or associated serious injury.
    - Absent pulses distal to the fracture site.

This form supersedes no other
Drowning or Near Drowning

**ABC'S**
- secure as needed
- CPR if indicated

**OXYGEN**
- BVM
- NRBM 15 lpm

**C-SPINE**
- assume spinal injury
- refer to spinal injury protocol

**ASSESSMENT**
- vitals
- history
- physical
- Lung sounds
- O2 saturation

**REMOVE CLOTHING**
- remove wet clothing
- cover with dry blankets

**EMT-B**
**TRANSPORT**
- move to unit
- begin transport
- contact receiving facility

**EMT-I**
**TRANSPORT**
- move to unit
- begin transport
- contact receiving facility

**Paramedic**
**TRANSPORT**
- move to unit
- begin transport
- contact receiving facility

**IV**
- .9 % NACL TKO

**IV**
- .9 % NACL TKO

**ECG**
- monitor
Drowning and Near Drowning

Considerations

- Scene assessment should include the following:

  1. Submersion time
  2. Water surface temp. and depth if possible
  3. MOI
  4. Type of clothing or floatation device
  5. Location victim last scene
  6. Time of last meal/fluids ingested

- If shocks are to be given, dry patient as much as possible before administration

- Resuscitation should be considered if submersion has been < 2 hrs. and if water temp. is < 70 degrees

- For every 10-ft. change in water depth may result in a 2-degree change in water temp.

- Any patient with significant submersion accident should be transported due to possible aspiration, pulmonary edema or pulmonary complications

This form supersedes no other
Anaphylaxis

ABC’S
- secure as needed

OXYGEN
- Nasal Cannula 1-6 lpm
- NRBM 15 lpm

ASSESSMENT
- vitals
- history
- physical

- Known sensitivities and allergies
- Onset of symptoms and source of toxin
- Pt. medications

- Be alert for rapidly progressing airway obstruction

LOOK FOR
- allergen and route of exposure
- urticaria
- diffuse erythema
- dyspnea
- flushing
- cough and/or stridor

ASSESSMENT
- Known sensitivities and allergies
- Onset of symptoms and source of toxin
- Pt. medications

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

EMT-B
EMT-I
Paramedic

TRANSPORT
- move to unit
- begin transport
- contact receiving facility

IV
.9 % NACL
TKO

IV
.9 % NACL
TKO

Pediatric Considerations
- Obtain order
  - SQ Epinephrine 0.15 mg
  - IM or IV Benadryl 1mg/kg; not to exceed 50 mg

Epinephrine
- 0.3 - 0.5 mg SQ 1:1000
- 0.3 mg IV 1:10,000 if hypotensive or 1:1000 ineffective

Benadryl
- 25 – 50 mg IV or IM

Consider nebulized Albuterol for respiratory distress
Consider Solu-Medrol 125 – 250 mgs

ECG
- monitor

This form supersedes no other

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