Criteria Based Dispatch

Emergency Medical Dispatch Guidelines
Fourth Edition May, 2004

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REVISED 05/04

Introduction to *Criteria Based Dispatch*

The Criteria Based Dispatch Guidelines which follow are tools the dispatcher uses to perform the duties of emergency medical dispatch.

Section I	**-**	***Medical abbreviations and terminology*.**
Sections II & III	**-**	***Medical Emergencies* and *Trauma* chief complaint categories.**
Section IV	**-**	***Emergency Medical Telephone Instructions* for the most life threatening emergencies.**

Each chief complaint category of the *Criteria Based Dispatch* guidelines includes*, Background Information, Dispatch Criteria*, *Vital Points* questions, *Pre-Arrival Instructions* and *Short Report* information.

All Callers Interrogation: The *All Callers Interrogation* is mandatory. The purpose of the *All Callers Interrogation* is to establish identifying information (name, address, phone number) and to determine the **chief complaint**. Questions #5 & #6 are designed to determine if the patient is in cardiac arrest and direct the dispatcher to the *Emergency Medical Telephone Instructions* or to another condition based on chief complaint.

Dispatch Criteria/Response Levels: The *Dispatch Criteria* describe four separate priority response levels defined according to the urgency in which care must be provided to the patient and the level of care required. Dispatchers should first determine if any MEDIC criteria are present. Only one criteria in the MEDIC category must be present in order for a MEDIC unit to be dispatched. If no MEDIC criteria are present, dispatchers should move to the BLS RED category. If no BLS RED criteria are present, the dispatcher should move to the BLS Yellow category. If no BLS criteria are present the dispatcher should then move to the Telephone Referral Program (TRP) category.

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 are ordered to coincide with the *dispatch criteria*. However, there is **no requirement** to ask these questions. If a *dispatch criteria* is volunteered by the caller, dispatch should be immediate. Mandatory questions are not included on the chief complaint cards.

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

Short Report: The short report consists of the patients age, gender, chief complaint, pertinent related symptoms, relevant medical surgical history, danger to field unit and other agencies responding. The dispatcher provides the short report to the responding units as soon as possible after toning the units out for response.

Emergency Medical Telephone Instructions: Medical instructions for the most life-threatening conditions including cardiac arrest, childbirth, choking and the patient who is unconscious/unresponsive but breathing normally.

***Pre-Arrival instructions*, *Vital Points* questions, *Short Report* questions and/or *Emergency Medical Telephone Instructions* should not interfere with answering incoming emergency calls.**

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CBD Introduction

Response Modes

MEDIC - Medic unit (ALS response) and BLS unit, sent Code Red.

BLS - BLS unit (BLS response), either Code Red or Code Yellow, **as determined by local agency policy**.

Code Red - Units respond with red lights and siren.

Code Yellow - Units obey speed limits and traffic laws.

BLS criteria may not always be emergent and may warrant a code yellow response. Local agency guidelines may allow a code yellow response for these criteria.

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 below.)**

Initial Dispatch Codes (IDC)

Immediately to the left of each criteria is an *Initial Dispatch Code (IDC).* This code should be assigned at the time of dispatch and reflects the criteria used by the dispatcher to select the level of response.

- The *Initial Dispatch Code* may be upgraded or downgraded by the dispatcher during the interrogation, but should NOT be altered by a request from scene for dispatch of a medic unit.
- The final IDC code selected should be based on the dispatcher's decision and must reflect the actual level of response the dispatcher sent on the call.
- **The *Initial Dispatch Code* should never be changed based on a 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

There are numerous instances in which an *Initial Dispatch Code* cannot be assigned to an incident. These include the following types of cases:

1. Still Alarms (walk-ins or calls directly in to 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 does not use the CBD Guidelines or was not able to interrogate the reporting party, and no IDC Code has been assigned. Always obtain an IDC code if possible.
   When sending a medic unit as a primary unit to another jurisdiction, do not use the 99M9 code. Obtain the correct IDC from the center requesting the Medic unit.
   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.

TRP '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.

REVISED 05/04

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BASIC MEDICAL ABBREVIATIONS AND TERMINOLOGY

Abd	Abdominal
Abras	Abrasion
Acc	Accident
AOB	Alcohol on Breath
BCA	Bicycle Accident
BP	Blood Pressure
CA	Cancer or Cardiac Arrest
CCU	Coronary Care Unit
CHF	Congestive Heart Failure
COPD	Chronic Obstructive Pulmonary Disease (Asthma, Emphysema, etc.)
C/O	Complains of...
CONSC	Conscious
CP(C/P)	Chest Pain
CPR	Cardiopulmonary Resuscitation (AKA: Mouth to Mouth)
CVA	Cerebro-Vascular Accident (Stroke)
DEFIB	Defibrillation
DKA	Diabetic Ketoacidosis
DOA	Dead on Arrival
ED	Emergency Department
EMD	Emergency Medical Dispatch
EMT-D	Emergency Medical Technician trained in defibrillation
EPI	Epinephrine
ER	Emergency Room
ETOH	Alcohol Intoxication
Fx	Fracture
GI	Gastro-Intestinal (Example: GI Bleed, possible perforated ulcer)
GOA	Gone on Arrival (Victim or patient has left scene of incident)
GSW	Gunshot Wound
HBP	High Blood Pressure (Hypertension)
Hx	History
ICU	Intensive Care Unit
Inj	Injury
Lac	Laceration
LBP	Low Blood Pressure (Hypotension) or Low Back Pain
LOC	Level of Consciousness
MCI	Multiple Casualty Incident
MCA	Motorcycle Accident
MI	Myocardial Infarction (Heart Attack)
MICU	Mobile Intensive Care Unit (Medic Unit)
MSDS	Material Safety Data Sheet
MVA	Motor Vehicle Accident
NTG	Nitroglycerin
O_2	Oxygen
OD	Overdose
P	Pulse
POV	Privately-operated Vehicle
Pt	Patient
Px	Pain
RHR	Rapid Heart Rate
R/O	Rule out (determined not to be, as in R/O MI or R/O Fx leg)
Rx	Treatment
SIDS	Sudden Infant Death Syndrome
SOB	Short of Breath (Dyspnea)
STHB	Said to have been...
TIA	Transient Ischemic Attack (Cerebrovascular related)
Unconsc	Unconscious
VF	Ventricular Fibrillation
VS	Vital Signs

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

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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, below 60/min.
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.
CLAVICLE	The collarbone or the bone that links the sternum and the scapula.
CHOLECYSTITIS	Inflammation of the gallbladder.
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 a pulseless, 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.
DECAPITATED	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	Sweaty, profuse perspiration, cold, clammy
DIAPHRAGM	A muscular wall separating the thoracic and abdominal cavities. The major muscle of breathing
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.
DT's	(Delerium tremors) - 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.
EMETIC	An agent which produces vomiting.
EMESIS	Vomiting
EMPHYSEMA	A chronic pulmonary disease where the lungs progressively lose their elasticity which can result in respiratory distress.
EPILEPSY	Recurring transient attacks of disturbed brain function, frequently altered state of consciousness or seizures.
EPIGLOTTIS	A lid-like cartilaginous structure at the entrance to the larynx to prevent food from entering the larynx and trachea while swallowing.

EPISTAXIS	Nose bleed.
ESOPHAGUS	(Esophageal) - A muscular canal extending from the throat to the stomach.
ESOPHAGITIS	Inflammation of the esophagus.
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.
HYPERGLYCEMIA	Abnormally high glucose level in the blood
HYPERTENSION	A condition of higher blood pressure than that which is considered normal for that particular paitent.

GLOSSARY OF TERMS (Continued)

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.
MAXILLA	Forms the upper jaw.
MANDIBLE	The lower jawbone.
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.
PERISTALSIS	The progressive contraction of muscles that propels food down the gastrointestinal tract.
PERICARDIAL SAC	The fibrous membrane covering the heart.
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.
PHALANGES	The bones of the fingers and toes.
PNEUMOTHORAX	A collection of air in the chest cavity caused by punctures of the chest wall or lungs.

GLOSSARY OF TERMS (Continued)

POLST	Physicians orders for life sustaining treatment. Formally known as DNR.
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 REPORT	A report taken from a person who is with the patient.
SEIZURE	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.
STOOL	Feces.
STOMA	A permanent surgical opening in the neck of a neck breather.
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.
TACHYCARDIA	A heart rate of over 100 beats per minute in an adult.
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	An opening in the trachea made by an operation for use as an airway.
TRAUMA	An injury inflicted, usually more or less suddenly, by some physical agent.
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.
ULNA	The inner and larger bone of the forearm, on the opposite side from the thumb.
UNILATERAL	One sided (as in stroke).
VERTEBRA	Any of the bones of the spinal column.
VERTIGO	An illusion that one’s surroundings are spinning.
XIPHOID PROCESS	The cartilage at the lower end of the sternum.

All Callers - Interrogation

1 What are you reporting?
2. What is the address of the patient?
3. What is the telephone number you are calling from?
4. What is your name? (*Optional*)
5. Is the person conscious (*awake, able to talk*)?

***If no*:** Go directly to **Question #6**.
***If yes*:** Go directly to **Other Conditions**.

6. 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.

7. I have advised the dispatcher to send help.* - **Stay on the line**. (Do not put the caller on hold, unless necessary.)

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: Would you like to do CPR until help arrives? I can help you with instructions.
***If no*:** Reassure the caller that the dispatcher has been advised* and stay on the line, if possible.
***If yes*:** Go to **Cardiac/Respiratory Arrest**, Section IV. Determine appropriate age group.

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

Go directly to **Unconscious/Unresponsive/Syncope**, Section II 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**. (Do not put the caller on hold, unless necessary.)
* Local agency protocols for acceptable wording should be followed.

REVISED 05/04

Background Information

Abdominal pain may be caused by many conditions, some of which are critical.

Critical causes of abdominal pain:

- **Myocardial Infarction** ("Angina") which may present as upper abdominal pain or indigestion.

- **Abdominal Aortic Aneurysm** which may present as abdominal pain or back pain ("Flank pain")with or without syncope or near syncope.

- **Ectopic Pregnancy** which may present as lower abdominal pain in women of childbearing age (12-50 yrs) with or without syncope or near syncope. Ectopic pregnancy can occur after tubal ligation and must be considered in all women of childbearing age. A number of problems may make recognition difficult:

  Problem A: Women who have had their tubes tied, often think they can't be pregnant.
  Problem B: Young women may deny pregnancy.
  Problem C: The bleeding may be mistaken for menstrual bleeding if the woman is due for her period.

- **GI Bleeding** with vomiting of red blood or dark tarry stools may be critical because of blood loss. Vomiting coffee ground-like material may also be indicative of ulcer disease but suggests much less rapid blood loss and is not critical unless there are other symptoms of blood loss such as syncope or near syncope.

