



**DeKalb County  
Department of Purchasing and Contracting**

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**March 4, 2019**

**REQUEST FOR PROPOSALS (RFP) NO. 19-500511**

**FOR**

**EMERGENCY AMBULANCE SERVICE PROVIDER FOR  
DEKALB COUNTY, GEORGIA**

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<b>Mandatory DeKalb First LSBE Meeting:</b> (Proposers must attend 1 meeting on either of the dates listed.)	<b>March 13, 2019, March 20, 2019 or March 27, 2019</b> 4572 Memorial Drive, Decatur, Georgia 30032 Main Conference Room - A (Meetings are held at 10:00 a.m. and 2:00 p.m.) Video Conference: Utilize the link supplied on our webpage labeled "DeKalb First LSBE Video Meeting" <u>Conference Call Dial-In: (770) 414-2144 (PIN: 199812)</u>
<b>Pre-Proposal Conference:</b>	<b>March 21, 2019 @ 10:00 A.M.</b> Location: The Maloof Building, 1300 Commerce Drive, 2 <sup>nd</sup> Floor, Decatur, GA 30030
Deadline for Submission of Questions:	5:00 P.M. ET, March 26, 2019
Deadline for Receipt of Proposals:	<u>3:00 P.M. ET, April 12, 2019</u>

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THE RESPONSIBILITY FOR SUBMITTING A RESPONSE TO THIS RFP TO THE DEPARTMENT OF PURCHASING AND CONTRACTING OF DEKALB COUNTY GOVERNMENT ON OR BEFORE THE STATED DATE AND TIME WILL BE SOLELY AND STRICTLY THE RESPONSIBILITY OF THE PROPOSER.

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**Department of Purchasing and Contracting**  
Maloof Administration Building, 1300 Commerce Drive, 2<sup>nd</sup> Floor, Decatur, Georgia 30030

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**FOR**

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DEKALB COUNTY GEORGIA**

**DEKALB COUNTY, GEORGIA**

DeKalb County Government (the County) requests qualified individuals and firms with proven professional experience and expertise in emergency ambulance services with billing and collections for ambulance transport accounts to submit proposals for Emergency Ambulance Service Provider for DeKalb County, Georgia.

**I. INTRODUCTION**

**A. GENERAL INFORMATION.**

The County is soliciting proposals from qualified ambulance services/firms to provide 911 ambulance services to DeKalb County. It is the intent of these specifications, terms and conditions to describe the requirements for qualified firms to work with DeKalb County Fire Rescue to provide 911 Ambulance Services. The 911 Ambulance Services include Emergency Ambulance Service, 911 Response, and ALS and BLS transport. This contract does not include non-emergency inter-facility or critical care transport. The County also desires to enhance the functional integration between other Fire Departments, Law Enforcement, hospitals and healthcare organizations, as well as cities and communities within the County and the ambulance provider(s).

The County does not currently schedule or dispatch scheduled calls from its 911 Dispatch Center. Scheduled non-emergency transports (NET) calls are not covered under this RFP. Units dedicated to the service area shall not be used outside of the 911 system. This in no way excludes the Proposer from providing or engaging in NET service.

### **Dual Response System and Rapid Response Vehicles**

The County uses an integrated, dual response system and will allow the creation of subzones with supplemental services for those municipalities or other portions of the County that desire additional service. DeKalb County Fire Rescue (DCFR) is a critical and integral component of the medical call response system in the County. DCFR utilizes medically trained fire rescue personnel who, in coordination with our contracted transport providers, are dispatched to all emergency medical calls, as well as select non-emergency medical calls. DCFR's system of medical response is designed to ensure that trained personnel and equipment are on scene of a call for assistance as soon as possible, so that medical care may be initiated promptly. In 2018, DCFR's 90<sup>th</sup> percentile response time for Priority 1 – 3 calls was 10:59, and the expanding use of Rapid Response Vehicles will maintain and potentially improve the responses.

DCFR's two ALS transport units are dispatched to medical calls within specified territories as determined by the County and are available to augment the Successful Proposer(s)'s (hereafter referred to as Contractor(s)) transport system when surges in the number of requests for medical assistance and/or transport inundate the system. These units are additionally tasked with responding to all working structure fires or large multi-unit responses in the County as a support component for DCFR personnel, thereby minimizing requests of the contracted transport provider to stand-by on these types of scenes. All DCFR's sworn personnel are trained and certified EMT professionals, including Basic, Intermediate, Advanced, and Paramedic levels. In instances where DCFR renders initial patient care, any subsequent medical care of patients requiring transport to the hospital is then transferred to the contracted transport service.

DCFR is a proponent of new ideas and concepts to further improve the EMS system within DeKalb County. To that extent, DCFR has begun an initiative to add ten Rapid Response Vehicles to our response capabilities, with the goal of increasing our ability to respond quickly to all emergency and select non-emergency calls for help.

### **Supplemental Service and Subparts of the County**

However, where requested, municipalities or other subdivisions of the County shall be permitted to purchase supplemental service, in the form of unit hours, to facilitate the pursuit of goals such as shorter response times, staging ambulances for use in a limited area, and/or other requirements that may be met through the purchase of supplemental services. Where supplemental services are purchased, the area receiving the supplement will be deemed a new subpart for statistical analysis and record keeping purposes. Under no circumstances shall the requirements of this RFP be reduced and the Contractor shall prepare to meet them across the County. The goal is to provide prompt medical care to those in need, with rapid transport to the appropriate medical facility when appropriate.

## **B. COUNTY BACKGROUND.**



The County is Georgia's third largest county with 753,253 residents calling it home. The population of the County increased by 9.8% between the last two census surveys and estimates from the Atlanta Regional Commission suggest that rate will climb to nearly 14% over the next 25 years. The population of the County comprises 17.7% of the "core" 10-county Atlanta region. According to the 2010 census there were 271,809 households, and 161,453 families residing in the County. The population density was 2,585.7 inhabitants per square mile and there were 304,968 housing units at an average housing density of 1,139.7 per square mile. The County has seen a housing growth rate of 16% since 2000 largely due to its maturation as an urban county with little available land. The County has the second highest percentage of multi-family units, 38.7%, in the 20-county Atlanta metro area. At 4.26 persons per acres, the County is the most densely populated county in the 20-county Atlanta metro area.

The County has emerged as one of Georgia's most culturally diverse communities. More than 64 languages representing Asian, Hispanic, European and African cultures are spoken. The County has also become a resettlement location for African, Iraqi and Latino asylum seekers displaced by war or turbulent political circumstances. In a recent five year period the County welcomed over 90% of the refugees resettled in the state of Georgia. The County is a combination community with urban and suburban characteristics represented throughout its 271 square miles. The racial makeup of the county was 55.1% black or African American, 29.1% white, 8.6% Hispanic or Latino, and 6.5% Asian. The per capita income for the County is \$28,412. About 12.4% of families and 16.1% of the population are below the poverty line, including 24.2% of those under age 18 and 11.2% of those ages 65 or over.

The County is the headquarters of some of the county's most prominent businesses and organizations including the Center for Disease Control (CDC), the only federal agency based outside of Washington, DC; the Yerkes Primate Center; American Cancer Society and Emory University's Rollins Research Center. Emory University, Agnes Scott College and Oglethorpe University, along with scores of public and private elementary and secondary schools and several other colleges are located in the County.

The County has 26 fire stations located throughout its geographic boundaries to provide efficient services to its residents and visitors, and to rapidly transport to hospitals. Exhibit 7, *Fire Station Locations*, and Exhibit 8, *Metro-Atlanta Hospital Locations*, are provided for reference purposes.

### **C. EMS STATISTICS.**

#### ***Health Insurance Coverage***

Health insurance coverage for the people in the State of Georgia, according to the Henry Kaiser Family Foundation, is provided by a mixture of employer-based coverage, including Federal and State employee policies, Medicare, Medicaid and other public plans. The highest numbers of people, at 49% of the population, are covered by an employer's plans. The next highest level of coverage comes from Medicaid, covering 17% of the population. Medicare covers the next 12%. The remainder of the insured population is covered by non-group insurance (7%) and other public insurance (4%). Approximately 12% of the population is uninsured.

The 2017 reported payer mix for transports are as follows:

Commercial Insurance	-	9%	-	6,832
Medicare	-	29%	-	21,229
Medicaid	-	22%	-	15,976
Private Pay	-	36%	-	26,310
Misc. Contracts	-	4 %	-	3,716
Totals	-	100%	-	74,063

The current daily deployment projections; for Daily Unit Hours are 717 hours.

***Current Workload Unit Hours***

Workload unit hours are calculated by tracking **ALL** ambulance times from dispatch until the unit is available for another incident. These times include units that were: dispatched and cancelled enroute, dispatched & arrived at the scene without transport, dispatch resulting in transport and other incidents where units were assigned.

Information was pulled from DeKalb County Police Dispatch CAD for periods November 1, 2017 through October 31, 2018. Total number of workload hours spent by all ambulances in the system as reported:

**130,842 Hours, 9 Minutes and 31 Seconds**

***Call Volume History***

Ambulance service call volume in the County is above average in per capita ambulance response call volume, which has increased steadily over the past four years as identified in Table below.

<b>Year</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
EMS Dispatches	95,680	97,646	98,572	100,051

**D. REQUIRED DOCUMENTS CHECKLIST.**

The following Required Documents Checklist includes a list of attachments, which **must** be completed and returned with Proposer's technical proposal:

<b>Required Documents</b>	<b>Attachment</b>
Cost Proposal Form (1 copy, separate & sealed)	A
Proposal Cover Sheet	B
Contractor Reference and Release Form	C
Subcontractor Reference and Release Form (make additional copies as needed)	D
LSBE Documents – Exhibits A and B	E
Proposer Affidavit	G
First Source Jobs Ordinance (with Exhibits 1 – 4)	H
Business License	
Exceptions to the Standard County Contract, if any	

- E. The County intends to award a five (5) year contract (multiyear contract) to the Contractor(s) selected as the most responsive (conforms to this RFP) and most responsible (meets the requirements of the RFP).
- F. The County reserves the right to make one (1) award or multiple awards.
- G. The County reserves the right to divide the response zone into smaller service areas to enhance service efficiency.

## **II. SCOPE OF WORK**

The County may issue exclusive operating rights to one or more private ambulance provider(s), along with the privilege to bill individuals for services rendered within the County.

- A. The County is taking a comprehensive systems approach to the overall EMS system of which ambulance services comprise one important part. This approach also calls for the County to maintain EMS coordination, oversight, and accountability, while allowing the Contractor(s)'s expertise and entrepreneurial talent to collaborate with the County to manage its day-to-day operations. This model is intended to promote high-quality clinical care, efficiency, economy, reliability, and operational and financial stability.
- B. As part of an innovative approach to responding to the EMS needs of the County, the County through DCFR will be the principle manager of the service including; handling of all dispatch calls, and overall management of the system. The County intends to contract with one or more ambulance service provider(s) to provide all 911 Ambulance Services described in this RFP and to provide the following dedicated personnel.
  1. EMS Chief/manager who will have oversight for the entire program.
  2. Quality Improvement & Education Coordinator to be responsible for the medical quality assurance evaluation of all services provided pursuant to RFP.
  3. Field Supervisors who will monitor the day-to-day field operations of the Contractor(s).

The Contractor(s) shall provide the following dedicated personnel (*titles are for demonstrative purposes only*)

1. Field Supervisors who will manage the day to day field operations.
2. Operations Director to oversee and be responsible for the overall functioning of emergency ambulance service.
3. Finance Manager to oversee the financial performance of the ambulance operations.
4. Health, Safety, Risk Management Specialist to be responsible for the development and maintenance of a comprehensive health, safety, and risk management programs.
5. Medical Director to oversee the Contractor(s)'s clinical performance and be responsible for the facilitating the procurement and oversight of pharmaceuticals used in delivering service including controlled substances.
6. Quality Improvement & Education Coordinator to be responsible for the medical quality assurance evaluation of all services provided pursuant to RFP.

The County may issue exclusive operating rights to one or more private ambulance provider(s), along with the privilege to bill individuals for services rendered within the County. Traditionally, the County does not pay the provider for ambulance services directly.

- C. The County desires to have the maximum level of flexibility with regard to deployment and contracting for services.
- D. The Contractor(s) agrees to provide DeKalb County and its municipal partners the ability to enhance their level of service. The enhancement may take the form of dedicated units for an area to be agreed upon by the entity or entities funding the enhancement.
- E. All costs submitted in response to this RFP will be for one year. Subsequent years after the first year will be re-evaluated periodically. Fees for service shall increase at a rate of 4% on January 1<sup>st</sup> of the full consecutive year after the signing of the contract for services, unless the inflation rate for medical care as defined by the U.S. Bureau of Labor Statistics increases by a rate greater than 4% from the previous year. If the increase of inflation is greater than 4%, the rate increase will be commensurate up to an annual cap of 10%.
- F. Proposers may submit a Fee Based System proposal to bill and collect based on a traditional fees for services model.

Submit a proposal that is similar to the traditional contracting relationship. Use the information found within the RFP as well as the Proposer's own experience and expertise to determine the appropriate number of unit hours needed to meet system demands. The Proposer will be expected to provide a complete "turnkey" operation capable of meeting the RFP's intent. The Proposer should include innovations and promote the Triple Aim of HealthCare: "Improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care, as well as 'out of the box' thinking that will lower the cost to the County and the patient."

This is known as a “fee based” system without subsidy. The Contractor(s) must be capable of providing the services they proposed in the RFP at the rates they provided in their Cost Proposal. The Contractor(s) will provide a complete breakdown of all charges and the amounts for each charge to arrive at an average charge per transport. The Contractor(s) will assume 100% of the liability for response times, unit hours, billing and collection and risk of non-payment.

Dispatches	DeKalb County
Bills and Collects	Contractor(s)
Assumes Risk of Non-Payment	Contractor(s)
Determines Number of Units in System	Contractor(s)
Determines Cost for System	Contractor(s)

## **G. MINIMUM QUALIFICATIONS.**

Proposer must meet the following minimum qualifications to be considered for award. Proposer shall provide a narrative with the technical proposal that addresses each requirement below.

### **1. Minimum Experience**

Proposer must have been operating an ambulance transportation service continuously providing ALS emergency services for a minimum of three (3) years in the last five (5) years. For the purposes of this RFP gurney/wheelchair services will not be considered “ambulance transport”.

Proposer must have been providing ambulance transportation services to a population of at least 100,000 for a period of three (3) years in the last five (5) years. Proposers who provides services to less than a population of 100,000 in a single location but provide services in multiple locations with a combined population of 100,000 or more will be eligible for this RFP. If a joint venture between one or more organizations is submitting the Proposal, population density may be combined to meet the minimum requirement.

### **2. Organizational Disclosures:**

Proposer must be a single legally established entity, but there are no preclusions of multiple organizations forming an entity to respond to this RFP. If such a “joint venture” is proposing on this RFP, questions regarding experience, organizational structure, financial

strength, and other items in this RFP must be answered for each member of the “joint venture.” The Proposer must provide the following information about its organization, experience, litigation, licenses, investigations, and other items:

- a. **Organizational Ownership and Legal Structure**  
Proposer shall describe its legal structure including type of organization, its date of formation, and state of formation.
- b. **Continuity of Business**  
Proposer shall provide the organization’s background and number of years under present business name, as well as prior business names.
- c. **Licenses and Permits**  
Proposer shall provide copies of business or professional licenses, permits or certificates required by the nature of the contract work to be performed. If Proposer does not have a local operation, examples of state licenses, and local permits for other operational locations may be submitted to fulfill this requirement.
- d. **Government Investigations**  
Proposer shall provide a listing of all federal, state, or local government regulatory investigations, findings, actions or complaints and their respective resolutions for the Proposer’s organization and any parent or affiliated organization within the last three (3) years. Proposer must provide documentation that it has resolved all issues arising from government investigations including any continued obligations of Proposer or describe the status and expected outcome of any and all open investigations.
- e. **Litigation**  
Proposer shall provide a listing of all resolved or ongoing litigation involving the Proposer’s organization including resolution or status for the last five (5) years. This listing shall include litigation brought against the Proposer’s organization or affiliated organization and any litigation initiated by the Proposer’s organization or affiliated organization against any governmental entity or competing ambulance service. The Proposer must provide documentation that it has resolved all issues arising from litigation or describe status of open litigation.
- f. **Experience as Sole Provider**  
Proposer must list its demonstrated experience as a sole provider of emergency ambulance services for a specified area. This element is intended to show that the Proposer has experience providing emergency services without relying on other providers to meet demand. If the proposal is a joint venture at least one of the entities must have demonstrated experience.
- g. **Identify Capability in Lieu of Experience**  
If the Proposer does not have direct comparable experience in being the sole provider of emergency ambulance services and elect(s) to provide evidence of capability in lieu of experience the Proposer must document in detail how it intends to fulfill its obligations specified in this RFP. This may be done by providing a comprehensive

deployment plan identifying the ambulance locations, unit-hour distribution, and procedures for redeploying resources based on demand. Alternatively, the Proposer may delineate personnel who have such experience and that these individuals will be actively and directly involved in the delivery of services in the operating area.

h. Comparable Experience

If Proposer(s) elect(s) to provide evidence of comparable experience instead of capability in lieu of experience (as detailed in the section above), the Proposer must document the areas in which it has provided comparable services in the past five (5) years, the locations of these services, population, description of services and a jurisdictional contact. This documentation shall include a letter from a government official confirming the ability or past experience providing exclusive emergency ambulance service and the length of time such services have been provided. The Proposer shall document that it has provided comparable services. Letters and documentation of sole provider status are limited to three jurisdictions.

i. Government Contracts

The Proposer shall provide a list of service area emergency ambulance service contracts completed or ongoing during the last five (5) years including the term or date of termination of the agreement, the services provided.

j. Contract Compliance

The Proposer shall detail any occurrence of its failure or refusal to complete a contract with a governmental entity for which Proposer was providing emergency ambulance services. This shall specifically state whether the Proposer or affiliated organization was found in material breach of the contract and the reasons why the contract was terminated, or state the term expired. If the Proposer has been found in material breach of a governmental contract or if the Proposer “walked away” from its obligations under a governmental contract within the last five (5) years, the Proposal may be rejected as not complying with Minimum Qualifications.

k. Demonstrated Response Time Performance

The Proposer must provide documentation of its demonstrated ability, in the past five (5) years, to meet response time requirements at the 90<sup>th</sup> percentile mark, similar to those required in this RFP. Documentation may include reports provided to government oversight entities and letters confirming compliance with mandated response times. Internal reports with adequate supporting documentation of the methodology used to create the reports may also be submitted.

If the Proposing organization does not have mandated response times in its emergency ambulance service area, the Proposer must submit adequate documentation of plans, procedures, and deployment strategies to demonstrate the organization has the knowledge and expertise to comply with mandated response times.

1. Demonstrated High Level Clinical Care

The Proposer must provide documentation of its demonstrated ability to provide high-level clinical care. Documentation may include descriptions of clinical sophistication and high levels of performance in systems in which it operates. The organization should describe how it ensures consistent, high quality clinical care and how it is able to verify and document its clinical competency and performance improvement activities. This should include clinical protocol compliance, skills verification, training methodology and minimum commitments per provider including systematic assessment of EMS core performance metrics and clinical guidelines.

## H. RESPONSE

Contractor(s) shall have response ready 120% of the peak hour ambulances required per the EMS RFP.

1. Contractor shall respond to all patients according to the DeKalb County Unit Dispatch Criteria. Unit Dispatch Criteria is attached as Exhibit 1 to the RFP. Contractor(s) shall respond to:
  - a) Priority One (1), Priority Two (2), and Priority Three (3) emergency calls with an expected response time of 11:59 seconds or less, to the 90<sup>th</sup> percentile mark.
  - b) Priority Four (4) emergency calls with an expected response time of 14:59 seconds or less, to the 90<sup>th</sup> percentile mark. .
  - c) Priority Five (5) non-emergency calls, which shall not include inter-facility or critical care transport, with an expected response time of 29:59 seconds or less, to the time 90<sup>th</sup> percentile mark. .

Calls exceeding the aforementioned response time standards will be subject to penalties.

2. Contractor(s) shall have response ready 120% of the peak hour ambulances required per the EMS RFP.
3. Contractor(s) shall respond to all calls, without delay, with the closest available appropriate unit when dispatched by the DeKalb County Communications 911 Center. ***All response times, measured in seconds and not whole minutes, shall be calculated starting at the moment the Contractor's unit receives the dispatch via notification by the CAD until the time the Contractor arrives on scene with a fully functional and fully staffed Advanced Life Support (ALS) or Basic Life Support (BLS) ambulance as first noted in the CAD by automatic entry (Geolocation). In the absence of Geolocation, either by manual entry by E911 personnel, or manual entry by ambulance personnel.***
4. Contractor(s)'s ambulances and personnel will be dispatched and monitored by the County's dispatch center. Contractor(s) shall also be responsible for monitoring ambulances and personnel; however, the County will provide dispatch services.



5. Contractor shall have a base of operations within the borders of the County.
  - a) This location may be the shift change and supply section for the Contractor's operation.
  - b) Contractor(s) may opt to have more than one facility for shift changes and supplies.
  - c) Contractor(s) will provide addresses of locations to DCFR and update if any changes are made during the term of the contract.
6. Contractor shall provide additional response ambulances, Advance Life Support (ALS) or Basic Life Support (BLS), if requested by the County and mutually agreed upon by both parties, in order to meet occasional needs. Additional services shall be provided at the hourly rate provided by the Contractor(s).
7. Contractor shall transport patients to the appropriate destination as determined by DeKalb County's Medical Director (See transport criteria in DeKalb County Fire Rescue Patient Care Protocols as Exhibit 2).
8. Contractor shall ensure a seamless transition of care without interruption to patient care for the duration of the incident through transport to the care of a hospital or release.
9. Contractor shall assess and revise (if necessary) its disaster and emergency operations plan on a schedule to be mutually agreed to by both parties.
10. The first agency on the scene shall have primary responsibility for patient care until such time as care is turned over to the most medically qualified person on scene. The highest ranking fire department officer on the scene shall have scene control as Incident Commander.
11. Contractor shall have a signed agreement with a secondary ambulance service to serve as a back-up transport service within ninety (90) days of execution of the contract. This agreement shall have sufficient language to ensure that back-up ambulances, if needed, are provided prior to reaching zero (0) ambulances available.

## **I. STAFFING**

All Contractor's personnel shall be certified by the State of Georgia Department of Public Health, Office of EMS and Trauma.

1. ALS Ambulances shall be staffed with the following:
  - a) One (1) state-certified Emergency Medical Technician-Paramedic (EMT-P) and
  - b) One (1) State Certified minimum level Emergency Medical Technician-Basic (EMT-B) or higher.

2. BLS Ambulances shall be staffed with the following:
  - a) One (1) state-certified Emergency Medical Technician-Intermediate (EMT-I) or higher and
  - b) One (1) State Certified minimum level Emergency Medical Technician-Basic (EMT-B) or higher.
3. Contractor(s) shall have an agent/representative available twenty-four (24) hours a day, seven (7) days a week to respond to any and all inquiries, problems and issues. Contractor(s) shall provide a list of individuals who will be responsible for responding to any and all inquiries and complaints and resolve any and all problems and issues that may arise. This list must identify the individuals who will be available on a twenty-four (24) hour, seven (7) day a week basis, including holidays and traditional non-business hours. The list of individuals must be current and on file in the DCFR Chief's office during the term of the contract and updated monthly or as needed.
4. The Contractor(s) agrees to deploy, staff, fuel, and maintain Advanced Life Support (ALS) Ambulances and Basic Life Support (BLS) Ambulances daily exclusively for the provision of Emergency Ambulance Service to the County.
5. Within ten (10) days after the Notice of Award, the Contractor and a representative from DCFR will coordinate and develop a System Status Plan that includes, but is not limited to, the post locations to be used, and the priority of post locations, move-up triggers and criteria. These post locations can be County fire stations.
6. Contractor shall ensure that there are no less than three (3) supervisors in the field at all times.

## **J. PERSONNEL**

1. The conduct of Personnel must be professional and courteous at all times.
2. Contractor(s) shall ensure that all staff wear appropriate uniforms and are neat in appearance at all times. Contractor(s) shall provide their grooming policy to the County for approval.
3. Contractor(s) shall ensure that their personnel have a safe work environment with all necessary safety equipment.
4. Contractor(s) shall make each employee aware of his/her responsibility to consent to the release of information between the County and the Contractor(s).

5. Contractor(s) shall allow County personnel to ride along with Contractor(s)'s staff for the purpose of training and/or remediation of DCFR personnel, to include all levels of licensure at no charge to the County.
6. All response personnel shall be physically capable of performing the tasks assigned by the Contractor(s) to meet the needs of this contract.
7. Contractor(s) shall provide their written policy demonstrating that they utilize management practices that ensure that field personnel working extended shifts, part-time jobs, voluntary overtime, or mandatory overtime are not fatigued to an extent that might impair judgment or motor skills.
8. The Contractor(s) will immediately transport to a facility for testing any Personnel suspected to be using or under the influence of drugs or alcohol or other intoxicant or have an agent of a testing facility come to the location of the employee to obtain a necessary sample. The Contractor(s) will be responsible for any and all costs associated with this testing. Any Personnel suspected of being under the influence of any drug or intoxicating substance will be immediately relieved of duty by Contractor(s) until there is clinical proof to the contrary.
9. Clinical performance must be consistent with approved medical standards, protocols and guidelines set forth by the State of Georgia and the County of DeKalb.
10. The County reserves the right to prohibit a specific employee of the Contractor(s) from working on units providing response within the DeKalb County response area.

## **K. CERTIFICATIONS**

1. Contractor(s) shall ensure that all drivers of vehicles have an appropriate, current and valid state issued driver's license and have held that driver's license for a minimum period of two (2) years.
2. Contractor(s) shall ensure that all personnel have a valid EMS License issued by the State of Georgia, Department of Public Health, Office of EMS and Trauma.
3. Contractor(s) shall ensure that all paramedics have a valid Advanced Cardiac Life Support (ACLS) certification issued by the American Heart Association.
4. Contractor(s) shall ensure that all personnel have a valid Basic Life Support (BLS) certification issued by the American Heart Association.
5. The cost of training and/or certification maintenance of Contractor(s)'s employees shall be the sole responsibility of the Contractor(s).

## **L. REPORTS/REPORTING**

1. Contractor(s) shall use an electronic based patient care reporting system (ePCR) that is Georgia Emergency Medical Services Information System (GEMSIS) compliant. The Contractor(s) will allow the DCFR Representative administrative access to their County related data stored on the GEMSIS server.
2. Within ten (10) days of the Notice of Award, Contractor(s) shall develop, in conjunction with the County, a comprehensive quality improvement program that satisfies the overall intent of the RFP, to include, but not be limited to meeting required response times, providing excellent patient care, and rapid transport to the appropriate medical facility.
3. Contractor shall provide security for all data collected, stored, or transmitted during the provision of services.
4. Within ten (10) business day of the award of the contract, Contractor shall provide a list of staff along with their certification numbers. List shall be kept current and up-to-date during the term of the contract and provided to DCFR quarterly or as requested.
5. Contractor shall afford the County access to any and all training records of staff.
6. Contractors shall submit a daily staffing roster for the previous 24 hours including the employee name and certification level and a deployment plan for the next 24 hours to the DCFR Representative no later than 0900 hrs. The roster and deployment plan must be updated and resubmitted as changes are made.
7. The County must be notified immediately whenever a motor vehicle accident involving a Contractor(s) operated ambulance has occurred.
8. Contractor shall notify the County in writing within four (4) hours of any and all, accidents, injuries, complaints or mechanical difficulties, or other matters warranting notice, with regard to services provided under the Contract.
9. Any incoming complaint calls must receive a return call to the customer/patient within two (2) business days. Incidents that require follow up to the customer must be resolved by the end of five (5) business days from when the call was received, and if not possible, a call must be made to the customer with the status of the request. The Contractor(s) must notify the County of the outcome or status of said complaint within five (5) business days of when the complaint was received.
10. The County must be notified in writing within two (2) business days whenever the following occurs:

- a. The hiring of any person involved in the delivery of services. The notification shall include the full name and provide necessary certification numbers.
  - b. The separation/termination or other status change of any of the Contractor(s)'s personnel involved in the delivery of Services.
  - c. Change in the Contractor(s)'s management or supervisory structure.
- 11. Contractor(s) shall provide DCFR with the name, address, telephone number, and e-mail for the Contractor(s)'s Medical Director during the term of the contract.
- 12. Contractor(s) shall notify the County of any changes in the name, address, telephone number, fax number, and e-mail for the Contractor(s)'s Medical Director during the term of the resulting contract.
- 13. Contractor(s) shall provide a monthly summary report of Quality Improvement issues, including remedies or corrective actions and attend a monthly meeting with a DCFR Representative to review the findings.
- 14. Monthly Report – Contractor(s) shall submit monthly reports, in a spreadsheet format, to the County/DCFR Representative including, but not limited to:
  - a. All information regarding average and 90<sup>th</sup> percentile performance measures for the following time segments:
    - i. Turnout Time – from when the call is received by the unit from the 911 Dispatch center via notification by the CAD until the unit is en route.
    - ii. Travel Time – from when the unit is en route to when the unit arrives on scene
    - iii. Total Response Time – (Turnout Time + Travel Time = Total Response Time).
    - iv. Scene Time – from when the unit arrives on scene until the unit is en route to the hospital or returns to service.
    - v. Transport Time – from when the unit is en route from the scene to a destination facility until arrival at a destination facility.
    - vi. At Hospital Time – from when the unit arrives at the destination facility until the unit returns to service
  - b. Monthly reports must be submitted to DCFR no later than the 5<sup>th</sup> day of each month for the preceding month.
  - c. Reports should include information specific to incorporated and unincorporated areas of the County.
  - d. Reports need to be countywide in scope, as well as individual reports using current geographic municipal boundaries for each City inside the County to include the above-mentioned information.
- 15. Annual Report - Contractor(s) shall also submit a year-end report summarizing services provided for the contract period and any renewal contract period by January 15<sup>th</sup> of each contract term.

16. Contractor(s) shall submit a monthly financial report to the County if requested, which should minimally include gross amount billed, net collected, and payer mix.
17. Contractor(s) shall provide the raw incident response data for any report submitted.

#### **M. EQUIPMENT/VEHICLES**

1. Contractor(s) shall provide state certified equipped ambulances for all County responses.
2. Supervisory staff shall not be utilized as a primary ambulance staff on any calls.
3. At least one (1) unit shall be equipped to handle bariatric transports.
4. The BLS ambulances responding to 911 calls shall comply with all requirements of the relevant County Policies and Procedures, as identified by the County. BLS ambulances responding to 911 calls will have an AED.
5. All ambulances shall carry all equipment and soft goods mandated by the Georgia Department of Public Health. See Vehicle Inspection Form for Registered Ambulances attached hereto as Exhibit 3.
6. When an ambulance is taken out of service due to mechanical failure or damage, a replacement ambulance must be available within 60 minutes.
7. When an ambulance is to be taken out of service for preventative or routine maintenance, a replacement ambulance must be immediately put in place without interruption of services.
8. All ambulances shall include specific markings on each vehicle that are approved by the County. Said markings shall promote 911 emergency number advertising and should display a logo or phrase approved by the County that the vehicle supports DCFR. County specific markings will be removed if the unit is detached from the County market.
9. Any restriping/lettering as a result of this contract, shall be at the Contractor(s)'s expense.
10. All costs of maintenance, including parts, supplies, spare parts, and costs of extended maintenance contracts shall be the responsibility of the Contractor(s).
11. Contractor shall ensure that all ambulances shall have a current and complete map book of the County and surrounding areas, as well as a commercially available dash mounted Global Positioning System (GPS).

12. Contractor shall ensure that all ambulances shall have Radio-Frequency Identification (RFID) gate access equipment installed to access properties utilizing RFID technology within un-incorporated DeKalb County as well as municipalities. RFID equipment will need to be approved by the County.
13. Contractor shall ensure that all vehicles and equipment used to transport patients are in good mechanical operating condition, and are clean and free of foreign matter and of offensive odors.
14. Contractor shall afford the County access to inspect any and all vehicles used to transport patients as requested.
15. Contractor shall afford the County access to any maintenance records regarding vehicles used to transport patients as requested.
16. Contractor shall ensure that all vehicles used to transport patients are maintained and equipped as ambulances in accordance with all applicable laws and regulations and Exhibit 3 of the RFP, Vehicle Inspection Form for Registered Ambulances.
17. Contractor shall ensure that all vehicles are appropriately licensed and registered in accordance with all applicable laws and regulations. No later than ten (10) business days prior to the start of operations in the County, Contractor(s) shall provide the County with a list of all vehicle inspection reports prior to contract execution and will provide the County with any current vehicle inspection reports upon request after contract execution.
18. Contractor shall ensure that all Contractor(s)'s vehicles shall be able to effectively communicate via radio and/or other equipment directly with the DeKalb Communications Center and DCFR apparatus. Determination as to whether the Contractor(s)'s communication system effectively interfaces with the County's system shall be determined by the County. The County's Communications Equipment Specifications can be found in Exhibit 4.
19. Contractor(s) shall purchase their own radios to be programmed by the County personnel. Two (2) portable radios and a telephone are required per unit. A 25% cache of reserve radios and telephones is to be maintained.
20. Each staff person should have their own radio. In the event that additional ambulances are required, this requirement can be adjusted if agreed to by both parties. \*Note\* The County plans to notify Contractor(s) of pending calls and dispatch via the existing DeKalb County Radio System.
21. The Contractor(s) shall be solely responsible for the cost of Contractor(s)'s communication equipment. Contractor(s) shall:

- a) Provide Mobile Data Terminal (MDT) in each ambulance and field supervisor unit must meet specifications of the DCFR (see Exhibit 4).
- b) Provide Equipment must be Advanced Vehicle Locator (AVL) equipped and compatible with the County Computer Aided Dispatch (CAD) system.
- c) Be responsible for procuring modems for CAD interior commercially-available data modems (CAD to Mobile/Mobile to CAD connectivity) for each ambulance.
- d) Fund CAD Mobile licenses for each unit.

The County's current CAD system is provided by ***Central Square***. The County will assist the Contractor(s) with Mobile software installation and configuration.

- 22. Contractor(s) must adhere to the County's Computer System Usage Policy (see Exhibit 5, Innovation and Technology Information Security Policy).
- 23. Contractor(s) shall be responsible for ensuring appropriate security of said radio equipment and also reporting to the Communication Supervisor any loss of said equipment immediately. Contractor(s) shall immediately replace any lost radio equipment.

## **N. PENALTIES FOR SUBSTANDARD PERFORMANCE**

### **1. Penalties Description**

- a) Contractor(s) Cannot Provide the Requested Supplemental Unit Hours – The Contractor(s) may incur penalties if they are not able to provide the amount of unit hours requested by the County, or by any municipality through an enhancement of service. This penalty only applies to the purchase of unit hours for supplemental service. The Contractor(s) may be penalized for every whole hour they are not able to provide the number of requested unit hours, at a rate of one and one half times the unit hour cost. For example, if a unit is scheduled to go in service at 1000 hours and does not go in service until 1230 hours, the Contractor may incur a penalty of the following:

$$(2 \text{ whole hours}) \text{ times } (\text{unit hour cost} \times 1.5) = \text{penalty}$$

- b) Quarterly Response Time Compliance below 90th percentile (industry standard) of contracted performance measure - The Contractor(s) may incur penalties if the 90th percentile response time for any of the priorities (measured quarterly) falls below the contracted performance measure (referenced above in Section G. Response). For each and every percentage point under the 90th percentile contracted performance measure, the County may impose a penalty of \$1,000. Percentage points will be rounded to the first decimal point: 89.4% will be rounded down to 89%, and 89.5% will be rounded up to 90%.



The industry standard of 90th Percentile will be calculated and computed utilizing a two-step process within the Microsoft excel software.

Step 1: Response times will be exported from the County's CAD system. Utilizing the "Quartile" function in Microsoft Excel, outliers will be identified. Outliers are points that are distant from the remaining response times that could potentially skew or bias any analysis performed on the dataset. Interquartile Range Outlier detection method will be used to exclude outliers. Interquartile Range is the difference between the third quartile and the first quartile. Outliers are any data point higher than 1.5 the Interquartile Range above the third quartile. The function to be used is: = QUARTILE(array, 3) + 1.5\*( QUARTILE(array, 3)- QUARTILE(array, 1)) where the array is the range of cells containing the date to be computed.

Step 2: The resulting range of response times will be entered into Microsoft Excel utilizing the "percentile" function to calculate the 90th Percentile. The function to be used is: =PERCENTILE.EXC(array,.9) where the array is the range of cells containing the date to be computed.

Therefore, for example, if the contracted performance measure for Priority 1-3 is 11:59 seconds, and the Contractor(s)'s quarterly performance demonstrates that they meet the 11:59 seconds at the 86.3 percentile, then the penalty will be calculated as follows:

$$90^{\text{th}} \text{ percentile minus } 86^{\text{th}} \text{ percentile} = 4$$

$$4 \text{ times } \$1000 = \$4000 \text{ penalty for the quarter for Priority 1-3 response}$$

\*Note\* The same methodology applies to Priority 4 and 5 contracted performance measures.

- c) Response Time Exceeds 29:59 for Priority 1-4 – The Contractor(s) may incur penalties for each emergency response greater than 29 minutes and 59 seconds that does not have an acceptable reason for the delay, as determined by the County. The County may impose an immediate penalty of \$250 per response for failure to maintain compliance. As noted in Section II. Scope of Work, G. Response, 2, ***all response times, measured in seconds and not whole minutes, shall be calculated starting at the moment the Contractor's unit receives the dispatch via notification by the CAD until the time the Contractor arrives on scene with a fully functional and fully staffed Advanced Life Support (ALS) or Basic Life Support (BLS) ambulance as first noted in the CAD by automatic entry (Geolocation). In the absence of Geolocation, either by manual entry by E911 personnel, or manual entry by ambulance personnel.***

For example, the Contractor takes 31 minutes and 20 seconds to arrive on scene of a Priority 1 call. The County may impose an immediate \$250 penalty.

- d) Response Time Exceeds 49:59 for Priority 5 - The Contractor(s) may incur penalties for each emergency response greater than 49 minutes and 59 seconds that does not have

an acceptable reason for the delay. The County may impose an immediate penalty of \$250 per response for failure to maintain compliance.

For example, the Contractor may take 50 minutes and 0 seconds to arrive on scene of a Priority 5 call. The County may impose an immediate \$250 penalty.

- e) Failure to Provide Requested Information within the Time Agreed Upon - The Contractor(s) may incur penalties if the County requests information that is not provided within a timeframe agreed upon by both parties including but not limited to: reports, complaint resolution, personnel issues, deployment model, staffing roster, maintenance records, licensing, and/or any other deliverable noted in this RFP.

For example, if the County requests the maintenance records of a vehicle involved in an accident, and the Contractor does not provide the information within the agreed upon timeframe, a penalty of \$1,000 may be accrued per occurrence.

## 2. Exceptions from Response Time Requirements

At the County's sole discretion, response time requirements, as outlined in this agreement, may be suspended or altered for an appropriate period of time by the Director of Public Safety, or the Director's designee, due to a variety of exceptions, which include, but are not limited to:

- a) Disaster situations
- b) Extreme weather conditions
- c) Out-of-service area requests
- d) Incorrect information received from the DeKalb E911 Center
- e) Cancelled calls
- f) Second unit response to scene
- g) Normal access denied situations (bridge out, train crossing, road closing, if not identified by the Georgia Department of Transportation

Table of Penalties

Contractor(s) cannot provide the requested unit hours for supplemental services	# of Hours x (Unit hourly rate x (1.5)) = penalty per hour
Quarterly Response Time Compliance below 90th percentile of contracted performance measure	\$1000 per each whole percentage point below 90 <sup>th</sup> percentile
Response Time Exceeds 29:59 for Priority 1-4	\$250 per occurrence
Response Time Exceeds 49:59 for Priority 5	\$250 per occurrence
Failure to Provide Requested Information	\$1000 per occurrence

## **O. OTHER**

1. Contractor(s) shall follow all Federal, State and Local regulations, requirements and guidelines and agrees to allow the County to independently verify the Contractor(s)'s compliance with said regulations, requirements and guidelines.
2. No later than ten (10) business days prior to the start of operations in the County, Contractor(s) shall provide a copy of their policies and procedures to DCFR for approval.
3. Contractor(s) shall obtain the appropriate and necessary authorization from the Georgia Department of Medical Assistance, the Health Care Financing Administration (HCFA) in order to obtain Medicare/Medicaid reimbursement for Medicare/Medicaid patients transported under the contract. Within ten (10) days after Notice of Award, said authorization shall be provided.
4. Contractor(s) shall ensure a seamless transition of services with previous ambulance contractor on behalf of the County. However, transition of services does not relieve the Contractor(s) of any obligations and Contractor(s) is solely responsible for delivering the service in compliance with this RFP from the first day of operations under this agreement. Contractor shall submit a transition plan within ten (10) days of Notice of Award, and County shall approve the transition plan within five (5) business days of receipt.
5. Contractor shall conduct annual training with DCFR on Mass Casualty Incidents (MCI's).
6. Contractor shall provide all services under the resulting agreement in accordance with Contractor(s)'s HIPPA Privacy Plan and Compliance Plan. Ensure a Proposer's Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Plan and Compliance Plan. Ensure a HIPPA compliance plan is in place and enforce and that all staff has received HIPPA training.
7. At the scene, Contractor(s) shall resupply DCFR first responders with all disposable medical supplies and medications on a one-for-one basis. Such resupply shall comply with County policy and any applicable state and federal laws. In the event proposer cannot resupply DCFR at the scene, the County may send an invoice to the Proposer with the expectation that the County will be reimbursed for all supplies that have not been resupplied. Contractor(s) shall pay invoice within thirty (30) days of receipt.

8. Contractor(s) shall operate under Exhibit 6, the County's Incident Command Guidelines. Contractor(s) will ensure that all personnel are trained under the National Incident Command System and have completed ICS 100 & ICS 200.
9. Contractor(s) shall comply with all County policies and procedures when engaged in the response, treatment, and transport of patients. Contractor(s) shall follow all of the DCFR Patient Care Protocols in Exhibit 2.
10. In each monthly period (beginning on the first day of each month), and commencing on the first day of operations, not less than one hundred percent (100%) of the Contractor(s)'s response to emergency requests shall be performed as set forth in the RFP. Contractor(s) assumes full responsibility for the failure, and any damages associated with the failure, to meet response time requirements as a result of Contractor(s) actions. Use of a subcontractor or other authorized user shall not relieve the Contractor(s) from any contractual obligations or liability for failure to meet these obligations through the subcontractor or authorized user.
11. At the County's sole discretion, Contractor(s)'s failure to provide ambulances as required by the purchase of supplemental service, may result in a deduction from the fees for supplemental service paid or a charge of penalty fees to the Contractor(s). The County's failure to impose penalties or deduct fees for any of Contractor(s)'s failures shall not constitute a waiver of the County's right to do so for any other failures by the Contractor(s) and the County's option to deduct fees and/or impose penalties shall be done on a case-by-case basis.
12. Exceptions to Response Time standards may be granted for requests during a disaster, locally or in a neighboring jurisdiction that a Contractor(s)'s ambulance is dispatched too. The County may also grant an exception for other good cause. The final determination on an exception shall be the sole discretion of the County.
13. Contractor(s) shall establish and publish a web-based customer service portal to include complaint submittals and Frequently Asked Questions (FAQ).FAQs.

**P. ACCOUNT MANAGER**

Contractor(s) shall also provide adequate, competent support staff that shall provide administrative services to the County during normal working hours, Monday through Friday. Such representative(s) shall be knowledgeable about the contract, products offered and able to identify and resolve quickly any issues including but not limited to order and invoicing problems.

Contractor(s) shall provide a dedicated competent account manager who shall be responsible for the County's account/contract. The account manager shall be the primary contact for all issues regarding Contractor(s)'s response to this RFP and any contract which may arise pursuant to this RFP. Contractor(s) account manager shall be familiar with the County's requirements and standards and

work with the County to ensure that established standards are met.

### III. PROPOSAL FORMAT

Proposer is required to submit their proposals in the following format:

#### A. Cost Proposal (10 points)

1. The cost proposal must be submitted in a separate, sealed envelope with the Proposer's name and **"Cost Proposal for Request for Proposals No. 19-500511 for Emergency Ambulance Service Provider for DeKalb County, Georgia" EMERGENCY AMBULANCE SERVICE PROVIDER FOR DEKALB COUNTY GEORGIA** on the outside of the envelope.
2. The sealed envelope containing the cost proposal is requested to be included in the sealed package containing the technical proposal.
3. **DO NOT INCLUDE FEES OR COSTS IN ANY AREA OUTSIDE OF THIS COST PROPOSAL.** Including fees in any area outside of the Cost Proposal in its separate, sealed envelope shall result in Proposer's proposal being deemed non-responsive.
4. Proposer is required to submit their costs on Attachment A, *Cost Proposal Form*. **Proposer shall not alter the cost proposal form.**

#### B. Technical Proposal

**DO NOT INCLUDE ANY COSTS OF ANY KIND IN THE TECHNICAL PROPOSAL OR ON THE DISCS/FLASH DRIVES CONTAINING THE TECHNICAL PROPOSAL.**

1. Technical Proposals must be submitted in a sealed envelope(s) or box(es) with the Proposer's name and **"Request for Proposal for Request for Proposals No. 19-500511 for Emergency Ambulance Service Provider for DeKalb County, Georgia"** on the outside of each envelope or box.
2. Proposer shall complete Attachment B, *Proposal Cover Sheet*, and include this as the first page of the technical proposal.
3. Proposer shall provide a narrative with all information requested in Section II.F to evidence Proposer meets the minimum qualifications required by the County to be considered eligible to propose for ambulance services.
4. **Technical Approach: (20 points)**

- a. Proposer is required to describe the procedures and methods that will achieve the required outcome of the project as specified herein;
- b. Include a listing of the County's responsibilities and the Proposer's responsibilities required to complete the project.
- c. Proposer shall provide a project schedule at the task level starting with the receipt of the Notice to Proceed and ending with project completion.
- d. Proposer shall provide a transition plan to detail at the task level evidencing the seamless transition of providers, without an interruption in services, while working in accord with the current Contractor and the County.
- e. Proposer shall provide a staff schedule.
- f. Proposer shall provide a detailed plan for the re-supplying of DCFR first responders with all disposable medical supplies and medications (excluding narcotics) on a one-for-one basis.
- g. Proposer shall name their electronic based patient care reporting system (ePCR), that is Georgia Emergency Medical Services Information System (GEMSIS) compliant, and provide proof of compliance.
- h. Proposer shall provide a Quality Improvement Plan that includes, but is not limited to, any identified patient care or operational concerns and actions taken under the plan.
- i. Proposer shall submit a Disaster and Emergency Operations Plan. Include a recall procedure.
- j. Proposer shall provide a copy of their HIPAA Privacy Plan and compliance report.

**5. Project Management: (20 points)**

- a. Proposer(s) shall describe how the project will be organized and managed;
- b. Proposer shall describe progress reporting procedures for the project;
- c. Proposer shall include the anticipated use of subcontractors or vendors; and
- d. Proposer shall describe the personnel and equipment resources necessary to accomplish the purpose of the project.
- e. Proposer shall describe the system status plan including, but not limited to, the number of ambulances (the number of ambulances on duty by hour and day) believed to be necessary to fulfill the services requested under this RFP, the post locations to be used, and the priority of post locations and move-up triggers and criteria. For supplemental service purchased by the County, the County shall determine the post locations to be used, and the priority of post locations and move-up triggers and criteria. When supplemental service is purchased by a municipality, the municipality shall identify, in writing, their request for priority of post locations and move-up triggers and criteria to the County for delivery to the Contractor(s).
- f. Proposer shall provide the minimum number of units they propose are required for peak hours, non-peak hours, and the average.
- g. Proposer must also describe any other equipment that will be used in this agreement, including but not limited to drug boxes, cardiac monitors, defibrillators, gurneys, and all equipment and things required to be in transport units. Proposer must use cardiac monitors that are capable of transmitting data into the Physio-LifeNet system and a receiving hospital. Proposer should also describe its policy for maintaining its equipment at a rate that exceeds the highest amount needed for minimum staffing.

- h. Proposer shall describe the type, brand, and quantity of ambulances proposed to be used for this agreement, including the age, mileage condition, and vehicle replacement schedule for each vehicle. At least one (1) ambulance must be capable of transporting a bariatric patient. All vehicles must be in good condition. Proposer should also describe its policy for maintaining vehicles at a rate that exceeds the highest amount needed for minimum staffing.
- i. Proposer shall describe their fleet maintenance program and vehicle replacement policy.
- j. Proposer shall provide detailed information regarding the communication equipment to be used, including interface capabilities. All ambulances should provide a system that is capable of bedside reporting and allow for the electronic sharing of information between first responder and ambulance paramedics. This section should explain how the proposer's equipment will wirelessly gather a patient's information and wirelessly communicate with the County's computer aided dispatch (CAD) system and wirelessly relay a patient's information to a receiving hospital's system.
- k. Proposer shall provide a copy of the policies and procedures to be used by the Proposer for the purposes of this agreement (if awarded), to DCFR for review.
- l. Within ninety (90) days of execution of the contract, Contractor(s) shall provide the County with a copy of the signed agreement with a secondary ambulance service that serves as a back-up transport service to the Successful Proposer.
- m. Proposer shall provide the minimum number of units per day during peak demand, off peak, and the average number of units required to provide the services detailed in this RFP.

#### **6. Personnel: (15 points)**

- a. Proposer shall identify the individuals who will be part of the project team and list the planned number of staff including managers and field supervisors in your system status plan that will be required for your proposed service levels
- b. Proposer shall identify the individuals who will be responsible for resolving problems. Proposer shall identify the individuals who will be available on a 24 hours per day, 7 days a week (24x7) basis, including holidays.
- c. Proposer shall include any outside personnel, such as subcontractors.
- d. Proposer shall provide detailed resumes of personnel and subcontractors who will be directly working on the project.
- e. Proposer shall include an overview of the personnel and equipment resources that will be available in the proposed system status plan
- f. Proposer shall identify "full-time" and "part-time" personnel.
- g. Proposer shall provide turn-over rates, by category of personnel and define "turn-over" and how it is calculated.
- h. Proposer shall provide the name, address, telephone and fax number, and email address of the Proposer's Medical Director.

## **7. Organizational Qualifications: (10 points)**

- a. Proposer shall describe its experience, capabilities and other qualifications for this project;
- b. Proposer shall state how many years has it operated under the current company name?
- c. Proposer shall state whether it has ever been debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency from doing business with the Federal Government? Proposer must provide documentation that it has resolved all issues arising from the debarment, suspension, proposed debarment, declaration of ineligibility, or voluntary exclusion by any Federal Department or agency.
- d. Proposer shall provide a listing of all resolved or ongoing litigation involving its organization including resolution or status for the last five (5) years. This listing shall include litigation brought against the Proposer's organization or affiliated organization and any litigation initiated by the Proposer's organization or affiliated organization against any governmental entity or competing ambulance service. Proposer must provide documentation that it has resolved all issues arising from litigation or describe status of open litigation.
- e. Proposer shall provide a listing of all federal, state, or local government regulatory investigations, findings, actions or complaints and their respective resolutions for its organization and any parent or affiliated organization within the last three (3) years. Proposer must provide documentation that it has resolved all issues arising from government investigations including any continued obligations of the Proposer or describe status and expected outcome of open investigations.
- f. Proposer shall describe its community education and outreach program.
- g. Proposer shall describe its experience, capabilities, and other qualifications for providing Advanced Life Support (ALS) level emergency ambulance service. State the number of years the organization has been practicing. If the Proposer does not have direct comparable experience in being the sole provider of emergency ambulance service, the Proposer must document in detail how it intends to fulfill its obligations specified in this RFP. This may be done by providing a comprehensive deployment plan identifying the ambulance locations, unit-hour distribution, and procedures for redeploying resources based on demand. Alternatively, the Proposer(s) may delineate personnel who have such experience and that these individuals will be actively and directly involved in the delivery of services in the operating area.
- h. Proposer shall provide the County with the name of its Chief Executive Officer, and if a partnership, corporation, firm, or association, the names, addresses, and phone numbers of any individual with fifty (50) percent proprietary interest.
- i. Proposer shall provide a copy of its current State of Georgia ambulance license and most recent inspection report.
- j. Proposer must provide documentation of its demonstrated ability to meet response time requirements similar to those required in this RFP. Documentation may include reports provided to government oversight entities and letters confirming compliance with mandated response times. Internal reports with adequate supporting documentation of the methodology used to create the reports may also be submitted. If the Proposing



organization does not have mandated response times in its emergency ambulance service area, the Proposer must submit adequate documentation of plans, procedures, and deployment strategies to demonstrate the organization has the knowledge and expertise to comply with mandated response times.

- k. Proposer must provide documentation of its demonstrated ability to provide high-level clinical care. Documentation may include descriptions of clinical sophistication and high levels of performance in systems in which it operates. Proposer should describe how it ensures consistent, high quality clinical care and how it is able to verify and document its clinical competency and performance improvement activities. This should include clinical protocol compliance, skills verification, training methodology and minimum commitments per provider including systematic assessment of EMS core performance metrics and clinical guidelines.
- l. Proposer shall provide a list of service area emergency ambulance service contracts completed or ongoing during the last five (5) years including the term or date of termination of the agreement, the services provided, the dollar amount of the agreement and the contracting entity.
- m. Proposer shall detail any occurrence of its failure or refusal to complete a contract with a governmental entity for which the Proposer was providing emergency ambulance services. This shall specifically state whether the Proposer or affiliated organization was found in material breach of the contract and the reasons why the contract was terminated. If the Proposer has been found in material breach of a governmental contract or if the Proposer “walked away” from its obligations under a governmental contract within the last five (5) years, the Proposal may be rejected as not complying with Minimum Qualifications.

## **8. Financial Responsibility (5 points)**

- a. Proposer must provide financial statements for the last three (3) years that evidences the Proposer’s financial capabilities to perform the scope of work. (Audited statements are preferable but a minimum of balance sheet, income statement and cash flow statement may be accepted.) Provide year of incorporation (if applicable).
- b. Proposer shall describe its legal structure including type of organization, its date, and state of formation.
- c. Proposer shall describe its company’s fiscal strength highlighting features of its financial documents provided as required, as well as other aspects of the Proposer that would allow evaluation of its fiscal ability to initiate, operate, and sustain this contract over the life of the contract.
- d. Proposer shall clearly demonstrate the source of capital to meet the initial investment and ongoing capital needs of the operations. It is the Proposer’s responsibility to conclusively document the source, the availability of the capital, and the firm commitment of the source or sponsoring agency, as appropriate.
- e. Proposer may submit any other financial information that they consider relevant.
- f. All Proposers should be aware that the documents requested will serve to confirm the soundness of their current financial positions. The County’s intent is to award the service to an organization(s) demonstrating the financial capability to operate successfully.

**9. References: (10 points)**

- a. Proposer(s) shall provide three (3) references for projects similar in size and scope to the project specified herein using the Reference and Release Form attached hereto as Attachment C.
- b. Proposer shall provide three (3) references for each subcontractor proposed as a part of the project team. The references shall be for the same or similar types of services to be performed by the subcontractor (including LSBE-DeKalb and LSBE-MSA firms) on projects similar in size and scope to the project outlined in this RFP. Use Attachment D, Subcontractor Reference and Release Form. Make additional copies as needed.

**10. Provide the following information: Are you a DeKalb County Firm? Yes/No.**

**C. DeKalb First Ordinance (LSBE) Program (10 points)**

1. It is the objective of the Chief Executive Officer and Board of Commissioners of the County to provide maximum practicable opportunity for all businesses to participate in the performance of government contracts. The current DeKalb County List of Certified Vendors may be found on the County website at <http://www.dekalbCountyga.gov/purchasing/pdf/supplierList.pdf>.
2. It is required that all responding Proposers attend the mandatory LSBE meeting within two-weeks of the solicitation's advertisement, and comply, complete and submit all LSBE forms with the Proposer's response to remain responsive. Attendance can be in person, via video conference and teleconference. Video conferencing is available through Skype/Lync. Instructions for attendance via video conference can be found on the County's website at <https://www.dekalbCountyga.gov/purchasing-contracting/dekalb-first-lsbe-program>.
3. For further details regarding the DeKalb First Local Small Business Enterprise Ordinance, contact the LSBE Program representative, Felton Williams at [fbwilliams@dekalbCountyga.gov](mailto:fbwilliams@dekalbCountyga.gov) or (404) 371-6312.

**D. Federal Work Authorization Program Contractor and Subcontractor Evidence of Compliance**

All qualifying contractors and subcontractors performing work with the County must register and participate in the federal work authorization program to verify the work eligibility information of new employees. Successful Proposer(s) shall be required to register and participate in the federal work authorization program which is a part of Attachment F, Sample County Contract. In order for a Proposal to be considered, it is **mandatory** that the *Proposer Affidavit*, Attachment G, be completed and submitted with Proposer's proposal.

#### IV. CRITERIA FOR EVALUATION

The following evaluation criteria and the maximum points stated below will be used as the basis for the evaluation of proposals.

- |                                      |                     |
|--------------------------------------|---------------------|
| A. Cost                              | (10 points)         |
| B. Technical Approach to the Project | (20 points)         |
| C. Project Management                | (20 points)         |
| D. Personnel                         | (15 points)         |
| E. Organizational Qualifications     | (10 points)         |
| F. Financial Responsibility          | (5 points)          |
| G. References                        | (10 points)         |
| H. LSBE Participation                | (10 points)         |
| I. Optional Interview                | (10 points) - bonus |

#### V. CONTRACT ADMINISTRATION

##### A. Standard County Contract

The attached sample contract is the County's standard contract document (see Attachment F), which specifically outlines the contractual responsibilities. All Proposers should thoroughly review the document prior to submitting a proposal. Any proposed revisions to the terms or language of this document must be submitted in writing with the Proposer's response to the request for proposals. Since proposed revisions may result in a proposal being rejected if the revisions are unacceptable to the County, Proposers should review any proposed revisions with an officer of the firm having authority to execute the contract. No alterations can be made in the contract after award by the Board of Commissioners.

##### B. Submittal Instructions

**One (1) original Technical Proposal stamped "Original" and seven (7) compact discs or flash drives with each containing an identical copy of the Technical Proposal (do not include the Cost Proposal on the discs/flash drives); and one (1) original Cost Proposal (see Section III.A. for additional instructions regarding submittal of Cost Proposal) must be submitted to the following address no later than 3:00 p.m. on Friday, April 12, 2019.**

DeKalb County Department of Purchasing and Contracting  
The Maloof Center, 2<sup>nd</sup> Floor  
1300 Commerce Drive  
Decatur, Georgia 30030

Proposals must be clearly identified on the outside of the packaging with the Proposer's name and "Request for Proposals (RFP) No. 19-500511 for Emergency Ambulance Service Provider for DeKalb County, Georgia" on the outside of the envelope(s) or box(es).

It is the responsibility of each Proposer to ensure that its submission is received by 3:00 p.m. on the bid due date. The time/date stamp clock located in the Department of Purchasing & Contracting shall serve as the official authority to determine lateness of any response. The RFP opening time shall be strictly observed. Be aware that visitors to our offices will go through a security screening process upon entering the building. Proposers should plan enough time to ensure that they will be able to deliver their submission prior to our deadline. Late submissions, for whatever reason, will not be evaluated. Proposers should plan their deliveries accordingly. Telephone or fax bids will not be accepted.

