

**Government of the
District of Columbia**



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Administration: Health Emergency Preparedness and Response Administration
Section: Emergency Medical Services
Policy Name: Patient Care Protocols for DOH Aid Stations
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Approved By: Beverly Pritchett, Senior Deputy Director, HEPRA
Applies To: Department of Health

Medical Reserve Corp

EMS Personnel Staffing DOH Aid Stations

Purpose: Protocols for Pre-hospital Care at DOH Aid Stations

Reference: EMS Act of 2008, Section 4

DOH EMS Policy 2010-0007 Patient Care Report for DOH Aid Stations

DOH EMS Policy 2010-0009 EMS Provider Scope of Practice

Revision: Original

The District of Columbia Department of Health is tasked with the staffing of Aid Stations during special events. The medical care delivered at the Aid Stations is aligned with the standards of pre-hospital care as delivered by the Emergency Medical Services providers in the District. These protocols allow for consistent and quality care at the Aid Stations and other medical assets deployed by the Department of Health during special events.

The protocols were developed for use by personnel staffing Aid Stations and other assets overseen by the District of Columbia Department of Health during special events. The use of these protocols is restricted to special events only. They have been developed to be consistent with the protocols of the DC Fire & EMS Department, version 1.8, released 14 May 2011.

The protocols are at the Basic Life Support level. Personnel operating in an EMS capacity during a special event must not perform beyond the level of the District EMS certification.

These protocols will be updated as needed to maintain currency and compatibility with the DC Fire & EMS Department protocols.

District of Columbia Department of Health
Health Emergency Preparedness and Response Administration

Special Events Pre-hospital Medical Treatment Protocols

25 August 2011



Special Events Pre-hospital BLS Medical Treatment Protocols

Release Notes

25 August 2011 – Initial Release

Preface

These protocols were developed for use by personnel staffing Aid Stations and other assets overseen by the District of Columbia Department of Health during special events. Their use is restricted to special events only. They have been developed to be consistent with the protocols of the DC Fire & EMS Department, version 1.8, released 14 May 2011. We also thank the DC Fire & EMS Department for the development of the initial special events protocols during the 56th Presidential Inauguration.

In the District of Columbia Advanced Life Support consists of personnel certified to the Paramedic or EMT-Intermediate level. Basic Life Support consists of personnel certified to the Emergency Medical Technician level. These protocols are at the Basic Life Support (BLS) level. Personnel operating in an EMS capacity during a special event must not perform beyond the level of the District EMS certification.

Our goal is to deliver high quality pre-hospital care to the citizens and visitor to the District of Columbia. We thank you for your willingness to serve in the role of a pre-hospital healthcare provider during these events.



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Notations Used In This Protocol



The teddy bear icon is used anytime there is reference to a pediatric skill or procedure.



The warning icon is used to emphasize an item of consequence.



The “i” icon is used to note information that may be of value.

Definitions Used

This protocol manual defines adult and pediatric patients based on age and/or weight:

- Adult: ≥ 15 years of age.
- Pediatric: < 15 years of age.

Medication dosing for pediatric patients:

- Pediatric doses apply to pediatric patients weighing less than 45 kg (100 lbs).
- For pediatric patients equal to or greater than 45 kg (100 lbs), utilize adult dosing.

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General Patient Management

I. Initial Scene Survey

1. Survey the scene for possible hazards and re-survey periodically.
2. Protect yourself first, then victims, from hazards. **Do not become a victim.**
3. Identify all potential patients.
4. Assess mechanism of injury and/or nature of illness.
 - Medical – determine nature of the illness from the patient, family or bystanders. Why EMS was activated?
 - Trauma – determine the mechanism of injury from the patient, family or bystanders, and inspection of the scene.
5. Identify mechanism of injury, if applicable. If injury or illness is the result of exposure to a hazardous chemical, the patient should be completely decontaminated before treatment.
6. If there is more than one patient, prioritize them using the START method. If inadequate resources are available to treat multiple, severely injured patients, treat cardiac arrest victims last.
7. Summon additional resources as necessary to manage the incident. Additional resources include, but are not limited to: fire, rescue, advanced life support, or law enforcement.

II. Initial Patient Assessment

1. Form a general impression of the patient (sick/not sick; hurt/not hurt).
2. Determine the chief complaint/apparent life threats.
3. Assess mental status (AVPU)
 - a. Alert
 - b. Responsive to **V**erbal stimulus
 - c. Responsive to **P**ainful stimulus
 - d. **U**nresponsive
4. Briefly note body position and extremity movement.
5. Airway
 - a. Assess airway status. If cervical spinal trauma is suspected, manually stabilize the spine. If the airway is blocked, adjust the head or jaw position to relieve the obstruction.
 - b. When the airway is open, insert an oral or nasopharyngeal airway as tolerated.

6. Breathing and Ventilation

- a. Assess adequacy of breathing. If the patient's respiratory rate is normal or near normal, administer oxygen as per the specific protocol.
- b. If the patient's respiratory rate is unusually rapid or slow for the age, size and condition of the patient, or if the patient is not breathing, ventilate with a bag-valve-mask.
- c. Seal sucking wounds with gloved hand, then an occlusive dressing.
- d. Splint flail segments with gloved hand, then a heavy bulky dressing.
- e. Frequently reassess the patient's breathing.