Non-critical causes of abdominal pain include:

- gastroenteritis;
- appendicitis;
- bowel obstruction;
- pelvic inflammatory disease (PID);
- gallbladder disease;
- kidney stone;
- gas secondary to constipation;
- back pain (non-traumatic).

Back pain may also be caused by many conditions; however they are rarely critical. Back pain is usually associated with muscular/skeletal strain, although it may be related to the kidney.

Abdominal/Back/Groin Pain

Dispatch Criteria

Medic Response

1M1 Unconscious or not breathing

1M2 Signs of shock (three required):
- Diaphoresis
- Syncope/near syncope when sitting/standing
- Pale, clammy skin • Nausea

1M3 Vomiting red blood, with three signs of shock

1M4 Black tarry stool with three signs of shock

1M5 Upper abdominal pain, age > 50

1M6 Heavy vaginal bleeding (soaked 3 pads/hr.) with three signs of shock

1M7 Lower abdominal pain/stomach/back pain, age > 65, with two or more signs of shock

BLS Red Response

1R1 Pain with vomiting

1R2 Signs of shock (one required):
- Diaphoresis
- Syncope/near syncope when sitting/standing
- Pale,clammy skin • Nausea

1R3 Flank pain/back pain (kidney stone)

1R4 Lower abdominal/stomach/back pain (non-traumatic) age >= 50

1R5 No verifiable info available from RP

1R6

1R7 Breathing Difficulty

BLS Yellow Response

1Y1 Groin injury

1Y2 Catheter problem

TRP

1T1 Pain unspecified

1T2 Abdominal/stomach/back pain (non-traumatic), age < 50

1T3 Chronic back pain

1T4 Side pain

1T5 Groin pain

1T6 Neck/back/shoulder pain (traumatic)

Vital Points

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

Medic:
- How does the patient look?
- How does the patient feel when he/she sits 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?
- If patient is a woman:
  - Is there a possibility of pregnancy?
  - Has she felt dizzy?
  - Has there been vaginal bleeding, any more than normal?
  - How many pads has she **soaked** in the last hour?

BLS Red:
- Is the patient able to speak in full sentences?
- Is the patient short of breath?

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

Pre-arrival Instructions

- If unconscious, go directly to **Unconscious/Breathing Normally - Airway Control (Non-trauma)** Instructions, Section IV.
- Nothing by mouth.
- Allow position of comfort.
- Gather patient meds.

Short Report

- Danger to field units, if present
- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding

REVISED 05/04

Background Information

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

- Ingestion
- Injection
- Inhalation
- Absorption

Critical allergic reactions usually but not always occur with a previous history of reaction. Critical reactions need paramedic evaluation and treatment to maintain an airway in the presence of swelling of the throat and larynx and to maintain blood pressure.

Anaphylactic: A sudden, severe, often life-threatening allergic reaction that is characterized by low blood pressure, shock (inadequate tissue perfusion) and difficulty breathing.

Critical symptoms of anaphalactic shock:

- **Respiratory distress** occurs because of swelling of the throat or larynx ("bronchospasm")
- **Difficulty swallowing** occurs because of swelling of the throat;
- **Signs of shock** (diaphoresis, syncope/near syncope when sitting, pale/clammy skin or nausea) occur because of decreasing blood pressure

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

Some very severe reactions may take up to an hour to manifest in some patients. Many patients with a history of severe allergic reactions have an Epi kit prescribed by their physician. You can encourage them to proceed with use **as their physician has directed them.**

Non-critical symptoms of allergic reactions include:

- hives;
- itching;
- swelling at site of bite;
- long duration of time since exposure (greater than two hours).

Anaphylaxis/Allergic Reaction

Dispatch Criteria

Medic Response

Anaphylaxis

2M1 Unconscious or not breathing

2M2 Respiratory Distress (one required):
- Sitting/leaning forward or standing to breathe
- Speaks in short sentences • Noisy breathing
- Pale and diaphoretic • Rapid, labored breathing

2M3

2M4 Swelling in throat, tongue or difficulty swallowing

2M5 Signs of shock (three required):
- Diaphoresis • Nausea • Pale, clammy skin
- Syncope/near syncope when sitting/standing

2M6 Epi pen used by patient/RP

BLS Red Response

Allergic Reaction

2R1

2R2

2R3 History of anaphylactic reaction occurring within 30 minutes of exposure

2R4 Reaction to medication

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, hives and/or no breathing difficulty

2T4 History of allergic reaction, but none now

Vital Points

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

Medic:
- Is the patient able to speak in full sentences?
- Is the patient short of breath?
- 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?
- When was the patient exposed (time of day)?
- How long ago was the patient exposed?
- Are the symptoms getting worse?
- Is the patient taking any medication?

Short Report:
- Is the patient wearing a Medic Alert tag?

Pre-arrival Instructions

- Have patient rest.
- Keep calm.
- Brush the stinger off, if possible.
- Ice to sting.
- Gather patient meds.
- Do you have an Epi kit?
  If yes, have you used it?
  Use as your physician has directed.

Short Report

- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding

REVISED 05/04

Background Information

Critical animal bites in King County are rare since there are no poisonous snakes indigenous to our county.

Critical animal bites requiring paramedic evaluation:

Poisonous snakes require urgent evaluation to expedite access to antivenom treatment.

Uncontrolled 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.**

Bites around the face or neck are considered critical because of the possibility of airway obstruction. Therefore, very superficial bites of the face or neck are not critical and do not require paramedic dispatch.

Respiratory Distress suggests that either the airway is compromised or, in the case of a poisonous animal, that the ability to breathe is compromised.

Other animal bites that do not present with critical symptoms should have BLS evaluation.

Resources: **Poison Control - (206) 526-2121**

Responding unit should call Poison Control directly, when possible.

Animal Bites

Dispatch Criteria

Medic Response

3M1 Unconscious or not breathing

3M2 Uncontrolled bleeding

3M3 Respiratory Distress (one required):
- Sitting/leaning forward or standing to breathe
- Speaks in short sentences • Noisy breathing
- Pale and diaphoretic • Rapid, labored breathing

3M4 Serious neck and face bites (one required):
- Airway compromised • Decreased LOC
- Uncontrolled bleeding

3M5 Bite from poisonous animal

3M6 Signs of shock (three required):
- Diaphoresis
- Syncope/near syncope when sitting/standing
- Pale, clammy skin • Nausea

BLS Red Response

3R1 Bites to face and neck with controlled bleeding

3R2 No verifiable info available from RP

3R3 Breathing difficulty

BLS Yellow Response

TRP

3T1 Swelling at bite site

3T2 Bites below neck, non-poisonous, controlled bleeding

Vital Points

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

Medic:
- Is the patient able to speak in full sentences?
- Is the patient short of breath?
- 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 he/she sits up?

TRP:
- Is there any swelling around the bite?

Short Report:
- Is the animal contained?
- Has animal control been notified?
- Description of animal?

Pre-arrival Instructions

- Contain the animal, if possible.
- Keep patient calm and still.
- If bleeding, use clean cloth and apply pressure directly over it. **DO NOT REMOVE** apply additional cloths, if needed**.**

Short Report

- Danger to field units, if present
- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding

REVISED 05/04

Background Information

Non-traumatic bleeding may be associated with many medical problems.

Patients may be critical due to:

- The amount of blood lost, or
- The underlying problem causing the blood loss.

Uncontrolled 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.**

Critical 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 treatment to replenish the lost blood.

Diaphoresis (cold, clammy skin) is associated with shock due to loss of blood from the cardiovascular system.

Vomiting red or dark red blood usually signifies a rapid loss of blood secondary to either GI bleeding or a problem with the esophagus. Vomiting coffee ground-like material usually indicates a much slower blood loss and less critical.

Black tarry stool usually is associated with a GI bleed with significant blood loss.

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

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

Drugs such as Coumadin or non steroidal anti-inflamatory drugs (aspirin, ibuprofen) may cause stomach bleeding because they weaken the vascular system. Patients taking these drugs may also bleed more freely and profusely because of the drug's blood thinning and decreased clotting effects.

Noncritical instances of bleeding may be:

- epistaxis (bloody nose)
- spontaneous rupture of a varicose vein
- other localized bleeding that is controllable

Bleeding (Non-traumatic)

Dispatch Criteria

Medic Response

4M1 Unconscious or not breathing

4M2 Signs of shock (three required):
- Diaphoresis
- Syncope/near syncope when sitting/standing
- Pale, clammy skin • Nausea

4M3

4M4

4M5 Vomiting red blood, with three signs of shock

4M6 Black tarry stool, with three signs of shock

4M7

4M8 Coughing up blood, with:
- Respiratory Distress or • Three signs of shock

4M9 Heavy vaginal bleeding, (soaked 3 pads/hr), with three signs of shock

BLS Red Response

4R1 Bleeding without Medic criteria

4R2 Multiple syncopal episodes (same day)

4R3 Weakness

4R4

4R5

4R6 Uncontrolled nosebleed

4R7 No verifiable info available from RP

BLS Yellow Response

TRP

4T1 Vaginal spotting

4T2 Controlled nosebleed

Vital Points

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

Medic:
- Is the patient coughing up blood?
  If yes, How much? What does the blood look like?
- Can the patient speak in full sentences?
- Is the patient short of breath?
- How does the patient look?
- How does the patient feel when he/she sits up?
- Is the patient vomiting? **If yes,** what does the vomit look like?
  - How much and how long has he/she been vomiting?
- Are the patient's bowel movements different than normal?
  If yes, how would you describe them?
- Has there been vaginal bleeding, any more than normal?
  - How many pads has she **soaked** in the last hour?
- If patient is a woman between 12-50 years, ask: Is there a possibility of pregnancy?

BLS Red:
- What part of the body is the bleeding from?
- Is the patient feeling weak?

***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?

Pre-arrival Instructions

- Have patient lie down, except if nosebleed.
- 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.**
- 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?

*Does the patient have a rash?

Note: If fever is present with cough or rash, respiratory protection advised

Short Report

- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response

***Advise Respiratory Protection**

- Pertinent related symptoms
- Medical/surgial history, if relevant
- Other agencies responding

REVISED 05/04

Background Information

Breathing difficulty can occur anytime air flow or the exchange of oxygen and carbon dioxide is impaired. The body attempts to overcome this impairment by increasing the rate and depth of respirations. Paramedic evaluation and treatment may be critical to reverse the process that is occuring in the patient.

Critical factors that should have paramedic evaluation:

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

Inhaled substances may cause considerable lung damage and should have paramedic evaluation.

Persons who are short of breath or **cannot speak in full sentences** because of respiratory distress have a significant impairment and should have paramedic evaluation.

Pulmonary embolism often occurs following surgery and blood clotting disorders, broken legs with casting or recent immobilization.

Children with asthma under the age of 12 are often very ill requiring paramedic intervention.

Drooling or difficulty swallowing associated with breathing difficulty may be epiglottitis or an allergic reaction and should have paramedic evaluation and assistance.