### **C. Pre-Proposal Conference**

A pre-proposal conference will be held at 10:00 a.m. on March 21, 2019 at The Maloof Center, 1300 Commerce Drive, 2<sup>nd</sup> Floor, Decatur, Georgia 30030. Interested Proposers are strongly encouraged to attend and participate in the pre-proposal conference. For information regarding the pre-proposal conference, please contact Cathryn Horner, at (404) 371-6334 or at [cghorner@dekalbcountyga.gov](mailto:cghorner@dekalbcountyga.gov). Proposers may attend via teleconference by dialing (770)414-2144 and utilizing PIN Number 199812.

### **D. Questions**

All questions concerning the Project and requests for interpretation of the Contract may be asked and answered at the pre-bid conference; however, oral answers are not authoritative. Questions must be submitted to Cathryn Horner, via email to [cghorner@dekalbcountyga.gov](mailto:cghorner@dekalbcountyga.gov), no later than 5:00 p.m. on March 26, 2019. Questions and requests for interpretation received by the Department of Purchasing and Contracting after this date will not receive a response or be the subject of addenda.

### **E. Acknowledgment of Addenda**

Addenda may be issued in response to changes in the RFP. It is the responsibility of the Proposer to ensure awareness of all addenda issued for this solicitation. Please acknowledge the addenda and submit to the Department of Purchasing and Contracting as requested. Proposer may call Cathryn Horner at (404)371-4943 or send an email to [cghorner@dekalbcountyga.gov](mailto:cghorner@dekalbcountyga.gov) to verify the number of addenda prior to submission. Addenda issued for this project may be found on DeKalb County's website, <https://www.dekalbCountyga.gov/purchasing-contracting/bids-itb-rfps>.

### **F. Proposal Duration**

Proposals submitted in response to this RFP must be valid for a period of One Hundred Twenty (120) days from proposal submission deadline and must be so marked.

### **G. Project Director/Contract Manager**

The County will designate a Project Director/Contract Manager to coordinate this project for the County. The successful Proposer will perform all work required pursuant to the contract

under the direction of and subject to the approval of the designated Project Director/Contract Manager. All issues including, payment issues, shall be submitted to the Project Director/Contract Manager for resolution.

#### **H. Expenses of Preparing Responses to this RFP**

The County accepts no responsibility for any expenses incurred by the Proposers submitting responses to this RFP. Such expenses are to be borne exclusively by the Proposers.

#### **I. Georgia Open Records Act**

Without regard to any designation made by the person or entity making a submission, the County considers all information submitted in response to this invitation or request to be a public record that will be disclosed upon request pursuant to the Georgia Open Records Act, O.C.G.A. §50-18-70 et seq., without consulting or contacting the person or entity making the submission, unless a court order is presented with the submission. You may wish to consult an attorney or obtain legal advice prior to making a submission.

#### **J. First Source Jobs Ordinance**

The DeKalb County First Source Jobs Ordinance requires contractors or beneficiaries entering into any type of agreement with the County, including purchase orders, regardless of what they may be called, for the procurement or disposal of supplies, services, construction projects, professional or consultant services, which is funded in whole or part with County funds or County administered funds in which the contractor is to receive \$50,000 or more in County expenditures or committed expenditures and recipient of urban redevelopment action grants or community development block funds administered in the amount of \$50,000 or more make a good faith effort to hire DeKalb County residents for at least 50% of jobs using the First Source Registry (candidate database). The work to be performed under this contract is subject to the provisions of the DeKalb County First Source Jobs Ordinance. Please complete the First Source Jobs Ordinance Acknowledgement and New Employee Tracking Form included in Attachment H, First Source Jobs Ordinance (with Exhibits 1 – 4) and submit with the Proposer's proposal.

For more information on the First Source Jobs Ordinance requirement, please contact WorkSource DeKalb at [www.worksourcedekalb.org](http://www.worksourcedekalb.org) or 404-687-3400.

#### **K. Business License**

Proposer shall submit a copy of its current, valid business license with its proposal or upon award. If the Proposer is a Georgia corporation, Proposer shall submit a valid County or city business license. If the Proposer is not a Georgia corporation, Proposer shall submit a certificate of authority to transact business in the state of Georgia and a copy of its valid business license issued by its home jurisdiction. If Proposer holds a professional certification which is licensed by the state of Georgia, then Proposer shall submit a copy of its valid professional license. Any license submitted in response to this requirement shall be maintained

by the Contractor for the duration of the contract.

#### **L. Ethics Rules**

Proposers are subject to the Ethics provision within the DeKalb County Purchasing Policy; the Organizational Act, Section 22A, the Code of DeKalb County; and the rules of Executive Order 2014-4. Any violations will be addressed, pursuant to these policies and rules.

To the extent that the Organizational Act, Section 22A, the Code of DeKalb County, and the rules of Executive Order 2014-4 allow a gift, meal, travel expense, ticket, or anything else of value to be purchased for a CEO employee by a contractor doing business with the County, the contractor must provide written disclosure, quarterly, of the exact nature and value of the purchase to the Chief Integrity Officer, if created, or the Finance Director or his/her designee. Every contractor conducting business with the County will receive a copy of these ethical rules at the time of execution of the contract.

#### **M. Right to Audit**

The County shall have the right to audit all books and records, including electronic records, relating or pertaining to this contract or agreement, including but not limited to all financial and performance related records, property, and equipment purchased in whole or in part with County funds and any documents or materials which support those records, kept under the control of the Contractor, including but not limited to those kept by the Contractor's employees, agents, assigns, successors and subcontractors. The County also has the right to communicate with Contractor's employees related to the audited records.

The Contractor shall maintain such books and records, together with such supporting or underlying documents and materials, for the duration of this contract and for seven (7) years after termination or expiration, including any and all renewals thereof. The books and records, together with supporting documents and materials shall be made available, upon request to the County or its designee, during normal business hours at the Contractor(s)'s office or place of business. In the event that no such location is available, then the books, records, and supporting documents shall be made available for audit at a time and location which is convenient for the County.

#### **N. Cooperative Procurement**

The County through the Department of Purchasing and Contracting may permit piggybacks to this contract from other city, County, local authority, agency, or board of education if the vendor will extend the same prices, terms, and conditions to the city. Piggybacking shall only be available where competition was used to secure the contract and only for a period of 12-months following entry, renewal or extension of the contract. This provision shall not apply to any contract where otherwise prohibited or mandated by state law.

## **VI. AWARD OF CONTRACT**

An evaluation committee will review and rate all proposals and shall determine if interviews are necessary.

If interviews are conducted, firms will be scheduled for an oral presentation to the evaluation committee, not to exceed one hour's duration, to respond to questions from the evaluation committee relevant to the firm's proposal.

The evaluation committee will make its recommendation for award to the DeKalb County Board of Commissioners, who will make the final decision as to award of contract.

**THE COUNTY RESERVES THE RIGHT TO REJECT ANY AND ALL PROPOSALS, TO WAIVE INFORMALITIES, AND TO RE-ADVERTISE.**

Sincerely,

\_\_\_\_\_  
Cathryn Horner  
Procurement Manager  
Department of Purchasing and Contracting

Attachment A:	Cost Proposal
Attachment B:	Proposal Cover Sheet
Attachment C:	Contractor Reference and Release Form
Attachment D:	Subcontractor Reference and Release Form
Attachment E:	LSBE Opportunity Tracking Form
Attachment F:	Sample County Contract
Attachment G:	Proposer Affidavit
Attachment H:	First Source Jobs Ordinance Information with Exhibits 1 - 4
Exhibit 1:	Unit Dispatch Criteria
Exhibit 2:	Patient Care Protocols
Exhibit 3:	Vehicle Inspection Form
Exhibit 4:	Communications Equipment Specification
Exhibit 5:	Information Technology Information Security Policy
Exhibit 6:	Incident Command Guidelines
Exhibit 7:	Fire Station Locations
Exhibit 8:	Metro-Atlanta Hospital Locations

**ATTACHMENT A**

**COST PROPOSAL FORM**

(consisting of 4 pages)

**RFP NO. 19-500511 EMERGENCY AMBULANCE SERVICE PROVIDER  
FOR DEKALB COUNTY GEORGIA**

**Proposer: Please complete the attached pages of the Cost Proposal Form and return them with this cover page. The cost proposal must be submitted in a separate, sealed envelope with the Proposer's name and "Request for Proposals No. 19-500511 Emergency Ambulance Service Provider for DeKalb County Georgia" clearly identified on the outside of the envelope.**

By signing this page, Proposer acknowledges that he has carefully examined and fully understands the Contract, Scope of Work, and other attached documents, and hereby agrees that if his proposal is accepted, he will contract with DeKalb County according to the Request for Proposal documents.

Please provide the following information:

Name of Firm: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Person Submitting Proposal: \_\_\_\_\_

Title of Contact Person: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

\_\_\_\_\_  
Signature of Contact Person

\_\_\_\_\_  
Title of Contact Person



## ATTACHMENT A

### COST PROPOSAL FORM

**I. Proposer:** The Cost proposed shall include the total cost of providing all services included in the RFP response by the Proposer including all costs, direct and indirect, administrative costs, and all things necessary. For the purposes of the proposal, a unit hour is defined as an equipped and staffed ambulance on a response or waiting for a response for one hour.

**Unit Hourly Cost** shall be based upon the Proposer delivering weekly unit hours that the County estimates will be needed to provide the services required by this RFP less billing/collections and dispatching. The Proposer shall propose only one Unit Hourly Cost. **Example;** *if proposer has three (3) BLS units operating 24 hours per day at \$10/hr. and three (3) ALS units operating 24 hours per day at \$20/hr. and one (1) 24/hr. field Supervisor at \$15/hr. the total number of system hours would be 168hrs. per 24/hr. shift. If the proposer's indirect and overhead costs are 10% of actual the resulting unit hour cost would be \$115.50 per unit hour.*

Description	Weekly Unit Hours	Unit Hourly Cost	Annual Cost
Year 1 - 911 Ambulance Services	5,019	\$ _____	\$ _____
Year 2 – 911 Ambulance Services	5,269	\$ _____	\$ _____
Year 3 – 911 Ambulance Services	5,532	\$ _____	\$ _____
Year 4 – 911 Ambulance Services	5,809	\$ _____	\$ _____
Year 5 – 911 Ambulance Services	6,099	\$ _____	\$ _____
Total Cost for Years 1 – 5	---	---	\$ _____

---

(State the Total Cost in writing on this line.)

**ATTACHMENT B**  
**PROPOSAL COVER SHEET**

**NOTE:** Read all instructions, conditions and specifications in detail before completing this Request for Proposal.

Please complete and include this cover sheet with your technical proposal.

Company Name		Federal Tax ID#	
Complete Primary Address	County	City	Zip Code
Mailing Address (if different)	City	State	Zip Code
Contact Person Name and Title	Telephone Number (include area code)		
Email Address	Fax Number (include area code)		
Company Website Address	Type of Organization (check one) <input type="checkbox"/> Corporation <input type="checkbox"/> Joint Venture <input type="checkbox"/> Proprietorship <input type="checkbox"/> Government		
<p>Proposals for RFP No. 19-500511 Emergency Ambulance Service Provider for DeKalb County Georgia described herein will be received in the Purchasing &amp; Contracting Department, Room 2<sup>nd</sup> Floor, The Maloof Center, 1300 Commerce Drive, Decatur, Georgia 30030 on April 12, 2019 until <u>3:00 p.m. (EST)</u>. Proposals shall be marked in accordance with the RFP, Section V.B.</p> <p><b>CAUTION:</b> The Decatur Postmaster will not deliver certified or Special Delivery Mail to specific addresses within DeKalb County Government. When sending bids or time sensitive documents, you may want to consider a courier that will deliver to specific addresses.</p>			
<p>Proposal Cover Sheet should be signed by a representative of Proposer with the authority to bind Proposer to all terms, conditions, services, and financial responsibilities in the submitted Proposal.</p>			
Authorized Representative Signature(s)		Title(s)	
Type or Print Name(s)		Date	

**ATTACHMENT C**  
**CONTRACTOR REFERENCE AND RELEASE FORM**

List below at least three (3) references, including company name, contact name, address, email address, telephone numbers and contract period who can verify your experience and ability to perform the type of service listed in the solicitation.

Company Name	Contract Period		
Contact Person Name and Title	Telephone Number (include area code)		
Complete Primary Address	City	State	Zip Code
Email Address	Fax Number (include area code)		
Project Name			

Company Name	Contract Period		
Contact Person Name and Title	Telephone Number (include area code)		
Complete Primary Address	City	State	Zip Code
Email Address	Fax Number (include area code)		
Project Name			

Company Name	Contract Period		
Contact Person Name and Title	Telephone Number (include area code)		
Complete Primary Address	City	State	Zip Code
Email Address	Fax Number (include area code)		
Project Name			

**REFERENCE CHECK RELEASE STATEMENT**

You are authorized to contact the references provided above for purposes of this RFP.

Signed \_\_\_\_\_ Title \_\_\_\_\_  
(Authorized Signature of Proposer)

Company Name \_\_\_\_\_ Date \_\_\_\_\_

**ATTACHMENT D**  
**SUBCONTRACTOR REFERENCE AND RELEASE FORM**

List below at least three (3) references, including company name, contact name, address, email address, telephone numbers and contract period who can verify your experience and ability to perform the type of service listed in the solicitation.

Company Name	Contract Period		
Contact Person Name and Title	Telephone Number (include area code)		
Complete Primary Address	City	State	Zip Code
Email Address	Fax Number (include area code)		
Project Name			

Company Name	Contract Period		
Contact Person Name and Title	Telephone Number (include area code)		
Complete Primary Address	City	State	Zip Code
Email Address	Fax Number (include area code)		
Project Name			

Company Name	Contract Period		
Contact Person Name and Title	Telephone Number (include area code)		
Complete Primary Address	City	State	Zip Code
Email Address	Fax Number (include area code)		
Project Name			

**REFERENCE CHECK RELEASE STATEMENT**

You are authorized to contact the references provided above for purposes of this RFP.

Signed \_\_\_\_\_ Title \_\_\_\_\_  
 (Authorized Signature of Proposer)

Company Name \_\_\_\_\_ Date \_\_\_\_\_

**ATTACHMENT E  
DEKALB FIRST LSBE INFORMATION  
WITH EXHIBITS A – B**

**SCHEDULE OF LOCAL SMALL BUSINESS ENTERPRISE PARTICIPATION  
OPPORTUNITY TRACKING FORM**

The Chief Executive Officer and the Board of Commissioners of DeKalb County believe that it is important to encourage the participation of small and local businesses in the continuing business of County government; and that the participation of these types of businesses in procurement will strengthen the overall economic fabric of DeKalb County, contribute to the County's economy and tax base, and provide employment to local residents. Therefore, the Chief Executive Officer and the Board of Commissioners have made the success of local small businesses a permanent goal of DeKalb County by implementing the DeKalb First Local Small Business Enterprise Ordinance.

**PROVISIONS OF DEKALB FIRST LOCAL SMALL BUSINESS ENTERPRISE (LSBE)  
ORDINANCE**

Percentage of LSBE Participation Required
20% of Total Award

Certification Designation	Request for Proposals (RFP)
LSBE Within DeKalb (LSBE-DeKalb)	Ten (10) Preference Points
LSBE Outside DeKalb (LSBE-MSA)	Five (5) Preference Points
Demonstrated GFE	Two (2) Preference Points

Certified Local Small Business Enterprises (LSBEs) located within DeKalb County and prime contractors utilizing LSBEs that are locally-based inside DeKalb County shall receive ten (10) points in the initial evaluation of their response to any Request for Proposal. Certified LSBEs located outside of DeKalb County but within the nine (9) County Metropolitan Statistical Area (MSA) consisting of Cherokee, Clayton, Cobb, Douglas, Fayette, Fulton, Gwinnett, Henry and Rockdale Counties shall receive five (5) points in the initial evaluation of their response to any Request for Proposal. Prime Contractors who demonstrate sufficient good faith efforts in accordance with the requirements of the ordinance shall be granted two (2) points in their initial evaluation of responses to any Request for Proposal. Pro-rated points shall be granted where a mixture of LSBE-DeKalb and LSBE MSA firms are utilized. Utilization of each firm shall be based upon the terms of the qualified sealed solicitation.

Prime Contractor(s) deemed responsible and remains responsive to an Invitation to Bid (ITB) because they are either a certified LSBE-DeKalb or LSBE-MSA firm or has obtained 20% participation of an LSBE-DeKalb or LSBE-MSA firm, submits the lowest bid price shall be deemed the lowest, responsive and responsible Proposer/Responder.

Prime Contractor(s) deemed responsible and remains responsive to an Invitation to Bid (ITB) and documented good faith efforts, submits a lower bid price than a Prime Contractor that achieved 20% LSBE participation, or otherwise required benchmark, then the Prime Contractor who actually met the

benchmark will be given the opportunity to match the lowest bid price of the Prime Contractor who only made good faith efforts. Prime Contractor(s) who choose **not** to match the lowest bid price, then the Prime Contractor who made the good faith efforts will be deemed the lowest, responsive and responsible Proposer/Responder.

For all qualified sealed solicitations, the Director of Purchasing and Contracting, DeKalb County Government, shall determine if the Proposer/Responder has included written documentation showing that at least twenty percent (20%) of the total contract award will be performed by a certified LSBE. This written documentation shall be in the form of a notarized Schedule of LSBE Participation (Attached hereto as "Exhibit A".) For all contracts, a signed letter of intent from all certified LSBEs describing the work, material, equipment and/or services to be performed or provided by the LSBE(s) and the agreed upon percentage shall be due with the bid or proposal documents and included with "Exhibit A". The certified vendor list establishes the group of Certified LSBE's from which the Proposer/Responder must solicit subcontractors for LSBE participation. This list can be found on our website <http://www.dekalbCountyga.gov/purchasing-contracting/about-purchasing-and-contracting> or obtained from the Special Projects LSBE Program team.

Prime Contractors failing to meet the LSBE benchmark must document and demonstrate Good Faith Efforts in accordance with the attached "Checklist for Good Faith Efforts" portion of "Exhibit A." The notarized Schedule of LSBE Participation shall be due and submitted with each bid or proposal. Failure to achieve the LSBE benchmark or demonstrate good faith efforts shall result in a bid or proposal being rejected. Prime Contractors that fail to attend the mandatory LSBE meeting in person or via video conference shall mean that the Prime Contractor has not demonstrated sufficient good faith efforts and its bid or proposal if submitted, shall be deemed non-responsive without any further review.

Upon award, Prime Contractors are required to submit a report detailing LSBE Sub-Contractor usage with each request for payment and not less than on a monthly basis. Prime Contractors shall ensure that all LSBE sub-contractors have been paid within seven (7) days of the Prime's receipt of payment from the County. Failure to provide requested reports/documentation shall constitute a material breach of contract, entitling the County to terminate the Contract for default or pursue other remedies. LSBE sub-contractors must confirm payments received from the Prime(s) for each County contract they participate in.

For eligible bids/proposals valued over \$5,000,000.00, the Mentor-Protégé provision of the Ordinance shall apply. Prime Contractors must agree to become mentors and take on an LSBE protégé in an effort to enhance the potential of future LSBEs. Qualifying projects shall be performed by both Mentor and Protégé through a subcontract between both parties. This requirement is in addition to all other applicable sections of the DeKalb First Ordinance. Please review the ordinance, section 2-214 or contact the LSBE Program Representative for detailed information regarding this initiative.

**EXHIBIT A**

**SCHEDULE OF DEKALB FIRST LOCAL SMALL BUSINESS ENTERPRISE  
PARTICIPATION  
OPPORTUNITY TRACKING FORM**

As specified, Proposers are to present the details of LSBE participation below:

PRIME

PROPOSER/RESPONDER/PROPOSER \_\_\_\_\_

SOLICITATION NUMBER: **RFP No. 19-500511**

TITLE OF UNIT OF WORK: **Emergency Ambulance Service Provider for DeKalb County**

1. My firm, as the prime Proposer/Responder/proposer on this unit of work, is a certified (check all that apply):  
\_\_\_\_ LSBE-DeKalb      \_\_\_\_ LSBE-MSA
2. If you are a Certified LSBE-DeKalb or MSA, please indicate below the percentage of that your firm will carry out directly: \_\_\_\_\_.
3. If the prime Proposer/Responder/proposer is a joint venture, please describe below the nature of the joint venture and level of work and percentage of participation to be provided by the LSBE-DeKalb or MSA joint venture firm.  
  
\_\_\_\_\_  
  
\_\_\_\_\_

4. List the LSBE-DeKalb or MSA subcontractors and/or firms (including suppliers) to be utilized in of this contract, if awarded. No changes can be made in the subcontractors listed below without the prior written approval of the County. Please attach a signed letter of intent from all certified LSBEs describing the work, materials, equipment or services to be performed and/or provided and the agreed upon percentage of work to be performed. A Letter of Intent form is attached hereto as "Exhibit B".

Name of Company	
Address	
Telephone	
Fax	
Contact Person	
Indicate certification status and attach proof of certification: LSBE-DeKalb/LSBE-MSA	
Description of services to be performed	

Percentage of work to be performed	
------------------------------------	--

Name of Company	
Address	
Telephone	
Fax	
Contact Person	
Indicate certification status and attach proof of certification: LSBE-DeKalb/LSBE-MSA	
Description of services to be performed	
Percentage of work to be performed	

Name of Company	
Address	
Telephone	
Fax	
Contact Person	
Indicate certification status and attach proof of certification: LSBE-DeKalb/LSBE-MSA	
Description of services to be performed	
Percentage of work to be performed	

Name of Company	
Address	
Telephone	
Fax	
Contact Person	
Indicate certification status and attach proof of certification: LSBE-DeKalb/LSBE-MSA	
Description of services to be performed	
Percentage of work to be performed	

Please attach additional pages, if necessary.



**EXHIBIT A, CONT'D**

**DEKALB COUNTY**  
**CHECKLIST FOR GOOD FAITH EFFORTS**

A Proposer/Responder/proposer that does not meet the County's LSBE participation benchmark is required to submit documentation to support all "Yes" responses as proof of "good faith efforts." Please indicate whether or not any of these actions were taken:

	Yes	No	Description of Actions
1.			Prime Contractors shall attend a <b>MANDATORY LSBE</b> Meeting in person or via video conference within two-weeks of advertisement of the solicitation.
2.			Provide a contact log showing the company's name, contact person, address, email and contact number (phone or fax) used to contact the proposed certified subcontractors, nature of work requested for quote, date of contact, the name and title of the person making the effort, response date and the percentage of work.
3.			Provide interested LSBEs via email, of any new relevant information, if any, at least 5 business days prior to submission of the bid or proposal.
4.			Efforts made to divide the work for LSBE subcontracting areas likely to be successful and to identify portions of work available to LSBEs consistent with their availability. Include a list of divisions of work not subcontracted and the corresponding reasons for not including them. The ability or desire of a Proposer/Responder/proposer to perform the contract work with its own organization does not relieve it of the responsibility to make good faith efforts on all scopes of work subject to subcontracting.
5.			Efforts were made to assist potential LSBE subcontractors meet bonding, insurance, or other governmental contracting requirements. Where feasible, facilitating the leasing of supplies or equipment when they are of such a specialized nature that the LSBE could not readily and economically obtain them in the marketplace.
6.			Communication via email or phone with DeKalb First Program Staff seeking assistance in identifying available LSBEs. Provide DeKalb First Program Staff representative name and title, and date of contact.
7.			For all contracts, a signed letter of intent from all certified LSBEs describing the work, materials, equipment or services to be performed or provided by the LSBE(s) and the agreed upon LSBE participation percentage shall be due with the bid or proposal documents.
8.			Other Actions, to include Mentor/Protégé commitment for solicitations \$5M and above (specify):

Please explain all “no” answers above (by number):

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This list is a guideline and by no means exhaustive. The County will review these efforts, along with attached supporting documents, to assess the Proposer/Responder/proposer’s efforts to meet the County’s LSBE Participation benchmark. If you require assistance in identifying certified, bona fide LSBEs, please contact the Purchasing and Contracting Department - DeKalb First Program, Felton Williams, Procurement Projects Manager at 404-371-6312.

## **EXHIBIT A, CONT'D**

### **DEKALB FIRST LOCAL SMALL BUSINESS ENTERPRISE SCHEDULE OF PARTICIPATION OPPORTUNITY TRACKING FORM**

#### **Proposer/Responder/Proposer Statement of Compliance**

Proposer/Responder(s)/Proposer(s) hereby state that they have read and understand the requirements and conditions as set forth in the objectives and that reasonable effort were made to support the County in providing the maximum practicable opportunity for the utilization of LSBEs consistent with the efficient and economical performance of this contract. The Proposer/Responder and any subcontractors shall file compliance reports at reasonable times and intervals with the County in the form and to the extent prescribed by the Director of DeKalb County Purchasing and Contracting Department. Compliance reports filed at such times as directed shall contain information as to the employment practices, policies, programs and statistics of Contractors and their subcontractors.

#### **1. Non-Discrimination Policy**

- a. During the performance of this agreement, Contractor agrees to conform to the following Non-Discrimination Policy adopted by the County.
- b. Contractor shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, or disability. The Contractor will take action to ensure that applicants are employed, and the employees are treated during employment without regard to their race, color, religion, sex, national origin, or disability. Such action shall include, but not be limited to, the following:
  - (1) Employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Contractor agrees to post in conspicuous places available to employees and applicants for employment, notices to be provided setting forth provisions of this non-discrimination clause.
  - (2) Contractor shall, in all solicitations or advertisements for employees placed by or on behalf of Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, or disability.
- c. Without limiting the foregoing, Contractor shall not discriminate on the basis of disability in the admission or access to, or treatment or employment in, the programs and activities, which form the subject of the contract. The Contractor will take action to ensure that applicants for participation in such programs and activities are considered without regard to disability. Such action shall include, but not be limited to, the following:
  - (1) Contractor agrees to post in conspicuous places available to participants in its programs and activities notices to be provided setting forth the provisions of this non-discrimination clause.

- (2) Contractor shall, in all solicitations or advertisements for programs or activities, which are the subject of the contract, state that all qualified applicants will receive consideration for participation without regard to disability.

2. **Commitment**

The undersigned certifies that he/she has read, understands, and agrees to be bound by the bid specifications, including the accompanying Exhibits and other terms and conditions of the Invitation to Bid and/or Request for Proposal regarding LSBE utilization. The undersigned further certifies that he/she is legally authorized by the Proposer/Responder or responder to make the statements and representations in Exhibit A and that said statements and representations are true and correct to the best of his/her knowledge and belief. The undersigned will enter into formal agreement(s) with the LSBE(s) listed in this Exhibit A, which are deemed by the owner to be legitimate and responsible LSBEs. Said agreement(s) shall be for the work and contract with the Prime Contractor. The undersigned understands and agrees that if any of the statements and representations are made by the Proposer/Responder knowing them to be false, or if there is a failure of the successful Proposer/Responder (i.e., Contractor) to implement any of the stated agreements, intentions, objectives, goals and commitments set forth herein without prior approval of the County, then in any such events the contractor's act or failure to act, as the case may be, shall constitute a material breach of contract, entitling the County to terminate the Contract for default. The right to so terminate shall be in addition to, and not in lieu of, any other rights and remedies the County may have for other defaults under the Contract. Additionally, the Contractor will be subject to the loss of any future contract awards by the County for a period of one year.

Firm Name (Please Print):

\_\_\_\_\_

Firm's Officer:

\_\_\_\_\_

(Authorized Signature and Title Required)

Date

Sworn to and Subscribed to before me this \_\_\_\_ day of \_\_\_\_\_, 201\_\_.

\_\_\_\_\_

Notary Public

My Commission Expires: \_\_\_\_\_

**EXHIBIT B**

**LETTER OF INTENT TO PERFORM AS A SUBCONTRACTOR  
PROVIDING MATERIALS OR SERVICES**

Instructions:

1. Complete the form in its entirety and submit with bid documents.
2. Attach a copy of the LSBE's current valid Certification Letter.

**To:** \_\_\_\_\_  
(Name of Prime Contractor Firm)

**From:** \_\_\_\_\_ ☐ **LSBE –DeKalb** ☐ **LSBE –MSA**  
(Name of Subcontractor Firm) (Check all that apply)

**ITB Number: 19-500511**

**Project Name: Emergency Ambulance Service Provider for DeKalb County**

The undersigned subcontractor is prepared to perform the following described work or provide materials or services in connection with the above project (specify in detail particular work items, materials, or services to be performed or provided).

Description of Materials or Services	Project/Task Assignment	% of Contract Award

**Prime Contractor**

**Sub-contractor**

**Signature:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Title:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ATTACHMENT F**  
**SAMPLE COUNTY CONTRACT**

## **SAMPLE COUNTY CONTRACT**

### **AGREEMENT FOR PROFESSIONAL SERVICES**

#### **DEKALB COUNTY, GEORGIA**

**THIS AGREEMENT** made as of this \_\_\_\_ day of \_\_\_\_, 20\_\_\_\_, (hereinafter called the “execution date”) by and between DEKALB COUNTY, a political subdivision of the State of Georgia (hereinafter referred to as the “County”), and \_\_\_\_\_, a corporation organized and existing under the laws of the State of \_\_\_\_\_, with offices in \_\_\_\_\_, \_\_\_\_\_ (hereinafter referred to as “Contractor”), shall constitute the terms and conditions under which the Contractor shall provide Emergency Ambulance Services in DeKalb County, Georgia.

**WITNESSETH:** That for and in consideration of the mutual covenants and agreements herein set forth, the County and the Contractor hereby agree as follows:

#### **ARTICLE I. CONTRACT TERM**

The Contractor shall commence the Work under this Contract within ten (10) days from the acknowledgement of receipt of the Notice to Proceed. As required by O.C.G.A §36-60-13, this Contract shall (i) terminate without further obligation on the part of the County each and every December 31<sup>st</sup>, as required by O.C.G.A. § 36-60-13, as amended, unless terminated earlier in accordance with the termination provisions of this Contract; (ii) automatically renew on each January 1<sup>st</sup>, unless terminated in accordance with the termination provisions of this Contract; and (iii) terminate absolutely, with no further renewals, on December 31, 2023, unless extended by Change Order adopted and approved by the DeKalb County Governing Authority and the Contractor in accordance with the terms of this Contract.

#### **ARTICLE III. PAYMENT**

As full payment for the faithful performance of this Contract, the County shall pay the Contractor, the Contract Price, which is an amount not to exceed \_\_\_\_\_ (\$\_\_\_\_\_), unless changed by written Change Order in accordance with the terms of this Contract. The term “Change Order” includes the term “amendment” and shall mean a written order authorizing a change in the Work, and an adjustment in Contract Price to Contractor or the Contract Term, as adopted and approved by the Contractor and the DeKalb County Governing Authority, or the Chief Executive Officer, if exempted from Governing Authority adoption and approval in accordance with the express terms of this Contract. The Chief Executive Officer or his/her designee shall have the authority to approve and execute a Change Order lowering the Contract Price or increasing the Contract Price up to twenty percent (20%) of the original Contract Price, provided that the total amount of the increase authorized by such Change Order is less than \$100,000.00. If the original Contract or Purchase Order Price does not exceed \$100,000.00, but the Change Order will make the total Contract Price exceed \$100,000.00, then the Change Order will require approval by official action of the Governing Authority. Any other increase of the Contract Price shall be by Change Order adopted and approved by the DeKalb County Governing Authority and the Contractor in accordance with the terms of this Contract. Amounts paid to the Contractor shall comply with and not exceed Attachment A, the Contractor’s Cost Proposal, consisting of \_\_\_\_\_ page(s) attached hereto and incorporated herein by reference. Payment is to be made no later than thirty (30) days after submittal of undisputed invoice.

Invoice(s) must be submitted as follows:

- A. Original invoice(s) must be submitted to:  
DeKalb County, Georgia  
Attention: Fire Rescue Services

B. Upon award, Prime Contractor(s) with Local Small Business Enterprise (LSBE) Subcontractor(s) shall enter utilization reports electronically at [www.dekalblsbe.info](http://www.dekalblsbe.info). Proof of payment to the LSBE Subcontractor must be uploaded and submitted. LSBE Subcontractors shall confirm receipt of payment from the Prime, electronically also, at [www.dekalblsbe.info](http://www.dekalblsbe.info)

#### **ARTICLE IV. STATEMENT OF WORK**

The Contractor agrees to provide all emergency ambulance services in accordance with the County's Request for Proposals (RFP) No. 19-500511 for Emergency Ambulance Service Provider for DeKalb County, Georgia, attached hereto as Appendix I and incorporated herein by reference, and the Contractor's response thereto, attached hereto as Appendix II and incorporated herein by reference.

#### **ARTICLE V. GENERAL CONDITIONS**

A. **Accuracy of Work** The Contractor shall be responsible for the accuracy of the Work and any error and/or omission made by the Contractor in any phase of the Work under this Agreement.

B. **Additional Work** The County shall in no way be held liable for any work performed under this section which has not first been approved in writing by the County in the manner required by applicable law and/or the terms of this Contract. The County may at any time order changes within the scope of the Work without invalidating the Contract upon seven (7) days written notice to the Contractor. The Contractor shall proceed with the performance of any changes in the Work so ordered by the County unless such change entitles the Contractor to a change in Contract Price, and/or Contract Term, in which event the Contractor shall give the County written notice thereof within fifteen (15) days after the receipt of the ordered change, and the Contractor shall not execute such changes until it receives an executed Change Order from the County. No extra cost or extension of time shall be allowed unless approved by the County and authorized by execution of a Change Order. The parties' execution of any Change Order constitutes a final settlement of all matters relating to the change in the Work which is the subject of the Change Order. The County shall not be liable for payment for any work performed under this section which has not first been approved in writing by the County in the manner required by applicable law and/or the terms of this Contract.

C. **Ownership of Documents** All documents, including drawings, estimates, specifications, and data are and remain the property of the County. The Contractor agrees that the County may reuse any and all plans, specifications, drawings, estimates, or any other data or documents described herein in its sole discretion without first obtaining permission of the Contractor and without any payment of any monies to the Contractor therefore. However, any reuse of the documents by the County on a different site shall be at its risk and the Contractor shall have no liability where such documents are reused.

D. **Right to Audit** The County shall have the right to audit all books and records, including electronic records, relating or pertaining to this contract or agreement, including but not limited to all financial and performance related records, property, and equipment purchased in whole or in part with County funds and any documents or materials which support those records, kept under the control of the Contractor, including but not limited to those kept by the Contractor's employees, agents, assigns, successors and subcontractors. The County also has the right to communicate with Contractor's employees related to the audited records.

The Contractor shall maintain such books and records, together with such supporting or underlying documents and materials, for the duration of this contract and for seven (7) years after termination or expiration, including any and all renewals thereof. The books and records, together with supporting documents and materials shall be made available, upon request to the County or its designee, during normal business hours at the Contractor's office or place of business. In the event that no such location is available, then the books, records, and supporting documents shall be made available for audit at a time and location which is convenient for the County.



E. **Successors and Assigns** The Contractor agrees it shall not sublet, assign, transfer, pledge, convey, sell, or otherwise dispose of the whole or any part of this Contract or his right, title, or interest therein to any person, firm, or corporation without the previous written consent of the County. If the County consents to any such assignment or transfer, then the Contractor binds itself, its partners, successors and assigns to all covenants of this Contract. Nothing contained in this Contract shall create, nor be interpreted to create privity, or any other relationship whatsoever, between the County and any person, or entity or than Contractor.

F. **Reviews and Acceptance** Work performed by the Contractor shall be subject to review and acceptance in stages as required by the County. Acceptance shall not relieve the Contractor of its professional obligation to correct, at his own expense, any errors in the Work.

G. **Termination of Agreement** The Contractor understands and agrees that the date of the beginning of Work, rate of progress, and time for completion of the Work are essential conditions of this Contract. The County may, for its own convenience and at its sole option, without cause and without prejudice to any other right or remedy of County, elect to terminate the Contract by delivering to the Contractor, at the address listed in the Notices article of this Contract, a written notice of termination specifying the effective date of termination. Such notice shall be delivered to Contractor at least thirty (30) days prior to the effective date of termination. If Contractor's services are terminated by the County, the termination will not affect any rights or remedies of the County then existing or which may thereafter accrue against Contractor or its surety. In case of termination of this Contract before completion of the Work, Contractor will be paid only for the portion of the Work satisfactorily performed through the effective date of termination as determined by the County. Neither party shall be entitled to recover lost profits, special, consequential or punitive damages, attorney's fees or costs from the other party to this Contract for any reason whatsoever. This Contract shall not be deemed to provide any third-party with any remedy, claim, right of action, or other right. The parties' obligations pursuant to this Section shall survive any acceptance of Work, or termination or expiration of this Contract.

H. **Indemnification Agreement** The Contractor shall be responsible from the execution date or from the time of the beginning of the Work, whichever shall be the earlier, for all injury or damage of any kind resulting from the Work, to persons or property, including employees and property of the County. The Contractor shall exonerate, indemnify, and save harmless the County, its elected officials, officers, employees, agents and servants, hereinafter collectively referred to in this Section as "the County Indemnitees," from and against all claims or actions based upon or arising out of any damage or injury (including without limitation any injury or death to persons and any damage to property) caused by or sustained in connection with the performance of this Contract or by conditions created thereby or arising out of or any way connected with Work performed under this Contract, as well as all expenses incidental to the defense of any such claims, litigation, and actions. Furthermore, Contractor shall assume and pay for, without cost to the County Indemnitees, the defense of any and all claims, litigation, and actions suffered through any act or omission of the Contractor, or any Subcontractor, or anyone directly or indirectly employed by or under the supervision of any of them. Notwithstanding any language or provision in this Contract, Contractor shall not be required to indemnify any County Indemnitee against claims, actions, or expenses based upon or arising out of the County Indemnitee's sole negligence. As between the County Indemnitees and the Contractor as the other party, the Contractor shall assume responsibility and liability for any damage, loss, or injury, including death, of any kind or nature whatever to person or property, resulting from any kind of claim made by Contractor's employees, agents, vendors, Suppliers or Subcontractors caused by or resulting from the performance of Work under this Contract, or caused by or resulting from any error, omission, or the negligent or intentional act of the Contractor, vendors, Suppliers, or Subcontractors, or any of their officers, agents, servants, or employees. The Contractor shall defend, indemnify, and hold harmless the County Indemnitees from and against any and all claims, loss, damage, charge, or expense to which they or any of them may be put or subjected by reason of any such damage, loss, or injury. The Contractor expressly agrees to provide a full and complete defense against any claims brought or actions filed against the County Indemnitees, where such claim or action involves, in whole or in part, the subject of the indemnity contained in this Contract, whether such claims or actions are rightfully or wrongfully brought or filed. The County has the sole discretion to choose the counsel who will provide the defense. No provision of this Contract and nothing herein shall be construed as creating any individual or personal liability on the part of any elected official, officer,

employee, agent or servant of the County, nor shall the Contract be construed as giving any rights or benefits hereunder to anyone other than the parties to this Contract. The parties' obligations pursuant to this Section shall survive any acceptance of Work, or termination or expiration of this Contract.

I. **Insurance** Prior to commencing work, Contractor shall, at its sole expense, procure and maintain insurance of the types and in the amounts described below from insurer(s) authorized to transact business in the state where the work or operations will be performed by Contractor. Such insurance shall be placed with admitted insurers that maintain an A.M. Best's rating of not less than "A" (Excellent) with a Financial Size Category of VII or better with coverage forms acceptable to Contractor. The insurance described below shall be maintained uninterrupted for the duration of the project, including any warranty periods, and shall protect Contractor, and others as required by contract, for liabilities in connection with work performed by or on behalf of Contractor, its agents, representatives, employees or Contractors.

1. Certificates of Insurance in companies doing business in Georgia and acceptable to the County covering:
  - (a) Statutory Workers' Compensation Insurance, or proof that Contractor is not required to provide such coverage under State law;
    - (1) Employer's liability insurance by accident, each accident \$1,000,000
    - (2) Employer's liability insurance by disease, policy limit \$1,000,000
    - (3) Employer's liability insurance by disease, each employee \$1,000,000
  - (b) Professional Liability Insurance on the Contractor's services in this Agreement with limit of \$1,000,000;
  - (c) Commercial General Liability Insurance covering all operations with combined single limit of \$1,000,000;
  - (d) Comprehensive Automobile Liability Insurance with form coverage for all owned, non-owned and hired vehicles with combined single limit of \$1,000,000.
  - (e) Umbrella or Excess Insurance. Umbrella or excess insurance is to be provided with General Liability, Auto Liability and Employers Liability scheduled as underlying policies with limits not less than the following:  
\$5,000,000 per occurrence  
\$5,000,000 aggregate
2. Additional Insured Requirement:
  - (a) The County, its elected officials, officers, employees and agents, hereinafter referred to in this article and in the article entitled "Certificates of Insurance" as "the County and its officers" are to be named as additional insured on all policies of insurance except worker's compensation insurance with no cross suits exclusion. The County and its officers shall be included as additional insureds under commercial general liability and commercial umbrella insurance, for liabilities arising out of both the ongoing and completed operations of Contractor. Such additional insured coverage shall be endorsed to Contractor's policy by attachment of ISO Additional Insured Endorsement forms CG 20 10 10 01 (ongoing operations) and CG 20 37 10 01 (products-completed operations), or form(s) providing equivalent coverage.
  - (b) All coverages required of the Contractor will be primary over any insurance or self-insurance program carried by the County.
  - (c) If the Contractor is a joint venture involving two (2) or more entities, then each independent entity will satisfy the limits and coverages specified here or the joint venture will be a named insured under each respective policy specified.
3. Fidelity Bond coverage shall be provided. Coverage limits shall not be less than the amount scheduled in the contract.
4. Certificates of Insurance must be executed in accordance with the following provisions:
  - (a) Certificates to contain policy number, policy limits, and policy expiration date of all policies issued in accordance with this Agreement;
  - (b) Certificates to contain the location and operations to which the insurance applies;
  - (c) Certificates to contain Contractor's protective coverage for any subcontractor's

- operations;
- (d) Certificates to contain Contractor's contractual liability insurance coverage;
  - (e) Certificates are to be **issued** to:

**DeKalb County, Georgia**  
**Director of Purchasing & Contracting**  
**The Maloof Center, 2<sup>nd</sup> Floor**  
**1300 Commerce Drive**  
**Decatur, Georgia 30030**

- 5. The Contractor shall be wholly responsible for securing certificates of insurance coverage as set forth above from all subcontractors who are engaged in this work.
- 6. The Contractor agrees to carry statutory Workers' Compensation Insurance and to have all subcontractors likewise carry statutory Workers' Compensation Insurance.
- 7. Contractor agrees to waive all rights of subrogation and other rights of recovery against the County and its officers and shall cause each Subcontractor to waive all rights of subrogation for all coverage, excluding Professional E&O.
- 8. Failure of the County to demand such certificate or other evidence of full compliance with these insurance requirements or failure of the County to identify a deficiency from evidence provided will not be construed as a waiver of the Contractor's obligation to maintain such coverage. Contractor understands and agrees that the purchase of insurance in no way limits the liability of the Contractor.
- 9. Certificates shall state that the policy or policies shall not expire, be cancelled or altered without at least sixty (60) days prior written notice to the County. Policies and Certificates of Insurance listing the County and its officers as additional insureds (except for workers' compensation insurance) shall conform to all terms and conditions (including coverage of the indemnification and hold harmless agreement) contained in this Contract.
- 10. If the County shall so request, the Contractor will furnish the County for its inspection and approval such policies of insurance with all endorsements, or confirmed specimens thereof certified by the insurance company to be true and correct copies. Contractor shall be responsible and have the financial wherewithal to cover any deductibles or retentions included on the certificate of insurance.

J. Georgia Laws Govern The laws of the State of Georgia shall govern the construction of this Contract without regard for conflicts of laws. Should any provision of this Contract require judicial interpretation, it is agreed that the court interpreting or construing the same shall not apply a presumption that the terms hereof shall be more strictly construed against one party, by reason of the rule of construction, that a document is to be construed more strictly against the party who itself or through its agent prepared same; it being agreed that the agents of all parties have participated in the preparation hereof, and all parties have had an adequate opportunity to consult with legal counsel. In interpreting this Contract in its entirety, the printed provisions of this Contract, and any additions written or typed hereon, shall be given equal weight, and there shall be no inference by operation of law or otherwise; that any provision of this Contract shall be construed against either party hereto.

K. Venue This Agreement shall be deemed to have been made and performed in DeKalb County, Georgia. For the purposes of venue, all suits or causes of action arising out of this Agreement shall be brought in the courts of DeKalb County, Georgia.

L. Contractor and Subcontractor Evidence of Compliance; Federal Work Authorization Pursuant to O.C.G.A. §13-10-91, the County cannot enter into a contract for the physical performance of services unless the Contractor, its Subcontractor(s) and sub-subcontractor(s), as that term is defined by state law, register and participate in the Federal Work Authorization Program to verify specific information on all new employees. Contractor certifies that it has complied and will continue to comply throughout the Contract Term with O.C.G.A. §13-10-91 and any related and applicable Georgia Department of Labor Rule. Contractor agrees to sign an affidavit evidencing its compliance with O.C.G.A. §13-10-91. The signed affidavit is attached to this Contract as Attachment B. Contractor agrees that in the event it employs or contracts with any Subcontractor(s) in connection with this Contract, Contractor will secure from each Subcontractor an affidavit that certifies the Subcontractor's current and continuing

compliance with O.C.G.A. §13-10-91 throughout the Contract Term. Any signed Subcontractor affidavit(s) obtained in connection with this Contract shall be attached hereto as Attachment C. Each Subcontractor agrees that in the event it employs or contracts with any sub-subcontractor(s), each Subcontractor will secure from each sub-subcontractor an affidavit that certifies the sub-subcontractor's current and continuing compliance with O.C.G.A. §13-10-91 throughout the Contract Term. Any signed sub-subcontractor affidavit(s) obtained in connection with this Contract shall be attached hereto as Attachment D.

**M. County Representative** The County may designate a representative through whom the Contractor will contact the County. In the event of such designation, said representative shall be consulted and his written recommendation obtained before any request for extra work is presented to the County. Payments to the Contractor shall be made only upon itemized bill submitted to and approved by said representative.

**N. Contractor's Status** The Contractor will supervise and direct the Work, including the Work of all Subcontractors. Only persons skilled in the type of work which they are to perform shall be employed. The Contractor shall, at all times, maintain discipline and good order among his employees, and shall not employ any unfit person or persons or anyone unskilled in the work assigned him. The relationship between the County and the Contractor shall be that of owner and independent contractor. Other than the consideration set forth herein, the Contractor, its officers, agents, servants, employees, and any Subcontractors shall not be entitled to any County employee benefits including, but not limited to social security, insurance, paid annual leave, sick leave, worker's compensation, free parking or retirement benefits. All services provided by Contractor shall be by employees of Contractor or its Subcontractors and subject to supervision by Contractor. No officer or employee of Contractor or any Subcontractor shall be deemed an officer or employee of the County. Personnel policies, tax responsibilities, social security payments, health insurance, employee benefits and other administrative policies, procedures or requirements applicable to the Work or services rendered under this Contract shall be those of the Contractor, not the County.

**O. Georgia Open Records Act** Contractor shall comply with the applicable provisions of the Georgia Open Records Act, O.C.G.A. §50-18-70 *et seq.*

**P. First Source Jobs Ordinance and Preferred Employees** The Contractor is required to comply with the DeKalb County First Source Jobs Ordinance, Code of DeKalb County as Revised 1988, section 2-231 *et seq.*, and among other things, is required to make a good faith effort to hire DeKalb County residents for at least fifty percent 50% of all jobs created by an Eligible Project, as that term is defined in the First Source Ordinance, using the First Source Registry. Contractors, subcontractors, and independent contractors bidding on this contract will be encouraged by DeKalb County to have 25% or more of their labor forces for this project consist of Preferred Employees selected from the First Source Registry. The First Source Registry has Preferred Employees trained by U.S. Department of Labor registered apprenticeship programs and other partners. For information on Preferred Employees, please contact the DeKalb County Workforce Development by telephone at 404-687-3417 or 404-687-7171 or in person at 320 Church Street, Decatur, GA 30030.

**Q. Business License** Contractor shall submit a copy of its current, valid business license with this Contract. If the Contractor is a Georgia corporation, Contractor shall submit a valid county or city business license. If Contractor is a joint venture, Contractor shall submit valid business licenses for each member of the joint venture. If the Contractor is not a Georgia corporation, Contractor shall submit a certificate of authority to transact business in the state of Georgia and a copy of its current, valid business license issued by its home jurisdiction. If Contractor holds a professional license, then Contractor shall submit a copy of the valid professional license. Failure to provide the business license, certificate of authority, or professional license required by this section, may result in the Contract being terminated. Contractor shall ensure that any insurance, license, permit or certificate submitted in response to the County's RFP or as part of the Contract shall be current and valid when submitted, and shall remain valid, current and maintained in good standing for the Contract Term.

**R. Sole Agreement** This Contract constitutes the sole contract between the County and the Contractor. The terms, conditions, and requirements of this Contract may not be modified, except by Change Order. No verbal agreement or conversation with any officer, agent, or employee of the County, either before or after the execution of the Contract, shall affect or modify any of the terms or obligations herein contained. No representations, oral or written, shall be binding on the parties unless expressly

incorporated herein. No Change Order shall be enforceable unless approved by official action of the County as provided by law or in this Contract.

**S. Attachments and Appendices** This Contract includes the following Attachments and Appendices all of which are incorporated herein by reference: Attachment A, Contractor's Cost Proposal; Appendix I, County's RFP; Appendix II, Contractor's Response; Attachment B, Contractor's Affidavit; Attachment C, Subcontractor's Affidavit(s); Attachment D, Sub-subcontractor's Affidavit(s); and Attachment E, Certificate of Corporate Authority or Joint Venture Certificate.

**T. Severability** If any provision of this Contract or the application thereof to any person or circumstance shall to any extent be held invalid, then the remainder of this Contract or the application of such provision to persons or circumstances, other than those as to which it is held invalid, shall not be affected thereby, and each provision of this Contract shall be valid and enforced to the fullest extent permitted by law.

**U. Notices** Any notice or consent required to be given by or on behalf of any party hereto to any other party hereto shall be in writing and shall be sent to the County's Chief Executive Officer and the Executive Assistant or to the Contractor or his authorized representative on the work site by (a) registered or certified United States mail, return receipt requested, postage prepaid, (b) personal delivery, or (c) overnight courier service. All notices sent to the addresses listed below shall be binding unless said address is changed in writing no less than fourteen days before such notice is sent. Future changes in address shall be effective upon written notice being given by the Contractor to the County's Executive Assistant or by the County to the Contractor's authorized representative via certified first class U.S. mail, return receipt requested. Such notices will be addressed as follows:

**If to the County:**

Chief Executive Officer  
1300 Commerce Drive, 6<sup>th</sup> Floor  
Decatur, GA 30030

and

Executive Assistant  
1300 Commerce Drive  
Decatur, Georgia 30030

With a copy to: Acting Chief Procurement Officer  
1300 Commerce Drive, 2<sup>nd</sup> Floor  
Decatur, Georgia 30030

With a copy to: Director of the Finance Department  
1300 Commerce Drive  
Decatur, Georgia 30030

**If to the Contractor:**

\_\_\_\_\_,  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**V. Counterparts** This Contract may be executed in several counterparts, each of which shall be deemed an original, and all such counterparts together shall constitute one and the same Contract.

**W. Controlling Provisions** The Contract for this Project shall govern the Work. If any portion of the Contract shall be in conflict with any other portion, the various documents comprising the Contract shall govern in the following order of precedence: Contract, Change Orders or modifications issued after execution of the Contract; the provisions of the County's RFP; and the Contractor's Response thereto.

**[SIGNATURES CONTINUE ON NEXT PAGE]**

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed in three counterparts, each to be considered as an original by their authorized representative.

**DEKALB COUNTY, GEORGIA**

By: \_\_\_\_\_ (SEAL) \_\_\_\_\_ **by Dir.** (SEAL)

Signature

MICHAEL L. THURMOND  
Chief Executive Officer  
DeKalb County, Georgia

\_\_\_\_\_  
Name (Typed or Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

\_\_\_\_\_  
Federal Tax I.D. Number

\_\_\_\_\_  
Date

**ATTEST:**

**ATTEST:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
BARBARA H. SANDERS, CCC, CMC  
Clerk of the Chief Executive Officer  
and Board of Commissioners of  
DeKalb County, Georgia

\_\_\_\_\_  
Name (Typed or Printed)

\_\_\_\_\_  
Title

**APPROVED AS TO SUBSTANCE:**

**APPROVED AS TO FORM:**

\_\_\_\_\_  
Department Director

\_\_\_\_\_  
County Attorney Signature

\_\_\_\_\_  
County Attorney Name (Typed or Printed)

**SAMPLE COUNTY CONTRACT**

**ATTACHMENT A**

**Contractor's Cost Proposal**



“The County’s Request for  
Proposals (RFP) No. 19-500511”

## **SAMPLE COUNTY CONTRACT**

### **APPENDIX I**

“Excerpts from the Contractor’s  
*Response to the County’s Request*  
for Proposals (RFP) No. 19-500511”

## **SAMPLE COUNTY CONTRACT**

## **APPENDIX II**

**SAMPLE COUNTY CONTRACT  
ATTACHMENT B**

**Contractor Affidavit under O.C.G.A. §13-10-91**

By executing this affidavit, the undersigned Contractor verifies its compliance with O.C.G.A. §13-10-91, stating affirmatively that the individual, firm or corporation which is engaged in the physical performance of services on behalf of DEKALB COUNTY has registered with, is authorized to use and uses the federal work authorization program commonly known as E-Verify, or any subsequent replacement program, in accordance with the applicable provisions and deadlines established in O.C.G.A. §13-10-91. Furthermore, the undersigned Contractor will continue to use the federal work authorization program throughout the Contract Term and the undersigned Contractor will contract for the physical performance of services in satisfaction of such contract only with Subcontractors who present an affidavit to the Contractor with the information required by O.C.G.A. §13-10-91. Contractor hereby attests that its federal work authorization user identification number and date of authorization are as follows:

\_\_\_\_\_  
Federal Work Authorization User Identification Number

\_\_\_\_\_  
Date of Authorization

\_\_\_\_\_  
Name of Contractor

Emergency Ambulance Service Provider for DeKalb County, Georgia

Name of Project

DeKalb County Georgia Government

Name of Public Employer

I hereby declare under penalty of perjury that the foregoing is true and correct.

Executed on \_\_\_\_\_, 20\_\_ in \_\_\_\_\_ (city), \_\_\_\_\_ (state).

By: \_\_\_\_\_  
Signature of Authorized Officer or Agent

\_\_\_\_\_  
Printed Name and Title of Authorized Officer or Agent

Subscribed and Sworn before me on this the  
\_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

\_\_\_\_\_  
NOTARY PUBLIC  
My Commission Expires:  
\_\_\_\_\_

**SAMPLE COUNTY CONTRACT  
ATTACHMENT C**

**Subcontractor Affidavit under O.C.G.A. § 13-10-91**

By executing this affidavit, the undersigned Subcontractor verifies its compliance with O.C.G.A. § 13-10-91, stating affirmatively that the individual, firm or corporation which is engaged in the physical performance of services under a contract with \_\_\_\_\_ (insert name of Contractor) on behalf of DEKALB COUNTY, GEORGIA has registered with, is authorized to use and uses the federal work authorization program commonly known as E-Verify, or any subsequent replacement program, in accordance with the applicable provisions and deadlines established in O.C.G.A. § 13-10-91. Furthermore, the undersigned Subcontractor will continue to use the federal work authorization program throughout the contract period and the undersigned subcontractor will contract for the physical performance of services in satisfaction of such contract only with sub-subcontractors who present an affidavit to the Subcontractor with the information required by O.C.G.A. § 13-10-91. Additionally, the undersigned Subcontractor will forward notice of the receipt of an affidavit from a sub-subcontractor to the Contractor within five business days of receipt. If the undersigned Subcontractor receives notice that a sub-subcontractor has received an affidavit from any other contracted sub-subcontractor, the undersigned Subcontractor must forward, within five business days of receipt, a copy of the notice to the Contractor. Subcontractor hereby attests that its federal work authorization user identification number and date of authorization are as follows:

\_\_\_\_\_  
Federal Work Authorization User Identification Number

\_\_\_\_\_  
Date of Authorization

\_\_\_\_\_  
Name of Subcontractor

Emergency Ambulance Service Provider for DeKalb County, Georgia  
Name of Project

DeKalb County Georgia Government  
Name of Public Employer

I hereby declare under penalty of perjury that the foregoing is true and correct.

Executed on \_\_\_\_\_, 20\_\_ in \_\_\_\_\_ (city), \_\_\_\_\_ (state).

By: \_\_\_\_\_  
Signature of Authorized Officer or Agent

\_\_\_\_\_  
Printed Name and Title of Authorized Officer or Agent

Subscribed and Sworn before me on this the  
\_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
NOTARY PUBLIC

My Commission Expires:

**SAMPLE COUNTY CONTRACT  
ATTACHMENT D**

**Sub-subcontractor Affidavit under O.C.G.A. § 13-10-91**

By executing this affidavit, the undersigned sub-subcontractor verifies its compliance with O.C.G.A. § 13-10-91, stating affirmatively that the individual, firm or corporation which is engaged in the physical performance of services under a contract for \_\_\_\_\_ (name of subcontractor or sub-subcontractor with whom such sub-subcontractor has privity of contract) and \_\_\_\_\_ (name of Contractor) on behalf of DEKALB COUNTY, GEORGIA has registered with, is authorized to use and uses the federal work authorization program commonly known as E-Verify, or any subsequent replacement program, in accordance with the applicable provisions and deadlines established in O.C.G.A. § 13-10-91. Furthermore, the undersigned sub-subcontractor will continue to use the federal work authorization program throughout the contract period and the undersigned sub-subcontractor will contract for the physical performance of services in satisfaction of such contract only with sub-subcontractors who present an affidavit to the sub-subcontractor with the information required by O.C.G.A. § 13-10-91(b). The undersigned sub-subcontractor shall submit, at the time of such contract, this affidavit to \_\_\_\_\_ (name of Subcontractor or sub-subcontractor with whom such sub-subcontractor has privity of contract). Additionally, the undersigned sub-subcontractor will forward notice of the receipt of any affidavit from a sub-subcontractor to \_\_\_\_\_ (name of Subcontractor or sub-subcontractor with whom such sub-subcontractor has privity of contract). Sub-subcontractor hereby attests that its federal work authorization user identification number and date of authorization are as follows:

\_\_\_\_\_  
Federal Work Authorization User Identification Number

\_\_\_\_\_  
Date of Authorization

\_\_\_\_\_  
Name of Sub-subcontractor

Emergency Ambulance Service Provider for DeKalb County, Georgia

\_\_\_\_\_  
Name of Project

DeKalb County Georgia Government

\_\_\_\_\_  
Name of Public Employer

I hereby declare under penalty of perjury that the foregoing is true and correct.

Executed on \_\_\_\_\_, 20\_\_ in \_\_\_\_\_ (city), \_\_\_\_\_ (state).