7. Circulation

- a. Assess for the presence of a pulse. If absent, immediately begin CPR and proceed with cardiac resuscitation. If the patient is very cold, assess the pulse for 45 seconds before determining that it is absent.
- b. Heart rate: compare to normal rate for age and situation.
- c. Central/truncal pulses (brachial, femoral, carotid): strong, weak or absent.
- d. Distal/peripheral pulses: present/absent, thready, weak, strong.
- e. Check perfusion by evaluating skin color, temperature, and moisture
-  f. Hydration status: anterior fontanel in infants, mucous membranes, skin turgor, crying tears, urine output history.
- g. Identify the priority of the patient based on assessment findings.
- h. Determine patient disposition. Expedite transport for high priority patients.
- i. Continue to assess and provide care.

8. Disability

- a. Evaluate neurological status by noting:
 - Mental status and level of consciousness.
 - Presence or absence of movement in the extremities, either spontaneously or in response to stimuli.
 - Pupil size and reactivity.
 - General evidence of trauma to the head or neck.
- b. Initiate spinal movement restrictions, if indicated.

9. Expose and Examine
 - a. Remove as much clothing as necessary to determine the presence or absence of an emergency condition or injury.
 - b. Proceed to the Focused History and Physical Exam.

III. Focused History

1. Conduct the physical examination.
2. Medical (unresponsive patient): perform a rapid physical examination to determine life-threatening problems.
3. Medical (responsive patient): assess body systems related to the patient's complaints.
4. Trauma (significant mechanism of injury MOI): perform rapid trauma physical examination to determine life-threatening injuries. Perform a detailed physical examination en route to the aid station or at the ambulance loading zone only after lifesaving assessments and interventions have been completed.

5. Baseline Vital Signs

1. Respiratory rate, depth, equality and rhythm (pattern).



2. Pulse rate and quality (strength, rhythm, equality).

DO NOT Utilize Pulse Oximeter As A Sole Means For Determining Heart Rate.

3. Skin color, temperature and moisture.
4. Capillary refill status (for adults, not a substitute for blood pressure).
5. Obtain blood pressure. The initial blood pressure should be obtained by auscultation on all patients. Subsequent blood pressures can be obtained manually or by electronic non-invasive blood pressure devices.
6. Vital signs should be monitored at a minimum of every 5 minutes for all critical patients and every 15 minutes for all other patients.



7. Normal Vital Signs

Age Group	Respirations	Pulse	Systolic BP
Adult	12-20	60-100	90-140
Adolescent	12-24	60-100	>90
Child (1-10 years)	22-34	80-140	>75*
Infant (1 month-1 year)	24-40	90-150	>70
Neonate (0-28 days)	30-60	100-160	>60

* For children 1 to 10 years of age, you can determine the lower limit of an acceptable blood pressure using the following formula:

$$\text{Minimal systolic blood pressure} = 70 + (2 \times \text{age in years}).$$

6. In addition to obtaining vital signs, providers should perform these additional skills to assist with patient assessment as needed:
 - a. Pulse Oximetry
 - b. Temperature as needed
7. Investigate the history of the present illness or event. You may use the mnemonic, “OPQRST”.
 - a. **O**nset – When did the pain/discomfort begin?
 - b. **P**rovocation/Palliative – What worsens or lessens the pain/discomfort?
 - c. **Q**uality – What does the pain/discomfort feel like?
 - d. **R**egion/Radiation/Referral – Where is the pain/discomfort? Does it move anywhere?
 - e. **S**everity – How severe is the pain/discomfort?
 - f. **T**iming – How long/often has this been occurring?
8. Inquire about pertinent past medical history. You may use the acronym, “SAMPLE”.
 - a. **S**igns/Symptoms
 - b. **A**llergies
 - c. **M**edication
 - d. **P**ast medical history
 - e. **L**ast oral intake
 - f. **E**vents leading up to illness or injury
9. Inquire about current health status.

IV. Focused Physical Examination

1. Performed to detect non-life threatening conditions and to provide care for those conditions/injuries. Perform enroute to the medical facility if the patient is unstable.
2. Inspect and palpate each of the major body systems for the following:
 - a. **D**eformities
 - b. **C**ontusions
 - c. **A**brasions
 - d. **P**enetrations/punctures
 - e. **B**urns
 - f. **T**enderness
 - g. **L**acerations
 - h. **S**welling/edema

- i. Instability
- j. Crepitus
- 3. Head
 - a. Inspect facial features for symmetry.
 - b. Note color of face.
 - c. Note presence of swelling or excessive perspiration.
 - d. Assess the pupils and observe their size, equality and reactivity.
 - e. If evidence of head trauma, have suction ready and prepare for seizure activity.
- 4. Neck
 - a. Inspect the neck of the upright patient for jugular venous distention.
 - b. Observe supra-sternal areas for retractions or use of accessory muscles.
 - c. Note the trachea's position.
- 5. Chest
 - a. Observe chest wall movement for symmetry, and auscultate breath sounds on both sides of the chest. Assess rate, depth and pattern of breathing, as well as the integrity of the chest wall.
 - b. Control serious external bleeding.
- 6. Abdomen and Pelvis
 - a. Palpate abdomen for pain, guarding, pulsations, masses, distention, rigidity and tenderness; and, using gentle pressure, the pelvis for crepitus and instability. **These indicate potential sources of significant blood loss.**
 - b. Control serious external bleeding.
- 7. Extremities
 - a. Inspect and palpate extremities for tenderness, gross deformity, swelling, lacerations and abrasions.
 - b. Note motor, sensory, and vascular integrity in each extremity.
 - c. Dress and splint extremity injuries as required and as time allows.
 - d. When possible, elevate injured extremities.
- 8. Back
 - a. Examine the patient's back, if possible, for gross deformities or penetrating injuries.
 - b. Initiate spinal movement restrictions if indicated.