Non-critical causes of breathing difficulty may be:
- asthma (without any critical symptoms)
- hyperventilation
- the common cold
- bronchitis

Breathing difficulty may be relayed as:

- pain with breathing
- inability to get a deep breath, secondary to pain
- hyperventilation (rarely)

Past history of breathing difficulties may be very helpful in determining the need for MEDIC or BLS intervention.

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 ariway.
- *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.

Breathing Difficulty

Dispatch Criteria

Medic Response

5M1 Unconscious or not breathing

5M2 Respiratory Distress(one required):
- Sitting/leaning forward or standing to breathe
- Speaks in short sentences • Noisy breathing
- Pale and diaphoretic • Rapid, labored breathing

5M3 Breathing difficulty with chest pain:
- Male/Female, age > 25

5M4 Epi pen used by patient/RP

5M5

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 <= 6

5R5 Hurts to breathe or pain with respiration

5R6

BLS Yellow Response

5Y1 O_2 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 able to speak in full sentences?
- Does the patient have to sit up to breathe?
- Does the patient have to lean forward to breathe?
- Is the patient short of breath?
- What was the patient doing just prior to when he/she became 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, or has he/she used it?
- Has the patient ever had this problem before?

BLS Red:
- Does the patient feel pain? **If yes,** where is the pain located?
- Is the patient experiencing any other problems right now?

BLS Yellow:
- Is the patient on oxygen?

***Respiratory Infection Screening for Responder protection and advisement -**
SEE PRE-ARRIVAL INSTRUCTION

Short Report:
- **If female:** Does she take birth control pills?
- Does the patient have any other medical/surgical history?

Pre-arrival Instructions

- Keep patient calm.
- 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?

*Does the patient have a rash?

Note: If fever is present with cough or rash, respiratory protection advised

Short Report

- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response

***Advise Respiratory Protection**

- Pertinent related symptoms
- Medical/surgial history, if relevant
- Other agencies responding

REVISED 05/04

Background Information

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

The causes of cardiac arrest are many and may include:

- Cardiovascular disease
- Cardiac Arrhythmia's
- Respiratory failure or arrest
- Trauma
- Drowning
- Electrocution

Critical symptoms of cardiac arrest:

- A sudden unconsciousness with absence of normal signs of life. (Normal breathing, coughing, movement)
- Agonal respiration's-if the arrest is witnessed, frequently agonal or inadequate respiration's will be present. These may continue for several minutes.
- A hypoxic seizure may also be described. This brief seizure activity is caused by the sudden interruption of oxygenated blood flow to the brain.

Agonal Respirations

The abnormal and inadequate respiratory effort commonly present at the onset of cardiac arrest is called agonal respirations. These muscular contractions are the result of messages being sent to the breathing muscles by the brainstem. They are typically slow, labored and often described as snoring, gasping, gurgling or moaning. It is very important to remember that these efforts are ineffective and by no means provide the patient with adequate air exchange or oxygen.

Dispatch Criteria

Medic Response

6M1 Unconscious or not breathing

6M2 Obvious DOA:

- Cold/stiff, age < 1 yr.

BLS Red Response

6R1 Obvious DOA:

- Cold/stiff, age >= 1 yr.
- Decapitated
- Burned beyond recognition

6R2 Confirmed POLST order on premises

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

If unsure about breathing normally, interrogate 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
  - every once in awhile
  - takes breath now and then
  - occassional
  - weak or heavy

**** If R/P cannot tell if the patient is breathing normally, assume the patient is not breathing normally, go directly to Cardiac/Respiratory arrest instructions, Section IV.**

Cardiac Arrest

Pre-arrival Instructions

- If unconscious, go directly to **Unconscious/Breathing Normally - Airway Control (Non-trauma)** Instructions, Section IV
- **Cardiac/Respiratory Arrest** instructions, Section IV. Determine appropriate age group.

Short Report

- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding

REVISED 05/04

Background Information

Chest pain may be caused by many conditions, some of which are critical. Although it is often difficult to determine which calls are critical, some of the following information may be helpful.

Critical causes of chest pain:

Myocardial Infarction occurs when a portion of the heart muscle is damaged due to lack of oxygenated blood flow to the heart muscle. Typically the pain associated with myocardial infarction is described as a pressure, tightness, crushing or squeezing in the chest. Associated symptoms that occur with myocardial infarction include:

- Shortness of breath
- Diaphoresis
- Nausea
- Vomiting
- Radiation of pain to arms, jaw, neck, shoulder or back

Chest Pain Equivalents:

The pain associated with Myocardial Infarction (heart attack) is typically described as a pressure, tightness, crushing or squeezing in the chest. *Occasionally, there is no pain associated with a heart attack or there is only left arm or shoulder pain.* Both history and associated symptoms may be helpful in making your decision.

Angina Pectoris is chest pain which occurs because of a lack of blood flow to heart muscle. It is distinguished from myocardial infarction by its transitory nature and is usually relieved by rest and/or Nitroglycerin (NTG).

Supraventricular Tachycardias (SVT) are a cause of rapid heart rates (RHR). The criteria for a MEDIC response is RHR's/palpitations with history of same, with or without chest pain. There are many causes of rapid heart rates which are not critical incidents and require only BLS evaluation.

Non-critical causes of chest pain include:

- chest wall pain
- pneumonia
- pleurisy
- esophageal reflux and/or spasm
- broken ribs
- costochondritis and pulled muscles

Chest Pain/Discomfort/Heart Problems

Dispatch Criteria

Medic Response	
7M1	Unconscious or not breathing
7M2	Male, age >= 40
7M3	Female, age >= 45
7M4	Male/female, age > 25 with: • Shortness of breath
7M5	Rapid heart rate/palpitations with history of same, with or without chest pain
7M6	Signs of shock (two required): • Diaphoresis • Syncope/near syncope when sitting/standing • Pale, clammy skin • Nausea
7M7	
7M8	Defib implant shock

BLS Red Response	
7R1	Male, age < 40
7R2	Female, age < 45
7R3	Rapid heart rate/palpitations, without history
7R4	No verifiable info available from RP
7R5	Indigestion: • Male, age >= 40 • Female, age >= 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 able to speak in full sentences?
• Is the patient short of breath?
• How does the patient look?
• How does the patient feel when he/she sits up?
• Is the patient nauseated or vomiting?
• Is the patient experiencing rapid heart rate ?
• Does the patient have a history of rapid heart rate?

Pre-Arrival:

• Is the patient taking nitroglycerin? (See Pre-Arrival Instructions)

Short Report:

• Has the patient ever had heart surgery or an MI?

Pre-arrival Instructions

• Have patient sit or lie down.
• Keep patient calm.
• Has the patient been prescribed 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.

Short Report

• Age
• Gender
• Chief complaint
• Dispatch criteria used to determine response
• Pertinent related symptoms
• Medical/surgical history, if relevant
• Other agencies responding

REVISED 05/04

Background Information

Choking is one of the most common causes of airway obstruction. You should consider choking anytime a person who has been eating is reported down **or** in a child under age 6.

Critical symptoms of choking:

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

Cyanosis - This suggests that there is no air exchange due to complete obstruction of the airway.

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

Choking

Dispatch Criteria

Medic Response

8M1 Unconscious or not breathing
8M2 Unable to talk or cry
8M3 Turning blue

BLS Red Response

8R1 Able to speak or cry
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 speak or cry?
- 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?
- If airway obstruction ruled out - go to PEDS card

Pre-arrival Instructions

- If unconscious, unable to speak or cry, go directly to **CHOKING** Instructions, Section IV. Determine appropriate age group.
- If patient is able to exchange air (i.e. talk, cry):
  - Allow position of comfort;
  - Encourage coughing

Short Report

- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding

REVISED 05/04

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 in 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 the 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.

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 it's 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 cause 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.

Diabetic

Dispatch Criteria

Medic Response

9M1 Unconscious or not breathing

9M2 Respiratory Distress(one required):
- Sitting/leaning forward or standing to breathe
- Speaks in short sentences • Noisy breathing
- Pale and diaphoretic
- Rapid, labored breathing

9M3 Decreased LOC or Uncooperative (Not following commands)

9M4 Signs of shock (three required): • Diaphoresis
- Syncope/near syncope when sitting/standing
- Pale, clammy skin • Nausea

9M5 Chest pain

9M6

9M7

9M8 Seizure

BLS Red Response

9R1 Disoriented, unusual behavior or acting strange

9R2 Not feeling well, non-specific

9R3

9R4 No verifiable info available from RP

9R5

BLS Yellow Response

TRP

9T1 Awake/alert

9T2 Weakness

Vital Points

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

Medic:
- Is the patient able to speak in full sentences?
- Is the patient short of breath?
- Is the patient acting normal?
  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 he/she is and where they are?
- Does the patient take insulin?
  When did the patient last take their medication?
- When did the patient last eat?
- What is the patient's blood sugar level?
- How does the patient look?
- How does the patient feel when he/she sits up?
- Is the patient complaining of any pain?
- Has the patient had a seizure?

TRP:
- Is the patient feeling weak?

Pre-arrival Instructions

- Nothing by mouth, if patient unable to take it by him/her self.
- Give juice with sugar (2-3 tbsp.) if patient able to take by him/her self.
- 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

- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding

REVISED 05/04

Background Information

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 medication. In King County, cold exposure usually occurs in the transient population that has no housing, in the elderly that have no heat in their homes, and in water exposure particularly in the winter months (in Puget Sound this is a year-round occurence). Initially, patients may be confused, disoriented or syncopal, and in extreme cold, exposure 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 to do 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. It is relatively rare in King County, but may occur during a heat wave or result from prolonged exercise such as marathons or other athletic events during hot weather. Hyperthermia may also occur in firefighters in the line of duty.

Hazardous material exposures may be quite dangerous and all responses are dependent upon the exposure and the danger that is involved from the chemical exposure.

Environmental Emergencies

Dispatch Criteria

Medic Response

10M1 Unconscious or not breathing

10M2 Respiratory Distress (one required):
- Sitting/leaning forward or standing to breathe
- Speaks in short sentences
- Noisy breathing • Pale and diaphoretic
- Rapid, labored breathing

10M3 Decreased LOC, disoriented

10M4 Signs of shock (three required):
- Diaphoresis
- Syncope/near syncope when sitting/standing
- Pale, clammy skin • Nausea

BLS Red Response

10R1 Chemical, (ingested or splashed on) w/o medic criteria

10R2 Patient with uncontrollable shivering

10R3 Patient excessively hot

10R4 Other injuries

10R5 No pertinent 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 able to speak in full sentences?
- Is the patient short of breath?
- How does the patient look?
- How does the patient feel when he/she sits up?
- Can the patient respond to you and follow simple commands?
- Can the patient answer your questions?
- Is the patient acting normal?
  If not, what is different?

BLS Red:
- What was the source of the heat, cold or chemicals?

