

# ***Criteria Based Dispatch***

## **Emergency Medical Dispatch Guidelines Sixth Edition - July, 2010**

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## ***Introduction to Criteria Based Dispatch***

Criteria Based Dispatch (CBD) is an Emergency Medical Dispatch (EMD) triage program that is based on patient signs and symptoms collected by 911 dispatchers. Comparing the patients' initial signs/symptoms at the time of the call, to the field report findings allows for the review of dispatch accuracy. Over the years these findings have provided an excellent avenue to adjust dispatch criteria, creating better patient care and more efficient resource utilization. The Criteria Based Dispatch Guidelines is the tool the dispatcher uses to perform the challenging duties of emergency medical dispatching.

### **How do guidelines differ from protocols?**

Protocols generally define very specific questions or an algorithm to be used during patient interview and triage. Guidelines, however, provide direction and assist in decision-making, without structuring the course of action to the point that it becomes restrictive or limits the dispatchers' ability to quickly gather critical information and take action. In CBD, guidelines are used to define appropriate levels of care in order to assist dispatchers in determining whether to send ALS or BLS units. Both the basic emergency medical dispatch and continuing medical education courses reinforce the use of these guidelines with a focus on the critical systems and the need to quickly identify patients that are unstable or "sick".

### ***YELLOW Tab Section***

The basics for understanding the CBD Guidelines are included in the Yellow Tab section. This overview provides a background on Dispatch Criteria/Response Levels, Vital Points Questions, Pre-Arrival Instructions, Short Reports, All Caller Interview, Response Modes and Initial Dispatch Codes (IDCs). The IDC is extremely important as this data provides the feedback needed to check the system performance. The yellow section also includes:

**Glossary and Medical Abbreviations** – A glossary with medical term definitions and a list of commonly used medical abbreviations.

**All Callers Interview:** The purpose of the All Callers Interview is to obtain identifying information from the caller and determine the chief complaint. Interviewing callers and obtaining the best information in the least amount of time is the backbone of successful dispatching. Dispatchers are responsible for helping to guide the callers through the triage process. The All Callers Interview must be used in every call.

### ***GREEN and BLUE Tab Section***

**Dispatch Criteria/Response Levels:** The Dispatch Criteria describe FOUR separate response level modes based on the urgency in which care must be provided to the patient and the level of care required.

#### **RESPONSE MODES:**

- **MEDIC** - Medic unit (ALS response) together with Basic Life Support unit (BLS response) sent Code Red.
- **BLS Code Red** - BLS unit responds with lights and siren.
- **BLS Code Yellow** – BLS unit responds obeying speed limits and traffic laws. BLS criteria may not always be emergent. Use of BLS Red or BLS Yellow is determined by local agency policy.
- **TRP** - (Telephone Referral Program) - Calls are transferred from dispatch to a consulting nurse line. No BLS unit is sent. If police request a response for a patient that meets TRP criteria, a BLS unit should be sent. (See Police ("P") coding.)

Dispatchers must first determine if any MEDIC criteria are present in order for a MEDIC unit to be dispatched. Specific MEDIC criteria (only one required) must be confirmed in order for a MEDIC unit to be dispatched. If no MEDIC criteria are present, dispatchers should move to the BLS RED category and again confirm a criteria present for a BLS RED response. No BLS RED criteria prompts the dispatcher to move to the BLS YELLOW category and lastly, if no BLS criteria are present, the TRP line is accessed.

**Vital Points Questions:** These questions serve two purposes – to assist the dispatcher in identifying the Dispatch Criteria and to gather additional information to be relayed to responding units. The Vital Points questions coincide with the dispatch criteria, however, there is NO REQUIREMENT to ask these questions. The Vital Points questions are there to assist the call-receiver/dispatcher in determining the appropriate response level.

REVISED 07/10

**Pre-arrival Instructions (PAI):** Pre-arrival instructions should be offered in all cases, except when workload does not allow.

**Short Report:** The short report consists of the age and gender of the patient, chief complaint(s), pertinent related symptoms, relevant medical/surgical history, DANGER TO RESPONDING UNITS and other agencies responding. Other information, such as specific access instructions, is helpful. The dispatcher provides the Short Report to the responding units as soon as possible after toning the units out for response.

**Background Information:** The page above each chief complaint offers the dispatcher a quick review to help understand the chief complaint category and is intended to be used for ongoing learning and review.

#### **Initial Dispatch Codes (IDC):**

Immediately to the left of each criteria is an Initial Dispatch Code (IDC). This code must be assigned at the time of dispatch and reflects the CRITERIA used by the dispatcher to select the LEVEL OF RESPONSE.

- The IDC code may be upgraded or downgraded by the dispatcher during the interview.
- The final IDC code selected should be based on the dispatcher's decision and in most cases should reflect the actual level of response the dispatcher sent on the call. An exception to this is when EMTs request an ALS unit from the scene, see next bullet.
- (Request from Scene) The Initial Dispatch Code should be changed after units are dispatched when the BLS Unit requests a Medic Unit to be dispatched. When this occurs, the alpha/letter in the IDC code should be changed to a "Q" to indicate Request from Scene. **At no time should an IDC code be changed based on an EMT/Paramedic diagnosis or information about the patient received from the aid personnel or paramedics after arrival at the scene.**
- When requesting a MEDIC unit to be dispatched into your area, all attempts should be made to relay the IDC to the primary dispatch center dispatching that MEDIC unit.

#### **Special IDC Codes - 99M9, 99R9 or 99Y9 Codes**

There are four instances when it may not be possible to assign an Initial Dispatch Code to an incident. These include the following types of cases:

1. Still Alarms (walk-ins or calls coming directly into a fire station).
2. On-view accidents.
3. Interhospital patient transports.
4. When receiving a request for a unit to be dispatched from a communications center that was not able to interview the reporting party, and no IDC Code has been assigned. Always obtain an IDC code from the initial communications center, if possible.

##### **The Initial Dispatch Codes for these instances should be as follows:**

- 99M9** - Medic unit was involved.
- 99R9** - BLS unit only (Code Red) was involved.
- 99Y9** - BLS unit only (Code Yellow) was involved.

**"Q" Codes** – When a BLS Unit requests a Medic Unit to be dispatched after the BLS unit arrives at the scene, the alpha/letter in the IDC code should be changed to a "Q" to indicate Request from Scene (Example: Change 5R4 to 5Q4).

**"P" Codes** - If a patient meets the TRP criteria, but police have requested a response, a BLS unit should be sent. These calls should be coded with a 'P' as the letter in the code. For example, a patient meets 21T1 criteria, the call should be coded as 21P1 and a BLS unit dispatched. The 'T' is simply replaced with a 'P' to indicate a "police request" which should be honored.

#### **RED Tab Section**

**Critical Life-Threatening Cases:** Pre-arrival instructions (PAIs) for life-threatening medical emergencies are outlined in this section to provide the dispatcher with instructions to aid the caller in assisting a critically ill patient.

## BASIC MEDICAL ABBREVIATIONS AND TERMINOLOGY

Abd	Abdominal	Hx	History
Abras	Abrasion	ICU	Intensive Care Unit
Acc	Accident	Inj	Injury
AOB	Alcohol on Breath	Lac	Laceration
BCA	Bicycle Accident	LBP	Low Blood Pressure (Hypotension) <u>or</u> Lower Back Pain
BP	Blood Pressure	LOC	Level of Consciousness
CA	Cancer or Cardiac Arrest	MCI	Multiple Casualty Incident
CCU	Coronary Care Unit	MCA	Motorcycle Accident
CHF	Congestive Heart Failure	MI	Myocardial Infarction (Heart Attack)
C/O	Complains of...	MICU	Mobile Intensive Care Unit (Medic Unit)
CONSC	Conscious	MSDS	Material Safety Data Sheet
(COPD)	Chronic Obstructive Pulmonary Disease (Asthma, Emphysema, etc.)	MVA	Motor Vehicle Accident
CP(C/P)	Chest Pain	NTG	Nitroglycerin
CPR	Cardiopulmonary Resuscitation (AKA: Mouth to Mouth)	O <sub>2</sub>	Oxygen
CVA	Cerebro-Vascular Accident (Stroke)	OD	Overdose
DEFIB	Defibrillation	P	Pulse
DKA	Diabetic Ketoacidosis	POV	Privately-operated Vehicle
DOA	Dead on Arrival	Pt	Patient
ED	Emergency Department	Px	Pain
EMD	Emergency Medical Dispatch	RHR	Rapid Heart Rate
EMT	Emergency Medical Technician	R/O	Rule out (determined not to be, as in R/O MI or R/O Fx leg)
EPI	Epinephrine	Rx	Treatment
ER	Emergency Room	SIDS	Sudden Infant Death Syndrome
ETOH	Alcohol Intoxication	SOB	Short of Breath (Dyspnea)
Fx	Fracture	STHB	Said to have been...
GI	Gastro-Intestinal (Example: GI Bleed, possible perforated ulcer)	TIA	Transient Ischemic Attack (Cerebrovascular related)
GOA	Gone on Arrival (Victim or patient has left scene of incident)	UNCONSC	Unconscious
GSW	Gunshot Wound	VF	Ventricular Fibrillation
HBP	High Blood Pressure (Hypertension)	VS	Vital Signs
		WOB	Work of Breathing

**Note:** When entering information into CAD, use only acronyms consistent with your agency policies.

REVISED 07/10

## GLOSSARY OF TERMS

ABRASION	An injury caused by the scraping or rubbing of skin against a rough surface.
ALIMENTARY CANAL	Organs of digestion.
ANAPHYLACTIC SHOCK	A sudden, severe, often life-threatening allergic reaction that is characterized by low blood pressure, shock (inadequate tissue perfusion) and difficulty breathing.
ANEURYSM	Ballooning of an artery due to the pressure of blood flowing through a weakened area resulting from disease, injury or defect of the blood vessel wall.
ANGINA PECTORIS	Spasmodic chest pain characterized by a sense of severe constriction in the chest.
ANOXIA	Absence or lack of oxygen.
AORTA	The main artery from the heart.
APNEA	Absence of respiration.
ARRHYTHMIA	An abnormality of the rhythm or rate of the heartbeat.
ASPHYXIA	Suffocation.
ASPIRATE	To breathe liquid or foreign material into the lungs.
ASTHMA	A respiratory condition caused by bronchiolar spasm.
AVULSION	Forcible separation or tearing away of a body part or tissue.
BRADYCARDIA	Slow heart rate.
CARDIAC	Pertaining to the heart.
CEREBRAL	Pertaining to the brain.

CERVICAL SPINE	The first seven bones of the spine, found in the neck.
CHF	(Congestive Heart Failure) - Cardiac failure, characterized by increased blood pressure and pulmonary edema.
CHOLECYSTITIS	Inflammation of the gallbladder.
CLAVICLE	The collarbone or the bone that links the sternum and the scapula.
COLOSTOMY	An operation in which part of the large intestine is brought through an incision in the abdominal wall to allow the discharge of feces.
COMA	A state of unconsciousness from which the patient does not respond to external stimuli.
COMBATIVE	Eager to fight or struggle.
CONTUSION	An injury in which the skin is not broken; a bruise.
COPD	(Chronic Obstructive Pulmonary Disease) - A group of diseases in which there is persistent disruption of airflow into or out of the lungs, including chronic bronchitis and emphysema.
CORONARY ARTERIES	The blood vessels that supply blood directly to the heart muscle.
CPR	(Cardiopulmonary resuscitation) - The artificial maintenance of circulation of the blood and movement of air into and out of the lungs in an unconscious, non-breathing patient.
CVA	(Cerebral vascular accident) - A stroke; a condition characterized by impaired blood supply to some part of the brain.
CYANOSIS	(Cyanotic) - A bluish or purplish discoloration of the skin due to a lack of oxygen in the blood.
D5W	An intravenous (IV) solution of glucose (sugar) in water.
DECAPITATION	Amputation of the head.

## GLOSSARY OF TERMS (Continued)

DEFIBRILLATION	Electrical shock to the heart muscle to produce a normal spontaneous rhythm. The act to arrest the fibrillation of heart muscle by applying electrical shock across the chest thus depolarizing the heart cells and allowing a normal rhythm to return.
DIABETES	A metabolic disorder in which the ability to metabolize carbohydrates (sugars) is impaired, usually because of a lack of insulin.
DIAPHORETIC	Profuse perspiration, cold, clammy skin.
DIAPHRAGM	A muscular wall separating the thoracic and abdominal cavities. The major muscle of breathing.
DIARRHEA	Abnormal frequency and fluidity of fecal evacuations.
DIASTOLE	The resting period of the heart muscle. Diastolic pressure is the pressure exerted on the internal walls of the arteries during this resting period. This is the second (or bottom) number when referring to blood pressure measurements.
DT's	(Delirium tremens) - A disorder involving visual and auditory hallucinations from habitual and excessive use of alcohol.
DUODENUM	(Duodenal) - The first part of the small intestines.
DYSPNEA	Air hunger resulting in labored or difficult breathing.
EDEMA	An excessive amount of fluid in the tissues.
EMBOLISM	Obstruction of a blood vessel by a foreign substance most commonly due to a blood clot.
EMESIS	Vomiting & vomit.
EMETIC	An agent which produces vomiting.
EMPHYSEMA	A chronic pulmonary disease where the lungs progressively lose their elasticity which can result in respiratory distress.

EPIGLOTTIS	A lid-like cartilaginous structure at the entrance to the larynx to prevent food from entering the larynx and trachea while swallowing.
EPILEPSY	Recurring transient attacks of disturbed brain function, frequently altered state of consciousness or seizures.
EPISTAXIS	Nose bleed.
ESOPHAGITIS	Inflammation of the esophagus.
ESOPHAGUS	(Esophageal) - A muscular canal extending from the throat to the stomach.
FEBRILE	Pertaining to fever.
FEBRILE SEIZURE	Febrile convulsions due to high fever in small children.
FEMUR	The thigh bone.
FIBRILLATION	Quivering or spontaneous contraction of individual muscle fibers (applicable in EKG readings).
FIBULA	The outer and smaller of the two bones extending from the knee to the ankle.
FIRST PARTY REPORT	A report taken by talking directly to the patient.
FLAIL CHEST	A condition of the chest caused by severe injury resulting in several ribs fractured in more than one place leaving a segment of the chest wall to move at opposition to the normal breathing motion.
FRACTURE	A broken bone.
GI	(Gastrointestinal) - Pertaining to the stomach and intestine.
GRAND MAL	A seizure or convulsion typically characterized by unconsciousness and generalized severe twitching of all of the body's muscles.
HEMATOMA	A swelling or mass of blood confined to an organ, tissue or space, resulting from a break in a blood vessel.
HEMORRHAGE	Abnormal internal or external discharge of blood.
HIVES	Intensely itching welts usually caused by an allergic reaction to a substance or food.
HUMERUS	Upper bone of the arm from the elbow to the shoulder.

## GLOSSARY OF TERMS (Continued)

HYPERGLYCEMIC	Abnormally high glucose level in the blood.
HYPERTENSION	High blood pressure.
HYPERTHERMIA	Having a body temperature above normal, >98.6.
HYPOGLYCEMIC	Deficiency of sugar in the blood.
HYPOTENSION	Low blood pressure.
HYPOTHERMIA	Having a body temperature below normal, <98.6.
HYPOXIA	Inadequate supply of oxygen to the body tissues.
HYPOXIC SEIZURE	Seizure resulting from an oxygen deficit.
INSULIN	A hormone secreted by the pancreas which aids the body in the metabolism of sugar.
IPECAC	(Syrup of Ipecac) A dried root of a shrub found in South America, used to induce vomiting.
ISCHEMIA	Local and temporary anemia due to obstruction of the circulation to a part.
JEJUNUM	That portion of the small intestine that extends from the duodenum to the ileum.
KETOACIDOSIS	An accumulation of certain acids in the blood occurring when insulin is not available in the body.
LACERATION	A wound or irregular tear of the flesh.
LARYNGECTOMY	Total removal of the larynx.
LARYNX	The organ of the throat responsible for voice production and for preventing food from entering the trachea. Commonly called the voice box.
MANDIBLE	The lower jawbone.
MAXILLA	Forms the upper jaw.

MEDIC ALERT TAG	A bracelet or necklace containing information on a patient's medical history, allergies, etc.
MENINGES	The 3 membranes that cover and protect the brain and spinal cord (dura mater, arachnoid mater and pia mater).
MENINGITIS	Inflammation of the meninges.
MI	(Myocardial infarction) - The death of an area of the heart muscle from a deprivation in the blood supply to that location.
MOBILE INTENSIVE CARE UNIT	(Medic Unit) A self contained ambulance staffed by paramedics designed to provide specialized emergency medical (MICU) care for serious conditions.
NITROGLYCERIN	Medication used in the treatment of angina pectoris (chest pain).
OCCLUSION	The closure of a passage.
PALPATION	Examination by touch; generally used to describe obtaining a pulse.
PALPITATION	Rapid, violent or throbbing pulsation, as an abnormally rapid throbbing or fluttering of the heart.
PANCREAS	A large elongated gland situated behind the stomach; the source of many digestive enzymes and the hormone insulin.
PANCREATITIS	Inflammation of the pancreas.
PARALYSIS	Temporary suspension or permanent loss of function, especially loss of sensation or voluntary motion.
PERICARDIAL SAC	The fibrous membrane covering the heart.
PERISTALSIS	The progressive contraction of muscles that propels food down the gastrointestinal tract.
PERITONITIS	Inflammation of the lining of the abdomen.
PETIT MAL	Mild form of epileptic attack, may involve loss of consciousness, but does not involve convulsions.

## GLOSSARY OF TERMS (Continued)

PNEUMOTHORAX	A collection of air in the chest cavity caused by punctures of the chest wall or lungs.
POLST	Physicians orders for life sustaining treatment. May include order for DO NOT RESUSCITATE.
RADIUS	The bone on the outer (or thumb side) of the forearm.
RINGERS	Normal saline solution that includes other elements present in blood, such as potassium and calcium.
SCAPULA	Shoulder blade.
SECOND PARTY	A report taken from a person who is with the patient, or has direct contact with someone who is with the patient.
SEIZURE REPORT	A sudden episode of uncontrolled electrical activity in the brain (convulsion).
SIDS	(Sudden Infant Death Syndrome) The sudden, unexpected death of an infant, which often cannot be explained even after an autopsy. It usually occurs between 1 month - 1 year.
SPOTTING	Vaginal bleeding less than a normal period.
STOMA	A permanent surgical opening in the neck of a patient who has had a tracheostomy.
STOOL	Feces.
SYNCOPE	Fainting (also syncopal episode).
SYSTOLE	The period of muscular contraction of the heart muscle. Systolic pressure is the pressure exerted on the internal walls of the arteries during this period of muscular contraction. This is the first (or top) number when referring to blood pressure measurement.
TACHYCARDIA	Fast Heart rate.
TELEMETRY	Transmission of medical information (i.e., EKG) via electronic equipment.