V. Ongoing Assessment



- 1. To Effectively Maintain Awareness Of Changes In The Patient's Condition, Repeated Assessments Are Essential And Should Be Performed At Least Every 5 Minutes On The Unstable Patient, And At Least Every 15 Minutes On The Stable Patient.**
2. Reassess mental status.
3. Reassess airway.
4. Reassess breathing for rate and quality.
5. Reassess circulation including pulses, hemorrhage control and skin perfusion.
6. Re-establish patient priority.
7. Reassess and record vital signs.
8. Repeat focused assessment regarding patient complaint or injuries.
9. Assess interventions.
10. Assess response to management.
11. Maintain or modify management plan.

VI. Transport Decision



1. Contact the EMS transport authority as outlined in your event briefing to arrange for transport of the patient to the appropriate care facility
- 2. Until EMS Transport Is Arranged And Carried Out, Perform Regular Assessment Of Patient's Condition, At Least Every 5 Minutes On The Unstable Patient, And At Least Every 15 Minutes On The Stable Patient.**

Clinical Priorities

After assessment of a patient, the ALS or BLS provider must assign a treatment priority. The following examples of priorities are not inclusive and sound judgment should be used when assessing patients.

I. Priority 1: Unstable Patients

1. Cardiac Arrest.
2. Post arrest with successful resuscitation.
3. Unconscious or GCS <13 and does not respond to therapy.
4. Moderate to severe respiratory distress with a respiratory rate >24, cyanosis, use of accessory muscles, or altered mental status.
5. Hypotensive (BP <90 systolic) with signs and symptoms of hypoperfusion.
6. Hypertensive (BP >220 systolic or >120 diastolic) with altered mental status or neurological deficit.
7. Cardiac related chest pain unrelieved by therapy with hypotension or cardiac dysrhythmia.
8. Suspected acute myocardial infarction.
9. Obstructed or uncontrolled airway.
10. Continuous vaginal hemorrhage with signs and symptoms of hypoperfusion.
11. Abnormal deliveries.
12. Evidence of prolapsed cord.
13. Eclampsia.
14. Allergic reaction with acute respiratory distress and hypotension (BP <90 systolic).
15. Status epilepticus.
16. Uncontrolled hemorrhage following trauma.
17. Multiple trauma patient(s).
18. Unstable chest injuries.
19. Penetrating wounds head, neck, chest, abdomen or pelvis.
20. Burn patients:
 - a. Respiratory burns.
 - b. 2nd degree burn with greater than 20% BSA any age.
 - c. Any 3rd degree burn larger than 1% BSA, or the size of the patient's hand.
 - d. Electrical burns.

- e. Chemical burns.
 - f. 2nd or 3rd degree burns hands, face, feet or perineum.
21. Acute neurological deficit less than four (4) hours.
 22. Unstable fracture with neurovascular compromise.
 23. Any patient that is deemed unstable by the senior provider.

II. Priority 2: Potentially Unstable Patients

1. Cardiac related chest pain.
2. Respiratory distress (mild to moderate).
3. Hypertensive (BP >220 systolic or >120 diastolic) without signs and symptoms.
4. Patients involved in trauma with a GCS of 15, without signs and symptoms of hypoperfusion and associated with one of the below:
 - a. MVC >40 mph.
 - b. Hit by vehicles >20 mph.
 - c. Patients thrown from moving vehicles.
 - d. Rollover MVC.
 - e. Falls \geq 20 feet without altered mental status or hypoperfusion.
5. Burn patients.
 - a. 2nd degree burns 10-20% BSA any age.
6. Any patient that is deemed potentially unstable by the senior provider.

III. Priority 3: Stable Patients

1. Uncomplicated fractures.
2. Minor burns.
3. Lacerations requiring suturing, with bleeding controlled.
4. Seizure patients with a return of a GCS 15.
5. Any patient that is deemed stable by the senior provider.

IV. Potential Transport Site

Depending on the event there may be alternate patient treatment sites available that may be considered appropriate for stable patients who need focused medical treatment. These are effectively an “urgent care center” and have personnel and equipment that can provide care to those with relatively minor illnesses and injuries. This will allow the hospitals and emergency

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departments to focus on patients with more significant medical problems. The sites of these alternate care facilities will be available to personnel operating under these protocols if available.

Under certain circumstances, these alternate treatment sites will be utilized for patients being moved or directed away from the events. The referral of patients to these facilities will be based on:

1. Location of the patient along a convenient pathway to the facilities
2. Traffic conditions that allow transport more conveniently than to a hospital
3. A stable patient, during a time when many unstable patients are being transported to hospitals
4. A patient with a stable “focused” problem that can be dealt with by the personnel using the equipment and resources available at these treatment sites



Priority III Patients Designated Above Should Be Considered As Appropriate For Transport To An Alternate Patient Treatment Site.

Refusal of Care

I. Purpose

To establish guidelines for the management and documentation of situations where patients refuse treatment or transportation, or insist on transportation to a destination other than that recommended by the EMS provider.

II. Patient Assessment

1. Providers should attempt to obtain a history and perform a physical assessment in as much detail as is permitted by the patient.
2. Conduct Three Assessments:
 - a. Legal competence
 - Ensure patient is at least 18 years of age in order to refuse care.
 - b. Mental competence
 - Start with the presumption that all patients are mentally competent unless your assessment clearly indicates otherwise.
 - Establish that patient is oriented to person, place, time and purpose.
 - Establish that patient is not a danger to himself or others.
 - Ensure that patient is capable of understanding the risks of refusing care or transportation and any proposed alternatives.
 - Check to be sure that patient is exhibiting no other signs or symptoms of potential mental incapacity, including drug or alcohol intoxication, unsteady gait, slurred speech, etc.
 - c. Medical or situational competence
 - Ensure that patient is suffering from no acute medical conditions that might impair his or her ability to make an informed decision to refuse care or transportation. Rule out conditions such as hypovolemia, hypoxia, head trauma, unequal pupils, metabolic emergencies (e.g., diabetic); hypothermia, hyperthermia, etc.