Short Report:
- Length of exposure?

Pre-arrival Instructions

Heat Exposure
- Loosen or remove clothing to assist in cooling.
- Nothing by mouth.

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 Exposure
- Do not touch patient.
- Have patient remove contaminated clothing, if possible.
- Continuously flush chemicals from eyes, remove contacts.
- If chemical is powder, brush off, no water.
- Get info on chemical (MSDS sheet if available).
- Nothing by mouth.

Short Report

- Danger to field units, if present
- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding

REVISED 05/04

Background Information

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 is often caused by an aneurysm of one of the blood vessels that supplies the brain. The aneurysm may begin leaking blood at any time but is often precipitated by anything that elevates blood pressure, such as:

- physical exertion
- sexual intercourse
- emotional anxiety

The patient usually complains of **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

(Neurologic deterioration, cont'd)

- difficulty speaking or slurred speech
- blurred/double vision
- weakness/paralysis
- diaphoresis
- vomiting

Subarachnoid hemorrhage may occur in any age range but often effects persons in the age range of 20-50 years of age. Females who smoke and are on birth control pills may be at increased risk of cerebral hemorrage.

Intracerebral hemorrhage often has the same symptoms as a subarachnoid hemorrhage but often occurs in an older population (> 50 years). It is critical because of increasing intracranial pressure leading to brain damage.

Noncritical 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, disoriented
12M3
12M4
12M5
12M6
12M7 Sudden onset of severe headache, associated with any one of the following:
- Slurred speech
- Blurred/double vision
- Weakness/paralysis
- Diaphoresis
- Vomiting

BLS Red Response

12R1 Disoriented, but able to talk and walk
12R2 No verifiable info available from RP
12R3 Minor head/neck injury
12R4 Visual difficulty
12R5 Vertigo
12R6

BLS Yellow Response

12Y1 Headache, after head injury, no medic criteria
12Y2 Minor mouth/facial injuries

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 he/she is and who he/she is?
- 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?

BLS Red:

- Does the patient have pain anywhere else in the body?

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.
- If nosebleed, pinch end of nose and do not release
- Gather patient meds.

Short Report

- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding

REVISED 05/04

Background Information

Very few mental or emotional problems are a critical medical problem unless the patient is threatening to harm him/herself 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 above the hands or feet

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

Overdose in the suicidal patient.

Noncritical responses may include:

- lacerated wrists with controlled bleeding
- street drug intoxication or ingestion
- arousable alcohol intoxication
- unusual behavior with a psychiatric history

Mental/Emotional/Psychological

Dispatch Criteria

Medic Response

13M1 Unconscious or not breathing

13M2 Suicide attempt with GSW, stabbing, crushing or penetrating injury above hands or feet

13M3

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 him/herself?
  If yes, with what?
  What are the injuries?
  What part of the body is injured?

BLS Red:

- Do you think the patient might harm him/herself?
  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 normal?
  If not, what is different or unusual?

Pre-arrival Instructions

- Keep patient in area, if safe.
- Keep patient calm.
- If you feel you are in danger, **leave the scene.**
- Gather patient meds.

Short Report

- **DANGER TO FIELD UNITS, IF PRESENT-INCLUDE SUSPECT/VEHICLE DESCRIPTION**
- Age • Gender • Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding

REVISED 05/04

Background Information

Many types of medications are central nervous system depressants. These include:

- **Narcotic medications**: heroin, morphine, methadone, Demerol, Tylox, Percodan, and codeine
- **Sedative medications:** Valium, Librium, all barbituates, sleeping pills, tranquilizers or "downers"
- **Tricyclic antidepressants:** Elavil, Sinequan, Asendin, Desyrel, Ludiomil, Norpramin, Tofranil, Triavil, and Vivactil

These medications suppress the respirations of the patient, who may become comatose very rapidly following ingestion, and necessitate a MEDIC response.

Cocaine and other CNS stimulants such as amphetamines may cause symptoms of excitability, increased blood pressure, irritability or cardiac complaints.

Critical overdoses or poisonings:

Intentional/Suicidal overdose with a prescription medication.

Respiratory distress or difficulty swallowing following any ingestion.

Chemical ingestion with household cleaners, antifreeze, methanol, solvents or cyanide.

Alcohol (ETOH) intoxication in the younger patient may be critical because of their tendency to rapidly ingest large amounts over a very brief period of time causing rapid loss of consciousness.

Combined alcohol and drug overdose.

Noncritical incidents may include ingestion/overdose of:

- Aspirin
- Tylenol
- most over-the-counter (OTC) medications
- hallucinogens (such as LSD, PCP, psychodelic mushrooms, etc.)

These usually do not require MEDIC response but should be evaluated by a BLS unit for referral to a medical facility.

Resources: **Poison Control - 526-2121**. Responding unit should call Poison Control directly, when possible.

O.D./Poisoning/Toxic Exposure

Dispatch Criteria

Medic Response

14M1 Unconscious or not breathing

14M2 Respiratory Distress (one required):
- Sitting/leaning forward or standing to breathe
- Speaks in short sentences
- Noisy breathing • Pale and diaphoretic
- Rapid, labored breathing

14M3 Decreased LOC/disoriented-excluding alcohol consumption

14M4 Intentional/accidental, with Rx meds < 2 hrs. since ingestion

14M5 Ingestion of caustic substance, w/ difficulty swallowing

14M6

14M7 Acute alcohol intoxication (unresponsive)
- Age < 17, and/or
- Combined alcohol and drugs, any age

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 or splashed on) w/o medic criteria

14R5 Intentional/accidental with Rx meds > = 2 hrs. since ingestion

14R6 Breathing difficulty

14R7 Combined alcohol and drugs(responsive)

BLS Yellow Response

14Y1 Known alcohol intoxication w/out other drugs (responsive)

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 in full sentences?
- Is the patient short of breath?
- 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?

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? Access to a weapon?
- Is the patient acting normal? **If not** what is different?
- Has the patient vomited?

Pre-arrival Instructions

- Keep patient in area/house if safe.
- Retrieve container of substance taken.
- Don't place patient in bath or shower.
- If unconscious, go directly to **Unconscious/Breathing Normally - Airway Control (Non-trauma)** instructions, Section IV
- Nothing by mouth.
- Gather patient meds.

Short Report

- Danger to field units, if present
- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding

REVISED 05/04

Background Information

Since pregnancy and childbirth is a natural process and not a medical illness, a normal delivery takes place most of the time. A MEDIC response should be sent for all imminent deliveries, not only to render assistance to the mother but to the newborn infant. Breaking of a woman's water may signify that labor is imminent but does not signify that delivery is imminent. MEDIC response is also indicated for the unusual or problematic delivery or problems that develop during the last trimester of pregnancy.

Critical problems:

Eclampsia or pre-eclampsia is a toxic state that develops in the last trimester. It is characterized by increased blood pressure, fluid retention and seizures (if very severe).

Vaginal bleeding in a pregnancy > 20 weeks can be dangerous because of the rapid blood loss through the placenta. Often this is associated w/ **placenta previa**, a condition where the placenta partially or completely blocks the cervix. **Abruptio placentae** occurs when the placenta separates prematurely from the uterine wall and results in bleeding from the site, usually as a result of trauma. Shock can ensue rapidly.

Abdominal injury with contractions in a pregnancy > 20 weeks should be a MEDIC response since any pregnancy > 20 weeks carries some chance of fetal survival if delivery occurs.

Labor pains or contractions < 2 minutes between contractions or in a 2nd pregnancy < 5 minutes between contractions. Second and subsequent pregnancies often have much shorter duration of labor since the cervix and the pelvic opening have been previously stretched during a delivery.

Prematurity > 4 weeks suggests that the delivery may be more precipitous and that the baby may require more intervention by paramedics.

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

Prolapsed cord - when the umbilical cord is born first, before baby, possibly cutting off oxygen to the baby.

Noncritical situations or symptoms include:

- abdominal injury w/out contractions
- abdominal injury in a pregnancy < 20 weeks
- abdominal pain
- vaginal bleeding/cramping in a pregnancy < 20 weeks

These patients are a BLS response w/ transport to the nearest hospital with obstetrical capabilities.

Dispatch Criteria

Medic Response

15M1 Unconscious or not breathing

15M2 Pregnant with heavy vaginal bleeding (soaked 3 pads/ hr) with one or more signs of shock

15M3 Signs of shock (three required):
- Diaphoresis • Pale, clammy skin • Nausea
- Syncope/near syncope when sitting/standing

15M4 Labor pains/contractions:
- 1st preg., < 2 mins. between contractions
- 2nd preg., < 5 min. between contractions
- Prior delivery with labor lasting < 1 hr.

15M5 Bleeding, > 20 weeks pregnant

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 Water broke, with contractions

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?
  If yes, how many pads an hour?
- 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 the first pregnancy?
- How far along is she?
- 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

- 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
- If childbirth is imminent (baby is crowning) labor pains / contraction and delivery, go directly to **Childbirth** Instructions, Section IV.

Short Report

- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding

REVISED 05/04

Background Information

Seizures are the result of uncontrolled electrical activity in the brain causing all circuits to fire resulting in seizure activity, loss of consciousness and no breathing. Febrile seizures occur commonly in children < age 6, are usually short in duration, grand mal (generalized body convulsions) and stop spontaneously w/out intervention. Seizures in children < age 6 are assumed febrile seizures unless they meet any of the critical criteria listed below.

Critical seizure criteria for MEDIC response:

Seizures lasting > 5 minutes or **multiple seizures** (greater than 3 per hour) are dangerous because of lack of oxygen to vital organs and brain dysfunction during the seizures.

Severe Headache A patient having a seizure after complaining of a severe headache could be experiencing an intracerebral hemorrhage. This bleed will cause increasing pressure on the brain with the possibility of causing herniation of the brain. A good description of the seizure will give clues to the location of the bleed. This patient requires rapid care and transport.

Diabetic patients with seizures usually seize because of hypoglycemia and should have immediate correction of their blood sugar level.

Pregnant women w/ seizures should be evaluated for toxemia of pregnancy, poor fetal circulation and oxygenation.

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

Recent head trauma presenting as seizures may be secondary to a subdural or epidural hematoma creating pressure on the brain, brain dysfunction must be relieved as soon as possible.

Most seizure calls will be patients w/ a history of seizures that may or may not be known by the RP. If additional history becomes known during the call, the dispatcher may upgrade or downgrade the call.

Seizures

Dispatch Criteria

Medic Response

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

BLS Red Response

16R1 First-time seizure
16R2 Single seizure with history of seizure disorder
16R3 Seizure, unknown history
16R4 No verifiable information from RP
16R5 Seizure aura
16R6

BLS Yellow Response

TRP

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:
• Drugs? • Alcohol? • Medications?
• Has the patient had a recent head injury?
If yes, when?

Short Report:

• Is the patient wearing a Medic Alert tag?

