This protocol is designed to provide personnel with a systematic approach to the evaluation and treatment of the ill or injured pediatric patient that will vary with the age of the patient. This protocol is the foundation for pediatric patient care, using the most appropriate approach to patient assessment with the respect to the patient's age according to the age classifications. If there is a doubt when to transition from Pediatric to Adult protocols, follow Adult protocols when a patient reaches age 14 and/or cannot be measured on the pediatric length base tape. Additional protocols should be instituted as necessary. This protocol is frequently referred to by other protocols and procedures that may override it in recommending more specific therapy.

A. Scene Size-Up

EMR/BLS

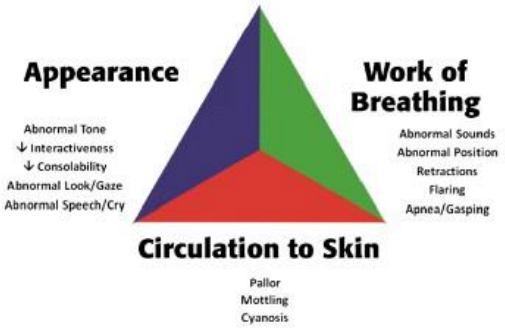
1. Perform a Scene Assessment and determine:
    a) Scene safety
    b) Mechanism of injury or Nature of Illness (NOI)
    c) Number of patients
    d) Severity of the patient(s)
    e) Need for additional resources

BLS

2. Determine if patient meets any Alert Criteria, i.e. STEMI, STROKE, or TRAUMA, notify dispatch and receiving facility as soon as possible.
3. For ALL calls, be prepared to administer immediate life-saving interventions (defibrillation, airway management, etc.) upon INITIAL patient contact.
4. Determine the medical priority, treatment strategies and notify corresponding facility

B. General Impression

The initial approach will encompass a rapid assessment of the general appearance of the patient. The Pediatric Assessment Triangle (PAT) shall be used to provide an accurate initial status of the child's underlying level of consciousness and cardiopulmonary status. The PAT encompasses three components that reflect the child's overall physiological status: appearance, work of breathing, and circulation to the skin.



General Care

BLS

1. Pediatric Assessment Triangle (PAT)

a) Appearance

Assess for specific features that the child may present to determine the severity of the illness or injury. Characteristics may include: tone, interactiveness, consolability, look/gaze, speech/cry.

b) Work of Breathing

Assess for the characteristics of the child's respiratory status, whether or not the child has an increased effort in order to properly oxygenate and ventilate their body. Characteristics may include: abnormal airway sounds (snoring, muffled, hoarse, stridor, grunting, wheezing), visual cues of increased work of breathing (sniffing position, tripod position, orthopnea) including using accessory muscles (retractions, nasal flaring).

c) Circulation

Assess the overall color of the skin and color pattern in order to determine the adequacy of overall perfusion. The circulation of the skin reflects the overall status of core circulation. Characteristics may include: pallor, mottling, cyanosis.

C. Primary Assessment

1. Airway

a) Assure a patent airway Protocol 07P and need for Spinal Motion Restriction Protocol 40.

b) If cervical or spinal injury is suspected, care must be taken not to move the head, but to maintain it in a neutral, in-line position as directed in Spinal Motion Restriction.

2. **Breathing** - patients should be observed for absence or evidence of difficulty in breathing and any unusual noises accompanying respirations.

a) Record the rate, rhythm and quality of respirations

b) Note the effort of breathing:

- Depth and effort?
- Use of accessory muscles?
- Symmetrical chest movements?

c) If breathing is abnormal, ensure the patency of the airway.

- Listen for abnormal sounds (wheezing, rales, rhonchi, absence of breath sounds, etc.)
- Evaluate for trauma (penetrating wounds, bruises, rib fractures, etc.)

3. Circulation

a) Record the patient's palpable pulse rate, rhythm, quality and location

b) Assess for obvious life-threatening external blood loss (active bleeds should be managed immediately).

c) Evaluate the patient's skin and perfusion

- Peripheral pulses present (radial, pedal)
- Capillary refill time
- Skin color, temperature, and moisture

4. Neurological Exam

a) Level of consciousness;

- Is patient oriented to person, place, time, and event?
- Determine the Glasgow Coma Score Appendix 6.
- Is a FAST-ED stroke assessment needed?

F: Is the face symmetrical?

A: Assess motor function and sensation

S: Check for abnormal speech, proper words, and/or slurring

T: Determine time of onset

b) Assess the patient's pupils size, equality and their reaction to light

c) If the patient is conscious, do all extremities move equally?

d) Assess patient for any pain

D. Medical Patient Management

BLS

1. Airway Management Protocol 07P.
2. Assess the need for administration of Oxygen Procedure 01. Obtain and document pulse oximetry reading and capnography as needed.
3. Perform a blood glucose check via finger/heel stick as indicated Procedure 19.

4. Administer Narcan (Naloxone) for significant respiratory depression due to suspected opiate overdose(Protocol 15P)

ALS

5. Perform advanced airway management, as indicated.
6. Cardiac evaluation and EKG monitoring.
7. Establish vascular access as indicated Procedure 13.
8. Utilize the Pediatric Length-Based Tape / Handtevy system if indicated.

MCP

8. Guidance for treatment not defined in these protocols.

E. Trauma Patient Management

BLS

1. Airway Management with C-spine control Protocol 07P.
2. Administer Oxygen Procedure 01.
3. Control any hemorrhage. Protocol 21P
4. Bandage and splint
5. Backboard and package the patient
6. Obtain and document a pulse oximetry reading.
7. If the patient is in shock, place patient in Trendelenburg position – in the absence of airway or breathing compromise.
8. Establish Trauma Center contact, if indicated.

ALS

9. Advanced airway management, as indicated.
10. Advanced interventions as needed.
11. Establish vascular access if indicated Procedure 13.
12. Utilize Pediatric Length-Based Tape if indicated.
13. EKG monitoring if situation allows.

MCP

14. Guidance for treatment not defined in these protocols.

F. Secondary Assessment

This assessment is a more thorough evaluation of the patient. These procedures can be carried out simultaneously along with the primary assessment and treatment when resources permit.

BLS

1. Identify a chief complaint.
2. Document vital signs and estimated weight. A second set of vitals will be obtained and documented for the following patients:
    a. Patients transported by MDFR.
    b. Patients transferred to an ambulance/BLS unit.
    c. Patients who refuse treatment/transport against medical advice. (The second set of vitals should be obtained just prior to release.)
    d. Unstable patients as indicated in other protocols
3. Document estimated weight whenever a medication is administered and/or anytime a patient is transported by MDFR.
4. Document a pertinent medical history:
    S: Signs and symptoms.
    A: Allergies
    M: Medications
    P: Past medical history.
    L: Last oral intake
    E: Events leading to the call for help
5. Complete a toe-to-head survey. Utilize the patient's complaint to guide your assessment.
6. Ongoing Assessment - Repeat PAT