TENSION PNEUMOTHORAX	Develops when air is continually pumped into the chest cavity outside the lung and is unable to escape; it is associated with compression of the lung and heart.
THIRD PARTY REPORT	A report taken from a person who is neither with the patient nor at the scene of the incident.
THORAX	The chest.
TIA	(Transient ischemic attack) - Temporary interference with the blood supply to the brain, like a stroke but without permanent damage.
TIBIA	The inner and larger of the two bones which extend from the knee to the ankle.
TRACHEA	The windpipe.
TRACHEOSTOMY	A surgical operation that creates an opening to the trachea for direct use as an airway.
TRAUMA	An injury to the body.
TRIAGE	The sorting or selection of patients to determine priority of care to be rendered to each.
ULCER	A lesion on the surface of the skin or membrane, usually accompanied by inflammation.
UNILATERAL	One-sided (as in stroke).
ULNA	The inner and larger bone of the forearm, on the opposite side from the thumb.
VERTEBRA	Any of the bones of the spinal column.
VERTIGO	An illusion that one's surroundings are spinning. Dizziness.
XIPHOID PROCESS	The cartilage at the lower end of the sternum.
SYMBOLS:	Less than: < Less than or equal to: ≤ Greater than: > Greater than or equal to: ≥

## All Callers - Interview

**\*Questions #1 - 5 as directed by your agency or your Center's established greeting.**

1. 9-1-1, What are you reporting?
2. What is the address of the patient?
3. What is patient's age/sex?
4. What is the telephone number you are calling from?
5. What is your name?

**6. Is the person conscious (*awake, responding to you*)?**

***If no:*** Go directly to Question #7.

***If yes:*** Go directly to Other Conditions.

**7. Is the person breathing Normally? If uncertain: Bring the telephone to the patient and check to see if the chest is rising and falling.**

***If no:*** Go directly to Unconscious and NOT breathing normally below.

***If yes:*** Go directly to Unconscious and breathing normally below.

***If R/P is still uncertain or describes the breathing as anything other than normal, go directly to Unconscious and NOT breathing normally below.***

8. I have advised the dispatcher to send help.\* - **Stay on the line.** My questions are not delaying the response.

**Unconscious and NOT breathing normally:** Dispatch **MEDIC** response.

Is there a defibrillator nearby? If premise information is available, tell the caller where the machine is located.

If there is more than one person present, consider having 1 perform CPR while the other retrieves the AED.

**If YES:** Go directly to **AED Instructions**.

**If NO:** "The patient needs CPR, listen carefully, I'll tell you what to do". - Go to **age-appropriate CPR instructions**.

**Unconscious and breathing normally:** Dispatch **MEDIC** response.

Go directly to **Unconscious/Breathing Normally Emergency Instructions** and Unconscious/Syncope Chief Complaint for Pre-arrival Instructions.

**Other Conditions:**

*Determine appropriate response level and dispatch Medic or BLS*

I have advised the dispatcher to send help\* - **Stay on the line.** My questions are not delaying the response.

\* Local agency protocols for acceptable terminology should be followed.

**Background Information****Abdominal Pain**

Abdominal pain may be caused by many conditions, some of which may be life-threatening. It is important to remember that abdominal pain associated with critical signs/symptoms of shock always indicates an unstable patient requiring a paramedic evaluation.

**Critical causes of abdominal pain:**

- **Cardiovascular Disease (Myocardial Infarction, Angina)** - Which may present as upper abdominal pain or indigestion because of the shared nerves in the region of the thorax and upper abdomen.
- **Abdominal Aortic Aneurysm** - Most often presents with severe abdominal pain, often radiating to the back, flank, groin/testicles and/or legs. In addition, most commonly these complaints will be accompanied with signs and symptoms of shock.
- **Ruptured Ectopic Pregnancy** - Typically presents with lower quadrant localized abdominal pain in a woman of child-bearing age who may or may not be aware they are pregnant. The presence of signs and/or symptoms of shock indicate the severity of the volume (blood) loss which may or may not be externally evident.

- **Gastrointestinal Bleeding** - May be critical due to blood loss. Vomiting red blood or expelling dark, tarry stools could be critical and if so would most likely present with signs and symptoms of shock. Vomiting coffee ground-like material may also indicate an ulcer disease, but suggests a much less rapid blood loss, and is not necessarily critical unless there are other symptoms of blood loss such as syncope or near syncope when sitting/standing.

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**Non-critical causes of abdominal pain may include:**

- Gastroenteritis
- Appendicitis
- Bowel obstruction
- Pelvic inflammatory disease (PID)
- Gallbladder disease
- Kidney stone
- Gas secondary to constipation
- GERD - Gastric esophageal reflux disease

## Dispatch Criteria

### Medic Response

- 1M1 Unconscious or not breathing
- 1M2 Sign of shock: Syncope or near syncope when sitting/standing
- 1M3 Vomiting red blood, with sign of shock (syncope or near syncope when sitting/standing)
- 1M4 Black tarry stool, with sign of shock (syncope or near syncope when sitting/standing)
- 1M5
- 1M6
- 1M7

### BLS Red Response

- 1R1 Pain with vomiting
- 1R2 Abdominal/back pain, no sign of shock
- 1R3 Flank pain/back pain (kidney stone)
- 1R4
- 1R5 No verifiable info available from RP
- 1R6 Upper abdominal pain, age > 50
- 1R7

### BLS Yellow Response

- 1Y1 Groin injury
- 1Y2 Back/side/groin pain - non-ambulatory

### TRP

- 1T1 Pain unspecified
- 1T2
- 1T3 Chronic back pain - ambulatory
- 1T4 Side pain - ambulatory
- 1T5 Groin pain - ambulatory
- 1T6 Back pain - previous injury
- 1T7 Urinary catheter problem

## Vital Points

- Ask to speak directly to the patient, if possible!

### Medic:

- How does the patient look?
- How does the patient feel when they sit/stand up?
- Has the patient vomited?  
**If yes**, what does the vomit look like?
- Are the patient's bowel movements different than normal?  
**If yes**, how would you describe them?
- Is the pain above or below the belly button?
- Is there a possibility of pregnancy?
  - Has she felt dizzy?

### Short Report:

- Does the patient have any other medical or surgical history?
- Is the patient wearing a Medic Alert tag?

## Abdominal/Back/Groin Pain

### Pre-arrival Instructions

- If patient unconscious and vomiting, position patient on their side and continue to sweep vomit out.
- Nothing by mouth.
- Allow position of comfort.
- Gather patient meds.

### Short Report

- Gender
- Age
- Chief complaint
- Pertinent signs and symptoms
- Medical/surgical history, if relevant
- Other agencies responding

**Background Information****Anaphylaxis/Allergic Reaction**

Anaphylaxis and allergic reaction is caused by the over response of the body's natural immune system. Specifically, when the body has detected a foreign invader, most likely a protein called an antigen, it responds by releasing several chemicals that are charged with attacking and isolating the invading organism. In most cases, this process takes place with little or no noticeable effects. Most effects related to an allergic reaction, while uncomfortable, are not critical in nature. In anaphylaxis however, the life-threatening signs and symptoms include respiratory distress, signs and symptoms of shock and possibly difficulty swallowing due to swelling of the throat.

Allergic reactions may be caused by almost anything, with introduction into the body by one of four mechanisms:

- Ingestion
- Injection
- Inhalation
- Absorption

Most allergic reactions are benign and do not pose a serious threat. Presentations are commonly limited to rashes, itching and localized swelling. Reactions that pose a serious threat and are considered to be life-threatening are those which involve breathing difficulty and/or signs and symptoms of shock.

Anaphylaxis is a sudden, severe and potentially life-threatening allergic reaction that is commonly characterized by low blood pressure, signs and symptoms of shock and breathing difficulty. These symptoms can present individually or in some cases of severe reaction, present together as a systemic over-response.

**Critical symptoms of a severe allergic reaction/anaphylactic shock:**

- **Respiratory distress** occurs because of swelling of the throat or larynx - bronchospasm
- **Difficulty swallowing** occurs because of swelling of the throat
- **Sign of shock** (syncope/near syncope when sitting/standing) occurs because of decreasing blood pressure.

History of severe reaction involving respiratory distress, difficulty swallowing or signs of shock usually produces a more severe reaction to the same agent with each subsequent exposure.

Some very severe reactions may take up to an hour to manifest in some patients, however most patients will have a much quicker response. Many patients with a history of severe allergic reactions have an Epi Pen prescribed by their physician. The call-receiver should encourage the patient to use the Epi Pen **as directed by their physician.**

The speed in which the symptoms appear following exposure to the causing agent (sting, medication, food ingestion) generally dictates the severity of the reaction. However, reactions have been known to appear up to several hours post exposure. The complaints of the patient at the time of the call should dictate the response.

**Non-critical symptoms of allergic reactions include:**

- Hives
- Itching
- Swelling at site of bite
- Long duration of time since exposure

## Dispatch Criteria

### Medic Response

#### Anaphylaxis

- 2M1 Unconscious or not breathing
- 2M2 Respiratory Distress (one required):
  - Unable to speak normally (work of breathing)
  - Sitting, standing or leaning forward to breathe (tripod)
- 2M3 Audible wheezing or stridor
- 2M4 Swelling in throat, tongue or difficulty swallowing and unable to speak normally (work of breathing)
- 2M5 Sign of shock: Syncope or near syncope when sitting/standing
- 2M6

### BLS Red Response

#### Allergic Reaction

- 2R1 Epi pen used by patient/RP
- 2R2 Swelling in throat, tongue or difficulty swallowing
- 2R3 History of anaphylactic reaction occurring within 30 minutes of exposure
- 2R4
- 2R5 No verifiable info available from RP
- 2R6 Breathing difficulty

### BLS Yellow Response

### TRP

- 2T1 Concern about reaction, but no history
- 2T2 Reaction present for > 30 minutes, no breathing difficulty
- 2T3 Itching or hives, without breathing difficulty
- 2T4 History of allergic reaction, but none now
- 2T5 Side effect or minor reaction to medication

## Vital Points

- *Ask to speak directly to the patient, if possible!*

#### Medic:

- Is the patient speaking normally?
- Is the patient having any trouble breathing?
- Is the patient having difficulty swallowing?
- How does the patient look?
- How does the patient feel when he/she sits up?

#### BLS Red:

- Does the patient have a history of severe reaction to (substance)?  
**If yes**, describe the reaction the patient has had before.
- How long ago was the patient exposed?
- Are there any changes in the symptoms?
- Is the patient taking any medication?

#### Short Report:

- Is the patient wearing a Medic Alert tag?

## Anaphylaxis/Allergic Reaction

### Pre-arrival Instructions

- Allow position of comfort.
- Keep calm.
- If bee sting: brush stinger off if possible. Ice to sting.
- Gather patient meds.
- Do you have an Epi pen?  
If yes, have you used it?  
**Use as your physician has directed.**

### Short Report

- Gender
- Age
- Chief complaint
- Pertinent signs and symptoms
- Medical/surgical history, if relevant
- Other agencies responding

**Background Information**

At the midpoint in the 20th century infectious diseases appeared to have been under control through the use of immunizations, antibiotics and better sanitation techniques. By the early 1990's, public health experts recognized that modern demographic and environmental conditions, the ability for bacteria to evolve and adapt, and the ease and frequency of international travel all contribute to the ability of infection to spread further and faster.

In 1992, the Institute of Medicine urged several federal agencies to work with state and local health departments to reestablish local surveillance of infectious diseases and to promote efforts to detect and control emerging infectious diseases.

Most recently concerns about pandemic influenza have been raised and experts are using elaborate surveillance methods in order to track not only avian influenza, but humans contracting new strains of influenza as well. Most subject matter experts are convinced that a flu strain will produce a pandemic eventually - they do not know which strain, when it will occur or how bad it will be.

**Role of the Communication Centers, Dispatchers/call-receivers**

Communication centers (dispatchers) serve an important function in every phase of EMS incident management, including those involving infectious disease pathogens.

Dispatch center personnel provide a critical link in identifying the presence of an infectious environment, determining resources required, initiating responses, advising responding units of prevailing conditions and providing pre-arrival instructions to citizens. In addition they may identify specific clusters of illness based on symptoms and geographic locations, which will serve as an important "Epidemiology-link" to Public Health and responder agencies.

**Operations**

Communications personnel must be trained and required to seek information from callers and transmit that information to responders, which indicates the presence of an infectious disease or a potentially infectious condition. In addition to the usual EMS questions, when an

infectious disease is either suspected or reported, the dispatcher/call-receiver should ask:

**Does the patient have:**

- **Fever**
- **Cough**
- **Shortness of breath**
- **Respiratory distress**
- **Unusual skin rash**
- **Gastro-intestinal symptoms (nausea, vomiting, diarrhea)**
- **Recent exposure to anyone that is/has been sick**
- **Recent travel to regions known to be affected with disease outbreaks**

**Be alert for multiple patients with the same complaints, signs, symptoms.**

**Short reports to responding units must include information on signs/symptoms of infectious disease and the term "PPE (personal protective equipment) advised". Pre-arrival instructions must include directions to provide scene security, limit number of individuals exposed and reduce the infection risk:**

- Caller to remain on location
- Avoid contact/exposure to other people
- Move outside, if possible
- Increase ventilation: open doors and windows

In addition, communication centers should:

- Monitor the daily hospital status in the region, including hospitals on divert or closed and the designation of any infectious disease receiving facilities, including established alternate care sites.
- Prepare to provide daily reports to Public Health Epidemiology regarding known or suspected infectious disease patients and responses as part of a regional I.D. surveillance and tracking program.

## Dispatch Criteria

### Medic Response

- 3M1** Unconscious or not breathing
- 3M2** Decreased LOC (non-responsive to verbal or touch).
- 3M3** Sign of shock: Syncope or near syncope when sitting/standing
- 3M4** Respiratory Distress (one required):
  - Unable to speak normally (work of breathing)
  - Sitting, standing or leaning forward to breathe (tripod)

### BLS Red Response

- 3R1** No verifiable information\*

### BLS Yellow Response

- 3Y1**

### TRP

- 3T1** Fever, cough
- 3T2** Exposed but no symptoms
- 3T3** Caring for H1N1 Influenza A patient
- 3T4** Medical advice regarding self-care

**Special Notes:** Stable patients (**stable LOC** - nervous system, **stable respiratory** - work of breathing has not been hindered except for stuffy nose etc., **stable circulatory** - does not pass out or feel like passing out when sitting up or standing up) should be directed to the TRP (*Nurse-line*) for triage. Use of the Nurse-line is recommended for these patients because it decreases the possibility of exposures to others. The Nurse-line has specific protocols in place for the H1N1 Influenza A virus, and can provide medical information, home care suggestions, and transportation options to callers.

Patients with Chief complaint other than flu-like symptoms should be screened as usual with the appropriate Chief complaint card.

If an EMS response is required, and the patient has a fever and cough (flu symptoms), advise the responders of the need for PPE. Reporting parties without symptoms (questions regarding containment, prevention, *worried well*, etc.) should be directed to the King County Public Health hotline (**PICC 877-903-5464**) or the appropriate King County or CDC website.

\* This 3R1 code should be used for the rare event when a response is needed for a possible H1N1 Influenza A case, but further information about the condition or symptoms of the patient is unavailable. A BLS response is used to rule out a "sick" patient.

## Vital Points

- *Ask to speak directly to the patient, if possible!*

### Medic:

- How does the patient look?
- Is the patient responding to you?
- Is the patient able to speak normally?
- How does the patient feel when they sit up or stand?
- Does the patient have a fever?
- Does the patient have a cough?
- Is the patient complaining of body aches or other symptoms?

## Infectious Disease

### Pre-arrival Instructions

#### Respiratory Infection Screening for Responder protection and advisement -

**\*\*SEE VITAL POINTS\*\***

- Position of comfort
- Refrain from contact with others if possible.

### Short Report

- **Danger to field units, if present**
- Gender • Age
- Chief complaint
- **Advise Respiratory Protection/PPE**, if necessary
- Pertinent signs and symptoms
- Medical/surgical history, if relevant
- Other agencies responding

## Background Information

## Bleeding (Non-traumatic)

### Bleeding (non-traumatic)

Non-traumatic bleeding may be associated with many medical problems. It is not important to diagnose the problem, but it is imperative that the signs and symptoms of a critical patient are identified as early as possible.

Patients may be critical or unstable due to a serious compromise in any of the following systems:

- Circulatory
- Respiratory
- Nervous

### Circulatory

Uncontrollable bleeding is bleeding that cannot be controlled by direct pressure with a clean cloth or sanitary napkin. Once the patient is unable to compensate for blood loss they become a critical or unstable patient.

### Critical signs/symptoms associated with bleeding:

**Syncope or near syncope** associated with bleeding is usually secondary to a large loss of blood and requires paramedic evaluation, and most likely treatment. **Remember, this blood loss could be completely internal. The patient could be critically ill without any obvious signs of blood loss.**

**Vomiting red or dark red blood** usually signifies a rapid loss of blood secondary to either gastro-intestinal bleeding or a problem with the esophagus (esophageal varices).

Vomiting coffee ground-like material usually indicates a much slower blood loss and is usually less critical.

**Black tarry stool** is usually associated with a lower gastrointestinal bleed. Note: Several different medications can also produce tarry stools.

**Vaginal bleeding** in the pregnant woman who is greater than twenty (20) weeks pregnant can be very serious and require a paramedic evaluation.

**Hemoptysis (coughing up blood)** may cause airway problems and can be significant if the amount is greater than just a few streaks. Many smokers with bronchitis may cough up small amounts of blood without any serious results.

**Remember, look for signs and/or symptoms of shock to differentiate between the stable and the unstable patient.**

*Patients taking blood thinning medications such as Coumadin, Plavix or Aspirin may have a greater risk of increased blood loss due to the anti-clotting mechanisms of these medications.*

### Non-critical Bleeding:

Controlled nose bleed (epistaxis), localized controlled bleeding and any spontaneous, non-traumatic bleeding without signs or symptoms of shock.