III. Who May Refuse Care

1. The Patient
 - a. If patient is legally, mentally, and situationally competent, the patient has a right to refuse care. Obtain refusal signature.

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2. Parent:
 - a. A custodial parent (i.e., a parent with a legal right to custody of a minor child) may refuse care on behalf of a minor child. Obtain refusal signature from parent.
3. Guardian
 - a. A legal guardian is one who is appointed by a court to act as “guardian of the person” of an individual found by a court to be incapacitated.

Acute Coronary Syndrome – Chest Pain

I. Application

This protocol applies to adult patients with non-traumatic chest pain that is suspected cardiac in etiology. The overall goal is to provide therapy in an effort to reduce ischemia, provide pain relief and rapidly identify and treat a patient suffering from a suspected cardiac event.

II. All Provider Levels

1. Initiate General Patient Care.
2. Administer supplemental Oxygen maintaining a SpO₂ >96%.
 - a. In chest pain patients, administer Oxygen by nasal cannula at 2-4 lpm.
3. Place the patient in a position of comfort.
4. BLS providers should assist patients in taking their own previously prescribed Nitroglycerin if the patient's systolic blood pressure is ≥ 100 mmHg.

Cardiac Arrest

I. Application

This protocol applies to patients experiencing a non-traumatic cardiac arrest.

II. All Provider Levels

1. Initiate General Patient Care ensuring that the patient is pulseless and apneic (agonal).
2. Initiate immediate CPR with an oral airway, BVM and 100% oxygen (≥ 15 lpm).
3. In cases of an un-witnessed cardiac arrest, CPR shall be performed for at least 2 minutes at a rate of 100 compressions per minute. This will be 5 cycles of CPR:
 - a. Adult at 30:2
 - b. Pediatric at 15:2
4. Attach AED and analyze the rhythm. If “no shock” is advised, immediately continue CPR. Reassess rhythm after 2 minutes or 5 cycles of CPR.
5. BLS providers are to continue with “shock” and CPR therapy for the remainder of the arrest, until the rhythm is no longer “shockable” or until patient care is taken over by ALS providers.

Bronchospasm / Asthma / COPD

I. Application

This protocol applies to patients experiencing respiratory distress associated with Asthma or COPD.

II. All Provider Levels

1. Initiate General Patient Care.
2. Administer supplemental Oxygen maintaining a SpO₂ >96%.
 - a. For patients with a history of COPD, administer the patients prescribed dose of Oxygen. If severe distress is present, administer 100% supplemental Oxygen.
3. Place the patient in a position of comfort.

Epistaxis / Nosebleed

I. Application

1. This protocol applies to patients having significant nosebleed.

II. All Provider Levels

1. Perform an accurate patient assessment to include the medications the patient is taking that may cause increased bleeding, such as aspirin, coumadin, heparin, or other blood thinners.
 - a. If the patient is on a blood thinner and has any significant bleeding, call for an ALS transport resource.
2. Place the patient in a position of comfort, with the nose forward. Ask the patient to blow any clots out of his/her nose, into a towel, basin, or tissues
3. Place a dressing (2x2 or similar) into the nostril.
 - a. Have the patient, or the rescuer, pinch the side of the nose that is bleeding firmly against the nasal septum.
 - b. Pressure may need to be applied for 5 minutes or so.
 - c. If the patient reports blood going down their throat, remove the packing, have the patient lean forward, and attempt again to control bleeding by placing the dressing and applying pressure
4. If the patient gets lightheaded or is perfusing poorly, lay the victim down on their side to allow any blood that is going down the throat to drain out the mouth.

Altered Mental Status / Syncope / Unconscious / Non-Traumatic

I. Application

This protocol applies to patients that present with altered mental status, syncope or unconsciousness that is non-traumatic.

II. All Provider Levels

1. Initiate General Patient Care and rule out trauma as a suspected etiology.
 - a. If stroke is suspected, proceed to Brain Attack / CVA Protocol (*page 26*).
2. Administer supplemental Oxygen maintaining a SpO₂ >96%.
 - a. If respiratory effort is inadequate provide ventilatory assistance with a BVM and 100% Oxygen.
3. Place the patient in a position of comfort if possible.

Anaphylaxis / Allergic Reaction

I. Application

The protocol applies to patients suffering from anaphylaxis as a result of an allergic reaction to a known or unknown allergen. It is imperative that when looking for signs and symptoms be cognizant that 10-20% of all anaphylaxis cases will not present with hives or other skin manifestations. Signs and symptoms of anaphylaxis / allergic reaction may include oral manifestations such as; itching of the lips, tongue and palate; edema of the lips and tongue or a metallic taste in the mouth. Skin related manifestations may include flushing, itching, hives, swelling or rash.

II. All Provider Levels

1. Initiate General Patient Care and determine a suspected cause of the reaction.
2. Administer supplemental Oxygen maintaining a SpO₂ >96%.
 - a. If respiratory effort is inadequate provide ventilatory assistance with a BVM and 100% Oxygen.
3. Place the patient in a position of comfort.
 - a. If signs of hypoperfusion exist, place the patient in the shock position if possible.