By: \_\_\_\_\_

Signature of Authorized Officer or Agent

\_\_\_\_\_  
Printed Name and Title of Authorized Officer or Agent

Subscribed and Sworn before me on this the  
\_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

\_\_\_\_\_  
NOTARY PUBLIC

My Commission Expires: \_\_\_\_\_

**SAMPLE COUNTY CONTRACT  
ATTACHMENT E  
CERTIFICATE OF CORPORATE RESOLUTION**

I, \_\_\_\_\_, certify the following:

That I am the duly elected and authorized Secretary of \_\_\_\_\_ (hereinafter referred to as the “\_\_\_\_\_”), an \_\_\_\_\_ organized and incorporated to do business under the laws of the State of \_\_\_\_\_;

That said corporation has, through lawful resolution of the Board of Directors of the corporation, duly authorized and directed \_\_\_\_\_, in his official capacity as \_\_\_\_\_ of the corporation, to enter into and execute the following described agreement with DeKalb County, a political subdivision of the State of Georgia:

Emergency Ambulance Service Provider for DeKalb County, Georgia;

That the foregoing Resolution of the Board of Directors has not been rescinded, modified, amended, or otherwise changed in any way since the adoption thereof, and is in full force and effect on the date hereof.

IN WITNESS WHEREOF, I have set my hand and corporate seal;

This the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

(CORPORATE  
SEAL)

\_\_\_\_\_  
(Secretary)

## ATTACHMENT G

### PROPOSER AFFIDAVIT

By executing this affidavit, the undersigned verifies its compliance with O.C.G.A. § 13-10-91, as amended, stating affirmatively that the Proposer submitting a proposal to DEKALB COUNTY, GA, a political subdivision of the State of Georgia, has registered with and is participating in a federal work authorization program\* [any of the electronic verification of work authorization programs operated by the United States Department of Homeland Security or any equivalent federal work authorization program operated by the United States of Homeland Security to verify information of newly hired employees, pursuant to the Immigration Reform and Control Act of 1986 (IRCA), P.L. 99-603], in accordance with the applicability provisions and deadlines established in O.C.G.A. § 13-10-91, as amended].

---

Proposer's Name

---

Federal Work Authorization  
Enrollment Date

---

BY: Authorized Officer or Agent

---

Title of Authorized Officer or Agent of Proposer

---

Identification Number

---

Printed Name of Authorized Officer or Agent

---

Address (\*do not include a post office box)

SUBSCRIBED AND SWORN

BEFORE ME ON THIS THE

\_\_\_\_\_ DAY OF \_\_\_\_\_, 20\_\_

---

Notary Public

My Commission Expires: \_\_\_\_\_



## ATTACHMENT H

### **FIRST SOURCE JOBS ORDINANCE INFORMATION** **(WITH EXHIBITS 1 – 4)**

#### **EXHIBIT 1**

#### **FIRST SOURCE JOBS ORDINANCE ACKNOWLEDGEMENT**

The DeKalb County First Source Ordinance requires contractors or beneficiaries of eligible projects entering into any type of agreement with the County, including purchase orders, regardless of what they may be called, for the procurement or disposal of supplies, services, construction projects, professional or consultant services, which is funded in whole or part with County funds or County administered funds in which the contractor is to receive \$50,000 or more in County expenditures or committed expenditures and recipient of urban redevelopment action grants or community development block funds administered in the amount of \$50,000 or more to make a good faith effort to hire DeKalb County residents for at least 50% of jobs created using the First Source Registry (candidate database) within one hundred twenty (120) days of contract execution. The work to be performed under this contract is subject to the provisions of the DeKalb County First Source Jobs Ordinance. All contractors will be asked to submit an Employment Roster and/or copies of active payroll registers on a monthly basis to verify compliance. The undersigned acknowledges and agrees to comply with the provisions of the DeKalb County First Source Jobs Ordinance.

#### **CONTRACTOR OR BENEFICIARY INFORMATION:**

---

Contractor or Beneficiary Name (Signature)

---

Contractor or Beneficiary Name (Printed)

---

Title

---

Telephone

---

Email

---

Name of Business

Please answer the following questions:

1. How many job openings do you anticipate filling related to this contract? \_\_\_\_\_
2. How many incumbents/existing employees will retain jobs due to this contract?  
DeKalb Residents: \_\_\_\_\_ Non-DeKalb Residents: \_\_\_\_\_
3. How many work hours per week constitutes Full Time employment? \_\_\_\_\_

**Please return this form to WorkSource DeKalb, (404)687-3900 or email to [fkadkins@dekalbCountyga.gov](mailto:fkadkins@dekalbCountyga.gov), [malee@dekalbCountyga.gov](mailto:malee@dekalbCountyga.gov), [vlricksion@dekalbCountyga.gov](mailto:vlricksion@dekalbCountyga.gov), or [jmjonas@dekalbCountyga.gov](mailto:jmjonas@dekalbCountyga.gov)**

*WorkSource DeKalb (WSD) is an EEO/M/F/D/V employer/program. Auxiliary aids/services are available upon request to individuals with disabilities. Persons with hearing impairments may call 1-800-255-0135 or 711 TTY for assistance. WSD is 100% funded by the U. S. Department of Labor and is a proud partner of the American Job Center Network. Revised March 2018*



**FIRST SOURCE JOBS ORDINANCE INFORMATION**

**EXHIBIT 2**

**NEW EMPLOYEE TRACKING FORM**

**Name of Proposer/Responder** \_\_\_\_\_

**Address** \_\_\_\_\_

**E-Mail** \_\_\_\_\_

**Phone Number** \_\_\_\_\_

**Fax Number** \_\_\_\_\_

**Do you anticipate hiring from the First Source Candidate Registry? Y or N (Circle one)**

**If so, the approximate number of employees you anticipate hiring:**

<b>Type of Position (s) you anticipate hiring: (List position title, one position per line) Attach job description per job title:</b>	<b>The number you anticipate hiring:</b>	<b>Timeline</b>

**Please return this form to WorkSource DeKalb, fax (404) 687-4099 or email to  
FirstSourceJobs@dekalbCountyga.gov.**

**FIRST SOURCE JOBS ORDINANCE INFORMATION**  
**EXHIBIT 3**

**BUSINESS SERVICE REQUEST FORM**

**Please note: We need one form completed for each position that you have available.**

**FEDERAL TAX ID:**

**COMPANY NAME:**

**WEBSITE:**

**ADDRESS:**

**(WORKSITE ADDRESS IF DIFFERENT):**

**CONTACT NAME:**

**CONTACT PHONE:**

**CONTACT FAX:**

**CONTACT E-MAIL ADDRESS:**

**Are you a private employment agency or staffing agency?** ☐YES ☐NO

---

**JOB DESCRIPTION: (PLEASE INCLUDE A COPY OF JOB DESCRIPTION)**

**POSITION TITLE:**

**NUMBER OF POSITIONS AVAILABLE:**\_\_\_\_\_ **TARGET START DATE:**\_\_\_\_\_

**WEEKLY WORK HOURS:**    20-30 hours ☐        30-40 hours ☐        Other ☐

**SPECIFIC WORK SCHEDULE:**

**SALARY RATE(OR RANGE):**

**PERM** ☐        **TEMP** ☐        **TEMP-TO-PERM** ☐        **SEASONAL** ☐

**PUBLIC TRANSPORTATION ACCESSIBILITY**    **YES** ☐        **NO** ☐

**IF SCREENINGS ARE REQUIRED, SELECT ALL THAT APPLY:**

☐CREDIT ☐DRUG ☐MVR ☐BACKGROUND ☐OTHER \_\_\_\_\_

**Please return form to: Business Solutions Unit (First Source)**

774 Jordan Lane Bldg. #4

Decatur, Ga. 30033

Phone: (404) 687-3400

FirstSourceJobs@dekalbCountyga.gov

## EMPLOYMENT ROSTER

### DeKalb County

19-500511-RFP Page 71

## EXHIBIT 1

### Unit Dispatch Criteria

#### Priority Code Categorization

Dekalb County Fire Rescue Priority Codes generally adhere to the International Academy of Emergency Medical Dispatch's Medical Priority Dispatch System call determinate categorizations.

Priority	Summary
1	Lights and siren, hot response. Call determined to require immediate response for the purpose of initiating life safety interventions. May include active cardiac arrests, ineffective breathing, choking with complete obstructions, drowning, etc.
2	Lights and siren, hot response. Call that may require rapid advanced life support intervention. May include not alert abdominal pain, allergies with difficulty speaking, assault and unconscious, chest pain and difficulty speaking, continuous seizures, etc.
3	Lights and siren, hot response. Call that may require advanced life support response. May include abnormal breathing, significant facial burns, chest pain with abnormal breathing, diabetic emergency with abnormal behavior, etc.
4	Lights and siren, hot response. Call that may require rapid intervention. May not require advanced life support. May include animal bite with serious hemorrhage, inhalation injury alert without difficulty breathing, eye problem with severe eye injuries, fall with injury to possibly dangerous body area, etc.
5	No lights or siren, cold response. Call that does not require rapid intervention. Does not require advanced life support. May include a minor burn, chest pain where caller is breathing normally and under 35, minor eye injury, headache and breathing normally, minor hemorrhage, sick with no priority symptoms, etc.

# **DeKalb County Fire Rescue Patient Care Protocols Guidelines and Procedures**



**Dr. William Hardcastle , MD  
Darnell Fullum, Fire Rescue Director**

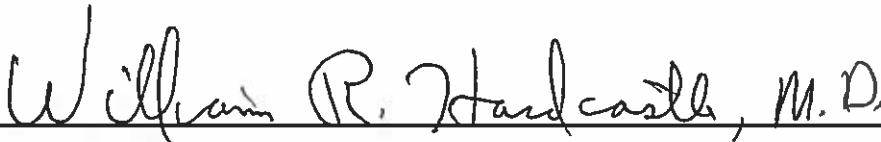
**2016**

Approved March 2016 by Fire Rescue Director  
Darnell Fullum and Dr. W. Hardcastle  
Effective April 1, 2016




---

Darnell Fullum, Fire Rescue Director



---

William Hardcastle, MD

 <b>DeKalb County Fire Rescue</b>	Medical Director:	William Hardcastle, MD
	Fire Rescue Director:	Darnell Fullum
	Effective Date:	April 1, 2016


## Revisions

The following revisions have been made on the date indicated above the change.

**Issued July 2013, Implemented August 1, 2013**


**Revised August 2013, Implemented August 7, 2013**

**Revised March 2016, Implemented April 1, 2016**

 <b>DeKalb County Fire Rescue</b>	Medical Director:	William Hardcastle, MD
	Fire Rescue Director:	Darnell Fullum
	Effective Date:	April 1, 2016

# FOR FUTURE REVISIONS



 <b>DeKalb County Fire Rescue</b>	Medical Director:	William Hardcastle, MD
	Fire Rescue Director:	Darnell Fullum
	Effective Date:	April 1, 2016

# FOR FUTURE REVISIONS



**DeKalb County  
Fire Rescue**

Medical Director: William Hardcastle, MD

Fire Rescue Director: Darnell Fullum

Effective Date: April 1, 2016

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**DeKalb County  
Fire Rescue**

Medical Director:

William Hardcastle, MD

Fire Rescue Director:

Darnell Fullum

Effective Date:

April 1, 2016

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**DeKalb County  
Fire Rescue**

Medical Director: William Hardcastle, MD

Fire Rescue Director: Darnell Fullum

Effective Date: April 1, 2016

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**DeKalb County  
Fire Rescue**

Medical Director: William Hardcastle, MD

Fire Rescue Director: Darnell Fullum

Effective Date: April 1, 2016

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**DeKalb County  
Fire Rescue**

Medical Director: William Hardcastle, MD

Fire Rescue Director: Darnell Fullum

Effective Date: April 1, 2016

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**DeKalb County  
Fire Rescue**

Medical Director: William Hardcastle, MD

Fire Rescue Director: Darnell Fullum

Effective Date: April 1, 2016

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# **Administrative**



 <b>DeKalb County Fire Rescue</b>	Medical Director:	William Hardcastle, MD
	Fire Rescue Director:	Darnell Fullum
	Effective Date:	April 1, 2016

## General Information

### **Purpose**

The purpose of this document is to provide knowledge and direction through protocols regarding permissible and appropriate emergency medical services procedures and treatment modalities which may be rendered by medics to a patient not in the hospital, and protocols regarding which medical situations require direct voice communication between medics and a physician (or his/her designee) prior to those medics rendering specified emergency medical services procedures to a patient not in a hospital.

The protocol sections include direction on guidelines of actions, procedures and clinical patient care management and can be found in the sections of Administrative, General, Pediatric Protocols, and Adult Protocols. Additional information that is not provided as protocol but as reference material is the Medication and Resource sections.

### **Professional Judgment**

Since each medical emergency must be dealt with on an individual basis and appropriate care determined accordingly, professional judgment is mandatory in determining treatment modalities within the parameters of these guidelines. If at any time the patients condition changes, move to the most appropriate protocol. It may be necessary to use more than one or even multiple protocols to appropriately manage the patient.


Personnel will make every effort to avoid conflict about patient care. If any provider believes care should be provided including transport other providers will cooperate by the recommendation. If a disagreement regarding care can not be agreed upon, providers will consult with a medical supervisor or medical control as the situations deems necessary.

Appropriate equipment should be anticipated and brought to the patient preventing delays in care. A suspicion for ALS intervention and/or a significant distance from the units should be carefully considered. When in doubt take the equipment that would manage the most severe patient condition.

### **Authority**

The authority for implementing these guidelines for care of pre-hospital patients is found in state law OCGA 31-11-60.1 (b) and (c), OCGA 31-11-50 (b), and the Rules of the Department of Public Health Chapter 511-9-2.

It is the responsibility of each medic to be familiar with the laws, rules and regulations, and guidelines and adhere to them. Even an order by a physician does not justify procedures not in accordance with laws, rules and regulations.

 <b>DeKalb County Fire Rescue</b>	Medical Director:	William Hardcastle, MD
	Fire Rescue Director:	Darnell Fullum
	Effective Date:	April 1, 2016

## Definitions

**The followings definitions are included in this section, for clarification purposes**

**DCFR Personnel or DCFR/EMS personnel**– This abbreviation is used throughout the protocols and refers to the personnel employed by DeKalb County Fire Rescue and personnel employed by the private EMS vendor selected by DeKalb County Fire Rescue to provide EMS care and transport.

**Effective Date** – This refers to the date that each Patient Care Guideline, Protocol or Procedure is expected to be followed. Each time one of these documents is changed a new *Effective Date* will be assigned. The Patient Care Protocols will be reviewed/changed as needed in order to provide the most up-to-date care. If a current Protocol is reviewed only a *Reviewed Date* will be documented.


**Medic** – This term will be used throughout the Patient Care Protocols to refer to DeKalb County Fire Rescue personnel or the private EMS contracted vendor personnel that are certified in the state of Georgia as an EMT, EMT-Intermediate (EMT-I), Advanced EMT (AEMT), Cardiac Technician (CT), or a Paramedic.

**Medical Control** – This refers to the hospital that your patient will be transported to, otherwise known as, the receiving facility. The hospital that you contact concerning requested orders, destination information, or to advise of Protocols used, becomes medical control for that particular patient.

**Medical Control Physician** – This refers to a physician at the hospital that your patient will be transported to, thus providing medical control for that particular patient. The medical control physician may provide guidance / direction concerning the management of the patient you are transporting to their facility.



**Preceptor** – An Georgia state certified EMS provider who has successfully taken a state approved preceptor course with successful completion. A Preceptor may mentor students whole level of certification is equal to or less than the scope of practice of Preceptor. A preceptor may not mentor EMS providers above the scope of practice of the preceptors Georgia certification. Students may perform skills they have been trained to perform while they are in attendance of a Preceptor and meet the requirements as stated in this definition.

**\*Special note concerning VA Hospital patients** – Any medical control orders for patients transported to the VA Hospital should be obtained from DeKalb Medical Center, the VA does not issue medical procedure approvals for pre-hospital services. Likewise, the physician's signature for requested orders or for the use of a Patient Care Protocol should be obtained from a physician from DeKalb Medical Center. The VA is not required to follow COBRA law and can refuse to accept any patient no matter of the patient's wishes.

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## Legend

The following chart provides explanations for icons and graphics found throughout the guidelines. An explanation of abbreviations utilized in specific protocols can be found in the resources section of this document.

	Emphasizes important points and reminders within guidelines
<p>Icons below indicate a procedure that is specific for the level of provider indicated in accordance with state and local laws. <b><i>All procedures must be performed in accordance with the Georgia Scope of Practice for EMS Personnel.</i></b></p> <p><b>P</b> <i>Paramedic intervention only</i></p> <p><b>CP</b> <i>Cardiac Technician and Paramedic intervention only</i></p> <p><b>ACP</b> <i>Adv. EMT, Cardiac Technician and Paramedic intervention only</i></p> <p><b>IACP</b> <i>EMT-Intermediate, Advanced EMT, Cardiac Technician and Paramedic intervention only</i></p> <p><b>EIACP</b> <i>EMT, EMT-Intermediate, Advanced EMT, Cardiac Technician and Paramedic intervention only</i></p>	
	Indicates the point within each protocol at which contact with medical control should be made. Treatments provided beyond this point should be performed in conjunction with online medical direction.

# General Protocols



**DeKalb County  
Fire Rescue**

Medical Director: William Hardcastle, MD


Fire Rescue Director: Darnell Fullum

Effective Date: April 1, 2016

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## Authorized to Consent

In situations when the patient may not be able to consent to treatment, the following list identifies others who are authorized to consent if the patient is unable.

### Persons authorized to consent, according to O.C.G.A. – Section 31-9-2(a) items (1) through (6)


- Any adult, for himself, whether by living will or otherwise;
- Any person authorized to give consent for the adult under a health care agency complying with the “Durable Power of Attorney for Health Care Act”;
- In the absence or unavailability of a living spouse, any parent, whether an adult or a minor, for his minor child;
- Any married person, whether an adult or minor, for himself and for his spouse;
- Any person temporarily standing in loco parentis, whether formally serving or not, for the minor under his care; and any guardian, for his ward;
- Any female, regardless of age or marital status, for herself when given in connection with pregnancy or childbirth;
- Upon the inability of any adult to consent for himself and in the absence of any person identified above in (c) through (f), the following persons, in the following order of priority may provide consent:
  - Any adult child, for his parents;
  - Any parent, for his adult child;
  - Any adult, for his brother or sister;
  - Any grandparent, for his grandchild;

## Patient Criteria



Personnel must clearly differentiate between calls where a person on scene denies illness/injury yet must be identified as a patient due to the nature of the incident or information relayed by bystanders, family or other resources. Persons identified in the following criteria are considered patients and require a thorough assessment and treatment as indicated unless the patient refuses any or all care:

- Persons who appears ill, in distress or with visible injury
- Persons that verbalizes a complaint regardless of the severity or nature of complaint
- Persons meeting Field Triage of Injured Patients or also known as Trauma Triage Criteria
- Persons appearing to be under the influence of drugs or alcohol or have an altered level of consciousness
- Persons threatening to harm himself or herself or are suspected of having already caused harm
- The above criteria are not inclusive of every situation where care of a patient may be necessary
- If the person is identified as a patient and refuses assessment or care follow the Refusal Guidelines of this document

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## Communications (Page 1 of 3)

**Early notification of Stroke, STEMI and patient's meeting Trauma Triage Criteria is essential.**

1. The DeKalb County Communications Center can be contacted from the landline at 678-406-7936 (recorded line) to assist you with a recorded conversation and should be the first line method of communicating with hospital personnel to request orders or assist from ED personnel.
2. The cellular phone assigned to the Unit should only be used when medics are unable to communicate by land line as indicated above. This line is not recorded, however; the cell phone can be used to contact DeKalb County Communications Center at the number listed above to a recorded line.

When contacting Medical Control and receiving facilities, patient reports should be brief and clear. 10 codes and other signals should not be used. A typical patient radio report should include the following:

- Identify Unit by service, number, and level of capability (BLS or ALS)
- Specify en route or on scene (state whether Emergency or Non-Emergency).
- Identify patient age and sex.
- Chief complaint/Mechanism of Injury
- LOC: AVPU
- Vital signs, pertinent clinical findings
- Pertinent patient medications, allergies, past history
- Care and treatment given.
- Patient's response to treatment.
- Request for any orders.
- ETA.

According to capability of receiving facility, patient report may be called in as alert or activation of Trauma, STEMI, or Stroke Alert.

The following information **should not** be transmitted over the radio:


- Patient name
- Patient race
- Personal or sensitive patient information (e.g., Social Security number, history of AIDS, etc.)

### **Medical Control must be notified in the following conditions / situations:**

- Whenever a patient is transported to a hospital prior to the transporting units arrival
- When the medics are unsure as to the most appropriate treatment or destination
- Suicidal patients who refuse treatment and/or transport
- Incidents involving multiple patient transports
- Patients requiring isolation upon arrival at ED
- Patients who are in full spinal immobilization
- Combative patients or those who will require additional resources from the ED or hospital security
- If you are transporting a patient who has been exposed to a Hazardous Material or has been or will need decontamination prior to entry into the ED

### **Cardiac Arrest Communications:**

- Once a patient is confirmed to be in cardiac arrest, Medics should contact the probable or requested facility as soon as possible, in order for the receiving ED to prepare for the patient as soon as possible.

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## Communication (Page 2 of 3)

### **Patient Report Guideline - Medical Patients**

**The following radio script should be used in the sequence presented**

#### **Primary Report:**

- Rank and name of medic
- Unit number
- Confirm that radio transmission is acceptable
- State the purpose for the transmission (**Requesting orders or relaying patient information**)
- Provide an ETA
- Provide age, sex, and weight of patient, if applicable
- Provide the chief complaint, pertinent Hx, medications and allergies of patient
- Provide your assessment findings, such as V/S, EKG, glucose level; treatment performed by others PTA of your unit, etc.
- Advise of the treatment that you have performed, and whether it was by PCP, (Patient Care Protocol), or earlier contact with medical control
- Request orders or confirm that you are not requesting orders, only relaying information
- If orders are received or denied, repeat the order or the denial of the order back to ED personnel


### **Patient Report Guideline - Patients meeting Trauma Triage Criteria (TTC) (also referred to as Field Triage Criteria)**

**The following radio script should be used in the sequence presented**

#### **Primary Report:**

- Rank and name of medic
- Unit number
- Confirm that radio transmission is acceptable
- Advise ED personnel that you have a patient who meets TTC, specify which category, and include the MOI
- Confirm whether or not the hospital can accept the patient
- Advise ED personnel that you will provide a more detailed secondary report, and an ETA, as soon as possible (If they accept your patient)



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### Communication (Page 3 of 3)

#### **Secondary Report:**

- Rank and name of medic
- Unit number
- Confirm that the radio transmission is acceptable
- State the purpose for the transmission (**Requesting orders or relaying patient information**)
- Provide an ETA
- Provide age, sex, and weight of patient, if applicable
- Re-advise the MOI
- Provide the chief complaint, pertinent Hx, medications, and allergies of patient
- Provide your assessment findings, such as V/S, EKG, glucose level; treatment performed by others PTA of your unit, etc.
- Relay the details about the treatment that you have performed, and whether it was by PCP's or earlier contact with medical control
- Request orders, or confirm that you are not requesting orders, only relaying information
- If orders are received or denied, repeat the order or the denial of the order back to ED personnel


#### **Note:**



**For trauma patients who do not meet Trauma Triage Criteria (TTC) follow the secondary report guideline**



**Advise Fire Ops Radio as soon as possible if you will be transporting**

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## Control of Patient Care: Physician On Scene

Control of patient care at the scene of an emergency shall be the responsibility of the individual in attendance most appropriately trained and knowledgeable in providing pre-hospital emergency stabilization and transport. When a medic arrives at the scene of a medical emergency, and contact is made with medical control by that medic, a physician/patient relationship is established between the patient and the physician providing medical control. The physician is responsible for the management of the patient and the medic acts as an agent of medical control unless the patient's physician is present. When a physician other than the patient's physician on the scene of a medical emergency properly identifies himself and demonstrates his willingness to assume responsibility for patient management and documents his intervention by signing the patient care report, the medic should place the intervening physician in communication with medical control. If there is disagreement between the intervening physician and the medical control physician, or if the intervening physician refuses to speak with medical control, the medic should continue to take orders from the medical control physician.

Reference: DPH Rule 511-9-2-.07 (6) (i) Control of patient care at the scene.

### Intervener Physician


An intervener physician is a physician on the scene who has no previous connection with the patient. For the Good Samaritan physician to assume control of the patient he/she must:

- Provide proof of licensure in Georgia.
- Be willing to assume responsibility for the patient at the scene and during patient transportation to the hospital. This includes accompanying the patient during transportation (except multi-casualty situations).
- Perform procedures outside the scope of EMS protocol his or herself.

If the physician is unwilling to comply with these requirements then his assistance should be respectfully declined.

### Physician in his/her Office


1. Personnel shall perform their duties per protocol.
2. The physician may elect to supervise care provided by DCFR/EMS Personnel.
3. If the physician directs DCFR/EMS Personnel to perform a procedure or administer a medication which is not covered by protocol, then DCFR/EMS Personnel shall advise him/her of such. **DCFR/EMS personnel will not perform this procedure.** DCFR/EMS Personnel may assist the physician in performing the procedure if it is within their Scope of Practice. If the physician initiates a medication which is to be continued during patient transportation, which is not covered by scope or protocol, then the physician is expected to accompany the patient to the hospital.

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## Crime Scene

If you believe a crime has been committed, immediately contact law enforcement. Scene safety is paramount. Protect yourself and other DCFR/EMS personnel. Once a crime scene is deemed safe by law enforcement, initiate patient contact and medical care.

- Do not touch or move anything at a crime scene unless it is necessary to do so for patient care.
- DCFR/EMS Personnel should not routinely attempt to secure crime scene evidence unless the patient's condition dictates immediate treatment or transport.
- Have all Personnel use the same path of entry and exit.
- Do not walk through fluids on the floor.
- Observe and document original location of items moved by crew.
- When removing patient clothing, leave it intact as much as possible.
- Do not cut through clothing holes made by gunshot or stabbing.
- If you remove any items from the scene, such as impaled objects or medication bottles, document your actions and advise investigating officers.
- Do not sacrifice patient care to preserve evidence.
- Do not go through the patient's personal effects.
- If transporting, inform staff at the receiving hospital that this is a "crime scene" patient.
- In the event DCFR/EMS personnel are in a position that necessitates securing potential evidence:
  - Any items that are potential evidence must be bagged in a brown paper bag. Items that are placed in plastic bags will putrefy.
  - Any jewelry that needs to be removed due to an injury should be bagged as evidence.
  - Any clothing that the patient is wearing should be left on if possible. If clothing has to be cut, to visualize an injury, it should be cut as little as possible. Also do not cut through any holes in the clothing.
  - If the patient is wrapped in a sheet, due to not being clothed or having to remove clothing, the sheet should be bagged for evidence.
  - Any gauze dressings that are used to treat the patient should be bagged as evidence. When cleansing the site for an IV, only cleans the site.

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## Destination Decisions (Page 1 of 5)

### Definitions

The following terms are defined for clarification purposes:

Specialty care facilities—Facilities that provide specialized equipment and expertise to manage a specific patient care need.

Informed consent decisions—Decisions made by the conscious, competent, and rational patient/guardian regarding the care to be initiated. Transportation to the hospital is considered a form of patient care. Associated risks and consequences must be explained and the patient/guardian must understand them to properly provide an informed consent decision.

PCI capable hospital - A hospital that has the equipment, expertise and facilities to administer percutaneous coronary intervention (PCI), a mechanical means of treating heart attack patients. PCI is the preferred means of treating STEMI (ST Elevation MI) patient.


Field Triage Criteria—The criteria developed to classify injuries that may require a trauma center (also referred to as Trauma Triage Criteria)

Burn Center Criteria—The criteria developed to classify burns that may require a burn center

Reasonable distance—All hospitals listed in this document are considered to be within a reasonable distance, and are approved by our Medical Director for transport to their Emergency Departments.

“Closest Appropriate ER”—The intention of this “Destination Decisions” protocol to provide continued quality care through the safest and most rapid arrival to an ER that is able to provide the necessary specialty care for the patient’s condition. The intention of specifying in this “Destination Decisions” protocol with the term “closest” ER is to provide a quick reference for the medic. It is logical that in some circumstances such as road construction or traffic hazards that the “closest” specialty care ER may not be the most rapidly reached by ground or air transportation. The medic must consider the intention of this document when determining where to transport the patient. Documentation on the PCR should include why the specific ER destinations were chosen if the “closest” specialty care ER is not the receiving hospital.

**Special note concerning VA Hospital patients** – Any medical control orders for patients transported to the VA Hospital should be obtained from DeKalb Medical Center, the VA does not issue medical procedure approvals for pre-hospital services. Likewise, the physician’s signature for requested orders or for the use of a Patient Care Protocol should be obtained from a physician from DeKalb Medical Center. The VA is not required to follow COBRA law and can refuse to accept any patient no matter of the patient’s wishes.


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## Destination Decisions (Page 2 of 5)

The following destination guidelines should be followed unless directed otherwise by the patient, patient's guardian, or physician.

Condition	Adult 15 yrs and older	Pediatrics 14 yrs & younger
<b>Traumatic Arrest</b>	Closest Adult <u>Trauma</u> Center	Closest Pediatric <u>Trauma</u> Center (Egleston, Scottish Rite)
<b>Medical Cardiac Arrest</b>	Closest Adult ED	Closest Pediatric ED (Egleston, Hughes Spalding, Scottish Rite)
<b>Inadequate/Unmanageable Airway</b> (needle cric., airway trauma, FBAO, airway edema)	Closest ED	Closest ED
<b>Meeting Field Triage Criteria</b> (Refer to Resource Section; "CDC Field Triage of Injured Patients")	Closest Adult <u>Trauma</u> Center	Closest Pediatric <u>Trauma</u> Center (Egleston, Scottish Rite)
<b>STEMI</b>	Closest Adult <u>PCI</u> ED	Closest Pediatric <u>PCI</u> ED (Egleston)
<b>Stroke</b>	Closest Adult <u>Stroke</u> Center	Closest Pediatric <u>Stroke</u> Center (Egleston)
<b>Meeting Burn Center Criteria</b>	Closest Burn Center	Closest Burn Center
<b>CO Poisoning</b>	Closest <u>Hyperbaric</u> Center ED	Closest <u>Hyperbaric</u> Center ED

**In trauma with adult and pediatric and no other ambulance is available take the most critical patient to the most appropriate facility with the least critical patient.**

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## Destination Decisions (Page 3 of 5)

### Hospital Diversions (Patients/Guardians *Able* to Decide)


If a patient or guardian requests transport to an ED on diversion:

- Contact the ED on a **recorded line** and provide a detailed patient report. If the ED personnel advise that they cannot accept the patient, verify the reason for the diversion if it is not already clear. Obtain the **name** of the physician who is diverting the patient.
- Explain the situation to the patient or guardian, such as the reason for the diversion and the potential consequences if transportation to that ED is continued.
- If the patient or guardian still requests transport to their chosen facility after the reason for the diversion and the potential consequences are explained, then transport the patient to the requested facility.
- Re-contact the facility to advise the ER of the patient's/guardian's decision to transport to that location and provide an ETA.

### Hospital Diversion (Patients/Guardians *Unable* to Decide)

If a patient or guardian is unable to decide what facility to transport to, refer to the table on page 2 of this protocol, ("Destination Decisions"). If the "**Closest Appropriate ER**" is on diversion:

- Contact the ED on a **recorded line** and provide a detailed patient report. If the ED personnel advise that they cannot accept the patient, verify the reason for the diversion if it is not already clear. Obtain the **name** of the physician who is diverting the patient. Request a physician's order to transport the patient to the next "**Closest Appropriate ER**" for your patient's condition. Obtain the name of the physician who provides the order for PCR documentation. If the physician **provides** an order for a location to transport, **follow** this order. If the physician **does not** provide an order, contact **DeKalb Medical Center (DMC)** to request an order to the next "**Closest Appropriate ER**" for the patient condition. Follow the physicians order from DMC for transport.
- Using the recorded line, contact the receiving ED to which you were ordered to transport. Provide a detailed patient report. Include documentation of diversion status and a physician's order on the PCR.

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## Destination Decisions (Page 4 of 5)

### Documentation of Diversion

Thorough documentation is required whenever a patient is transported to a location that is different than represented in this guideline. Include how patient/guardian has been informed when a decision is made to override the medic's recommendation on where to transport the patient. Thorough documentation is required for diversion status each time the transport unit is diverted. If the patient/guardian has been informed of the reason for the diversion and decides to be transported to the diverting facility, notify the diverting facility and thoroughly document the actions taken.

### ***Example of Documentation of Diversion Statement***

"Mr./Ms.           (first and last name)          , the hospital to which you have requested transport, has informed us that they do not have adequate resources to manage your situation at this time. They have requested we offer you transport to another facility that can better handle your current situation. According to Georgia State Law, you have the right to deny this option and go to the hospital of your choice. Understand that if you choose this option, your wait to see a physician may be extended. Would you still prefer to go to \_\_\_\_\_ ER?"

### Notification to ER

Hospital resources and capabilities may **change** from shift to shift. **Always** contact the hospital that will be receiving the patient to confirm that that hospital will be able to provide the resources your patient is requiring prior to your transport.





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## Destination Decisions (Page 5 of 5)

HOSPITALS	PHONE #	DOOR CODE	OB	PCI	CVA	TRAUMA	TRAUMA LEVEL	HYPER- BARIC	PSYCH	BURNS	MICRO SURGERY
ATLANTA MEDICAL	404-265-4136	1190 #	OB	PCI	CVA	ADULT	1				
COBB MEDICAL	770-732-3800	111 ENTER	OB	PCI	CVA				PSYCH	BURNS	
EMORY MIDTOWN	404-686-2435	254*	OB	PCI	CVA			HB			
DEKALB HILLANDALE	404-501-8110	9111#			CVA						
DEKALB MEDICAL	404-501-5350	9111#		PCI	CVA				PSYCH		
LABOR/DELIVERY	404-501-2250										
SECURITY OFC	404-501-5339										
DOUGLASVILLE	770-920-6420	PHONE	OB	PCI	CVA			HB	PSYCH		
EASTSIDE	770-736-2440		OB	PCI	CVA						
EGLESTON	404-785-6422	BUTTON		PCI	CVA	PED	1				
EMORY UNIV HOSP	404-712-7100	706#		PCI	CVA				PSYCH		
GRADY MEMORIAL	404-616-6440/6441	GUARD	OB	PCI	CVA	ADULT	1		PSYCH	BURNS	
LABOR/DELIVERY	404-616-4950										
POISON CONTROL	404-616-9000										
BURN UNIT	404-616-3714										
SICKLE CELL	404-616-4539										
GWINNETT L'VILLE	678-312-3338	BUTTON	OB	PCI	CVA	ADULT	2				
GWINNETT DULUTH	678-312-6778	26911			CVA						
HENRY MEDICAL	678-604-1010	099*	OB	PCI	CVA			HB			
HUGHES SPALDING	404-785-9562										
JOHNS CREEK	678-474-7100	511#	OB	PCI	CVA						
KENNESTONE	770-793-5680	111#	OB	PCI	CVA	ADULT	2		PSYCH		
NEWTON	770-385-4414		OB								
N. FULTON	770-751-2555	327#	OB		CVA	ADULT	2	HB			
NORTHSIDE	404-303-3827	634#	OB	PCI	CVA						
PIEDMONT	404-605-3297	BUTTON	OB	PCI	CVA			HB			HANDS ONLY
ROCKDALE	770-918-3030	BUTTON	OB	PCI	CVA						
ST. JOSEPHS	678-843-7164	714#		PCI	CVA						
SCOTTISH RITE	404-785-2275					PED	2				
AMC SOUTH	404-466-1600	9999*			CVA						
SOUTHERN REG.	770-991-8198/8199		OB	PCI	CVA				PSYCH		
V.A HOSPITAL	404-728-7614				CVA				PSYCH		

KEY: PCI - HEART ATTACKS; CVA - STROKE; \*\* ALL HOSPITALS HAVE DECON FOR HAZARDOUS MATERIALS



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## Documentation

Documentation information becomes the legal record of a patient's history and treatment by pre-hospital personnel. It may be used as defense or prosecution if an EMS provider is charged with medical negligence.



**For every patient contact, a PCR must be done and the following must be documented:**

- A clear history of the present illness, including chief complaint, time of onset, associated complaints, pertinent negatives, and mechanism of injury.
- A complete physical exam appropriate for the emergency condition.
- Level of consciousness using the AVPU method.
- Patients who are treated but not transported under the Non Transport Protocol, must have 2 sets of vital signs
- Patients transported shall have at least three complete sets of vital signs documented.
- Vital signs should be repeated after every drug administration.
- For drug administration, note patient weight, dosage of the drug, route of administration, time of administration, and response.
- A complete listing of treatments performed in chronological order.
- For extremity injuries, neurovascular status must be noted before and after immobilization.
- For potential spinal injuries, document motor function before and after immobilization.
- For IV or IO administration, note the size of catheter, placement location, number of attempts, type of vascular access fluid or medication, flow rate and purpose this procedure.
- An ECG lead II strip (at a minimum) shall be documented for all patients placed on the cardiac monitor.
- Any significant rhythm changes should be noted.
- For cardiac arrest, document the initial strip, ending strip, pre and post defibrillation, pacing attempts, or code summary report.
- For intubation, document the centimeter mark at teeth, methods which confirm placement (tube visualized passing through cords, equal breath sounds, chest wall movement, absent gastric sounds, CO2 detector and wave form capnography), size of ET tube, and number of attempts.
- Any Medical Control orders requested whether approved or denied.
- Stroke and STEMI patients shall have the time of activation documented and medic ECG interpretation.
- If childbirth, time of delivery.
- Obtain a signature from a nurse at the receiving facility
- Obtain a physicians signature for all procedures that are IV/IM/IN/IO, medications, fluids, advanced airways and additional medical control orders

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## Emergency Vehicle Operations

The driver of any authorized emergency vehicle must always drive with due regard for the safety of all persons, including the patient being transported, the transport crew, and the public.

When operating a vehicle as "an authorized emergency vehicle", both the warning lights and audible signal must be in use. Operating a vehicle with only one of these warning devices in use does not satisfy the requirements of OCGA 40-6-6 (below).

### Authorized emergency vehicles

- (a) The driver of an authorized emergency vehicle when responding to an emergency call, but not upon returning from an emergency call, may exercise the privileges set forth in this section.
- (b) The driver of an authorized emergency vehicle may:
  - (1) Park or stand for safe scene operation
  - (2) Proceed past a red or stop signal or stop sign, but only after stopping and using due regard
  - (3) Exceed the maximum speed limits so long as he or she does not endanger life or property
  - (4) Disregard regulations governing direction of movement or turning in specified directions.
- (c) The exceptions granted by this section to an authorized emergency vehicle shall apply only when such vehicle is making use of an audible signal and use of a flashing or revolving red light visible under normal atmospheric conditions from a distance of 500 feet to the front of such vehicle,
- (d) The foregoing provisions shall not relieve the driver of an authorized emergency vehicle from the duty to drive with due regard for the safety of all persons.

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## Handling Patient's Personal Property (Page 1 of 2)


- A medic's first responsibility is to treat the patient. Handling a patient's valuables or personal property is secondary to proper pre-hospital emergency care. However, special attention needs to be paid to how a patient's personal property is handled by the medic (when handling it cannot be avoided). In "load and go" situations, patient care and transport are priority.
- Proper procedure is determined by location of the patient (at home, incident scene, etc.), whether family members or friends of the patient are present, whether law enforcement personnel is present, and other factors. Every situation cannot be described here, but the following will serve as a guideline.
- Patient's personal property could include but not be limited to: glasses, dentures, wallets, money, watches, jewelry, clothing, medication, and keys.

### **Patient at Home or a Residence**

- Advise and encourage the patient to leave all unnecessary personal items and valuables at home or with a trusted family member or friend.
- Patient medication in most cases will need to go to the hospital either with the patient or carried by a family member or friend. If it is necessary to transport these medications with the patient, they should be treated like any other patient's valuables.
- Do not remove a watch, jewelry, or wallet from a patient unless it is necessary to treat the patient, (e.g., start an IV). If it is necessary to do so, tell the patient you are removing the item. Give the item to the patient (if conscious and alert) or to a family member (if present). Document the item(s) and disposition of personal property on the patient care report. If possible, have another medic or law enforcement officer witness what you did with the patient's personal property.
- If the patient insists on taking personal items with him, the patient must be alert enough to maintain possession of the items.
- If you are concerned about the security of the patient's home or the premises you are leaving, notify law enforcement.

### **Patient at Incident Scene or Not at Home**

- If the patient is conscious, encourage the patient to give personal property and valuables to a responsible person of choice. If you have to remove any items from the patient (e.g., watch, jewelry, etc.) to treat the patient, return the items to the patient if possible. Document the details of the situation on the patient care report and have a third party witness this via signature.
- If law enforcement presents you with a patient's personal items, request that law enforcement present the items to the patient (if conscious and alert), to the patient's family (if available), or to hospital staff.
- If personal items or valuables are handled by first responders or bystanders before they were presented to you, document this with as much detail as possible on the patient care report.


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## Handling Patient's Personal Property (Page 2 of 2)


If a patient is disoriented or unconscious, give the patient's personal items to a family member or law enforcement officer if possible. Document any incident involving valuables on the patient care report and obtain a signature from the person receiving the valuables. If a family member or law enforcement officer is unavailable, transport valuables with the patient.

### **Taking Responsibility of the Patient's Personal Property**

When the medic finds himself in possession of a patient's personal property, carefully document the individual items and what was done with those items. If possible, place the items in a container (such as a zip lock bag or plastic garbage bag) used for the sole purpose of containing the patient's personal property. Make a list of the items placed in each bag, and secure the list in, or on, the bag. Medications should be listed separately. Currency should be listed by amount. Have your partner or a law enforcement officer verify (by signature) the list of items included in the container. Upon arrival at the hospital, turn the container over to the appropriate hospital staff member, verify content, and obtain a signature from the individual receiving the property.

 Document the items in the Narrative of the PCR.

If personnel locate any patient's property within the ambulance after care of the patient has been transferred to the receiving facility, Personnel should make every effort to ensure the patient's property is returned to the patient. Any property that has been located after transfer of care should be returned to the patient, witnessed by the hospital staff, and documented on an addendum to the patient care report.

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## Refusal of Care

The Patient Refusal Guideline provides required information that must be considered and documented anytime a patient refuses an assessment, transport, treatment or some portion of the treatment recommended by DeKalb County Fire Rescue personnel. When a refusal occurs a Paramedic Supervisor must be contacted **PRIOR** to resolving the call.

In order for a patient to refuse medical treatment and/or transport the patient must be mentally competent and authorized to consent per O.C.G.A Section 31-9-2 which is outlined in the Persons Authorized to Consent Guidelines of the DeKalb County Fire Rescue Protocols, Guidelines and Procedures.

**Before allowing a patient to refuse care or transport, the following questions must be confirmed:**


- Is the patient competent? Mental capacity may be influenced by mental illness, mental disability, the use of drugs or alcohol, shock, pain, fever or an altered mental status from unknown causes. If there is any question regarding the mental status of a patient, contact medical control for assistance.
- Is the patient authorized to consent? (See “*Authorized to Consent*” Protocol) If the patient/persons authorized to consent, then they will have the right to allow or refuse care even if the decision is clearly not in the best interest of the patient.

**If the patient or the person authorized to consent is deemed competent then the following elements must be addressed to allow the patient/person to make an informed decision. Ensure that each element is explained in a manner that can be understood by the patient.**

- The patient must understand the extent and severity of their medical condition.
- The patient must understand the nature of the treatment being proposed.
- The patient must understand the risks and consequences associated with accepting or refusing treatment and/or transport.
- The patient should be advised of any alternative treatment available, if any.
- The patient should be advised that they have the right to change their mind and can re-contact 911 for Fire Rescue assistance.

**Patients who meet consent criteria and are deemed mentally competent have a legal right to refuse treatment and/or transport, even if the decision may result in serious consequences or death. The documentation for refusals must be very detailed and must include the following:**

- The patient’s mental status (A & O X 3)
- The name and relationship of the person refusing care / transport for the patient if the patient is unable (Jane Doe, wife)
- Information pertaining to the five elements listed above
- The name of the supervisor assisting and the type of assistance provided (Spoke to patient over phone, responded to the scene, spoke to medic over radio, etc.)

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## Resuscitation Decisions – Initiating/Continuing

In all situations where any possibility of life exists, make every effort to resuscitate except in valid advanced directives. (see below)

### **DO NOT TERMINATE TREATMENT EFFORTS IF:**

- Patient is under age 18
- Patient is visibly pregnant OR reported to be pregnant
- Arrest may be due to hypothermia, drug overdose, toxins, or electrocution
- Any ROSC or neurologic signs
- Scene situations that places EMS in jeopardy

For patients whose family members advise that the patient did not want to be resuscitated and the family does not want them to be resuscitated and they do not have an advanced directive, continue with FULL resuscitation efforts.

Family member conflicts – Remember that persons authorized to consent are identified by our current “Authorized to Consent” portion of this document. However, if there is a conflict between family members regarding performing or not performing resuscitation efforts, continue FULL resuscitative efforts and transport.

**The following information is present in each of the Resuscitation Decisions Protocols for quick reference.**


### **DNR Orders and Other Advanced Directives:**

If advised that the patient has an existing valid Advanced Directive, (DNR, Living Will, Durable Power of Attorney for Health Care) but the document is **NOT PRESENTED** at the scene:

- Initiate compressions and ventilations only and immediately contact Medical Control for resuscitation guidance.
- Adequate compressions and ventilations must not be delayed while confirming the existence of a valid Advanced Directive.
- If orders from Medical Control have not been obtained, and 5 cycles of compressions have been provided, **full resuscitation efforts according to scope of practice** are to be initiated.

If advised that the patient has an existing valid Advanced Directive, (DNR, Living Will, Durable Power of Attorney for Health Care) and the document **IS PRESENTED** at the scene:

- When **compressions and/or ventilations HAVE been initiated** prior to your arrival, continue compressions and ventilations only and contact medical control for guidance on termination of resuscitation efforts.
- When **resuscitative efforts have NOT been initiated** (compressions and/or ventilations), do not initiate resuscitation efforts. Therefore contacting Medical Control for termination of resuscitation is not needed.

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## Resuscitation Decisions Termination of Resuscitative Efforts (Page 1 of 3)

**In all situations where any possibility of life exists, make every effort to resuscitate except in valid advanced directives. (see below)**

**Note: This Protocol is Intended to be Considered for Adult Cardiac Arrest Patients, who are not Hypothermic.**

### DNR Orders and Other Advanced Directives:

If advised that the patient has an existing valid Advanced Directive, (DNR, Living Will, Durable Power of Attorney for Health Care) but the document is NOT PRESENTED at the scene:

- Initiate compressions and ventilations only and immediately contact Medical Control for resuscitation guidance.
- Adequate compressions and ventilations must not be delayed while confirming the existence of a valid Advanced Directive.
- If orders from Medical Control have not been obtained, and 5 cycles of compressions have been provided, full resuscitation efforts are to be initiated.

If advised that the patient has an existing valid Advanced Directive, (DNR, Living Will, Durable Power of Attorney for Health Care) and the document IS PRESENTED at the scene and compressions and/or ventilations HAVE been initiated prior to your arrival, continue compressions and ventilations and contact medical control for guidance on termination of resuscitation efforts.

If presented with a document other than a valid DNR that appears to be an Advanced Directive regarding resuscitation, initiate CPR until medical control is contacted for guidance.


If a family member does not want an Advanced Directive to be honored, (DNR, Living Will, Durable Power of Attorney for Health Care), and the patient has obvious signs of death as defined in this protocol, provide full resuscitation efforts and transport. Refer to *Authorized to Consent* in this document.

Obvious death in the field (absence of vital signs and any of the following):

- Decapitation
- Decomposition
- Rigor mortis
- Incineration
- Visual trauma incompatible with life, (crushing and/or open head wound, crushing and/or open torso wound, with patient in cardiac arrest).

For traumatic injuries not compatible with life that are not specified above, initiate CPR and contact medical control for termination of resuscitation, if appropriate.



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## Resuscitation Decisions Termination of Resuscitative Efforts (Page 2 of 3)

If CPR efforts are in progress upon your arrival, you must continue CPR. You may not stop CPR without permission from an online medical control physician.

If it is reported or possible that CPR efforts are or were being performed (from dispatch, family, bystanders, etc.) you must continue/initiate CPR, contact medical control and request an order to terminate resuscitation efforts if appropriate.

### TERMINATION

If, during the performance of BLS, it becomes evident that the patient has obvious signs of death as described on page 1 of this protocol, continue BLS and quickly contact online medical control to request permission to terminate resuscitation efforts, unless the family objects.

**When completing the PCR, incident times (response, at scene, delays in accessing the patient, BLS initiated, contact with medical control, family responses, etc.) should show a systematic and rapid sequence of events that are supportive of the decision to terminate resuscitation.**

**The following information is present in each of the Resuscitation Decisions Protocols for quick reference.**

### **DNR Orders and Other Advanced Directives:**


If advised that the patient has an existing valid Advanced Directive, (DNR, Living Will, Durable Power of Attorney for Health Care) but the document is **NOT PRESENTED** at the scene:

- Initiate compressions and ventilations only and immediately contact Medical Control for resuscitation guidance.
- Adequate compressions and ventilations must not be delayed while confirming the existence of a valid Advanced Directive.
- If orders from Medical Control have not been obtained, and 5 cycles of compressions have been provided, **full resuscitation efforts** are to be initiated.

If advised that the patient has an existing valid Advanced Directive, (DNR, Living Will, Durable Power of Attorney for Health Care) and the document **IS PRESENTED** at the scene:

- When **compressions and/or ventilations HAVE been initiated** prior to your arrival, continue compressions and ventilations only and contact medical control for guidance on termination of resuscitation efforts.
- When **resuscitative efforts have NOT been initiated** (compressions and/or ventilations), do not initiate resuscitation efforts. Therefore contacting Medical Control for termination of resuscitation is not needed.



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## Resuscitation Decisions Termination of Resuscitative Efforts (Page 3 of 3)

If BLS is initiated by DCFR/EMS personnel or the contracted provider, and all of the pulseless arrest procedures are appropriate to the patient's condition, Medical Control can be contacted to consider termination of resuscitation if the patient meets all of the following criteria:


- Patient's terminal rhythm is asystole (This includes patients who are found in asystole, as well as those who start in another ARREST rhythm; PEA, V-Fib, Pulseless V-Tach)
- ETT or Supraglottic Airway Device has been successfully inserted
- A patent IV or IO line has been established
- At least 3 rounds of appropriate medications have been administered
- Patient is greater than 18 years old
- Patient is not hypothermic
- The arrest is not due to electrocution
- Patient is not visibly pregnant or reported to be pregnant
- The arrest is not from a drug overdose or toxins
- No ROSC or neurologic signs are present
- No unsafe scene situations are present, if termination orders are received, that will place personnel in jeopardy
- Patient's family is in agreement with the decision to terminate the resuscitative measures

If Medical Control agrees with the decision, stop all resuscitative measures.

- Leave all tubes and IV/IO lines in place and ensure that PD is notified.
- Remain on scene until PD arrives

If Medical Control has not given an order to stop resuscitation, transport

- Notify the receiving facility of patient condition and ETA

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## Resuscitation Decisions Withholding Resuscitation (Page 1 of 2)

**In all situations where any possibility of life exists, make every effort to resuscitate except in valid advanced directives. (see below)**

**DO NOT INITIATE** resuscitation if:

- Obvious death in the field: absence of vital signs **and** any of the following:
  - Decapitation
  - Decomposition
  - Rigor mortis
  - Incineration
  - Visual trauma incompatible with life, (crushing and/or open head wound, crushing and/or open torso wound, with patient in cardiac arrest).
- The individual has been pronounced dead by a Georgia Licensed Physician, Medical Examiner, or Coroner.
- Valid DNR order (see below)

**For traumatic injuries not compatible with life that are not specified above, initiate CPR and contact medical control for termination of resuscitation, if appropriate.**

If you received a report that CPR was in progress and you do not witness this, ask whether CPR has been performed. If CPR was not performed then you may withhold resuscitation for patients who have "Obvious Signs of Death" as described in this protocol.

**The following information is present in each of the Resuscitation Decisions Protocols for quick reference.**


### **DNR Orders and Other Advanced Directives:**

If advised that the patient has an existing valid Advanced Directive, (DNR, Living Will, Durable Power of Attorney for Health Care) but the document is **NOT PRESENTED** at the scene:

- Initiate compressions and ventilations only and immediately contact Medical Control for resuscitation guidance.
- Adequate compressions and ventilations must not be delayed while confirming the existence of a valid Advanced Directive.
- If orders from Medical Control have not been obtained, and 5 cycles of compressions have been provided, **full resuscitation efforts** are to be initiated.

If advised that the patient has an existing valid Advanced Directive, (DNR, Living Will, Durable Power of Attorney for Health Care) and the document **IS PRESENTED** at the scene:

- When **compressions and/or ventilations HAVE been initiated** prior to your arrival, continue compressions and ventilations only and contact medical control for guidance on termination of resuscitation efforts.
- When **resuscitative efforts have NOT been initiated** (compressions and/or ventilations), do not initiate resuscitation efforts. Therefore contacting Medical Control for termination of resuscitation is not needed.

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## Resuscitation Decisions Withholding Resuscitation (Page 2 of 2)

Advanced Directives and Living Wills are addressed in State Code: OCGA Chapter 32 Title 31. (see below)

### **The Law**

O.C.G.A. § 31-39-6.1 (2012)

§ 31-39-6.1. Form of order not to resuscitate; bracelet or necklace; revocation or cancellation of order  
(a) In addition to those orders not to resuscitate authorized elsewhere in this chapter, any physician, health care professional, nurse, physician assistant, caregiver, or emergency medical technician shall be authorized to effectuate an order not to resuscitate for a person who is not a patient in a hospital, nursing home, or licensed hospice if the order is evidenced in writing containing the patient's name, date of the form, printed name of the attending physician, and signature of the attending physician on a form substantially similar to the following:

"DO NOT RESUSCITATE ORDER

NAME OF PATIENT:

THIS CERTIFIES THAT AN ORDER NOT TO RESUSCITATE HAS BEEN ENTERED ON THE ABOVE-NAMED PATIENT.

SIGNED:

ATTENDING PHYSICIAN (PRINTED OR TYPED NAME OF ATTENDING PHYSICIAN)

ATTENDING PHYSICIAN'S TELEPHONE NUMBER:

DATE: "

(b) A person who is not a patient in a hospital, nursing home, or licensed hospice and who has an order not to resuscitate pursuant to this Code section may wear an identifying bracelet on either the wrist or the ankle or an identifying necklace and shall post or place a prominent notice in such person's home. The bracelet shall be substantially similar to identification bracelets worn in hospitals. The bracelet, necklace, or notice shall provide the following information in boldface type:

"DO NOT RESUSCITATE ORDER

PATIENT'S NAME:

AUTHORIZED PERSON'S NAME AND TELEPHONE NUMBER, IF APPLICABLE


PATIENT'S PHYSICIAN'S PRINTED NAME AND TELEPHONE NUMBER:

DATE OF ORDER NOT TO RESUSCITATE: "

Any physician, health care professional, or emergency medical technician shall be authorized to regard such a bracelet or necklace as a legally sufficient order not to resuscitate in the same manner as an order issued pursuant to this chapter unless such person has actual knowledge that such order has been canceled or consent thereto revoked as provided in this chapter.

(c) Any order not to resuscitate evidenced pursuant to subsection (a) or (b) of this Code section may be revoked as provided in Code Section 31-39-6 and may be canceled as provided in Code Section 31-39-5.

**\*Termination of resuscitation is referenced in the *Resuscitation Decisions - Termination Protocol*.**


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## Safe Transport of Pediatric Patients

Children are at risk of injury during transport. Appropriate protection must be provided for all pediatric patients. The National Highway and Traffic Safety Administration recently published Best Practice Recommendations for Safe Transport of Children.

See: <http://www.nhtsa.gov/staticfiles/nti/pdf/811677.pdf>

- No child or infant should ever be held in the arms or lap of parent, caregiver, or medic during transport. **NEVER.**
- All monitoring devices and equipment should be tightly secure.
- Personnel should be secure.
- Children who are not patients should be transported, properly restrained, in an alternate passenger vehicle, whenever possible.
- Available child restraint devices should be used for all pediatric patients less than 40 pounds, according to manufacturer's instructions, if the patient is not secured by other means as part of patient care.
- Do not transport a pediatric patient who meets CDC Field Triage Criteria in a child seat that was involved in an MVC.
- While manufacturers do not recommend using a child's own car seat for transportation post accident, this may be better than no restraint during transport providing the patient does not meet the need for neck and spine immobilization. Use of child safety seat after involvement in a minor MVC may be allowed if all of the following apply:
  - Visual inspection, including under movable seat padding, does not reveal cracks or deformity.
  - Vehicle in which safety seat was installed was capable of being driven from the scene.
  - Vehicle door nearest the child safety seat was undamaged.
  - Air bags (if any) did not deploy.


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## Special Healthcare Needs Patients

Children and adults with special healthcare needs include those on ventilators; with tracheotomies, indwelling catheters, gastrostomy tubes; left ventricular assist devices (LVAD); and bariatric patients. As medical technology advances and home health capabilities increase, new equipment and patient needs will appear.

General considerations:

- Do not be overwhelmed by equipment. Treat the ABCs first. Treat the patient, not the equipment. If the emergency is due to an equipment malfunction, manage the patient using your own equipment.
- Parents and caretakers are usually trained in device management, and can assist DCFR/EMS Personnel. Ask for their guidance.
- When moving a special needs patient, use slow, careful transfer.
- Transfer of bariatric patients will require additional manpower.
- Do not use excessive force to straighten or manipulate contracted extremities, as this may cause injury or pain to the patient.
- Ask for the **“go bag”** which generally has the patient’s spare equipment and supplies and bring this with you during transport. Also, this may have equipment you need on scene.
- Physical handicaps do not necessarily imply mental deficits. Remember to communicate with the patient .
- Find out the patient’s baseline vital signs, medications, allergies, and other medical information, which may not be typical.

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## Suspected Abuse

All healthcare providers are obligated by law to report cases of suspected child, elder, or vulnerable adult abuse.

Report all alleged or suspected abuse or neglect to the appropriate agency. Georgia Code requires providers to report incidents of abuse to their county's public children services agency and a municipal or county peace officer.

**Simply notifying hospital personnel about concerns of maltreatment do not meet mandated reporting responsibilities. If any maltreatment is suspected, the provider MUST, by law, notify the local public children services agency (DFACS) or law enforcement as soon as possible.**

Physical abuse and neglect is often difficult to determine - the following are indicators of possible abuse:

- Injuries scattered on many areas of the body
- Malnutrition or lack of cleanliness
- Any fracture in an child under 2 years of age
- Injuries in various stages of healing
- More injuries than are usually seen in other children of the same age.

Initial Management:

- **DO NOT** confront or become hostile to the parent or caregiver
- Treat any obvious injuries.
- In cases of suspected sexual abuse or assault
  - Discourage patient from washing and/or using the restroom
  - If the child/patient has not changed clothes, transport patient in these clothes.
  - If clothes have been removed but unwashed, bring clothes and underwear with patient in a paper (not plastic) bag.
  - Do not delay transport to search for evidence.
- If caregivers refuse to let you transport the child/patient after treatment, remain at the scene and notify law enforcement
- Contact Medical Control and advise of questionable injuries but **DO NOT** report abuse and neglect over the radio.