## Dispatch Criteria

### Medic Response

- 4M1 Unconscious or not breathing
- 4M2 Sign of shock: Syncope or near syncope when sitting/standing
- 4M3
- 4M4
- 4M5 Vomiting red blood, with sign of shock (syncope or near syncope when sitting/standing)
- 4M6 Black tarry stool, with sign of shock (syncope or near syncope when sitting/standing)
- 4M7
- 4M8 Coughing up blood, with either:
  - Respiratory Distress (unable to speak normally or sitting/standing/leaning forward to breathe) or
  - Sign of shock (syncope or near syncope when sitting/standing)
- 4M9 Vaginal bleeding, with sign of shock (syncope or near syncope when sitting/standing)

### BLS Red Response

- 4R1 Bleeding, without Medic criteria
- 4R2
- 4R3 Weakness
- 4R4
- 4R5
- 4R6 Uncontrollable nosebleed
- 4R7 No verifiable info available from RP

### BLS Yellow Response

### TRP

- 4T1 Vaginal spotting
- 4T2 Controlled nosebleed
- 4T3 Blood in urine or urinary catheter problem

## Vital Points

- *Ask to speak directly to the patient, if possible!*

### Medic:

- How does the patient look?
- How does the patient feel when they sit/stand up?
- Is the patient speaking normally?
- Is the patient having any trouble breathing?
- Is the patient vomiting?
- Are the patient's bowel movements different than normal?  
**If yes**, how would you describe them?
- Is the patient coughing up blood?
- Has there been vaginal bleeding, any more than normal?

### BLS Red:

- What part of the body is the bleeding from?
- Is the patient feeling weak?
- Is there a possibility of pregnancy?

### Respiratory Infection Screening for Responder protection and advisement -

**\*\*SEE PRE-ARRIVAL INSTRUCTION\*\***

### Short Report:

- Has the patient been taking any medication?  
**If yes**, what kind?
- Does the patient have any other medical or surgical history?

## Bleeding (Non-traumatic)

### Pre-arrival Instructions

- Position of comfort
- Nothing by mouth.
- If external bleeding, use clean cloth and apply pressure directly over it. **DO NOT REMOVE, apply additional clean cloths on top if needed.**
- If nosebleed, pinch end of nose and do not release.
- If vaginal/rectal bleeding, do not flush the toilet.
- Gather patient meds.
- \*Respiratory Infection Screening:**
  - \*Does the patient have a fever?  
If unknown, are they hot to the touch?
  - \*Does the patient have a cough?  
If yes, how long has the cough lasted?
  - \*Recent international travel?
  - \*Does the patient have a rash?
- Note:** If fever is present with cough or rash, respiratory protection/PPE advised

### Short Report

- Gender
- Age
- Chief complaint
- \*Advise Respiratory Protection/PPE**, if necessary
- Pertinent signs and symptoms
- Medical/surgical history, if relevant

## Background Information

## Breathing Difficulty

### Breathing Difficulty

Breathing difficulty, "shortness of breath", can occur anytime there is a problem with the mechanics of breathing (getting air in and out) or on a cellular level, when there is a problem with the exchange of gases (oxygen and carbon-dioxide). Most commonly, the patient who is critically "short of breath" will have difficulty speaking normally and position themselves upright in the tri-pod position.

### Work of Breathing

Work of breathing is the effort it takes to exchange a sufficient amount of air. **The best way to discern the patient's work of breathing is to speak to the patient.**

Abnormal position, retractions and audible breath sounds are signs of increased work of breathing and possible respiratory distress.

- *Tripod position*: Leaning forward to breathe. This positions the airway in the path of least resistance.
- *Retractions*: Visible "sinking in" of the soft tissues in the chest wall or neck indicating a significant increased work of breathing. These are most often seen in infants and children.
- *Wheezes*: "Musical" high-pitched noises heard on exhalation. Often described as whistling and caused by bronchospasm or swelling of the large airways.
- *Stridor*: Harsh, high-pitched sound heard on inhalation. Caused by swelling and spasms of the upper airways.

### Common causes of potentially life-threatening shortness of breath include:

- **Chest pain** with difficulty breathing may be due to a myocardial infarction, pulmonary edema, pulmonary embolus or critical pneumonia.

- **Patients who are short of breath and exhibit an increased work of breathing** need a paramedic evaluation. The best way to measure work of breathing is to speak directly to the patient. If it sounds as if the patient just ran up a flight of stairs, but they didn't and cannot speak normally, they need a paramedic evaluation.
- **Pulmonary embolus (PE)** often occurs with blood clotting disorders and following surgery, broken legs with casting, recent immobilization and even on, or after, a very long flight. This is a critical presentation and the patient needs an immediate ALS evaluation. Attempt to speak to the patient if possible but keep in mind the patient with a PE will often be in respiratory distress.
- **Drooling or difficulty swallowing** associated with breathing difficulty may be epiglottitis or a severe allergic reaction and should be dispatched as an ALS response.

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### Non-critical causes of breathing difficulty:

- Controlled asthma
- Hyperventilation
- Common cold
- Bronchitis
- Pneumonia

Past history of breathing difficulty/distress may be helpful in determining the need for ALS or BLS intervention. Patients with chronic breathing problems like COPD or asthma may wait to call 911. They have usually tried all their medications with no relief. These patients are unstable and require ALS intervention.

## Dispatch Criteria

### Medic Response

- 5M1 Unconscious or not breathing
- 5M2 Respiratory Distress (one required):
  - Unable to speak normally (work of breathing)
  - Sitting, standing or leaning forward to breathe (tripod)
- 5M3 Breathing difficulty with chest discomfort, unable to speak normally:
  - Male/Female, age > 25
- 5M4
- 5M5 Audible wheezing or stridor
- 5M6
- 5M7
- 5M8

### BLS Red Response

- 5R1 Breathing difficulty
- 5R2 Tingling or numbness in extremities or around the mouth
- 5R3 No verifiable info available from RP
- 5R4 Breathing difficulty with barking cough, age  $\leq$  6
- 5R5 Hurts to breathe or pain with respiration
- 5R6

### BLS Yellow Response

- 5Y1 O<sub>2</sub> bottle empty
- 5Y2 Pepper spray
- 5Y3 Patient assist
- 5Y4 Hyperventilation/Panic Attack w/history of same

### TRP

- 5T1 Stuffy nose, cold symptoms

## Vital Points

- *Ask to speak directly to the patient, if possible!*

### Medic:

- Is the patient speaking normally?
- Does the patient have to sit up to breathe?
- Does the patient have to lean forward to breathe?
- Is the patient having any trouble breathing?
- What was the patient doing just prior to becoming short of breath?
- What substance did the patient inhale?
- Could the patient be having an allergic reaction?
- Is the patient drooling or having a difficult time swallowing?
  - **If yes**, is this causing breathing difficulty?
- Is the patient on breathing treatment, and have they used it?
- Has the patient ever had this problem before?
- Does the patient have any other medical/surgical history?

### BLS Red:

- Is the patient experiencing any other problems right now?

### BLS Yellow:

- Is the patient prescribed oxygen?

### Respiratory Infection Screening for Responder protection and advisement -

**\*\*SEE PRE-ARRIVAL INSTRUCTION\*\***

## Breathing Difficulty

### Pre-arrival Instructions

- Position of comfort.
- Patient may be more comfortable sitting up.
- Do not allow patient to exert him/herself.
- Gather patient meds, if possible.
- \*Respiratory Infection Screening -**
- \*Does the patient have a fever?  
If unknown, are they hot to the touch?
- \*Does the patient have a cough?  
If yes, how long has the cough lasted?
- \*Recent international travel?
- \*Does the patient have a rash?
- Note:** If fever is present with cough or rash, respiratory protection/PPE advised

### Short Report

- Gender
- Age
- Chief complaint
- Pertinent signs and symptoms
- Medical/surgical history, if relevant
- \*Advise Respiratory Protection/PPE**, if necessary
- Other agencies responding

**Background Information****Cardiac Arrest**

Cardiac arrest is a state in which the heart fails to generate an effective blood flow to the vital organs of the body. A patient in cardiac arrest will be unconscious, unresponsive and without adequate or effective respirations.

**Pump, pipes, fluid:**

In order for oxygenated blood to be distributed to the body we must have a working pump (heart), pipes (blood vessels) and fluid (blood). If any one of these three components fails, the patient will lose the ability to transport and use much needed oxygen.

**Causes of Cardiac Arrest**

There are many causes of cardiac arrest:

- Cardiovascular disease
- Cardiac arrhythmias
- Respiratory arrest or failure
- Trauma
- Drowning
- Electrocution

It is not important to determine the cause of the arrest but it is very important to quickly identify the patient in cardiac arrest and provide appropriate emergency instructions as soon as possible.

We use the "All-Caller" questions in order to determine if the patient is in cardiac arrest:

**Is the patient conscious?**

**Is the patient breathing normally?**

If the patient is not conscious and is not breathing normally, then we can assume they have experienced cardiac arrest and give the appropriate CPR instructions immediately.

**Critical symptoms of cardiac arrest:**

- A sudden unconsciousness with absence of normal signs of life
- Agonal respirations - The abnormal, inadequate and often misidentified respiratory effort commonly present at the onset of cardiac arrest. These muscular contractions are the result of messages being sent by the brain stem, which remains functional for a short period of time after "death". Agonals are typically not rhythmic and short-lived. They are described as snoring, gasping, gurgling, moaning, breathing once-in-a-while, or trying to breathe. **It is very important to distinguish agonal respirations from normal respirations as they are inadequate and by no means provide the patient with sufficient air exchange. If in doubt, start CPR!**
- Hypoxic seizure may also occur due to the lack of oxygen to the brain. Make sure to assess breathing after the seizure.

## Dispatch Criteria

### Medic Response

- 6M1 Unconscious or not breathing
- 6M2 Obvious DOA - child

### BLS Red Response

- 6R1 Obvious DOA - no CPR in progress
- 6R2 Verbal confirmation of "Do Not Resuscitate Order" on premise

### BLS Yellow Response

### TRP

## Vital Points

### Medic:

**If unsure about consciousness, use questions below to probe further:**

- Does the patient respond to you?
  - Respond to your voice (can they answer your questions).
  - Respond when you try to wake them up.

**If unsure about breathing normally, inquire further:**

- Does the patient's chest rise and fall?
- Describe the patient's breathing. Listen for sounds and frequency of breaths (agonal respirations described as):
  - gasping
  - snoring
  - snorting
  - gurgling
  - moaning
  - barely breathing
  - breathing every once in awhile
  - takes breath now and then
  - occasional breathing

**\*\* If RP cannot tell if the patient is breathing normally, assume the patient is not breathing normally, go directly to age-appropriate CPR PAI.**

- **Is AED Available?**

## Cardiac Arrest

### Pre-arrival Instructions

- If AED available, go directly to **AED PAI**
- If unconscious and not breathing normally, go directly to **age-appropriate CPR PAI**
- If unconscious and breathing normally, go directly to **Unconscious/Breathing PAI**

### Short Report

- Gender
- Age
- Chief complaint (Cause-if known)
- Pertinent signs and symptoms
- Medical/surgical history, if relevant
- Other agencies responding

## Background Information

## Chest Pain/Discomfort/Heart Problems

### Chest Pain

Chest pain may be caused by many conditions, some of which are potentially life-threatening. Because of its nature, differentiating potentially life-threatening causes of chest pain from non-critical causes can be quite difficult. For this reason, we rely primarily on the patient's age when determining the need for ALS evaluation.

### Critical causes of chest pain:

Myocardial infarction (MI) occurs when a portion of the heart muscle is damaged due to lack of oxygenated blood flow to the heart muscle. Typically the discomfort or pain associated with an MI is described as pressure, tightness, crushing or squeezing in the chest. The patient may describe the symptom as "discomfort" and not pain. Remember, different people have different levels of tolerance for pain.

Female patients often report very different symptoms. They may report upper back and/or neck discomfort. Here are some of the more common symptoms associated with MI:

- Shortness of breath
- Diaphoresis - cold, clammy skin
- Nausea and/or vomiting
- Discomfort that radiates from chest to arms, jaw, neck, shoulder or back
- Anxiety or feeling of impending doom

Note: Occasionally there is no "pain" associated with an MI and the patient may present with just tightness or pressure

on the chest area or shoulder/arm. Age is the determinant in the need for ALS intervention. If the patient meets the age identified in the criteria they need an ALS response even if they do not present with any signs or symptoms of shock.

If the patient does not meet the age determinants but shows signs and symptoms of shock, shortness of breath, or has a family history or medical history that is indicative of a possible MI, they may need a paramedic evaluation.

### Angina

Angina Pectoris is chest pain which occurs because of a lack of blood flow to heart muscle. It is distinguished from MI by its transitory nature and is usually relieved by rest and/or Nitroglycerin (NTG). If the patient has used their "normal" means of attempting to control the pain and this has not worked, they need an ALS evaluation. Increased activity can produce angina however it becomes more concerning when angina is produced when the patient is at rest.

### Supraventricular Tachycardia (SVT)

SVT is a cause of rapid heart rate (RHR). The criteria for a paramedic response is designed to capture both patients with a history of such and those with no history.

- Rapid heart rate/palpitations, age  $\geq$  40.

**Non-critical causes of chest pain** include pleurisy, pulled muscles, and typically, pneumonia.

## Dispatch Criteria

### Medic Response

- 7M1** Unconscious or not breathing
- 7M2** Male, age  $\geq 40$  chief complaint ongoing chest pain
- 7M3** Female, age  $\geq 45$  chief complaint ongoing chest pain
- 7M4** Male/Female, age  $\geq 25$ , with breathing difficulty - unable to speak normally
- 7M5** Rapid heart rate/palpitations, age  $\geq 40$
- 7M6** Sign of shock: Syncope or near syncope when sitting/standing
- 7M7** Diabetic
- 7M8** Defib implant shock

### BLS Red Response

- 7R1** Male, age  $< 40$
- 7R2** Female, age  $< 45$
- 7R3** Rapid heart rate/palpitations, age  $< 40$
- 7R4** No verifiable info available from RP
- 7R5** Indigestion:
  - Male, age  $\geq 40$
  - Female, age  $\geq 45$

### BLS Yellow Response

- 7Y1** Muscle/chest wall/rib pain

### TRP

- 7T1** Male, age  $< 40$  or  
Female, age  $< 45$  with chest wall trauma
- 7T2** Indigestion:
  - Male, age  $< 40$
  - Female, age  $< 45$

## Vital Points

- *Ask to speak directly to the patient, if possible!*

### Medic:

- Where is the pain located?
- Does the patient feel pain anywhere else in the body?
- How long has the pain been present?
- Is the patient speaking normally?
- Is the patient having any trouble breathing?
- How does the patient look?
- How does the patient feel when they sit up?
- Is the patient experiencing rapid heart rate?
- Does the patient have a history of rapid heart rate?
- Is the patient diabetic?

### Symbols:

Less than:  $<$

Less than or equal to:  $\leq$

Greater than:  $>$

Greater than or equal to:  $\geq$

### TRP

- Is the patient nauseated or vomiting?

### Short Report:

- Is the patient taking nitroglycerin (NTG)? (See Pre-Arrival Instructions)
- Has the patient ever had heart surgery or an MI?

## Chest Pain/Discomfort/Heart Problems

### Pre-arrival Instructions

- Have patient sit or lie down.
- Keep patient calm.
- Has the patient been prescribed nitroglycerin (NTG)?  
If the patient has a prescription for NTG, **and they DO NOT FEEL FAINT OR LIGHTHEADED!** - Advise the patient to take the medication only as their doctor has prescribed.
- Gather patient meds.
- If caller/patient asks about aspirin-advise: "We can not recommend medication".

### Short Report

- Gender
- Age
- Chief complaint
- Pertinent signs and symptoms
- Medical/surgical history, if relevant
- NTG with/without relief

**Background Information****Choking**

Choking is one of the most common causes of airway obstruction. Consider choking anytime a patient who has been eating is reported down or especially in a child under the age of six.

**Critical symptoms of Choking:**

If the patient is unable to talk (or cry, if an infant), consider a total airway obstruction and begin your emergency instructions. If the patient is conscious, use the choking instructions designed for the conscious patient. **Once the patient becomes unconscious, switch to the age-appropriate CPR instructions.** Never ever ask anyone to discontinue emergency instructions unless the item is dislodged and the patient is able to talk or cry (infant).

**Inability to talk** - This suggests the patient is unable to move any air due to complete obstruction of the airway.

**Cyanosis** - Cyanosis is a very late sign. If the patient is turning blue, their oxygen saturation levels have dropped severely and the situation can become grave unless there is immediate intervention.

**If there is any suggestion of airway obstruction by the RP/patient, the pre-arrival emergency instructions for Choking should be given immediately. If the patient is,**

**or becomes, unconscious go directly to age-appropriate CPR instructions. Remember to have the RP look in the patients mouth prior to giving the ventilations. If they see an obstruction, remove it and proceed.**

***\*Remember to switch to CPR instructions if the patient becomes unconscious during the rescue attempt.***

***Review and practice the emergency pre-arrival instructions for choking (especially for infants) as often as possible. These instructions are not given frequently but when they are needed the call-receiver should be as familiar with them as possible.***

***Infants and children have very small airways which can swell even after the item is expelled. These patients require a BLS evaluation.***

## Dispatch Criteria

### Medic Response

- 8M1** Unconscious or not breathing
- 8M2** Unable to talk or cry (infants)
- 8M3** Turning blue

### BLS Red Response

- 8R1** Able to talk or cry (infants)
- 8R2** Breathing without difficulty
- 8R3** No verifiable info available from RP

### BLS Yellow Response

- 8Y1** Airway cleared, patient assist

### TRP

## Vital Points

- *Ask to speak directly to the patient, if possible!*

### Medic:

- Does the chest rise and fall?
- Is the patient able to talk or cry (infants)?
- Is the patient turning blue?
- Was the person eating or did they have something in their mouth?
- *If child is 6 years or below,*
  - **Is the child hot to the touch?**

Remember, sometimes febrile seizures are originally reported as obstructed **airways.**

- If airway obstruction ruled out - go to PEDS card

## Choking

### Pre-arrival Instructions

- If patient is unable to talk or cry (infant), go directly to **age-appropriate Choking PAI**
- If patient is able to breathe, talk or cry (Infant):
  - Allow position of comfort
  - Encourage coughing

### Short Report

- Gender
- Age
- Chief complaint
- Pertinent signs and symptoms
- Medical/surgical history, if relevant

## Background Information

Diabetes mellitus is a medical condition caused by decreased insulin production by the pancreas. Diabetes can sometimes be controlled by diet, but it often requires either oral medication or insulin injections to keep the blood sugar within a normal range.

The diabetic that requires medication (either oral or insulin) is at great risk for developing a sugar level in the body that is either too high or too low. The brain responds to either with a decrease in the level of consciousness (LOC). Both of these problems may be life-threatening.