Brain Attack / CVA

I. Application

This protocol applies to adult patients exhibiting signs and symptoms of a cerebral vascular accident or bleed. It is very difficult in some patients to determine the time of onset of the new symptoms, but try to establish the time interval of the new deficit. Treatment for strokes is time dependent, and will be carried out at a verified stroke center. In many cases, it will be up to the hospital providers to determine more precisely when the patient had first onset of new symptoms. Providers should document any information they have.

II. All Provider Levels

1. Initiate General Patient Care to include the Capital Area Pre-hospital Stroke Screen (CAPSS).



Capital Area Pre-hospital Stroke Screen (CAPSS)

Obtain history from the patient, family members, or other persons who are present on the scene.

- Date and time at baseline or symptom-free and awake.
- Age ≥ 18 .
- Symptom duration ≤ 24 hours.
- Blood glucose is between 70 and 400 mg/dl.
- Patient has one or more of the following abnormalities.
 - Facial weakness or droop on left or right side.
 - Arm weakness (drifts or falls) on left or right side.
 - Leg weakness on left or right side.
- Patient has unilateral weakness.
- Reassess patient every 5 minutes.

2. Administer supplemental Oxygen maintaining a SpO₂ >96%.
3. Place the patient in a position of comfort.
4. Notify the transportation officer of the need to transport to a verified stroke center.

Overdose / Poisoning

I. Application

This protocol applies to patients that have been exposed to a poison, overdosed on a medication or exhibits signs and symptoms related to the affects of drugs of abuse.

II. All Provider Levels

1. Initiate General Patient Care and attempt to identify any medications or products taken or exposed to. Save samples if possible.
2. Administer supplemental Oxygen maintaining a SpO₂ >96%. If respiratory effort is inadequate provide ventilatory assistance with a BVM and 100% Oxygen.
3. Contact Poison Control at 1-800-222-1222 for assistance in managing specific overdoses.

Seizures

I. Application

This protocol applies to patients with unusually prolonged altered mental status after seizure activity, and patients experiencing multiple or continuous seizure activity.

II. All Provider Levels

1. Initiate General Patient Care and protect the patient from injury.
2. Consider manual stabilization and spinal immobilization if the possibility of suspected head or c-spine injury exists.
3. Administer supplemental Oxygen maintaining a SpO₂ >96%.
 - a. If respiratory effort is inadequate provide ventilatory assistance with a BVM and 100% Oxygen.

Hyperthermia

I. Application

This protocol applies to patients suffering from a suspected heat related emergency. Hyperthermic reactions generally relate to heat cramps, heat exhaustion or in severe cases, heat stroke.

II. All Provider Levels

1. Initiate General Patient Care.
2. If heat exhaustion or cramps are suspected, move the patient to a cool environment and obtain a temperature.
3. Place the patient in a position of comfort. If signs of hypoperfusion exist, place the patient in the shock position if possible.
4. Administer supplemental Oxygen maintaining a SpO₂ >96%. If respiratory effort is inadequate provide ventilatory assistance with a BVM and 100% Oxygen.
5. If heat stroke is suspected, initiate immediate aggressive cooling techniques such as removing as much clothing as possible, cold packs at the groin, under the axilla and around the neck; covering the patient with a cool wet sheet and set windows and ventilation system in the unit to provide mechanical cooling.

Hypothermia

I. Application

This protocol applies to patients suffering from cold-related emergencies such as mild frostbite to severe hypothermia. Hypothermia is defined as a core temperature below 95°F. Moderate to severe hypothermia often presents with altered mental status and occasionally a decreased pulse, respiratory rate and blood pressure. Patients in cardiac arrest with suspected severe hypothermia shall not be considered dead until re-warming has been completed at a medical facility.

II. All Provider Levels

1. Initiate General Patient Care and handle the patient gently.
2. Remove any wet clothing and cover the patient in blankets to prevent heat loss.
3. Administer supplemental Oxygen maintaining a SpO₂ >96%. If respiratory effort is inadequate provide ventilatory assistance with a BVM and 100% Oxygen.
4. If the patient is in cardiac arrest, attach AED and analyze the rhythm. If the AED advises “shock advised” ensure that all providers are clear of the patient and depress the shock button.
 - a. If no response from the first defibrillation, defer from further attempts until the patient’s core temperature is increased.

Envenomations / Bites / Stings

I. Application

This protocol applies to patients experiencing venomous or non-venomous, bites or stings from animals, snakes or spiders.

II. All Provider Levels

1. Initiate General Patient Care.
2. Attempt to identify the insect, reptile or animal that caused the injury, if safe to do so.



- a. **DO NOT transport a living snake/animal/spider to the hospital.**
 - b. Determine if the patient has access to anti-venom that can be transported to the hospital with them.
3. If an anaphylactic reaction occurs as a result of a bite or sting, refer to the Allergic Reaction / Anaphylaxis protocol (*page 23*).
 4. Administer supplemental Oxygen maintaining a SpO₂ >96%. If respiratory effort is inadequate provide ventilatory assistance with a BVM and 100% Oxygen.
 5. Have the patient remain calm and immobilize the effected extremity.
 6. Remove any rings, bracelets, jewelry and constricting clothing from the affected extremity.
 7. Do not apply tourniquets, cold packs, or make incisions around the affected area.
 8. Contact Poison Control at 1-800-222-1222 for assistance in managing specific envenomations.
 9. Provide rapid transport to the appropriate medical facility if the patient is symptomatic. Notification of the receiving facility is required.

Amputations

I. Application

This protocol applies to patients with near or complete amputations.