Reporting:

- Report your suspicions to the ED physician.
- Notify the local public children services agency or law enforcement as soon as possible. **You are legally responsible for reporting your suspicions.**
- **DO NOT** initiate the report in front of the patient or caregiver.

Documentation:

- Document any statement the child/patient makes in their own words. All verbatim statements made by the patient, the parent, or caregiver should be placed in quotation marks.
- Document unexplained injuries, discrepant history, delays in seeking medical care, and repeated episodes of suspicious injuries.
- Document history, physical exam findings, environmental surroundings, and ED notification on the Prehospital Care Report.

NOTE: For further information refer to the Resource Section of this document under O.C.O.G Title 19-7-5 (2015) and O.C.O.G. Title 31-8-82 (2015)

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## Transport Criteria (Page 1 of 2)


The Transport Criteria Guidelines identify certain conditions or situations that require transport by DeKalb County Fire Rescue. Specific assessment findings are also identified that require transport. Since the criteria identified are not the only situations that will require transport, the medics must determine the need for transport based upon the patient's complaint(s) and their assessment findings.

The only exception to a patient not being transported, who falls within the transport criteria, is the patient who is alert and oriented to person, place, and date, and refuses transport after a thorough explanation of the consequences of the refusal, allowing the patient to make an informed decision.

### Transport Criteria

- Any patient 30 years old and older, that complains of chest pain. This includes patients that complain of chest pain at the time of the initial 911 call, but deny chest pain upon assessment by medics.
- Patients exhibiting any signs or symptoms common to cardiac emergencies, if they have a cardiac or diabetic history.
- Any patient that complains of difficulty breathing or presents with signs and symptoms of respiratory distress.
- Any patient under the age of 18, presenting with obvious or probable injury or illness, in the absence of a guardian.
- Any patient who has attempted suicide, threatens suicide, or has stated the intent to harm themselves or others (verbally or by gesture).
- Patients that have admitted to taking an overdose or if you suspect the patient has taken an overdose based upon information obtained or received.
- Any patient that is hemodynamically unstable.
- Patients with a history of AMS prior to arrival of medics, but have normal mentation upon assessment by medics.
- Patients who are intoxicated or you suspect to be intoxicated, presenting with AMS, signs and symptoms of head trauma, or a Glasgow Coma score of < 13.
- Any female patient with abnormal vaginal bleeding, regardless of whether or not they have abdominal pain.
- Any female with abdominal pain in child bearing years with or without vaginal bleeding.
- Any patient that meets Trauma Triage Criteria
- Any pregnant patient that presents with signs and symptoms of labor.
- All patients with AMS, regardless of the cause.
- Anyone with immune system compromise, including Sickle Cell patients, if their chief complaint is directly related to their immune compromised condition.
- All hemophiliacs that have requested transport by DeKalb County Fire Rescue.
- Patients who have been exposed to the effects of the Taser when a thorough physical examination reveals a need for transport whether dictated medically or physically. Also, if the 'barbs' penetrated the skin in the areas of the face/neck/groin and/or female breast. Also, if the barbs are still in the patient.



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## Transport Criteria (Page 2 of 2)

- Any pediatric patient less than 1 year old that presents with or has been reported to have experienced a period of being limp, apneic, cyanotic, or choking. This could be an indication of an Apparent Life Threatening Event (**ALTE**). (**ALTE is defined as an episode that is frightening to the observer and characterized by some combination of apnea, color change, muscle tone, choking/gagging. This is a serious disorder requiring a thorough evaluation at a hospital.**)
- Any patient that has experienced a near drowning.
- Any hypoglycemic patient that is currently taking oral glucose medication.


### Febrile pediatric patients:

- Patients less than 2 months old with a rectal temperature greater than 100.4 degrees F
- Patients from 3 to 12 months old with a temperature > 101 degrees F, or a history of a temperature > 101 degrees F within the last 36 hours.
- Patients 1 to 8 years old that have an axillary temperature of 103 degrees F or greater.
- Patients 1 to 8 years old with a history of a temperature of 103 degrees F or greater or patients 9 to 18 years old with a history of a temperature of 104 degrees F or greater within the last 36 hours, but are afebrile on upon assessment by medics, may be transported by a parent or guardian. The parent or guardian must have POV transportation on site and be willing and able to transport the child to a medical facility immediately. A child or adolescent that falls into these age groups must not have a petechial (tiny red or purple spots) rash, resistance to flexion of the neck or an associated headache. These signs/symptoms are highly indicative of meningitis and would require us to transport by ambulance.

### Note:

**Assess a rectal temperature in patients under the age of 6 months, an axillary temperature from 6 months to 8 years old, and an oral temperature in patients older than 8 years.**



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## Treat No Transport (Page 1 of 3)

The Non Transport Criteria Guidelines section of the Patient Care Guidelines identifies patients whose chief complaint or condition typically does not require transport by DeKalb County Fire Rescue. All patients, however, must receive a thorough assessment to determine whether or not treatment and/or transport are indicated. If there is any doubt concerning transport or the patient presents with multiple complaints or abnormal findings, then the patient should be transported. If **any** of DCFR/EMS personnel on scene believe that the patient should be transported, then the patient is to be transported.

If a patient meeting criteria for non-transport requests assistance, then it is appropriate for the medics to explain the situation to them and to assist them with choosing an alternate mode of transportation (family, friend or private ambulance).

### **NON TRANSPORT CRITERIA:**

#### **Trauma Related**

Minor contusions, abrasions, or lacerations without neurological or neurovascular complications

Minor closed fractures of a distal extremity, as long as there is no gross displacement, patient does not meet any section of Trauma Triage Criteria, and there is normal sensation, color, temperature, and pulses are present in the injured extremity.

#### **Cold and flu-like signs and symptoms: (Ages 18 to 60)**

**\*Caution: Weakness may be a sign of a serious medical condition including AMI especially in diabetics and females**

Patient does not exhibit or complain of respiratory distress

Temperature less than 101 degrees F

No neck pain or rigidity upon movement

No signs of dehydration

No history of recent tick bites

No rash

#### **Headaches:**

No head trauma within the last 72 hours

No fever within the last 24 hours

No vomiting

No resistance to flexion of the neck or neck pain upon movement


No signs or symptoms of a stroke

No dizziness

No syncope

Pupils are within normal limits and reactive to light

Not described as "the worst headache of my life"

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## Treat No Transport (Page 2 of 3)

### ETOH Abuse

Glasgow Coma Scale 15

SBP between 90-140

HR between 60-100

No history of trauma to torso or head within the last 5 days

No suicidal or homicidal ideations

### Diarrhea and Vomiting

Must be without fever

No neurological deficits

No signs of dehydration

Hemodynamically stable, with no orthostatic changes

### Patients with non-priority complaints

Boils

Non-traumatic bumps

Infected wound (**local or surface**)

Hungry

Can't sleep

Defecation

Hemorrhoids

Constipation

Enema (**patients requiring or administering**)

Urinary catheter problems (**pulled out, without bleeding / insertion**)

Difficult to urinate (**must be without abdominal pain**)

Penis problem or pain (**without testicular pain / edema**)

Venereal diseases (**STD's**)

Nervousness (**not due to an overdose**)

Sore throat (**without dyspnea / difficulty swallowing**)

Toothache

Earache

Extremity Muscle Cramps

Spasms (**in extremities**)

Requests to cut ring(s) off

Hiccups


Hepatitis

Gout

Deafness (**no recent head trauma, bleeding from ears nor hypertensive**)


Rash / Skin disorder (**without dyspnea or difficulty swallowing**)

Transportation only

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## **Treat No Transport (Page 3 of 3)**

### **Note:**

 **Patients with non-priority complaints must not present with any signs or symptoms that meet the Transport Criteria Guidelines. Also, whenever the Non-Transport Criteria Guidelines are used, a Paramedic Supervisor must be notified PRIOR to leaving the scene.**

# **Pediatric Protocols**



**DeKalb County  
Fire Rescue**

Medical Director:

William Hardcastle, MD

Fire Rescue Director:

Darnell Fullum


Effective Date:

April 1, 2016

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## Pediatric Assessment 1 of 2

- First Impression/PAT (Patient Assessment Triangle)
- Appearance - Observe muscle tone, interactivity, consolability, look/gaze, and speech/cry.
  - Breathing - Observe chest wall movement and accessory muscle use. Listen for abnormal airway sounds.
  - Circulation - Observe the skin color for pallor, mottling, or cyanosis.

YES	Based on your First Impression, does the child appear sick?	NO
<p><b>Urgent</b></p> <ul style="list-style-type: none"> <li>▪ Proceed immediately with evaluation of the Primary Survey (ABCDE).</li> <li>▪ If a problem is identified, perform necessary interventions.</li> </ul> <p>Primary Survey</p> <ul style="list-style-type: none"> <li>○ <u>A</u>irway - assess airway patency                             <ul style="list-style-type: none"> <li>▪ open, clear, and maintain airway</li> </ul> </li> <li>○ <u>B</u>reathing - assess rate and quality of breathing                             <ul style="list-style-type: none"> <li>▪ assure adequate ventilation</li> <li>▪ initiate appropriate oxygen therapy</li> </ul> </li> <li>○ <u>C</u>irculation - assess pulses and perfusion status                             <ul style="list-style-type: none"> <li>▪ control major bleeding</li> <li>▪ manage shock appropriately</li> </ul> </li> <li>○ <u>D</u>isability - assess LOC                             <ul style="list-style-type: none"> <li>▪ is the child responding and acting appropriately</li> </ul> </li> <li>○ <u>E</u>xposure/<u>E</u>nvironment - undress the child as appropriate                             <ul style="list-style-type: none"> <li>▪ evaluate body temperature</li> <li>▪ examine skin for rashes, discoloration, and trauma.</li> <li>▪ assess the behavior of adults, appearance of other children, and safety of the home</li> </ul> </li> </ul> <p>Secondary Assessment</p>		<p><b>Not Urgent</b></p> <ul style="list-style-type: none"> <li>▪ Proceed systematically with the patient assessment.</li> </ul> <p> <b>Though they may not appear sick, trauma patients should receive a rapid primary survey and rapid transport when significant mechanism of injury exist. These patients may appear well despite their emergent condition.</b></p> <p>Primary Survey (ABCDE)</p> <ul style="list-style-type: none"> <li>○ <u>A</u>irway</li> <li>○ <u>B</u>reathing</li> <li>○ <u>C</u>irculation</li> <li>○ <u>D</u>isability</li> <li>○ <u>E</u>xposure/Environment</li> </ul> <p>Secondary Assessment</p> <ul style="list-style-type: none"> <li>○ Vital signs</li> <li>○ Focused history</li> <li>○ Physical examination</li> </ul> <p>Ongoing assessment</p>

Blood pressure on pediatric maybe difficult but should be performed if possible, however the level of consciousness, skin color and temperature and CRT are important indicators of the degree of perfusion

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## Pediatric Assessment 2 of 2


- Vital signs are to be checked at least every 15 minutes on stable patients, and every 5 minutes on unstable patients.
- A **minimum** of 3 sets of vital signs are to be checked on every patient that is transported (**On Scene / Enroute / ED arrival**) with the initial set of vital signs performed **manually**.
- Use of the NIBP cuff is then permissible if there is not at 20 point difference in either systolic/diastolic between the manual blood pressure reading and the automated blood pressure reading.
- If there is more than a 20 point difference, all blood pressures must be taken manually
- **Only manual BP should be taken on all unstable patients.**



- Patients are to be reassessed after every intervention for positive or negative changes and responses to treatment regiments.

- Potential cardiac events with or without chest pains should have ECG monitoring to include 12 lead within 5 minutes of patient contact
- Do not delay transport if your patient is unstable or appears to be experiencing a cardiac event.
- Have high suspicion for patients with cardiac related signs, symptoms, irregular pulse, lower body size than expected for patients age.

For the non-urgent child, a toe-to-head assessment, with the least invasive parts of the examination being performed first, will allow the child some time to become accustomed to you and will help maximize the information gained from the assessment.

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## Pediatric Altered Level of Consciousness (Page 1 of 2)


Applies to patients who are disoriented, weak, dizzy, confused, agitated, exhibit bizarre behavior, have had a syncopal episode, or are unconscious.

- First Impression
  - Appearance
  - Breathing
  - Circulation

- Primary Survey
- Assure airway - assure patency and proper positioning
  - Consider immobilization if evidence of trauma
  - ! Assess breathing - give O<sub>2</sub> as tolerated by mask or blow-by
    - If ineffective respiratory effort, ventilate with BVM with 100% oxygen using OPA/NPA
- IACP** Consider advanced airway management ETT/Supraglottic airway device or, Needle Cric., according to the scope of practice
  - Do not delay resuscitation for advanced airway placement
  - If advanced airway is utilized, initiate and document ET/CO<sub>2</sub> monitoring
  - Assess circulation - manage shock appropriately
  - Assess disability - assess LOC
  - Exposure/environment - undress the child as appropriate
  - ! ○ **Altered LOC and signs of poor perfusion could indicate shock and should be managed appropriately**

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Initiate cardiac monitoring
  - Physical exam and OPQRST/SAMPLE history
- Advanced airway/ventilatory management as needed
- IACP** Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock



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## Pediatric Altered Level Of Consciousness (Page 2 of 2)

- Perform blood glucose analysis

### EIACP

If BGA less than 60mg/dl

- If patient is able to protect and maintain own airway, administer **oral glucose** 7.5g PO

### IACP

- If patient is not able to protect own airway, give **dextrose** IV/IO
- If BGA is less than 60mg/dl and the patient is symptomatic
  - < 1 yr: 0.5 ml/kg of **D10W** IV/IO (mix 2 ml D50W with 8cc Normal Saline)
  - 1 yr-8 yr: 2ml/kg of **D25W** IV/IO (mix D50 with NS for a 1:1 ratio)
  - > 8yrs: 1ml/kg of **D50W** IV/IO

### ACP

- If IV/IO cannot be established: give **Glucagon** 0.1 mg/kg IM or intranasal if over age 8

### IACP


If BGA is greater than 250mg/dl

- Establish IV/IO of normal saline 10ml/kg, administer over 20-30 minutes
- If tachycardia and/or signs and symptoms of dehydration are present, administer 20ml/kg fluid bolus normal saline to maintain a radial pulse for pediatric and brachial pulse for infant.

- If patient shows respiratory depression, consider narcotic overdose, refer to the *Pediatric Toxic Ingestion Protocol*
- If overdose or toxic ingestion refer to the *Pediatric Toxic Ingestion Protocol*
- If toxic exposure, refer to the *Pediatric Toxic Exposure Protocol*
- If patient requires restraint refer to the *Pediatric Combative Patient Restraint Protocol*

### AEIOU TIPPS: Possible Causes of Altered Mental Status

<b>A:</b> alcohol	<b>T:</b> trauma
<b>E:</b> electrolytes	<b>I:</b> infection
<b>I:</b> insulin (hypoglycemia)	<b>P:</b> poison
<b>O:</b> opiates	<b>P:</b> psychogenic
<b>U:</b> uremia	<b>S:</b> seizure; shock

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## Airway-Pediatric

Applies to patients either medical, trauma or cardiac who are in need of a secure airway.

- First Impression
  - Appearance
  - Breathing
  - Circulation

- Primary Survey
- Assure airway - assure patency and proper positioning
  - Consider immobilization if evidence of trauma
- Assess breathing - give O<sub>2</sub> as tolerated by mask or blow-by
  - If ineffective respiratory effort, ventilate with BVM with 100% oxygen using OPA/NPA
  - ! ○ Consider advanced airway management ETT/Supraglottic airway device or, Needle Cric., according to the scope of practice
    - Do not delay resuscitation for advanced airway placement
    - If advanced airway is utilized, initiate and document ETCO<sub>2</sub> monitoring
  - Assess circulation - manage shock appropriately
  - Assess disability - assess LOC
  - Exposure/environment - undress the child as appropriate
  - **Altered LOC and signs of poor perfusion could indicate shock and should be managed appropriately**

**IACP**

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Initiate cardiac monitoring
  - Physical exam and OPQRST/SAMPLE history
- Advanced airway/ventilatory management as needed


**CP** Anytime a medic deems that the patient needs to be intubated by ETT the medic may perform this procedure

**IACP** Supraglottic airway device the medic may perform the procedure

- In the pediatric patient that has been intubated with an ETT use the VIVAC method in addition to chest rise, V-visualize / I- intubate / V – ventilate / A – auscultate / C- capnography

If a supraglottic airway has been inserted and the patient is being ventilated well the device should be left in place.

**CORE**

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## Airway-Pediatric

- Obstructed Airway

### EIACP

Conscious patient-

Pediatric- Perform the abdominal thrusts

- Infant - perform 5 Back slaps and 5 chest thrusts until obstruction is relieved or patient becomes unconscious
- Unconscious patient- Perform CPR and assess the airway after each cycle of compressions


### CP

Removal of foreign body substance by use of Magill forceps as necessary

### P

Unable to ventilate or intubate

- Perform a needle cricothyroidotomy as a temporary secure airway to oxygenate and ventilate a patient in severe respiratory distress when other less invasive methods have failed or are not likely to be successful

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## Pediatric Vascular Access (Page 1 of 2)

Applies to patients presenting with signs and symptoms consistent with a need for vascular access..

- First Impression
  - Appearance
  - Breathing
  - Circulation

- Primary Survey
  - Assure airway - assure patency and proper positioning
    - Consider immobilization if evidence of trauma
  - Assess breathing - give (high-flow) O<sub>2</sub> as tolerated by mask or blow-by to maintain SpO<sub>2</sub> ≥ 94%
    - If ineffective respiratory effort (refer to the *Pediatric Airway Management Protocol*)
  - Assess circulation - control bleeding if present
  - Assess disability - assess LOC
  - Exposure/environment - take measures to prevent hypothermia

- Secondary Assessment and History
    - Monitor vital signs and oxygen saturation,
    - Perform blood glucose analysis - treat hypoglycemia if present (refer to the *Pediatric Altered level of Consciousness Protocol*)
    - Initiate cardiac monitoring - treat dysrhythmias per appropriate guideline
    - Initiate ETCO<sub>2</sub> monitoring (If available)
    - OPQRST/SAMPLE history
    - Physical exam
  - Keep the patient NPO
- IACP** Advanced airway/ventilatory management as needed (refer to *Pediatric Airway Management Protocol*)

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## Vascular Access- Pediatric (Page 2 of 2)

- For all pediatric patients in shock refer to *Pediatric Shock Management Protocol*
- At any time that the medic feels that the patient needs vascular access, and it is not covered under a particular protocol, the medic can initiate vascular access at their discretion.

### IACP

If you cannot establish an IV in 2 attempts consider an IO.

Critical patients require X2 IV lines when possible

- Breath sounds are to be assessed before and after fluid bolus
- Fluid bolus is age dependent, titrate fluid bolus to a systolic blood pressure of  $70 + (\text{age} \times 2)$  or to maintain a radial/brachial pulse (age dependent)

- IO Access

### IACP

May establish an IO in the tibial tuberosity in conscious patient




### P

Pain Management for the pediatric patient is lidocaine 0.5mg/kg titrate to effect to max of 3mg/kg

### IACP

Unconscious patient-establish IO in tibial tuberosity if venous access does not appear to be easily available

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## Combative/Severely Agitated – Pediatric 1 of 2

There are many reasons why a patient may be combative, mental illness, drug/alcohol ingestion, post-ictal state, hypoxia, traumatic head injuries or from an unknown etiology. The priority when caring for medical patients who present with combative behavior is to identify and treat the underlying cause. Be aware of scene safety and remain highly vigilant of dangers. Behavioral emergencies involving children present special challenges to EMS personnel. Often with chaotic scenes, an initial impression of abuse or neglect may be misleading. What may appear as aggressive behavior may be a symptom of an underlying disorder or disability.

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - Assure patency and proper positioning, suction as needed
    - Consider immobilization if evidence of trauma
  - Assess breathing - Assist with BVM if ineffective respiratory effort with use of OPA/NPA
    - Give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation - Manage shock appropriately
  - **Altered LOC and signs of poor perfusion could indicate shock and should be managed appropriately**


- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis – refer to the *Adult Altered Level of Consciousness Protocol* for management
  - Initiate cardiac monitoring - treat dysrhythmias per appropriate protocol
  - Initiate ETCO<sub>2</sub> monitoring (If available)
  - OPQRST/SAMPLE history
  - Physical exam

Note: Prior to restraining a patient, the medic must :

- assess the patient's mental status
- determine whether the patient presents a potential or definite life threat to themselves or others.
- attempt verbal de-escalation being honest, straightforward, friendly tone avoiding direct eye contact and encroachment of personal space.



Indications for restraints: Any patient who may harm himself, herself, or others may be restrained to prevent injury to the patient or crew. Restraining must be performed in a humane manner and used only as a last resort.




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## Combative/Severely Agitated – Pediatric 2 of 2

### Procedure for an suspected altered behavioral emergency requiring restraints:

1. Ensure adequate assistance is available to restrain the patient.
2. Notify a Supervisor.
3. All personnel should be instructed as to how the patient will be restrained. This will ensure the safety of the patient as well as emergency personnel.
4. Explain the procedure and reassure the parent/guardian all attempts of gentleness and calming the child will be maintained.
4. Restrain the patient.

#### Restraint procedure:

- Soft medical restraints only are secured to each extremity
  - Place patient supine on a LSB
  - Both lower extremities are secured to the LSB
  - Left arm is secured to the LSB beside the patients body
  - Right arm is flexed above the patient's head and secured to the LSB by the wrist
  - Patients body is secured to the LSB using DCFR strapping technique – refer to the Pediatric Neck and Spine Protocols in conjunction with the above direction
5. Perform a complete assessment on the patient and reassess every 5 minutes
  6.  **Do not administer Haldol on pts. Under age 5.**
  7.   From ages 6-12 years, contact medical control for **Haldol** 0.15mg/kg IM if needed. AND/OR contact medical control for administration of **Midazolam** 2.5mg -5mg IV/ IO/ IM or intranasal if needed
  8. Notify the receiving facility of transport

### Suicidal patient who is alert and oriented as normal and refusing transport:

- Attempt to convince the parent/guardian to allow transport, use family and/or friends to assist. Normally it is most appropriate to not separate the child from the parent/guardian.
- Contact the receiving facility and request an order to restrain and transport the patient.
- Once order is approved by the ED physician, follow the above; "Procedures for suspected behavioral emergency requiring restraints".


### Documentation:

- Names and unit numbers for all personnel present, rank needed for officers • Reason(s) why restraint was necessary
- Any assessment findings obtained through observation (injuries, behavior, mental status, etc.) prior to restraining
- Describe the position in which the patient was restrained
- Time the patient was restrained
- Assessment findings after the patient was restrained and during transport.

### Note:



- **Do not place or allow any restraint to impair circulation or respirations.**
- The dignity of the patient must be considered during and after the restraining process.
- Advise any family members present why restraint is necessary and how it will be performed. Allow the family to stay close to the patient if this is helpful.
- Once the patient is restrained, one medic must remain with the patient at all times.

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## Pediatric Pain Management (Page 1 of 2)

Applies to patients suffering from severe pain or discomfort from trauma injuries, sickle cell crisis or burns.




All other pain management, contact medical control for orders.

- |   |
|---|
| <ul style="list-style-type: none"> <li>First Impression <ul style="list-style-type: none"> <li>Appearance</li> <li>Breathing</li> <li>Circulation</li> </ul> </li> </ul>  |
| <ul style="list-style-type: none"> <li>Primary Survey <ul style="list-style-type: none"> <li>Assure airway - assure patency and proper positioning <ul style="list-style-type: none"> <li>Consider immobilization if evidence of trauma</li> </ul> </li> <li>Assess breathing - give O<sub>2</sub> as tolerated by mask or blow-by to maintain SpO<sub>2</sub> ≥ 94% <ul style="list-style-type: none"> <li>Assist with BVM if ineffective respiratory effort (refer to the <i>Pediatric Airway Management Protocol</i>)</li> </ul> </li> <li>Assess circulation - manage bleeding and/or shock appropriately (refer to the <i>Pediatric Shock Management Protocol</i>)</li> <li>Assess disability - assess LOC</li> <li>Exposure/environment - undress the child as appropriate</li> </ul> </li> </ul> |
| <ul style="list-style-type: none"> <li>Secondary Assessment and History <ul style="list-style-type: none"> <li>Monitor vital signs and oxygen saturation</li> <li>Initiate cardiac monitoring</li> <li>OPQRST/SAMPLE history</li> <li>Physical exam</li> </ul> </li> <li>Place patient in position of comfort</li> <li>Immobilize any obvious injuries <ul style="list-style-type: none"> <li>Elevate injured extremities, if possible</li> <li>Consider application of a cold pack</li> </ul> </li> <li>Keep the patient NPO</li> </ul>  |

**IACP** Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock



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## Pediatric Pain Management (Page 2 of 2)

- Assess the patient's pain
  - Ages 3-8 years - use Wong-Baker FACES scale (below)
  - Ages 8-18 years - use numerical scale

**P** If pain scale  $\geq 6$ , consider administration of either **morphine or fentanyl**

**P** **Morphine** - 0.1mg/kg IV/IO slowly or IM up to 4mg max

**P** **Fentanyl** – 1mcg/kg IV/IO slowly or IN up to a 75 mcg max



- Subsequent doses require contacting Medical Control.



- After intervention, reassess mental status, pain level, and signs of respiratory depression every 5 minutes. If respirations become depressed administer Naloxone:**

**ACP**

**EIACP**

**EIACP**

**Naloxone** IM/IV/IO – 0.1mg/kg to max of 2mg (titrate to effect) OR

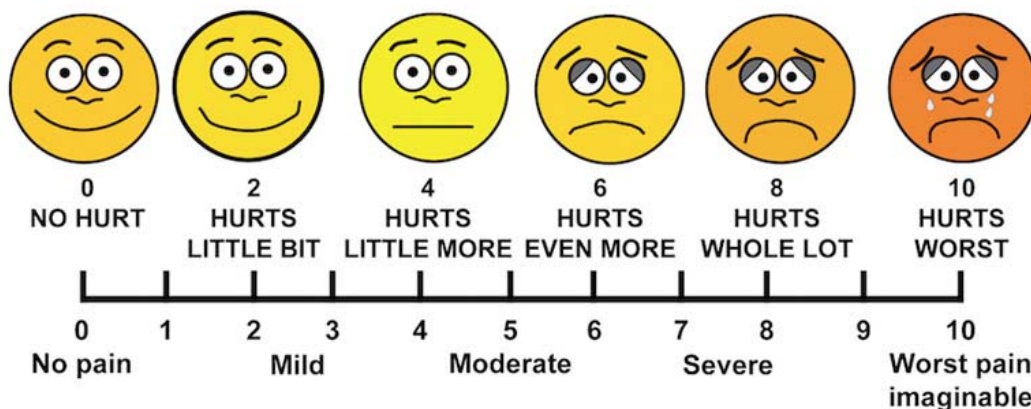
**Naloxone** IN <20kg administer 1mg (0.5ml/nare)


**Naloxone** IN >20kg administer 2mg (1ml/nare)

**P**

If patient becomes nauseated or vomits, administer 0.1mg/kg **Ondansetron** (Zofran) IV/IO over 2-5 minutes or IM, If older than 4 yr can adm. 4mg ODT (oral dissolving tablet) instead of IV

## PAIN MEASUREMENT SCALE



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## Pediatric Shock Management/Bleeding Control (Page 1 of 2)

Applies to patients presenting with signs and symptoms consistent with shock.

All forms of shock are associated with inadequate tissue perfusion.


- First Impression
  - Appearance
  - Breathing
  - Circulation

- Primary Survey
  - Assure airway - assure patency and proper positioning
    - Consider immobilization if evidence of trauma
  - Assess breathing - give (high-flow) O<sub>2</sub> as tolerated by mask or blow-by to maintain SpO<sub>2</sub> ≥ 94%
    - Assist with BVM if ineffective respiratory effort (refer to the *Pediatric Airway Management Protocol*)
  - Assess circulation - control bleeding if present
  - Assess disability - assess LOC
  - Exposure/environment - take measures to prevent hypothermia



**Children possess very strong compensatory mechanisms which allow them to appear relatively well in early shock. However, once these mechanisms are overwhelmed they tend to decompensate rapidly. Early manifestations of shock may be subtle. The perfusion status of infants and children must be evaluated carefully and frequently.**


- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation,
  - Perform blood glucose analysis - treat hypoglycemia if present (refer to the *Pediatric Altered level of Consciousness Protocol*)
  - Initiate cardiac monitoring - treat dysrhythmias per appropriate guideline
  - Initiate ETCO<sub>2</sub> monitoring (If available)
  - OPQRST/SAMPLE history
  - Physical exam
- Keep the patient NPO
- **IACP** Advanced airway/ventilatory management as needed (refer to *Pediatric Airway Management Protocol*)
- **IACP** Initiate IV/IO

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## Pediatric Shock Management (Page 2 of 2)

- For hemorrhagic shock
  - IACP**
    - administer normal saline 20ml/kg
    - Fluid boluses may be repeated x 2 - titrate to clinical effect
    - Contact Medical Control for further direction
- For cardiogenic shock
  - administer normal saline at KVO rate
  - P**
    - Initiate **Dopamine** infusion at 5 mcg/kg/min-20 mcg/kg/min - titrate to clinical effect
    - Contact Medical Control for further direction
- For distributive shock (septic)
  - administer normal saline at 20 ml/kg
  - P**
    - If patient is fluid resistant, begin administration of a **Dopamine** infusion at 5 mcg/kg/min
    - Continue fluid resuscitation at 20 ml/kg
    - Monitor for pulmonary edema/rales, restrict fluid boluses if present
    - Contact Medical Control for further direction
  - IACP** For all other types of shock, administer normal saline 20ml/kg bolus – may be repeated x 2 – titrate to clinical effect
    - Contact Medical Control for further direction
- Attempt to identify cause and treat in accordance with appropriate guideline (tension pneumothorax, overdose, trauma, etc.)


- Initiate patient transport as soon as possible
- Continue resuscitation and evaluation enroute – Frequently reevaluate ABCs and mental status.

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## Pediatric Apparent Life Threatening Event (ALTE)

Applies to patients who have experienced an episode that is frightening to the observer and involved some combination of apnea, choking or gagging, color change, and/or marked change in muscle tone (child is floppy). ALTE usually occurs in infants less than 12 months.

<ul style="list-style-type: none"> <li>First Impression <ul style="list-style-type: none"> <li>Appearance</li> <li>Breathing</li> <li>Circulation</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>Primary Survey <ul style="list-style-type: none"> <li>Assure airway - assure patency and proper positioning <ul style="list-style-type: none"> <li>Consider immobilization if evidence of trauma</li> </ul> </li> <li>Assess breathing - give O<sub>2</sub> as tolerated by mask or blow-by <ul style="list-style-type: none"> <li>Assist with BVM if ineffective respiratory effort (refer to <i>Pediatric Airway Management Protocol</i>)</li> </ul> </li> <li>Assess circulation - manage shock appropriately</li> <li>Assess disability - assess LOC</li> <li>Exposure/environment - undress the child as appropriate</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>Secondary Assessment and History <ul style="list-style-type: none"> <li>Monitor vital signs and oxygen saturation</li> <li>Perform blood glucose analysis - treat hypoglycemia if present <div style="background-color: black; color: white; padding: 2px;"><b>IACP</b></div> If BGA is less than 60mg/dl and the patient is symptomatic <ul style="list-style-type: none"> <li>&lt; 1 yr: 0.5 ml/kg of <b>D10W</b> IV/IO (mix 2 ml D50W with 8cc Normal Saline)</li> <li>1 yr-8 yr: 2ml/kg of <b>D25W</b> IV/IO (mix 1 ml D50W with 1 cc Normal Saline for a 1:1 ratio)</li> <li>&gt; 8yrs: 1ml/kg of <b>D50W</b> IV/IO</li> </ul> </li> <li>Initiate cardiac monitoring</li> <li>Complete thorough history and physical <ul style="list-style-type: none"> <li>Assess for history of apnea, decreased tone, pallor or cyanosis</li> <li>Obtain history of possible med/toxin exposure and/or ingestions</li> </ul> </li> </ul> </li> </ul> <div style="background-color: black; color: white; padding: 2px;"><b>IACP</b></div> Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock <div style="color: green; font-size: 1.2em; float: left; margin-right: 5px;">!</div> <b>TRANSPORT! Often patients with ALTE are asymptomatic when EMS arrives. Evaluation and transport is still needed. Contact medical control if parent/guardian is refusing medical care and/or transport.</b>
<ul style="list-style-type: none"> <li>If patient shows continued respiratory depression and narcotic overdose is suspected, consider administration of Naloxone: <div style="background-color: black; color: white; padding: 2px; display: inline-block;"><b>ACP EIACP EIACP</b></div> <b>Naloxone</b> IM/IV/IO – 0.1mg/kg to max of 2mg (titrate to effect) OR <b>Naloxone</b> IN &lt;20kg administer 1mg (0.5ml/nare) <b>Naloxone</b> IN &gt;20kg administer 2mg (1ml/nare) </li> </ul>

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## Pediatric Bradycardia


Applies to patients with a heart rate < 60 beats per minute and 8 years of younger

- First Impression
  - Appearance
  - Breathing
  - Circulation

- Primary Survey
  - Assure airway - assure patency and proper positioning
  - Assess breathing - give O<sub>2</sub> as tolerated by mask or blow-by
    - ventilate with BVM and 100% O<sub>2</sub> if ineffective respiratory effort.
    - avoid hyperventilation
  - Consider Advanced airway placement with ETCO<sub>2</sub> monitoring
  - ! **The most common cause of bradycardia in a child is hypoxia. Assure airway is patent and ventilation is adequate.**
  - Assess circulation - peripheral pulses, CRT, skin color/temp
    - if patient is stable, monitor and transport.
    - if HR<60 with signs of shock after adequate ventilation, start CPR
  - Assess disability - assess LOC
  - Exposure/environment - undress the child as appropriate

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis - treat hypoglycemia if present (refer to the *Pediatric Altered Level of Consciousness Protocol*)
  - Initiate cardiac monitoring
  - Physical exam and OPQRST/SAMPLE history
  - ! **Signs and symptoms: may be nonspecific, such as dizzy or weak, or may be dramatic with shock, altered LOC, difficulty breathing and collapse**
  - IACP** Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock
  - If bradycardia and signs of cardiopulmonary compromise persist,
    - CP** 1:10,000 **Epinephrine**; 0.01 mg/kg IV/IO
      - May repeat every 3-5 minutes


- If no response,
  - ! **Consider transcutaneous pacing (Contact Medical Control For Guidelines)**
  - If suspected poisoning or overdose, (refer to the *Pediatric Toxic Emergencies Protocol*)


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## Pediatric Tachycardia (Page 1 of 2)

Applies to patients with a heart rate that is fast compared to normal for the patient's age; and too fast for the child's level of activity and clinical condition.

- First Impression
  - Appearance
  - Breathing
  - Circulation

- Primary Survey
    - Assure airway - assure patency and proper positioning
    - Assess breathing - give O<sub>2</sub> as tolerated by mask or blow-by
      - Ventilate with BVM and 100% O<sub>2</sub> if ineffective respiratory effort
      - Avoid hyperventilation
      - Consider advanced airway placement, refer to *Pediatric Airway Management Protocol*
    - Assess circulation - evaluate peripheral pulses, verify heart rate
      - If no pulse, start CPR, treat according to the *Pediatric Pulseless Arrest Protocol*
    - Assess disability - assess LOC
    - Exposure/environment - undress the child as appropriate
-  **Altered LOC and signs of poor perfusion could indicate shock and should be managed appropriately.**

- Secondary Assessment and History
    - Monitor vital signs and oxygen saturation
    - Perform blood glucose analysis - treat hypoglycemia if present
    - Initiate cardiac monitoring
    - Record and evaluate 12-lead ECG (if available) - don't delay therapy
    - Physical exam and OPQRST/SAMPLE history
-  **Signs and symptoms: may be nonspecific, such as dizzy or weak, or may be dramatic with shock, altered LOC, difficulty breathing and collapse**



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## Pediatric Tachycardia (Page 2 of 2)

### Sinus Tachycardia



HR <180/min in children  
or <220/min in infants  
QRS ≤0.08 Seconds

IACP

- If signs of cardio-pulmonary compromise, IV/IO NS 20ml/kg if no presence of pulmonary edema
- Search for and treat causes – hypovolemia, dehydration, etc

The most common causes of sinus tachycardia in children are hypovolemia and dehydration.

### SVT



HR >180/min in children or >220/min in infants

IACP

- If signs of cardio-pulmonary compromise, IV/IO NS 20ml/kg if no presence of pulmonary edema
- If stable – consider vagal maneuvers
  - Adenosine IV/IO
    - 1<sup>st</sup> Dose 0.1mg/kg
    - 2<sup>nd</sup> Dose 0.2mg/kg
- If unstable, consider sedation of Midazolam 0.2mg/kg IV/IO/IN, don't delay cardioversion

CP

P

CP

Synchronized cardiovert with 1 J/Kg; may repeat with 2J/kg

### Wide-Complex Tachycardia



QRS >0.08 Seconds

IACP

- If signs of cardio-pulmonary compromise,
  - IV/IO NS 20ml/kg if no presence of pulmonary edema

CP

P

CP


CP

- If stable – adm. Amiodarone 5mg/kg in 100 cc NS over 20-60 min
- If unstable- Consider sedation of Midazolam 0.2mg/kg IV/IO/IN, don't delay cardioversion
- Synchronized cardiovert with 1 J/kg; may repeat with 2 J/kg.

If cardioversion is ineffective and shock persists, consider Amiodarone 5mg/kg in 100 cc NS over 20-60 min

If at anytime a cardiac rhythm other than tachycardia is noted, treat based on the appropriate protocol.



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## Pediatric Pulseless Arrest

### Resuscitation

- Assess patient for respiratory and cardiac arrest
- Initiate CPR 30:2 for one rescuer; 15:2 more than one rescuer, reassess and rotate compressor every 2 minutes
- AED/Defibrillator using appropriate size pads per manufacturer recommendation and pre-set AHA recommended energy delivery (200j, 300j, 360j).
- Provide high-quality compressions, minimizing interruptions
- Compressions should be at a rate of about 100-120 per minute (**Once advanced airway in place continuous compressions Ventilations every 6 seconds**)

### IACP

- Ventilate with BVM and 100% oxygen, consider OPA/NPA
- Consider advanced airway management ETT/Supraglottic airway device
  - Do not delay resuscitation for advanced airway placement
  - **If advanced airway is utilized, initiate and document ETCO2 monitoring**



YES

Shockable Rhythm???

NO

### VF/ Pulseless VT

#### CP

- Defibrillate 2 joules/kg

#### IACP

- Resume CPR for 2 min,
- Initiate IV/IO normal saline

#### CP

- 1:10,000 **Epinephrine** 0.01mg/kg (0.1ml/kg) IV/IO, repeat every 3-5 minutes
- Reassess rhythm every 2 minutes, if rhythm is organized, check pulse

#### CP

- Defibrillate 4 joules/kg (increase by 2j/kg increments to a max of 10j/kg every 2 minutes as needed)
- Resume CPR for 2 minutes between defibrillations; reassess

#### CP

- **Amiodarone**\* 5mg/kg bolus, may repeat up to 2 times for refractory VF/ VT
- Continue CPR/treatment as indicated
- Consider and treat reversible causes

### IACP

### Asystole/PEA

Initiate IV/IO normal saline

#### CP

1:10,000 **Epinephrine** 0.01mg/kg (0.1ml/kg) IV/IO, repeat every 3-5 minutes

- Reassess rhythm every 2 minutes, if rhythm is organized, check pulse
- Continue CPR/treatment as indicated
- Consider and treat reversible causes

Hypovolemia

Tension Pnuemo

Hydrogen Ion

Tamponade

Hypokalemia

Toxins

Hypothermia

Thrombosis

Hypoxia

Hypoglycemia


- **Transport to the closest appropriate facility. (Reference Destination Decisions Protocol in this document)**

### CP

- If cardiac rhythm change is noted treat based on the appropriate Protocol
- **Lidocaine** 1mg/kg to a max of 3mg/kg if **Amiodarone** is not available

CARDIAC




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## Pediatric Abdominal Discomfort


Applies to patients with pain/discomfort presenting in the abdomen or the flanks with no history or signs of trauma.

- First Impression
  - Appearance
  - Breathing
  - Circulation

- Primary Survey
  - Assure airway - assure patency and proper positioning
  - Assess breathing - give O<sub>2</sub> as tolerated by mask or blow-by to maintain SpO<sub>2</sub> ≥ 94%
  - Assist with BVM if ineffective respiratory effort
  - Assess circulation - manage shock appropriately (Refer to *Pediatric Shock Management Protocol*)
  - Assess disability - assess LOC
  - Exposure/environment - undress the child as appropriate
  -  **Altered LOC and signs of poor perfusion could indicate shock and should be managed appropriately**


- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis - treat hypoglycemia if present
  - Cardiac monitor - record and evaluate 12 Lead ECG (if available)
  - OPQRST/SAMPLE history
    - History of blood in vomit or stool? Prior abdominal surgery? Last meal?
  - Physical exam - assess for signs of dehydration/shock
- Consider possible causes; GI, GU, cardiac, meds/toxic ingestion, pregnancy
- Save emesis or other drainage for signs of GI bleed, etc.
- Keep the patient NPO
- **IACP** Initiate IV/IO normal saline -manage shock appropriately per the *Pediatric Shock Management Protocol*


- For pain management, see *Pediatric Pain Management Protocol*
- If nausea or vomiting present, see *Pediatric Nausea/Vomiting Protocol*

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## Pediatric Allergic Reaction/Anaphylaxis

Patients presenting with rash, hives, shortness or breath, or other signs and symptoms, up to and including shock, possibly due to an allergic reaction.


<ul style="list-style-type: none"> <li>First Impression <ul style="list-style-type: none"> <li>Appearance</li> <li>Breathing</li> <li>Circulation</li> </ul> </li> </ul>	
<ul style="list-style-type: none"> <li>Primary Survey <ul style="list-style-type: none"> <li>Assure airway - assure patency and proper positioning</li> <li>Assess breathing - give O<sub>2</sub> as tolerated by mask or blow-by</li> <li>Assess circulation - manage shock appropriately</li> <li>Assess disability - assess LOC</li> <li>Exposure/environment - undress the child as appropriate</li> </ul> </li> </ul> <p><b>EIACP</b> If respiratory compromise and/or signs of shock, treat immediately with <b>Epinephrine</b>. All EMS provider levels are authorized to utilize epinephrine auto-injectors as specified in the OEMS scope of practice.</p> <p><b>ACP</b> May draw up and give 0.01mg/kg 1:1000 <b>Epinephrine</b> SQ to a minimum of 0.1mg and to a max of 0.5mg</p>	
<ul style="list-style-type: none"> <li>Isolate the patient from the source of allergen, if possible.</li> <li>Secondary Assessment and History <ul style="list-style-type: none"> <li>Monitor vital signs and oxygen saturation</li> <li>Monitor capnography (if available)</li> <li>Initiate cardiac monitoring</li> <li>Physical exam and OPQRST/SAMPLE history</li> </ul> </li> <li><b>IACP</b> Advanced airway/ventilatory management as needed</li> <li>Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock</li> <li>If localized reaction (hives) <ul style="list-style-type: none"> <li><b>P</b> <b>Diphenhydramine</b> 1-2mg/kg IV slowly or deep IM, max 25mg</li> </ul> </li> <li>If respiratory distress, along with diphenhydramine <ul style="list-style-type: none"> <li><b>ACP</b> 1:1,000 <b>epinephrine</b> 0.01mg/kg SQ if not already administered (minimum of 0.1mg and to a max of 0.5mg) (IM; auto-injector preferred)</li> <li><b>IACP</b> Nebulize <b>albuterol</b>* 2.5mg &lt;15kg, 5mg &gt;15kg for bronchospasm may repeat continuously if adverse side effects are not present</li> </ul> </li> <li>If anaphylactic shock <ul style="list-style-type: none"> <li><b>EIACP</b> <b>Epinephrine Auto-Injector</b> IM; repeat q 5 min PRN <b>OR</b></li> <li><b>ACP</b> 1:1,000 <b>epinephrine</b> 0.01mg/kg SQ</li> <li><b>P</b> <b>Solu-medrol</b> 2mg/kg IV/IO, maximum dose 60mg</li> </ul> </li> </ul>	
<p> <b>CP</b> If no response to the IM or SQ epinephrine and fluid bolus, administer 1:10,000 <b>Epinephrine</b> 0.01mg/kg slow IV/IO, q 3-5 min.</p>	

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## Pediatric Cold Related Emergencies (Page 1 of 2)

Applies to patient's having a body temperature below 95°F (35°C) secondary to environmental exposure.

<ul style="list-style-type: none"> <li>First Impression <ul style="list-style-type: none"> <li>Appearance</li> <li>Breathing</li> <li>Circulation</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>Primary Survey <ul style="list-style-type: none"> <li>Assure airway - use least invasive means possible to secure airway <div>CP</div> Intubate only if necessary, as gently as possible </li> <li>Assess breathing - if signs of compromise, give O<sub>2</sub> as tolerated <ul style="list-style-type: none"> <li>Assist with BVM if apnea or ineffective respiratory effort</li> <li>Do not hyperventilate hypothermic patients.</li> </ul> </li> <li>Assess circulation - check for pulse, if no pulse begin CPR <div>!</div> <b>It may be necessary to assess pulse and respirations for up to 30-45 seconds to confirm arrest.</b> </li> <li>CPR 30:2 for one rescuer; 15:2 more than one rescuer</li> <li>AED/Defibrillator using appropriate size pads per manufacturer recommendation and pre-set AHA recommended energy delivery (200j, 300j, 360j). <ul style="list-style-type: none"> <li>If <b>severe</b> hypothermia (&lt;86°F/30°C) is strongly suspected, limit defibrillation attempts to 1 and <b>withhold</b> medications</li> <li>If body temperature is &gt;86°F (30°C), treat in accordance with <i>Pediatric Pulseless Arrest Protocol</i></li> <li>Resuscitation efforts should continue until core temperature approaches normal. <ul style="list-style-type: none"> <li>If pulse present, <b>Do Not</b> initiate CPR if there is any pulse present, no matter how slow <ul style="list-style-type: none"> <li>Treat bradycardia only if patient is hypotensive per the <i>Pediatric Bradycardia Protocol</i></li> </ul> </li> </ul> </li> <li>Assess disability - assess LOC</li> <li>Exposure/environment - <b>carefully</b> move patient to warm environment, remove all wet clothing, dry the patient, and cover with blankets</li> </ul> </li> </ul> </li></ul>
<ul style="list-style-type: none"> <li>Avoid any rough movement that may cause cardiac dysrhythmias. It may be beneficial to immobilize the patient on the backboard.</li> <li>Secondary Assessment and History <ul style="list-style-type: none"> <li>Monitor vital signs and oxygen saturation</li> <li>Perform blood glucose analysis - treat hypoglycemia if present</li> <li>Initiate cardiac monitoring</li> <li>Physical exam and OPQRST/SAMPLE history</li> </ul> </li> <li><div>IACP</div> Initiate IV/IO normal saline (warm if available), administer 20ml/kg bolus if signs of shock</li> <li>Apply warm-packs to groin, axilla, neck and chest.</li> </ul>


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## Pediatric Cold Related Emergencies (Page 2 of 2)

- Protect injured, frostbitten areas, do not rub or place on heated surface
  - Remove clothing and jewelry from injured parts
  - Do not attempt to thaw injured part with local heat
  - Severe frostbite injuries should be transported to a trauma center






**Do not** initiate the use of Morphine from the *Pediatric Pain Management Protocol* for this patient without obtaining a Medical Control order.

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## Pediatric Fever

Applies to patients with a body temperature of 100.4°F (38°C) or greater. Fever may be associated with seizures, hallucinations, and other forms of altered mental status. The febrile patient may be dehydrated.

<ul style="list-style-type: none"> <li>First Impression <ul style="list-style-type: none"> <li>Appearance</li> <li>Breathing</li> <li>Circulation</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>Primary Survey <ul style="list-style-type: none"> <li>Assure airway - assure patency and proper positioning</li> <li>Assess breathing - give O<sub>2</sub> as tolerated by mask or blow-by <ul style="list-style-type: none"> <li>Assist with BVM if ineffective respiratory effort <i>refer to the Pediatric Airway Management Protocol</i></li> <li>for airway management</li> <li>If signs of respiratory distress is present refer to the <i>Pediatric Respiratory Distress Protocol</i></li> <li>Assess circulation – see <i>Pediatric Shock Management Protocol</i>; manage shock appropriately</li> </ul> </li> <li>Assess disability - assess LOC</li> <li>Exposure/environment - undress the child as appropriate</li> <li> <b>Altered LOC and signs of poor perfusion could indicate shock and</b></li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>Secondary Assessment and History <ul style="list-style-type: none"> <li>Monitor vital signs and oxygen saturation</li> <li>Initiate cardiac monitoring</li> <li>Perform blood glucose analysis – treat If BGA is less than 60mg/dl refer to the <i>Pediatric Altered Level of Consciousness Protocol</i> for management</li> <li>Physical exam and OPQRST/SAMPLE history</li> <li>Document history of fever and record temperature (forehead, ear, or tympanic membrane - if available)</li> </ul> </li> </ul> <p><b>IACP</b> Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock, dehydration, hypotension, and/or sepsis</p> <p><b>EIACP</b> Administer <b>acetaminophen</b> 15mg/kg PO if &gt;4 hours since last antipyretic</p>
<p>If high grade fever (103°F or 39.5°C), initiate gradual cooling</p> <p> <b>Remove clothing and examine for <u>purpuric</u> rash and prepare for septic shock symptoms</b></p> <ul style="list-style-type: none"> <li>Consider placing moistened towels in axilla and groin</li> <li><b>Do Not</b> use ice or rubbing alcohol to cool</li> <li>Avoid rapid cooling, <b>Do Not</b> allow patient to shiver</li> </ul> <p><b>EIACP</b> Administer <b>acetaminophen</b> 15mg/kg PO if &gt;4 hours since last antipyretic</p>
<ul style="list-style-type: none"> <li>Prepare for seizures, see <i>Pediatric Seizure Protocol</i> for management of seizures.</li> </ul>

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## Pediatric Heat Related Emergencies


Applies to patients with fatigue or altered level of consciousness secondary to environmental heat exposure.

- First Impression
  - Appearance
  - Breathing
  - Circulation

- Primary Survey
  - Assure airway - assure patency and proper positioning
  - Assess breathing - give O<sub>2</sub> as tolerated by mask or blow-by
    - Assist with BVM if ineffective respiratory effort *refer to the Pediatric Airway Management Protocol*)
    - Assess circulation – *refer to the Pediatric Shock Management Protocol; manage shock appropriately*
  - Assess disability - assess LOC
  - Exposure/environment - remove the patient from the environment
    - Undress the child as appropriate
- ! **Altered LOC and signs of poor perfusion could indicate shock and should be managed appropriately**

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Initiate cardiac monitoring
  - Perform blood glucose analysis - treat if BGA is less than 60mg/dl *refer to the Pediatric Altered Level of Consciousness Protocol*
  - Physical exam and OPQRST/SAMPLE history
- **IACP** Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock, dehydration, and/or hypotension
- If conscious and not vomiting or extremely nauseous provide oral fluids
- If heat stroke suspected, active cooling with cold packs, water, and fan
- ! **Signs/symptoms of heat stroke may include: hot, dry skin (25% of patients will still be moist), seizures, altered mental status, dilated pupils, rapid heart rate, or arrhythmia**

- Prepare for seizures, see *Pediatric Seizure Protocol* for management of seizures.

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## Pediatric Nausea/Vomiting

Applies to patients presenting with prolonged vomiting, or those actively vomiting after EMS arrival with no other symptoms or complaints present. Assess any acute abdominal pain prior to resolving nausea/vomiting.


- First Impression
  - Appearance
  - Breathing
  - Circulation

- Primary Survey
  - Assure airway - have suction ready
  - Assess breathing - if signs of compromise, give O<sub>2</sub> as tolerated
  - Assess circulation - manage shock appropriately
  - Assess disability - assess LOC
  - Exposure/environment - undress the child as appropriate

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis - treat hypoglycemia if present
  - Consider cardiac monitoring
  - Physical exam and OPQRST/SAMPLE history
- Keep the patient NPO
- Consider IV normal saline KVO rate
- **IACP** If fluid resuscitation is needed, 20ml/kg bolus IV/IO normal saline




- **P** If patient becomes nauseated or vomits, administer 0.1mg/kg **Ondansetron** (Zofran) IV/IO over 2-5 minutes or IM, If older than 4 yr can adm. 4mg ODT (oral dissolving tablet) instead of IV




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## Pediatric Respiratory Distress (non-anaphylactic) (Page 1 of 2)

Applies to patients presenting with inadequate ventilation or oxygenation; which may include increased or decreased respirations, cyanosis, nasal flaring, grunting, retractions, absent or diminished breath sounds, or decreased responsiveness


<ul style="list-style-type: none"> <li>First Impression <ul style="list-style-type: none"> <li>Appearance</li> <li>Breathing</li> <li>Circulation</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>Primary Survey <ul style="list-style-type: none"> <li>Assure airway - assure patency and proper positioning</li> <li>Suction airway as needed</li> <li>Assess breathing - give O<sub>2</sub> as tolerated by mask or blow-by <ul style="list-style-type: none"> <li>Assist with BVM if ineffective respiratory effort <i>refer to the Pediatric Airway Management Protocol</i></li> </ul> </li> <li>Assess circulation – <i>refer to the Pediatric Shock Management Protocol</i>; <b>manage shock appropriately</b></li> <li>Assess disability - assess LOC</li> <li>Exposure/environment - undress the child as appropriate</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>Secondary Assessment and History <ul style="list-style-type: none"> <li>Monitor vital signs and oxygen saturation</li> <li>Auscultate breath sounds</li> <li>Apply capnography (if available)</li> <li>Initiate cardiac monitoring</li> <li>Physical exam and OPQRST/SAMPLE history</li> </ul> </li> <li> <b>If fever is present with any respiratory signs or symptoms or if the patient is coughing, sneezing or generating airborne droplets, a HEPA mask should be worn by EMS personnel to avoid transmission of infection. (Refer to the <i>Pediatric Fever Protocol</i> for management of fever)</b></li> <li>Consider IV normal saline KVO rate</li> <li>If wheezing or capnography indicates bronchospasm <ul style="list-style-type: none"> <li>Assist pt./ Administer Nebulized <b>albuterol</b> <ul style="list-style-type: none"> <li>2.5mg &lt;15kg,</li> <li>5mg &gt;15kg</li> </ul> </li> <li>May repeat continuously if adverse side effects are not present</li> <li>Consider administer Albuterol treatment through BVM if needed</li> </ul> </li> <li> <b>Advanced and CT s can not give Epi SQ without anaphylaxis</b></li> <li>If stridor and history and exam suggestive of croup <ul style="list-style-type: none"> <li><b>ACP</b>  <b>Nebulize Epinephrine</b> 1:1000 : <ul style="list-style-type: none"> <li>&lt; 15kg - 2.5mg (2.5ml) with 2.5ml of NS</li> <li>&gt;15kg – 5mg (5ml)</li> </ul> </li> <li>Contact Medical Control for repeated treatment orders</li> </ul> </li> <li>If stridor and history and exam suggestive of Epiglottitis <ul style="list-style-type: none"> <li>Manage with O<sub>2</sub> in a manner to not cause distress to patient</li> <li>Place in position of comfort</li> </ul> </li> </ul>



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## Pediatric Respiratory Distress(non-anaphylactic) (Page 2 of 2)

- If stridor is suggestive of FBAO
  - Use age dependent airway clearing techniques per American Heart Association guidelines.
  - P** ○ If unable to remove obstruction, use Magill forceps with direct laryngoscopy
  - P** ○ If still unable to remove obstruction or if obstruction is due to trauma or edema, and ventilations remain compromised, perform needle cricothyrotomy

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## Pediatric Seizure


Applies to patients actively seizing or those that have a history of seizures prior to EMS arrival.

- First Impression
  - Appearance
  - Breathing
  - Circulation

- Primary Survey
  - Assure airway - have suction ready
  - Assess breathing - give O<sub>2</sub> as tolerated by mask or blow-by
    - Assist with BVM if ineffective respiratory effort
  - Assess circulation - manage shock appropriately
  - Assess disability - assess LOC
  - Exposure/environment – undress the child as appropriate
  - ! **Altered LOC and signs of poor perfusion could indicate shock and should be managed appropriately**

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis - treat hypoglycemia if present refer to the *Pediatric Altered Level of Consciousness Protocol*
  - Consider cardiac monitoring
  - Physical exam and OPQRST/SAMPLE history
    - Obtain description of seizure activity - duration and severity
    - Note any history of illness or trauma
- Advanced airway/ventilatory management as needed refer to *Pediatric Airway Management Protocol*
- **IACP** Initiate IV normal saline KVO rate
  - If fluid resuscitation is needed, 20ml/kg bolus IV/IO normal saline
- If evidence of fever, refer to the *Pediatric Fever Protocol*

- If the patient is actively seizing
  - P** **Midazolam** 0.2 mg/kg IV/IO slowly or IM/IN, max 10mg


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## Pediatric Sickle Cell Crisis


Applies to patients presenting with sickle cell crisis. The typical sickle cell EMS call in children is severe pain in the abdomen, chest, or joints, and/or difficulty breathing with hypoxia. Many of these patients are dehydrated.

- First Impression
  - Appearance
  - Breathing
  - Circulation

- Primary Survey
  - Assure airway - assure patency and proper positioning
  - Assess breathing - give O<sub>2</sub> as tolerated by mask or blow-by to maintain SpO<sub>2</sub> ≥ 94%
    - Assist with BVM if ineffective respiratory effort, refer to *Pediatric Airway Management Protocol*
    - Assess circulation – refer to the *Pediatric Shock Management Protocol*, **manage shock appropriately**,
  - Assess disability - assess LOC
  - Exposure/environment - undress the child as appropriate

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Initiate cardiac monitoring
  - OPQRST/SAMPLE history
  - Physical exam
-  **If fever is present do not administer Tylenol**
- Keep the patient NPO
- **IACP** Initiate IV/IO normal saline administer 20ml/kg bolus if signs of shock
- Comfort measures, such as support for painful joints.
- Assess the patient's pain
  - Ages 3-8 years - use Wong-Baker FACES scale (below)
  - Ages 8-18 years - use numerical scale

 If pain scale is > 6 (see below), refer to *the Pediatric Pain Management Protocol*

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## Pediatric Toxic Exposure (Page 1 of 2)

Applies to patients with toxic exposure secondary to the ingestion, inhalation, contact or intravenous administration of a potentially toxic substance.