### Critical diabetic reactions:

**Insulin shock** is the most frequent reason for accessing the 911 system for the diabetic. It occurs most often in the patient on Insulin (vs. oral medication) and results from an imbalance of too much insulin and not enough blood sugar. This often happens if the person does not eat enough, over exercises, takes too much insulin, has a fever or is ill with nausea and vomiting. Insulin shock is usually of rapid onset.

**Never tell a patient or an RP to take or administer insulin!**

**Ketoacidosis (Diabetic coma)** is an accumulation of acids in the blood secondary to a lack of insulin in the body. The lack of insulin forces the body to switch from its primary source of fuel, carbohydrates (sugar), to burning fats which

produces waste products in the form of acids. This accumulation of acids, and other electrolyte changes in the body, causes profound dehydration, signs and symptoms of shock and altered level of consciousness.

**Hyperglycemia** is a greater than normal amount of glucose present in the blood, usually associated with diabetes.

**Hypoglycemia** is a deficiency of glucose present in the blood.

## Dispatch Criteria

### Medic Response

- 9M1 Unconscious or not breathing
- 9M2 Respiratory Distress (one required):
  - Unable to speak normally (work of breathing)
  - Sitting, standing or leaning forward to breathe (tripod)
- 9M3 Decreased/Altered LOC or Uncooperative (not following commands)
- 9M4 Sign of shock: Syncope or near syncope when sitting/standing
- 9M5 Chest pain/discomfort
- 9M6
- 9M7
- 9M8 Seizure

### BLS Red Response

- 9R1 Disoriented, unusual behavior or acting strange (able to follow commands)
- 9R2 Not feeling well, weak or non-specific
- 9R3
- 9R4 No verifiable info available from RP
- 9R5

### BLS Yellow Response

### TRP

- 9T1 Awake/alert
- 9T2
- 9T3 Blood sugar > 150, no symptoms

## Vital Points

- Ask to speak directly to the patient, if possible!

### Medic:

- Is the patient speaking normally?
- Is the patient having any trouble breathing?
- Is the patient acting normally?  
**If not**, what is different?
- Can the patient respond to you and follow simple commands?
- Can the patient answer your questions?
- Does the patient know who they are, where they are?
- How does the patient look?
- Has the patient had a seizure?
- Does the patient take meds for their diabetes?  
**If yes**, when did they take it?
- When did the patient last eat?
- What is the patient's blood sugar level?
- How does the patient feel when they sit up?
- Is the patient complaining of any discomfort?

### BLS Red:

- Is the patient feeling weak?

## Diabetic

### Pre-arrival Instructions

- Under no circumstances should patient take any meds prior to EMS arrival.
- Give liquid with sugar (2-3 tbsp.) if patient able to take on their own.
- Nothing by mouth, if patient unable to take it by themselves.
- Clear area around patient
- Gather patient meds (If not done already). Test the patient's blood sugar, if you have the equipment and training to do this. Give the results to the aid crew when they arrive.

### Short Report

- Gender
- Age
- Chief complaint
- Pertinent signs and symptoms
- Medical/surgical history, if relevant

**Background Information****Environmental Emergencies**

Environmental exposures may include exposure to excessive heat or cold or exposure to a hazardous material.

**Critical environmental emergencies:**

**Hypothermia** results from prolonged cold exposure or inappropriate thermoregulatory body metabolism such as what occurs in patients taking certain psychiatric medications. Cold exposure usually occurs in the transient population that has no ability to shelter themselves from the weather. It can also occur with the elderly who may have no heat in their homes. In water exposure, particularly in the winter months, hypothermia can result from excessive exposure to cold waters. Initially, the hypothermic patient may be confused, disoriented or syncopal. In extreme cold exposure, this may result in cardiac arrest.

Exposure to cold can result in a general cooling of the body that can go through the following stages:

- Shivering - as the body attempts to generate heat
- Feeling of numbness
- Drowsiness, unwilling or unable to complete simple tasks
- Decreased muscle function
- Decreased LOC
- Decreased vital signs, slow pulse, respirations and heart rate
- Freezing body parts (in extreme cold)

**Hyperthermia** results from prolonged heat exposure.

Depending on what part of the country you live in, this can be relatively rare. However, weather is not the only contributor to hyperthermia. Prolonged exercise in warm weather, such as marathons or other athletic events, could cause a participant to become hyperthermic. Hyperthermia may also occur in firefighters in the line of duty.

**Hazardous material exposures** may be quite dangerous.

All responses are dependent upon the type of exposure and the danger involved to both the patient and the responders. There are multiple haz-mat reference guides available as resources. It is important to determine the type of chemical etc. and the wind direction if possible. Look for indications of haz-mat events whenever you have multiple patients with very similar symptoms.

**Remember to notify responders of any possible exposures.**

## Dispatch Criteria

### Medic Response

- 10M1** Unconscious or not breathing
- 10M2** Respiratory Distress (one required):
  - Unable to speak normally (work of breathing)
  - Sitting, standing or leaning forward to breathe (tripod)
- 10M3** Decreased LOC, non-responsive to verbal or touch
- 10M4** Sign of shock: Syncope or near syncope when sitting/standing
- 10M5** Burns with blisters and/or skin sloughing on face, neck, chest or back

### BLS Red Response

- 10R1** Chemicals (ingested, inhaled or splashed on), w/o medic criteria
- 10R2** Patient with uncontrollable shivering
- 10R3** Patient excessively hot
- 10R4** Other injuries
- 10R5** No verifiable info available from RP
- 10R6** Breathing difficulty

### BLS Yellow Response

- 10Y1** Pepper spray

### TRP

- 10T1** No symptoms, but has been exposed

## Vital Points

- *Ask to speak directly to the patient, if possible!*

### Medic:

- What happened?
  - Does the patient have any complaints?
  - Is the patient speaking normally?
  - Is the patient having any trouble breathing?
  - How does the patient look?
  - How does the patient feel when they sit up?
  - Can the patient respond to you and follow simple commands?
  - Can the patient answer your questions?
  - Is the patient acting normally?  
**If not, what is different?**
  - How long has the patient been exposed?
- ### BLS Red:
- What was the source?

### Short Report:

- Length of exposure?

## Environmental/Toxic Exposure

### Pre-arrival Instructions

#### Heat Exposure:

- Move patient into the shade
- Loosen or remove clothing to assist in cooling.
- Nothing by mouth, if decreased LOC

#### Cold Exposure

- If patient is cold and dry, cover patient.
- If patient is cold and wet, remove wet clothes and cover patient.
- Nothing by mouth.

#### Chemical/Toxic Exposure

- Have patient move to fresh air.
- Do not touch patient.
- Have patient remove contaminated clothing, if possible.
- Continuously flush chemicals from eyes, remove contacts.
- If chemical is powder, brush off then flush with water.
- Get info on chemical (MSDS sheet if available).
- Nothing by mouth.

### Short Report

- **Danger to field units, if present**
- Gender
- Age
- Chief complaint
- Pertinent signs and symptoms
- Medical/surgical history, if relevant

## Background Information

## Medical Knowledge (Medical Facility Only)

### Medical Knowledge

The Medical Knowledge criteria was developed and implemented to assist the call-receiver with requests from medical facilities where the provider/caller is unable to identify a specific chief complaint. This criteria should be used only in those instances where the medical facility is only able to provide diagnostic information such as blood sugar or oxygen saturation levels.

The Medical Knowledge category is intended for use when information regarding a patient's symptoms is not available, however a specific medical diagnosis or measurement is given. Typically these calls would be from doctors' offices, medical clinics, or any other facility with trained personnel.

If a chief complaint is identified, use the appropriate criteria and base your response and pre-arrival decisions on the signs and symptoms of the patient.

Even if the Health Care Provider is only able to provide specifics about pulse rate, blood sugar level, oxygen saturation levels, etc., it is still important to ask the caller if the patient is conscious and if they are breathing normally. It is difficult to imagine, but even someone experienced in patient care can forget to provide that information at the onset of the call.

If a medical practitioner (e.g. Doctor, Nurse) is not on site, do not use this category but instead go to the appropriate chief complaint card.

## Dispatch Criteria

### Medic Response

- 11M1** Abnormal EKG, Arrhythmia
  - Rule out MI
- 11M2** Patient needs/has IV
- 11M3** Provider is currently administering medication for this chief complaint
- 11M4** BP < 90, Systolic (first number)
- 11M5** O<sub>2</sub> sat. < 90
- 11M6** Pulse Rate > 130 or < 60
- 11M7** Glucose < 60 w/DLOC
- 11M8** School Nurse advising patient/student needs prescription medication(s)
- 11M9** Provider states patient requires or received Epi, requesting ALS response

### BLS Red Response

- 11R1** Non-Cardiac
- 11R2** Stable patient
- 11R3** No medications/No IV
- 11R4** BP > 90, Systolic (first number)
- 11R5** O<sub>2</sub> sat. > 90
- 11R6** Pulse Rate between 60-130

### BLS Yellow Response

- 11Y1** Standby/transport assist
  - Private ambulance not available

## Vital Points

- **Ask to speak directly to someone with knowledge of the patient, if possible!**

### Medic:

- Is the doctor or nurse on site?
  - If no, revert to Chief complaint card
- Ask to speak to a person knowledgeable about the patient
- Is the patient stable?
  - What are the patient's vital signs?
- Have you treated the patient with medications today?

### BLS Red:

- Does the patient only require transportation?
- What is the patient seeing the doctor for?

## Medical Knowledge (Medical Facility Only)

### Pre-arrival Instructions

- Have someone available to meet the unit at the access door.

### Short Report

- Gender
- Age
- Chief complaint
- Pertinent signs and symptoms
- Medical/surgical history, if relevant
- Other agencies responding

**Head/Neck**

Critical headaches are usually because of rapidly increasing pressure within the fixed volume that the skull provides to protect the brain. As the pressure increases within this fixed volume, the brain is compressed and neurologic deterioration begins.

**Critical causes of headache:**

**Subarachnoid hemorrhage** occurs when a blood vessel supplying the outer area of the brain ruptures. This spontaneous rupture can occur at any time, but frequently it is associated with events that cause blood pressure to be elevated.

The patient usually complains of a **very sudden onset of the worst headache they have ever experienced**. They may display neurologic deterioration such as:

- Mental confusion
- Decreased LOC
- Vertigo
- Loss of balance or coordination
- Weakness of one side of the body
- Difficulty speaking or slurred speech
- Blurred/double vision
- Weakness/paralysis
- Diaphoresis
- Vomiting

**Intracerebral hemorrhage** often has the same symptoms as a subarachnoid hemorrhage but often occurs in an older population (> 50 yrs of age). Bleeding deep within the brain is frequently a grave condition with a poor prognosis.

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**Non-critical causes of headaches include:**

- Post-concussive headaches, which may occur after a minor head injury
- Migraine headaches, which may have associated symptoms of numbness and weakness but generally have a history of similar symptoms
- Tension headaches

## Dispatch Criteria

### Medic Response

- 12M1** Unconscious or not breathing
- 12M2** Decreased LOC, non-responsive to verbal or touch
- 12M3**
- 12M4**
- 12M5**
- 12M6**
- 12M7** Sudden onset of severe headache, with one of the following:
  - Slurred speech
  - Blurred/double vision
  - Weakness/paralysis
  - Vomiting

### BLS Red Response

- 12R1** Disoriented, but able to walk and talk
- 12R2** No verifiable info available from RP
- 12R3**
- 12R4** Visual difficulty
- 12R5** Vertigo/Dizziness
- 12R6**

### BLS Yellow Response

- 12Y1**
- 12Y2**

### TRP

- 12T1** Headache
- 12T2** Migraine(s)
- 12T3** Minor head/neck/facial pain
- 12T4** Eye, ear, nose, throat pain
- 12T5**

## Vital Points

- *Ask to speak directly to the patient, if possible!*

### Medic:

- Did the headache come on suddenly or gradually?
- Does the patient have any vision problems?
- Can the patient respond to you and follow simple commands?
- Can the patient answer your questions?
- Does the patient know where they are and who they are?
- Is the headache different than headaches the patient has had in the past?
- What was the patient doing when the headache started?
- How is the patient acting?  
**If unusual**, what is different about them?
- How does the patient look?

### TRP:

- Has the patient had a recent illness or injury?
- Does the patient have a history of headaches?

### Short Report:

- Is the patient wearing a Medic Alert tag?

## Head/Neck

### Pre-arrival Instructions

- Nothing by mouth.
- Allow patient to find position of comfort.
- Gather patient meds.

### Short Report

- Gender
- Age
- Chief complaint
- Pertinent signs and symptoms
- Medical/surgical history, if relevant

## Background Information

## Mental/Emotional/Psychological

Very few mental or emotional problems are a critical medical problem unless the patient is threatening to harm themselves or others. However, sometimes it is very difficult to distinguish a mental/emotional problem from a medical problem such as a diabetic or drug reaction.

### **Critical responses in the mental/emotional patient:**

**Penetrating wounds** that are self-inflicted.

**Diabetic patients** with hypoglycemia or insulin shock may present as a mental/emotional problem.

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### **Non-critical responses may include:**

- lacerated wrists with controlled bleeding
- unusual behavior with a psychiatric history

## Dispatch Criteria

### Medic Response

- 13M1** Unconscious or not breathing
- 13M2** Suicide attempt with GSW, stabbing, crushing or penetrating injury
- 13M3** Excited Delirium, if requested by police

### BLS Red Response

- 13R1** Self-inflicted injuries
- 13R2** Unusual behavior
- 13R3** Panic attack, unknown history
- 13R4**
- 13R5** No verifiable info available from RP

### BLS Yellow Response

- 13Y1** Police request for stand-by, threats against self or others
- 13Y2** Pepper Spray or Taser
- 13Y3** Patient assist
- 13Y4** Panic attack with known history (hyperventilation)

### TRP

- 13T1** Patient out of psych medications

## Vital Points

- *Ask to speak directly to the patient, if possible!*

### Medic:

- What happened?
- Is the scene secure?
- Is the suspect in the area? If yes, get description.
- Does the patient have a weapon/or access to a weapon?
- Has the patient harmed themselves?  
**If yes**, with what?  
What are the injuries?  
What part of the body is injured?

### BLS Red:

- Do you think the patient might harm themselves?  
**If yes**, with what?
- Can the patient respond to you and follow simple commands?
- Can the patient answer your questions?  
**If appropriate**,
- Has the patient taken any drugs or alcohol?
- Is the patient acting normally?  
**If not**, what is different or unusual?

## Mental/Emotional/Psychological

### Pre-arrival Instructions

- Keep patient in area, **if safe**.
- Keep patient calm.
- If you feel you're in danger **leave the scene, if it's safe to do so**.
- Does patient have access to any weapons?
- Gather patient meds.

### Short Report

- **DANGER TO FIELD UNITS, IF PRESENT - INCLUDE SUSPECT/VEHICLE DESCRIPTION**
- Gender
- Age
- Chief complaint
- Pertinent signs and symptoms
- Medical/surgical history, if relevant
- Other agencies responding

## Background Information

## O.D./Poisoning

### Overdose/Poisoning

The term overdose is used to describe both the intentional and unintentional ingestion of a medication that exceeds the recommended dosing schedule. Often, in intentional overdose the patient ingests more than one type of medication and often the amount and type of substance is unknown. This is why it is important to pay particularly close attention to the patients presenting signs and symptoms. Use these signs and symptoms to help identify critical, unstable patients.

**Critical patients will present with one or all of the following:**

- **Decreased LOC** - Decreased or altered level of consciousness indicates a central nervous system depression and should receive ALS evaluation.
- **Signs and symptoms of shock** - Some medications impact cardiovascular function and can result in shock or inadequate perfusion. Patients exhibiting signs and symptoms of shock should receive ALS evaluation.
- **Respiratory difficulty** - Patients in respiratory distress or depression should receive ALS evaluation. Speak to the patient, whenever possible, to assess work of breathing.

Many types of medications are central nervous system depressants. It is not important to memorize these medica-

tions or drugs, but it is important to assess the patient's level of consciousness to determine if an ALS evaluation is warranted. It is just as important to assess the patient's work of breathing. There is always a concern that the drugged or intoxicated patient will not be able to maintain their airway. There is also a concern that the patient could vomit and aspirate fluid into the lungs. All of these situations would be critical and would require ALS evaluation.

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**Non-critical incidents may include ingestion/overdose of the following:**

- Aspirin
- Tylenol
- Most over-the-counter medications
- Hallucinogens (such as LSD, PCP, psychedelic mushrooms, etc.)
- SSRI's (prozac etc.)

**Remember to assess the LOC, possible signs or symptoms of shock, and respiratory effort or work of breathing to help make a determination of a critical or non-critical patient.**

## Dispatch Criteria

### Medic Response

- 14M1 Unconscious or not breathing
- 14M2 Respiratory Distress (one required):
  - Unable to speak normally (work of breathing)
  - Sitting, standing or leaning forward to breathe (tripod)
- 14M3 Decreased LOC, non-responsive to verbal or touch
- 14M4 Intentional overdose, with Rx meds
- 14M5 Ingestion of caustic substance, w/difficulty swallowing
- 14M6 Excited Delirium, if requested by police
- 14M7 Acute alcohol and/or drug intoxication (non-responsive to verbal or touch)
- 14M8
- 14M9
- 14M10 Seizure, secondary to alcohol and/or drug overdose, use or withdrawals

### BLS Red Response

- 14R1 Intentional/accidental, with over-the-counter (OTC) medicines
- 14R2 No verifiable info available from RP
- 14R3 Reported O.D., patient denies taking meds, or unknown if meds/substances were taken
- 14R4 Chemicals (ingested, inhaled or splashed on), w/o medic criteria
- 14R5 Accidental overdose, with Rx meds
- 14R6 Breathing difficulty
- 14R7 Acute alcohol and/or drug intoxication (responsive)
- 14R8 Withdrawal symptoms (responsive)

### BLS Yellow Response

- 14Y1
- 14Y2 Street drugs
- 14Y3 Pepper spray or Taser

### TRP

- 14T1 No symptoms, but has been exposed

## Vital Points

- *Ask to speak directly to the patient, if possible!*

### Medic:

- Can the patient speak normally?
- Is the patient having any trouble breathing?
- Can the patient respond to you and follow simple commands?
- Can the patient answer your questions?
- Is the patient having difficulty swallowing?
- What type of substance did the patient take?

Was alcohol involved?

**If yes**, what age is the patient?

Recreational drugs?

**If yes**, what kind?

Prescription Meds?

**If yes**, what kind and how many?

- Has the patient had a seizure?
- Has the patient vomited?