II. All Provider Levels

1. Initiate General Patient Care.
2. Control bleeding with:
 - a. Direct pressure.
 - b. Utilize a tourniquet as the last resort.
3. If c-spine injury is suspected, provide spinal immobilization.
4. Administer supplemental Oxygen maintaining a SpO₂ >96%.
5. Provide extremity splinting as required.
6. Care of the amputated part if recovered shall include:
 - a. Removing gross contaminations with saline.
 - b. Wrap the part in moist sterile dressings and place the part in a plastic bag or container.
 -  c. If possible, place that bag or container into a separate bag or container with ice packs to keep the part cool. **Do not allow the part to freeze.**
7. Transport to the closest appropriate facility with trauma capabilities if the patient has abnormal vital signs, multi-system trauma or amputations of the toe or finger tip at the distal end.
8. Notify the transportation officer of the need to transfer the patient to a specialty referral center for stable patients that present with the following:
 - a. Complete or incomplete amputation, de-gloving, crushing or de-vascularization injuries.
 - b. Specific injuries might include, complete or incomplete hand amputation, partial or complete proximal finger or thumb amputation at the joint that meets the hand, de-gloving, crushing or de-vascularization injuries of hand, clean cut amputation at the ankle.

Burns / Electrocution / Lightning

I. Application

This protocol applies to patients sustaining injury as a result of high voltage electricity (>200 volts) or lightning strikes. In addition to burns, these patients have a high probability of cardiac rhythm disturbances and penetrating trauma as a result of the electrical injury.

II. All Provider Levels

1. Remove the patient from the source of injury, if safe to do so.
2. Initiate General Patient Care.
3. Consider spinal immobilization if the mechanism of injury exists.
4. Administer supplemental Oxygen maintaining a SpO₂ >96%.
 - a. If respiratory effort is inadequate provide ventilatory assistance with a BVM and 100% Oxygen.
5. If the patient is in cardiac arrest, attach AED and analyze the rhythm. If the AED advises “shock advised” ensure that all providers are clear of the patient and depress the shock button.
 - a. Reassess rhythm after 2 minutes or 5 cycles of CPR (30:2).
6. Providers are to continue with “shock” and CPR therapy for the remainder of the arrest, until the rhythm is no longer “shockable” or until patient care is taken over by ALS providers.

Eye Injuries

I. Application

This protocol applies to patients with eye injuries as a result of trauma or burns (including pepper spray).

II. All Provider Levels

1. All providers shall utilize proper PPE at all times.
2. If the injury is related to a chemical exposure:
 - a. Remove patient from exposure source if safe to do so.
 - b. Remove contact lenses if possible and transport them with the patient.
 - c. Irrigate the eye(s) immediately with Normal Saline for a minimum of 20 minutes utilizing IV tubing or a nasal cannula.
 - d. Determine the chemical involved. If MSDS is available transport with patient.
3. If the eye injury is related to trauma:
 - a. Do not irrigate if penetrating trauma.
 - b. Cover the injured eye.
 - Do not use a pressure or absorbent dressing on any eye that may have ruptured, or have penetrating trauma.
 - c. Cover both eyes to limit movement.
 - d. Transport the patient with head elevated at least 30°.

Single / Multiple System Trauma

I. Application

This protocol applies to patients injured as a result of trauma with a GCS of ≤ 15 , penetrating injuries to the head, neck, chest, and abdomen, extremities proximal to the elbow or knee. Patients with 2 or more proximal long bone fractures flail chest, combination or trauma with burns, pelvic fractures, amputation or crush injuries proximal to the wrist or ankle and limb paralysis. Automobile crashes >40 mph with major deformity to the vehicle >20 inches, intrusion into passenger compartment >12 inches, vehicle rollover and ejection from a vehicle. When in doubt, transport the patient to the closest open trauma center for evaluation and treatment.

II. All Provider Levels

1. Initiate General Patient Care.
2. Ensure that spinal immobilization is performed if the mechanism of injury warrants.
 - a. This would also include penetrating injuries to the head, chest or abdomen with or without neurological deficit.
3. Administer supplemental Oxygen maintaining a SpO₂ $>96\%$.
 - a. If respiratory effort is inadequate provide ventilatory assistance with a BVM and 100% Oxygen.
4. Treat all life threatening injuries as soon as possible such as sealing of a sucking chest wound, stabilization of a flail chest, and stabilization of a protruding object from a head, neck, eye, chest or abdomen.

Mass Casualty Incident (MCI) START & JumpSTART Triage

I. Purpose

To provide structure to the triage and treatment of persons involved in a multiple or mass casualty incident or a multiple patient scene.

II. Responsibility

During an MCI primary care givers will be overwhelmed and all additional personnel will be expected to assist in the triage and treatment of patients.