- Scene Safety and Initial Management
  - ! **Prevent exposure of personnel! Assess and assure scene security prior to proceeding with guideline.**
    - If toxic environment, have patient moved to safety by appropriately trained personnel using proper level PPE.
    - If signs of hazardous materials incident, call for HazMat team, keep patient(s) isolated in contaminated zone until HazMat team arrives
      - Coordinate efforts with HazMat personnel
    - Identify agent and mechanism/route of exposure (inhaled, contact, etc.)
    - Decontaminate as appropriate -personnel must be wearing PPE prior to helping with the decontamination process

- Primary Survey
  - Assure airway - have suction ready, keep the patient NPO
  - Assess breathing - if signs of compromise, give O<sub>2</sub> as tolerated
    - Assist with BVM if ineffective respiratory effort, refer to *Pediatric Airway Management Protocol*
  - Assess circulation – refer to *Pediatric Shock Management Protocol*, **manage shock appropriately**
  - Assess disability - assess LOC
  - Exposure/environment - take measures to prevent hypothermia, especially following decontamination

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - ! **Pulse oximetry may not be accurate for toxic inhalation victims**
    - Perform blood glucose analysis - treat hypoglycemia if present, refer to the *Pediatric Altered Level of Consciousness Protocol*
  - Initiate cardiac monitoring
  - Physical exam and OPQRST/SAMPLE history
    - Identify substance/toxin and amount of exposure
    - Determine mechanism, time, and duration of exposure
    - If ingestion, see Poisoning/Overdose guideline
  - **IACP** Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock

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## Pediatric Toxic Exposure (Page 2 of 2)

- If known or suspected carbon monoxide poisoning
  - Provide 100% O<sub>2</sub>, if not yet initiated
  - Monitor carbon monoxide saturation (if CO-oximetry is available) Consult Medical Control for destination choice, including consideration of medical facilities equipped with a hyperbaric capability
- Narcotic overdose:
  - ACP** **Naloxone** IM/IV/IO – 0.1mg/kg to max of 2mg (titrate to effect) OR
  - EIACP** **Naloxone** IN <20kg administer 1mg (0.5ml/nare)
  - EIACP** **Naloxone** IN >20kg administer 2mg (1ml/nare)
- If organophosphate, carbamate, or nerve agent poisoning,
  - P** Administer **Atropine** if available 0.02 mg/kg IV/IO or IM every 3-5 minutes, titrate to clinical symptoms (drying of secretions)
- If patient is asymptomatic, monitor for delayed affects.




**Frequently reassess patient, manage any presenting respiratory distress, seizures, and/or dysrhythmia's in accordance with appropriate protocol.**

All suspected suicide attempts must be reported to law enforcement before leaving the scene.

EMS personnel may contact Poison Control directly. EMS personnel are directed to follow the advice offered by the Poison Control Center as if it came directly from Medical Control. Georgia Poison Control: 1-800-222-1222.

Consultation for Chempack deployment, see Chempack resources.

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## Pediatric Toxic Ingestion (Page 1 of 2)

Applies to patients with an acute overdose and/or toxic ingestion.

- First Impression
  - Appearance
  - Breathing
  - Circulation

- Primary Survey
  - Assure airway - have suction ready, keep the patient NPO
  - Assess breathing - if signs of compromise, give O<sub>2</sub> as tolerated
    - Assist with BVM if ineffective respiratory effort
  - Assess circulation – refer to *Pediatric Shock Management Protocol*, **manage shock appropriately**
  - Assess disability - assess LOC
  - Exposure/environment - undress the child as appropriate

- Secondary Assessment and History
    - Monitor vital signs and oxygen saturation
    - Perform blood glucose analysis - treat hypoglycemia if present
    - Consider cardiac monitoring
    - Physical exam and OPQRST/SAMPLE history
      - Identify substance/toxin and amount of exposure
- IACP** Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock

- If calcium-channel blocker or beta-blocker overdose:
 


**P** **Glucagon** 0.025-0.1mg/kg IV/IO slowly or IM/IN, max 1mg
- If narcotic overdose:
 

**ACP** **Naloxone** IM/IV/IO – 0.1mg/kg to max of 2mg (titrate to effect) OR


**EIACP** **Naloxone** IN <20kg administer 1mg (0.5ml/nare)

**EIACP** **Naloxone** IN >20kg administer 2mg (1ml/nare)
- If tricyclic antidepressants overdose with wide complex tachycardia
 

**CP** **Sodium Bicarbonate** 1mEq/kg IV/IO slowly

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## Pediatric Toxic Ingestion (Page 2 of 2)

- Aspirin overdose, look for signs of fast and deep respirations
  -  Contact medical control for direction with administration of sodium bicarbonate infusion
    - If hypotension develops refer to *Pediatric Shock Management Protocol*
- If a stimulant/hallucinogen overdose (cocaine, amphetamine, ecstasy, etc.)
  - **P Midazolam** 0.2mg/kg slowly IV/IO or IM/IN, max 10mg
  - Cool patient passively but do not allow patient to shiver
- If patient is asymptomatic, monitor for delayed affects.




**Frequently reassess patient, manage any presenting respiratory distress, seizures, and/or dysrhythmia's in accordance with appropriate protocol.**

All suspected suicide attempts must be reported to law enforcement before leaving the scene.

EMS personnel may contact Poison Control directly. EMS personnel are directed to follow the advice offered by the Poison Control Center as if it came directly from Medical Control. Georgia Poison Control: 1-800-222-1222.

Consultation for Chempack deployment, see Chempack resources.

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## Pediatric Major Trauma

- First Impression
  - Appearance
  - Breathing
  - Circulation


- Primary Survey
  - Assure airway - assure patency, manually stabilize C-spine
  - Assess breathing - give O<sub>2</sub> as tolerated by mask or blow-by
    - Assist with BVM/BVT if ineffective respiratory effort, refer to *Pediatric Airway Management Protocol*
    - Manage any injuries impairing ventilation
  - Assess circulation - assess pulses and perfusion status
    - Control major bleeding and manage shock appropriately
    - If direct pressure to an extremity does not control bleeding and a tourniquet is indicated apply the tourniquet-refer to the *Pain Management Protocol as needed*
    - Apply a second tourniquet proximal to the first tourniquet if bleeding is still not controlled
  - Assess disability - assess LOC, note any disability
  - Exposure/environment - undress the child as appropriate
    - Take measures to prevent hypothermia

- Secondary Assessment and History
  - Physical exam and OPQRST/SAMPLE history
    - Expose and rapidly assess the head, chest, abdomen, pelvis and extremities for injury (evaluate patient's posterior when possible)
  - Monitor vital signs and oxygen saturation, determine GCS
  - Administer prehospital care and resuscitate as needed
  - Perform immobilization, apply a rigid c-collar and secure to LSB
- Initiate patient transport as soon as possible
- Advanced airway/ventilatory management as needed
- Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock, refer to *Pediatric Shock Management Protocol*
- Reevaluate ABCs and perform detailed/focused assessment of the head, neck, chest, abdomen, pelvis, and extremities x4 and repeat neuro exam
  - Perform blood glucose analysis - treat hypoglycemia if present, refer to the *Pediatric Altered Level of Consciousness Protocol for management*
  - Consider cardiac monitoring
- Continue resuscitation and evaluation enroute

 **On scene times should be less than 10 minutes if possible**


- Manage any presenting respiratory distress, seizures, and/or dysrhythmia's in accordance with appropriate protocol.
- Transport to the appropriate facility. Refer to the *Destination Decision Protocol*




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## Pediatric Head Injuries (Page 1 of 2)

Applies to patients presenting with injuries to the head or spine.

- First Impression
  - Appearance
  - Breathing
  - Circulation
- Primary Survey
  - Assure airway - assure patency, manually stabilize C-spine
    - Have suction ready
  - Assess breathing - give O<sub>2</sub>, maintain SpO<sub>2</sub> ≥ 95%
    - Assist with BVM if ineffective respiratory effort
  - 
**Maintain normal ventilation rate if providing PPV, hyperventilation should be avoided unless signs of cerebral herniation**
  - Assess circulation - assess pulses and perfusion status
    - Control major bleeding and manage shock appropriately
  - Assess disability - assess LOC, note any disability
  - Exposure/environment - undress the child as appropriate
    - Take measures to prevent hypothermia
    - Consider possibility of non-accidental trauma

- Secondary Assessment and History
  - Physical exam and OPQRST/SAMPLE history
    - Perform rapid trauma exam
    - Determine GCS, assess pupillary size and reaction
  - Monitor vital signs and oxygen saturation
  - Evaluate and treat other trauma
  - Perform immobilization, apply a rigid c-collar and secure to LSB
- Initiate patient transport as soon as possible
- Advanced airway/ventilatory management as needed, refer to *Pediatric Airway Management Protocol*
- Initiate ET/CO<sub>2</sub> monitoring (if available)
  - Maintain normal ventilation rate (ET/CO<sub>2</sub> 35-40 mmHg)
- IACP**
  - Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock
  - Perform a detailed assessment of the patient
    - Reevaluate ABCs, perform a detailed/focused physical assessment
    - Repeat neuro exam
    - Perform blood glucose analysis - treat hypoglycemia if present, refer to the *Pediatric Altered Level of Consciousness Protocol*
    - Initiate cardiac monitoring

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## Pediatric Head Injuries (Page 2 of 2)




- **Frequently reassess for clinical signs of cerebral herniation: dilated and unreactive pupils, asymmetric pupils, extensor posturing or no motor response, decrease GCS > 2 points in patients with an initial GCS < 8.**
- Hyperventilation therapy titrated to clinical effect may be necessary for **brief** periods in cases of cerebral herniation or acute neurologic deterioration
  - Hyperventilation is administered as:
    - 25 breaths per minute in a child
    - 30 breaths per minute in an infant less than 1 year old
    - Maintain ETCO<sub>2</sub> of 30-35 mmHg (if ETCO<sub>2</sub> monitoring is available)



- **Children with Traumatic Brain Injury are likely to exhibit post-traumatic seizures**
- Manage any presenting seizures in accordance with the *Pediatric Seizure Protocol*



- **If patient presents with bradycardia secondary to increased ICP or neurogenic shock, consult with Medical Control regarding management.**
- Transport to the most appropriate facility. Refer to the *Destination Decision Protocol*


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## Neck and Spine Injuries-Pediatric

**!** Applies to patients presenting with possible neck and spinal injuries from newborn to 15<sup>th</sup> birthday. Determining the need for spinal immobilization requires a careful assessment of the patient's MOI, assessment of patient and scene.

**!** Provide immobilization for BLUNT MOI through an approved pediatric immobilization device. A car seat does not immobilize the patient adequately.

- Primary Survey
    - Assess LOC - AVPU
    - Assure airway - assure patency, manually stabilize C-spine as needed
      - Have suction ready
    - Assess breathing - give O<sub>2</sub>, maintain SPO<sub>2</sub> ≥ 95%
      - Assist with BVM if ineffective respiratory effort if needed
    - Assess circulation - assess pulses and perfusion status
      - Control major bleeding and manage shock appropriately
    - Assess disability - assess LOC, note any disability
      - Take measures to prevent hypothermia
  - Secondary Assessment and History
    - Physical exam and OPQRST/SAMPLE history
      - Perform rapid trauma exam
      - Determine GCS, assess pupillary size and reaction
    - Monitor vital signs and oxygen saturation
    - Initiate cardiac monitoring-watch for bradycardia
    - Evaluate and treat other trauma
    - Determine need for immobilization. Perform as determined.
    - Initiate patient transport as soon as possible
    - If a cervical spine injury is suspected, transport to the most appropriate trauma center.
  - Advanced airway/ventilatory management as needed, refer to the *Pediatric Airway Management Protocol*
    - Initiate ET/CO<sub>2</sub> monitoring (if available)
      - Maintain normal ventilation rate (ET/CO<sub>2</sub> 35-40 mmHg)
  - **IACP** Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock
  - Perform a detailed assessment of the patient
    - Reevaluate ABCs, perform a detailed/focused physical assessment
    - Repeat neuro exam
- Perform blood glucose analysis - treat hypoglycemia if present, refer to the *Pediatric Altered Level of Consciousness*


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## Pediatric Eye Trauma


Applies to patients with blunt or penetrating trauma to the eye or who have chemical substances in the eye.

- First Impression
  - Appearance
  - Breathing
  - Circulation

- Primary Survey
  - Assure airway - initiate immobilization if needed
  - Assess breathing - initiate O<sub>2</sub> administration if needed
  - Assess circulation - control bleeding and manage shock appropriately
  - Assess disability - assess LOC, note any disability
  - Exposure/environment

- Secondary Assessment and History
  - Physical exam and OPQRST/SAMPLE history
    - Establish the mechanism and nature of injury
  - 
**Assess vision, if possible, with injured eye: can the patient count the number of fingers you hold up; if not, can the patient perceive light**
    - Never apply pressure to the eyeball
  - Monitor vital signs and oxygen saturation
- If the eye has been avulsed or if the globe has been ruptured,
  - Carefully cover the injured eye to protect it
  - Prevent conjugated eye movements - also cover the uninjured eye
  - **Do Not** apply any pressure; **Do Not** apply absorbent dressing
- If a foreign body is embedded in the eye,
  - Do not attempt to remove the object
  - Do attempt to stabilize the object.
  - Carefully cover both eyes
- If eyes are injured by chemical exposure, pepper spray or mace:
  - Responders should protect themselves with appropriate PPE
  - Remove victim from source of exposure
  - Remove contaminated clothing and sealed in plastic bags
  - Irrigate eyes with copious amounts of water or normal saline


- Transport patient with head elevated about 30 degrees, and BOTH eyes closed or loosely patched (unless irrigating).
- For pain refer to the *Pediatric Pain Management Protocol*

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## Pediatric Chest Trauma (Page 1 of 2)

Applies to patients presenting with chest trauma.

- First Impression
  - Appearance
  - Breathing
  - Circulation

- Primary Survey
  - Assure airway - assure patency, manually stabilize C-spine
  - Assess breathing - give O<sub>2</sub> as tolerated by mask or blow-by
    - Assist with BVM if ineffective respiratory effort
    - Manage any injuries impairing ventilation
  - Assess circulation - assess pulses and perfusion status
    - Control major bleeding and manage shock appropriately
  - Assess disability - assess LOC, note any disability
  - Exposure/environment - undress the child as appropriate
    - Take measures to prevent hypothermia
-  **If at any time during the primary survey or secondary assessment the following chest injuries are identified, treat immediately**
  - For **penetrating trauma** or **sucking chest wound**
    - Seal initially with a glove hand
    - Apply Asherman Chest seal or occlusive dressing, secured on (3) sides
    - Monitor for tension pneumothorax
  - For **flail segment** – rare in children
    - Stabilize with bulky dressing
      - gentle pressure, **Do not impair ventilation**
    - Provided positive pressure ventilation
  - **Tension pneumothorax**
    - Perform needle decompression on affected side

- Secondary Assessment and History
  - Physical exam and OPQRST/SAMPLE history
    - Perform rapid trauma exam
    - Examine the chest for bruising, abrasions, instability, crepitus, and/or open wounds
    - Auscultate breath sounds and heart tones
  - Monitor vital signs and oxygen saturation, determine GCS
  - Administer prehospital care and resuscitate as needed
  - Perform immobilization, apply a rigid c-collar and secure to LSB
- Initiate patient transport as soon as possible
- Advanced airway/ventilatory management as needed, refer to *Pediatric Airway Management Protocol*

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## Pediatric Chest Trauma (Page 2 of 2)

- IACP**
- Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock
  - Reevaluate ABCs and perform detailed/focused assessment of the head, neck, chest, abdomen, pelvis, and extremities x4 and repeat neuro exam
    - Frequently reevaluate patients respiratory and perfusion status
    - Auscultate breath sounds
    - Apply capnography (if available)
    - Perform blood glucose analysis - treat hypoglycemia if present refer to the *Pediatric Altered Level of Consciousness Protocol*
    - Initiate cardiac monitoring
    - Treat dysrhythmia's in accordance with appropriate protocol
  - Continue resuscitation and evaluation enroute

- Transport to the appropriate facility, refer to the *Destination Decision Protocol* .


### IMPORTANT - NEEDLE CHEST DECOMPRESSION

**Indications:** Peri-arrest or PEA; shock, with hypotension; and at least one of the following:

- Neck vein distention
- Tracheal deviation away from the injured side
- Increased resistance when ventilating
- Hyper-expanded chest with little movement with respiration

**Needle chest decompression should never be utilized based solely on the presence of poor or absent breath sounds on one side of the chest. The procedure has complications, and should not be used lightly. However, when used appropriately, it can be life-saving.**

**CAUTION:** Overly aggressive PPV may cause a pneumothorax or exacerbate an existing pneumothorax.


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## Pediatric Abdominal and Pelvic Trauma (Page 1 of 2)

Applies to patients presenting with injury to abdomen and/or pelvis.

- First Impression
  - Appearance
  - Breathing
  - Circulation

- Primary Survey
  - Assure airway - assure patency, manually stabilize C-spine
  - Assess breathing - give O<sub>2</sub> as tolerated by mask or blow-by
    - Assist with BVM if ineffective respiratory effort
  - Assess circulation - assess pulses and perfusion status
    - Control major bleeding and manage shock appropriately
  - Assess disability - assess LOC, note any disability
  - Exposure/environment - undress the child as appropriate
    - Take measures to prevent hypothermia

- Secondary Assessment and History
  - Physical exam and OPQRST/SAMPLE history
    - Perform rapid trauma exam.
    - Note any abdominal rigidity, distention, tenderness, etc
    - Note any pelvic instability
    - Monitor vital signs and oxygen saturation, determine GCS
  - For **evisceration** - do not attempt to replace protruding organs
    - Apply a moistened sterile dressing directly to the site
    - Cover this dressing with an occlusive dressing
    - Place patient on their back, with legs flexed at the knees, to reduce pain by relaxing the strain on the abdominal muscles
  - For impaled objects - do not remove an impaled object
    - Carefully cut away any clothing that is around the object
    - Manually stabilize object - avoid applying pressure to the object
    - Use bulky dressings and cravats to stabilize object
    - Minimize patient movement
  -  **If impaled object removed before your arrival, try to bring it with you.**
    - Perform immobilization, apply a rigid c-collar and secure to LSB
- Initiate patient transport as soon as possible

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## Pediatric Abdominal and Pelvic Trauma (Page 2 of 2)

### IACP

- Advanced airway/ventilatory management as needed, refer to the *Pediatric Airway Management Protocol*
- Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock
- Reevaluate ABCs and perform detailed/focused assessment of the head, neck, chest, abdomen, pelvis, and extremities x4 and repeat neuro exam
  - Perform blood glucose analysis - treat hypoglycemia if present
  - Consider cardiac monitoring
- Continue resuscitation and evaluation enroute

- Transport to a appropriate facility, refer to the *Destination Decision Protocol*




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## Pediatric Extremity Trauma (Page 1 of 2)

Applies to patients presenting with extremity trauma.

<ul style="list-style-type: none"> <li>First Impression <ul style="list-style-type: none"> <li>Appearance</li> <li>Breathing</li> <li>Circulation</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>Primary Survey <ul style="list-style-type: none"> <li>Assure airway - initiate immobilization if needed</li> <li>Assess breathing - give O<sub>2</sub> as tolerated by mask or blow-by</li> <li>Assess circulation - control bleeding and manage shock appropriately <ul style="list-style-type: none"> <li>Direct pressure is usually sufficient</li> <li>Tourniquet may applied as last resort</li> </ul> </li> <li>Assess disability - assess LOC, note any disability</li> <li>Exposure/environment</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>Secondary Assessment and History <ul style="list-style-type: none"> <li>Physical exam and OPQRST/SAMPLE history <ul style="list-style-type: none"> <li>Establish the mechanism and nature of injury</li> </ul> </li> <li>Monitor vital signs and oxygen saturation</li> <li>For fractures or dislocation <ul style="list-style-type: none"> <li>Assess distal pulse, motor and sensation before/after splinting and during transport</li> <li>If open fractures, control bleeding and cover with dry, sterile dressing.</li> <li>If the extremity is severely angulated <b>AND</b> pulses are absent, apply gentle traction in an attempt to straighten it</li> <li>Otherwise if pulses are present or if resistance is encountered, splint the extremity in the angulated position</li> <li>Apply appropriate splinting device</li> <li>To reduce swelling, elevate extremity and apply cold pack</li> </ul> </li> <li>For amputation - if located initiate care for amputated part <ul style="list-style-type: none"> <li>Remove gross contaminants by rinsing with saline</li> <li>Wrap in saline moistened gauze and place in plastic bag or container (sterile, if available)</li> <li>Seal the bag or container tightly and place in solution of ice water, if available</li> <li>Transport part to the hospital regardless of the condition</li> <li>If the part cannot be immediately located, transport the patient and have other field providers search for and transport the part as soon as possible</li> </ul> </li> </ul> </li> <li>Initiate patient transport as soon as possible</li> </ul>


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## Pediatric Extremity Trauma (Page 2 of 2)

### IACP


- Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock
- Reevaluate patient's ABCs and perform a detailed/focused assessment
- Consider cardiac monitoring

- For pain, refer to the *Pediatric Pain Management Protocol*
- Transport to the appropriate facility, refer to the *Destination Decision Protocol*.

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## Pediatric Trauma Arrest (Page 1 of 2)

- First Impression
  - Appearance
  - Breathing
  - Circulation

- Primary Survey
    - Assess for signs of life
    - Initiate spinal motion restriction
    - Begin high quality CPR and restrict interruptions of compressions as much as possible
    - Assure airway/ventilatory support - a blind insertion airway device (BIAD) or a supra-glottic airway (SGA) may be inserted early, otherwise ventilate with a BVM and 100% oxygen
    - Ventilate with 100% oxygen only until the chest rises (do not over-ventilate) Refer to the *Pediatric Airway Management Protocol*
    - Control life-threatening bleeding
-  **Airway management, bleeding control and rapid transport are the most important interventions for victims of traumatic arrest. Minimize scene time to 10 minutes or less, barring extrication time), and perform only critical interventions before transport.**


- Secondary Assessment and History
  - Attempt to obtain OPQRST /SAMPLE History, if relevant, prior to transport
  - Begin transport as soon as possible. Minimize scene time
  - Continue guideline en route
  - Move as rapidly and safely as possible toward an appropriate facility
  - Initiate cardiac monitoring
    - Manage dysrhythmias per appropriate guideline
  - Initiate ETCO<sub>2</sub> monitoring (if available)

**IACP**

- Advanced airway/ventilatory management as needed
- Continue with compressions until return of adequate pulses
- Establish IV/IO access using normal saline with rapid infusion and monitor for the return of a palpable pulse. If a pulse is restored, titrate the infusion rate to a blood pressure of 80-90 systolic.

**IACP**

**TRAUMA**

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## Pediatric Trauma Arrest (Page 2 of 2)


**P**

If mechanism of injury, symptoms, and physical exam suggests a tension pneumothorax, consider needle decompression on the affected side(s)



Contact Medical Control with patient status and treatment as soon as possible.

- Transport to the appropriate facility, refer to the *Destination Decision Protocol*.

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## Pediatric Burns (Page 1 of 2)

Applies to patients who have sustained thermal, chemical or electrical burns and/or have sustained inhalation injuries. Hypotension is not normally seen with prehospital burn patients. Hypotension suggests other trauma. Refer to the trauma guidelines as needed.

- Assure scene safety
- Remove from burning process if possible (only if properly trained)
- First Impression
  - Appearance
  - Breathing
  - Circulation

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - be prepared to aggressively manage the airway
  - Assess breathing - give O<sub>2</sub> as tolerated to maintain SpO<sub>2</sub> ≥ 94%
  - Assess circulation - manage bleeding and shock appropriately
  - Assess disability - assess LOC
  - Exposure/environment - Cover with dry sterile dressing, children are more susceptible to hypothermia, use wet dressing if < 10% BSA
  - ! **Look closely for evidence of inhalation injury (hoarseness, stridor, sooty sputum, facial burns, or singed nasal or facial hair). Aggressive airway management may be warranted.**
  - ! **Burn victims may have suffered carbon monoxide poisoning and may show a false reading on the pulse oximeter.**

- Initial Burn Management
  - Initiate spinal movement restrictions, as needed.
    - If no suspicion of spinal injury, place the patient in position of comfort.
    - If evidence of shock, place the patient supine and monitor airway closely. Treat shock according to the *Shock* guideline.
  - Remove and secure any jewelry, belts, shoes, etc. from burned areas.
  - Remove burned or singed clothing not stuck to the skin.
  - Initiate care for burn wounds
    - Chemical injury - brush off chemical, flush with water to remove any residual chemical
    - Electrical injury - treat dysrhythmias per appropriate guideline
    - Thermal injury – dry sterile dressings
  - Begin transport as soon as possible.
    - If no other trauma mechanism, consider transport to burn center
    - If trauma mechanism exists, consider transport to a trauma center
  - ! **Transport patients with an **unmanageable airway** to the closest facility.**

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## Pediatric Burns (Page 2 of 2)

- Advanced airway/ventilatory management as needed
- Secondary Assessment and History
  - Record and monitor vital signs, oxygen saturation, and CO-
  - Monitor carbon monoxide saturation (if CO-oximetry is available)
  - Initiate cardiac monitoring
  - Assess
    - Possible carbon monoxide poisoning
    - Heat inhalation injury/airway
    - Approximate burn size, depth, and location
    - Other injuries and illnesses
  - Initiate IV/IO normal saline - see below
    - Do not delay transport for IV access



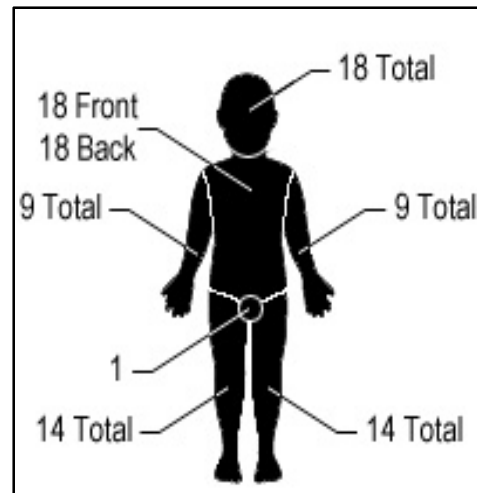
For pain management, see *Pediatric Pain Management Protocol*.

### IACP




#### Initial Fluid Resuscitation

- If patient presents with shock, Initiate IV/IO of NS 20ml/kg bolus
- If patient is not in shock, calculate the patients wt. in kilograms and percent and degree of the burn.
- Consult Medical Control for fluid resuscitation direction. If unable to contact medical control, utilize Burn Fluid Resuscitation Formula found in the resource section of this document.



To calculate body surface area involved, use Rule of Nines or estimate using the patient's palm size as approximately 1% of BSA

Transport to Burn Center if meets criteria. Refer to the *Destination Decision Protocol*.


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## Pediatric Snakebite


**Special Note: Safety of rescue personnel is top priority! Assure scene safety and determine location of snake. Do not transport snake. DEAD SNAKES ARE STILL DANGEROUS!**

- First Impression
  - Appearance
  - Breathing
  - Circulation

- Primary Survey
  - Assure airway - assure patency and proper positioning
  - Assess breathing - give O<sub>2</sub> as tolerated by mask or blow-by
    - Assist with BVM if ineffective respiratory effort
  - Assess circulation - manage shock appropriately
  - Assess disability - assess LOC
  - Exposure/environment - undress the child as appropriate

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis - treat hypoglycemia if present
  - Consider cardiac monitoring
  - Physical exam and OPQRST/SAMPLE history
    - Assess for swelling, skin color changes, shock
  -  **Mark on skin the leading edge of swelling and erythema and record time, repeat if leading edge progression**
    - If able, safely determine type, size, and length of snake
  - Advanced airway/ventilatory management as needed
  - Place patient in position of comfort. Minimize movement and exertion.
  - Do not place bitten extremity in an elevated or lowered position.
  - Clean wound - apply light dressing, unless wound is bleeding profusely
    - No ice, no constricting bands, no cutting
  - **IACP** Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock

- Frequently reassess patient, manage any presenting respiratory distress, seizures, and/or dysrhythmia's in accordance with appropriate protocol.
- Contact Medical Control for *Pediatric Pain Management Protocol*
- Treat dysrhythmias and conditions according to appropriate protocol

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## Pediatric Submersion Event

Applies to any patient that has been submerged under water for any period of time.  
**Special Note: Safety of rescue personnel is top priority! Enter water only if trained and as a last resort.**

- First Impression
  - Appearance
  - Breathing
  - Circulation


- Primary Survey
  - Assure airway - assure patency and proper positioning
    - Consider immobilization if evidence of trauma
  - Assess breathing - give O<sub>2</sub> as tolerated by mask or blow-by
    - Assist with BVM if ineffective respiratory effort
  - Assess circulation - manage shock appropriately
  - Assess disability - assess LOC
  - Exposure/environment - take measures to prevent hypothermia
    - Remove wet clothes
    - Cover and warm the patient

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis - treat hypoglycemia if present refer to the *Pediatric Altered Loss of Consciousness Protocol*
  - Consider cardiac monitoring
  - Physical exam and OPQRST/SAMPLE history
- **IACP** Advanced airway/ventilatory management as needed
- Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock, refer to the *Pediatric Shock Management Protocol*
- If patient is hypothermic, refer to *Pediatric Cold Related Emergencies Protocol*



**ALL SUBMERSION VICTIMS SHOULD BE TRANSPORTED EVEN IF THEY APPEAR UNINJURED OR APPEAR TO HAVE RECOVERED.**




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## Childbirth/Labor (Page 1 of 2)


Applies to women whose chief complaint is related to labor and /or impending delivery.


- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - have suction ready
  - Assess breathing - give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> <94%
  - Assess circulation - manage shock appropriately
  - ! **Altered LOC and signs of poor perfusion could indicate shock and should be managed appropriately.**
  - ! **If a patient is unstable, initial resuscitation/stabilization must precede any action specified in this protocol. Resuscitation of the mother is the key to survival of both mother and fetus**

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis - treat hypoglycemia if present
  - Consider cardiac monitoring
  - OPQRST/SAMPLE, LMP, obstetric, and gynecological history
  - ! **Determine: how many previous deliveries, due date, onset of contractions, if membranes have ruptured, if bleeding or vaginal discharge present, if patient has urge to push or move bowels, and if pregnancy is high risk**
    - Time contractions - frequency and duration
    - Physical exam - assess for signs of shock
  - IACP** IV/IO access if needed, refer to the *Adult Shock Protocol*
  - If active labor, inspect the perineum for crowning
    - If crowning, apply gentle pressure with your glove hand to the infant's head and prepare for delivery.
    - If no crowning, monitor and reassess frequency and duration of contractions.
  - If feet or buttocks presentation – **DO NOT** pull on Infant
    - Support head and trunk
    - Place your gloved hand inside the vagina and form **V** with first two fingers, place over infant's face -keep vagina wall away from infant's face
    - Rapid transport to receiving facility L & D/Birthcare/Women's Wellness Center
  - If prolapsed cord
    - Place mother in a knee chest position to relieve pressure on the cord.
    - Place your gloved hand inside the vagina and push upward on the presenting part to further reduce pressure on the cord
    - Cover the cord with moist sterile dressings and avoid manipulating it
  - ! **Priority symptoms: Crowning < 36 weeks gestation, prolapsed cord, abnormal presentation, severe vaginal bleeding, multiple gestation or seizure. If noted, expedite transport and notify Medical Control as early as possible.**

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## Childbirth/Labor (Page 2 of 2)

- Delivery and Post Delivery Care of Mother
  - Maintain gentle pressure on the infant's head and allow it to deliver in a controlled gradual manner. *Routine suctioning of the oropharynx and nasal pharynx as soon as the head is delivered is no longer recommended.*
  - Check around the infant's neck for the umbilical cord.
  - If the cord has looped around the baby's neck, use your finger to hook the cord and pull it over the baby's head.
  - If unable to free the cord, clamp the cord in two places and cut the cord between the clamps.
  - Gently direct the infant's head and body downward to deliver the anterior shoulder and support the rest of the body as it delivers.
  - Keep the infant at the level of the vagina and use a gauze pad to wipe any secretions around the mouth and nose.
  - Vigorously dry the infant and provide warmth (increasing ambient temperature, cover with blanket)
  - If needed, stimulate breathing by flicking the soles of the baby's feet or rubbing the baby's back.
  - Clamp the cord at 4 and 6 inches and cut the cord between the clamps.
  - Wrap the baby in dry, clean towels or blankets.
  - Note time of delivery. Obtain APGAR score at 1 and 5 minutes after delivery.  
**Score ≤ 3: critical. Score ≥ 7: good to excellent**
  - If excessive secretions AND signs of compromise are present, clear airway with bulb syringe.
-  **If the newborn fails to respond to initial stimulation and are in need of resuscitation efforts, initiate resuscitation and refer to the *Newborn Resuscitation* guideline.**
  - Once the placenta delivers, place it in a clean container and transport it to the hospital with the mother and infant.
  - After delivery, keep mother warm and watch for signs of shock.
  - If excessive blood loss, > 500ml - apply ABD pad to external vaginal area
- **IACP**
  - consider an additional fluid bolus at 20 ml/kg of Normal saline
  - massage the uterus to promote uterine contraction
  - consider allowing mother to breastfeed infant
- Transport to a facility capable of handling an obstetrical patient .

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## Newborn Resuscitation (Page 1 of 2)

Applies to term and pre-term newborn patients who fail to respond to initial stimulation and are in need of resuscitation efforts. This guideline also applies to all newborns and infants in the first few weeks of life.

### Within the first thirty seconds:


- As soon as the baby is born: vigorously dry the infant and provide warmth (increasing ambient temperature, cover with blanket)
- Position the infant to open the airway.
- Clamp and cut cord.
- If excessive secretions AND signs of compromise are present, clear airway with bulb syringe.
  - Routine suctioning of the oropharynx and nasal pharynx as soon as the head is delivered is no longer recommended.
  - If meconium staining is present AND the newborn is not vigorous (weak or absent respiratory efforts, weak or absent muscle tone, heart rate less than 100 beats per minute), tracheal suctioning may be considered
- Stimulate breathing (flicking the soles of the baby's feet or rubbing the baby's back).

### Assess respirations:

- If inadequate or gasping respirations are present, assist ventilation at a rate of 40 to 60 breaths per minute using a BVM with 100% oxygen.
- If the respirations are shallow or slow, attempt a 1-minute period of stimulation while administering oxygen via blow-by.
  - If respirations do not increase, assist ventilation at a rate of 40 to 60 breaths per minute using a BVM with 100% oxygen.

### Assess heart rate:

- If less than 60 beats per minute, begin chest compressions.
  - Compression-to-ventilation ratio of 3:1 in neonatal resuscitation, compress at 120/min.
  - Compressions should be discontinued when the heart rate is higher than 60 beats/min.

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## Newborn Resuscitation (Page 2 of 2)

Most neonates transition to post-natal life without difficulty. About 10% of infants require some assistance to begin breathing at birth. Less than 1% require extensive resuscitative measures.

### Advanced Resuscitation:

- Consider advanced airway (one attempt only) for:
  - Persistent apnea
  - Central cyanosis
  - Bradycardia (HR < 100)
- If HR persistently < 60:
  - Continue CPR
  - IACP** Ensure that optimal ventilation is being provided with 100% oxygen
    - Initiate IV/IO normal saline
  - CP** For persistent HR < 60, administer 1:10,000 **Epinephrine** 0.01mg/kg (0.1ml/kg) IV/IO every 3-5 minutes as needed
  - If BGA is less than 60mg/dl
    - IACP** 0.5 ml/kg of **D10W** IV/IO (mix 2 ml D50W with 8cc NaCL)
- If no improvement despite adequate ventilation, chest compressions, and epinephrine, consider fluid administration: 10 mL/kg normal saline over 5 to 10 minutes.
- Consider underlying causes.

APGAR score to be calculated at 1 and 5 minutes after delivery. Score ≤ 3: critical. Score ≥ 7: good to excellent.

### APGAR CHART

	0 points	1 point	2 points
Appearance (skin color)	Body and extremities cyanotic	Body pink, extremities cyanotic	No cyanosis
Pulse rate	Absent	< 100 beats/minute	>100 beats/minute
Grimace (irritability)	No response to stimulation	Grimace, feeble cry when stimulated	Cry or pull away when stimulated
Activity (muscle tone)	None or limp	Some flexion	Active motion; arms and legs flexed
Respiration	Absent	Weak, gasping	Strong cry, good respiratory effort

# **Adult Protocols**



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## Assessment-Adult Page 1 of 2

- Primary Survey
  - Assess LOC - determine responsiveness, utilize AVPU scale
  - Assure airway - assess airway patency
    - Open, clear, and maintain airway
    - Simultaneously initiate immobilization if indicated
  - Assess breathing - assess rate and quality of breathing
    - Assure adequate ventilation
    - Initiate appropriate oxygen therapy
  - Assess circulation - assess pulses and perfusion status
    - Control major bleeding
    - Manage shock appropriately
- ! **Perform necessary interventions for all identified life-threats and determine patient priority**

### Trauma


**Initiate Secondary Assessment and History**  
*If new life threats identified, treat immediately!*

### Medical

<p>! <b>If primary survey is abnormal, minimize scene time. Perform only necessary interventions, such as immobilization, initial airway management, BVM ventilation, and control of major bleeding, in the field.</b></p> <ul style="list-style-type: none"> <li>○ Continue immobilization support as indicated. If no spinal injury is suspected, place the patient in position of comfort.</li> <li>○ Initiate basic care for specific injuries</li> <li>○ Perform physical examination           <ul style="list-style-type: none"> <li>- Expose and examine any potentially injured area.</li> <li>- Take measures to prevent hypothermia</li> </ul> </li> <li>○ Monitor vital signs and SpO2</li> <li>○ Consider cardiac monitoring.</li> <li>○ Consider ETCO2 monitoring</li> <li>○ If indicated, perform blood glucose analysis</li> <li>○ Obtain OPQRST/SAMPLE history           <ul style="list-style-type: none"> <li>- <u>O</u>nset                      - <u>S</u>igns, Symptoms</li> <li>- <u>P</u>rovocation           - <u>A</u>llergies</li> <li>- <u>Q</u>uality                   - <u>M</u>edications</li> <li>- <u>R</u>egion, <u>R</u>adiation - <u>P</u>PMHx</li> <li>- <u>S</u>everity                - <u>L</u>ast Oral Intake</li> <li>- <u>T</u>ime                      - <u>E</u>vents</li> <li>                                  proceeding illness or injury</li> </ul> </li> <li>○ Perform ongoing assessment           <ul style="list-style-type: none"> <li>- Repeat primary survey and vital signs</li> <li>- Evaluate response to treatment</li> <li>- Repeat physical exam</li> </ul> </li> </ul>	<p>! <b>If patient is unresponsive or has a diminished LOC, perform a rapid head-to-toe examination to rule out presence of trauma and identify medically significant physical findings.</b></p> <ul style="list-style-type: none"> <li>○ Obtain OPQRST/SAMPLE history           <ul style="list-style-type: none"> <li>- <u>O</u>nset                      - <u>S</u>igns, Symptoms</li> <li>- <u>P</u>rovocation           - <u>A</u>llergies</li> <li>- <u>Q</u>uality                   - <u>M</u>edications</li> <li>- <u>R</u>egion, <u>R</u>adiation - <u>P</u>PMHx</li> <li>- <u>S</u>everity                - <u>L</u>ast Oral Intake</li> <li>- <u>T</u>ime                      - <u>E</u>vents</li> <li>                                  proceeding illness or injury</li> </ul> </li> <li>○ Perform physical examination</li> <li>○ Monitor vital signs and SpO2</li> <li>○ Place patient on cardiac monitor.</li> <li>○ Consider 12-lead ECG</li> <li>○ Consider ETCO2 monitoring</li> <li>○ Perform blood glucose analysis</li> <li>○ Perform ongoing assessment           <ul style="list-style-type: none"> <li>- Repeat primary survey and vital signs</li> <li>- Evaluate response to treatment</li> <li>- Repeat physical exam</li> </ul> </li> </ul>
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CORE



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## Assessment – Adult Page 2 of 2

- Vital signs are to be checked at least every 15 minutes on stable patients, and every 5 minutes on unstable patients.
- A **minimum** of 3 sets of vital signs are to be checked on every patient that is transported (**On Scene / Enroute / ED arrival**) with the initial set of vital signs performed **manually**.
- Use of the NIBP cuff is then permissible if there is not at 20 point difference in either systolic/diastolic between the manual blood pressure reading and the automated blood pressure reading.
- If there is more than a 20 point difference, all blood pressures must be taken manually
- **Only manual BP should be taken on all unstable patients.**



- Patients are to be reassessed after every intervention for positive or negative changes and responses to treatment regiments.

- Potential cardiac events with or without chest pains should have ECG monitoring to include 12 lead.
- Do not delay transport if your patient is unstable or appears to be experiencing a cardiac even.
- Have high suspicion for patients with cardiac related signs, symptoms, irregular pulse, lower body size than expected for patients age.



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## Adult Altered Level of Consciousness (Page 1 of 2)

Applies to patients who are disoriented, weak, dizzy, confused, agitated, exhibit bizarre behavior, have had a syncopal episode, or are unconscious.

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - Assure patency and proper positioning, suction as needed
    - Consider immobilization if evidence of trauma
  - Assess breathing - Assist with BVM if ineffective respiratory effort with use of OPA/NPA
    - Give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation - Manage shock appropriately
  - **Altered LOC and signs of poor perfusion could indicate shock and should be managed appropriately**

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Cardiac monitor - record and evaluate 12 Lead ECG (if available; **do not delay therapy**)
  - Physical exam and OPQRST/SAMPLE history
- Consider possible causes - AEIOUTIPS; alcohol, electrolytes, insulin (hypoglycemia), opiates, uremia, trauma, infection, poison, psychogenic, seizure, and/or shock
- Advanced airway/ventilatory management as needed
  - IACP**
    - Consider advanced airway management ETT/Supraglottic airway device or Needle Cric., according to scope of practice
    - Do not delay resuscitation for advanced airway placement
      - If advanced airway is utilized, initiate and document ETCO<sub>2</sub> monitoring
  - Initiate IV/IO refer to the *Adult Shock Management Protocol*
  - Cardiac – refer to the *Adult Chest Pain Management Protocol*
  - EIACP**
    - Perform blood glucose analysis – treat if BGA is less than 60mg/dl
    - If patient is able to protect and maintain own airway, administer **Oral Glucose** 15g PO
  - IACP**
    - If patient is not able to protect own airway, give **D50W** 25g IV/IO
    - Reassess in 5 min. If glucose is still less than 60mg/dl may give **D50W** 25g IV/IO
  - ACP**
    - If IV/IO cannot be established: give **Glucagon** 1 mg IM or intranasal
  - P**
    - If history of alcohol abuse with thiamine deficiency: malnourishment or has unknown medical history: administer **Thiamine** 100 mg IV/IO

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## Adult Altered Level of Consciousness (Page 2 of 2)


Applies to patients who are disoriented, weak, dizzy, confused, agitated, exhibit bizarre behavior, have had a syncopal episode, or are unconscious.

- If BGA is greater than 250mg/dl

### IACP

- Establish IV/IO of normal saline 200ml/hr
- If tachycardia and/or signs and symptoms of dehydration are present, administer 20ml/kg fluid bolus normal saline to maintain a radial pulse or systolic bp of 90

- *If overdose or toxic ingestion refer to the Adult Toxic Ingestion Protocol*
- *If toxic exposure, refer to the Adult Toxic Exposure Protocol*
- *If patient requires restraint, refer to the Adult Combative Patient Restraint Protocol*

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## Airway – Adult (Page 1 of 2)

Applies to patients either trauma, medical or cardiac who are in need of a secure airway.

- Primary Survey
    - Assess LOC - AVPU
    - Assure airway - Assure patency and proper positioning, suction as needed
      - Consider immobilization if evidence of trauma
    - Assess breathing - Assist with BVM if ineffective respiratory effort with use of OPA/NPA
      - Give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
    - Assess circulation - Manage shock appropriately
    - **Altered LOC and signs of poor perfusion could indicate shock and should be managed appropriately**
  - Secondary Assessment and History
    - Monitor vital signs and oxygen saturation
    - Cardiac monitor - record and evaluate 12 Lead ECG (if available; **do not delay therapy**)
    - Physical exam and OPQRST/SAMPLE history
      - Consider possible causes - AEIOUTIPS; alcohol, electrolytes, insulin (hypoglycemia), opiates, uremia, trauma, infection, poison, psychogenic, seizure, and/or shock
        - Consider advanced airway management ETT/Supraglottic airway device or Needle Cric., according to scope of practice
        - Do not delay resuscitation for advanced airway placement
- CP** Anytime a medic deems that the patient needs to be intubated by ETT (utilize waveform capnography and record readings to confirm ETT placement) or by
- IACP** supraglottic airway device the medic may perform the procedure
- In the adult patient that has been intubated with an ETT use the VIVAC method in addition to chest rise, V-visualize / I- intubate / V – ventilate / A – auscultate / C- capnography
- IACP** Initiate IV/IO refer to the *Adult Shock Management Protocol*  
Cardiac – refer to the *Adult Chest Pain Management Protocol*




If a supraglottic airway has been inserted and the patient is being ventilated well the device should be left in place.

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## Airway- Adult (Page 2 of 2)

- Obstructed Airway
  - EIACP** Conscious patient- Perform the Heimlich maneuver  
Unconscious patient- Perform CPR and assess the airway after each cycle of compressions
  - CP** Removal of foreign body substance by use of magill forceps as necessary
    - Unable to ventilate or intubate
      - P** Perform a needle cricothyroidotomy as a temporary secure airway to oxygenate and ventilate a patient in severe respiratory distress when other less invasive methods have failed or are not likely to be successful


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## Adult Vascular Access

Applies to patients presenting with signs and symptoms consistent with a need for vascular access.

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - Assure patency and proper positioning
    - Consider immobilization if evidence of trauma
  - Assess breathing - Assist with BVM if ineffective respiratory effort
    - Give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation - Control bleeding if present
    - Take measures to prevent hypothermia
- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis – refer to the *Adult Altered Level of Consciousness Protocol* for management
  - Initiate cardiac monitoring - treat dysrhythmias per appropriate protocol
  - Initiate ETCO<sub>2</sub> monitoring (if available)
  - OPQRST/SAMPLE history
  - Physical exam
- Keep the patient NPO
- Advanced airway/ventilatory, refer to the Adult Airway Management Protocol

- For all adult patients in shock refer to *Adult Shock Management Protocol*
- **IACP** At any time that the medic feels that the patient needs IV access, and it is not covered under a particular protocol, the medic can initiate an IV at their discretion.
  - Critical patients require X2 IV when possible
- All meds given by IV or IO should be followed by a 10cc NS flush unless a patient is in cardiac arrest all medications are to be flushed by 20 cc NS
- **IACP** If you cannot establish an IV in 2 attempts consider an IO
  - Breath sounds are to be assessed before and after each fluid bolus
  - No bolus given if patient has s/s of pulmonary edema
  - Fluid bolus is titrated to maintain a blood pressure of 90/systolic
- **IO Access**
  - **IACP** Conscious Adult patients – may establish an IO in the tibial tuberosity if necessary
    - **P** IO Pain Management: **Lidocaine** 20-40 mg administered at the injection site
  - **IACP** Unconscious patient establish IO if no venous access is available. Proximal humerus location is preferred for cardiac arrest and rapid fluid replacement

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## Combative/Severely Agitated – Adult 1 of 2

There are many reasons why a patient may be combative, mental illness, drug/alcohol ingestion, post-ictal state, hypoxia, traumatic head injuries or from an unknown etiology. The priority when caring for medical patients who present with combative behavior is to identify and treat the underlying cause. Be aware of scene safety and remain highly vigilant of dangers.

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - Assure patency and proper positioning, suction as needed
    - Consider immobilization if evidence of trauma
  - Assess breathing - Assist with BVM if ineffective respiratory effort with use of OPA/NPA
    - Give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation - Manage shock appropriately
  - **Altered LOC and signs of poor perfusion could indicate shock and should be managed appropriately**


- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis – refer to the *Adult Altered Level of Consciousness Protocol* for management
  - Initiate cardiac monitoring - treat dysrhythmias per appropriate protocol
  - Initiate ETCO<sub>2</sub> monitoring (If available)
  - OPQRST/SAMPLE history
  - Physical exam

Note: Prior to restraining a patient, the medic must :

- assess the patient's mental status
- determine whether the patient presents a potential or definite life threat to themselves or others.
- attempt verbal de-escalation being honest, straightforward, friendly tone avoiding direct eye contact and encroachment of personal space.




Indications for restraints: Any patient who may harm himself, herself, or others may be restrained to prevent injury to the patient or crew. Restraining must be performed in a humane manner and used only as a last resort.

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## Combative/Severely Agitated – Adult 2 of 2

### Procedure for an suspected altered behavioral emergency requiring restraints:

1. Ensure adequate assistance is available to restrain the patient.
  2. Notify a Supervisor.
  3. All personnel should be instructed as to how the patient will be restrained. This will ensure the safety of the patient as well as emergency personnel.
  4. Restrain the patient.  
Restraint procedure:
    - Soft medical restraints only are secured to each extremity
    - Place patient supine on a LSB
    - Both lower extremities are secured to the LSB
    - Left arm is secured to the LSB beside the patients body
    - Right arm is flexed above the patient's head and secured to the LSB by the wrist
    - Patients body is secured to the LSB using DCFR strapping technique – refer to the Adult Neck and Spine on strapping in conjunction with the above direction
  5. Perform a complete assessment on the patient and reassess every 5 minutes
  6. **Haldol 5 mg IM if needed (adult patient only) AND/OR**
  7. **P Midazolam 2.5mg -5mg IV/ IO/ IM or intranasal if needed**
-  Notify the receiving facility of transport

### Suicidal patient who is alert and oriented as normal and Refusing Transport:

- Attempt to convince the patient to allow transport, use family and/or friends to assist. however, they may agitate the patient and need to be distanced.
- Contact the receiving facility and request an order to restrain and transport the patient.
- Once order is approved by the ED physician, follow the above; "Procedures for suspected behavioral emergency requiring restraints".

### Documentation:


- Names and unit numbers for all personnel present, rank needed for officers • Reason(s) why restraint was necessary
- Any assessment findings obtained through observation (injuries, behavior, mental status, etc.) prior to restraining
- Describe the position in which the patient was restrained
- Time the patient was restrained
- Assessment findings after the patient was restrained and during transport.

### Note:



- **Do not place or allow any restraint to impair circulation or respirations.**
- The dignity of the patient must be considered during and after the restraining process.
- Advise any family members present why restraint is necessary and how it will be performed. Allow the family to stay close to the patient if this is helpful.
- Once the patient is restrained, one medic must remain with the patient at all times.



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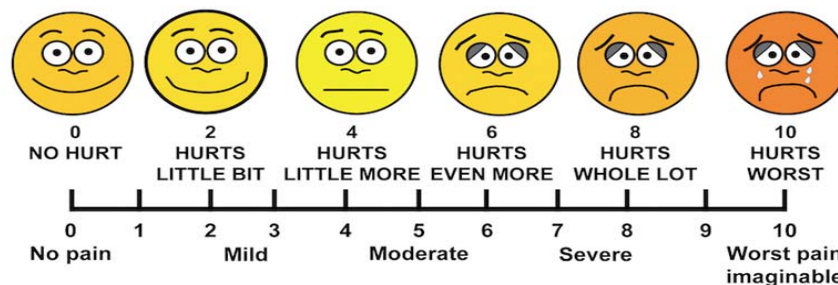
## Adult Pain Management (Page 1 of 2)


Applies to patients suffering from severe pain or discomfort from isolated fractures or dislocations without any significant trauma (head, brain, spinal torso or abdominal injuries), flank pain from suspected kidney stone, sickle cell crisis, burns, and other causes.

- Primary Survey
  - Assess LOC – AVPU
  - Assure airway - Have suction ready
    - Consider immobilization if evidence of trauma
  - Assess breathing - give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation – manage bleeding and/or shock appropriately


- Secondary Assessment and History
  - Place the patient in position of comfort and minimize patient exertion
    - If hypotensive, place supine, treat according to Adult *Shock Management protocol*.
  - Monitor vital signs and oxygen saturation
  - Initiate ETCO<sub>2</sub> monitoring (if available)
  - Cardiac monitor - record and evaluate 12-lead ECG (if able)
  - OPQRST/SAMPLE history
  - Physical Exam
- Place patient in position of comfort
- Immobilize any obvious injuries
  - Elevate injured extremities, if possible
  - Consider application of a cold pack
- Keep the patient NPO
- **IACP** Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock


## PAIN MEASUREMENT SCALE



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## Adult Pain Management (Page 2 of 2)


○	<b>Cardiac pain</b> (Do not administer Toradol for cardiac pain) unrelieved by NTG or if NTG is contraindicated:	
<b>CP</b>	○	<b>Morphine</b> 2.5 to 10 mg slow IV/IO, given in 2.5mg increments
	○	Titrate administration to pain relief
○	<b>Trauma pain</b> (such as fractures, dislocations, lacerations, contusions ) from blunt or penetrating MOI :	
<b>P</b>	○	<b>Fentanyl</b> administer up to 50-100mcg IV/IO/IN
○	<b>Flank pain from suspected kidney stone:</b>	
<b>P</b>	○	Pain <6 <b>Toradol</b> 30mg IV/IO or 60mg IM
	○	Pain >6 <b>Fentanyl</b> 50-100 mcg IV/IO/IN
○	<b>Sickle cell crisis with pain &gt;6:</b>	
<b>P</b>	○	<b>Fentanyl</b> - 50mcg-100mcg IV/IO/IN
○	<b>Burns:</b>	
<b>P</b>	○	<b>Morphine</b> 2.5 to 10 mg slow IV/IO, given in 2.5mg increments
	○	Titrate administration to pain relief
	<b>All other pain management, contact medical control for direction.</b>	
▪	After intervention, reassess mental status, pain level, blood pressure and signs of respiratory depression.	
○	If respiratory depression due to opiates administer Naloxone:	
<b>ACP</b>	▪	<b>Naloxone</b> IM/IV/IO 0.4mg to 2mg (titrate to desired effect) OR
<b>EIACP</b>	▪	<b>Naloxone</b> IN 2mg (1ml/nare)
○	If hypotension develops due to opiates	
<b>IACP</b>	▪	Fluid bolus of 20cc/kg, if not contraindicated,
	▪	Maintain a systolic bp of 90 or presence of radial pulse
○	If nausea/vomiting presents,	
<b>P</b>	▪	<b>Ondansetron</b> (Zofran) 4mg IV/IO over 2-5 min. or IM undiluted; may adm. 8mg ODT (oral dissolving tablet) rather than IM/IV/IO

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## Adult Shock Management

Applies to patients presenting with signs and symptoms consistent with shock. All forms of shock are associated with inadequate tissue perfusion.

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - Assure patency and proper positioning
    - Consider immobilization if evidence of trauma
  - Assess breathing - Assist with BVM if ineffective respiratory effort
    - Give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation - Control bleeding if present
    - Take measures to prevent hypothermia
- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis – refer to the *Adult Altered Level of Consciousness Protocol* for management
  - Initiate cardiac monitoring - treat dysrhythmias per appropriate protocol
  - Initiate ETCO<sub>2</sub> monitoring (if available)
  - OPQRST/SAMPLE history
  - Physical exam
- Keep the patient NPO
- Advanced airway/ventilatory, refer to the *Adult Airway Management Protocol*
- **IACP** Initiate IV/IO as directed below for radial pulse or systolic blood pressure of 90
- For hemorrhagic shock, administer **Lactated Ringers** 20ml/kg; titrate to clinical effect to maintain radial pulse or systolic blood pressure of 90
- For cardiogenic shock, administer **Normal Saline** at KVO rate
  - Assure rate and rhythm have been treated
- **CP** Consider **Dopamine** drip 5-10 mcg/kg/minute - titrate to clinical effect to maintain radial pulse or systolic bp of 90
- For all other types of shock, administer **Normal Saline** 20ml/kg
  - Fluid boluses may be repeated to maintain a radial pulse or systolic bp of 90
- Attempt to identify cause and treat in accordance with appropriate protocol, (tension pneumothorax, overdose, trauma, etc.)
- Initiate patient transport as soon as possible
- Continue resuscitation and evaluation of ABC's, mental status and vital signs every 5 minutes for unstable patients and every 15 minutes for stable patients.

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## Adult Bradycardia (Poor Perfusion) (Page 1 of 2)

Applies to patients with a heart rate < 60 beats per minute. This guideline is not intended for patients with bradycardia secondary to increased intracranial pressure.

**In the differential diagnosis you determine that the patient has signs and symptoms of poor perfusion and any of the follow rhythms have been identified; Sinus Bradycardia, Junctional Rhythm, 1<sup>st</sup> Degree Block, 2<sup>nd</sup> Degree AV Block Type I, 2<sup>nd</sup> Degree AV Block Type 2, 3<sup>rd</sup> Degree AV Block, or Idio-ventricular the treatment shall be follows:**

**Note: High Degree AV Blocks and AMI**

2<sup>nd</sup> Degree AV Block (**Mobitz Type II**) may be associated with AMI

3<sup>rd</sup> Degree AV Block can result from AMI, Digitalis toxicity, or a degeneration of the electrical conduction system, as often occurs in the elderly

Use Atropine **cautiously** in the presence of AMI as it may extend the infarct

**Signs and Symptoms:**

Altered Mental Status/ Shortness of breath /Chest Pain/Syncope /Pulmonary Congestion / CHF/ AMI/ Hypotension/Weakness/Fatigue/Light-headedness

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - assure patency and proper positioning
  - Assess breathing - give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation - peripheral pulses, CRT, skin color/temp

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis – refer to the *Adult Altered Level of Consciousness Protocol* for management
  - Cardiac monitor - record and evaluate 12 Lead ECG
    - Do not delay therapy for 12 lead acquisition
  - Consider ETCO<sub>2</sub> monitoring (if available)
  - Physical exam and OPQRST/SAMPLE history
    - Initiate IV/IO normal saline - KVO

**IACP**

**CARDIAC**



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## Adult Bradycardia (Poor Perfusion) (Page 2 of 2)

- CP** • Administer 0.5mg IVP **Atropine** every 3-5 minutes to a maximum of 3mg, if **this medication is unavailable immediately proceed to TCP**

Note: In 2<sup>nd</sup> Degree AV Block; Mobitz Type II and 3<sup>rd</sup> Degree AV Block, if initial dose of Atropine is ineffective, immediately begin **TCP** and chronotropic agents, (Dopamine then Epinephrine as listed below), if warranted.

- CP** • **TCP** in the Demand Mode, rate of 70 BPM, beginning at 30 mA, increase by 10 mA every 10-15 seconds until you have mechanical capture or until maximum mA output is acquired.
- If the patient experiences discomfort / pain from **TCP**, administer one of the following:

**P**

○ **Valium** - 5-10 mg slow IVP if SBP is above 90

○ **Versed** - 5 mg slow IVP if SBP is above 90



**Do not administer both Valium and Versed to the same patient.**

- If the patient is still experiencing discomfort or pain after sedation:

**CP**

**Morphine** - 2 .5 mg - 5 mg IVP, in increments of 2.5 mg (max of 5 mg) if SBP is above 90

- If the patient remains with poor perfusion during **TCP** (inconsistent capture) and continues to rapidly shows signs of cardiovascular collapse (pulmonary edema, CHF, hypotension, SBP less than 90, altered mental status) also begin an infusion of:


**CP**

• **Dopamine Drip** – 2-10 mcg/kg/min, titrate to maintain SBP greater than 90 or a radial pulse.