### BLS Red:

- If the patient took medications, were they prescription medications?

**If yes**, how many?

- How long ago did they ingest the substance?

### Short Report:

- Is the patient violent?
- Does the patient have access to a weapon?
- Is the patient acting normally?

**If not** what is different?

## O.D./Poisoning

### Pre-arrival Instructions

- If unconscious and breathing normally, go directly to **Unconscious/Breathing PAI**
- If patient responsive and laying down put them on their side.
- Keep patient in area/house if safe.
- Retrieve container of substance taken.
- Don't place patient in bath or shower.
- Nothing by mouth.
- Gather patient meds.

### Short Report

- **Danger to field units, if present**
- Gender
- Age
- Chief complaint
- Pertinent signs and symptoms
- Medical/surgical history, if relevant
- Other agencies responding

## Background Information

Pregnancy and childbirth is a very natural process that takes place in many parts of the world without the assistance of medical professionals. A normal delivery can occur without any assistance from pre-hospital personnel.

However, there may be concern whenever the mother has not received any pre-natal care because she may not be aware of issues occurring with this particular pregnancy.

### Imminent delivery

ALS should respond for all imminent deliveries, not only to render assistance to the mother but to assist in the care of the newborn infant. Breaking of waters does not always indicate imminent delivery. It does, however, indicate that labor will begin if it has not already. ALS response is also indicated for unusual or problematic delivery or issues that develop in the last trimester of the pregnancy.

### Possible Critical Issues:

**Eclampsia, or toxemia**, is a toxic state that develops in the last trimester. It is characterized by increased blood pressure, fluid retention and seizures (in the most severe cases).

**Vaginal bleeding in a pregnancy > 20 weeks** can be dangerous due to possible rapid blood loss through the placenta. Often this is associated with **placenta previa**, a condition where the placenta partially or completely blocks the cervix. Another possible critical issue with the placenta is **abruptio placenta**. Abruptio placenta occurs when the placenta separates prematurely from the uterine wall and results in bleeding from the site. This can occur spontaneously but it is usually a result of some kind of trauma. Without quick intervention shock can occur, and that can be serious for both mom and baby.

**Abdominal injury with contractions in a pregnancy > 20 weeks gestation** should have an ALS evaluation. Any pregnancy over 20 weeks carries a chance of fetal survival if delivery occurs.

**Contractions < 2 minutes apart in a first pregnancy or < 5 minutes apart in a second or subsequent pregnancy** - Most of the time first-time pregnancy/delivery will take longer than those of the third or fourth child. Second and subsequent pregnancies often have a shorter duration of labor since the cervix and the pelvic area have been previously stretched during prior deliveries.

**Premature birth > 4 weeks** suggests the delivery may be more precipitous and the baby may require more ALS intervention.

**Breech delivery** - When the presenting part of the baby is anything but the head.

**Prolapsed cord** - If the RP sees the cord presenting, there is concern that the pressure of the baby's head within the mother's birth canal could cut off circulation of blood through the cord and to the baby. This can be very serious and requires not only ALS intervention but immediate delivery of emergency medical dispatch instructions to take the pressure off of the cord.

### Non-critical issues:

- Abdominal injury without contractions
- Abdominal injury in a pregnancy < 20 weeks
- Abdominal pain
- Vaginal bleeding/cramping in a pregnancy < 20 weeks

**Remember**, miscarriage in a pregnancy < 20 weeks without other issues is a BLS response. However, the event can be devastating to a family.

## Dispatch Criteria

### Medic Response

- 15M1** Unconscious or not breathing
- 15M2** Pregnant, vaginal bleeding with sign of shock (syncope or near syncope when sitting/standing)
- 15M3** Sign of shock: Syncope or near syncope when sitting/standing
- 15M4** Labor pains/contractions:
  - 1st preg., < 2 min. between contractions
  - 2nd preg., < 5 min. between contractions
  - Prior delivery with labor lasting < 1 hr.
- 15M5**
- 15M6** Complications: Breech, abnormal presentation
- 15M7** Delivery
- 15M8** Abdominal injury, with contraction, > 20 weeks
- 15M9** Seizure, > 20 weeks pregnant

### BLS Red Response

- 15R1** Vaginal bleeding
- 15R2** 1st pregnancy with > 2 mins. between contractions
- 15R3** 2nd pregnancy with > 5 mins. between contractions
- 15R4** Abdominal injury, w/o contractions, > 20 weeks pregnant
- 15R5**
- 15R6** No verifiable info available from RP

### BLS Yellow Response

### TRP

- 15T1** Pregnant < 20 weeks or menstrual, with any of the following:
  - Cramps • Pelvic Pain • Spotting
- 15T2** Water broke, no contractions

## Vital Points

- *Ask to speak directly to the patient, if possible!*

### Medic:

- Is she bleeding?
- How does the patient look?
- How does she feel when she sits up?
- How long has she been having contractions?
- How many minutes between the beginning of one contraction to the beginning of the next?
- Is this her first pregnancy?
- How many weeks along is she?
- Has she received pre-natal care?
- Was there an injury?
- Has she had a seizure?
- Does she feel the urge to have a bowel movement?
- If post delivery, is the baby breathing?

### BLS Red:

- Has she had any problems during pregnancy?

## Pregnancy/Childbirth/GYN

### Pre-arrival Instructions

- If childbirth is imminent, go directly to **appropriate Childbirth PAI**
- Do not let patient go to toilet.
- Have patient lie down on left side.
- Keep patient warm.
- Gather patient meds.
- Gather clean clothes or towels.

### Short Report

- Gender
- Age
- Chief complaint
- Pertinent signs and symptoms
- Medical/surgical history, if relevant
- Pre-natal care?

## Background Information

## Seizures

### Seizures

Seizures are the result of uncontrolled electrical activity in the brain causing convulsions and temporary loss of consciousness. **Febrile seizures** occur commonly in children between the ages of 6 months and 3 years and are short in duration. Seizures in children < 3 yrs of age are assumed febrile seizures unless they meet any of the critical criteria listed below.

### Critical issues:

**Seizures lasting longer than 5 minutes or multiple seizures** (greater than 3 per hour) are dangerous due to hypoxia associated with prolonged or repeated convulsions.

**Severe Headache:** A patient having a seizure after complaining of a severe headache could be experiencing an intracerebral hemorrhage. Bleeding into the cranial space places increased pressure on the brain tissue often leading to convulsions.

**Diabetic patients with seizures** usually experience convulsions because of hypoglycemia and should have immediate paramedic evaluation and correction of their blood sugar level.

**Pregnant women with seizures** should be evaluated for

toxemia of pregnancy, poor fetal circulation and oxygenation.

**Drug and/or alcohol overdoses with seizures** are critical because of the recurrent nature of seizures present with toxicity of the overdose.

**Recent (within the last 24 hours) head trauma presenting with seizures** may indicate bleeding or increased intracranial pressure, a serious and potentially life-threatening condition.

Most seizure calls will be concerning patients with a history of seizures that the RP may or may not know about. If additional history becomes available during the call, the call-receiver may upgrade or downgrade the call as necessary.

**Remember to assess and re-assess breathing after the seizure. Hypoxic seizure can occur with cardiac arrest. If the patient is not breathing start CPR!**

## Dispatch Criteria

### Medic Response

- 16M1** Not breathing after seizure stops
- 16M2** Seizing now, > 5 minutes
- 16M3** Multiple seizures, > 3 per hour
- 16M4** Severe headache prior to seizure
- 16M5** Diabetic
- 16M6** Pregnant > 20 weeks
- 16M7** Secondary to alcohol and/or drug over dose, use or withdrawals
- 16M8** Secondary to head injury within the last 24 hours
- 16M9**

### BLS Red Response

- 16R1** First-time seizure
- 16R2** Seizure(s) with history of seizure disorder
- 16R3** Seizure(s), unknown history
- 16R4** No verifiable information available from RP
- 16R5**
- 16R6**

### BLS Yellow Response

### TRP

- 16T1** Seizure aura

## Vital Points

- *Ask to speak directly to the patient, if possible!*

### Medic:

- How long has the patient been seizing?
- Is the patient still seizing?
- Has the patient had a seizure before?
- Is the patient a diabetic?
- If female, is the woman pregnant?  
**If yes**, how many weeks pregnant?
- Has the patient taken any medication, recreational drugs or alcohol?
- Has the patient had a recent head injury?  
**If yes**, when?
- **Remember to assess and re-assess breathing after the seizure!**

### Short Report:

- Is the patient wearing a Medic Alert tag?

## Seizures

### Pre-arrival Instructions

- If unconscious and not breathing, go directly to **age-appropriate CPR PAI**.
- If unconscious and breathing normally, go directly to **Unconscious/Breathing PAI**.
- Clear area around patient.
- Do not restrain patient.
- Do not place anything in patient's mouth.
- **After seizure has stopped, assess breathing.**
- Have patient lie on side.
- If peds seizure, remove clothing to cool patient.
- Gather patient meds.

### Short Report

- Gender
- Age
- Chief complaint
- Pertinent signs and symptoms
- Medical/surgical history, if relevant
- Other agencies responding

## Background Information

## Sick (Unknown)/Other

### Sick (Unknown)/Other

Use this card for situations when a chief complaint cannot be identified.

**This card should only be used when the patient's complaint does not fit into any other card in this chart.**

**Critical patients will present with one or all of the following:**

- **Decreased LOC** - Decreased or altered level of consciousness indicates a central nervous system depression and should receive ALS evaluation. Critical patients will not respond to verbal or physical attempts to wake them.
- **Signs and symptoms of shock** - Some medications impact cardiovascular function and can result in shock or inadequate perfusion. Patients exhibiting signs and symptoms of shock should receive ALS evaluation.
- **Respiratory difficulty** - Patients in respiratory distress or depression should receive ALS evaluation. Speak to the patient, whenever possible, to assess work of breathing. The critical patient will not be able to speak normally.

## Dispatch Criteria

### Medic Response

- 17M1 Unconscious or not breathing
- 17M2 Decreased LOC, non-responsive to verbal or touch
- 17M3
- 17M4
- 17M5 Sign of shock: Syncope or near syncope when sitting/standing

### BLS Red Response

- 17R1 Vertigo/Dizziness
- 17R2 Generalized weakness/unspecified pain
- 17R3 No verifiable info available from RP
- 17R4 Medical alarm company, confirmed medical emergency
- 17R5
- 17R6
- 17R7

### BLS Yellow Response

- 17Y1
- 17Y2
- 17Y3
- 17Y4 Patient Assist
- 17Y5 Hang up Call-Consider PD Response
- 17Y6 Med alarm, confirmed non-critical or no information

### TRP

- 17T1 Flu symptoms (any one): • Nausea • Vomiting • Chills • Sore throat • Cough • Headache
- 17T2 High blood pressure w/o specific symptoms
- 17T3 Temperature/Fever
- 17T4 Other

## Vital Points

- *Ask to speak directly to the patient, if possible!*

### Medic:

- How does the patient feel when they sit up?
- How does the patient look?
- What is the patient doing?
- What is the patient complaining of?
- Can the patient respond to you and follow simple commands?
- Can the patient answer your questions?
- Is the patient acting normally?  
**If not**, what is different?
- Is the patient experiencing any discomfort? Where?

### Respiratory Infection Screening for Responder protection and advisement -

**\*\*SEE PRE-ARRIVAL INSTRUCTION\*\***

### Short Report:

- If patient is not a family member:  
Have you checked for a Medic Alert tag?  
Have you checked in the refrigerator for Insulin?

## Sick (Unknown)/Other

### Pre-arrival Instructions

- Keep patient warm.
- Position of comfort.
- Gather patient meds.

### \*Respiratory Infection Screening:

\*Does the patient have a fever?

If unknown, are they hot to the touch?

\*Does the patient have a cough?

If yes, how long has the cough lasted?

\*Recent international travel?

\*Does the patient have a rash?

**Note:** If fever is present with cough or rash, respiratory protection/PPE advised.

### Short Report

- Gender • Age
- Chief complaint
- \***Advise Respiratory Protection/PPE**, if necessary
- Pertinent signs and symptoms
- Medical/surgical history, if relevant
- Other agencies responding

## Background Information

A stroke occurs when a blood vessel in the brain is either blocked or bursts open. In this event, brain tissue becomes oxygen-deprived and cells begin to die off. It is imperative that we identify signs and symptoms of stroke as soon as possible and send a pre-hospital response.

The brain is a very complex organ that performs functions we take for granted everyday. Whichever part of the brain has diminished will affect the ability for that patient to perform normal tasks. That is why it is so important to get the patient to an appropriate hospital as soon as possible. **Lost time is lost brain!**

**Early identification and treatment are the keys to stroke recovery!**

Many stroke victims present with difficulty speaking or slurred speech. This speech difficulty is common and by itself does not necessarily indicate a decreased level of consciousness or difficulty breathing.

The FAST test is often used to help determine signs/symptoms of stroke.

### **F.A.S.T.**

**Face:** ..... Smile - does one part of the face droop?

**Arm:** ..... Raise both arms - does one arm drift downward?

**Speech:** ... Speak a simple sentence - did you slur or repeat it incorrectly?

**Time:** ..... If the answer to ANY of these is yes, call 911 immediately. Time is important!

### **Critical instances:**

**Rupture of an artery or an aneurysm** may occur in the brain tissue and present as a stroke with additional symptoms of decrease in level of consciousness, respiratory difficulty, seizures or a severe headache.

A stroke may be so extensive as to create **severe brain dysfunction** with a decrease in LOC or respiratory difficulty.

**Diabetics presenting with stroke symptoms** may be experiencing a simple hypoglycemic or hyperglycemic reaction. Altered blood glucose levels can present with the same, or similar, symptoms as an acute stroke and should be considered as a possible cause.

### **\*\*\*\*Stroke Warning Signs\*\*\*\***

- Sudden numbness or weakness of the face, arm or leg especially on one side of the body
- Sudden confusion, trouble speaking or understanding
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, loss of balance or coordination
- Sudden, severe headache with no known cause

**Quick intervention provides an opportunity for better possible outcomes!**

## Stroke (CVA)

### Dispatch Criteria

#### Medic Response

- 18M1** Unconscious or not breathing
- 18M2** Sudden onset of severe headache, with one of the following:
- Slurred speech
  - Blurred/double vision
  - Weakness/paralysis
  - Vomiting
- 18M3** Decreased LOC, non-responsive to verbal or touch
- 18M4**
- 18M5**
- 18M6**

#### BLS Red Response

- 18R1** Unilateral (one-sided) weakness, paralysis
- 18R2** Weakness, numbness or unable to stand or walk
- 18R3** Diabetic
- 18R4** Breathing difficulty
- 18R5** No verifiable info available from RP
- 18R6** Disoriented, incoherent or trouble speaking

#### BLS Yellow Response

#### TRP

### Vital Points

- *Ask to speak directly to the patient, if possible!*

#### Medic:

- When did symptoms start?
- **When was patient last seen acting normally?**  
IF LESS THAN 6 hrs SINCE ONSET OF SYMPTOMS, PROMPT RESPONDERS FOR STROKE PROTOCOL
- Does the patient respond to you?
- Respond to your voice? (Can they answer your questions or follow simple commands)?
- Respond when you try to wake them?
- If acting unusual, what is different?
- Has the patient had a headache?
- Is the patient's speech slurred?
- Is the patient having any trouble breathing?
- Is the patient a diabetic?

#### BLS Red:

- How does the patient look?

#### Short Report:

- Does the patient have any other medical or surgical history?

### Pre-arrival Instructions

- Keep patient calm.
- Position of comfort.
- Nothing by mouth.
- Gather patient meds (If not done already)
- Test the patient's blood sugar, if you have the equipment and training to do this. Give results to the aid crew when they arrive.

### Short Report

- Gender
- Age
- Chief complaint
- Patient meets stroke protocol for rapid transport
- Pertinent signs and symptoms (when appropriate - less than 6 hrs since onset of symptoms.)
- Medical/surgical history, if relevant
- Other agencies responding

## Background Information

## Unconscious/Unresponsive/Syncope

### **Unconscious/Unresponsive/Syncope**

Anytime a patient is unconscious or unresponsive we have a critical situation. A patient with a decreased level of consciousness that can not be awakened verbally or by touch requires an ALS evaluation. It is not imperative that we discover the physiology behind the sign, however, it is important to remember some of the reasons that a patient may be unconscious.

### **Circulatory/Cardiovascular**

The patient may be unconscious due to a compromise in the cardiovascular system. Perhaps the pump (heart) is not operating due to cardiac arrest, or maybe the pipes (blood vessels) cannot sustain sufficient pressure to carry the blood to the brain or heart due to a problem within the brain. Or it is possible that the fluid (blood) is leaking out of a vessel and even though there is no exterior blood loss the patient has experienced considerable internal bleeding.

### **Respiratory**

The patient may be unconscious due to lack of oxygen to the brain or heart. This could be due to respiratory arrest or cardiac arrest. If the pumping mechanism is not working, the oxygenated blood cannot be delivered to the heart or to the brain.

### **Syncope**

Syncope is a sudden temporary loss of consciousness. It can be caused by something as simple as dehydration. If

there is not enough blood volume or pressure for oxygen rich blood to reach the brain, a patient could become light-headed and experience a sudden temporary loss of consciousness.

## Dispatch Criteria

### Medic Response

- 19M1** **CONFIRMED** Unconscious
- 19M2** Decreased LOC, non-responsive to verbal or touch
- 19M3**
- 19M4** Acute alcohol and/or drug intoxication (non-responsive to verbal or touch)
- 19M5** Respiratory Distress (one required):
  - Unable to speak normally (work of breathing)
  - Sitting, standing or leaning forward to breathe (tripod)
- 19M6** Sign of shock: Syncope or near syncope when sitting/standing
- 19M7**
- 19M8** Syncope associated with Chest pain/discomfort/palpitations, age > 40
- 19M9**

### BLS Red Response

- 19R1** **UNCONFIRMED** unconscious
- 19R2** Multiple syncopal episodes (same day)
- 19R3** No verifiable info available from RP
- 19R4** Single syncope
- 19R5** Acute alcohol and/or drug intoxication (responsive)
- 19R6** Syncope associated with headache
- 19R7** Vertigo/Dizziness
- 19R8**

### BLS Yellow Response

- 19Y1** Slumped over wheel - Consider PD response
- 19Y2**

### TRP

- 19T1**
- 19T2**

## Vital Points

- *Ask to speak directly to the patient, if possible!*

### Medic:

- Does the patient respond to you?
  - Respond to your voice (can they answer your questions)?
  - Respond when you try to wake them?
- Is this the first time today the patient has been unconscious?
- What was the patient doing before they became unconscious?
- Did the patient have any complaints just before they became unconscious?
- Has the patient taken any medications, recreational drugs or alcohol?
- Is the patient having any trouble breathing?
- Is the patient speaking normally?
- How does the patient feel when they sit up?
- Is the patient experiencing a rapid heart rate/palpitations?
- Is the patient experiencing any discomfort? Where?

