Pediatric BLS Standing Orders

- **Universal Patient Protocol**
- Control patient airway and breathing
- **Hemorrhage Control Protocol**
- Keep patient warm
- **Immediate transport (goal < 10 minutes on scene) if patient is critical or mechanism of injury is significant**
- Consider **Air Ambulance Activation Policy**
- Consider **Trauma Triage Policy**
- Continuous heartrate, pulse oximetry, blood pressure, and capnography PRN

TRAUMATIC ARREST – See Traumatic Arrest Protocol

ABDOMINAL TRAUMA

- Cover eviscerated bowel with saline soaked pads
- NEVER attempt to reduce eviscerated bowel

EXTREMITY TRAUMA

- Place tourniquet for uncontrolled bleeding (see **Hemorrhage Control Protocol**)
- Splint fractures as they lie, if no neurovascular impairment
- Fractures with neurovascular impairment may be realigned. Provide gentle, unidirectional traction before splinting
- If circulation in not restored after two (2) attempts at straightening, splint as it lies and transport immediately
- Splint dislocations in position found
- Immobilize joints above and below injury, if possible
- Pelvic wrap for unstable patients with concern for pelvic fractures

AMPUTATED PARTS

- Place in plastic bag if possible and keep cool during transport
- Do not place in water or directly on ice
- Place avulsed teeth in milk if possible. Avoid touching root of tooth

IMPALED OBJECTS

- Immobilize object
- May remove object if in face, neck or chest if airway ventilation is compromised, or interferes with CPR

OPEN NECK WOUNDS

- Cover with occlusive dressing

HEAD TRAUMA

- Always consider spinal injury and see **Spinal Motion Restriction Protocol**
- Always consider traumatic brain injury, and consider patient impairment if patient is altered, argumentative, or attempting care refusal, see **Patient Refusal Policy**
- **Avoid hypotension and hypoxia.** Single episodes of either can result in permanent damage in head injured patients

- DO NOT HYPERVENTILATE PATIENTS

Pediatric LALS Standing Orders

- Establish IV (2 large bore if massive blood loss or suspected internal injury)
- 10-20 mL/kg NS IV bolus; titrated to age-appropriate systolic BP MR x1

HEAD TRAUMA

- Avoid hypotension, hypoxia and hypercarbia
- If GCS ≤ 14, maintain normal blood pressure for age
- 10-20 mL/kg NS IV bolus; titrated to age-appropriate systolic BP MR x1

CRUSH INJURY (with extended compression >2 hours of extremity or torso)

- Fluid bolus **20 ml/kg IV** bolus just prior to extremity or torso release

Pediatric ALS Standing Orders

- Monitor EKG
- Establish IV/IO
- Capnography
- 12 Lead ECG
- **Pain Medication Protocol** PRN

Nausea and vomiting

- Ondansetron 0.1 mg/kg, max 4 mg - IV/IO/IM/ODT PRN MR x1

Hypotension

- 10-20 mL/kg NS IV bolus; titrated to age-appropriate systolic BP MR x1
- TXA for hypotensive patients > 15 years old

HEAD TRAUMA

- Avoid hypotension, hypoxia and hypercarbia
- If GCS ≤ 14, maintain normal blood pressure for age
- 10-20 mL/kg NS IV bolus; titrated to age-appropriate systolic BP MR x1

CRUSH INJURY (with extended compression >2 hours of extremity or torso)

- Calcium Chloride per dosing chart IV/IO over 30 seconds **BH**
- Sodium Bicarbonate 1 mEq/kg IV/IO per dosing chart **BH**
- 10-20 mL/kg NS IV bolus; titrated to age-appropriate systolic BP MR x1

CHEST TRAUMA

- **Needle Thoracostomy Procedure BHO for pediatric patients. SO for patients > 15 years old or larger than pediatric measurement tape**

Pediatric Base Hospital Orders

CRUSH INJURY (with extended compression >2 hours of extremity or torso)

- BH - Calcium Chloride – weight-based dosing IV/IO over 30 seconds
- BH – Sodium Bicarbonate – 1 mEq/kg IV/IO weight-based dosing

PERSISTENT HYPOTENSION

- BH - Consider TXA if indicated per **Hemorrhage Control Policy based on appropriate patient size and weight**
  - TXA 1 gram in 100 ml NS IV/IO infused over 10 minutes.
- BH – Consider Dopamine Drip

Notes:

- Cover open chest wound with three-sided occlusive dressing following needle thoracostomy. Release or "burp" dressing if suspected tension pneumothorax redevelops
- It is critical to transport ill trauma patients to definitive care as soon as possible.
- Consider early activation of air ambulance if patient fulfills criteria for **Air Ambulance Activation Policy**
- **Prioritize scene and provider safety. Ensure patient does not have any weapons, contact PD if assistance required.**

APPROVED:

Signature on File
Katherine Staats, M.D. FACEP
EMS Medical Director