Pre-arrival Instructions

• Move anything away from patient that patient could be hurt by striking.
• 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.
• If unconscious after seizure, go directly to **Unconscious/Breathing Normally - Airway Control (Non-trauma)**, Section IV.
• Gather patient meds.

Short Report

• Age
• Gender
• Chief complaint
• Dispatch criteria used to determine response
• Pertinent related symptoms
• Medical/surgical history, if relevant
• Other agencies responding

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Background Information

The **Sick (unknown)** category must be used for the calls that are received that have no specific complaint or do not fall under other categories.

High blood pressure or high temperature without other critical symptoms is not a life-threatening condition.

Dispatch Criteria

Medic Response

17M1 Unconscious or not breathing
17M2 Decreased LOC, disoriented
17M3
17M4 Rapid heart rate with history of same, with or without chest pain.
17M5 Signs of shock (two required):
- Diaphoresis
- Syncope/near syncope when sitting/standing
- Pale, clammy skin
- Nausea

BLS Red Response

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

BLS Yellow Response

17Y1 Generalized/unspecified pain
17Y2
17Y3
17Y4 Patient Assist
17Y5 Hang up Call-Consider PD Response
17Y6 Med alarm, confirmed noncritical 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 he/she sits up?
- How does the patient look?
- Describe what the patient is 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 normal?
  If not, what is different?
- Is the patient complaining of pain? Where?

***Respiratory Infection Screening - SEE PRE-ARRIVAL INSTRUCTIONS**

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?
* Does the patient have a rash?

Note: If fever is present with cough or rash, respiratory protection advised

Short Report

- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- ***Advise Respiratory protection**
- Pertinent related symptoms
- Medical/surgial history, if relevant
- Other agencies responding

REVISED 05/04

Background Information

A **stroke** or **cerebrovascular accident (CVA)** may be caused by an interruption of blood flow to the brain lasting long enough to cause permanent damage. A **transient ischemic attack (TIA)** is an interruption of blood flow which does not cause permanent damage and usually lasts from 30 minutes to 2 hours in duration, w/ symptoms that are identical to a stroke. Many stroke victims have difficulty speaking or slurred speech, part of the brain dysfunction inherent in the CVA. **This speech difficulty is common and does not necessarily mean a decreased level of consciousness or difficulty breathing**. Most strokes are not life-threatening, although there are some instances in which a life-threatening process is occurring.

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 severe headache.

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

Diabetics presenting as a stroke may be a simple hypoglycemic or hyperglycemic reaction.

In summary, most strokes or CVA's do not require a MEDIC response but you should be aware of the critical symptoms that would give you a key toward a life-threatening problem that is associated with a CVA.

Stroke (CVA)

Dispatch Criteria

Medic Response

18M1 Unconscious or not breathing

18M2 Sudden onset of severe headache (not migraine), associated with one of the following:
- Slurred speech
- Blurred/double vision
- Weakness/paralysis
- Diaphoresis
- Vomiting

18M3 Decreased LOC, disoriented with Respiratory distress: (one required)
- Sitting/leaning forward or standing to breathe.
- Speaks in short sentences
- Noisy breathing
- Pale and diaphoretic
- Rapid, labored breathing

18M4

18M5

18M6 Diabetic

BLS Red Response

18R1 Unilateral (one-sided)

18R2 Weakness, numbness or unable to stand or walk

18R3

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:
- Has the patient had a headache?
- Is the patient's speech slurred?
- Can the patient respond to you and follow simple commands?
- Can the patient answer your questions?
- If acting unusual, what is different?
- Is the patient short of breath?
- Is the patient a diabetic?
- Is the patient complaining of any pain?

BLS:
- How does the patient look?

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

Pre-arrival Instructions

- Keep patient calm.
- Don't allow patient to move around.
- Keep neck straight (remove pillows).
- Nothing by mouth.
- Gather patient meds.

Short Report

- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding

REVISED 05/04

Background Information

Unconscious/Unresponsive is another category that does not have a diagnostic differential easily available. This is a place to look for critical symptoms that might suggest a life-threatening illness or problem. You will often need to remember illnesses or problems that have shown up in other categories. Use your critical symptoms to formulate your dispatch plan rather than looking for a diagnosis.

Unconscious/Unresponsive/Syncope

Dispatch Criteria

Medic Response

19M1 **CONFIRMED** Unconscious
19M2
19M3
19M4 Acute alcohol intoxication (unresponsive)
- Age < 17 and/or • Combined alcohol and drugs, any age

19M5 Respiratory Distress(one required):
- Sitting/leaning forward or standing to breathe
- Speaks in short sentences • Noisy breathing
- Pale and diaphoretic • Rapid, labored breathing

19M6 Syncope associated with another sign of shock
- Diaphoresis • Pale, clammy skin • Nausea

19M7 Syncope associated with headache
19M8 Syncope associated with Chest pain/discomfort/ palpitations, age > 40
19M9 Diabetic

BLS Red Response

19R1 **UNCONFIRMED** unconscious
19R2 Multiple syncopal episodes (same day)
19R3 No verifiable info available from RP
19R4 Single syncope
19R5 Combined alcohol and drugs (responsive)
19R6
19R7
19R8 Alcohol intoxication without medic criteria

BLS Yellow Response

19Y1 Slumped over wheel-Consider PD response
19Y2 Known alcohol intoxication w/out other drugs (responsive)

TRP

19T1 Near syncope
19T2 Conscious, with minor injuries

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 he/she became unconscious?
- Has the patient taken any medications, recreational drugs or alcohol?
- Is the patient short of breath?
- Is the patient able to speak in full sentences?
- How does the patient feel when he/she sits up?
- Is the patient experiencing a rapid heart rate/palpitations?
- Is the patient experiencing pain/discomfort? Where?

Short Report:

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

Pre-arrival Instructions

- **Unconscious/Breathing Normally - Airway Control (Non-trauma)** instructions, Section IV
- If conscious now, have patient lie down.
- If patient vomiting, have patient lie on side.
- Do not leave patient, be prepared to do CPR.
- Gather patient meds, if possible.

Short Report

- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related 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.

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 child's interest or attention?
- Consolability: Can parent or caregiver comfort child?
- Eye contact: Does child maintain eye contact?
- Speech/Cry: Is speech/cry strong? Weak or muffled? Hoarse?
- Spontaneous motor activity: Is 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 ariway.
- 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 < age 6, are usually short in duration, grand mal (generalized body convulsions) and stop spontaneously w/out intervention. Seizures in children < age 6 are assumed febrile seizures.

Pediatric Emergencies

Dispatch Criteria

Medic Response

20M1 Unconscious/unresponsive: Listless, limp

20M2 Able to awaken/appearance: blue lips, mottled, gray-white

20M3 Respiratory Distress (one required):
- Noisy breathing • Rapid, labored breathing
- Sitting/leaning forward or standing to breathe
- Speaks in short sentences • Pale and diaphoretic

20M4 Seizures: • multiple > 3 per hour
• extended > 5 min.

20M5 Medication overdose, confirmed ingestion < 30 min

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 Seizures (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

20Y2

TRP

20T1 Minor skin rashes

20T2 Ear ache/Teething

20T3 Temperature/Fever

Vital Points

- *Ask to speak directly to 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 difficulty 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?

Note: *Consider suspicious RP/abuse, check previous events history! Consider police response.*

BLS Red:

- Does the child have any medical or congenital problems?

Pre-arrival Instructions

- Keep child calm
- If febrile seizure, remove clothing to cool patient.
- If patient is unconscious and not breathing normally, go directly to **Cardiac/Respiratory Arrest** Instructions, Section IV.

Short Report

- Danger to field units, if present
- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related 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) above the hands or feet. MEDIC responses may also be needed in the patient with significant head injury with a decreased level of consciousness.

Uncontrolled 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 the 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

Noncritical symptoms of head injuries include:

- a brief loss of consciousness (< five 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

Assault/Trauma

Dispatch Criteria

Medic Response

21M1 Unconscious or not breathing

21M2 Secondary to head injury:
- Decreased LOC • Disoriented or combative • Seizure

21M3 GSW or stabbing, crushing or penetrating injury, above hands or feet

21M4 Uncontrolled bleeding

21M5 Respiratory Distress (one required):
- Sitting/leaning forward or standing to breathe
- Speaks in short sentences • Noisy breathing
- Pale and diaphoretic • Rapid, labored breathing

BLS Red Response

21R1 GSW, stabbing, crushing or penetrating injury to hands or feet

21R2 Unknown injuries

21R3 Minor injuries with weapons

21R4
- Multiple extremity fracture
- Single femur fracture • Hip fracture and/or dislocation

21R5 Single syncope, secondary to trauma

21R6 No verifiable info available from RP

21R7

21R8 Breathing difficulty

BLS Yellow Response

21Y1 Major lacerations w/controlled bleeding

21Y2

21Y3 Isolated fracture/dislocation: • Extremity

21Y4 Police request stand-by/check for injuries

21Y5 Sexual assault

21Y6 Pepper Spray or Taser

TRP

21T1 Minor injuries without weapons

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 able to speak in full sentences?
- Is the patient short of breath?
- 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:
- Has law enforcement been notified?

Pre-arrival Instructions

- Do not remove/touch impaled object.
- Do not touch weapons or disturb scene.
- Preserve evidence.
- If unconscious, go directly to **Unconscious/Breathing Normally - Airway Control (Trauma)** instructions, Section IV.
- Have patient lie down and remain calm.
- If bleeding, use clean cloth and apply pressure directly over it. **DO NOT REMOVE.** Apply additional cloths on top, if needed.
- Patient should not change clothing, bathe or shower.
- Keep patient warm.
- Gather patient meds, if possible.

Short Report

- Danger to field units, if present
- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding

REVISED 05/04

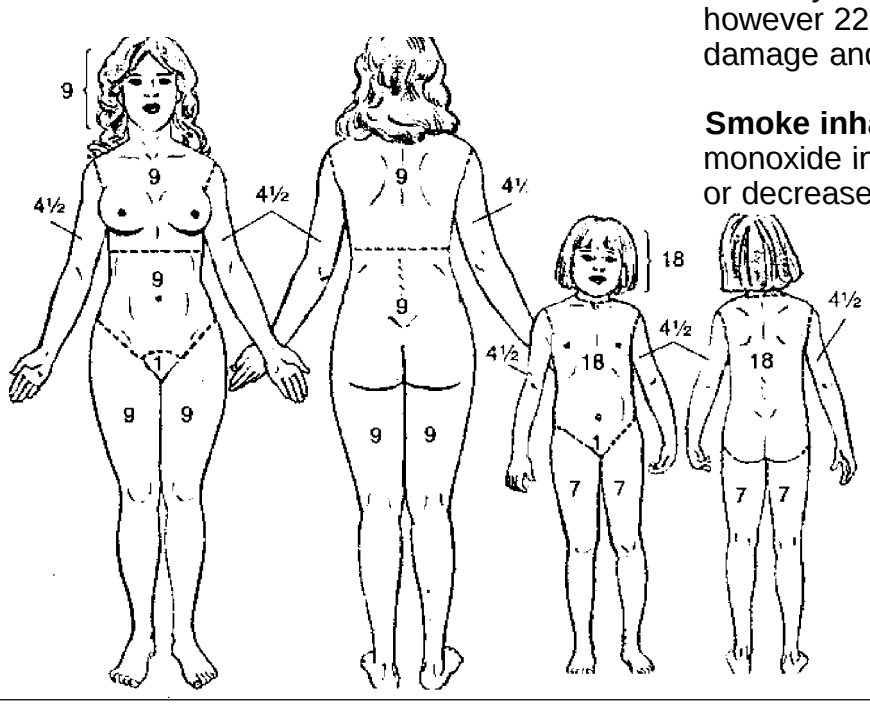
Background Information

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

- **First degree** is superficial.
- **Second degree** is blistering and 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. Severity of burns is classified by the 'Rule of Nines'.