### Short Report:

- Does the patient have any medical or surgical history?
- Is the patient wearing a Medic Alert tag?

## Unconscious/Unresponsive/Syncope

### Pre-arrival Instructions

- If unconscious and not breathing, go directly to **age-appropriate CPR PAI**.
- If unconscious and breathing normally, go directly to **Unconscious/Breathing PAI**.
- If conscious now, have patient lie down.
- If vomiting, have patient lie on side.
- Do not leave patient, be prepared to do CPR.
- Gather patient meds, if possible.

### Short Report

- Gender
- Age
- Chief complaint
- Pertinent signs and symptoms
- Medical/surgical history, if relevant
- Other agencies responding

**Background Information**

Obtaining information in the case of a pediatric patient can be challenging. In most cases the patient is too young to be able to complain of pain or describe symptoms they may be experiencing. Additionally, small children do not present with common progression of illnesses or shock as adults do, often making the early recognition of critical signs difficult to detect. For these reasons, the EMS community has adopted what is commonly referred to as the "pediatric triangle" for making a rapid determination of the pediatric patient's status. The three components of this triangle are: OVERALL APPEARANCE, WORK OF BREATHING and CIRCULATION SKIN SIGNS. Don't rely on the traditional measurement of vital signs, such as pulse rate and blood pressure, to identify an unstable patient. Because this evaluation is primarily visual, it could be easily assessed with the vital point questions and a cooperative RP.

**OVERALL APPEARANCE:**

Appearance tells a lot about oxygenation, brain perfusion and central nervous system function. There are several components that constitute appearance:

- Alertness: Is the child responsive? Restless, agitated or listless?
- Distractibility: Are you able to attract the child's interest or attention?
- Consolability: Can parent or caregiver comfort the child?
- Eye contact: Does the child maintain eye contact?
- Speech/Cry: Is speech/cry strong? Weak or muffled? Hoarse?
- Spontaneous motor activity: Is the child moving? Is there good muscle tone?
- Color: Is the child pink? Or pale, dusky or mottled?

**WORK OF BREATHING:**

Abnormal position, retractions and audible breath sounds are signs of increased work of breathing and respiratory distress.

- *Tripod position*: Leaning forward to breathe? This may improve breathing of the distressed child by aligning the structures of the airway.
- *Retractions*: Visible sinking-in of the soft tissues in the chest wall or neck indicating a significant increased work of breathing.
- *Wheezes*: "Musical," high-pitched noises heard on exhalation. Often described as whistling and caused by bronchospasm or swelling of the large airways.
- *Stridor*: Harsh, high pitched sounds heard on inhalation. Caused by swelling and spasms of the upper airways.

**CIRCULATION/SKIN SIGNS:**

Skin signs are a direct reflection of the overall status of the circulatory systems.

- Skin Color: Is it normal? Pink? Mottled, pale, grayish?  
**Cyanosis is a late finding and should not be relied upon as the only determination of an ill child.**
- Temperature: Is it normal? Hot? Cool?
- Capillary Refill Time: A very accurate way to determine the circulatory status in any patient. Depress the fingertip and the pink color should return in less than 2 seconds. Any slower may indicate a problem with perfusion.

**Febrile Seizures:**

Febrile seizures occur commonly in children between the age of 6 months and 3 years and are short in duration. Seizures in children < 3 yrs of age are assumed febrile seizures, unless they meet critical criteria.

## Dispatch Criteria

### Medic Response

- 20M1** Unconscious/unresponsive: Listless, limp, difficult or unable to awaken
- 20M2** Able to awaken. Poor appearance: Blue lips, mottled, gray-white
- 20M3** Respiratory Distress (one required):
  - Unable to speak normally (work of breathing)
  - Sitting, standing or leaning forward to breathe (tripod)
- 20M4** Seizures: • multiple > 3 per hour
  - extended, seizing now, > 5 minutes
- 20M5** Medication overdose, confirmed ingestion < 30 minutes
- 20M6** Confirmed ingestion of caustic substance w/difficulty swallowing
- 20M7** Life threatening congenital defects/anomalies
- 20M8** Illness/infection w/rapid onset (< 10 hours) with:
  - dramatic decrease in LOC
  - Listless,limp or quiet
  - drooling w/difficulty swallowing

### BLS Red Response

- 20R1** Breathing difficulty
- 20R2** Seizure(s), no longer in seizure (any one):
  - First time seizure
  - w/history
  - w/fever
- 20R3** Medication overdose:
  - Unconfirmed
  - > 30 min since ingestion
- 20R4** Ingestion of caustic substances:
  - Unconfirmed
  - No difficulty swallowing
- 20R5** Congenital health conditions/anomalies with:
  - Not feeling well
  - Non-specific symptoms
  - RP request for evaluation

### BLS Yellow Response

- 20Y1** Confirmed choking - expelled item, airway clear. No other symptoms
- 20Y2**

### TRP

- 20T1** Minor skin rashes
- 20T2** Ear ache/Teething
- 20T3** Temperature, Fever, Minor cold symptoms

## Vital Points

- **Ask to speak directly to someone with the patient, if possible!**

### Medic:

- Does the child respond to you?
- How does the child look?
- What is the child's skin color?
- Is the child having any trouble breathing?
- Was the child eating or did they have something in their mouth?
- Has the child had a seizure?
- Has the child been sick?
  - If yes, was it a rapid onset?
  - If yes, how long has the child been sick?
- Does the child have a fever or feel hot to the touch?
- Is the child drooling or having a difficult time swallowing?

### BLS Red:

- Does the child have any medical or congenital problems?

**Note:** Consider suspicious RP/abuse, check previous events history! Consider police response, especially if described mechanism does not fit severity of injury/condition.

## Pediatric Emergencies

### Pre-arrival Instructions

- If unconscious and not breathing normally, go directly to **age-appropriate CPR PAI.**
- Keep child calm
- Nothing by mouth
- If febrile seizure, remove clothing to cool patient.

### Short Report

- Gender
- Age
- Chief complaint
- Pertinent signs and symptoms
- Medical/surgical history, if relevant
- Other agencies responding

## Background Information

Statistically this is very seldom a paramedic response; however, it is important to get good information about weapons and injuries to identify those cases of penetrating injury (GSW or stabbing). MEDIC responses may also be needed for the patient with significant head injury and a decreased level of consciousness.

**Uncontrollable bleeding** is bleeding that cannot be controlled by direct pressure with a clean cloth or sanitary napkin. **Paramedics should not be dispatched until the RP has attempted to control bleeding without success.**

### Head Injuries

The best indicator of severity of injury in the head injured patient is their level of consciousness. A patient with a decreased level of consciousness indicates there is ongoing injury to the brain. This is often from a collection of blood that may be developing around the brain (subdural or epidural hematoma) or within the brain tissue (intracerebral hematoma).

Swelling of brain tissue due to bruising of the brain (contusion) may also cause a deteriorating level of consciousness. Obviously the unconscious, unresponsive patient has severe brain dysfunction and requires immediate paramedic intervention.

Mechanism of injury is important in all trauma assessment. Head injuries are very commonly associated with cervical spine injuries and patients with head injuries should not be moved until EMS personnel are on the scene, unless a life-threatening situation exists.

### Critical symptoms associated with head injuries include:

- decreasing level of consciousness
- combative patient - often due to a frontal hematoma in the brain
- breathing difficulty - may be due to airway difficulty or associated injuries
- seizures following a head injury

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### Non-critical symptoms of head injuries include:

- a brief loss of consciousness (< 5 minutes) followed by an awake, alert state (this is very common and does not indicate a critical risk factor in evaluating head injuries)
- amnesia for the event causing the injury

## Dispatch Criteria

### Medic Response

- 21M1 Confirmed unconscious or not breathing
- 21M2 Secondary to head injury (one required):
  - Decreased LOC, non-responsive to verbal or touch
  - Disoriented or combative
  - Seizure
- 21M3 GSW or stabbing, crushing or penetrating injury
- 21M4 Uncontrollable bleeding
- 21M5 Respiratory Distress (one required):
  - Unable to speak normally (work of breathing)
  - Sitting, standing or leaning forward to breathe (tripod)

### BLS Red Response

- 21R1
- 21R2
- 21R3 Minor injuries
- 21R4 Extremity fracture
- 21R5 Single syncope, secondary to trauma
- 21R6 No verifiable info available from RP
- 21R7 Major lacerations, with controllable bleeding
- 21R8 Breathing difficulty
- 21R9 Minor head/neck/shoulder injuries

### BLS Yellow Response

- 21Y1
- 21Y2
- 21Y3
- 21Y4 Police request stand-by/check for injuries
- 21Y5 Sexual assault
- 21Y6 Pepper Spray or Taser
- 21Y7

### TRP

- 21T1 Minor previous injuries
- 21T2 Concerned without apparent injuries
- 21T3 Pain associated with recent medical surgical procedure
- 21T4 Isolated fracture/dislocation: • Finger/Toe
- 21T5 Minor lacerations w/controlled bleeding

## Vital Points

- *Ask to speak directly to the patient, if possible!*

### Medic:

- Is the suspect still in the area?  
**If yes**, get description
- Is the scene secure?
- Describe what happened.
- Is the patient speaking normally?
- Is the patient having any trouble breathing?
- Can the patient respond to you and follow simple commands?
- Can the patient answer your questions?
- Is the patient combative (wanting to fight you)?
- Is the patient seizing?
- What was the patient assaulted with?
- Where on their body were they injured?
- Is the patient bleeding?  
**If yes:**
  - How much? • How long?
  - Can it be controlled with pressure?
- Has the patient had a recent head injury?  
**If yes:**  
How long ago?

### Short Report: (call-receiver/dispatcher)

- Have the police been notified?
- If suspect in area consider giving suspect/vehicle descriptions to Fire/EMS responders.

## Assault/Trauma

### Pre-arrival Instructions

- Do not remove/touch impaled object.
- If external bleeding, use clean cloth and apply pressure directly over it. **DO NOT REMOVE**, apply additional cloths on top, if needed.
- Have patient lie down and remain calm.
- Keep patient warm.
- Do not touch weapons or disturb scene.
- Preserve evidence.
- Patient should not change clothing, bathe or shower.
- Request witness remain at the scene if safe to do so.

### Short Report

- **Danger to field units, if present**
- Gender
- Age
- Chief complaint
- Pertinent signs and symptoms
- Medical/surgical history, if relevant
- Other agencies responding

## Background Information

## Burns - Thermal/Electrical/Chemical

Burns may be thermal, electrical, chemical, nuclear or solar. Burns are classified by degree:

- **First degree** is superficial.
- **Second degree** is blistering with deep reddening.
- **Third degree** is damage to all skin layers and is either charred/black or white/dry.

Burns to the airway are very dangerous because of swelling and secondary airway obstruction.

### Critical burn injuries:

**2nd or 3rd degree burns** are dangerous because of rapid loss of fluids through the burn surface, loss of body temperature regulation on the burn surface and the loss of skin integrity for prevention of infection.

**Respiratory tract burns** (airway, nose, mouth, larynx, or lungs) w/difficulty swallowing, hoarseness, or difficulty breathing.

**Electrical burns** are dangerous because of the body tissue damage that is not seen along the path of the current through the body. Normal household current carries little danger. However, 220 volts or greater can cause significant tissue damage and cardiac electrical dysfunction.

**Smoke inhalation**, often associated with significant carbon monoxide inhalation, should be suspected in the unconscious or decreased LOC patient.

## Dispatch Criteria

### Medic Response

- 22M1 Unconscious or not breathing
- 22M2
- 22M3 Respiratory Distress (one required):
  - Unable to speak normally (work of breathing)
  - Sitting, standing or leaning forward to breathe (tripod)
- 22M4 Burns to airway, nose, mouth, neck: (one required)
  - Hoarseness • Difficulty talking • Difficulty swallowing
- 22M5
- 22M6 Burns with blisters or skin sloughing on face, neck, chest or back
- 22M7 Electrical burns from power lines or panel boxes, 220V or greater
- 22M8

### BLS Red Response

- 22R1 Spilled hot liquids
- 22R2 Battery explosion
- 22R3
- 22R4 Minor burns on body surface
- 22R5 Chemical burns to eyes
- 22R6 No verifiable info available from RP
- 22R7 Breathing difficulty
- 22R8 Burns to hands, feet or genitals

### BLS Yellow Response

- 22Y1 Pepper Spray or Taser
- 22Y2 Household electrical shock, no symptoms

### TRP

- 22T1 Small burn from match, cigarette
- 22T2 Freezer burns
- 22T3 Severe sunburn

## Vital Points

- *Ask to speak directly to the patient, if possible!*

### Medic:

- Where is the patient burned?
- What is the extent of the burns?  
Blisters/skin sloughing?
- Is the patient speaking normally?
- Is the patient having any trouble breathing?
- Is the patient having difficulty swallowing?
- If head or face burn:
  - Is the patient coughing?
  - Are the patient's nose hairs burned?
  - Is the patient burned around their mouth or nose?
  - If male, is the mustache burned?
- How was the patient electrocuted?

### BLS Red:

- If household electrocution, what was the source?
- Are they still in contact with the electrical source?
- Are there any other injuries?

## Burns - Thermal/Electrical/Chemical

### Pre-arrival Instructions

- If unconscious and not breathing normally, go directly to **age-appropriate CPR PAI**
- If unconscious and breathing normally, go directly to **Unconscious/Breathing (trauma) PAI**

### Thermal (Heat, Smoke Inhalation, Hot Substances) :

- Loosely cover the patient with a clean sheet or blanket, to prevent heat loss.
- Remove patient from heat source.
- If burning agent is still on skin (tar, hot oil, plastics), flush burned area in cool clean water (not ice).

### Electrical (Electrocution, Lightning Strike):

- Turn power off, if safe.

### Chemical:

- Have patient remove contaminated clothing, if possible.
- Continuously flush chemicals from burns to eyes, remove contacts.
- If chemical is powder, brush off completely and rinse with water.
- Get information on chemical (Acid/Alkali) (MSDS Sheet if available).

### Short Report

- **Danger to field units, if present**
- Gender
- Age
- Chief complaint
- Pertinent signs and symptoms
- Medical/surgical history, if relevant
- Other agencies responding

## Background Information

## Drowning/Near Drowning/Diving or Water-related Injury

It is very important to remember that there are often head or neck injuries present in water-related accidents and near drowning victims. Also, accidents involving scuba diving are often associated with air embolism or the “bends” which are nitrogen “bubbles” in the tissues. Patients that have been in cold water such as Puget Sound often have severe hypothermia and require more support than a warm water victim.

### **Critical incidents:**

**Any respiratory difficulty** will only get worse in the water-related injury for the first 24 hours following immersion.

**Scuba diving accidents** are critical because of the potential for air embolism or the “bends” to develop.

Additional advice that can be given to on scene RP’s is to assure that the patient conserves body heat with warm, dry clothes or blankets pending EMS arrival.

### **Non-critical incident:**

**Confirmed submersion** of the patient may be significant since many of these patients will develop lung difficulties after (up to 24 hours) they are pulled out of the water and are assumed to be stable.

## Dispatch Criteria

### Medic Response

- 23M1** Unconscious or not breathing
- 23M2** Respiratory Distress (one required):
  - Unable to speak normally (work of breathing)
  - Sitting, standing or leaning forward to breathe (tripod)
- 23M3**
- 23M4** Scuba diving accident

### BLS Red Response

- 23R1** Submersion, patient conscious
- 23R2** Patient coughing
- 23R3** Other injuries: neck/back
- 23R4** No verifiable info available from RP
- 23R5** Breathing difficulty
- 23R6** Minor water-related injury, patient not submerged:
  - Extremity fracture
  - Major lacerations w/controllable bleeding

### BLS Yellow Response

**23Y1**

### TRP

- 23T1** Minor water-related injury, patient not submerged:
  - Isolated fracture/dislocation of toe/finger
  - Minor lacerations w/controlled bleeding

## Vital Points

- *Ask to speak directly to the patient, if possible!*

### Medic:

- Is the patient in or out of the water?
- Is the patient speaking normally?
- Is the patient having any trouble breathing?
- Is this a scuba diving accident?

### BLS Red:

- How long was the patient under water?
- Has the patient been removed from the water?
- What was the patient doing before the incident?

### Short Report:

- Is patient out of the water
- Is the patient on land or in a boat?

## Drowning/Near Drowning/Diving or Water-related Injury

### Pre-arrival Instructions

- If unconscious and not breathing normally, go to **age-appropriate CPR PAI with ventilations.**
- If unconscious and breathing normally, go directly to **Unconscious/Breathing (Trauma) PAI.**
- Toss them a floatation jacket/object, if available.
- Keep patient warm.
- Do not move patient around, attempt to protect head and neck.
- If patient vomits roll patient on their side.

### Short Report

- Gender
- Age
- Chief complaint
- Pertinent signs and symptoms
- Other agencies responding

## Background Information

Much of EMS work in the trauma field is based on mechanism of injury, and this category depends significantly on the mechanism of injury to assess dispatch priorities.

### Critical priorities:

**Falls associated with significant medical problems** such as chest pain, dizziness, headache or diabetes may be heralding a life-threatening illness that should have a paramedic evaluation.

**Industrial accidents with crushing or penetrating injury** have the potential for significant blood loss or vital organ impairment.

**Amputations or entrapments above the level of the fingers or toes** should have MEDIC evaluation for significant blood loss.

**Spinal injuries** should have paramedic evaluation for neurogenic shock.

**Uncontrollable bleeding** is bleeding that cannot be controlled by direct pressure with a clean cloth or sanitary napkin. **Paramedics should not be dispatched until the RP has attempted to control bleeding without success.**

**Head Injuries** - The best indicator of severity of injury in the patient with a head injury is level of consciousness. A patient with a decreased level of consciousness indicates there is ongoing injury to the brain. This is often from a collection of blood that may be developing around the brain (subdural or epidural hematoma) or within the brain tissue (intracerebral hematoma).

## Falls/Accidents/Pain

Swelling of brain tissue due to bruising of the brain (contusion) may also cause a deteriorating level of consciousness. Obviously the unconscious, unresponsive patient has severe brain dysfunction and requires immediate paramedic intervention.

Mechanism of injury is important in all trauma assessment. Head injuries are very commonly associated with cervical spine injuries and patients with head injuries should not be moved until EMS personnel are on the scene, unless a life-threatening situation exists.