- Once a **Dopamine** infusion of 10 mcg/kg/min is obtained and patient's SBP remains less than 90 and continued signs of cardiovascular collapse are present, discontinue Dopamine Drip and initiate:

**CP**

• **Epinephrine Drip**-2-10 mcg/min, titrate to maintain SBP greater than 90 or a radial pulse. , (mix Epi 1:1,000 4mg in 1,000cc NS)

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## Adult Chest Pain-Cardiac Origin 1 of 2

Applies to patients presenting with chest pain/discomfort suspected to be ischemic in nature. This may include classic presentations or anginal equivalents (i.e. epigastric pain, neck or jaw pain, and indigestion).

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - Have suction ready
  - Assess breathing - give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation - manage shock appropriately

- **EIACP** If patient is not allergic, administer **Aspirin** 324 mg (4 baby ASA) by mouth
  - Instruct patient to chew before swallowing
  - Administer regardless of whether ASA was taken prior to EMS arrival
- Secondary Assessment and History
  - Place the patient in position of comfort and minimize patient exertion
    - If hypotensive, place supine, treat according to *Adult Shock Management Protocol*
  - Monitor vital signs and oxygen saturation
  - Initiate ETCO<sub>2</sub> monitoring (if available)
- **EIACP** Cardiac monitor - record and evaluate 12-lead ECG within 5 min of patient contact
  - ! ○ Call a STEMI Alert for the closest PCI facility if AMI is present
    - Transmit 12-lead if capabilities are available.
    - Monitor continuously until patient is in care of ER/cath lab staff.
    - Treat arrhythmias under the appropriate protocol
  - OPQRST/SAMPLE history
  - Physical Exam
- Consider possible causes; AMI, angina, aneurysm, PE, GI, etc.
- **IACP** Initiate IV/IO normal saline - KVO
  - 2<sup>nd</sup> IV line can be established, if time permits



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## Adult Chest Pain-Cardiac Origin 2 of 2

**!** If presents with Inferior AMI (ST elevation in leads II, III, AVF, and V4R). Avoid NTG and fluid bolus, use caution in administering Morphine, may cause fatal hypotension,

**!** Adm. **NTG** and fluid bolus for all other AMI's (Inferior with out right ventricular involvement, Anterior, Septal, Lateral and Posterior ) if no contraindications.

### **EIACP**

• **EMT/EMT-I (assist w/pt.'s own NTG)** **ACP** Administer **NTG**

• **Nitroglycerin** 0.4 mg SL; may repeat every 5 minutes x2 as long as SBP remains above 90mmHg.

○ If the SBP falls below 90 mmHg in response to NTG therapy:

- Position patient flat
- Do not administer additional NTG
- Administer 250mL fluid bolus IV, repeat up to a total of 1L (if no pulmonary edema), titrate to keep SBP above 90 mmHg.

**DO NOT administer nitroglycerin to any patient who has taken an erectile dysfunction medication in the last 24 hours.**



### **CP**

○ Administer **Morphine** sulfate in 2.5 mg increments to a max of 10 mg IV/IO push slowly.

○ Titrate morphine sulfate administration to pain relief and BP of 90 systolic.

○ If nausea develops,

○ If nausea/vomiting presents,

### **P**

▪ **Ondansetron** (Zofran) 4mg IV/IO over 2-5 min. or IM undiluted; may adm. 8mg ODT (oral dissolving tablet) rather than IV/IO/ or IM



- Fluid resuscitation in the presence of Inferior AMI, contact medical control
- if patient presents with right ventricular involvement (ST segment elevation in V4R)
- Fluid resuscitation in all other patients, administer 250ml NS IV, repeat as needed to 1 liter. Reassess between each bolus.

○ If patient presents with cardiogenic shock or hypotension in an Inferior AMI,

○ Assure rate and rhythm have been treated.

### **CP**


○ If the systolic blood pressure is less than 90mmHg, consider a **Dopamine** infusion at 5-10mcg/kg/min, titrate to effect

○ If the chest pain is thought to be stimulant-induced (cocaine, amphetamine, ecstasy) and pulse rate is >120

### **P**

○ **Midazolam** 2.5mg slowly IV/IO or Intranasal, repeat 2.5mg if needed



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## Adult Tachycardia (Page 1 of 2)

Applies to patients who present with a palpable pulse rate > 150.

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - assure patency and proper positioning
  - Assess breathing - give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation - peripheral pulses, CRT, skin color/temp

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis – refer to the *Adult Altered Level of Consciousness Protocol*
  - Cardiac monitor - record and evaluate 12 Lead ECG (if available)
    - Do not delay therapy for 12 lead acquisition
  - Consider ETCO<sub>2</sub> monitoring (if available)
  - Physical exam and OPQRST/SAMPLE history
- **IACP** Initiate IV/IO normal saline - KVO
  - 2<sup>nd</sup> IV line can be established, if time permits
- Advanced airway/ventilatory management as needed, refer to the *Adult Airway Management Protocol*
- **Attempt to rule out sinus tachycardia as a potential cause of the symptoms. 220 minus the patient's age is the upper limit of sinus tach.**
- If sinus tachycardia, search for and treat causes - hypovolemia, dehydration, etc.
- **For narrow-complex tachycardia: (Stable)**
  - If no hypotension, acute AMS, signs of shock, ischemic chest discomfort, and/or acute heart failure
    - If narrow-complex, attempt vagal maneuvers
  - **CP** Consider **Adenosine** IV/IO, preferably right AC
    - 1<sup>st</sup> Dose 6mg, administer rapidly followed by 20 ml NS flush
    - 2<sup>nd</sup> Dose 12mg (if required)
  - **If signs of cardiopulmonary compromise, (Unstable)**
    - **P** If conscious, consider administration of **Midazolam** 2.5mg-5mg IV/IO slowly or Intranasal prior to cardioversion (**Monitor Respirations**)
    - **CP** Perform immediate synchronized cardioversion at 100j, Increase sequential synchronized cardioversion by 50j each attempt until maximum joule of 360j
    - If synchronized cardioversion is unsuccessful, administer **Adenosine** IV/IO, preferably right AC
      - 1<sup>st</sup> Dose 6mg, administer rapidly followed by 20 ml NS flush
      - 2<sup>nd</sup> Dose 12mg (if required) administer rapidly followed by 20 ml NS flush





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## Adult Tachycardia (Page 2 of 2)

- **For wide- complex tachycardia ( $\geq 0.12$  sec) (Stable)**

- If no hypotension, acute AMS, signs of shock, ischemic chest discomfort, and/or acute heart failure

**CP**

- If regular **and** monomorphic consider **Adenosine** IV/IO
  - 1<sup>st</sup> Dose 6mg, administer rapidly followed by 20 ml NS flush
  - 2<sup>nd</sup> Dose 12mg (if required) administer rapidly followed by 20 ml NS flush

**CP**

- Administer **Amiodarone**\*\* 150mg in 100ml of NS IV/IO over 10 min

- **For wide –complex tachycardia ( $\geq 0.12$  sec) (Unstable)**

**P**

- If conscious, consider administration of **Midazolam** 2.5mg IV/IO slowly or Intranasal prior to cardioversion (**Monitor Respirations**)

**CP**

- Perform immediate synchronized cardioversion at 100j
- Increase sequential synchronized cardioversion by 50j each attempt to a maximum joule of 360j
- attempt until maximum joule is reached on cardiac monitor
- Administer **Amiodarone**\*\* 150mg in 100ml of NS IV/IO over 10 minutes

**For Polymorphic wide –complex tachycardia ( $\geq 0.12$  sec) (Stable)**

**CP**

- Administer **Magnesium Sulfate** 1-2g in 100ml NS over 10 minutes

**For Polymorphic wide –complex tachycardia ( $\geq 0.12$  sec) (Unstable)**

**CP**

- Perform immediate defibrillation at 200J, if refractory repeat at 300J, if continued refractory 360J of cardiac monitor, if continued refractory adm. **Magnesium Sulfate** 1-2g in 100ml NS over 10 min and continue defibrillation at 360J
- If conversion , administer **Magnesium Sulfate** 1-2g in 100ml NS over 10 minutes if not initiated



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## Adult Pulseless Arrest (Page 1 of 2)

- Resuscitation
  - Assess patient for respiratory and cardiac arrest
  - Initiate CPR 30:2 for one or more than one rescuer; reassess and rotate compressor every 2 min.
  - AED pre-set manufacturer recommendations for energy delivery (200j, 300j, 360j biphasic)
  - **CP** Manual defibrillation per manufacturer recommendation for energy delivery (200j, 300j, 360j biphasic)
  - Provide high-quality compressions, minimizing interruptions
  - Compressions should be at a rate of about 100-120 per minute. (**Once advanced airway in place, continuous compressions and ventilations every 6 seconds**)
  - Ventilate with BVM and 100% oxygen, consider OPA/NPA
    - Consider advanced airway management, refer to the Adult Altered Level of Consciousness
      - Do not delay resuscitation for advanced airway placement
      - If advanced airway is utilized, initiate ETCO2 monitoring

**YES**

**Shockable Rhythm???**

**NO**

### VF/ Pulseless VT

**EIACP**

- AED or Defibrillate-200J; CPR for 2 min, reassess

**IACP**

- Initiate IV/IO normal saline

**CP**

- 1:10,000 **epinephrine** 1mg IV/IO, repeat every 3-5 min. (drug/shock/drug/shock)

**IACP**

- Consider advanced airway, capnography

**EIACP**

- AED or Defibrillate-300J; CPR for 2 min, reassess

**CP**

- **Amiodarone**\* 300mg IV/IO; Rapid IVP; repeat Amiodarone 150mg in 3-5 min. (drug/shock/drug/shock); If refractory after **Amiodarone**, administer. **Mag. Sulfate** 2g IV/IO 1<sup>st</sup> dose; 4g IV/IO 2<sup>nd</sup> dose 3-5 min apart

**EIACP**

- AED or Defibrillate 360J q 2 min as needed, CPR for 2 min, reassess,

**CP**

### Polymorphic VT (Torsades)

Primary Antiarrhythmic: - **Mag. Sulfate**

1<sup>st</sup> dose 2g IV/IO; 2<sup>nd</sup> dose 4g IV/IO

Secondary Antiarrhythmic:

**Amiodarone** 300mg IV/IO; Rapid

IVP; repeat 3-5 min. **Amiodarone**

150mg IV/IO



Consider and treat reversible causes

### Asystole/PEA

**IACP**

Initiate IV/IO normal saline

**CP**

1:10,000 **epinephrine** 1mg

IV/IO repeat every 3-5 minutes

**IACP**

Consider advanced airway, capnography

- Reassess rhythm every 2 minutes,
- If rhythm is organized, check pulse
- Continue CPR/treatment as indicated
- Consider and treat reversible causes

Hypovolemia Tension Pneumo

Hydrogen Ion Tamponade

Hypokalemia Toxins

Hypothermia Thrombosis

Hypoxia

Hypoglycemia

Hyperkalemia

**See Next Page for Treatment of**

**H's/T's**

**\*\*** When terminal rhythm is Asystole, refer to the *Resuscitation Decisions – Termination Protocol* if appropriate



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## Adult Pulseless Arrest (Page 2 of 2)

### Search for causes that can be treated out-of-hospital:

#### IACP

Hypovolemia – administer 500 ml boluses of Normal Saline, titrated to attain and/or maintain a SBP of 90 or the return of a radial pulse

Hypoxia – Assisted ventilations of 100 % O<sub>2</sub>

#### CP

Hydrogen ion (acidosis) – Treat the causes of acidosis; Administer **Sodium Bicarb** 1mEq/kg IV/IO if metabolic acidosis arrest. Treat with effective compression and ventilations for prolonged cardiac arrest. Do not administer Sodium Bicarbonate for the treatment of an extended resuscitation down time

#### CP

Hyperkalemia (including Renal Dialysis patient's) –Administer **Sodium Bicarb** 50 mEq and **Calcium Chloride** 1 gram. If this is the suspected cause, initiate this treatment prior to administration of Epi. Take time to flush the IV line well with Normal Saline between each drug or preferably through a different IV site.

Hypokalemia – Contact Medical Control

Hypothermia – See *Adult Cold Related Emergencies Protocol*

#### P

Tension Pneumothorax - Perform chest decompression

Cardiac Tamponade – Rapid transport

#### CP

Toxins – Treat suspected agent per protocol, contact medical control as needed

#### P


OD with Tricyclics – Administer **Sodium Bicarb** 50mEq IV/IO

#### ACP EACP

OD with Narcotics – Administer **Naloxone**:  
**Naloxone** IM/IV/IO - 0.4mg to 2mg (titrate to desired effect) OR  
**Naloxone** IN – 2mg (1ml/nare)

Pulmonary/Coronary Thrombosis – Transport to the closest PCI capable facility



- **Transport to the closest appropriate facility.**
- If cardiac rhythm change is noted treat based on the appropriate protocol


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## Post Resuscitation

This protocol has been developed for **CP** use only and applies to patients with history of cardiac arrest and ROSC.


 **Exclusion criteria: Pregnancy and Trauma**

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - assure patency and proper positioning
  - Assess breathing - assure airway/ventilatory support
    - Provide 100% oxygen, respiratory rate <12
    - DO NOT Hyperventilate
  - Assess circulation - pulses, CRT, skin color/temp
- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis - treat hypoglycemia if present  
(Refer to the Adult Altered Level of Consciousness Protocol)
  -  ○ Cardiac monitor - record and evaluate **12 Lead ECG**
    - Do not delay therapy for 12 lead acquisition;
      - Rule In AMI (septal, anterior, lateral, inferior)
  - Consider ETCO2 monitoring – ideally >20
  - Physical exam and OPQRST/SAMPLE history
- Initiate IV/IO normal saline
- **All unconscious ROSC patients**
  - 1-2L NS bolus if no presence of inferior AMI (ST elevation in II, III, AVF, V4R)
  - Titrate to systolic BP of 90
  - **Patients with Inferior AMI; avoid fluid bolus**
    - If hypotensive, initiate **Dopamine** 5-10mcg/kg/min to systolic BP of 90
    - 2<sup>nd</sup> IV line can be established, if time permits
- If systolic BP < 90, despite normal saline, Initiate a **Dopamine** IV infusion 5-10mcg/kg/min
-  **The condition of post-resuscitation patients fluctuates rapidly and continuously, monitor patients closely.**
- Treat any presenting non-perfusion dysrhythmias in accordance with the *Adult Pulseless Arrest Protocol*
- Conversion for VT/VF: Adm. drip of the last antiarrhythmic used. (**Amiodarone** 150mg in 100cc of normal saline over 10 min; **Mag. Sulfate** 4g in 1000cc NS, infused at 1-4 mg/min)
- Conversion to a bradycardic rhythm, refer to the *Adult Bradycardia Protocol*
- Transport per the *Destination Decision's Protocol* (STEMI to PCI facility, Trauma to appropriate trauma facility)

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## Adult Left Ventricular Assist Device (LVAD)

Applies to patients who have a left ventricular assist device (LVAD) implanted. A ventricular assist device is a mechanical pump that is used to support heart function and blood flow in people who have weakened hearts.

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - have suction ready
  - Assess breathing - give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> ≤94%
  - Assess circulation - manage shock appropriately
- 
**In a majority of these patients a pulse will not be palpable. This occurs because the LVAD unloads the ventricle in a continuous fashion. Mental status and skin color are best indicators of oxygenation and perfusion status.**


- Secondary Assessment and History
  - Locate emergency contact sheet per patient's hospital/physician
    - Call coordinator if device fails
  - Listen over pump pocket - will hear hum if running
  - Check for specific alarms
    - If alarms show red buttons - critical status
  - Perform blood glucose analysis - treat hypoglycemia if present refer to the *Adult Altered Level of Consciousness Protocol*
  - Cardiac monitor - no pads over pump - don't stop device to assess
  - OPQRST/SAMPLE history - these patients, along with their families, have been well trained in the care of themselves and their devices. **LISTEN TO THEM!**
  - Physical exam - assess for evidence of poor perfusion and/or CHF
- Initial LVAD management
  - Check LVAD percutaneous lead connection
  - Make sure driveline and power sources(battery or AC power) are connected to the system controller
  - Change battery if < 2 lights showing - one battery at a time
  - Transport with 4-6 back up batteries and back up control unit
- If in cardiac arrest, **NO CPR**
- **IACP** Initiate IV/IO normal saline - rate dependent upon perfusion status

- If signs/symptoms of CHF, withhold fluid bolus and see CHF in the *Adult Respiratory Distress Protocol*
- Transport to an appropriate facility

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## Adult Abdominal Discomfort

Applies to patients with pain/discomfort presenting in the abdomen or the flanks with no history or signs of trauma.

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - have suction ready
  - Assess breathing - give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation - manage shock appropriately, refer to the *Adult Shock Management Protocol*
  -  **Altered LOC and signs of poor perfusion could indicate shock and should be managed appropriately**
- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis - treat hypoglycemia if present refer to the *Adult Altered Level of Consciousness Protocol*
  - Cardiac monitor - record and evaluate 12 Lead ECG (if available)
  - OPQRST/SAMPLE history
    - History of blood in vomit or stool? Prior abdominal surgery? Last meal?
  - Physical exam - assess for signs of dehydration/shock
- Consider possible causes; GI, GU, cardiac, aneurysm, meds/toxic ingestion, pregnancy, etc.
- Save emesis or other drainage for signs of GI bleed, etc.
- Keep the patient NPO
- **IACP** Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock
  - Titrate to >90 systolic BP, refer to the *Adult Shock Management Protocol*
- For pain management, refer to the *Adult Pain Management Protocol*
- If nausea or vomiting present, see *Adult Nausea/Vomiting Protocol*



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## Adult Allergic Reaction/Anaphylaxis


Applies to patients presenting with rash, hives, shortness or breath, or other signs and symptoms, up to and including shock, possibly due to an allergic reaction.

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - have suction ready
  - Assess breathing - give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation - manage shock appropriately
- ! **If respiratory compromise and/or signs of shock, treat immediately with epinephrine. All EMS provider levels are authorized to utilize epinephrine auto-injectors. (AEMT, CT, and P providers may give 1:1000 Epinephrine SQ or IM)**

- Isolate the patient from the source of allergen, if possible.
- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Monitor capnography (if available)
  - Perform blood glucose analysis - treat hypoglycemia if present, refer to the *Adult Altered Level of Consciousness Protocol*
  - Initiate cardiac monitoring
  - Record and evaluate 12-lead ECG (if available) - don't delay therapy
  - Physical exam and OPQRST/SAMPLE history
- Advanced airway/ventilatory management as needed
- IACP** Initiate IV/IO refer to the *Adult Shock Management Protocol*
- If localized reaction (hives)
  - P** Administer **Diphenhydramine** 50mg IV slowly or deep IM
- If respiratory distress,
  - EIACP** Administer **Epinephrine** 1:1,000 Auto-Injector IM **or**
  - ACP** Administer **Epinephrine** 1:1,000 0.3mg SQ (IM preferred)
  - EIACP** Nebulize **Albuterol** 2.5 mg with **Atrovent** 0.5mg initial dose for bronchospasm
    - Administer repeated **Albuterol** 5.0mg X 2 nebulized
  - P** Administer **Solu-medrol** 125mg IV/IO/IM
- If anaphylactic shock
  - Do not delay epinephrine administration attempting IV/IO access
  - ACP** 1:1,000 **epinephrine** 0.3 mg IM (preferred) or SQ
  - **All levels may repeat 1:1000 epinephrine IM/SQ/auto-injector (in accordance with their scope of practice) every 5 minutes as needed**


**P** If no response to the Benadryl, Solu-medrol or SQ epinephrine and fluid bolus, mix Epinephrine 1:1,000 1mg in 100cc NS, infuse 5ml/min.



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## Adult Cold Related Emergencies (Page 1 of 2)

Applies to patient's having a body temperature below 95°F (35°C) secondary to environmental exposure.

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - use least invasive means possible to secure airway
    - Intubate only if necessary, as gently as possible
  - Assess breathing - Assist with BVM if ineffective respiratory effort
    - Give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
    - Do not hyperventilate hypothermic patient.
  - Assess circulation - check for pulse, if no pulse begin CPR
-  **It may be necessary to assess pulse and respirations for up to 30-45 seconds to confirm arrest.**
  - If no pulse, initiate CPR 30:2 and AED or Defibrillator as appropriate
    - If **severe** hypothermia (<86°F/30°C) is strongly suspected, limit defibrillation attempts to 1 and **withhold** medications
    - If body temperature is >86°F (30°C), treat in accordance with *Adult Pulseless Arrest Protocol*
    - Resuscitation efforts should continue until core temperature approaches normal.
  - If pulse present, **Do Not** initiate CPR if there is any pulse present, no matter how slow
    - Treat bradycardia only if patient is hypotensive, refer to the *Adult Bradycardia Protocol*

- **Carefully** move patient to warm environment, remove all wet clothing, dry the patient, and cover with blankets
- Avoid any rough movement that may cause cardiac dysrhythmias. It may be beneficial to immobilize the patient on the backboard.
- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis - treat hypoglycemia if present
  - Initiate cardiac monitoring
  - Physical exam and OPQRST/SAMPLE history
- IACP** Initiate IV/IO normal saline (warm if available)– refer to the *Adult Shock Management Protocol*
- Apply warm-packs to groin, axilla, neck and chest.




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## Adult Cold Related Emergencies (Page 2 of 2)

- Protect injured, frostbitten areas, do not rub or place on heated surface
  - Remove clothing and jewelry from injured parts
  - Do not attempt to thaw injured part with local heat
  - Severe frostbite injuries should be transported to a trauma center

- P** Consider morphine for pain relief when the patient is conscious, alert, is not hypotensive, and is complaining of severe pain.
- See *Adult Pain Management Protocol*

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## Adult Heat Related Emergencies

Applies to patients with fatigue or altered level of consciousness secondary to environmental heat exposure.

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - Have suction ready
  - Assess breathing - Assist with BVM if ineffective respiratory effort, refer to the *Adult Airway Management Protocol*
    - Give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation - Manage shock appropriately
    - Remove the patient from the environment
- ! **Altered LOC and signs of poor perfusion could indicate shock and should be managed appropriately**

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Cardiac monitor - record and evaluate 12 Lead ECG (if available)
  - Perform blood glucose analysis – refer to the *Adult Altered Level of Consciousness Protocol*
  - Physical exam and OPQRST/SAMPLE history
- **IACP** Initiate IV/IO normal saline – refer to the *Adult Shock Management Protocol* if signs of dehydration, and/or hypotension
- If conscious and not vomiting or extremely nauseous provide oral fluids
- If heat stroke suspected, active cooling with cold packs, water, and fan
- ! **Signs/symptoms of heat stroke may include: hot, dry skin (25% of patients will still be moist), seizures, altered mental status, dilated pupils, rapid heart rate, or arrhythmia**

- Prepare for seizures, refer to the *Adult Seizure Protocol* for management of seizures.


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## Adult Acute Hypertensive Crisis

Applies to patients demonstrating an acute, potentially life-threatening elevation of blood pressure with evidence of end-organ perfusion damage.


- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - have suction ready
  - Assess breathing - give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation - manage shock appropriately

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis - treat hypoglycemia refer to the *Adult Altered Level of Consciousness Protocol*
  - Cardiac monitor - record and evaluate 12 Lead ECG (if available)
  - OPQRST/SAMPLE history
  - Physical exam - assess for evidence of end-organ perfusion damage (i.e. stroke, ACS/CHF, renal failure)
- **Signs/symptoms may included: elevated BP, headache, dizziness, N/V, blurred vision, dyspnea, pulmonary/peripheral edema, etc.**
- Consider possible causes; chest pain, CHF, overdose, increased ICP, tachycardia
- **IACP** Initiate IV/IO normal saline - KVO

- If suspected overdose of cocaine or amphetamine use,
    - **P** **Midazolam** 2.5mg slowly IV/IO or Intranasal, repeat 2.5mg as needed
-  **Otherwise, DO NOT attempt to lower BP without contacting medical control.**




**OTHER BENZODIAZEPINES MAY BE UTILIZED IF AUTHORIZED BY MEDICAL CONTROL.**

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## Adult Nausea/Vomiting


Applies to patients presenting with acute onset of nausea and/or vomiting.

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - have suction ready
  - Assess breathing - give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation - manage shock per *Adult Shock Management Protocol*
- 
**Altered LOC and signs of poor perfusion could indicate shock and should be managed appropriately**

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis – refer to the *Adult Altered Level of Consciousness*
  - Cardiac monitor - record and evaluate 12 Lead ECG (if available)
  - OPQRST/SAMPLE history
  - Physical exam - assess for signs of dehydration/shock
- Consider possible causes; GI, GU, cardiac, meds/toxic ingestion, pregnancy, etc.
- Save emesis for signs of GI bleed, etc.
- Keep the patient NPO
- Initiate IV/IO normal saline – refer to the *Adult Shock Management Protocol*


- If nausea/vomiting presents,
  - P**

**Ondansetron** (Zofran) 4mg IV/IO over 2-5 min. or IM undiluted; may adm. Repeat X1 OR
    - 8mg ODT (oral dissolving tablet) rather than IV/IO/ or IM may repeat X1.

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## Adult Respiratory Distress (Page 1 of 2)

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - have suction ready
  - P** If unable to remove obstruction or if obstruction is due to trauma or edema, and ventilations remain compromised, perform needle cricothyrotomy
  - Assess breathing - give supplemental O<sub>2</sub> 10-15 lpm via non-rebreather. If known COPD, start 2-6 lpm via nasal cannula and increase as required. Be prepared to ventilate.
  - Assess circulation - manage shock appropriately, refer to the *Adult Shock Management Protocol*

- Secondary Assessment and History
  - Record and monitor vital signs and oxygen saturation
  - Monitor capnography (if available)
  - Perform blood glucose analysis – refer to the *Adult Altered Level of Consciousness Protocol*
  - Cardiac monitor - record and evaluate 12 Lead ECG (if available)
  - OPQRST/SAMPLE history
  - Physical exam
-  **If patient is coughing, apply surgical mask to the patient (if tolerated) and providers should don N95 masks**
- Consider possible causes; anaphylaxis, pulmonary edema, COPD, asthma, TB etc.



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## Adult Respiratory Distress (Page 2 of 2)

If inadequate ventilatory effort, assist ventilations and consider advanced airway placement, confirm placement with ETCO<sub>2</sub>, refer to the *Adult Airway Management Protocol*



*Use ETCO<sub>2</sub> monitoring for appropriate treatment*

### Pulmonary Edema/CHF

- Reassure/calm patient
- Assist the patient in to a semi-sitting or sitting position
- **IACP** IV NS KVO rate
- **CP** Administer **nitroglycerin** 0.4mg SL if SBP  $\geq$  110
- **IACP** Apply CPAP if patient is alert and able to maintain airway at liter flow recommended per manufacturer unless contraindicated
- Watch for hypotension (maintain systolic  $<$ 90) if no response:

- **CP** Consider administration of **Lasix** 40 mg IV/IO,
- Note: If patient is on Lasix, double the prescribed dose to a max. of 120mg for IV/IO

- **CP** Adm. **Morphine** at 2.5mg increments to A max of 5mg

- If systolic bp  $<$ 90:
- Administer **Dopamine** 5-20mcg/kg/min, titrate to effect of radial pulse or bp of 90 systolic

- If Chest Pain is present, refer to the *Adult Chest Pain Protocol*

### COPD

- Reassure/calm patient
- Allow patient to assume position of comfort
- **EIACP** Assist patient in taking their own bronchodilators
- **IACP** IV NS KVO rate
- **EIACP** Nebulize **Albuterol** 2.5mg mix with Atrovent 0.5mg for Initial dose
- Nebulize **Albuterol** 5mg repeated X 2 for total of 3 doses

- **P** If hx of asthma, administer **Solu-medrol** 125 mg IV/IO

- **P** If history of asthma, **Mag. Sulfate** 2g in 100 cc NS over 10 min

- **EIACP** Consider administration of nebulized Aerosol treatment via the BVM

- Consider CPAP if patient is alert and able to maintain airway at liter flow recommended per manufacturer.

- Watch for hypotension (maintain systolic  $<$ 90)

### Asthma

- Reassure/calm patient
- Allow patient to assume position of comfort
- **EIACP** Assist patient in taking their own bronchodilators
- Consider humidified O<sub>2</sub>
- **IACP** IV NS KVO rate

- **EIACP** Nebulize **Albuterol** 2.5mg mix with **Atrovent** 0.5mg for Initial dose

- Nebulize **Albuterol** 5mg repeated X 2 for total of 3 doses

- **P** Consider **Solu-medrol** 125 mg IV/IO


- **P** Consider **Mag. Sulfate** 2g in 100 cc NS over 10 min
- Consider administer nebulized aerosol treatment via the BVM

- **P** If status asthmaticus, 1:1,000 **Epinephrine** 0.3mg SQ

- **P** If stridor is present, administer **Epinephrine** 1:1,000 5mg nebulized. Notify receiving facility


- **IACP** Consider CPAP if patient is alert and able to maintain airway at liter flow recommended per manufacturer.

- Watch for hypotension (maintain systolic  $<$ 90)

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## Adult Seizure

Applies to patients actively seizing or those that have a history of seizures prior to EMS arrival.

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - have suction ready
  - Assess breathing - give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation – refer to the *Adult Shock Management Protocol*, manage shock appropriately
- 
**Altered LOC and signs of poor perfusion could indicate shock and should be managed appropriately**

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis – refer to the *Adult Altered Level of Consciousness Protocol*
  - Initiate cardiac monitoring
  - Record ECG if/when able
  - Physical exam and OPQRST/SAMPLE history
    - Obtain description of seizure activity - duration and severity
    - Note any history of illness or trauma
- **IACP** Advanced airway/ventilatory management as needed
- Initiate IV/IO normal saline – refer to the *Adult Shock Management Protocol*

- If the patient is actively seizing:
  - P** ○ **Midazolam** 2.5mg IV/IO/ or 5mg IM/IN (intranasal), repeat if needed to max of 10mg
  - P** ○ If given intranasal, adm. 2.5mg each nare
- If the patient continues to seize after **Midazolam**:
  - **Diazepam** 2-5mg to a max. of 10 mg IV/IO

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## Adult Stroke

Applies to patients presenting with full or one sided body weakness, facial droop, difficulty speaking, and altered mental status; occurring separately or in conjunction with each other.

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - have suction ready
  - Assess breathing - give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation
  
- Secondary Assessment and History
  - Record and monitor vital signs and oxygen saturation
    - Do not attempt to lower BP
  - Perform blood glucose analysis - treat hypoglycemia if present, refer to the *Adult Altered Level of Consciousness Protocol*
  - Cardiac monitor - record and evaluate 12 Lead ECG (if available)
  - OPQRST/SAMPLE history
    - If possible, determine the time patient was last seen normal
    - Obtain the name and contact information of witness
  - Physical exam
  - **Remember F.A.S.T.**
    - **Face:** Check for facial droop
    - **Arms:** Assess for extremity weakness
    - **Speech:** Assess for slurred speech
    - **Time:** Note when the patient was last seen normal.
- Rule out stroke mimics such as hypoglycemia, seizures, and head injury
  - *Consult the appropriate guideline for treatment options*
- Reassure and calm the patient
- If no trauma, place patient in a position of comfort or in left lateral position.
- Protect paralyzed extremities
- Limit on-scene times to < 10 minutes.
- **IACP** IV/IO KVO X2, avoid primary access in paralyzed extremities

**Rapid transport to the closest Stroke Center**  
(If Stroke Center is not within a reasonable distance, consult Medical Control for destination choice)



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## Adult Toxic Exposure (Page 1 of 2)

Applies to patients with toxic exposure secondary to the ingestion, inhalation, contact or intravenous administration of a potentially toxic substance.

- Scene Safety and Initial Management
  - ! **Prevent exposure of personnel! Assess and assure scene security prior to proceeding with guideline.**
    - If toxic environment, have patient moved to safety by appropriately trained personnel using proper level PPE.
    - If signs of hazardous materials incident, call for HazMat team, keep patient(s) isolated in contaminated zone until HazMat team arrives
      - Coordinate efforts with HazMat personnel
    - Identify agent and mechanism/route of exposure (inhaled, contact, etc.)
    - Decontaminate as appropriate - personnel must be wearing PPE prior to helping with the decontamination process

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - have suction ready, keep the patient NPO
  - Assess breathing - if signs of compromise, give O<sub>2</sub> as tolerated
    - Assist with BVM if ineffective respiratory effort, refer to the *Adult Airway Management Protocol*
  - Assess circulation - manage shock appropriately, take measures to prevent hypothermia, especially following decontamination
  - Assess disability - assess LOC

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - ! **Pulse oximetry may not be accurate for toxic inhalation victims**
  - Perform blood glucose analysis - treat hypoglycemia if present
  - Initiate cardiac monitoring
  - Physical exam and OPQRST/SAMPLE history
    - Identify substance/toxin and amount of exposure
    - Determine mechanism, time, and duration of exposure
    - If ingestion, refer to the *Adult Toxic Ingestion Protocol*
  - **IACP** Initiate Normal Saline IV/IO
  - If signs of shock, refer to the *Adult Shock Management Protocol*

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## Adult Toxic Exposure (Page 2 of 2)

- If known or suspected carbon monoxide poisoning
  - Provide 100% O<sub>2</sub> if not yet initiated
  - Monitor carbon monoxide saturation (if CO-oximetry is available)
  - Transport to the most appropriate facility (consider hyperbaric capability)
- If narcotic overdose
  - ACP** ○ **Naloxone** IM/IV/IO 0.4mg to 2mg (titrate to desired effect) OR
  - EIACP** ○ **Naloxone** IN 2mg (1ml/nare)
- If organophosphate, carbamate, or nerve agent poisoning,
  - P** Administer **Atropine** 2 mg (if available) IV/IO or IM every 5 min. titrate to clinical symptoms (drying of secretions)
    - Contact Georgia Poison Control 1-800-222-1222 for consultation and/or Chempack deployment. See *Chempack* in resources.
- If patient is asymptomatic, monitor for delayed affects.



**Frequently reassess patient, manage any presenting respiratory distress, seizures, and/or dysrhythmia's in accordance with appropriate protocol.**

- All suspected suicide attempts must be reported before leaving the scene.
- EMS personnel may contact Poison Control directly. EMS personnel are directed to follow the advice offered by the Poison Control Center as if it came directly from Medical Control. Georgia Poison Control: 1-800-222-1222.


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## Adult Toxic Ingestion

Applies to patients with an acute overdose and/or toxic ingestion including chronic ETOH abuse

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - have suction ready
  - Assess breathing - give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
    - Assist with BVM with OPA/NPA if ineffective respiratory effort refer to the *Adult Airway Management Protocol*
  - Assess circulation - manage shock appropriately
- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis – refer to the *Adult Altered Level of Consciousness Protocol* for management
  - Initiate cardiac monitoring
  - Physical exam and OPQRST/SAMPLE history
    - Identify substance/toxin and amount of exposure
- Keep the patient NPO
- **IACP** Initiate IV/IO
- If signs of shock, refer to the *Adult Shock Management Protocol*
- If calcium-channel blocker or beta-blocker overdose
  - P** ○ **Glucagon** 1mg IV/IO slowly or IM/IN
- If tricyclic antidepressants overdose with wide complex tachycardia
  - CP** ○ **Sodium Bicarbonate** 1mEq/kg IV/IO slowly
- If narcotic overdose
  - ACP** **Naloxone** IM/IV/IO 0.4mg to 2mg (titrate to desired effect) OR
  - EIACP** **Naloxone** IN 2mg (1ml/nare)
- If a stimulant/hallucinogen overdose (cocaine, amphetamine, ecstasy, etc.)
  - P** ○ If patient is actively seizing, refer to the *Adult Seizure Protocol*
  - If patient is not actively seizing, give **Midazolam** 2.5mg slowly IV/IO/IM or intranasal.
  - P** ○ May repeat Midazolam 2.5mg slowly IV/IO/IM or intranasal if needed
  - Cool patient passively but do not allow patient to shiver
- If aspirin overdose, look for tachypnea and deep respirations
  - CP** ○ If tachypnea and deep respirations are present, administer **Sodium Bicarbonate** 1mEq/kg IV/IO bolus
  - CP** ○ After 10 minutes, if tachypnea and deep respirations continue, repeat **Sodium Bicarbonate** 1mEq/kg IV/IO bolus

- All suspected suicide attempts must be reported before leaving the scene
- EMS personnel may contact Poison Control directly for recommendations advice on patient management. Georgia Poison Control: 1-800-222-1222
- Contact Medical Control if orders are needed.


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## Adult Major Trauma

Applies to patients presenting with injury to more than one body system,

- First Impression
  - Appearance
  - Breathing
  - Circulation
- Primary Survey
  - Assure airway - assure patency, manually stabilize C-spine
  - Assess breathing - give O<sub>2</sub> as tolerated by mask or blow-by
    - Assist with BVM/BVT if ineffective respiratory effort, refer to *Pediatric Airway Management Protocol*
    - Manage any injuries impairing ventilation
  - Assess circulation - assess pulses and perfusion status
    - Control major bleeding and manage shock appropriately
    - If direct pressure to an extremity does not control bleeding and a **tourniquet** is indicated apply the tourniquet-refer to the *Pain Management Protocol as needed*
  - Apply a second **tourniquet** proximal to the first tourniquet if bleeding is still not controlled
  - Assess disability - assess LOC, note any disability
  - Exposure/environment - undress as appropriate
    - Take measures to prevent hypothermia
- Secondary Assessment and History
  - Physical exam and OPQRST/SAMPLE history
    - Expose and rapidly assess the head, chest, abdomen, pelvis and extremities for injury (evaluate patient's posterior when possible)
  - Monitor vital signs and oxygen saturation, determine GCS
  - Administer prehospital care and resuscitate as needed
  - Consider immobilization with a rigid c-collar and secure to LSB
- Initiate patient transport as soon as possible
- Advanced airway/ventilatory management as needed
- **IACP** Initiate IV/IO **Lactated Ringers** - administer 20ml/kg bolus if signs of shock, refer to *Adult Shock Management Protocol*
- Reevaluate ABCs and perform detailed/focused assessment of the head, neck, chest, abdomen, pelvis, and extremities x4 and repeat neuro exam
  - Perform blood glucose analysis - treat hypoglycemia if present, refer to the *Adult Altered Level of Consciousness Protocol for management*
  - Consider cardiac monitoring
- Continue resuscitation and evaluation enroute
- **On scene times should be less than 10 minutes if possible**

- Manage any presenting respiratory distress, seizures, and/or dysrhythmia's in accordance with appropriate protocol.
- Transport to the appropriate facility. Refer to the *Destination Decision Protocol*


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## Adult Head Injuries

Applies to patients presenting with injuries to the head including the report of a head injury and a history of a bleeding disorder or taking anticoagulant medications

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - assure patency, consider SMR (Spinal Motion Restriction)
    - Have suction ready
  - Assess breathing - give O<sub>2</sub>, maintain SpO<sub>2</sub> ≥ 95%
    - Assist with BVM if ineffective respiratory effort
  - ❗ **Maintain normal ventilation rate if providing PPV, hyperventilation should be avoided unless signs of cerebral herniation**
  - Assess circulation - assess pulses and perfusion status
    - Control major bleeding and manage shock appropriately
  - Assess disability - assess LOC, note any disability
    - Take measures to prevent hypothermia

- Secondary Assessment and History
  - Physical exam and OPQRST/SAMPLE history
    - Perform rapid trauma exam
    - Determine GCS, assess pupillary size and reaction
  - Monitor vital signs and oxygen saturation
  - Initiate cardiac monitoring
  - Evaluate and treat other trauma
  - Provide SMR (Spinal Motion Restriction) as needed, refer to the *Neck & Spinal Injury Protocol* Initiate patient transport as soon as possible
- Advanced airway/ventilatory management as needed, refer to the *Adult Airway Management Protocol*
  - Initiate ET/CO<sub>2</sub> monitoring (if available)
    - If no signs of ICP-maintain normal ventilation rate (ET/CO<sub>2</sub> 35-45 mmHg)
  - ❗ **ICP** Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock
    - If Traumatic Brain Injury, titrate NS to maintain a SBP of at least 110-120mmHg
    - **A single incident of hypotension in an adult with a brain injury may increase the mortality rate by 150%.**
- Perform a detailed assessment of the patient
  - Reevaluate ABCs, perform a detailed/focused physical assessment
  - Repeat neuro exam
  - Perform blood glucose analysis - treat hypoglycemia if present, refer to the *Adult Altered Level of Consciousness Protocol*

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## Adult Head Injuries (Page 2 of 2)




**Frequently reassess for clinical signs of cerebral herniation:**

- **dilated and unreactive pupils**
- **asymmetric pupils**
- **extensor posturing or no motor response**
- **decrease GCS > 2 points in patients with an initial GCS < 8.**
- Hyperventilation therapy titrated to clinical effect may be necessary for **brief** periods in cases of cerebral herniation or acute neurologic deterioration
  - Hyperventilation is administered as:
    - 20 breaths per minute in an adult
    - Maintain ETCO of 30-40 mmHg \*\* Never less than 25mmHg
- Manage any presenting seizures in accordance with *Adult Seizure Protocol*



- If patient presents with bradycardia secondary to increased ICP or neurogenic shock, consult with Medical Control regarding management.
- Consider transport to a trauma center (see *Destination Decision Protocol*)

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## Adult Neck and Spine Injuries (Page 1 of 3)

Applies to patients presenting with possible neck and spinal injuries



**Determining the need for spinal immobilization requires a careful assessment of the patient's MOI, mental status of the patient to recognize the presence of spinal injury symptoms, physical complaints and overall condition.**


- Primary Survey
    - Assess LOC - AVPU
    - Assure airway - assure patency, manually stabilize C-spine as needed
      - Have suction ready
    - Assess breathing - give O<sub>2</sub>, maintain SpO<sub>2</sub> ≥ 95%
      - Assist with BVM if ineffective respiratory effort if needed
    - Assess circulation - assess pulses and perfusion status
      - Control major bleeding and manage shock appropriately
    - Assess disability - assess LOC, note any disability
      - Take measures to prevent hypothermia
  - Secondary Assessment and History
    - Physical exam and OPQRST/SAMPLE history
      - Perform rapid trauma exam
      - Determine GCS, assess pupillary size and reaction
    - Monitor vital signs and oxygen saturation
    - Initiate cardiac monitoring-watch for bradycardia
    - Evaluate and treat other trauma
    - Determine need for immobilization. Perform as determined.
    - Initiate patient transport as soon as possible
    - If a cervical spine injury is suspected, transport to the most appropriate trauma center.
  - Advanced airway/ventilatory management as needed, refer to the *Adult Airway Management Protocol*
    - Initiate ET/CO<sub>2</sub> monitoring (if available)
      - Maintain normal ventilation rate (ET/CO<sub>2</sub> 35-40 mmHg)
  - **IACP** Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock
  - Perform a detailed assessment of the patient
    - Reevaluate ABCs, perform a detailed/focused physical assessment
    - Repeat neuro exam
- Perform blood glucose analysis - treat hypoglycemia if present, refer to the *Adult Altered Level of Consciousness*

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## Adult Neck and Spine Injuries (Page 2 of 3)

### Spinal Motion Restriction

- Spinal Motion Restriction (SMR) describes the procedures in caring for patients with suspected unstable cervical spine injuries by restriction, preventing further injury.
- Typical immobilization is performed by applying a properly sized rigid cervical collar, log rolling a patient onto a long backboard, securing the patient with a 5 strap method and applying a manufactured head securing device as per the manufacturers guidelines.
- When SMR is required utilize a long backboard (**LSB**) that has a five point strapping system. Two straps are crisscrossed across the torso of the patient, one strap goes under the arms and across the chest, one goes across the bony prominence of the pelvis, and one goes above the patient's knees. Additional straps can be added, such as over the ankles, but no less than five straps will be used in order to properly secure the patient to the board. Keep in mind that the torso is always immobilized first, and the head / neck last.
- Consider removal of stable patients requiring SMR from a vehicle is the use of the KED
- Careful assessment of the airway and proper ventilations should be continually performed as SMR may impede this ability. Swelling and irritation to injuries from a hard surface may agitate and even worsen injuries. Pad voided areas.

 Caution and careful consideration should be taken when determining to provide SMR to a patient as adverse effects such as respiratory distress and further neurological damage may occur.



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## Adult Neck and Spine Injuries (Page 3 of 3)

Spinal immobilization **is required** for BLUNT trauma in the following:

- Altered mental status including suspected intoxication or drugs
- Tenderness/pain to cervical and/or spine
- Neurological deficits or complaints
- Spinal deformity not present prior to injury
- Distracting injury (injury that may impair the ability to appreciate other injuries)
- Inability to communicate (language barrier)
- When in doubt, immobilize


May consider immobilization of patients (SMR) to a long backboard with a cervical collar that meet the following from BLUNT trauma:

- High risk MOI that include the following , but are not limited to:
  - Axial load (diving, spearing tackle)
  - Roll over
  - High speed impact with potential MOI (older vehicle)
  - Falls >3 feet or 5 steps with high suspicion MOI
  - Sudden deceleration or acceleration

- When MOI is present with BLUNT trauma, a cervical spine is determined to be stable and immobilization is not necessary if the patient is oriented and able to communicate orientation to person, place, time and event and the following criteria is met:
  - **No posterior midline cervical-spine tenderness**
  - **No evidence of intoxication**
  - **No altered mental status**
  - **No focal neurological deficit**
  - **No painfully distracting injuries (Injuries that may impair the pts. Ability to appreciate other injuries. i.e. fractures, visceral injuries, large burns, injuries impairing functional capabilities)**
- When immobilization of the cervical spine is determined, it is inappropriate to only partially immobilize the cervical spine unless ordered by medical control



**Penetrating trauma is only Immobilized at the discretion of the medic on scene**

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## Adult Eye Trauma

Applies to patients with blunt or penetrating trauma to the eye or who have chemical substances in the eye.

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - Assure patency and proper positioning
    - Initiate immobilization if needed
  - Assess breathing - Give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation - Control bleeding and manage shock appropriately

- Secondary Assessment and History
  - Physical exam and OPQRST/SAMPLE history
    - Establish the mechanism and nature of injury
  - **Assess vision, if possible, with injured eye: can the patient count the number of fingers you hold up; if not, can the patient perceive light**
    - Never apply pressure to the eyeball
  - Monitor vital signs and oxygen saturation
- If the eye has been avulsed or if the globe has been ruptured,
  - Carefully cover the injured eye to protect it
  - Prevent conjugated eye movements - also cover the uninjured eye
  - **Do Not** apply any pressure; **Do Not** apply absorbent dressing
- If a foreign body is embedded in the eye,
  - Do not attempt to remove the object
  - Do attempt to stabilize the object.
  - Carefully cover both eyes
- If eyes are injured by chemical exposure, pepper spray or mace:
  - Responders should protect themselves with appropriate PPE
  - Remove victim from source of exposure
  - Remove contaminated clothing and sealed in plastic bags
  - Irrigate eyes with copious amounts of water or normal saline

- Transport patient with head elevated about 30 degrees, and BOTH eyes closed or loosely patched (unless irrigating).
- For pain, refer to the *Adult Pain Management Protocol*


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## Adult Chest Trauma (Page 1 of 2)

Applies to patients presenting with chest trauma.

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - Assure patency and proper positioning
    - Initiate immobilization if needed
  - Assess breathing - Assist with BVM if ineffective respiratory effort
    - Give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94
    - Manage any injuries impairing ventilation
  - Assess circulation – Assess pulses and perfusion status
    - Control bleeding and manage shock appropriately
    - Direct pressure is usually sufficient
    - Take measures to prevent hypothermia
- ! **If at any time during the primary survey or secondary assessment the following chest injuries are identified, treat immediately**
  - For **penetrating trauma** or **sucking chest wound**
    - Seal initially with a gloved hand
    - Apply occlusive dressing, tape on (3) sides/Asherman's Chest Seal
    - Monitor for tension pneumothorax
  - For **flail segment**
    - Stabilize with bulky dressing
      - gentle pressure, **Do Not impair ventilation**
    - Provided positive pressure ventilation as needed
  - **Tension pneumothorax**
    - P** Perform needle decompression on affected side

- Secondary Assessment and History
  - Physical exam and OPQRST/SAMPLE history
    - Perform rapid trauma exam
    - Examine the chest for bruising, abrasions, instability, crepitus, and/or open wounds
    - Auscultate breath sounds and heart tones
  - Monitor vital signs and oxygen saturation, determine GCS
  - Initiate cardiac monitoring - treat dysrhythmia's in accordance with appropriate guideline.
  - Administer prehospital care and resuscitate as needed
  - Perform immobilization, apply a rigid c-collar and secure to LSB
- Initiate patient transport as soon as possible



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## Adult Chest Trauma (Page 2 of 2)


- Advanced airway/ventilatory management as needed, refer to the *Adult Airway Management Protocol*
- **IACP** Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock
- Reevaluate ABCs and perform detailed/focused assessment of the head, neck, chest, abdomen, pelvis, and extremities x4 and repeat neuro exam
  - Frequently reevaluate patients respiratory and perfusion status
  - Auscultate breath sounds
  - Apply capnography (if available)
  - Perform blood glucose analysis - treat hypoglycemia if present, refer to the *Adult Altered Level of Consciousness Protocol*
- Continue resuscitation and evaluation enroute

- Transport to a trauma center (see *Destination Decision Protocol*)

### IMPORTANT - NEEDLE CHEST DECOMPRESSION

-  **Indications:** Peri-arrest or PEA; shock, with hypotension; and at least **one** of the following:
- Neck vein distention
  - Tracheal deviation away from the injured side
  - Increased resistance when ventilating
  - Hyper-expanded chest with little movement with respiration
-  **Needle chest decompression should never be utilized based solely on the presence of poor or absent breath sounds on one side of the chest. The procedure has complications, and should not be used lightly. However, when used appropriately, it can be life-saving.**


**CAUTION:** Overly aggressive PPV may cause a pneumothorax or exacerbate an existing pneumothorax.


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## Adult Abdominal and Pelvic Trauma (Page 1 of 2)

Applies to patients presenting with injury to abdomen and/or pelvis.

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - Assure patency and proper positioning
    - Initiate immobilization if needed
  - Assess breathing - Assist with BVM if ineffective respiratory effort
    - Give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation - Control bleeding and manage shock appropriately, refer to the *Adult Shock Management Protocol*
    - Direct pressure is usually sufficient


- Secondary Assessment and History
  - Physical exam and OPQRST/SAMPLE history
    - Perform rapid trauma exam.
    - Note any abdominal rigidity, distention, tenderness, etc
    - Note any pelvic instability
    - Monitor vital signs and oxygen saturation, determine GCS
  - For **evisceration** - do not attempt to replace protruding organs
    - Apply a moistened sterile dressing directly to the site
    - Cover this dressing with an occlusive dressing
    - Place patient on their back, with legs flexed at the knees, to reduce pain by relaxing the strain on the abdominal muscles
  - For impaled objects - do not remove an impaled object
    - Carefully cut away any clothing that is around the object
    - Manually stabilize object - avoid applying pressure to the object
    - Use bulky dressings and cravats to stabilize object
    - Minimize patient movement
  -  **If impaled object removed before your arrival, try to bring it with you.**
    - Perform immobilization, apply a rigid c-collar and secure to LSB
    - Initiate patient transport as soon as possible
  - **IACP** Advanced airway/ventilatory management as needed, refer to the *Adult Altered Level of Consciousness Protocol*
  - **IACP** Initiate IV/IO, refer to the *Adult Shock Management Protocol*

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## Adult Abdominal and Pelvic Trauma (Page 2 of 2)

- Reevaluate ABCs and perform detailed/focused assessment of the head, neck, chest, abdomen, pelvis, and extremities x4 and repeat neuro exam
  - Perform blood glucose analysis - treat hypoglycemia if present, refer to the *Adult Altered Level of Consciousness Protocol*
  - Consider cardiac monitoring
- Continue resuscitation and evaluation enroute


- Transport to appropriate facility, refer to the *Destination Decision Protocol*.

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## Adult Extremity Trauma (Page 1 of 2)

Applies to patients presenting with extremity trauma.

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - Assure patency and proper positioning
    - Initiate immobilization if needed
  - Assess breathing - Assist with BVM if ineffective respiratory effort, refer to the *Adult Airway Management Protocol*
    - Give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation - Control bleeding and manage shock appropriately, refer to the *Adult Shock Management Protocol*
    - Direct pressure is usually sufficient
    - If Direct pressure is unsuccessful, a tourniquet may applied
- Secondary Assessment and History
  - Physical exam and OPQRST/SAMPLE history
    - Establish the mechanism and nature of injury
  - Monitor vital signs and oxygen saturation
  - For fractures or dislocation
    - Assess distal, pulse, motor and sensation before/after splinting and during transport
    - If open fractures, control bleeding and cover with dry, sterile dressing.
    - If the extremity is severely angulated **AND** pulses are absent, apply gentle traction in an attempt to straighten it
    - Otherwise if pulses are present or if resistance is encountered, splint the extremity in the angulated position
    - Apply appropriate splinting device
    - To reduce swelling, elevate extremity and apply cold pack
  - For amputation - if located initiate care for amputated part
    - Remove gross contaminants by rinsing with saline
    - Wrap in saline moistened gauze and place in plastic bag or container (sterile, if available)
    - Seal the bag or container tightly and place in solution of ice water, if available
    - Transport part to the hospital regardless of the condition
    - If the part cannot be immediately located, transport the patient and have other field providers search for and transport the part as soon as possible
- Initiate patient transport as soon as possible


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## Adult Extremity Trauma (Page 2 of 2)

- IACP**
- Initiate IV/IO, *refer to the Adult Shock Management Protocol*
  - Reevaluate patient's ABCs and perform a detailed/focused assessment
  - Consider cardiac monitoring

- For pain, refer to the *Adult Pain Management Protocol*
- Consider transport appropriate facility, refer to the *Destination Decision Protocol*




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## Adult Trauma Arrest (Page 1 of 2)


- Primary Survey
  - Assess for signs of life
  - Initiate spinal motion restriction
  - Begin high quality CPR and restrict interruptions of compressions as much as possible
  - Assure airway/ventilatory support – A supra-glottic airway device may be inserted early, otherwise ventilate with a BVM and 100% oxygen, refer to the *Adult Airway Management Protocol*
  - Do not over-ventilate
  - Control life-threatening bleeding,
  - **Airway Management, bleeding control and rapid transport are the most important interventions for victims of traumatic arrest. Minimize scene time to 10 minutes or less, barring extrication time, and perform only critical interventions before transport.**

- Secondary Assessment and History
  - Attempt to obtain OPQRST /SAMPLE History, if relevant, prior to transport
  - Begin transport as soon as possible.
  - Move as rapidly and safely as possible toward an appropriate Trauma facility
  - Initiate cardiac monitoring
    - Manage dysrhythmias or pulseless arrest with the *Adult Pulseless Arrest Protocol*
  - Initiate ETCO<sub>2</sub> monitoring (if available)
- Advanced airway/ventilatory management as needed
- Continue with compressions until return of adequate pulses
- **IACP** Establish IV bilaterally using **normal saline** with rapid infusion and monitor for the return of a palpable pulse. If a pulse is restored, titrate the infusion rate to a blood pressure of 80-90 systolic.

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## Adult Trauma Arrest (Page 2 of 2)


**P** If mechanism of injury, symptoms, and physical exam suggests a tension pneumothorax, consider needle decompression on the affected side(s)

 Contact receiving facility with patient status and treatment as soon as possible.


### IMPORTANT - NEEDLE CHEST DECOMPRESSION

**Indications:** Peri-arrest or PEA; shock, with hypotension; and at least **one** of the following:

- Neck vein distention
- Tracheal deviation away from the injured side
- Increased resistance when ventilating
- Hyper-expanded chest with little movement with respiration

 **Needle chest decompression should never be utilized based solely on the presence of poor or absent breath sounds on one side of the chest. The procedure has complications, and should not be used lightly. However, when used appropriately, it can be life-saving.**

 **CAUTION: Overly aggressive PPV may cause a pneumothorax or exacerbate an existing pneumothorax.**

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## Adult Burns (Page 1 of 2)

Applies to patients who have sustained thermal, chemical or electrical burns and/or have sustained inhalation injuries. Hypotension is not normally seen with prehospital burn patients. Hypotension suggests other trauma. Refer to the trauma guidelines as needed.

- Assure scene safety
- Remove from burning process if possible (only if properly trained)

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - be prepared to aggressively manage the airway
  - Assess breathing - give supplemental O<sub>2</sub>, maintain SpO<sub>2</sub> ≥ 94%.
  - Assess circulation - manage bleeding and shock appropriately, refer to the *Adult Shock Management Protocol*
  - **Look closely for evidence of inhalation injury (hoarseness, stridor, sooty sputum, facial burns, or singed nasal or facial hair). Aggressive airway management may be warranted.**
  - **Burn victims may have suffered carbon monoxide poisoning and may show a false reading on the pulse oximeter.**

- Initial Burn Management
  - Initiate spinal movement restrictions, as needed.
    - If no suspicion of spinal injury, place the patient in position of comfort.
    - If evidence of shock, place the patient supine and monitor airway closely. Treat shock according to the *Adult Shock Management Protocol*
  - Remove and secure any jewelry, belts, shoes, etc. from burned areas.
  - Remove burned or singed clothing not stuck to the skin.
  - Exposure/environment - Cover with dry sterile dressing, to prevent hypothermia, use wet dressing if < 10% BSA
  - Initiate care for burn wounds
    - Chemical injury - brush off chemical, flush with water to remove any residual chemical
    - Electrical injury - treat dysrhythmias per appropriate cardiac dysrhythmia protocol
    - Thermal injury - dry sterile dressings
  - Begin transport as soon as possible.
    - If no other trauma mechanism, consider transport to burn center
    - If trauma mechanism exists, consider transport to a trauma center
    - Transport patients per the *Destination Decisions Protocol*



**DeKalb County  
Fire Rescue**

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## Adult Burns (Page 2 of 2)

- Advanced airway/ventilatory management as needed, refer to the *Adult Airway Management Protocol*
- Secondary Assessment and History
  - Record and monitor vital signs, oxygen saturation, and CO
  - Monitor carbon monoxide saturation (if CO-oximetry is available)
  - Cardiac monitor - record and evaluate 12 Lead ECG (if available)
  - Assess
    - Possible carbon monoxide poisoning
    - Heat inhalation injury/airway
    - Approximate burn size, depth, and location
    - Other injuries and illnesses
  - **IACP** Initiate IV/IO normal saline - see below
    - Do not delay transport for IV access

- For pain management, see *Adult Pain Management Protocol*

### Initial Fluid Resuscitation

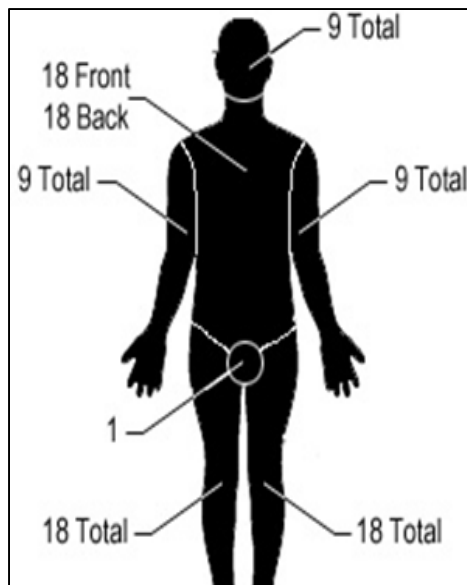
- If patient presents with shock
  - Initiate IV/IO of NS 20ml/kg bolus
- Otherwise, administer fluid infusion utilizing USAISR Rule of Ten
  - Estimate burn size to the nearest 10
  - For adult patients weighing 40–80 kg,  $\%TBSA \times 10 =$  Initial fluid rate in mL/hr
  - For every 10 kg above 80 kg, increase the rate by 100 mL/h




**Do not exceed 1 liter of IV fluids unless authorized by Medical Control.**



**Contact Medical Control for fluid orders in patients with CHF or cardiac disease.**



**To calculate body surface area involved, use Rule of Nines or estimate using the patient's palm size as approximately 1% of BSA**

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## Adult Snakebite

**Special Note: Safety of rescue personnel is top priority! Assure scene safety and determine location of snake. Do not transport snake. (A picture will suffice.)  
DEAD SNAKES ARE STILL DANGEROUS!**

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - assure patency and proper positioning
  - Assess breathing - assist with BVM if ineffective respiratory effort
    - Give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation - manage shock appropriately, refer to the *Adult Shock Management Protocol*

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis - treat hypoglycemia if present, refer to the *Adult Altered Level of Consciousness Protocol*
  - Consider cardiac monitoring
  - Physical exam and OPQRST/SAMPLE history
    - Assess for swelling, skin color changes, shock
    - **Mark on skin the leading edge of swelling and erythema and record time, repeat if leading edge progression**
      - If able, safely determine type, size, and length of snake
- Advanced airway/ventilatory management as needed, refer to the *Adult Airway Management Protocol*
- Place patient in position of comfort. Minimize movement and exertion.
- Do not place bitten extremity in an elevated or lowered position.
- Clean wound - apply light dressing, unless wound is bleeding profusely
  - No ice, no constricting bands, no cutting
- **IACP** Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock, refer to the *Adult Shock Management Protocol*

- Frequently reassess patient, manage any presenting respiratory distress, seizures, and/or dysrhythmia's in accordance with appropriate protocol.
- For pain treatment, refer to the *Adult Pain Management Protocol*

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## Adult Submersion Event

Applies to any patient that has been submerged under water for any period of time.