Rule of Nines



Critical burn injuries:

2nd or 3rd degree burns > 20% of body surface for adults (10% for children) 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 w/ significant carbon monoxide inhalation, should be suspected in the unconscious or decreased LOC patient.

Burns - Thermal/Electrical/Chemical

Dispatch Criteria

Medic Response

22M1 Unconscious or not breathing
22M2
22M3 Respiratory Distress (one required):
- Sitting/leaning forward, standing to breathe
- Speaks in short sentences • Noisy breathing
- Pale and diaphoretic • Rapid, labored breathing

22M4 Burns to airway, nose, mouth, neck: (one required)
- Hoarseness • Difficulty talking • Difficulty swallowing

22M5
22M6 Burns over body surface: 20% or more adults and 10% or more children
22M7 Electrical burns from power lines or panel boxes
22M8

BLS Red Response

22R1 Spilled hot liquids
22R2 Battery explosion
22R3 Household electric shock, w/o Medic criteria
22R4 Burns over body surface: • Adult < 20% • Child < 10%
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?
- Describe the extent of the burns?
- Is the patient able to speak in full sentences?
- Is the patient short of breath?
- Is the patient having difficulty swallowing?
- Where is the patient burned? 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?

Pre-arrival Instructions

For all types of burns:
- If patient is unconscious, go directly to **Unconscious/Breathing Normally - Airway Control (Trauma)** Instructions, Section IV.
- If patient is unconscious and not breathing normally, go directly to **Cardiac/ Respiratory Arrest** Instructions, Section IV.

Electrical: *(Electrocution, Lightning Strike):*
- Turn power off, if safe.

Thermal: *(Heat, Smoke Inhalation, Hot Substances)*:
- 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).
- For all other thermal burns, leave burn area exposed.

Chemical:
- Have patient remove contaminated clothing, if possible.
- Continuously flush chemicals from burns to eyes, remove contacts.
- If chemical is powder, brush off, no water.
- Get information on chemical (Acid/Alkali) (MSDS Sheet if available).

Short Report

- Danger to field units, if present
- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding

REVISED 05/04

Background Information

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 divers 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 additional support that a warm water victim does not require.

Noncritical 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 okay.

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.

Dispatch Criteria

Medic Response

23M1 Unconscious or not breathing

23M2 Respiratory Distress (one required):

- Sitting/leaning forward or standing to breathe
- Speaks in short sentences
- Noisy breathing
- Pale and diaphoretic
- Rapid, labored breathing

23M3

23M4 Scuba diving accident

BLS Red Response

23R1 Near drowning, patient conscious

23R2 Patient coughing

23R3 Other injuries: neck/back

23R4 No verifiable info available from RP

23R5 Breathing difficulty

23R6 Patient confirmed submerged > 1 min. w/out Medic criteria

BLS Yellow Response

23Y1 Minor water-related injury, patient not submerged:

- Isolated fractures/dislocation of arm/leg
- Major lacerations w/controlled bleeding

TRP

23T1 Minor water-related injury, patient not submerged:

- Minor lacerations w/controlled bleeding
- Isolated fracture/dislocation of toe/finger

Vital Points

Drowning/Near Drowning/Diving or Water-related Injury

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

Medic:

- Is the patient able to speak in full sentences?
- Is the patient short of breath?
- 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 the patient on land or in a boat?

Pre-arrival Instructions

- If unconscious/not breathing normally, go directly to **Cardiac Arrest** Instruction, Section IV.
- Do not enter the water
- Toss them a floatation jacket/object, if available.
- If unconscious, go directly to **Unconcious/Breathing Normally** - **Airway Control (Trauma)** instructions, Section IV.
- Keep patient warm.
- Do not move patient around.

Short Report

- Danger to field units, if present
- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding

REVISED 05/04

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 evaluation.

Industrial accidents with crushing or penetrating injury above the hands and feet have the potential for significant blood loss or vital organ impairment.

Amputations 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.

Uncontrolled 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 the 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 injruy

Noncritical symptoms of head injuries include:

- a brief loss of consciousness (< five 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

Falls/Accidents/Pain

Dispatch Criteria

Medic Response

24M1	Unconscious or not breathing
24M2	Decreased LOC, disoriented
24M3	Respiratory Distress (one required): • Sitting/leaning forward or standing to breathe • Speaks in short sentences • Noisy breathing • Pale and diaphoretic • Rapid, labored breathing
24M4	Trauma with signs of shock (three required): • Diaphoresis • Syncope/near syncope when sitting/standing • Pale, clammy skin • Nausea
24M5	
24M6	
24M7	Amputation/entrapment above finger/toes
24M8	Patient paralyzed
24M9	Uncontrolled 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	
24R7	• Multiple extremity fracture •Single femur fracture • Hip fracture and/or dislocation
24R8	No verifiable info available from RP
24R9	Breathing difficulty

BLS Yellow Response

24Y1	Major lacerations/controlled bleeding
24Y2	Patient assist
24Y3	Isolated extremity fracture, dislocation
24Y4	Hip pain

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 able to speak in full sentences?
- Is the patient short of breath?
- 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 pain or illness just prior to the fall?
- If accident, what part of the body has been injured?

Pre-arrival Instructions

- If unconscious, go directly to **Unconcious/Breathing Normally - Airway Control (Trauma)** instructions, Section IV.
- If machinery, turn it off. (Try to locate maintenance).
- Do not move patient (if no hazards).
- Do not allow patient to move.
- Cover patient w/ blanket and keep calm.
- Nothing by mouth.
- If 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.
- Gather patient meds, if possible.

Short Report

- Danger to field units, if present
- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding

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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:

- Vehicle (car/motorcycle) vs. immovable object
- Car vs. pedestrian
- Car vs. motorcycle or bicycle
- Victim ejected from vehicle
- MCI criteria

Other critical criteria include patients with:

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

Noncritical criteria for MVA include:

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

Head Injuries - The best indicator of severity of injury in the head injured patient is the 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

Noncritical symptoms of head injuries include:

- a brief loss of consciousness (< five 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

Motor Vehicle Accident (MVA)

Dispatch Criteria

Medic Response

25M1 Unconscious or not breathing

25M2 Decreased LOC, disoriented

25M3 Respiratory Distress (one required):
- Sitting/leaning forward or standing to breathe
- Speaks in short sentences • Noisy breathing
- Pale and diaphoretic • Rapid, labored breathing

25M4 High rate of speed with no one moving or getting out of vehicles with any one of the following mechanisms:
- Veh vs. immovable object • Veh vs. pedestrian
- Veh vs. veh (head-on/t-bone)

25M5 MCI Criteria

25M6 Trauma with signs of shock (three required):
- Diaphoresis • Pale, clammy skin • Nausea
- Syncope/near syncope when sitting/standing

25M7 Patients ejected

BLS Red Response

25R1 Injury accident:
- Low speed
- Victims walking around
- Unknown extent of injuries

25R2 Roll-over

25R3 No verifiable info available from RP

25R4 Victim trapped

BLS Yellow Response

25Y1

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

TRP

Vital Points

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

Medic:
- 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 short of breath?
- Are all of the patients free of the vehicle? Is anyone trapped in the vehicle due to injuries?
- Was anyone thrown from the vehicle?
- How fast was the vehicle traveling?

BLS Red:
- Can the patient describe where their pain is located?

Short Report:
- Are there any hazards present?
  - Fire?
  - Water?
  - Wires down?

Pre-arrival Instructions

- Do not move (if no hazards).
- If bleeding, use clean cloth and apply pressure directly over it. **DO NOT REMOVE!** apply additional cloths on top, if needed**.**
- If unconscious, go directly to **Unconscious/Breathing Normally - Airway Control (Trauma)** instructions, Section IV.
- Gather patient meds, if possible.

Short Report

- Danger to field units, if present
- Age
- Gender
- Chief complaint
- Dispatch criteria used to determine response
- Pertinent related symptoms
- Medical/surgical history, if relevant
- Other agencies responding

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AUTOMATED EXTERNAL DEFIBRILLATOR INSTRUCTIONS

- Has anyone there been trained to use the defibrillator?
- **Get** the person flat on his/her back on the floor.
- **Bring the defibrillator next to the person's ear. Make sure it is not touching the person.**
- **Kneel** next to the person.
- **Bare** his/her chest**.**
- **Open** the defibrillator case. (Look for a zipper, snaps on the side or a black button on the lid.)
  <u>If help is needed, use the following instructions</u>: *(Remind RP that help has been dispatched.)*

- **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 cords to the pads are plugged into the defibrillator. If not, do so now. *(If the defibrillator is HeartStream, tell rescuer to plug in the cord at the flashing yellow light.)*

- **Push** the **green** button to turn on the machine.
- **"Analyzing"** means the defibrillator is deciding whether to shock.
- **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? *(Heartstream & Survivalink have a red, flashing light; Physio's is bright orange.)*

<u>YES</u>

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.

<u>NO</u>

NO SHOCK ADVISED: (No shock will be given at this time)
- **Is she/he conscious & breathing normally?**
  If no: · **Begin CPR**, I will help you.
- **Leave Pads on Chest & Defibrillator turned on.**
- After 1 minute of CPR the difibrillator will tell you to stand clear to analyze. Follow the defibrillators instructions.
- Help has been dispatched.

CARDIAC/RESPIRATORY ARREST/Adults

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 him/her **FLAT** on his/her back on the floor.
   - **BARE** the chest.
   - **KNEEL** by his/her side.
   - **PINCH** the nose.
   - With your **OTHER** hand, **LIFT** the **CHIN** so the head **BENDS BACK**.
   - **COMPLETELY COVER** his/her mouth with your mouth.
   - **GIVE 2 BREATHS** of AIR into his/her **LUNGS** — just like your blowing up a big balloon.

