

ROUTINE MEDICAL CARE - PEDIATRIC (# 7300)

The defined age of a pediatric patient is **14 years old or less**, and unless specified otherwise, pediatric protocols should be used to treat these patients. Note: An infant is considered to be < 1 year old. A child is considered to be ≥ 1 year old. Specified ages for transport or treatment other than 14 include:

TRANSPORT	TREATMENT
<p>5150 Psych Evaluation (#8105): ✓ Children (≤ 11) – Children’s Hospital ✓ Adolescents (≥ 12 & ≤ 17) – Willow Rock</p> <p>Trauma Destination (#7100): ✓ ≤ 14 – Children’s Hospital ✓ ≥ 15 – Closest Adult Trauma Center</p> <p>Sexual Assault (#7006): ✓ Children (≤ 14) – Children’s Hospital ✓ All Others (≥ 15) – Highland</p>	<p>Advanced Airway Management (#10102): ✓ ≤ 12 - preferred airway is OPA/NPA and BVM</p> <p>CPAP (#10100): ✓ < 8 – Absolute Contraindication</p> <p>IO (#10135 and #10133): ✓ ≥ 8 and ≥ 40 kg – Use EZ-IO ✓ < 8 or < 40 kg – Use manual IO needle</p> <p>Refusal of Care (#8040): ✓ ≤ 17 may not refuse transport or treatment unless legally emancipated</p>

A pediatric **length-based resuscitation tape (LBRT)** will be used to determine drug doses, fluid volumes, defibrillation settings and equipment sizes. The tape is designed to estimate a child’s weight based on length (head to heel). The tape also includes information about abnormal vital signs.

PRIMARY SURVEY	SPECIAL CONSIDERATIONS												
Establish level of responsiveness.	<ul style="list-style-type: none"> • AVPU: Alert, Verbal, Painful, Unresponsive 												
Evaluate airway and protective airway reflexes.	<ul style="list-style-type: none"> • Identify signs of airway obstruction and respiratory distress, including: <table style="width: 100%; border: none;"> <tr> <td>✓ cyanosis</td> <td>✓ intercostal retractions</td> <td>✓ choking</td> </tr> <tr> <td>✓ stridor</td> <td>✓ absent breath sounds</td> <td>✓ grunting</td> </tr> <tr> <td>✓ drooling</td> <td>✓ apnea or bradypnea</td> <td>✓ nasal flaring</td> </tr> <tr> <td>✓ tachypnea</td> <td></td> <td></td> </tr> </table> 	✓ cyanosis	✓ intercostal retractions	✓ choking	✓ stridor	✓ absent breath sounds	✓ grunting	✓ drooling	✓ apnea or bradypnea	✓ nasal flaring	✓ tachypnea		
✓ cyanosis	✓ intercostal retractions	✓ choking											
✓ stridor	✓ absent breath sounds	✓ grunting											
✓ drooling	✓ apnea or bradypnea	✓ nasal flaring											
✓ tachypnea													
Secure airway. Consider spinal immobilization.	<ul style="list-style-type: none"> • Open airway using jaw-thrust and chin-lift (and/or head tilt if no suspected spinal trauma). Suction as needed. Consider placement of an oral or nasal airway adjunct if the child is unconscious. • If cervical spine trauma is suspected, see policy # 10117. 												
Assess need for ventilatory assistance	<ul style="list-style-type: none"> • Use chest rise as an indicator of ventilation. • Use pulse oximetry. 												
Evaluate and support circulation. Stop Hemorrhage	<ul style="list-style-type: none"> • CPR as needed (see CPR policy #7007) • Assess perfusion using the following indicators: <table style="width: 100%; border: none;"> <tr> <td>✓ heart rate</td> <td>✓ mental status</td> <td>✓ skin signs</td> </tr> <tr> <td>✓ quality of pulse</td> <td>✓ capillary refill</td> <td>✓ blood pressure</td> </tr> </table> 	✓ heart rate	✓ mental status	✓ skin signs	✓ quality of pulse	✓ capillary refill	✓ blood pressure						
✓ heart rate	✓ mental status	✓ skin signs											
✓ quality of pulse	✓ capillary refill	✓ blood pressure											
Continue with secondary survey	<ul style="list-style-type: none"> • Perform a head-to-toe assessment, including temperature. • Obtain a patient history. • Do environmental assessment, consider possibility of intentional injury 												
Determine appropriate treatment protocols	<ul style="list-style-type: none"> • Provide family psychosocial support • For drugs not on the LBRT see policy # 7301 “Pediatric Drug Chart.” • When starting an IV/IO/saline lock, use chlorhexidine as a skin prep. Label insertion site with “PREHOSPITAL IV – DATE and TIME” • Pediatric patients are subject to rapid changes in body temperature. Steps should be taken to prevent loss of or increase in body temperature. • Compared to the adult patient, a small amount of fluid, lost from or administered to, a pediatric patient can result in shock or pulmonary edema. • Scene time for treatment of pediatric patients should be kept at a minimum. Most treatment should be done enroute. 												