III. Definitions

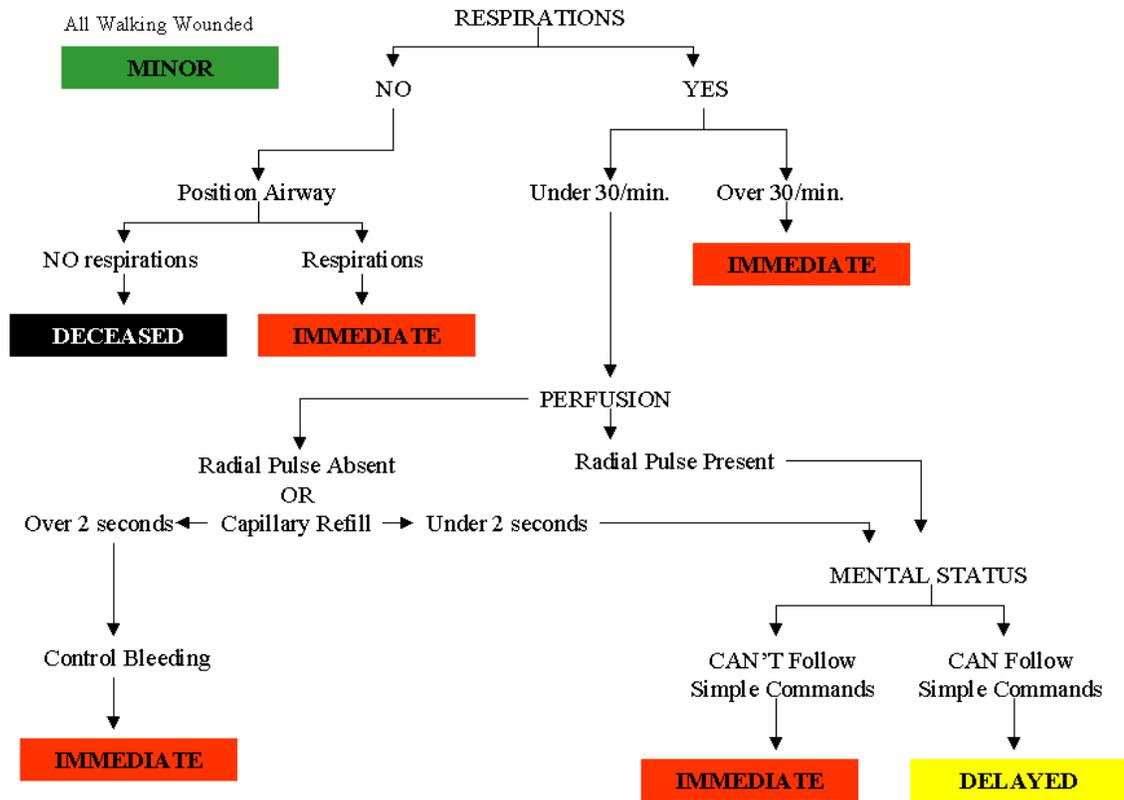
1. A multiple or mass casualty incident is an emergency scene that creates a number of patients sufficient to significantly overwhelm available resources.
2. Multiple Casualty Incident: <9 patients (does not need to be declared)
3. Mass Casualty Incident: 9 or more patients (needs to be declared)
4. Triage: The process of sorting and categorizing patients based on the severity of their symptoms. Patients will be categorized into the four following groups. Each group has a color designation to assist in the rapid sorting of triaged patients.
 - a. Red (Immediate) – Critically injured patients who must be transported as soon as resources allow.
 - b. Yellow (Delayed) – Severely injured patients who must be evaluated and treated but may not need immediate treatment.
 - c. Green (Minor) – Those patients who need minor treatment or prophylactic evaluation.
 - d. Black (Deceased) – Patients who are or will be deceased before appropriate treatment would be available.

IV. Procedure

1. Patients will be triaged according to START and JumpSTART triage criteria during every MCI.
2. During primary triage, providers should spend no more than 30 seconds with each patient.
3. Only after all patients have been triaged and staged per Medical Command, may patients be treated on the scene.
4.  **ALS providers should consider providing care at the BLS level in order to give care to as many patients as possible.**

V. START Triage

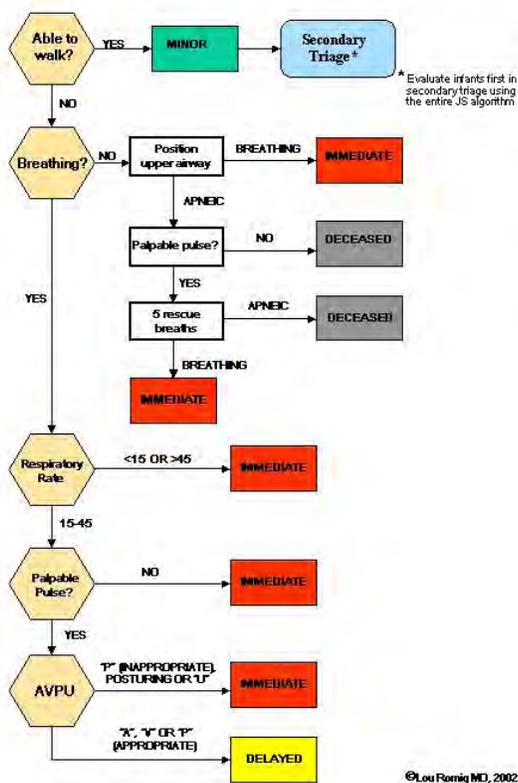
1. START Triage should be used for all adult patients
2. Walking wounded should be encouraged to congregate in a designated location under their own power and triaged in the GREEN (minor) category.
3. Patients with no respiratory effort should be triaged in the BLACK (deceased) category following an attempt to open the airway.
4. Patients with difficulty in respirations, perfusion or mental status as specified below should be triaged in the RED (immediate) category.
 - a. Respirations >30/min
 - b. Perfusion – No radial pulse or capillary refill times >2 seconds
 - c. Mental Status – Unable to follow simple commands
 - d. All patients who cannot walk, have respiratory effort, and do not meet criteria for the RED category should be triaged to the YELLOW (delayed) category.



