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**
- Consider on scene helicopter rendezvous protocol
- Continuous heartrate, pulse oximetry, blood pressure, and capnography (if ALS present) PRN

TRAUMATIC ARREST – See Traumatic Arrest Protocol

CHEST TRAUMA

- See **Needle Thoracostomy Procedure** if tension pneumothorax suspected
- Cover open chest wound with three-sided occlusive dressing
  Release dressing if suspected tension pneumothorax develops

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, per **BH** with gentle, unidirectional traction before splinting
- If circulation in not restored after two 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)
- **NS 0.9% 10-20 ml/kg IV** bolus for low BP. May repeat per **BH**

HEAD TRAUMA

- **NS 0.9% 10-20 ml/kg IV** – if GCS ≤ 14, maintain normal blood pressure for age
- Avoid hypotension, hypoxia and hypercarbia

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

- Administer **NS 0.9% 10-20 ml/kg IV** bolus just prior to extremity or torso release

Pediatric ALS Standing Orders

- NS 0.9% 20 mL/kg IO bolus via Volutrol rapid IV drip for hypotension, repeat per **BH**
- **Pain Medication Protocol** PRN
- **Ondansetron 0.1 mg/kg (max 4 mg)** ODT/IV/IM/IO for nausea and vomiting
- Establish IO PRN
- Airway control per **Airway Policy**
- Continuous heartrate, pulse oximetry, blood pressure, and capnography
- Consider TXA for hypotensive patients > 15 years old

HEAD TRAUMA

- **NS 0.9% 10-20 ml/kg IO** – if GCS ≤ 14, maintain normal blood pressure for age
- Avoid hypotension, hypoxia and hypercarbia

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

Notes:

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 #4240.**

APPROVED:

Signature on File
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