   REMEMBER:
   - **FLAT** on his/her **BACK.**
   - **BARE** the **CHEST**.
   - **PINCH THE NOSE.**
   - With your **OTHER** hand, **LIFT** the **CHIN** so the head **BENDS BACK. GIVE 2 BREATHS.**
   - **THEN, COME BACK TO THE PHONE!** If I'm not here, stay on the line.

4. Is he/she **MOVING** or **BREATHING NORMALLY**?

   (If yes): Roll the person on his/her side and check for breathing until help takes over.

   (If NO)**:** Listen carefully. I'll tell you what to do next.
   - Put the **HEEL** of your **HAND** on the **CENTER** of his/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, 1-1/2 to 2 inches.
   - Do it 15 times, just like you're **PUMPING** his/her chest.
   - Count **OUTLOUD** so I can hear you, like this 1-2-3...
   - **MAKE SURE** the **HEEL** of your hand is on the **CENTER** of his/her chest, **RIGHT BETWEEN** the **NIPPLES.**
   - Pump 15 times.
   - Then, **PINCH** the **NOSE** and **LIFT** the **CHIN** so the head **BENDS BACK.**
   - **2 MORE** breaths and **PUMP** the **CHEST** 15 times.
   - **KEEP DOING IT: PUMP** the **CHEST** 15 times. Then 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 his/her head to one side.
- Sweep it all out with your fingers before you start mouth-to-mouth

CARDIAC RESPIRATORY ARREST/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 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.
   - Completely **COVER** his/her mouth with your mouth and give **2** breaths.

3. Is the child **BREATHING NORMALLY**?

   ***(If yes)**:* Roll the child on his/her side and check for breathing until help takes over.
   ***(If NO)**:* Do it again. **REMEMBER, PINCH** the nose. With your **OTHER** hand, **LIFT** the **CHIN** so the head **BENDS BACK**
   - Completely **COVER** his/her mouth with your mouth and give **2** breaths.
   - Then come **BACK** to the phone. If I'm not here, stay on the line.

4. Did the chest rise? *(**If no**: Go to **CHOKING/Children**).*

5. Is he/she breathing normally?

   ***(If yes)**:* Roll the child on his/her side and check for breathing until help takes over.
   ***(If NO)**:* 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 1 to 1-1/2 inches.
   - Do this 5 times **QUICKLY**.
   - Count **OUTLOUD** so I can hear you, like this 1-2-3-4-5.
   - Then **PINCH** the **NOSE**, **LIFT** the **CHIN**, and tilt the head back.
   - Give one breath.
   - Keep doing it until help can take over. I'll stay on the line.

NOTE: IF CALLER REPORTS VOMITING, INSTRUCT CALLER TO:

- Turn his/her head to one side.
- Sweep it all out with your fingers before you start mouth-to-mouth.

CARDIAC/RESPIRATORY ARREST/ 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 his/her **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 2 BREATHS** of air into his/her lungs.
   - Then come back to the phone. If I'm not here, stay on the line.

4. Is the baby breathing normally?

   (If yes)*:* Roll the baby on his/her side and check for breathing until help takes over.

   (If NO)**:** Do it again. **REMEMBER** — **LIFT THE CHIN** slightly, **MAKING SURE THE NECK REMAINS LEVEL**.
   - **COMPLETELY COVER** the baby's **MOUTH AND NOSE** with your mouth and
   - **GENTLY GIVE 2 BREATHS** into his/her **LUNGS**.
   - Then come back to the phone.

5. Did the chest rise? ***(If no****: Go to CHOKING/Infants.)*

6. Is the baby breathing normally?

   (If yes)*:* Roll the baby on his/her side and check for breathing until help takes over.

   (If NO)*:* 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 **SLIGHTLY** — 1/2 to 1 inch. Do it 5 times **RAPIDLY**.
   - Count **OUTLOUD** so I can hear you, like this 1-2-3-4-5.
   - Go do that. Then come back to the phone.

7. Listen carefully.
   - **NEXT, LIFT** the **CHIN** slightly, **MAKING SURE THE NECK REMAINS LEVEL**, and give one quick breath of air.
   - Then, put your **FIRST AND MIDDLE FINGERS** on the **CENTER OF THE CHEST**, right **BETWEEN the NIPPLES**.
   - **PUSH** down **SLIGHTLY** — 1/2 to 1 inch. Do it 5 times **RAPIDLY**
   - Count **OUTLOUD** 1-2-3-4-5, blow; 1-2-3-4-5, blow.
   - **KEEP DOING THIS. REMEMBER,** one breath, then 5 quick compressions.
   - Keep doing it until help takes over. I'll stay on the line.

NOTE: IF CALLER REPORTS VOMITING, INSTRUCT CALLER TO:

- Turn his/her head to the side.
- Sweep it out with your fingers before you start mouth-to-mouth.

REVISED 05/04

CPR FOR THE PREGNANT WOMAN

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.**
   - **COMPLETELY COVER** her mouth with your mouth.
   - **GIVE** 2 breaths of air into his/her lungs — just like you're blowing up a big balloon.

REMEMBER:

- **FLAT** on her **BACK**.
- **WEDGE** the pillow under the **RIGHT SMALL** of the **BACK**.
- **BARE** the chest.
- **PINCH** the nose.
- With your **OTHER** hand, **LIFT** the **CHIN** so the head **BENDS BACK**.
- **GIVE** 2 breaths.
- **THEN, COME BACK TO THE PHONE!** If I'm not here, stay on the line.

4. Is she **MOVING** or **BREATHING NORMALLY?**

(*If yes*): Roll her on her left side and check for breathing until help takes over.

***(If NO)*:** 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, 1-1/2 to 2 inches.
- Do it 15 times, just like you're **PUMPING** her chest.
- Count **OUTLOUD** so that I can hear you, like this 1-2-3...
- **MAKE SURE** the **HEEL** of your hand is on the **CENTER** of her chest, **RIGHT BETWEEN** the **NIPPLES.** Pump 15 times.
- Then, **PINCH** the **NOSE** and **LIFT** the **CHIN** so the head **BENDS BACK.**
- **2 MORE** breaths and **PUMP** the **CHEST** 15 times.
- **KEEP DOING IT: PUMP** the **CHEST** 15 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 lesson 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.

REVISED 05/04

CARDIAC/RESPIRATORY ARREST/NECK BREATHERS

(Tracheostomy/Laryngectomy Patients)

Some patients have a tracheostomy, a surgical opening in their necks. 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 him/her **FLAT** on his/her **BACK** on the floor.
   - **BARE** the **CHEST** and **NECK**. **KNEEL** by his/her 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 his/her **LUNGS** — just like you’re blowing up a big balloon.

REMEMBER:

- **FLAT** on his/her **BACK**.
- **BARE** the **CHEST** and **NECK**. **KNEEL** by his/her side.
- **TILT** the head back slightly. **DO NOT** let it turn to the side.
- **COMPLETELY SEAL** the **MOUTH** and **PINCH** the **NOSE** shut.
- **COMPLETELY COVER** the stoma with your **MOUTH. GIVE** 2 **BREATHS.**
- **THEN, COME BACK TO THE PHONE!** If I’m not here, **STAY ON THE LINE!**

4. Is he/she **MOVING** or **BREATHING NORMALLY?**
   (*If yes*): Check for breathing until help takes over.
   ***(If NO)*:** Listen carefully, I’ll tell you what to do next.

   - Put the **HEEL** of your **HAND** on the **CENTER** of his/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, 1-1/2 to 2 inches.
   - Do it 15 times, just like you’re **PUMPING** his/her chest.
   - Count **OUTLOUD** so I can hear you, like this 1-2-3...
   - **MAKE SURE** the **HEEL** of your hand is on the **CENTER** of his/her chest, **RIGHT BETWEEN** the **NIPPLES.** Pump 15 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** 15 times. Then 2 **BREATHS**.
   - **KEEP DOING IT UNTIL HELP CAN TAKE OVER.**
   - I’ll stay on the line.

NOTES:

- Remember to have them 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 or handkerchief.

REVISED 05/04

CHOKING INSTRUCTIONS FOR PREGNANT WOMEN & OBESE PERSONS

If event is **NOT WITNESSED** and the person is **UNCONSCIOUS:** Go to **CARDIAC/RESPIRATORY ARREST/Adults or CPR for Pregnant Women**

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

1. Is the person is 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** his/her **CHEST.**
   - Place the thumb side of one fist on the **MIDDLE** of the his/her **BREASTBONE.**
   - **GRAB** that fist with your other hand and **THRUST INWARD** until the object is expelled.
   - If the person becomes unconscious, come back to the phone.

If **WITNESSED** and person is **UNCONSCIOUS** or becomes **UNCONSCIOUS**: Follow steps 1-2 below.

1. Is the person **MOVING** or **BREATHING**?
   (If yes): **ROLL** the person on his/her **SID**E and **CHECK FOR BREATHING** until help takes over.

   (**If NO)**: Listen carefully. I'll tell you what to do next.
   - Place the person **FLAT** on his/her back on the floor.
   - Get a pillow or a blanket and **WEDGE** it under the **RIGHT SMALL** of the **BACK**.
   - Kneel by his/her side.
   - **PINCH** the **NOSE**. With your other hand, **LIFT** the **CHIN** so the head bends back.
   - Completely **COVER** his/her mouth with yours.
   - **GIVE 2 BREATHS** of air into his/her lungs, just like you're blowing up a big balloon. Watch to see if the chest rises. If the chest does not rise, repeat the above process. If the chest still does not rise:
   - **BARE** the chest.
   - Place the **HEEL** of your hand on the center of his/her chest, right between the nipples.
   - Press into the chest with **FIRM**, downward thrusts five (5) times.

2. Next:
   - Lift the **CHIN** so the **HEAD** bends back. **OPEN** the mouth.
   - If you see something, try to **SWEEP** it out. **DON'T** push the object backwards.
   - Is the person **MOVING** or **BREATHING**?

   (If NO): Have the caller repeat steps 1-2 until the item is expelled or the person begins breathing or help arrives. Keep trying!

   (If yes): **ROLL** the person on his/her **SIDE** and **CHECK FOR BREATHING** until help takes over.

CHOKING/Adult

If event is NOT WITNESSED **and person is** UNCONSCIOUS**: Go to** CARDIAC/RESPIRATORY ARREST**/Adults.**

<u>If person is CONSCIOUS</u>:

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 he/she becomes unconscious, come back to the phone.

<u>If person is UNCONSCIOUS</u> or becomes **<u>UNCONSCIOUS</u>:**

1. Is the person **MOVING** or **BREATHING**?
   (If yes): **ROLL** the person on his/her **SID**E and **CHECK FOR BREATHING** until help takes over.
   (**If NO**): Listen carefully. I'll tell you what to do next.
   - **PINCH** the **NOSE**. With your other hand, **LIFT** the **CHIN** so the head bends back.
   - Completely **COVER** his/her mouth with yours.
   - **GIVE 2 BREATHS** of air, just like you're blowing up a big bal loon. Watch to see if the chest rises.