### Critical symptoms associated with head injuries include:

- decreasing level of consciousness
- breathing difficulty - may be due to airway difficulty or associated injuries
- signs/symptoms of shock

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### Non-critical symptoms of head injuries include:

- a brief loss of consciousness (< 5 minutes) followed by an awake, alert state (this is very common and does not indicate a critical risk factor in evaluating head injuries)
- amnesia for the event causing the injury

## Dispatch Criteria

### Medic Response

- 24M1 Unconscious or not breathing
- 24M2 Decreased LOC, non-responsive to verbal or touch
- 24M3 Respiratory Distress (one required):
  - Unable to speak normally (work of breathing)
  - Sitting, standing or leaning forward to breathe (tripod)
- 24M4 Trauma with sign of shock: Syncope or near syncope when sitting/standing
- 24M5 Falls 10ft or greater, patient still down
- 24M6 Bilateral femur fractures
- 24M7 Amputation/entrapment above finger/toes
- 24M8 Trauma with paralysis
- 24M9 Uncontrollable arterial bleeding
- 24M0

### BLS Red Response

- 24R1 Single syncope
- 24R2 Falls associated with or preceded by:
  - Pain/discomfort in chest
  - Dizziness
  - Headache
  - Diabetic
- 24R3 Amputation/entrapment of fingers/toes
- 24R4 Minor head/neck/shoulder injury
- 24R5 Patient trapped, without obvious injury
- 24R6 Major laceration with controllable bleeding
- 24R7
  - Extremity fracture
  - Single femur fracture
  - Hip fracture and/or dislocation
- 24R8 No verifiable info available from RP
- 24R9 Breathing difficulty

### BLS Yellow Response

- 24Y1
- 24Y2 Patient assist
- 24Y3
- 24Y4 Hip pain, ambulatory

### TRP

- 24T1 Minor lacerations (controlled bleeding), bumps or bruises
- 24T2 Involved in accident, no complaints
- 24T3 Neck/back/shoulder pain
- 24T4 Fracture/dislocation of finger or toe

## Vital Points

- *Ask to speak directly to the patient, if possible!*

### Medic:

- Is the patient speaking normally?
- Is the patient having any trouble breathing?
- Can the patient respond to you and follow simple commands?
- Can the patient answer your questions?
- Is the patient combative (wanting to fight you)?
- How far did the patient fall?
- What did the patient land on?
- What part of the body has been amputated?
- Do you have the amputated parts?
- Is the patient able to move their fingers and toes?
- Is the patient bleeding?  
**If yes, from where?**

### BLS Red:

- Are there any obvious injuries?
- Did the patient complain of any discomfort or illness just prior to the fall?
- If accident, what part of the body has been injured?

## Falls/Accidents/Pain

### Pre-arrival Instructions

- If unconscious and breathing normally, go directly to **Unconscious/Breathing (trauma) PAI**
- If machinery, turn it off. (Try to locate maintenance).
- Do not move patient (if no hazards).
- Cover patient w/blanket and keep calm.
- Nothing by mouth.
- If external bleeding, use clean cloth and apply pressure directly over it. **DO NOT REMOVE**, apply additional cloths on top if needed.
- Locate any amputated parts or skin and place in clean plastic bag, not on ice.
- Request witness to remain at scene, if possible.

### Short Report

- **Danger to field units, if present**
- Gender
- Age
- Chief complaint
- Pertinent signs and symptoms
- Medical/surgical history, if relevant
- Other agencies responding

**Background Information**

Much of EMS work in the trauma field is based on mechanism of injury, and this category depends significantly on the mechanism of injury to assess dispatch priorities.

**Critical priorities:**

Confirmed or unknown injuries with the following mechanisms at a speed greater than or equal to 40 mph:

- Vehicle (car/motorcycle) vs. immovable object
- Vehicle vs. vehicle (Head-on or T-Bone)
- Vehicle vs. motorcycle
- Patient ejected from vehicle
- MCI criteria
- Vehicle vs. pedestrian/bicyclist - patient still down
- Roll over, patient trapped

Other critical criteria include patients with:

- Head injury with decreased level of consciousness
- Chest pain precipitating accident
- Unconscious/not breathing

**"No Verifiable information from the RP" indicates that the RP simply passed by the accident and has no information. Information being fed to the caller from another party at the scene is considered "Verifiable Information".**

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**Non-critical criteria for MVA include:**

- rollover accidents less than 40 mph (which have a low incidence of life-threatening injury)
- patients who are walking about at scene
- police call for injury evaluation
- low speed less than 40 mph MVA's

**Head Injuries** - The best indicator of severity of injury in the patient with a head injury is level of consciousness. A patient with a decreasing level of consciousness indicates there is ongoing injury to the brain. This is often from a collection of blood that may be developing around the brain (subdural or epidural hematoma) or within the brain tissue (intracerebral hematoma).

Swelling of brain tissue due to bruising of the brain (contusion) may also cause a deteriorating level of consciousness. Obviously the unconscious, unresponsive patient has severe brain dysfunction and requires immediate paramedic intervention.

Mechanism of injury is important in all trauma assessment. Head injuries are very commonly associated with cervical spine injuries and patients with head injuries should not be moved until EMS personnel are on the scene, unless a life-threatening situation exists.

**Critical symptoms associated with head injuries include:**

- decreasing level of consciousness
- combative patient - often due to a frontal hematoma in the brain
- breathing difficulty - may be due to airway difficulty or associated injuries
- seizures **following** a head injury

**Non-critical symptoms of head injuries include:**

- a brief loss of consciousness (< 5 minutes) followed by an awake, alert state (this is very common and does not indicate a critical risk factor in evaluating head injuries)
- amnesia for the event causing the injury

## Dispatch Criteria

### Medic Response

- 25M1** Unconscious or not breathing
- 25M2** Decreased LOC, non-responsive to verbal or touch
- 25M3** Respiratory Distress (one required):
  - Unable to speak normally (work of breathing)
  - Sitting, standing or leaning forward to breathe (tripod)
- 25M4** Vehicle speed  $\geq$  40 MPH with any of the following mechanisms:
  - Veh vs. immovable object
  - Veh vs. Veh (Head-on or T-bone)
  - Veh vs. Motorcycle
  - Roll over, patient trapped
- 25M5**
- 25M6** Trauma with sign of shock: Syncope or near syncope when sitting/standing
- 25M7** Patients ejected
- 25M8** Vehicle vs. Pedestrian/Bicyclist - patient still down

### BLS Red Response

- 25R1** Injury accident:
  - Vehicle speed < 40 MPH
  - Vehicle speed  $\geq$  40 MPH, no medic criteria
  - Unknown extent of injuries
- 25R2** Roll-over, < 40 MPH
- 25R3** No verifiable info available from RP
- 25R4** Patient trapped, < 40 MPH
- 25R5** Vehicle vs. Pedestrian/Bicyclist - minor injuries

### BLS Yellow Response

- 25Y1**
- 25Y2** Request for evaluation via personnel on location:
  - Police • Fire Dept.

## Vital Points

- *Ask to speak directly to the patient, if possible!*

### Medic:

- How fast was the vehicle traveling?
- What did the vehicle hit?
- Did the caller stop or drive by?
- How many patients are injured?
- Are the patients able to respond to you and follow simple commands?
- Are the patients having any trouble breathing?
- Are all of the patients free of the vehicle? Is anyone trapped in the vehicle due to injuries?
- Was anyone thrown from the vehicle?

### BLS Red:

- Is the patient complaining of any discomfort?

### Short Report:

- Are there any hazards present (fire, water, wires down?)

## Motor Vehicle Accident (MVA)

### Pre-arrival Instructions

- Do not move patient, attempt to protect head and neck (if no hazards).
- If external bleeding, use clean cloth and apply pressure directly over it. **DO NOT REMOVE**, apply additional cloths on top if needed.
- Request witness to remain at scene, if safe to do so.

### Short Report

- **Danger to field units, if present**
- Gender
- Age
- Chief complaint
- Pertinent signs and symptoms
- Medical/surgical history, if relevant
- Other agencies responding

**Background Information****Critical Bites****Concern for airway**

Bites around the face or neck are considered critical because of the possibility of airway obstruction. If these bites are superficial, they may not be critical and therefore may not require a paramedic evaluation/response. If uncertain whether or not airway compromise exists, err on the side of caution and send a paramedic.

**Uncontrollable Bleeding**

Uncontrollable bleeding is bleeding that cannot be controlled by direct pressure with a clean cloth or sanitary napkin. If the RP and/or patient has made an attempt to control the bleeding and has not been successful, then a paramedic response is needed.

**Respiratory Distress**

Speak to the patient whenever possible to determine the work of breathing. Work of breathing is the effort it takes to move a sufficient amount of air.

Respiratory distress could be the result of airway compromise due to location of bite, systemic response to the venom, or secondary to shock due to blood loss. In any case, it is not important to determine why the patient is in respiratory distress, it is important to quickly assess the breathing and determine if the patient has any signs/symptoms of respiratory compromise.

**Danger to Field Units**

It is important to determine the location of the poisonous snake or the vicious animal in order to quickly notify the responding units of this location and make them aware of the situation.

If appropriate, call out animal control or other entity to assist in the containment and/or capture of the animal.

## Animal Bites

### Dispatch Criteria

#### Medic Response

- 26M1** Unconscious or not breathing
- 26M2** Uncontrollable bleeding
- 26M3** Respiratory Distress (one required):
  - Unable to speak normally (work of breathing)
  - Sitting, standing or leaning forward to breathe (tripod)
- 26M4** Serious neck and/or face bites (one required):
  - Airway compromised
  - Decreased LOC
  - Uncontrollable bleeding
- 26M5** Bite from poisonous animal
- 26M6** Sign of shock: Syncope or near syncope when sitting/standing

#### BLS Red Response

- 26R1** Bites to face and/or neck with controlled bleeding
- 26R2** No verifiable info available from RP
- 26R3** Breathing difficulty

#### BLS Yellow Response

#### TRP

- 26T1** Swelling at bite site
- 26T2** Bites below neck, non-poisonous, controlled bleeding

### Vital Points

- *Ask to speak directly to the patient, if possible!*

#### Medic:

- Is the patient speaking normally?
- Is the patient having any trouble breathing?
- What part of the body was bitten?
- Is the patient bleeding?
- Does the bleeding stop when you apply pressure?
- What type of animal bit the patient?
- How does the patient look?
- How does the patient feel when they sit up?

#### TRP:

- Is there any swelling around the bite?

#### Short Report:

- Is the animal contained?
- Have PD and/or Animal Control been notified?
- Description of animal?

### Pre-arrival Instructions

- Contain the animal, if it is safe to do so.
- Keep patient calm and still.
- If external bleeding, use clean cloth and apply pressure directly over it. **DO NOT REMOVE**, apply additional cloths if needed.
- Request witness remain at scene, if safe to do so.

### Short Report

- **Danger to field units, if present**
- Gender • Age
- Chief complaint
- Pertinent signs and symptoms
- Medical/surgical history, if relevant
- Other agencies responding PD and/or Animal Control?

## AUTOMATED EXTERNAL DEFIBRILLATOR INSTRUCTIONS

(Use if patient is over 8 years of age unless RP has PEDS attachment and has been trained)

- Has anyone there been trained to use the defibrillator?
- Get the patient **flat** on their **back** on the **floor**.
- **Bring the defibrillator next to the patient's ear. Make sure it is not touching the patient.**
- **Kneel** next to them.
- **Bare** the chest.
- **Open** the defibrillator case. (Look for a zipper, snaps on the side or a black button on the lid.)
- Turn the machine on and follow instructions.

***If help is needed, use the following instructions:*** (Remind RP that your assistance is not delaying the response.)

- **Pull out and open** the foil pouch containing the electrode pads.
- **Peel the backing off the pads.**
- **Place the pads on the person's chest following the pictures. Look to see that one pad is on the person's upper right chest, below the collarbone, and the other pad is on the person's left side, below the armpit.**
- **Check** that the cord to the pads are plugged into the defibrillator. If not, do so now.
- **Push the green** button to turn on the machine.
- **"Analyzing"** means the defibrillator is deciding whether to shock or not.
- **Push** the analyze button if told to do so. **DO NOT** touch the person. (*No one should be touching the cords or the person during analysis.*)

**The defibrillator will give one of two messages: "Shock advised" or "No shock advised."**

Did the defibrillator tell you to push the shock button?

### **If YES:**

**SHOCK ADVISED:** (*The defibrillator is charging.*)

- **SHOUT, "STAND CLEAR!"**
- **MOVE BACK** and make sure no one is touching the patient, including yourself.
- **Push** the shock button.
- The defibrillator may deliver up to 3 shocks in a row, with an automatic, short analysis between each shock. After 3 shocks, the AED will tell you to check pulse. If no pulse, begin CPR.

### **If NO:**

**NO SHOCK ADVISED:** (*No shock will be given at this time.*)

- **Is she/he conscious & breathing normally?**
- **Begin CPR**, I will help you, go directly to **age-appropriate CPR PAI**.
- **Leave Pads on Chest & Defibrillator turned on.**
- After a period of CPR the defibrillator will tell you to stand clear to analyze. Follow the defibrillator's instructions.

## CPR/Adults

1. Is there an AED (Automatic External Defibrillator) on the premise?
2. Does anyone there know **CPR**? (*Trained bystanders may still need instructions. Ask!*)
3. Get the phone **NEXT** to the person.
4. Listen carefully. I'll tell you what to do.
  - Get them **FLAT** on their **back** on the **floor**.
  - **BARE** the chest.
  - **KNEEL** by their side.
  - Put the **HEEL** of your **HAND** on the **CENTER** of their **CHEST**, right **BETWEEN** the **NIPPLES**.
  - Put your **OTHER HAND ON TOP** of **THAT** hand.
  - **PUSH DOWN FIRMLY, ONLY** on the **HEELS** of your hands, **2 inches**.
  - Do it **50** times, just like you're **PUMPING** the chest. Count **OUTLOUD 1-2-3...50**. **\*\*\***(correct rate if needed)
  - **KEEP DOING IT: KEEP PUMPING** the **CHEST UNTIL HELP TAKES OVER**. I'll stay on the line.

**\*\*\*If rescuer becomes too tired to continue instruct them to rest a short time then continue **compressions as soon as possible**\*\*\***

**Ventilation Instructions:** (for use when suspected cardiac arrest secondary to respiratory arrest)

- **PINCH** the **NOSE**: With your other hand, **LIFT** the **CHIN** so the head **BENDS BACK**.
- Completely **COVER** their **MOUTH** with your **MOUTH**.
- **GIVE TWO BREATHS OF AIR** (come back to the phone).

**\*\*\*Then back to compression instructions (#4 above) but give 30 compressions between breaths.\*\*\***

**Foreign Body Airway Obstruction:** (***confirmed*** choking now unconscious)

- *After each set of 30 compressions "Look inside the mouth, remove any obvious obstruction". If object is removed give two ventilations between each set of 30 compressions. If object not seen continue with compressions.*

***NOTE: IF CALLER REPORTS VOMITING, INSTRUCT CALLER TO:***

- Turn their head to one side.
- Sweep out contents with your fingers before you resume.

## CPR/Children 1-8 Years

1. Does anyone there know **CHILD** CPR? (*Trained bystanders may still need instructions. **Ask!***)
2. Listen carefully. I'll tell you what to do .
  - Move the child to a **HARD** surface (*table or floor*) near the phone.
  - **BARE** the chest.
  - **PINCH** the **NOSE**.
  - With your **OTHER** hand, **LIFT** the **CHIN** and **TILT** the head back.
  - If possible choking: "**Look inside mouth, remove any obvious obstruction**".
  - Completely **COVER** their mouth with your mouth and give **2 breaths**.
3. **THEN COME BACK TO THE PHONE**. If I'm not here, **stay on the line**.
4. Listen carefully. I'll tell you what to do next.
  - Put the **HEEL** of **ONLY ONE HAND** on the **CENTER** of the chest, right **BETWEEN** the **NIPPLES**.
  - **PUSH** down firmly **one-half the depth of the chest**.
  - Do this **30** times **QUICKLY**. Count **OUTLOUD** 1-2-3-4-5...30
  - Then **PINCH** the **NOSE**, **LIFT** the **CHIN**, and gently tilt the head back.
  - Give **2 breaths**.
  - **Keep doing it until help can take over**. I'll stay on the line.

**NOTE: IF CALLER REPORTS VOMITING, INSTRUCT CALLER TO:**

- Turn their head to one side.
- Sweep it all out with your fingers before you resume ventilations.

### CPR/Neonate (Newborn-associated with field delivery)

1. Does anyone there know CPR for newborns? (*Trained bystanders may still need instructions. Ask!*)
2. Bring the baby to the phone.
3. Listen carefully. I'll tell you what to do.
  - Lay the baby **FLAT** on their **BACK** on a table.
  - **BARE** the baby's **CHEST**.
  - **LIFT** the **CHIN** slightly. **MAKE SURE THE NECK REMAINS LEVEL.**
  - **TIGHTLY COVER** the baby's **MOUTH AND NOSE** with your mouth.
  - **GIVE 1** short **BREATH** of air.
  - Then come back to the phone. If I'm not here, **stay on the line.**
4. Listen carefully. I'll tell you what to do next.
  - Put your **FIRST AND MIDDLE** fingertips on the **CENTER** of the chest, right **BETWEEN** the **NIPPLES**.
  - **PUSH** down **one-half the depth of the chest, 3** times. Count **OUTLOUD 1-2-3**.
  - Go do that. Then come back to the phone.
  - **NEXT, LIFT** the **CHIN. MAKING SURE THE NECK REMAINS LEVEL.**
  - **TIGHTLY COVER** the baby's **MOUTH AND NOSE** with your mouth.
  - **GIVE 1** short **BREATH** of air.
  - Then come back to the phone.
  - **KEEP DOING THIS until HELP CAN TAKE OVER.**
  - **REMEMBER, 1 breath, then 3 compressions.** I'll stay on the line.

**NOTE: IF CALLER REPORTS VOMITING, INSTRUCT CALLER TO:**

- Turn newborn on their side.
- Sweep out anything you can see with your fingertips. (Do not attempt to get anything out of the mouth that you cannot see)
- No blind finger sweeps).