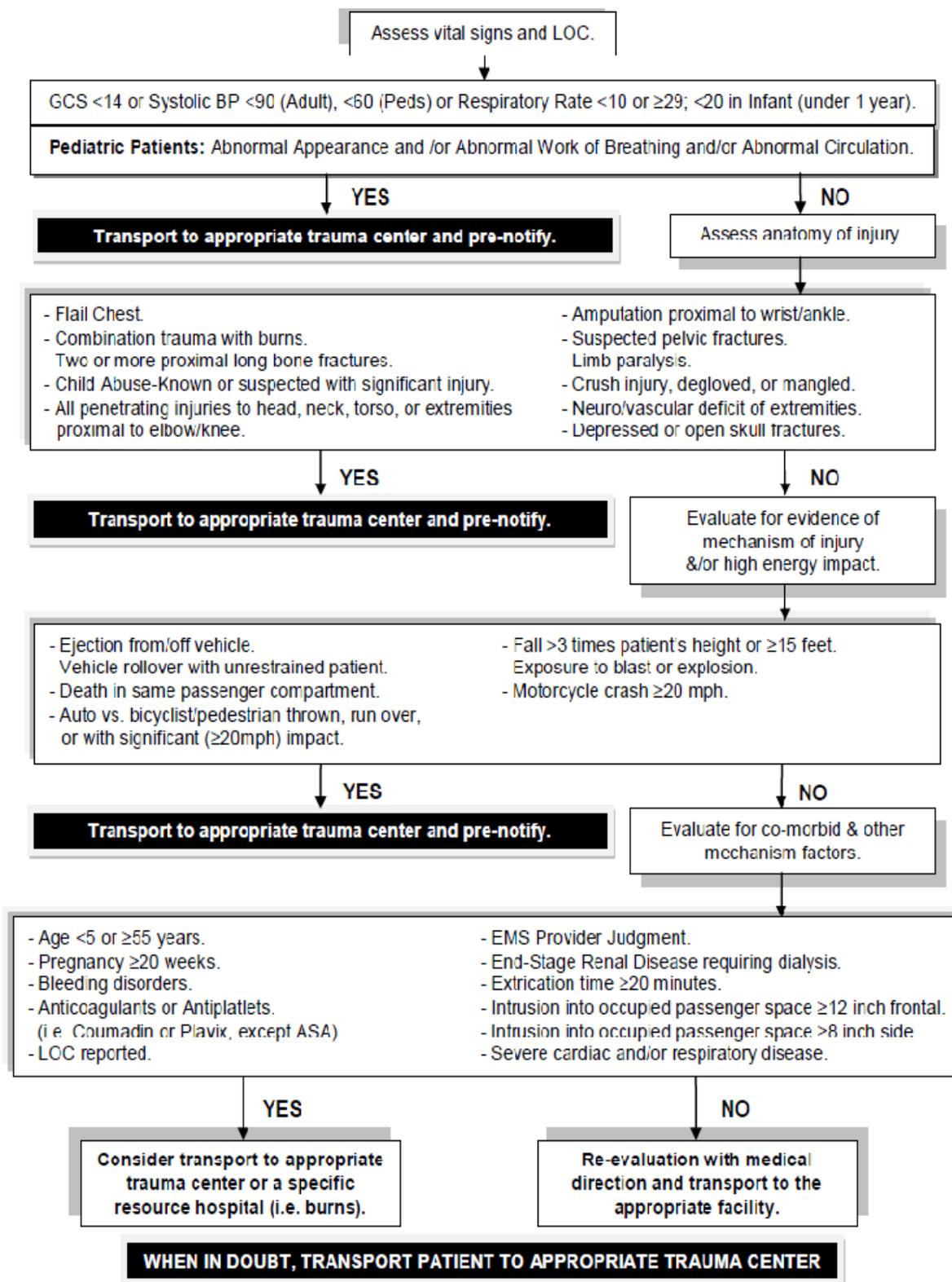
V. JumpSTART Triage

1. JumpSTART Triage should be used for all pediatric patients (≤ 14 years old)
2. Walking wounded should be encouraged to congregate in a designated location under their own power and triaged in the GREEN (minor) category.
3. Patients with no respiratory effort or peripheral pulse should be triaged in the BLACK (deceased) category.
4. Patients with difficulty in respirations, perfusion or mental status as specified below should be triaged in the RED (immediate) category.
 - a. Respirations >45 /min or <15 /min
 - b. Perfusion – No peripheral pulse or capillary refill times >2 seconds
 - c. Mental Status – unresponsive or responsive to painful stimulus
5. Patients with a peripheral pulse but without respiratory effort should receive 5 ventilations then categorized as RED (immediate) if respiratory effort resumes or BLACK (deceased) if apnea continues.
6. All patients who cannot walk, have respiratory effort, and do not meet criteria for the RED category should be triaged to the YELLOW (delayed) category.

JumpSTART Pediatric MCI Triage®



Trauma Decision Tree Algorithm



Glascow Coma Scale

Adult (> 4 years)

Eye Opening	Score	Best Verbal Response	Score	Best Motor Response	Score
Spontaneously	4	Oriented	5	Obeys commands	6
To verbal	3	Confused	4	Localizes pain	5
To pain	2	Inappropriate words	3	Withdraws to pain	4
No response	1	Incomprehensible	2	Abnormal flexion	3
		No response	1	Abnormal extension	2
				No response	1
Eye Score		Verbal Score		Motor Score	
Total Glasgow Coma Score (Eye + Verbal + Motor)					

Hospital Emergency Department Phone List

Hospital	ED Emergency Number
Children's National Medical Center	202-476-5433
George Washington University Hospital	202-715-4911
Georgetown University Hospital	202-444-2119
Howard University Hospital	202-865-1141
Providence Hospital	202-269-7001
Sibley Memorial Hospital	202-537-4080
United Medical Center	202-574-6545
Veterans Affairs Medical Center	202-745-8357
Washington Hospital Center	202-877-6701