2. Did the **CHEST RISE**?
   (If yes, ask): Is the person **MOVING** or **BREATHING**?
   (If yes): **ROLL** the person on his/her **SIDE** and **CHECK FOR BREATHING** until help takes over.
   If chest did not rise, and patient not moving or breathing: Go to CPR/ Adults.

   (If NO, the chest DID NOT RISE): Listen carefully. I'll tell you what to do next.
   - Get him/her **FLAT** on his/her back on the floor.
   - **BARE** the chest and **STRADDLE** the **THIGHS**.
   - Place the **HEEL** of your hand against the stomach, in the **MIDDLE**, slightly above the **NAVEL**.
   - Place your other hand directly on **TOP** of the first hand. **PRESS** into the stomach with **QUICK, UPWARD** thrusts. Do 5 of these thrusts, then come back to the phone.
   - If I'm not here, stay on the line.

3. Is the person **MOVING** or **BREATHING**?
   (If yes): **ROLL** the person on his/her **SIDE** and **CHECK FOR BREATHING** until help takes over.
   (If NO): Listen carefully. I'll tell you what to do next.
   - Lift the **CHIN** so the **HEAD** bends back. **OPEN** the mouth.
   - **IF** you **SEE** something, turn the head to the side and try to **SWEEP** it out. **DON'T** push the object backwards.
   - If nothing is visible, **Repeat Step 1-3** until:
     - the item is expelled, or
     - the person begins breathing, or
     - help arrives. Keep trying!

REVISED 05/04

CHOKING/**Child (Children 1-8 Years)**

If event is NOT WITNESSED **and child is** UNCONSCIOUS**: Go to** CARDIAC/RESPIRATORY ARREST**/Child.**

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 chiled becomes unconscious, come back to the phone.

IF THE CHILD IS, OR BECOMES, UNCONSCIOUS:

1. Is the child **MOVING** or **BREATHING**?
   (**If yes**): **ROLL** the child on his/her **SIDE** and **CHECK FOR BREATHING** until help takes over.

   (**If NO**): Listen carefully. I'll tell you what to do next.
   - **PINCH** the **NOSE**. With your other hand, **LIF**T the **CHIN** so the head bends back.
   - Completely **COVER** his/her mouth with yours.
   - **GIVE 2 BREATHS** of air. Watch to see if the chest rises.

2. Did the **CHEST RISE**?
   (**If yes, ask**): Is the child **MOVING** or **BREATHING**?
   (**If yes)**: **ROLL** the child on his/her **SIDE** and **CHECK FOR BREATHING** until help takes over.

If not moving or breathing: Go to CARDIAC/RESPIRATORY ARREST/Child.

   (**If NO**, the chest **DID NOT RISE**):
   - **PINCH** the **NOSE**. With your other hand, **LIFT** the **CHIN** so the head bends back.
   - Completely **COVER** his/her mouth with yours.
   - **GIVE 2 BREATHS** of air. Watch to see if the chest rises.

3. If the chest does not rise, continue:
   - Get him/her **FLAT** on his/her back on the floor. **BARE** the chest and **STRADDLE** the **THIGHS.**
   - Place the **HEEL** of your hand against the stomach, in the **MIDDLE**, slightly above the **NAVEL**.
   - Place your other hand directly on **TOP** of the first hand. **PRESS** into the stomach with **QUICK, UPWARD** thrusts. Do 5 of these thrusts, then come back to the phone.
   - If I'm not here, stay on the line.

4. Is the child **MOVING** or **BREATHING**?
   (**If yes**): **ROLL** the child on his/her **SIDE** and **CHECK FOR BREATHING** until help takes over.
   (**If NO**): Listen carefully, I'll tell you what to do next:
   - Lift the **CHIN** so the head **BENDS BACK. OPEN** the mouth.
   - **IF** you **SEE** something, turn the head to the side and try to **SWEEP** it out. **DON'T** push the object backwards.
   - If nothing visible, Repeat steps 1-4 until the item is expelled, the child begins breathing, or help arrives. Keep trying!

REVISED 05/04

<u>CHOKING/Infant</u> - <u>CONSCIOUS</u> (Infants 0-12 Months)

If the event is **UNWITNESSED** and infant is **UNCONSCIOUS**, go to **CARDIAC/RESPIRATORY ARREST/infants.**

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.
   - **PICK** up the baby, and turn the baby **FACE DOWN** so he/she lies along your forearm.
   - **SUPPORT** the baby's JAW in your HAND with your arm resting on your thigh for support.
   - Let me repeat that. (Repeat above instructions.)
   - **TILT** the baby, with the head down slightly. Use the heel of your other **HAND** to strike the **BACK** 5 times, right between the **SHOULDER BLADES**. Do that and come back to the phone.

3. Listen carefully.
   - Lay the baby **FLAT** on his/her back on a table or a hard surface.
   - Put your **FIRST** and **MIDDLE FINGERS** directly **BETWEEN** the **NIPPLES**.
   - Push down ½ to 1 inch. Push down 5 times RAPIDLY.
   - Count **OUTLOUD** so I can hear you, like this 1-2-3-4-5.
   - Do that and come back to the phone.

4. Is the baby breathing?
   (If yes): **ROLL** the baby on his/her **SIDE** and **CHECK FOR BREATHING** until help takes over.

   (If NO): Repeat steps 2 – 4 until the item is expelled or the baby becomes unconscious.

IF THE BABY BECOMES UNCONSCIOUS, GO TO INSTRUCTIONS ON THE FOLLOWING PAGE.

<u>CHOKING/Infant</u> - <u>UNCONSCIOUS</u> (Infants 0-12 Months)

1. Is the baby **MOVING** or **BREATHING**?
   (If yes): **ROLL** the baby on his/her **SIDE** and **CHECK FOR BREATHING** until help takes over.
   (If NO): Listen carefully. I'll tell you what to do next.
   - Get the baby **FLAT** on his/her back.
   - **TIGHTLY** cover the baby's **MOUTH AND NOSE** with your mouth. Make sure the baby's neck remains level.
   - **GIVE 2 BREATHS** of air into the baby, watching to see if the chest rises.
   - Do that and **COME BACK** to the phone.

2. Did the **CHEST RISE**?

   (If yes): Is the baby **MOVING** or **BREATHING**?
   (If yes): **ROLL** the baby on his/her **SIDE** and **CHECK FOR BREATHING** until help takes over.
   (If NO): Go to **CARDIAC/RESPIRATORY ARREST/Infants.**

   <u>(If NO, the chest DID NOT rise):</u>
   - Make sure the baby's neck remains level, then **TIGHTLY** cover the baby's **MOUTH AND NOSE** with your mouth.
   - **GIVE 2 BREATHS** of air into the baby, watching to see if the chest rises.
   - Do that and **COME BACK** to the phone.

3. If the chest **DID NOT RISE** while giving the breaths:
   - Turn the baby **FACE DOWN** so he/she 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** 5 times, right between the **SHOULDER BLADES**. Do that and come back to the phone.

4. Next:
   - Lay the baby **FLAT** on his/her back on a table or hard surface.
   - Put your **FIRST** and **MIDDLE FINGERS** directly **BETWEEN** the **NIPPLES.**
   - Push down ½ to 1 inch. Push down 5 times **RAPIDLY.**
   - Count **OUTLOUD** so I can hear you, like this 1-2-3-4-5.
   - Do that and come back to the phone.

5. Is the baby **MOVING** or **BREATHING**?
   (If yes): **ROLL** the baby on his/her **SIDE** and **CHECK FOR BREATHING** until help takes over.
   (If NO):
   - Make sure the baby's mouth is clear.
   - **IF** you see something, turn the head to the side and try to **SWEEP** it out.
   - **DON'T** push the object backwards.
   - **LIFT** the **CHIN** slightly, **MAKING SURE THE NECK REMAINS LEVEL.**

6. If nothing visible, Repeat steps 1 – 5 until the item is expelled, the baby begins breathing or help takes over.
   KEEP TRYING!

REVISED 05/04

UNCONSCIOUS PATIENT/BREATHING NORMALLY - AIRWAY CONTROL

BREATHING NORMALLY (Non-trauma)

1. Listen carefully. I'll tell you what to do.
   - Roll the patient on his/her side.
   - Check for normal breathing until help takes over:
     - Watch for the chest to rise and fall.
     - Put your cheek next to the nose and mouth to listen and feel for air movement.

2. If the patient stops breathing normally or vomits, call back. **I have advised the dispatcher to send help.**
   Vomiting/Unconscious Person
   - Listen carefully. I'll tell you what to do.
     - Turn his/her 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 **CHOKING**, determine appropriate age group.

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.
     - Put your cheek next to the nose and mouth to listen and feel for air movement.

2. If the patient stops breathing normally or vomits, call back. **I have advised the dispatcher to send help.**
   Vomiting/Unconscious Person
   - Listen carefully. I'll tell you what to do.
     - **Do not turn his/her 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)**:* Go to **CHOKING**, determine appropriate age group.

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 fmany minutes between your contractions? Contractions with **less than 2 minutes between the end of one and the start of the next** (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 **BACK** or **SIDE**.
   - Take **DEEP** breaths in through your nose and out through your mouth.
   - Help has been dispatched.

4. If there are more **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 on the floor.
   - 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 **CARDIAC/ RESPIRATORY ARREST/ Infants.**
   - If possible, **STAY ON THE LINE WITH ME**.

6. If there are complications (leg, arm, buttocks or umbilical cord presenting):
   - **REASSURE** the mother. Tell her you have dispatched aid.
   - 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**.
   - Tell her you have dispatched aid.

CHILDBIRTH

1. Has she had a baby before?
2. How many minutes between her contractions*(pains)?* Contractions with **less than 2 minutes between the end of one and the start of the next** (especially if the women feels a **strong desire to push**), indicate birth may be **imminent**.
3. If there are less than 2 minutes between contractions: Listen carefully. I'll tell you what to do.
   Have her **LIE** in a comfortable position on the **BACK** or **SIDE** and have her take **DEEP** breaths. Help has been dispatched.
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 *(water broken, bloody discharge, 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 it's **MOUTH** and **NOSE** with a **CLEAN**, **DRY** cloth.
   - Do **NOT** attempt to **CUT** or **PULL** the cord.
   - Wrap the baby in a blanket, a towel, or whatever is handy, and place it between mother's legs on the floor.
   - 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 its own: Go to **CARDIAC/RESPIRATORY ARREST/**Infants.
   - When the placenta *(tissue at the other end of the umbilical cord)* is delivered, **WRAP IT**. This delivery may take as long as 20 minutes.
   - Keep the placenta **LEVEL** with or **SLIGHTLY ABOVE** the baby.
   - If you need additional help or advice, **CALL BACK** *(or come back to the phone).* 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:

7. 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.

8. 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 on either side with legs and buttocks elevated.

9. 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.

REVISED 05/04