## CPR/Infants 0-12 Months

1. Does anyone there know **INFANT** CPR? (*Trained bystanders may still need instructions. **Ask!***)
  2. Bring the baby to the phone.
  3. Listen carefully. I'll tell you what to do.
    - Lay the baby **FLAT** on their **BACK** on a table.
    - **BARE** the baby's **CHEST**.
    - **LIFT** the **CHIN** slightly. **MAKE SURE THE NECK REMAINS LEVEL**.
    - If possible choking: "**Look inside mouth, remove any obvious obstruction**".
    - **TIGHTLY COVER** the baby's **MOUTH AND NOSE** with your mouth.
    - **GIVE 2 BREATHS** of air.
    - **THEN COME BACK TO THE PHONE**. If I'm not here, **stay on the line**.
  4. Listen carefully. I'll tell you what to do next.
    - Put your **FIRST AND MIDDLE** fingertips on the **CENTER** of the chest, right **BETWEEN** the **NIPPLES**.
    - **PUSH** down **one-half the depth of the chest**. Do it **30** times **RAPIDLY**. Count **OUTLOUD** 1-2-3-4-5...30
    - Go do that. Then come back to the phone.
  5. Listen carefully.
    - **NEXT, LIFT** the **CHIN** slightly, **MAKING SURE THE NECK REMAINS LEVEL**, and give **2 quick breaths** of air.
    - Then, put your **FIRST AND MIDDLE FINGERS** on the **CENTER OF THE CHEST**, right **BETWEEN** the **NIPPLES**.
    - **PUSH** down one-half the depth of the chest. Do it **30** times **RAPIDLY**. Count **OUTLOUD** 1-2-3-4-5...30.
    - Follow with **2 breaths**
    - **KEEP DOING THIS. REMEMBER, 2 breaths, then 30 quick compressions.**
    - **Keep doing it until help takes over**. I'll stay on the line.
- NOTE: IF CALLER REPORTS VOMITING, INSTRUCT CALLER TO:**
- Turn their head to the side.
  - Sweep it out with your fingers before you resume ventilations. (Do not attempt to get anything out of the mouth that you cannot see - No Blind finger sweeps).

## CPR/Pregnant Woman (3rd Trimester)

1. Does anyone there know **CPR**? (*Trained bystanders may still need instructions. Ask!*)
2. Get the phone **NEXT** to her, if you can.
3. Listen carefully. I'll tell you what to do.
  - Get her **FLAT** on her **BACK** on the floor.
  - Get a pillow or folded blanket and **WEDGE** it under the **RIGHT SMALL** of the **BACK**.\*
  - **BARE** the chest.
  - **KNEEL** by her side.
  - **PINCH** the nose.
  - With your **OTHER** hand, **LIFT** the **CHIN** so the head **BENDS BACK**.
  - If possible choking: **"Look inside mouth, remove any obvious obstruction"**.
  - **COMPLETELY COVER** her mouth with your mouth.
  - **GIVE 2** breaths of air.
  - **THEN, COME BACK TO THE PHONE!** If I'm not here, **stay on the line**.
4. Listen carefully, I'll tell you what to do next.
  - Put the **HEEL** of your **HAND** on the **CENTER** of her **CHEST**, right **BETWEEN** the **NIPPLES**.
  - Put your **OTHER HAND ON TOP** of **THAT** hand.
  - **PUSH DOWN FIRMLY, ONLY** on the **HEELS** of your hands, **2 inches**.
  - Do it **30** times, just like you're **PUMPING** her chest. Count **OUTLOUD** 1-2-3-4-5...30.
  - **MAKE SURE** the **HEEL** of your hand is on the **CENTER** of her chest, **RIGHT BETWEEN** the **NIPPLES**. Pump **30** times.
  - Then, **PINCH** the **NOSE** and **LIFT** the **CHIN** so the head **BENDS BACK**.
  - **2 MORE** breaths and **PUMP** the **CHEST 30** times.
  - **KEEP DOING IT: PUMP** the **CHEST 30** times. Then **2 BREATHS**.
  - **KEEP DOING IT UNTIL HELP CAN TAKE OVER.** I'll stay on the line.

**\*NOTE:** When the woman is flat on her back, the position of the pregnant uterus can put pressure on the iliac vessels, the inferior vena cava and the abdominal aorta. To decrease this pressure, the person who is going to do CPR can wedge a pillow or a folded blanket, under the right small of the back, thus moving the uterus to the left side of the abdomen and alleviating pressure on areas where blood flow is vital.

**BACKGROUND INFORMATION:** Causes of cardiac arrest during pregnancy can be any of the following:

- Pulmonary embolism (blockage of the pulmonary artery by blood clot)
- Hypovolemia (diminished blood supply due to internal hemorrhaging)
- Amniotic fluid embolism
- Congenital and acquired cardiac disease
- Trauma

## CPR/Tracheostomy/Laryngectomy Patients (Stoma)

Some patients have a tracheostomy - a surgical opening in the neck. This may be a result of a laryngectomy (removal of part of the upper airway) or other problem. This opening is called a “stoma” and the person breathes through it rather than through their mouth and nose. The stoma connects the airway (trachea) to the skin of the neck. This may appear as a small 1/2 inch slit or hole in the neck or as a metal or plastic flange plate with a “breathing hole.” All patients with a stoma must be ventilated through this opening, **NOT** through the nose and mouth. In most patients, the mouth and nose are no longer connected to the lungs (laryngectomy), but in some there is still a partial connection through which air could escape (partial laryngectomy). In such cases the mouth and nose must be blocked whenever the patient is being ventilated through the stoma, or the air blown in will go out through the mouth and nose instead of into the lungs.

1. Does anyone there know **CPR**? (*Trained bystanders may still need instructions. Ask!*)
2. Get the phone **NEXT** to the person, if you can.
3. Listen carefully. I'll tell you what to do.
  - Get them **FLAT** on their **BACK** on the floor.
  - **BARE** the **CHEST** and **NECK**.
  - **KNEEL** by their side.
  - **TILT** the head back slightly. **DO NOT** let it turn to the side.
  - **COMPLETELY SEAL** the **MOUTH** by covering it with your hand and **PINCH** the **NOSE** shut.
  - **COMPLETELY COVER** the stoma with your **MOUTH** and **GIVE 2 BREATHS** of **AIR** into their **LUNGS**.
  - **THEN COME BACK TO THE PHONE!** If I'm not here, **STAY ON THE LINE!**
4. Listen carefully, I'll tell you what to do next.
  - Put the **HEEL** of your **HAND** on the **CENTER** of their **CHEST**, right **BETWEEN** the **NIPPLES**.
  - Put your **OTHER HAND ON TOP** of **THAT** hand.
  - **PUSH DOWN FIRMLY, ONLY** on the **HEELS** of your hands, **2 inches**.
  - Do it **30** times, just like you're **PUMPING** their chest. Count **OUTLOUD** 1-2-3-4-5...30.
  - **MAKE SURE** the **HEEL** of your hand is on the **CENTER** of their chest, **RIGHT BETWEEN** the **NIPPLES**. Pump **30** times.
  - **COMPLETELY SEAL** the **MOUTH** and **PINCH** the **NOSE** shut.
  - **COMPLETELY COVER** the stoma with your **MOUTH**. **GIVE 2 BREATHS**.
  - **KEEP DOING IT: PUMP** the **CHEST 30** times. Then **GIVE 2 BREATHS**.
  - **KEEP DOING IT UNTIL HELP CAN TAKE OVER**. I'll stay on the line.

### NOTES:

- Remember to have the caller completely seal the mouth and pinch nose when performing ventilations through the stoma.
- If the caller reports that the neck opening is encrusted with mucous, instruct the caller to clean the opening with a clean cloth.

## CHOKING - PREGNANT WOMEN (3rd Trimester) or OBESE

If person is **UNCONSCIOUS**, go to CPR/Adults or CPR for Pregnant Women Instructions.

If person is **CONSCIOUS**: Follow Step 1 below.

1. Is the person able to **TALK** or **COUGH**:

(If **YES**): STOP.

(If **NO**): Listen carefully. I'll tell you what to do next:

- Stand **BEHIND** the person.
- With your arms directly under the person's armpits. **ENCIRCLE** their **CHEST**.
- Place the thumb side of one fist on the **MIDDLE** of their **BREASTBONE**.
- **GRAB** that fist with your other hand and **THRUST INWARD** until the object is expelled.
- **If the person becomes unconscious, go to appropriate CPR Instructions.**

## CHOKING - ADULT

If person is **UNCONSCIOUS**, go to **CPR/Adult Instructions**.

If person is **CONSCIOUS**:

1. Is the person able to **TALK** or **COUGH**:

(If **YES**): STOP

(If **NO**): Listen carefully. I'll tell you what to do next.

- Stand **BEHIND** the person. Wrap your arms **AROUND** the waist.
- Make a fist with **ONE** hand and place it against the **STOMACH**, in the **MIDDLE** slightly **ABOVE** the navel.
- **GRASP** your fist with the other hand.
- **PRESS** into the stomach with **QUICK, UPWARD** thrusts. **Repeat thrusts until the item is expelled.**
- **If the person becomes unconscious, go to CPR/Adult Instructions.**

## CHOKING - CHILD (1-8 Yrs.)

If child is **UNCONSCIOUS**, go to **CPR/Child Instructions**.

If child is **CONSCIOUS**:

1. Is the child able to **TALK** or **COUGH**:

(If **YES**): STOP.

(If **NO**): Listen carefully. I'll tell you what to do next.

- Stand **BEHIND** the child. Wrap your arms **AROUND** the waist.
- Make a fist with **ONE** hand and place it against the **STOMACH**, in the **MIDDLE** slightly **ABOVE** the navel.
- **GRASP** your fist with the other hand.
- **PRESS** into the stomach with **QUICK, UPWARD** thrusts. **Repeat thrusts until the item is expelled.**
- **If child becomes unconscious, go to CPR/Child Instructions.**

## CHOKING - INFANT (0 - 12 months)

If infant is **UNCONSCIOUS**, go to **CPR/Infants Instructions**.

If infant is **CONSCIOUS**:

1. There might be something blocking the baby's airway. **Bring the baby to the phone.**
2. Is the baby able to **CRY** or **COUGH**:

**(If YES):** STOP.

**(If NO):** Listen carefully. I'll tell you what to do next:

- **BARE** the baby's chest (open the shirt, lift the shirt).
  - **PICK** up the baby, and turn the baby **FACE DOWN** so it lies along your forearm.
  - **SUPPORT** the baby's **JAW** in your **HAND** with your arm resting on your thigh for support.
  - **TILT** the baby, with the head down slightly. Use the heel of your other **HAND** to strike the **BACK** firmly **5** times, right between the **SHOULDER BLADES** Do that and come back to the phone.
3. Listen carefully.
    - Lay the baby **FLAT** on their back on a table or a hard surface.
    - Put your **INDEX (First)** and **MIDDLE FINGERS** on the **CENTER** of the chest, right **BETWEEN** the **NIPPLES**.
    - Push down **1 inch**. Push down **5** times **RAPIDLY**. Count **OUTLOUD** 1-2-3-4-5.
    - Do that and come back to the phone.
    - **Repeat steps until the item is expelled.**
    - **If the baby becomes unconscious go to CPR/Infant Instructions.**

## UNCONSCIOUS PATIENT/BREATHING NORMALLY - AIRWAY CONTROL

### BREATHING NORMALLY (Non-trauma)

1. Listen carefully. I'll tell you what to do.
  - Roll the patient on their side.
  - Check for normal breathing until help takes over.
  - Watch for the chest to rise and fall.
2. **I have advised the dispatcher to send help.** If the patient stops breathing normally or vomits, call back.

### **VOMITING/UNCONSCIOUS PERSON**

Listen carefully. I'll tell you what to do.

- Turn their head to the side.
- Sweep it all out of the mouth with your fingers.
  
- Is the person breathing normally?  
**(If YES):** Continue watching the person. If the person stops breathing normally, **CALL BACK.**

**(If NO):** Go to **age-appropriate CPR Instructions.**

### BREATHING NORMALLY (Trauma)

1. Listen carefully. I'll tell you what to do.
  - **Do not move the patient (especially head and neck),** unless imminent danger to life.
  - Check for normal breathing until help takes over.
  - Watch for the chest to rise and fall.
2. **I have advised the dispatcher to send help.** If the patient stops breathing normally or vomits, call back.

### **VOMITING/UNCONSCIOUS PERSON**

Listen carefully. I'll tell you what to do.

- **Do not turn their head.**
- Sweep it all out of the mouth with your fingers.
  
- Is the person breathing normally?  
**(If YES):** Continue watching the person. If the person stops breathing normally, **CALL BACK.**

**(If NO): IF PATIENT MEETS CRITERIA FOR CPR, GO TO AGE-APPROPRIATE CPR INSTRUCTIONS.**

**NOTE: Vomiting in an unconscious person is very serious. If possible, try to stay on the line until emergency personnel arrive at the scene.**

## CHILDBIRTH (for woman by herself)

1. Have you had a baby before?
2. How many minutes between your contractions? Contractions with **less than 2 minutes between them** (especially if the woman feels a **strong desire to push**), indicate birth may be **imminent**.
3. If there are **more than 2 minutes between contractions**: Listen carefully. I'll tell you what to do.
  - **LIE** in a comfortable position on your **LEFT SIDE**.
  - Take **DEEP** breaths in through your nose and out through your mouth.
  - We will get someone there as soon as possible.
4. If there are **less than 2 minutes between contractions**, and there is a **strong desire to push**: Listen carefully. I'll tell you what to do.
  - Try to stay on the line with me or keep the phone nearby.
  - If possible, get some clean towels or sheets. Place some on the floor. Keep the rest handy for later.
  - Remove your underwear.
  - Lie down on your **BACK** on the towels and relax, breathing **DEEPLY** through your **MOUTH**.
  - **BEND** your **KNEES**.
5. If she begins to deliver (crowning and pushing): Listen carefully. I'll tell you what to do.
  - The baby's head should deliver first.
  - There will be water and blood with delivery. **THIS IS NORMAL**.
  - When the baby is delivered, gently try to clean out its mouth and nose with a clean, dry cloth.
  - Do not **CUT** or **PULL** the cord.
  - Wrap the baby in a towel, or whatever is handy, and place it between your legs.
  - If/when the placenta (tissue at the other end of the umbilical cord) is delivered, **WRAP IT**.
  - Keep the placenta **LEVEL** with or **SLIGHTLY ABOVE** the baby.
  - If the baby does **NOT** start breathing on its own, rub its back or gently slap the soles of its feet.

**If the baby DOESN'T begin breathing IMMEDIATELY on its own: Go to CPR-Neonates.**

**If possible, STAY ON THE LINE WITH ME.**

6. If there is a leg, arm or buttock presenting:
  - **REASSURE** the mother. Tell her you will have someone there as soon as possible.
  - Ask her to remain on her **BACK** with her **KNEES BENT**.
  - Ask her to **RELAX** and **BREATHE** through her **MOUTH**.
  - Tell her **NOT TO PUSH** and **NOT TO PULL ON THE LIMB**.
7. If the umbilical cord is presenting, have the mother get on her knees with her head resting on the floor and her buttocks in the air. The Knee-Chest Position. Attempt to keep pressure off of the cord.

**Postpartum Hemorrhage** (external bleeding from the vagina, persistent abdominal rigidity or tenderness and signs of shock.)

- Firmly massage the lower abdomen in a circular motion.
- (*Treat for shock*): Keep the mother warm and elevate legs.
- Place a sanitary napkin over the vaginal opening.

## CHILDBIRTH

1. Has she had a baby before?
2. How many minutes between her contractions? Contractions with **less than 2 minutes between them** (especially if the woman feels a **strong desire to push**), indicate birth may be **imminent**.
3. If there are **more than 2 minutes between contractions**: Listen carefully. I'll tell you what to do.  
Have her **LIE** in a comfortable position on her **LEFT SIDE** and take **DEEP** breaths. **I have advised the dispatcher to send help.**
4. If contractions are **less than 2 minutes** between contractions and if there is a **strong desire to push**: Listen carefully, I'll tell you what to do.
  - Get the phone **NEXT** to her, if you can.
  - Ask her to **LIE** on her **BACK** and relax, breathing **DEEPLY** through her **MOUTH**.
  - Ask her to remove underwear and **BEND** her **KNEES**.
  - Place clean towels **UNDER** her **BUTTOCKS** and have additional clean towels ready.
5. If she starts to deliver (*baby's head appears*): Listen carefully. I'll tell you what to do.
  - The baby's head should deliver first. **CRADLE** it and the rest of the baby as it is delivered. **DO NOT PUSH OR PULL**.
  - There will be water and blood with delivery. **THIS IS NORMAL**.
  - When the baby is delivered, **CLEAN** out its **MOUTH** and **NOSE** with a **CLEAN, DRY** cloth.
  - Do **NOT** attempt to **CUT** or **PULL** the cord.
  - Wrap the baby in a clean towel, or whatever is handy, and place it between mother's legs.
  - Massage mother's lower abdomen very gently.
  - **If the baby does NOT start breathing on its own**, rub its back or gently slap the soles of its feet. If the baby **DOESN'T** begin breathing **IMMEDIATELY**, come back to the phone.

**IF THE BABY DOES NOT BEGIN BREATHING ON IT'S OWN: GO TO CPR/Neonate Instructions.**

  - If/When the placenta (*tissue at the other end of the umbilical cord*) is delivered, **WRAP IT**.
  - Keep the placenta **LEVEL** with or **SLIGHTLY ABOVE** the baby.
  - If possible, **STAY ON THE LINE**.
6. If there are complications (*leg, arm, buttocks or umbilical cord presenting*):
  - **REASSURE** the mother. Tell her you have dispatched aid.

### **Pre-Arrival Instructions for Common Complications:**

**Postpartum Hemorrhage** (external bleeding from the vagina, persistent abdominal rigidity or tenderness and signs of shock.)

- Firmly massage the lower abdomen in a circular motion.
- (*Treat for shock*): Keep the mother warm and elevate legs.
- Place a sanitary napkin over the vaginal opening.

### **Breech presentation**

- (*If a foot or arm presents, delivery is not possible in the field.*)
- Support the baby with your hands, allowing the buttocks and trunk to deliver spontaneously.
- Support the legs and trunk of the infant. **Never attempt to pull baby from vagina by legs or trunk.**
- Raise the infant's body up until its face protrudes.
- Did the baby deliver?
- (*If unsuccessful, provide an airway for the baby*): Push the vaginal wall away from baby's face.
- Keep doing that until help arrives.

If the head does not deliver within 3 minutes of trying the above: Maintain the airway. Don't pull or touch the extremity.

Place the mother with legs and buttocks elevated (Put something under her buttocks to elevate).

### **Prolapsed Umbilical Cord**

- Place the mother on her knees with her head resting on the floor and her buttocks in the air. Do not permit her to lie flat.
- Attempt to keep pressure off the cord.