**Special Note: Safety of rescue personnel is top priority! Enter water only if trained and as a last resort.**

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - assure patency and proper positioning
    - Consider immobilization if evidence of trauma
  - Assess breathing - assist with BVM if ineffective respiratory effort
    - Give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation - manage shock appropriately
    - Take measures to prevent hypothermia - remove wet clothes, cover and warm the patient
- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis - treat hypoglycemia if present, refer to the *Adult Altered Level of Consciousness Protocol*
  - Initiate cardiac monitoring
  - Record and evaluate 12-lead ECG (if available) - don't delay therapy
  - Physical exam and OPQRST/SAMPLE history
- Advanced airway/ventilatory management as needed, refer to the *Adult Airway Management Protocol*
- **IACP** Initiate IV/IO normal saline - administer 20ml/kg bolus if signs of shock
- If patient is hypothermic, refer to *Cold Related Emergencies Protocol*

**ALL SUBMERSION VICTIMS SHOULD BE TRANSPORTED EVEN IF THEY APPEAR UNINJURED OR APPEAR TO HAVE RECOVERED.**


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## Childbirth/Labor (Page 1 of 2)

Applies to women whose chief complaint is related to labor and /or impending delivery.

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - have suction ready
  - Assess breathing - give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> <94%
  - Assess circulation - manage shock appropriately
  - ! **Altered LOC and signs of poor perfusion could indicate shock and should be managed appropriately, refer to appropriate protocol.**
  - ! **If a patient is unstable, initial resuscitation/stabilization must precede any action specified in this protocol. Resuscitation of the mother is the key to survival of both mother and fetus**

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis - treat hypoglycemia if present, refer to the *Adult Altered Level of Consciousness Protocol*
  - Consider cardiac monitoring
  - OPQRST/SAMPLE, LMP, obstetric, and gynecological history
  - ! **Determine: how many previous deliveries, due date, onset of contractions, if membranes have ruptured, if bleeding or vaginal discharge present, if patient has urge to push or move bowels, and if pregnancy is high risk**
    - Time contractions - frequency and duration
    - Physical exam - assess for signs of shock
  - **IACP** IV/IO access if needed, refer to the *Adult Shock Protocol*
  - If active labor, inspect the perineum for crowning
    - If crowning, apply gentle pressure with your glove hand to the infant's head and prepare for delivery.
    - If no crowning, monitor and reassess frequency and duration of contractions.
  - If feet or buttocks presentation – **DO NOT** pull on Infant
    - Support head and trunk
    - Place your gloved hand inside the vagina and form **V** with first two fingers, place over infant's face -keep vagina wall away infant's face
  - If prolapsed cord
    - Place mother in a knee chest position to relieve pressure on the cord.
    - Place your gloved hand inside the vagina and push upward on the presenting part to further reduce pressure on the cord
    - Cover the cord with moist sterile dressings and avoid manipulating it
  - ! **Priority symptoms: Crowning < 36 weeks gestation, prolapsed cord, abnormal presentation, severe vaginal bleeding, multiple gestation or seizure. If noted, expedite transport and notify Medical Control as early as possible.**


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## Childbirth/Labor (Page 2 of 2)

- Delivery and Post Delivery Care of Mother
  - Maintain gentle pressure on the infant's head and allow it to deliver in a controlled gradual manner. *Routine suctioning of the oropharynx and nasal pharynx as soon as the head is delivered is no longer recommended.*
  - Check around the infant's neck for the umbilical cord.
  - If the cord has looped around the baby's neck, use your finger to hook the cord and pull it over the baby's head.
  - If unable to free the cord, clamp the cord in two places and cut the cord between the clamps.
  - Gently direct the infant's head and body downward to deliver the anterior shoulder and support the rest of the body as it delivers.
  - Keep the infant at the level of the vagina and use a gauze pad to wipe any secretions around the mouth and nose.
  - Vigorously dry the infant and provide warmth (increasing ambient temperature, cover with blanket)
  - If needed, stimulate breathing by flicking the soles of the baby's feet or rubbing the baby's back.
  - Clamp the cord at 4 and 6 inches and cut the cord between the clamps.
  - Wrap the baby in dry, clean towels or blankets.
  - Note time of delivery. Obtain APGAR score at 1 and 5 minutes after delivery.  
**Score ≤ 3: critical. Score ≥ 7: good to excellent**
  - If excessive secretions AND signs of compromise are present, clear airway with bulb syringe.
- ! If the newborn fails to respond to initial stimulation and are in need of resuscitation efforts, initiate resuscitation and refer to the **Newborn Resuscitation** guideline.
  - Once the placenta delivers, place it in a clean container and transport it to the hospital with the mother and infant.
  - After delivery, keep mother warm and watch for signs of shock.
  - If excessive blood loss, > 500ml - apply ABD pad to external vaginal area
- IACP**
  - consider an additional fluid bolus
  - massage the uterus to promote uterine contraction
  - consider allowing mother to breastfeed infant

Transport to a facility capable of handling an obstetrical patient .



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## OB/GYN Emergencies

Applies to women whose chief complaint is related to pregnancy, impending delivery, or 1st month postpartum, or whose chief complaint is gynecological.

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - have suction ready
  - Assess breathing - give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation - manage shock appropriately, refer to the *Adult Shock Management Protocol*
  - **Altered LOC and signs of poor perfusion could indicate shock and should be managed appropriately.**
  - **If a patient is unstable, initial resuscitation/stabilization must precede any action specified in this protocol. Resuscitation of the mother is the key to survival of both mother and fetus.**

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis – refer to the *Adult Altered Level of Consciousness*
  - Cardiac monitor - record and evaluate 12 Lead ECG (if available)
  - OPQRST/SAMPLE, LMP, obstetric, and gynecological history
  - Physical exam - assess for signs of shock
- Consider possible causes; ruptured ectopic pregnancy, spontaneous abortion, placenta abruption, trauma, abnormal menstrual flow, etc.
- Place the pregnant patient in position of comfort, EXCEPT after 20 weeks gestation place the patient on her left side to prevent Supine Hypotensive Syndrome this Includes patients that are immobilized.
- Keep the patient NPO
- **IACP** Initiate IV/IO normal saline – refer to the *Adult Shock Management Protocol*
- If bleeding, apply abd pad to external vaginal area.
- Bring any products of conception to the hospital.



- If bleeding, seizure, or premature labor is present or pregnancy is high-risk, contact receiving facility as early as possible.
- Transport to a facility capable of handling a complicated obstetrical emergency.

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## Adult Toxemia

Applies to obstetrical patient experiencing hypertension and /or eclampsia (seizures, swelling/edema, visual hallucination, or coma) activity.

- Primary Survey
  - Assess LOC - AVPU
  - Assure airway - have suction ready
  - Assess breathing - give supplemental O<sub>2</sub> if signs of compromise or SpO<sub>2</sub> < 94%
  - Assess circulation - manage shock appropriately, refer to the *Adult Shock Management Protocol*

- Secondary Assessment and History
  - Monitor vital signs and oxygen saturation
  - Perform blood glucose analysis - treat hypoglycemia if present, refer to the *Adult Altered Level of Consciousness Protocol*
  - Cardiac monitor - record and evaluate 12 Lead ECG (if available)
  - OPQRST/SAMPLE and obstetric history
  - Physical exam
-  **Signs/symptoms may included: elevated BP, severe headache, dizziness, N/V, blurred vision, dyspnea, edema, etc.**
- Advanced airway/ventilatory management as needed
- Position patient on left side.
-  **IACP** IV/IO access with normal saline - KVO

**P**

For active seizures,

- Administer **Magnesium sulfate** 2-4g IVP or 2g IM slowly
- If ineffective, adm. **Midazolam** 2.5mg IV/IO or 5mg IM/IN (intranasal), repeat if needed to max of 10mg
- If ineffective, adm. **Diazepam** 2-5mg IV/IO Push slow to max of 10 mg.


For non-seizing patient with SBP > 160 on two readings,

- Adm. **Magnesium sulfate** 4g over 10 minutes IV in 100 cc of NS



**Monitor patient for hypotension, respiratory depression, and heart block when administering mag sulfate and/or benzodiazepines.**


# Medications

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## Acetaminophen (Tylenol®)

**Indication:** Fever, pain

**Adult dose range:** 15 mg/kg every 4 hours; max 4g a day

**Pediatric dose range:** 15 mg/kg every 4 hours

**Time to onset:** 20 to 30 minutes

**Contraindications:** Allergy to acetaminophen

**How is it given?**

- PO/oral

**What should be monitored?**

- General patient monitoring

**Major drug interactions:**


- No acute drug interactions

**What side effects/potential complications are expected?**

- No acute side effects or complications in the emergency setting

**Are there any special instructions/considerations?**

- Liver infection or liver failure will slow metabolism of acetaminophen
- No acute special considerations

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## Adenosine (Adenocard®)

**Indication:** PSVT & undifferentiated regular wide complex tachycardia

**Adult dose range:** 6 mg; if not effective within 1-2 minutes, 12 mg may be given needed

**Pediatric dose range: (Given only after orders from Medical Control)** 0.1 mg/kg; if not effective administer 0.2 mg/kg. Maximum initial dose: 6mg / Maximum additional single dose: 12 mg

**Time to onset:** Rapid

**Contraindications:**

- 2<sup>nd</sup> or 3<sup>rd</sup> degree AV block, or sick sinus syndrome, or any bradycardic rhythm (except in patients with pacemaker)
- Known hypersensitivity

**How is it given?**

- Rapid IV push over 1-2 seconds via peripheral line with at least 20mL NS flush

**What should be monitored?**

- ECG
- Heart rate
- Blood pressure

**Major drug interactions:**


- Theophylline and caffeine (may require increased dose of adenosine)
- Dipyridamole (may require reduced dose of adenosine)
- Carbamazepine (may increase heart block)

**What side effects/potential complications are expected?**

- Facial flushing
- Palpitations
- Chest pain
- Hypotension
- Headache
- Shortness of breath/dyspnea
- Sweating

**Are there any special instructions/considerations?**

- Use large, proximal vein
- Follow medication immediately with syringe flush of normal saline (not just open line; not fast enough)
- Use two syringe technique if possible
- Consider other arrhythmias such as Atrial Flutter, Atrial Fibrillation, or Ventricular Tachycardia before administering

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## Albuterol (Proventil®, ProAir®, Xopenex®)

**Indication:** Bronchodilator in reversible airway obstruction due to reactive airway disease, asthma, COPD, anaphylaxis or other respiratory conditions causing bronchospasm.

**Adult dose range:** 2.5-5 mg as needed. Pre-hospital personnel may assist a patient with self-administration of their MDI.

**Pediatric dose range:**  
 If < 15kg- 2.5 mg  
 If > 15 kg- up to 5mg

**Time to onset:** 5 to 15 minutes (if inhaled)

### Contraindications:

- Hypersensitivity to albuterol
- Adult heart rate above 180 bpm w/o contacting Med Control
- Pediatric heart rate above 220 bpm w/o contacting Med Control

### How is it given?

- Via nebulization

### What should be monitored?

- Heart rate
- CNS stimulation
- Respiratory status

### Major drug interactions:


- Beta blockers (decrease effect)
- MAO inhibitors and TCA's (may increase cardiovascular effects)
- Other sympathomimetic aerosol bronchodilators or epinephrine should not be used concomitantly with Albuterol, including over-the-counter-aerosols.

### What side effects/potential complications are expected?

- Tachycardia, palpitations, pounding heartbeat
- GI upset, nausea
- CNS stimulation
- Tremor

### Are there any special instructions/considerations?

- Patient may need assistance and coaching with the treatment

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## Amiodarone (Cordarone®)

**Indication:** Recurring ventricular fibrillation, pulseless ventricular tachycardia, unstable ventricular tachycardia

**Adult dose range:**

- V-Fib/pulseless VT: 300 mg rapid IV bolus or IO, repeat dose of 150 mg can be given in 3-5 minutes.
- VTach w/ Pulse : 150mg slow IV/IO over 10 minutes
- Infusion: 150 mg amiodarone in 100 ml of NS or D5W infuse over 10 minutes

**Pediatric dose range:**

- Treatment of pulseless VF or VT: 5 mg/kg rapid IV bolus or IO - can repeat ↑2 times
- Treatment of perfusing tachycardias: Loading dose: 5 mg/kg IV over 20-60 minutes or IO

**Time to onset:** Immediate

**Contraindications:**

- Hypersensitivity
- Severe sinus node dysfunction
- 2<sup>nd</sup> and 3<sup>rd</sup> degree AV block
- Cardiogenic shock
- Relative- Asthma- contact Medical Control
- Sinus bradycardia, except if pacemaker is placed
- Pregnancy

**How is it given?**

- IV, IO

**What should be monitored?**

- ECG
- Heart rate

**Major drug interactions:**

- Beta blockers
- Calcium channel blockers
- Digoxin


**What side effects/potential complications are expected?**

- Hypotension
- CNS effects
- Myocardial depression
- Nausea/vomiting
- Arrhythmias
- Flushing
- Visual disturbances

**Are there any special instructions/considerations?**

- Do not give rapid IV push to a patient with a pulse



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## Aspirin

**Indication:** Onset chest pain suggestive of MI signs/symptoms

**Adult dose range:** 160mg-325mg chewable tablets

**Pediatric dose range:** Not recommended

**Time to onset:** 15 to 30 minutes

**Contraindications:**

- Hypersensitivity to aspirin
- Stomach ulcers
- GI Bleeding

**How is it given?**

- Orally

**What should be monitored?**

- Heart rate
- Respiratory Rate

**Major drug interactions:**


- Blood thinners

**What side effects/potential complications are expected?**

- GI upset, nausea
- Vomiting
- Wheezing

**Are there any special instructions/considerations?**

- Do not give large amounts of water to drink, as vomiting may occur
- Relatively contraindicated in persons with asthma

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## Atropine

**Indication:** 1) Bradycardia, per cardiac protocol  
2) Symptomatic organophosphate exposure: nerve gas (terrorism) or pesticides (industrial, farming).

**Adult dose range:**

- Bradycardia: 0.5mg IV/IO bolus every 3-5 minutes as needed, not to exceed total dose of 3 mg for all bradycardias with poor perfusion EXCEPT high degree
- Blocks (Mobiltz II and 3<sup>rd</sup> degree).
- For high degree blocks provide a single dose of 0.5mg
- Organophosphate Poisoning/Nerve Agents: 2 mg IV/IO bolus every 5 minutes, until bronchial secretions and bradycardia are controlled.

**Pediatric dose range:**

- Bradycardia: IV/IO: 0.02 mg/kg bolus; minimum dose is 0.1 mg, maximum single dose is 0.5 mg maximum total dose is 1 mg; for ET dosing: 0.04-0.06mg/kg followed by 5mL flush and 5 ventilations.
- Organophosphate Poisoning/Nerve Agents: 0.02mg/kg IV/IO bolus every 5 minutes until bronchial secretions and bradycardia are controlled.

**Time to onset:** Immediate

**Contraindications:**

- Absence of bradycardia
- Absence of signs of organophosphate poisoning

**How is it given?**

- IV, IO: administer undiluted by IV bolus
- IM: Only if IV is not established
- ET dose at 2-2.5 normal dosing followed by flush and ventilations
- Auto-injector, eg. Mark I kits

**What should be monitored?**

- Airway secretions
- Heart rate
- Mental status

**Major drug interactions:**


- Phenothiazines (Promethazine, prochlorperazine)
- Antihistamines

**What side effects/potential complications are expected?**

- Dry, hot skin and mouth
- Tachycardia
- Urinary retention
- Decreased GI motility

**Are there any special instructions/considerations?**

- For large-scale exposures to organophosphates/nerve agents, access ChemPack caches - see *ChemPack Fact Sheet* in the *Resources* section of Guidelines, or call Georgia Poison Center directly at 1-800-222-1222.
- ET dosing should only be performed if IV/IO attempts have been made and are unsuccessful.

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## Dextrose in Water

**10%, 25%, 50%**

**Indication:** Hypoglycemia, Hyperkalemia

**Adult dose range:** D<sub>50</sub>W - 25-50g IV as needed

**Pediatric dose range:**

- D<sub>10</sub>W <1 year 0.5g/kg (0.5mL/kg)
- D<sub>25</sub>W 1 – 8 year 0.5g/kg (2mL/kg)
- D<sub>50</sub>W > 8 years (1mL/kg)

**Time to onset:** Immediate

**Contraindications:**

- None in the emergency setting for hypoglycemic events

**How is it given?**

- Slow IV bolus
- For pediatric use:
  - Dilute dose with NS in a 1:1 ratio to create 25% (D<sub>25</sub>W)
  - Dilute 2mL D<sub>50</sub>W in 8mL of NS to create D<sub>10</sub>W

**What should be monitored?**

- Blood glucose
- Level of consciousness
- IV Site

**Major drug interactions:**


- No major drug interactions

**What side effects/potential complications are expected?**

- Hyperglycemia
- Vein irritation
- Cerebral edema in stroke patients

**Are there any special instructions/considerations?**

- For concentrations above 25%, give by patent peripheral vein, or IO route.
- May cause tissue necrosis
- May precipitate neurologic symptoms in thiamine deficient patients; consider administration of 100mg thiamine IV in malnourished patients
- Use caution in the setting of the following:
  - Acute stroke
  - Diabetic coma and hyperglycemia
  - Delirium tremens in dehydrated patients

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## Diazepam (Valium®)

**Indication:** Seizure activity; excited delirium; acute agitation

**Adult dose range:** 2- 5 mg slow IV/IO, up to a max dose of 10mg.

**Pediatric dose range:** 0.1-0.3mg/kg, slow IV/IO to a max of no more than 5mg for peds <5yrs, and 10mg max for >5yrs. **Contact Medical Control for advisement on use.**

**Time to onset:** 1 to 5 minutes, IV

**Contraindications:**

- Hypersensitivity to diazepam
- Pre-existing CNS depression
- Respiratory depression

**How is it given?**

- Slow IV push; do not exceed 1-2 mg/minute in children, 5 mg/minute in adults.

**What should be monitored?**

- Airway
- Level of consciousness
- Heart rate
- Respiratory rate
- Blood pressure

**Major drug interactions:**


- Any opiates
- Any medication for mood disorder
- Seizure medications
- Antihistamines

**What side effects/potential complications are expected?**

- Decreased level of consciousness
- Inability to maintain airway
- Respiratory depression/apnea
- Hypotension

**Are there any special instructions/considerations?**

- Contact Medical Control for patients with:
  - Neurologic disorders
  - Geriatric
  - Pregnancy or lactating patients
- Respiratory depression lasts longer than seizure activity – be prepared to support respirations

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## Diphenhydramine (Benadryl®)

**Indications:** Allergic reaction, anaphylaxis, dystonic reactions

**Adult dose range:** 50 mg/dose PO/IM/IV/IO

**Pediatric dose range:** 1 mg/kg with max dose of 25mg

**Time to onset:** 15 to 30 minutes

**Contraindications:**

- Hypersensitivity to diphenhydramine
- Newborns or infants
- Nursing mothers

**How is it given?**

- PO, IV, IO, IM; Can be given undiluted at a rate of 25 mg per 1 minute

**What should be monitored?**

- Pulse Oximetry
- Blood Pressure
- Improvement of symptoms being treated
- Sedation level

**Major drug interactions:**


- Additive CNS depression with alcohol, sedatives, narcotics

**What side effects/potential complications are expected?**

- Sedation, dizziness, lightheadedness, altered mental status
- Hypotension, tachycardia
- Blurred vision

**Are there any special instructions/considerations?**

- For respiratory depressions and signs of shock secondary to anaphylaxis, epinephrine should be administered early and often

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## Dopamine (Inotropin)

**Indications:** Cardiogenic shock; hemodynamically significant hypotension not resulting from hypovolemia; symptomatic bradycardia

**Adult dose range:** 2-20mcg/kg/min titrated to desired response

- 2-4 mcg/kg/min: Renal Dose
- 5-10 mcg/kg/min: Inotropic Dose
- 10-20 mcg/kg/min: Pressor Dose

**Pediatric dose range:** 2-20 mcg/kg/min titrated to desired response

**Time to onset:** Less than 5 minutes

**Contraindications:**

- Hypersensitivity to sulfites
- Hemorrhagic shock
- Tachyarrhythmias
- Ventricular fibrillation

**How is it given?**

- Administer as a continuous infusion, titrating to effect. Gradually increase dosage until optimum response occurs.
- Direct intravenous push is not recommended.
- See infusion charts on next page

**What should be monitored?**

- Blood pressure
- Heart rate
- Peripheral pulses
- IV Site

**Major drug interactions:**


- Deactivated by sodium bicarbonate
- Hypotension and/or bradycardia occurs with phenytoin
- Reduced effects with Beta-adrenergic blocker
- Potentiated effects with MAO inhibitors

**What side effects/potential complications are expected?**

- Hypertension
- Tachycardia, palpitations, arrhythmias

**Are there any special instructions/considerations?**


- Tissue necrosis is associated with extravasation.
- Medical Control should be consulted before initiating dopamine on any patient taking MAO inhibitors.

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## Dopamine (Continued)

### Adult Dopamine Infusion Chart:

Dopamine Infusion: Standard 1600mcg/ml Concentration													
Weight		Milliliters hour or drops per minute with micro drip tubing (60gtt/ml)											
lbs	kg	2 mcg/kg/hr	3 mcg/kg/hr	4 mcg/kg/hr	5 mcg/kg/hr	6 mcg/kg/hr	7 mcg/kg/hr	8 mcg/kg/hr	9 mcg/kg/hr	10 mcg/kg/hr	15 mcg/kg/hr	20 mcg/kg/hr	
77	35	3	4	5	7	8	9	10	11	13	20	26	
88	40	3	5	6	8	9	11	12	14	15	23	30	
99	45	3	5	7	8	10	12	14	15	17	25	34	
110	50	4	6	8	9	11	13	15	17	19	28	38	
121	55	4	6	8	10	12	14	17	19	21	31	41	
132	60	5	7	9	11	14	16	18	20	23	34	45	
143	65	5	7	10	12	15	17	20	22	24	37	49	
154	70	5	8	11	13	16	18	21	24	26	39	53	
165	75	6	8	11	14	17	20	23	25	28	42	56	
176	80	6	9	12	15	18	21	24	27	30	45	60	
187	85	6	10	13	16	19	22	26	29	32	48	64	
198	90	7	10	14	17	20	24	27	30	34	51	68	
209	95	7	11	14	18	21	25	29	32	36	53	71	
220	100	8	11	15	19	23	26	30	34	38	56	75	
231	105	8	12	16	20	24	28	32	35	39	59	79	
242	110	8	12	17	21	25	29	33	37	41	62	83	
253	115	9	13	17	22	26	30	35	39	43	65	86	

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## Dopamine (Continued)

### Pediatric Dopamine Infusion Charts:

<b>Dopamine Infusion: Standard 1600mcg/ml Concentration</b>						
Broselow Color	Weight (kg)	Milliliters hour or drops per minute with micro drip tubing (60gtt/ml)				
		5 mcg/kg/hr	7.5 mcg/kg/hr	10 mcg/kg/hr	15 mcg/kg/hr	20 mcg/kg/hr
Gray	3	0.6*	0.8*	1.1	1.7	2.3
Gray	4	0.8*	1.1	1.5	2.3	3.0
Gray	5	0.9*	1.4	1.9	2.8	3.8
Pink	6-7	1.2	1.9	2.4	3.7	4.9
Red	8-9	1.6	2.4	3.2	4.8	6.4
Purple	10-11	2	3	3.9	5.9	7.9
Yellow	12-14	2.4	3.7	4.9	7.3	9.8
White	15-18	3.1	4.7	6.2	9.3	12.4
Blue	19-23	3.9	5.9	7.9	11.8	15.8
Orange	24-29	5	7.5	9.9	14.9	19.9
Green	30-36	6.2	9.3	12.4	18.6	24.8
*For rates <1 mL/hour, consider using 800 mcg/mL concentration.						

<b>Dopamine Infusion: 800mcg/ml Concentration</b>						
Broselow Color	Weight (kg)	Milliliters hour or drops per minute with micro drip tubing (60gtt/ml)				
		5 mcg/kg/hr	7.5 mcg/kg/hr	10 mcg/kg/hr	15 mcg/kg/hr	20 mcg/kg/hr
Gray	3	1.1	1.7	2.3	3.4	4.5
Gray	4	1.5	2.3	3.0	4.5	6.0
Gray	5	1.9	2.8	3.8	5.6	7.5



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## Epinephrine (Adrenalin®)

**Indication:** Anaphylaxis, cardiac arrest, croup, severe bronchospasm, symptomatic bradycardia



**See note under special instructions/considerations on the following page in reference to different concentrations of epinephrine.**

### Adult dose range:

- Cardiac Arrest: 1 mg (**1:10,000**) every 3 - 5 minutes IV or IO; ET 2-2.5 times normal dosing followed by flush and ventilations
- Symptomatic Bradycardia not relieved by atropine or TCP: 1 mg (**1:1,000**) in 250 cc NS or D5W administered at 2 - 10 mcg/min

Epinephrine Infusion: 4mcg/ml Concentration									
mcg/min	2	3	4	5	6	7	8	9	10
microdrops/min	30	45	60	75	90	105	120	135	150

- Bronchospasm/Anaphylaxis:
  - 1) 0.3 mg (**1:1,000**) SQ or IM using an auto-injector.
  - 2) Mix Epinephrine 1:1000 1mg in 100 cc NS, infuse @5ml/min(IF SEVERE OR NO RESPONSE TO SQ/IM)

### Pediatric dose range:

- Cardiac Arrest: 0.01mg/kg (**1:10,000**) every 3 - 5 minutes IV or IO; ET dosing: 0.1mg/kg (**1:1000**) followed by 5mL flush and 5 ventilations.
- Symptomatic Bradycardia: 0.01mg/kg (**1:10,000**) every 3 - 5 minutes IV or IO
- Bronchospasm/Anaphylaxis: 0.01 mg/kg (**1:1000**) SQ to a maximum dose of 0.3 mg/dose
  - Patient >30kg 0.3 mg IM using an auto-injector
  - Patient 10-30kg 0.15mg IM using junior auto-injector
- Croup:
  - Patient < 15kg 2.5ml (**1:1000**) in 3ml NS nebulized
  - Patient > 15kg 5ml (**1:1000**) nebulized

**Time to onset:** < 1 minute IV, 3-10 IM,SQ

**Duration of effect:** 3-5 minutes IV

### Contraindications:


- None in cardiac arrest
- Hypersensitivity to epinephrine
- Hypertension or tachyarrhythmias

### How is it given?

- IV, IO, ET, IM, SQ, Auto-injector

### What should be monitored?

- Blood pressure
- Heart rate
- Pulmonary function

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## Epinephrine (Continued)

### Major drug interactions:


- Deactivated by sodium bicarbonate
- Reduced effects with Beta-adrenergic blocker
- Potentiated effects with MAO inhibitors
- Increased arrhythmias with sympathomimetics (eg. caffeine, cocaine) and phosphodiesterase inhibitors (Viagra®, Cialis®, Levitra®)

### What side effects/potential complications are expected?

- Tachycardia, palpitations, angina
- Flushing, hypertension

### Are there any special instructions/considerations?

- Do not confuse concentration strengths of epinephrine 1:1000 and 1:10000
- **1:1000 is not for IV/IO use**
- Do not mix with sodium bicarbonate
- For anaphylaxis, give epinephrine early and often
- ET dosing should not be administered until attempts have been made at IV/IO insertions without success

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## Fentanyl (Sublimaze®)

**Indications:** Moderate to severe pain

**Adult dose range:** 25-100 mcg

**Pediatric dose range:** 2-12 years: 1mcg/kg

**Time to onset:** Rapid

**Contraindications:**

- Severe hemorrhage
- Shock
- Respiratory depression

**How is it given?**

- Slow IV, IO,
- IN

**What should be monitored?**

- Level of conscious
- Airway
- Respirations
- Watch for dysrhythmias (bradycardia)

**Major drug interactions:**


- Other CNS depressants may potentiate the effects of fentanyl (narcotics, barbiturates, tranquilizers)
- MAO Inhibitor use within previous 14 days - contact Medical Control for advisement

**What side effects/potential complications are expected?**

- Inability to maintain airway
- Decreased level of consciousness
- Respiratory depression
- Bradycardia


**Are there any special instructions/considerations?**

- Use caution to patients with liver and kidney dysfunction
- Narcotic antagonist such as naloxone should be readily available to manage apnea
- Reduced dosages may be necessary for high-risk or geriatric patients

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## Fentanyl (Sublimaze®)

Weight (kg)	Dose	100mcg/2ml strength
	<b>1.5mcg/kg</b>	<b>(ml)</b>
7	10mcg	0.2ml
10	15mcg	0.3mg
12	18mcg	0.35ml
14	20mcg	0.4ml
16	24mcg	0.5ml
18	27mcg	0.55ml
20-24	30mcg	0.6ml
25-29	37.5mcg	0.75ml
30-34	45mcg	0.9ml
35-39	52.5mcg	1.05ml
40-44	60mcg	1.2ml
45-49	67.5mcg	1.35ml
>50	75mcg	1.5ml

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## Glucagon

**Indications:** Hypoglycemia; Beta blocker overdose

**Adult dose range:** 1 mg IM, IN

**Pediatric dose range:** 0.1 mg/kg IM, IN

**Time to onset:** 5 to 20 minutes

**Contraindications:**

- Known hypersensitivity to glucagon

**How is it given?**

- IM, SC, IN

**What should be monitored?**

- Level of consciousness
- Blood pressure
- Pulse rates
- Blood sugar

**Major drug interactions:**


- No acute interactions in the emergency setting

**What side effects/potential complications are expected?**

- Rare side effects may include: hypotension, dizziness, headache, nausea/vomiting

**Are there any special instructions/considerations?**

- Glucagon will only work if there are sufficient glucose stores in the liver and may be ineffective for poorly nourished patients
- Effects are slower than dextrose IV administration and should be considered only if an IV line cannot be established
- Positive inotropic effects may be seen with administration
- Glucagon for parenteral administration is derived from pork or beef pancreas

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## Haloperidol (Haldol®)

**Indications:** Acute psychotic episodes, severe agitation

**Adult dose range:** 5 mg IM. Contact Medical Control for additional dosing

**Pediatric dose range:** ***Contact Medical Control for advisement on use***

- Not recommended for pediatrics under the age of 5.
- 6-12 years old: 1-3 mg/kg with max dose of 0.15mg/kg/day.

**Time to onset:** 30 to 45 minutes

**Contraindications:**

- Ventricular arrhythmia, or known prolonged QT interval
- Caution and/or contact Medical Control if patient is already taking any sedative or psychoactive drugs (including lithium), or appears intoxicated
- Decreased level of consciousness
- Hypotension

**How is it given?**

- IM, IV, IO

**What should be monitored?**

- Decreased level of consciousness
- Airway
- Respirations
- Blood pressure
- Pulse

**Major drug interactions:**


- Used along with antihypertensives may lead to hypotension

**What side effects/potential complications are expected?**

- Altered level of consciousness
- Inability to maintain airway
- Respiratory depression
- Hypotension
- Tachycardia
- Extrapyramidal symptoms (EPS)

**Are there any special instructions/considerations?**

- Watch for cardiovascular effects such as prolonged QT or torsades de pointes

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## Ipratropium (Atrovent®)

**Indications:** Bronchial asthma and reversible bronchospasm associated with COPD

**Adult dose range:** 0.5 mg

**Pediatric dose range:** *Contact Medical Control for advisement on use*

- Not recommended for use in pediatrics under the age of 12 years.
- Over 12 years, may administer 0.5mg adult dosage.

**Time to onset:** 30 minutes to 1 hour

**Contraindications:**

- Hypersensitivity to ipratropium
- Not indicated for acute treatment of bronchospasms

**How is it given?**

- Nebulized; may also assist patient with MDI

**What should be monitored?**

- General patient assessment
- Respiratory effort

**Major drug interactions:**


- No acute interactions in the emergency setting

**What side effects/potential complications are expected?**

- Palpitations
- Anxiety, dizziness
- Nausea/Vomiting

**Are there any special instructions/considerations?**

- May be administered with Beta agonist in same nebulizer unit
- Caution should be used when administering to elderly patients and those with cardiovascular disease or hypertension

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## Lidocaine (Xylocaine®)

**Indications:** Used as an antiarrhythmic for: ventricular tachycardia; ventricular fibrillation; and malignant PVCs

**Adult dose range:** 1-1.5mg/kg for first dose, 0.50-0.75 for subsequent doses up to a max of 3mg/kg

- For pulseless rhythms, repeat dosing every 3-5 minutes
- For pulse rhythms, doses may be repeated every 5-10 minutes.
- If conversion, begin infusion at 2-4mg/min.
- If no pre-mixed bags available, place 1g of lidocaine in 250mL bag (or 2g in 500mL) of D<sub>5</sub>W or NS for a 4:1 ratio of drug per milliliter.

Lidocaine Infusion: 4mg/ml Concentration			
mg/min	2	3	4
microdrops/min	30	45	60

**Pediatric dose range:** 1 mg/kg IV/IO; infusions at 20-50mcg/kg/min

**Time to onset:** 1 to 3 minutes

**Contraindications:**

- Second-degree Mobitz II and Third-degree AV blocks
- Not to be given in bradycardic rhythms as first line treatment

**How is it given?**

- IV, IO

**What should be monitored?**

- Level of consciousness
- Blood pressure
- Pulse
- Cardiac monitor

**Major drug interactions:**

- Use with caution when administering concomitantly with: procainamide, phenytoin, quinidine and beta-blockers


**What side effects/potential complications are expected?**

- Altered level of consciousness/drowsiness
- Seizures
- Hypotension
- Bradycardia/heart blocks
- Nausea/vomiting

**Are there any special instructions/considerations?**

- Dosage of lidocaine should be reduced by 50% in patients over the age of 70, patients with liver disease, and heart failure
- Lidocaine 2% can be used to reduce discomfort of IO insertions on conscious patients. Dosage given through IO line after insertion: Adults - 20-40mg; pediatrics- 0.5mg/kg



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## Magnesium Sulfate

**Indication:** Torsades de pointes, treatment of cardiac arrhythmias caused by hypomagnesia; seizure activity associated with toxemia/eclampsia of pregnancy

**Adult dose range:**

- 1-2 grams IV gtt over 10 min if pulse is present for abnormal ventricular rhythms;
- 2-4 grams IV/IO push for polymorphic pulseless arrest. If pt converts to viable rhythm, 4gram in 1000cc ns given at 1-4mg/min
- 4grams in 100 cc NS over 10 minutes for pre-eclampsia
- 2-4 grams for seizure activity related to toxemia- if no IV available, give 2 grams IM

**Pediatric dose range:** 25-50 mg/kg; max single dose of 2g

**Time to onset:** Immediate when given IV

**Contraindications**

- Heart block

**How is it given?**

- Slow IV

**What should be monitored**

- Blood pressure
- Respiratory and CNS depression during rapid IV administration
- Magnesium levels
- Monitor for arrhythmias

**Major drug interactions**


- No major drug interactions

**What side effects/potential complications are expected?**

- CNS depression
- Respiratory depression
- Complete heart block

**Are there any special instructions/considerations?**

- Hypotension and asystole may occur with rapid administration

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## Methylprednisolone (Solu-Medrol®)

**Indication:** Anti-inflammatory medication; asthma, exacerbation of COPD, anaphylaxis

**Adult dosage range:** 125 mg

**Pediatric dosage range:** 1.0-2.0mg/kg

**Time to onset:** Rapid

**Contraindications:**

- Known hypersensitivity to methylprednisolone

**How is it given?**

- Slow IV, IM

**What should be monitored?**

- Blood pressure, blood glucose, electrolytes

**Major drug interactions:**


- Decreased by phenytoin, phenobarbital, and rifampin (anti-TB)

**What side effects/potential complications are expected?**

- Rare, but possible side effects:
- Fluid retention
- CHF
- Hypertension
- Vertigo
- Headache
- Projectile Vomiting if pushed too fast
- Hiccups

**Are there any special instructions/considerations?**

- Dosing should be based on the lesser of ideal body weight or actual body weight
- Long-term use may cause GI bleeding, prolonged wound healing - watch for possible problems if patient is on home therapies - consider lower dosing (80mg)
- Recent administration of live vaccines may cause reduced effects

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## Midazolam (Versed®)

**Indication:** Seizure activity; excited delirium; acute agitation

**Adult dose range:** 2.5 mg IV/IO or 5mg IM/IN If given IN (intranasal), administer 2.5mg in each nare. May repeated to max of 10mg IV/IO/IM/IN

**Pediatric dose range:** 0.2 mg/kg to a max of 10mg

**Time to onset:** 1 to 3 minutes, IV

**Contraindications:**

- Hypersensitivity to midazolam
- Pre-existing CNS depression
- Respiratory depression

**How it is given?**

- Slow IV, IO; IN, IM

**What should be monitored?**

- Airway
- Level of consciousness
- Heart rate
- Respiratory rate
- Blood pressure

**Major drug interactions:**


- Any opiates
- Seizure medications
- Antihistamines
- Any medication for mood disorder

**What side effects/potential complications are expected?**

- Inability to maintain airway
- Decreased level of consciousness
- Respiratory depression/apnea
- Hypotension

**Are there any special instructions/considerations?**

- Lower doses are recommended when administered for sedation prior to cardioversion or transcutaneous pacing- 1-2.5mg, titrating to desired effect
- Contact Medical Control for patients with:
  - Neurologic disorders
  - Geriatric
  - Pregnancy or lactating patients

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## Morphine Sulfate

**Indications:** Moderate to severe pain control

**Adult dose range:** 2.5mg increments to max of 10 mg - titrate to pain relief

**Pediatric dose range:** 0.1mg/kg - titrate to pain relief; **Not recommended in pediatrics under the age of 2 years**

**Time to onset:** 1 to 3 minutes

**Contraindications:**

- Head injury
- Volume depletion
- Respiratory depression
- Hypotension
- Caution in patient with acute inferior MI

**How is it given?**

- IV, IO, IM

**What should be monitored?**

- Level of consciousness
- Respirations
- Blood pressure

**Major drug interactions:**


- Use caution with other vasodilators or CSN depressants

**What side effects/potential complications are expected?**

- Altered level of consciousness
- Inability of patient to maintain airway
- Respiratory depression
- Hypotension
- Nausea/vomiting

**Are there any special instructions/considerations?**

- Have airway management equipment and naloxone ready and available for respiratory depression

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## Naloxone (Narcan®)

**Indication:** Antidote for narcotic agonists

**Adult Dosage Range:**

IM/IV/IO 0.4-2 mg , may repeat at 2-3 minute intervals to  
desired effect  
IN 2mg (1ml/nare)

**Pediatric Dosage Range:**

IM/IV/IO 0.1mg/kg to a max of 2mg titrate to desired effect  
IN <20kg administer 1mg (0.5ml/nare)  
IN >20kg administer 2mg (1ml/nare)

**Time to onset:** Within 2 minutes

**Contraindications:**

- Hypersensitivity to naloxone
- Caution in patient known to be narcotic dependent

**How is it given?**

- IM/IV/IO/IN/ET \*\*\* Avoid ET administration in newborn

**What should be monitored?**

- Blood pressure
- Respiratory rate
- Heart rate

**Major Drug Interactions:**


- Decreased effect of narcotic analgesia
- May precipitate acute narcotic withdrawal in patient who is narcotic dependent

**What side effects/potential complications are expected?**

- Rare, but sometimes seen side effects:
  - Hypertension
  - Hypotension
  - Tachycardia
  - Ventricular arrhythmias
  - Cardiac arrest
  - Nausea/vomiting
  - Dyspnea
  - Pulmonary edema
  - Sneezing
  - Diaphoresis

**Are there any special instructions?**

- Effectiveness is due to narcotic reversal, not to an effect on opiate receptors. Therefore, adverse events occur secondary to reversal (withdrawal) of narcotic analgesia and sedation, which can cause severe reactions.

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## Nitroglycerin (Nitroquick®, Nitrostat®)

**Indication:** Angina pectoris; pulmonary/systemic hypertension

**Adult Dosage Range:** Sublingual: 0.4mg tab, 0.4 mg spray- may repeat once every 5 minutes to a max of 3 doses; ½-1 inch paste for transdermal administration.

**Pediatric Dosage Range:** Contraindicated

**Time to onset:** Sublingual - 1 to 3 minutes; 30 minutes with topical administration with longer lasting effects.

**Contraindications:**

- Withhold from any patient taking erectile dysfunction drugs within last 72 hours; consult Medical Control
- Caution and contact Medical Control for patient with ECG signs of acute inferior MI or right ventricular MI
- Hypersensitivity to nitroglycerin
- Increased ICP
- Systolic blood pressure less than 110 mmHg

**How is it given?**

- SL

**What should be monitored?**

- Level of consciousness
- Blood pressure
- Heart rate

**Major Drug Interactions:**


- Alcohol, beta-blockers, calcium channel blockers may enhance nitroglycerin's hypotensive effect
- Sildenafil and other drugs for erectile dysfunction may increase vasodilatory effects and result in severe irreversible hypotension

**What side effects/potential complications are expected?**

- Headache
- Dizziness
- Hypotension/orthostasis
- Postural syncope
- Tachycardia

**Are there any special instructions?**

- Do not chew or swallow sublingual dosage forms
- Keep patient supine when possible and monitor blood pressure frequently
- Use with caution in hypovolemia, hypotension, and right ventricular infarctions

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## Ondansetron (Zofran®)

**Indication:** Antiemetic for vomiting or severe nausea

**Adult dosage range:**

Ondansetron (Zofran) 4mg IV/IO over 2-5 min. or IM undiluted; may adm. 8mg ODT (oral dissolving tablet) rather than IV/IO/ or IM

**Pediatric dosage range**

0.1mg/kg Ondansetron (Zofran) IV/IO over 2-5 minutes or IM undiluted, If older than 4 yr may adm. 4mg ODT (oral dissolving tablet) instead of IV/IO or IM

**Time to onset:** 3 to 5 minutes

**Contraindications:**

- Hypersensitivity to drug
- Hypotension

**How is it given?**

- Slow IV, IO, IM, PO, ODT

**What should be monitored?**

- Blood Pressure
- Heart Rate
- Sedation
- ECG - prolonged QT

**Major drug interactions:** *Contact Medical Control for advisement*


- Phenytoin (Dilantin)
- Phenobarbital (Luminal)
- Carbamazepine (Carbatrol)
- Rifampin (Rifadin, Rimactane, Rifater)
- Apomorphine (Apokyn, Uprima, Spontane)

**What side effects/potential complications are expected?**

- Blurring of vision
- Dizziness
- Headache
- Constipation
- Chest pain
- Hypotension

**Are there any special instructions/considerations?**

- As with other antiemetics, routine prophylaxis is not recommended for patients in whom there is little expectation of nausea and/or vomiting
- Hepatic Impairment: Maximum dose of 8mg/IV

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## Oral Glucose (Glucose®, Insta-Glucose®)

**Indications:** Conscious patient with suspected hypoglycemia

**Adult dose range:** 15g PO

**Pediatric dose range:** 7.5g PO

**Time to onset:** 5 to 10 minutes

**Contraindications:**

- Decreased level of consciousness
- Inability to swallow
- Nausea/vomiting

**How is it given?**

- PO

**What should be monitored?**

- Level of consciousness
- Blood glucose

**Major drug interactions:**

- None in the emergency setting


**What side effects/potential complications are expected?**

- Nausea/vomiting
- Improvement in blood sugar levels

**Are there any special instructions/considerations?**

- Must be swallowed.
- Check glucose readings before and at least 10 minutes after administration
- With altered level of consciousness, start IV/IO and administer dextrose solution; in the event an IV cannot be established, administer glucagon IM/IN



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## Oxygen

**Indications:** Hypoxia, carbon monoxide toxicity

**Adult dose range:** 24-100 percent (FiO<sub>2</sub>) as required

**Pediatric dose range:** 24-100 percent (FiO<sub>2</sub>) as required

**Time to onset:** rapid

**Contraindications:**

- None in the emergency setting

**How is it given?**

- Inhalation, positive pressure assist

**What should be monitored?**

- Level of consciousness
- Pulse oximetry

**Major drug interactions:**


- None in the emergency setting

**What side effects/potential complications are expected?**

- Drying of mucus membranes without humidification
- Improvement of hypoxic event as indicated by patient presentations, pulse rates, and SpO<sub>2</sub> readings

**Are there any special instructions/considerations?**

- In most situations, oxygen is administered to maintain an SpO<sub>2</sub> reading of ≥ 95%
- Pulse rates are good indicators of oxygen administration's effectiveness. Bradycardia, especially in the pediatric patient, indicates severe hypoxic conditions
- Closely monitor COPD patients treated with oxygen; these patients may rapidly become sedated from loss of hypoxic drive.
- Humidify whenever possible when providing high flow volumes
- Cold oxygen may worsen asthma or create hypothermic conditions in some patients.

 <b>DeKalb County Fire Rescue</b>	Medical Director:	William Hardcastle, MD
	Fire Rescue Director:	Darnell Fullum
	Effective Date:	April 1, 2016

## Sodium Bicarbonate

**Indication:** Metabolic acidosis; hyperkalemia; tricyclic antidepressant overdose with wide QRS

**Adult Dosage Range:** 1 mEq/kg (8.4%) when appropriate, may repeat with 0.5 mEq/kg

**Pediatric Dosage Range:**

- **Age <2 years:** 1mEq/kg (4.2%) may repeat with 0.5 mEq/kg in 10 minutes x 1 or as indicated by patient's acid-base status
- **Age >2 years:** 1mEq/kg (8.4%) may repeat with 0.5 mEq/kg in 10 minutes x 1 or as indicated by patient's acid-base status

**Time to onset:** Rapid

**Contraindications:**

- Alkalosis
- Hypocalcemia/hyponatremia
- Inadequate ventilation during cardiopulmonary resuscitation

**How is it given?**

- IV, IO

**What should be monitored?**

- Vein patency
- Blood pH
- PO<sub>2</sub>
- PCO<sub>2</sub>
- Cardiac arrhythmias

**Major Drug Interactions:**


- Inhibits
  - Tetracyclines
  - Chlorpropamide
  - Lithium carbonate
  - Methotrexate
  - Salicylates
- Potentiates
  - Anorexiant
  - Sympathomimetics
  - Quinidine

**What side effects/potential complications are expected?**

- Rare when used with caution
  - Alkalosis
  - Hyponatremia
  - Hypokalemia
  - Local site irritation

**Are there any special instructions?**

- Extravasation causes tissue necrosis
- Patients should be adequately ventilated before administration during cardiac arrest

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## Thiamine (Vitamin B1)

**Indication:** Coma of unknown origin

**Adult Dosage Range:** 100mg

**Pediatric Dosage Range:** Rarely indicated for pediatrics

**Time to onset:** Rapid

**Contraindications:** None in the emergency setting

**How is it given?**

- IV slow

**What should be monitored?**

- Vein patency

**Major Drug Interactions:**


- None known

**What side effects/potential complications are expected?**

- Tingling
- Pain
- Pruritus
- Urticaria
- Weakness
- Sweating
- Nausea
- Dyspnea

**Are there any special instructions?**

- **SHOCK & DEATH** have followed rapid IV infusion

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## Toradol (Ketorolac Tromethamine)

**Indication:** Mild to moderate pain

**Adult Dosage Range:** 30mg IV/IO diluted with 10cc Normal Saline slow IVP  
Or 60mg IM

**Pediatric Dosage Range:** Not for use in the patient younger than 14 years of age

**Time to onset:**

- Approximately 10 minutes

**Contraindications:**

- Patients allergic to aspirin
- Known hypersensitivity to Toradol
- Not for use in the presence of Altered Level of Consciousness
- Do not use in suspected medical or traumatic bleeding
- History or Active peptic ulcer disease
- History or Recent GI bleeding or perforation
- Advanced renal impairment and in patients at risk for renal failure because of volume depletion
- Suspected or confirmed cerebrovascular bleeding
- Hemorrhagic diathesis, incomplete hemostasis, and patients at high risk of bleeding
- Labor and delivery
- Lactation
- Concomitant use with aspirin or other NSAIDs
- Concomitant use with probenecid.

**How is it given?**

- IV, IM

**What should be monitored?**

- Vein patency

**Major Drug Interactions:**

- Aspirin  
Do not administer to patients with recent ingestion of Aspirin or Aspirin containing products as this increases bleeding risks.
- NSAIDs  
Do not administer to patients with recent ingestion of NSAIDs or NSAID containing products as this increases bleeding risks.


**What side effects/potential complications are expected?**

- Edema
- Drowsiness
- Vomiting
- Headache
- Rash
- Pallor
- Dizziness
- Sweating
- Constipation
- Heartburn

**Are there any special instructions?**

Ketorolac is the preferred first-line medication for Kidney Stones; May consider alternative medications under current *Pain Management Protocol*; Ondansetron may be administered to patients receiving Ketorolac also.

# Resources

 <b>DeKalb County Fire Rescue</b>	Medical Director:	William Hardcastle, MD
	Fire Rescue Director:	Darnell Fullum
	Effective Date:	April 1, 2016

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## Abbreviations and Definitions

AC power.....	Alternating Current Power
ACS.....	Acute Coronary Syndrome
AED.....	Automated External Defibrillator
AEIOUTIPS...	Alcohol, Electrolytes, Insulin, Opiates, Uremia, Trauma, Infection, Poison, Psychogenic, Seizure, Shock
AHA .....	American Heart Association
AIDS.....	Acquired Immune Deficiency Syndrome
ALS.....	Advanced Life Support
ALTE.....	Apparent Life Threatening Event
AMI.....	Acute Myocardial Infarction
AMS.....	Altered Mental Status
APGAR.....	Appearance, Pulse Rate, Grimace, Activity, Respiration
ASA.....	Aspirin
AVPU.....	Response level: Alert, responsive to verbal stimuli, responsive to painful stimuli only, unresponsive
BGA.....	Blood Glucose Analysis
BIAD.....	Blind Insertion Airway Device
BLS.....	Basic Life Support
BP.....	Blood Pressure
BSA.....	Body Surface Isolation
BSA.....	Body Surface Area
BVM.....	Bag Valve Mask
°C.....	Degrees Celsius
Cardiac monitoring.....	Using electrodes to identify rhythm with continuous readout
CDC.....	Centers for Disease Control
CHF.....	Congestive Heart Failure
cm.....	Centimeters
CO <sub>2</sub> .....	Carbon Dioxide
COPD.....	Chronic Obstructive Pulmonary Disease
CPAP.....	Continuous Positive Airway Pressure
CPR.....	Cardiopulmonary Resuscitation
CRT .....	Capillary Refill Time
D5W.....	5% Dextrose in water
D10W.....	10% Dextrose in water
D25W.....	25% Dextrose in water
D50W.....	50% Dextrose in water
DIB.....	Difficulty in Breathing
dL.....	Deciliter
DNR.....	Do Not Resuscitate
DPH.....	Department of Public Health
ECG.....	Electrocardiogram
ET.....	Endotracheal Intubation

## Abbreviations and Definitions (Continued)

ETA.....	Estimated Time of Arrival
ETCO2.....	End-Tidal CO2
°F.....	Degrees Fahrenheit
FAST.....	Stroke Assessment; Facial droop, Arm drift, Speech, Time
FBAO.....	Foreign Body Airway Obstruction
g.....	Gram
GCS.....	Glasgow Coma Scale
GI.....	Gastrointestinal
gtt/min.....	drops per minute (with <b>micro drip</b> tubing, equivalent to milliliters per hour)
gtt.....	Drop
GU.....	Gastrourinary
HEPA.....	High Efficiency Particulate Air (HEPA mask)
HR.....	Heart Rate
ICP.....	Intracranial Pressure
IM.....	Intramuscular
IN.....	Intranasal
IV.....	Intravenous
J.....	Joules
KG.....	Kilogram
KVO.....	Keep vein open
L.....	Liter
LMP.....	Last Menstrual Period
LOC.....	Level of Consciousness
LPM.....	Liter Per Minute
LSB.....	Long Spine Board
LVAD.....	Left Ventricular Assist Device
mcg.....	Microgram
MDI.....	Metered Dose Inhaler
mEq.....	Milliequivalent
mg.....	Milligram
ml.....	Milliliter
mmHg.....	Millimeters of Mercury
MVC.....	Motor Vehicle Collision
NPA.....	Nasopharyngeal Airway
NPO.....	Nothing by mouth
NS.....	Normal saline
NV.....	Nausea and Vomiting
O2.....	Oxygen
ODT.....	Oral Dissolving Tablet
OCGA.....	Official Code of Georgia



## Abbreviations and Definitions (Continued)

OPA.....	Oropharyngeal Airway
OPQRST.....	History of present illness; Onset, Provocation, Quality, Region and Radiation, Severity, Time
Pallor.....	Pale skin
PE.....	Pulmonary Embolism
PEA.....	Pulseless Electrical Activity
PO.....	Per Oral; by mouth
PPE.....	Personal Protective Equipment
PPMHx.....	Past Pertinent Medical History
PPV .....	Positive pressure ventilation
PR Interval.....	The period from the beginning of the P wave to the beginning of the QRS complex
q.....	Each, every
QRS.....	Ventricular depolarization complex
ROSC.....	Return of Spontaneous Circulation
SAI.....	Sedation Assisted Intubation
SAMPLE.....	Symptoms, Allergies, Medications, Past medical history, Last oral intake, Events
SBP.....	Systolic Blood Pressure
SGA.....	Supraglottic Airway
SL.....	Sublingual; under tongue
SpO2.....	Oxygen Saturation (Ideally greater than or equal to 94%)
SQ.....	Subcutaneous (beneath skin)
SVT.....	Supraventricular Tachycardia
TB.....	Tuberculosis
TBI.....	Traumatic Brain Injury
TBSA.....	Total Body Surface Area
TCP.....	Transcutaneous Pacing
Tourniquet.....	Device used to control venous/arterial bleeding to and extremity
URI.....	Upper Respiratory Infection
USAISR.....	United States Army Institute of Surgical Research
VF.....	Ventricular Fibrillation
VT.....	Ventricular Tachycardia

## Important Numbers

### State and National Resources

Adult Protective Services .....	1-888-774-0152
CHEMPACK Request.....	1-800-222-1222
CHEMTREC.....	1-800-424-9300
Georgia Child Protective Services.....	1-404-657-3400 or 1-855-422-4453
Georgia Crisis and Access Line (Mental Health).....	1-800-715-4225
Georgia Critical Incident Stress Foundation Crisis Hotline.....	1-404-419-6506
Georgia Division of Aging Services.....	1-866-552-4464
Georgia Office of Emergency Medical Services.....	1-404-679-0547
Georgia Poison Control.....	1-800-222-1222
Mental Health Hotline.....	1-800-715-4225
National Domestic Violence Hotline.....	1-800-799-7233
Trauma Communications Center.....	1-866-556-3314
or FREE mobile to mobile.....	1-404-229-6405

### Office of Emergency Medical Services and Trauma

Georgia Office of EMS.....	1-404-679-0547
Northwest Georgia Region I EMS.....	1-706-295-6176
North Georgia Region II EMS.....	1-770-535-5743
Metro Atlanta Region III EMS.....	1-404-248-8995
West Georgia Region IV EMS.....	1-706-845-4035
Central Georgia Region V EMS.....	1-478-993-4990
East Central Georgia Region VI EMS.....	1-706-667-4336
West Central Georgia Region VII EMS.....	1-706-321-6150
Southwest Georgia Region VIII EMS.....	1-404-989-5173
Southeast Georgia Region IX EMS.....	1-912-262-3035
Northeast Georgia Region X EMS.....	1-706-583-2862

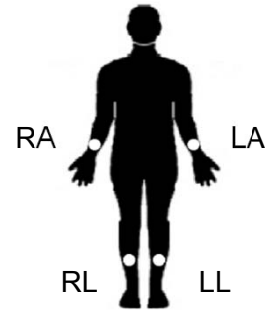
### Georgia Air Ambulance Providers

Air Evac Lifeteam.....	1-800-247-3822
<i>Carrollton, Cordele, Dublin, Jesup, Lagrange, Statesboro, Vidalia, Waycross</i>	
Air Methods Georgia.....	1-888-763-1010
<i>Augusta, Carrollton, Conyers, Griffin, Gainesville, Jasper, Kennesaw, Newnan, (Air Life Georgia); Springfield and Vidalia (Life Star)</i>	
Children's Healthcare (Children's 1).....	1-404-785-6540
<i>Atlanta</i>	
Gold Cross (AirMed).....	1-888-792-9245
<i>Augusta</i>	
Med Trans (Life Force).....	1-800-523-6723 or 1-423-778-5433
<i>Blue Ridge, Calhoun</i>	

## 12 Lead ECG

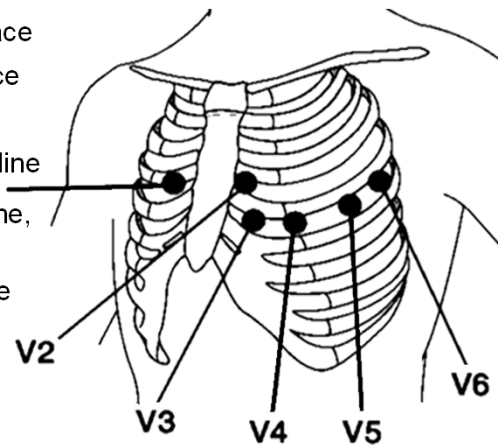
### Limb Lead Placement

- LA - Left arm, any where below the shoulder
- LL - Left leg, anywhere below the torso
- RA - Right arm, any where below the shoulder
- RL - Right leg, anywhere below the torso



### Precordial Lead Placement

- V1 - Right side of sternum, 4<sup>th</sup> Intercostal space
- V2 - Left side of sternum, 4<sup>th</sup> intercostal space
- V3 - Directly between V2 and V4
- V4 - 5<sup>th</sup> intercostal space, left mid clavicular line
- V5 - 5<sup>th</sup> intercostal space, anterior axillary line, directly between V4 and V6
- V6 - 5<sup>th</sup> intercostal space, left midaxillary line

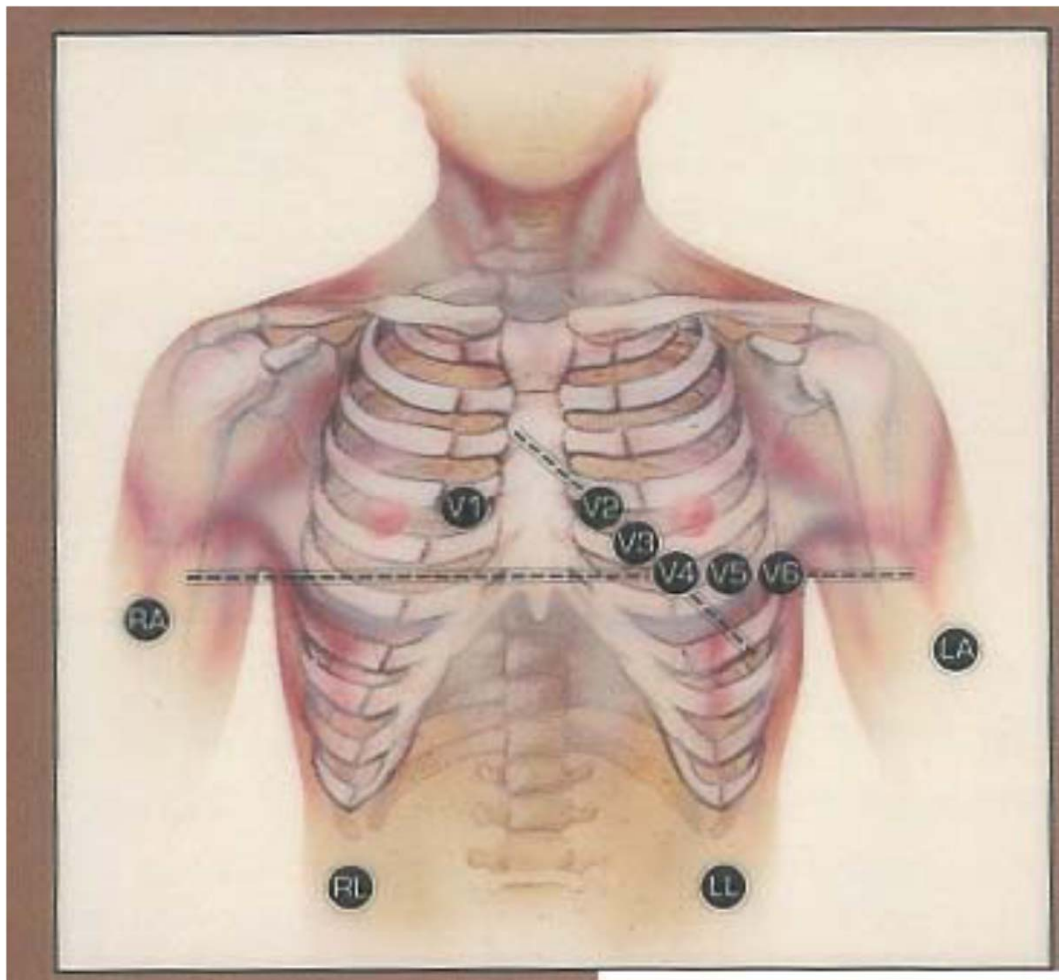


### Continuous Leads

- II, III, aVF - Inferior Leads
- V1-V2 - Septal Leads
- V3-V4 - Anterior Leads
- V5-V6, I, aVL - Lateral Leads

<b>I</b> Lateral left ventricle	<b>aVR</b>	<b>V1</b> Septal	<b>V4</b> Anterior
<b>II</b> Inferior portion of the left ventricle	<b>aVL</b> Lateral left ventricle	<b>V2</b> Antero-Septal	<b>V5</b> Lateral left ventricle
<b>III</b> Inferior portion of the left ventricle	<b>aVF</b> Inferior portion of the left ventricle	<b>V3</b> Antero-Septal	<b>V6</b> Lateral left ventricle

## 12 Lead EKG placement



## Medication Administration

### **Assisting Patient with Taking OTC and/or Own Prescription Medications**

- Georgia Scope of Practice allows all levels of EMT to assist patients in taking their own prescribed medications and/or over-the-counter medications.

### **Auto Injector Drug Delivery**

- All levels of EMS licensure are allowed to administer epinephrine through auto-injector to patients experiencing anaphylaxis. EMT and EMT-I may administer by auto-injector only.
- All levels of licensure are allowed to administer unit dose commercially pre-filled containers or auto-injectors for the administration of life saving medications intended for self, peer, or patient rescue in hazardous materials situations

### **Nasal Drug Delivery**

- Medications administered via the IN route require a higher concentration of drug in a smaller volume of fluid than typically used in the IV route. In general, administer no more than 1 mL of volume per nostril.
- Do not administer medications via the IN route if the patient's nose is bleeding or if nasal congestion or nasal discharge is present. Nasal administration does not always work for every patient and is less likely to be effective if the patient has been abusing vasoconstrictors, such as cocaine.
- Medications commonly delivered IN are:
  - midazolam
  - naloxone
  - glucagon
  - ondansetron
  - Fentanyl

### **Nebulized Drug Delivery**

- All levels of EMS licensure are allowed to deliver inhaled medications through a nebulizer or through use of metered-dose-inhaler to patients with difficulty breathing.
- Treatment should continue until medication in reservoir is depleted.
- Nebulized medications may be used with CPAP.
- Patient monitoring should include pulse, respiratory rate, and breath sounds

### **Intra-osseous Drug Delivery**

- IO placement or removal is approved for EMT-I, AEMT, CT, and paramedic. This includes placement in both adults and children.
- All fluids and medications that can be administered via IV may be given IO, unless specified by local medical director
  - If the patient experiences pain during infusion, inject lidocaine into the marrow cavity.
  - Adult: 2 – 5ml (20 – 50mg) 1% or 2% lidocaine (Paramedic only).
  - Pediatric: 0.5mg/kg 1% or 2% lidocaine (Paramedic only).
- Contraindications include
  - Placement in or distal to a fractured bone
  - Placement through area with infection or burn.

### **Pre-existing Indwelling Catheters or Other Implanted Ports (DCFR/EMS is not approved for these catheters and ports)**

- DCFR/EMS providers are not approved for these catheters and implantable port(s) access in compliance with the Georgia Scope of practice dated 12/03/2015.

### **AEMT Scope**

- Medications allowed for AEMT to administer in addition to those allowed for EMT-I are:
  - Glucagon for hypoglycemia, via IM, SC, IV, IO, or IN
  - Nitroglycerine for chest pain of suspected cardiac origin
  - Naloxone to patient with suspected narcotic overdose, via IM, SC, IV, IO, or IN
  - Nitrous Oxide (50/50 mix) for pain relief
  - Epinephrine for anaphylaxis, prepared by AEMT, via IM or SC.

## Standard Precautions

### **Indications**

- Standard precautions are guidelines for reducing the risk of transmission of blood-borne and other pathogens that apply all patients receiving care regardless of their diagnosis or presumed infection status.

### **Type and Use of Personal Protective Equipment**

- Gloves - for any patient contact, and when cleaning/disinfecting contaminated equipment. Puncture resistant gloves will be worn in situations where sharp or rough edges are likely to be encountered, i.e., auto extrication.
- Face mask & eye protection - facial protection will be used in any situation where splash contact with the face is possible. This protection may be afforded by using both a face mask and eye protection, or by using a full-face shield. When treating a patient with a suspected or known airborne transmissible disease, particulate facemasks should be used. For respiratory illnesses (TB, SARS) it is beneficial to mask the patient.
- Coverall/fluid resistant gowns - designed to protect clothing from splashes, gowns may interfere with, or present a hazard to, the member in some circumstances. The decision to use gowns to protect clothing will be left to the member. Structural fire fighting gear also protects clothing from splashes and is preferable in fire, rescue, or vehicle extrication activities.
- Shoe/Head Coverings - fluid barrier protection will be used if suspected contamination is possible.

### **General Precautions Against Disease**

- If it's wet, it's infectious - use gloves
- If it could splash onto your face, use eye shields and mask or full face shield.
- If it's airborne, mask yourself or patient.
- If it can splash on your clothes, use a gown or structural fire fighting gear.
- If it could splash on your head or feet, use appropriate barrier protection.

### **Post Exposure Management**

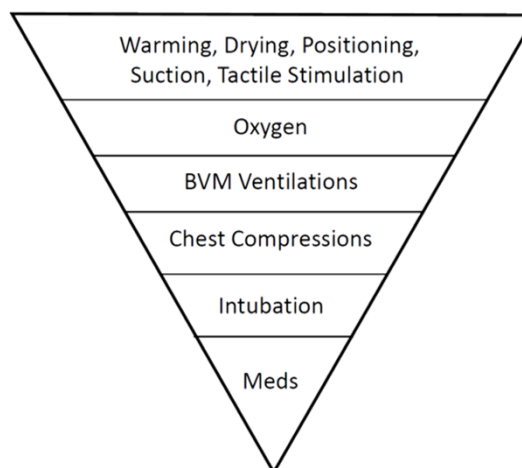
- Provide first aid
  - Secure area to prevent further contamination. (Stop bleeding with direct pressure.)
  - Remove contaminated clothing and flush.
  - Wash the contaminated area well with soap and water, or waterless hand cleanser.
  - If the eyes, nose, or mouth are involved, flush them well with large amounts of water.
- Notification and relief of duty - the worker's supervisor should be immediately notified if a worker experiences an exposure involving potentially infectious source material. The supervisor should determine if the worker needs to be relieved of duty.
- Report the exposure - the worker or immediate supervisor should promptly complete an exposure report, appropriate for the agency, and submit it to the designated Infection Control Officer.
- Seek medical attention, counseling, consent and testing per protocol

## APGAR Scoring

The **APGAR score** was devised in 1952 by the eponymous Dr. Virginia Apgar as a simple and repeatable method to quickly and summarily assess the health of newborn children immediately after birth. The APGAR score is determined by evaluating the newborn baby on five simple criteria on a scale from zero to two, then summing up the five values thus obtained. The resulting Apgar score ranges from zero to 10. The APGAR score should be calculated at 1 and 5 minutes after delivery. A score  $\leq 3$  is considered critical. A score  $\geq 7$  is good to excellent.

Criteria	0 points	1 point	2 points
<b>Appearance (skin color)</b>	Body and extremities cyanotic	Body pink, extremities cyanotic	No cyanosis;
<b>Pulse rate</b>	Absent	< 100 beats/minute	>100 beats/minute
<b>Grimace (irritability)</b>	No response to stimulation	Grimace, feeble cry when stimulated	Cry or pull away when stimulated
<b>Activity (muscle tone)</b>	None or limp	Some flexion	Active motion; arms and legs flexed
<b>Respiration</b>	Absent	Weak, gasping	Strong cry, good respiratory effort

The Neonatal Resuscitation Pyramid is a stepwise approach for treatment of a newborn. The American Academy of Pediatrics and the American Heart Association have developed standards and guidelines for neonatal resuscitation. The care that may be required is depicted as an inverted pyramid. The interventions, which are most commonly required, are at the top of this pyramid. As you progress down the pyramid the interventions indicated become less commonly required. Most neonates transition to post-natal life without difficulty. About 10% of infants require some assistance to begin breathing at birth. Less than 1% Require extensive resuscitative measures.





## Burns: Fluid Resuscitation

### 1- Parkland Formula

The formula for fluid resuscitation of the burn patient, the Parkland Formula, is used to calculate the amount of fluid to be administered to burn patient's over the first 24 hours. The Parkland formula is patient's weight in kilograms (PW) × percent of body surface area burned (TBSA) × 4ml. The first half of this amount is delivered in the first 8 hours and the remaining fluid is delivered in the next 16 hours. EMS focuses on the care given during the 1st hour or several hours following the event. Thus the formula as adapted for EMS and the first 8 hours is:  $PW \times TBSA \times 4ml$ , divide by 2. To determine the hourly rate, divide that solution by 8 and the equation becomes:  $PW \times TBSA \times 4ml \div 2 \div 8 =$  total to be infused for each of the first 8 hours. Another way to state the equation is to use:  $PW \times TBSA \times 0.25ml$  or  $\frac{PW \times TBSA}{4}$ .

*Example: 80 kg (198 lb) patient with 50 %TBSA  $\times 0.25 ml = 1000ml/hr$ .  
Two IV's are started, thus each are running at 500 ml/hr per IV*

Reminder: If two IV's are running, divide total amount to be infused each hr. by 2

Also, this is based on a timely response following the burn event. If there is a delay between the time of the burn event and the initiation of fluid therapy, the patient should be bolused to compensate for the delay.

*Example: If a delay of two hours occurs before fluid therapy can start for the patient in the first example. The patient would receive a fluid bolus of 2000 ml and a maintenance infusion of 1000 ml/hr should be initiated.*

### Parkland Formula:

**$PW \times TBSA \times 4ml =$  amount to be infused over 1<sup>st</sup> 24 hours**

### EMS Modification:

**$PW \times TBSA \times 0.25ml$  or  $\frac{PW \times TBSA}{4} =$  amount to be infused each hour of the 1<sup>st</sup> 8 hours**



**Do not exceed 1 liter of IV fluids unless authorized by Medical Control.**



**Contact Medical Control for fluid orders in patients with CHF or cardiac disease.**



## Burns: Fluid Resuscitation (continued)

### 2- Rule of Ten (Adults 40-80kg)

Rule of Ten: initial pre-hospital IV/IO fluid management for adults (wt 40 to 80 kg); normal saline may be used pre-hospital; LR is preferred if available. This is an infusion (mL/hr) not a bolus, unless the patient requires fluid resuscitation from hemorrhagic trauma.

- **Estimate the burn size to the nearest 10% BSA (this can be done with palm method or using the Rule of Nines burn chart).**
- **Multiply this number by 10: this is the initial fluid rate in ml/hr for adults up to 80 kg.**
- **For every 10 kg above 80 kg, increase the rate by 100 ml/hr.**

After fluid infusion has been initiated, further fluid management guidance should be obtained from destination or medical control.

This method was developed by the US Army Institute of Surgical Research.  
Reference: Bacomo FK, Chung KK. A primer on burn resuscitation. J Emerg Trauma Shock 2011;4:109-13.

### 3- Advanced Burn Life Support Recommendation (Children < 40kg)

In the pre-hospital and early hospital settings, prior to calculating the Total Body Surface Area (TBSA) burned, the following guidelines are recommended as starting points for fluid resuscitation rates:

- **5 years old and younger: 125 ml/hour**
- **6 – 13 years old: 250 ml/hour**
- **14 years and older: 500 ml/hour**

More definitive calculation of hourly fluid rates is performed during the secondary survey.

**Note: These recommendations are for fluid infusions (ml/hour) and are not to be given as an IV bolus administration**



**Do not exceed 1 liter of IV fluids unless authorized by Medical Control.**

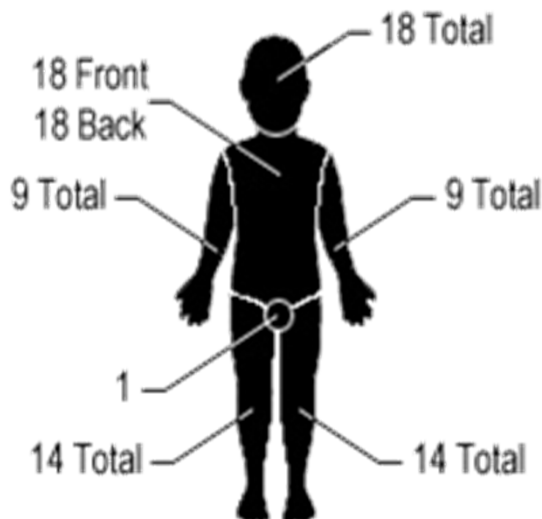
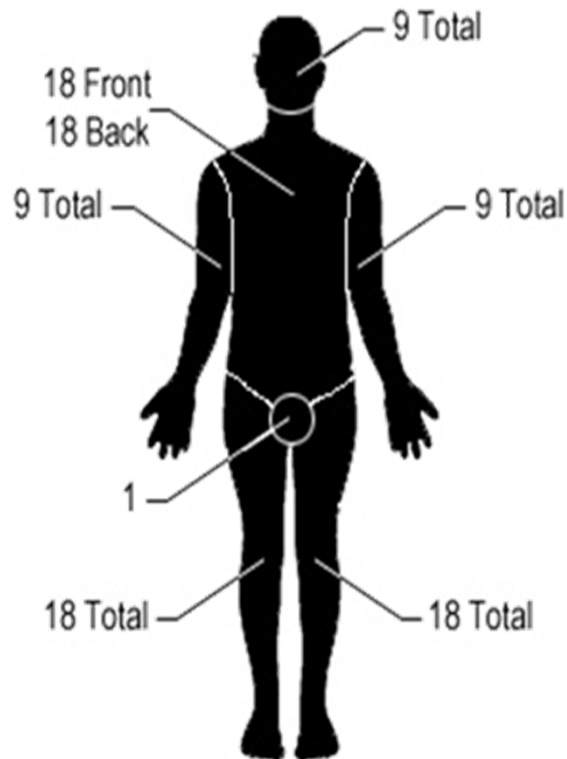


**Contact Medical Control for fluid orders in patients with CHF or cardiac disease.**

## Burns: Rule of Nines

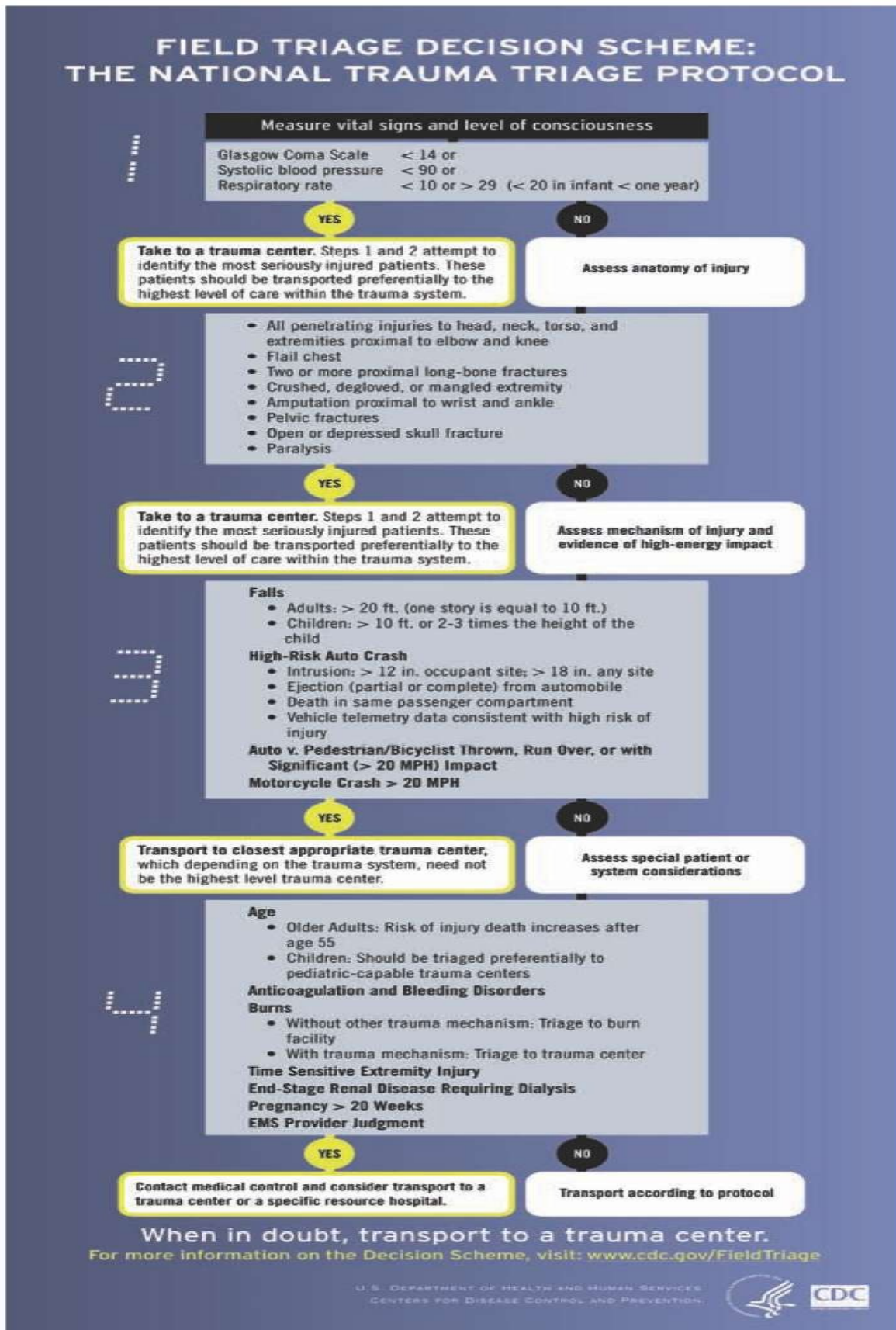
Total body surface area (TBSA) is an assessment measure of burns of the skin. In adults, the "Rule of Nines" is used to determine the total percentage of area burned for each major section of the body. In some cases, the burns may cover more than one body part, or may not fully cover such a part; in these cases, burns are measured by using the casualty's palm as a Resource point for 1% of the body.

Adult	
Anatomic structure	Surface area
Anterior head	4.5%
Posterior head	4.5%
Anterior torso	18%
Posterior torso	18%
Anterior leg, each	9%
Posterior leg, each	9%
Anterior arm, each	4.5%
Posterior arm, each	4.5%
Genitalia/perineum	1%



Child	
Anatomic structure	Surface area
Anterior head	9%
Posterior head	9%
Anterior torso	18%
Posterior torso	18%
Anterior leg, each	7%
Posterior leg, each	7%
Anterior arm, each	4.5%
Posterior arm, each	4.5%
Genitalia/perineum	1%

# 2011 Guidelines for Field Triage of Injured Patients



## CHEMPACK - FACT SHEET

### **What is the CHEMPACK?**

The CHEMPACK is a cache of antidotes for nerve agent or organophosphate exposure/toxicity.

### **What is CHEMPACK?**

The Centers for Disease Control and Prevention's (CDC) CHEMPACK Program is a nationwide initiative for the placement of CHEMPACK caches in local communities.

The CHEMPACK program fills a void in emergency preparedness by placing timely, critical, and life-saving antidotes in communities where they will be readily available to EMS, Hospitals, Fire, Law Enforcement and other CHEMPACK response partners.

### **Georgia's CHEMPACK Program**

Georgia's CHEMPACK program consists of more than 40 CHEMPACK sites pre-positioned throughout the state.

CHEMPACK assets can be requested and received quickly to support emergency response.

Training and additional support materials are available for EMS, Hospitals, Fire, Law Enforcement, and other CHEMPACK response system partners.

### **Georgia's Poison Center**

The center provides clinical guidance for potential nerve agent or organophosphate exposure/toxicity.

The center also receives all requests for CHEMPACK assets and coordinates delivery.

### **CHEMPACK Container**

CHEMPACK requests are scalable and will be configured based upon need.

The CHEMPACK is for use by first responders and hospital staff.

### **CHEMPACK Container Formulary Components**

Mark I Nerve Agent Antidote Kit

Diazepam Auto-Injectors

Atropine, Pralidoxime, Diazepam Multi-Dose Vials

Atropen Pediatric Doses

## CHEMPACK REQUESTS?

## CALL

## 1-800-222-1222

# Georgia Critical Incident Stress Foundation

**Crisis Hotline: 404-419-6506**

## What is a Critical Incident?

A critical incident or traumatic event is defined as an event so stressful that it overwhelms the existing coping skills of the individual or group. After being exposed to the critical incident, an individual may experience a range of reactions, which are manifested physically, cognitively, behaviorally, and/or emotionally, and may interfere with one's ability to function at work and at home. The stress reaction may include, but is not limited to: fatigue, muscle tremors, rapid heart rate, confusion, poor attention, poor problem solving, nightmares, anxiety, grief, fear, depression, inappropriate emotional responses, withdrawal, changes in activity, etc. A critical incident often leads to increased absenteeism and poor work performance.

### Critical Incidents:

- Suicide
- Violent crimes
- Homicide
- Death or violence to child
- Traffic accidents
- Mass casualty incidents
- Unexpected death
- School-related crisis
- Robbery
- Life threatening injury
- Natural disasters
- Workplace violence

## What is the CISM Program?

Critical Incident Stress Management, or CISM, is a comprehensive, multi-component crisis intervention approach. CISM is considered to be comprehensive because it consists of multiple crisis intervention components, which functionally span the entire temporal spectrum of a crisis. CISM interventions range from the pre-crisis phase through the acute crisis phase, and into the post-crisis phase. CISM consists of interventions which may be applied to individuals, small functional groups, large groups, families, organizations, and communities.

The seven core components include:

1. Pre-crisis preparation
2. Disaster or large-scale incident
3. Defusing
4. Critical Incident Stress Debriefing (CISD)
5. One-on-one crisis intervention/counseling
6. Family crisis intervention and organizational consultation
7. Follow-up and referral mechanisms for assessment and treatment

## Georgia Critical Incident Stress Foundation

GCISF is dedicated to the prevention and mitigation of disabling stress through the provision of education, training, crisis response support services and coordination for all at risk populations. They provide and promote consistent crisis response training relevant to the needs of Emergency Services, Law Enforcement, Critical Healthcare professionals, School systems, Mental Health professionals, and lay persons who are referred to as peer support providers. GCISF offers consultation and direction in the establishment of comprehensive crisis response programs to organizations and communities throughout the State of Georgia. Local GCISF networked CISM teams actively pursue the concept that no one should ever face the harmful effects of critical incident stress without appropriately trained, well-qualified assistance. GCISF maintains a 24/7/365 hotline for the coordination of crisis response activities.

## Emergency Medical Treatment and Active Labor Act (EMTALA)

**EMTALA** is a U.S. Act of Congress passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation ACT (COBRA). It requires hospitals and ambulance services to provide care to anyone needing emergency healthcare treatment regardless of citizenship, legal status, or ability to pay. There are no reimbursement provisions. As a result of the act, patients needing emergency treatment can be discharged only under their own informed consent or when their condition requires transfer to a hospital that is better equipped to administer the treatment they need.

EMTALA was passed to combat the practice of “patient dumping”, i.e. refusal to treat people because of their inability to pay or having insufficient insurance, or transferring or discharging emergency patients on the basis of high anticipated diagnosis and treatment costs. The law applies when an individual with a medical emergency “comes to the emergency department”, regardless of whether the condition is visible to others, or is simply stated by the patient with no external evidence.

- Unstable patients may occasionally be transferred if essential services are not available at the sending hospital – “a higher level of care transfer”.
- Patients being transferred from one acute care facility to another **MUST** have been accepted by the receiving facility. Ambulance crews should ensure that the appropriate arrangements have been made prior to the loading of the patient
- The ambulance crew should ensure that ALL transfer paperwork accompanies the patient
- If paramedics suspect that a transfer has the risk of being a possible EMTALA violation they should attempt to tactfully discuss the matter with the hospital personnel. The On-Duty Field Supervisor or Operations Manager should be a resource if the crew is in doubt about the appropriateness of the transfer.

## Glasgow Coma Score

### Modified Glasgow Coma Score – Infants

Eye Opening	Verbal Response	Motor Response
4-Spontaneous	5-Coos, babbles	6-Spontaneous
3-To verbal Commands	4-Irritable cries	5-Localizes pain
2-To pain	3-Cries to pain	4-Withdraws from pain
1-No response	2-Moans, grunts	3-Flexion
	1-No response	2-Extension
		1-No response

### Glasgow Coma Score –Children <3

Eye Opening	Verbal Response	Motor Response
4-Spontaneous	5-Oriented & converses	6-Obeys verbal commands
3-To verbal Commands	4-Disoriented & converses	5-Localizes pain
2-To pain	3-Inappropriate words	4-Withdraws from pain
1-No response	2-Incomprehensible sounds	3-Flexion
	1-No response	2-Extension
		1-No response

### Glasgow Coma Score – Adults & Children >3

Eye Opening	Verbal Response	Motor Response
4-Spontaneous	5-Oriented & converses	6-Obeys verbal commands
3-To verbal Commands	4-Disoriented & converses	5-Localizes pain
2-To pain	3-Inappropriate words	4-Withdraws from pain
1-No response	2-Incomprehensible sounds	3-Flexion
	1-No response	2-Extension
		1-No response



# **HIPAA Fact Sheet: Emergency Medical Services**

## **Public Health Activities Protected by HIPAA**

The comments to the preamble of the Privacy Rule explicitly protect state public health laws by making it clear that “nothing in this [Rule] shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth or death, public health surveillance, or public health investigation or intervention.”

## **HIPAA Does Not Preempt State Public Health Laws**

The Privacy Rule specifically states that it does not preempt contrary state public health laws, including state procedures established under such laws that provide for the reporting of disease or injury, child abuse, birth or death, or for the conduct of public health surveillance, investigation, or intervention. [45 CFR 160.203 (a)(1)(iv)&(c)]

## **Public Health Authorities Defined**

Public health authorities include state public health agencies (e.g., state public health departments, divisions, districts or regions); local public health agencies; and anyone performing public health functions under a grant of authority from a public health agency. [45 CFR 164.501]

## **Disclosures Required by Law**

The Privacy Rule permits covered entities to disclose protected health information, without authorization, to public health authorities who are authorized by law to receive such reports for the purpose of preventing or controlling disease, injury, or disability and for conducting public health surveillance, investigations, or interventions. This includes federal, tribal, local or state laws (or state procedures established under such law) that provide for receiving reporting of disease, injury or conducting public health surveillance, investigation, or intervention. [45 CFR 164.512 (a)&(b)]

## **Public Health Authorities are Not Business Associates of Covered Entities**

Public health authorities receiving information from covered entities as required or authorized by law [See 45 CFR 164.512 (a)&(b)] are not business associates of the covered entities and therefore are not required to enter into business associate agreements. [CDC MMWR, Vol. 52, page 8 (May 2003)]

## **Minimum Necessary Rule**

Generally, a covered entity must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. [45 CFR 164.502 (b)]. However, covered entities are not required to make a minimum necessary determination for public health disclosures that are required by law. [45 CFR 164.502 (b)]. For disclosures to a public health authority, covered entities may reasonably rely on a requested disclosure, as the minimum necessary if the public health authority represents that the information requested is the minimum necessary for the stated purpose. [45 CFR 164.514 (d)(3)(iii)]

## **Accounting for Public Health Disclosures**

The Privacy Rule provides for a simplified means of accounting because the vast amount of data exchanged between covered entities and public health authorities is made through ongoing regular reporting. For example, ambulance service providers are required by law regularly submit copies of prehospital care reports to regional offices that are part of the state.



## HIPAA Fact Sheet (Continued)

public health authority. In such cases, the covered entity need only identify the recipient of such repetitive disclosures (regional public health authority), the purpose of the disclosure (required for injury control and prevention), and describe the protected health information routinely disclosed. The date of each disclosure need not be tracked. Rather, the accounting may include the date of the first and last such disclosure during the accounting period (June 1, 2003 to July 1, 2003), and a description of the frequency or periodicity (monthly) of such disclosures. Therefore, the covered entity would not need to annotate each patient's medical record whenever a routine public health disclosure was made. [CDC MMWR, Vol. 52, page 9 (May 2003)]

### **Relevant State Laws:**

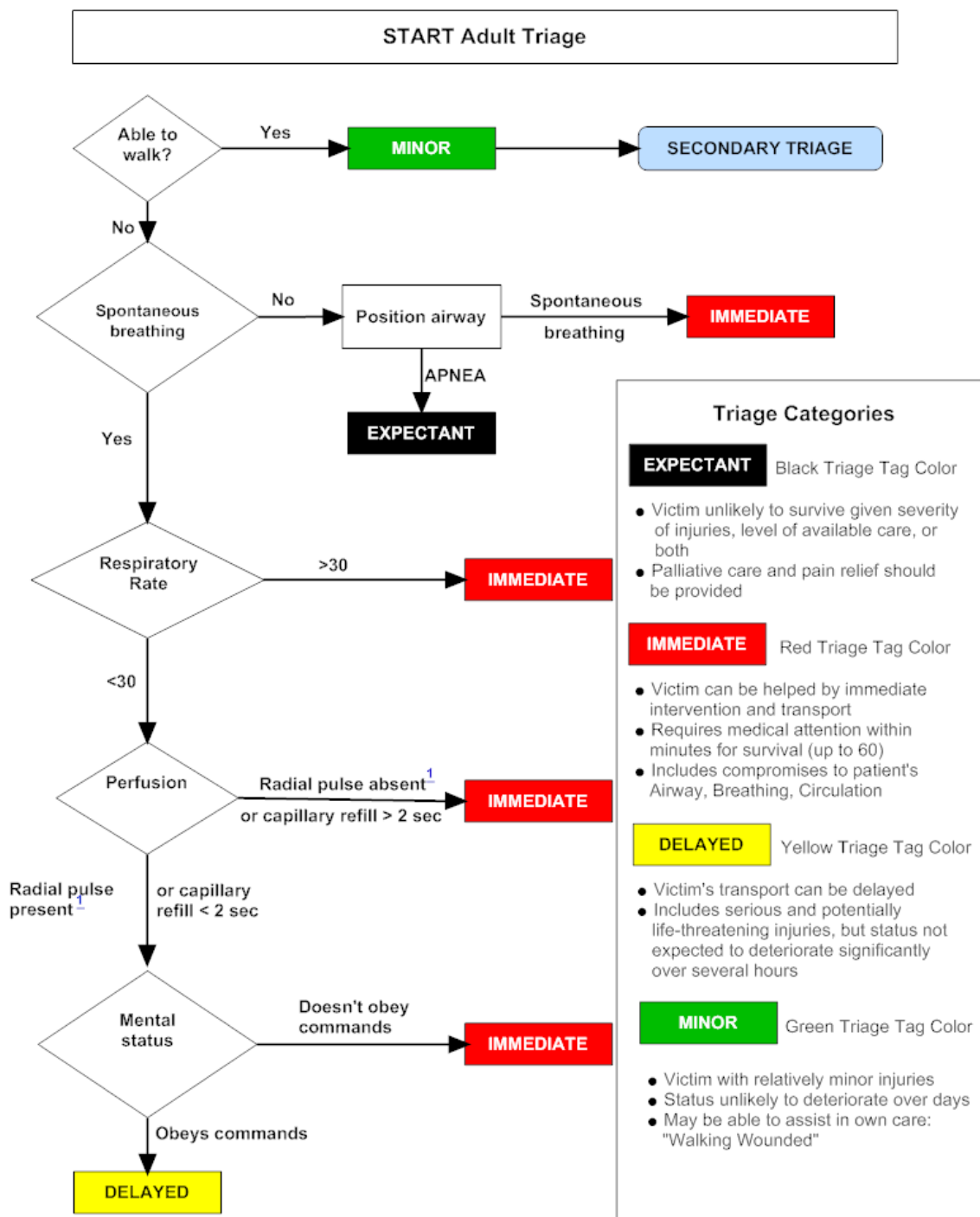
O.C.G.A. § 31-11-5; Rules and Regulations for Ambulance Services  
 O.C.G.A. § 31-12-6; Records of Ambulance Services  
 DHR Rules and Regulations, Chapter 290-5-30; Emergency Medical Services

### **Sources:**

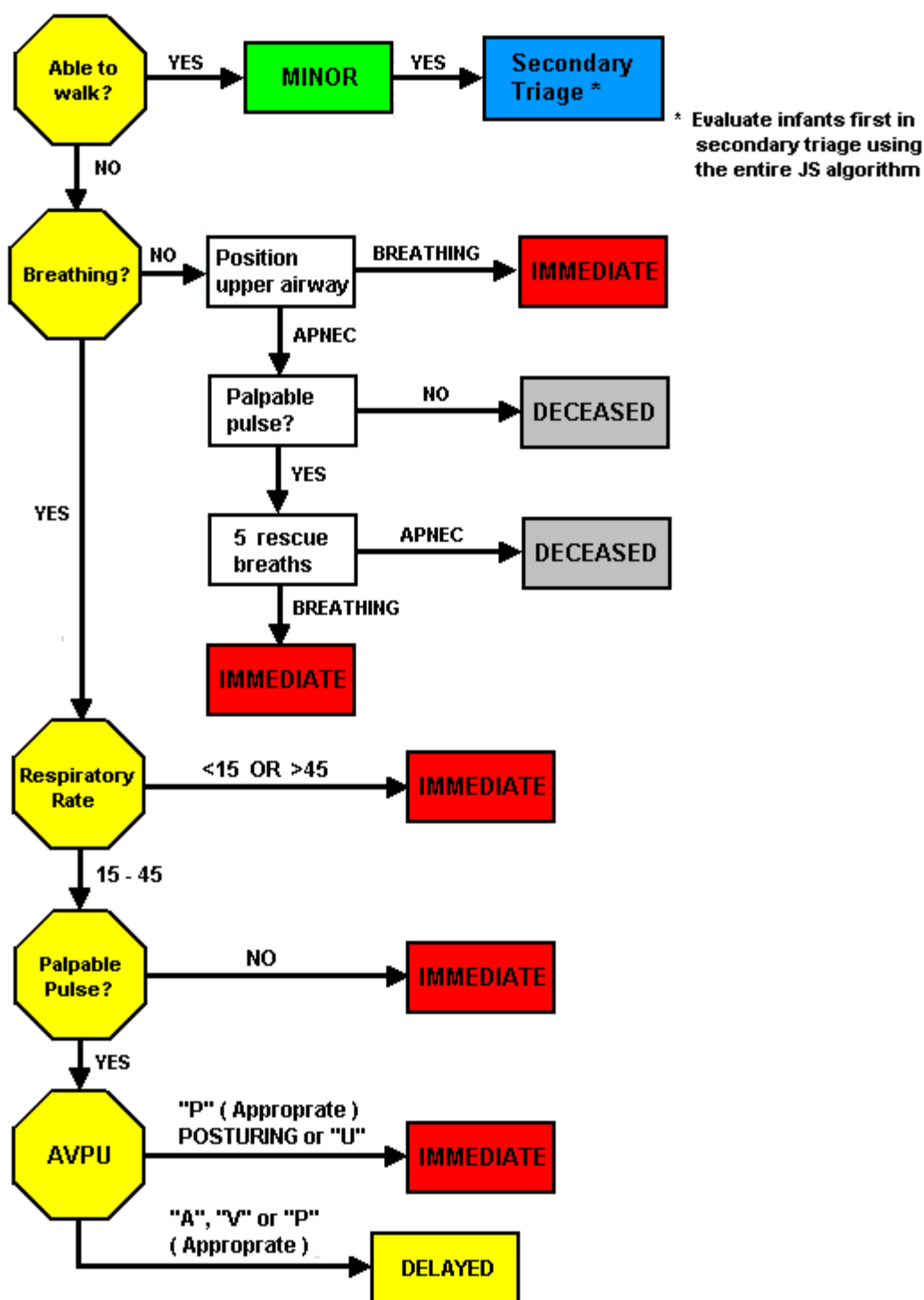
U.S. Department of Health and Human Services  
 Office of Civil Rights  
 HIPAA Privacy - Disclosure for Public Health Activities (Revised April 3, 2003)  
 Summary of the HIPAA Privacy Rule (May 2003)  
<http://www.hhs.gov/ocr/hipaa/privacy.html>

U.S. Department of Health and Human Services  
 Centers for Disease Control and Prevention  
 Morbidity and Mortality Weekly Report  
 Vol. 52 Supplement (May 2, 2003)  
[http://www.cdc.gov/mmwr/preview/ind2003\\_su.html](http://www.cdc.gov/mmwr/preview/ind2003_su.html)

# START MCI Triage Algorithm

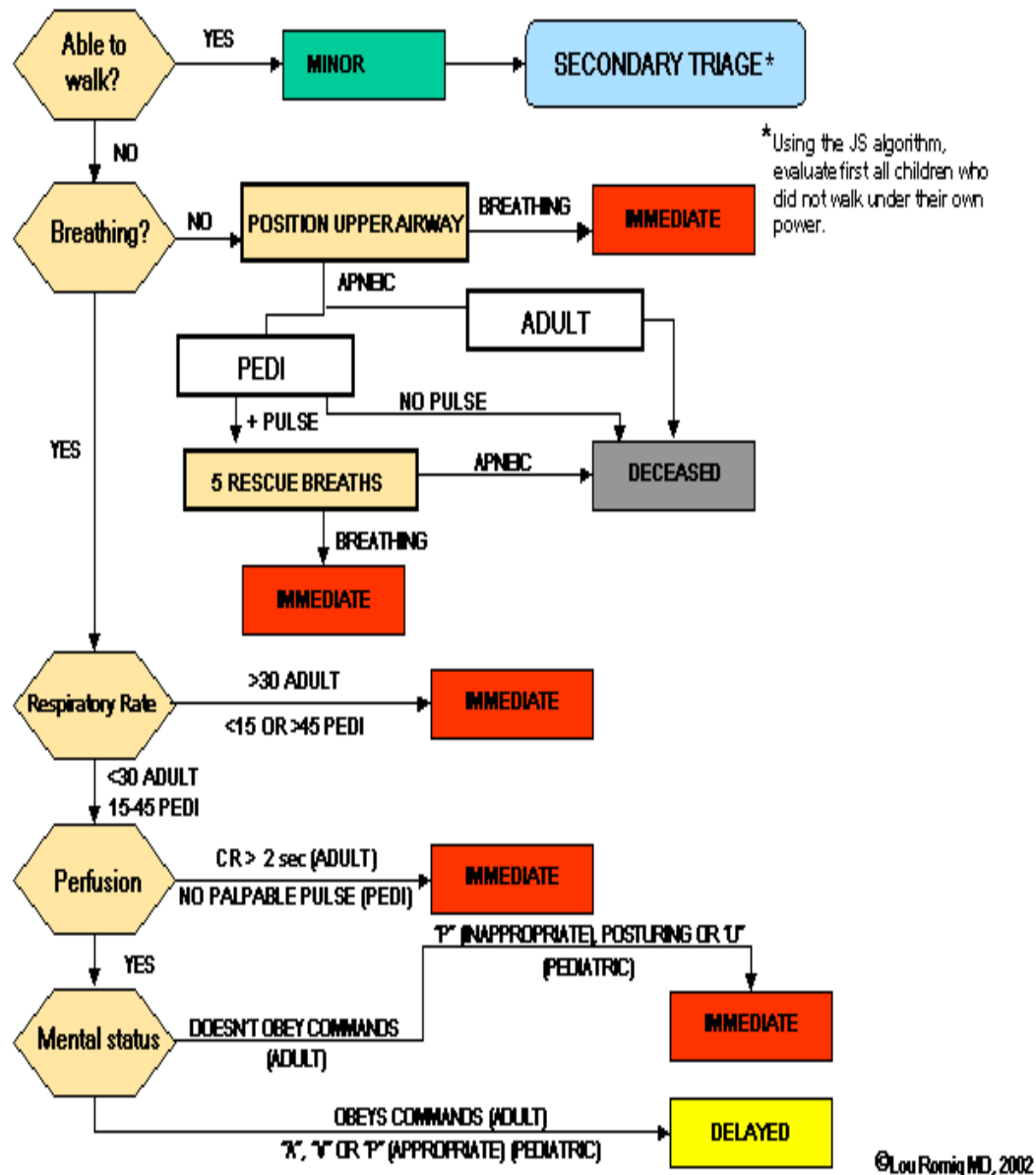


# JumpSTART Pediatric MCI Triage ®



© Lou Romig MD, 2002

# Combined START/JumpSTART Triage Algorithm



## Pediatric Assessment Triangle (PAT)

The Pediatric Assessment Triangle (PAT) is a tool for medical professionals to rapidly assess a pediatric patient on sight and obtain a “first impression” of the child’s condition. Using the PAT, an EMS provider can determine if a child is in immediate need of rapid transport or emergency treatment before a full assessment.

Below are the parameters to be assessed using the PAT.

Appearance	
Characteristic:	Features to Look For:
<b>Tone</b>	Good muscle tone OR limp, listless, flaccid
<b>Interactivity</b>	Alert, will reach for toy, light, OR is uninterested in playing or interacting
<b>Consolability</b>	Can be consoled OR crying or agitation is unrelieved
<b>Look/Gaze</b>	Fixes on face, object OR glassy eyed stare
<b>Speech/Cry</b>	Cry strong and spontaneous OR weak or high pitched. Is Speech age appropriate OR confused, garbled?



Breathing	
Characteristic:	Features to Look For:
<b>Abnormal Airway Sounds</b>	Snoring, muffled or hoarse speech, stridor, grunting, wheezing
<b>Abnormal Positioning</b>	Sniffing position, tripodding, refusing to lie down
<b>Retractions</b>	Supraclavicular, intercostal, sternal, retractions of the chest wall; head bobbing in infants
<b>Flaring</b>	Flaring of the nares on inspiration

Circulation/Skin Color	
Characteristic:	Features to Look For:
<b>Pallor</b>	White or pale skin or mucous membranes
<b>Mottling</b>	Patchy/lacey skin discoloration due to vasoconstriction/vasodilation
<b>Cyanosis</b>	Bluish discoloration of skin/mucous membranes
<b>Flaring</b>	Flaring of the nares on inspiration

## Pediatric Vital Signs

Age	Pulse	Respirations	Normal B/P	Abnormal B/P
Newborn to 1 Month	140-150	40-60	60+ age in months	< 60/ Systolic
1 Month to 1 Year	130-140	30-40	70 + (age x 2)	<70 + (age x 2)
1 Year to 4 Years	120-130	20-30	80 + (age x 2)	< 70 + (age x 2)
4 Years to 8 Years	100-120	20-30	80 + (age x2)	< 70 + (age x 2)
8 Years to 10 Years	80-100	12-20	80 + (age x 2)	< 70 + (age x 2)
10 Years to 12 years	80-100	12-20	90 + (age x 2)	< 90/Systolic
13 Years to 18 Years	80-100	12-20	90 + (age x 2)	< 90/Systolic

### Calculations

Weight calculation - (Averages) is equal to age + 0 for Pounds  
 Divided by 2 = (Average) kilograms  
 ( Example: 3 years old + 0 = 30 pounds / 2 = 15 Kilograms)

Fluid resuscitation - 20 cc/Kg or weight plus a 0 = fluids to be given  
 (Example: 3 year old weighs 30 pounds + 0 = 300 cc fluid bolus)

Defibrillation – initial 2J/kg to 4J/kg Max 10J/kg  
 Initial energy to defibrillate at 2J/kg is equal to patients weight  
 (Example 3 year old weighs 30 pounds defibrillate at 30 Joules)



SCOPE OF PRACTICE FOR EMS PERSONNEL  
GEORGIA OFFICE OF EMS AND TRAUMA  
FORM R-P11A

Emergency medical personnel are permitted to perform only those skills listed under their licensure level, and only once they have been trained on those skills, and credentialed to perform those skills by their local EMS Medical Director. Emergency medical personnel are permitted to administer only medications listed under their licensure level, and only once they are trained in the pharmacology of that medication, and credentialed to administer that medication by their local EMS Medical Director.

Key to Provider Levels		
EMT	E	Emergency Medical Technician
EMT-I	I	Emergency Medical Technician-Intermediate/85
AEMT	A	Advanced Emergency Medical Technician
CT	C	Cardiac Technician
PMDC	P	Paramedic

**NOTE:** If a provider code (the single letter code from the table above) is listed for a particular skill, then that level of EMS provider is permitted to perform that skill. Interpretive guidelines serve to clarify and/or modify the skill listed. If an asterisk (\*) appears with the letter code for a specific provider level, then the interpretive guidelines may modify the skill for that provider level.

Airway and Breathing Skills	Levels	Interpretive Guidelines
1. Supplemental oxygen therapy		
a. Oxygen delivery devices	E I A C P	This would include any type of cannula or mask designed for the delivery of oxygen.
b. Humidified oxygen	E I A C P	

EMT	E	EMT-I	I	AEMT	A	CT	C	PMDC	P
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Airway and Breathing Skills		Levels					Interpretive Guidelines
2. Basic airway management							
a. Manual maneuvers to open and control the airway	E	I	A	C	P		This would include procedures such as: head-tilt, chin-lift, tongue-jaw lift; jaw thrust; Sellick's maneuver.
b. Manual maneuvers to remove the airway	E	I	A	C	P		
c. Insertion of airway adjuncts intended to go into oropharynx	E	I	A	C	P		
d. Insertion of airway adjuncts intended to go into nasopharynx	E	I	A	C	P		
3. Ventilation management							
a. Mouth to barrier devices	E	I	A	C	P		
b. Bag-valve mask	E	I	A	C	P		
c. Manually triggered ventilators	E	I	A	C	P		
d. Automatic transport ventilators	E*	I*	A*	C	P		EMTs, EMT-Is and AEMTs are limited to the initiation during resuscitative efforts that only adjust rate and tidal volume.
e. Chronic-use home ventilators	E	I	A	C	P		
4. Suctioning							
a. Upper airway suctioning	E	I	A	C	P		
b. Tracheobronchial suctioning			A*	C	P		AEMTs are limited to tracheobronchial suctioning of patients with pre-established airways.
5. Advanced airway management							
a. CPAP/BiPAP administration and management		I	A	C	P		

EMT **E** EMT-I **I** AEMT **A** CT **C** PMDC **P**





5. Advanced airway management					
b. BIAD (blind insertion airway device) insertion		I*	A*	C	P
c. Endotracheal intubation				C	P
d. Airway obstruction removal by direct laryngoscopy				C	P
e. Percutaneous cricothyrotomy					P*
f. Gastric decompression					P
g. Pleural decompression via needle thoracostomy					P
h. Chest tube monitoring					P

Assessment Skills	Levels					Interpretive Guidelines
1. Basic assessment skills						
a. Perform simple patient assessments	E	I	A	C	P	
b. Perform comprehensive patient assessments	E	I	A	C	P	
c. Obtaining vital signs manually	E	I	A	C	P	

EMT **E** EMT-I **I** AEMT **A** CT **C** PMDC **P**



2. Advanced assessment skills					
a. Obtaining vital signs by electronic devices	E	I	A	C	P
b. Blood chemistry analysis					P

*This would include the use of non-invasive blood pressure monitoring devices, as well as pulse oximetry measurement and blood glucose monitoring.*

Pharmacological Interventions Skills	Levels					Interpretive Guidelines
1. Fundamental pharmacological skills						
a. Use of unit dose commercial pre-filled containers or auto-injectors for the administration of life saving medications	E	I	A	C	P	
b. Assist patients in taking their own prescribed medications as approved by the local EMS Medical Director	E	I	A	C	P	
c. Administration of over-the-counter medications with appropriate medical direction.	E	I	A	C	P	Includes oral glucose for hypoglycemia and aspirin for chest pain of suspected ischemic origin.
2. Advanced pharmacological skills: Venipuncture/vascular access						
a. Obtaining peripheral venous blood specimens		I	A	C	P	This is either through direct venipuncture or through an existing IV catheter.
b. Peripheral IV insertion and maintenance; includes removal as needed		I	A	C	P	This includes placement of an INT/saline lock. Peripheral lines include external jugular veins, but does not include placement of umbilical catheters.
c. Intraosseus device insertion; includes removal as needed		I	A	C	P	This includes placement in both adult and pediatric patients. This also includes both manual and mechanical assisted devices as approved by the local EMS Medical Director.

EMT **E** EMT-I **I** AEMT **A** CT **C** PMDC **P**



2. Advanced pharmacological skills: Venipuncture/vascular access				
a. Crystalloid IV solutions		I*	A*	C P
This includes hypotonic, isotonic and hypertonic solutions as approved by the local EMS Director. This also includes combination solutions, such as D5NS. EMT-Is and AEMTs are limited to the initiation of crystalloid solutions that do not have added pharmacological agents.				
b. Administration of hypertonic dextrose solutions for hypoglycemia		I	A	C P
Hypertonic dextrose solutions may be given IV/IO.				
c. Administration of glucagon for hypoglycemia			A	C P
Glucagon may be administered via IM, SC, IV, IO or intranasal routes as approved by the local EMS Medical Director.				
d. Administration of SL nitroglycerine to a patient experiencing chest pain of a suspected ischemic origin			A	C P
Includes oral glucose for hypoglycemia and aspirin for chest pain of suspected ischemic origin.				
e. Parenteral administration of epinephrine for anaphylaxis	E*	I*	A*	C P
EMTs and EMT-Is may only administer epinephrine via an auto-injector. AEMTs may prepare and administer epinephrine via IM or SC routes.				
f. Inhaled (nebulized) medications to patients with difficulty breathing or wheezing	E*	I*	A	C P
Inhaled (nebulized) means atomization of the medication through an oxygen/air delivery device with a medication chamber or through the use of a metered-dose inhaler. EMTs and EMT-I may only administer pre-measured unit doses of nebulized medications.				
g. Administration of a narcotic antagonist to a patient of suspected narcotic overdose	E*	I*	A	C P
EMTs and EMT-Is may only administer narcotic antagonists via auto-injector or intranasal routes.				
h. Administration of nitrous oxide (50% mixture) for pain relief			A	C P

EMT **E** EMT-I **I** AEMT **A** CT **C** PMDC **P**



2. Advanced pharmacological skills: Venipuncture/vascular access					
i. Vaccine administration		I*	A*	C*	P
j. Paralytic administration					P*
k. Administration other physician approved medications				C*	P*
l. Maintain an infusion of blood or blood products					P

EMT-Is, AEMTs and CTs may only administer vaccinations during designated events such as mass vaccination clinics or in the event of a declared public health emergency and then only after approved training.

Administration of paralytics for the purpose of RSI is not permitted unless the EMS agency has met the RSI requirements promulgated by OEMS and has received approval for RSI use from OEMS. Paramedics are authorized to use paralytics to maintain the paralysis of already intubated patients, if approved by the local EMS Medical Director.

CTs are only authorized to give the following: anti-arrhythmics, vagolytic agents, chronotropic agents, alkalizing agents, analgesic agents and vasopressor agents. Paramedics are authorized to give any medication via enteral or parenteral routes, if approved by the local EMS Medical Director.

Cardiac /Medical Skills	Levels					Interpretive Guidelines
1. Fundamental cardiac skills						
a. Manual external CPR	E	I	A	C	P	
b. Use of an automated external defibrillator	E	I	A	C	P	
2. Advanced cardiac skills						
a. Use mechanical CPR assist devices	E	I	A	C	P	
b. ECG monitoring and interpretation	E*	I*	A*	C	P	Includes 12-lead ECGs. EMTs, EMT-Is, and AEMTs may only obtain and transmit a 12-lead ECG for suspected STEMI patients, if approved and trained by the local EMS Medical Director. ECG interpretation is limited to CTs and Paramedics.

EMT **E** EMT-I **I** AEMT **A** CT **C** PMDC **P**





2. Advanced cardiac skills						
c. Manual cardiac defibrillation				C*	P	CTs may only defibrillate a pulseless and apneic patient.
d. Emergency cardioversion; includes vagal maneuvers				G	P	
e. Transcutaneous cardiac pacing				C	P	
3. Emergency childbirth management						
a. Assist in the normal delivery of a newborn	E	I	A	C	P	This includes external fundal massage for post-partum bleeding, but does not include internal fundal massage.
b. Assist in the complicated delivery of a newborn	E	I	A	C	P	
4. Behavioral emergency skills						
a. Manual and mechanical patient restraints for behavioral emergencies	E	I	A	C	P	Includes soft disposable and leather restraints, as approved by the local EMS Medical Director.
b. Chemical restraints of combative patients					P	

Trauma Care Skills		Levels					Interpretive Guidelines
1. Managing injuries, including but not limited to:							
a. Manual cervical stabilization and cervical collar use	E	I	A	C	P		
b. Manual stabilization of orthopedic trauma	E	I	A	C	P		
c. Spinal motion restriction	E	I	A	C	P	Includes use of commercial devices such as KED®.	
d. Splinting	E	I	A	C	P	Includes traction splint.	
e. MAST/PASG						Not approved for use in Georgia.	

EMT **E**    EMT-I **I**    AEMT **A**    CT **C**    PMDC **P**



<b>2. Managing other trauma injuries, including but not limited to:</b>					
a. Fundamental bleeding control	E	I	A	C	P
b. Progressive bleeding control	E	I	A	C	P
<i>In the use of tourniquets and hemostatic agents as approved by the local EMS Medical Director.</i>					
c. Fundamental eye irrigation	E	I	A	C	P
d. Complex eye irrigation with Morgan's lens					P
e. Fundamental management of soft tissue injuries	E	I	A	C	P
f. Complex management of soft tissue injuries	E	I	A	C	P
<b>3. Movement/extrication of patients, including but not limited to:</b>					
a. Emergency moves endangered patients	E	I	A	C	P
b. Rapid extrication of patients	E	I	A	C	P

EMT **E**    EMT-I **I**    AEMT **A**    CT **C**    PMDC **P**



## CINCINNATI PREHOSPITAL STROKE SCALE



UNIFORM DOCUMENT FOR GEORGIA EMS PROVIDERS

<b>DATE:</b>		<b>TIME OF ASSESSMENT:</b>	
<b>ASSESSED BY:</b>		<b>SERVICE:</b>	

<b>NAME OF PATIENT:</b>	
-------------------------	--

### FACIAL DROOP

	<b>NORMAL: BOTH SIDES OF FACE MOVE EQUALLY</b>
	<b>ABNORMAL: ONE SIDE OF FACE DOES NOT MOVE AT ALL</b>

### ARM DRIFT

	<b>NORMAL: BOTH ARMS MOVE EQUALLY OR NOT AT ALL</b>
	<b>ABNORMAL: ONE ARM DRIFTS COMPARED TO THE OTHER</b>

### **SPEECH:** HAVE THE PATIENT STATE THE FOLLOWING SENTENCE **YOU CAN'T TEACH AN OLD DOG NEW TRICKS.**

	<b>NORMAL: PATIENT USES CORRECT WORD WITH NO SLURRING</b>
	<b>ABNORMAL: SLURRED OR INAPPROPRIATE WORDS OR MUTE</b>

### **TIME: LAST SEEN NORMAL**

	<b>ACTUAL TIME IF KNOWN</b>
	<b>UNKNOWN</b>

### **WITNESS**

	<b>NAME OF WITNESS IF KNOWN</b>
	<b>CONTACT TELEPHONE NUMBER OF WITNESS</b>

Form Revised 11/14/2011  
Version 4

## Stroke Thrombolytic Checklist

This checklist is intended as a tool for the pre-hospital identification of patients who may benefit from the administration of thrombolytics for acute stroke.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Unit: \_\_\_\_\_ PSS: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Est. Wt: \_\_\_\_\_ lbs/kg

Time last seen at baseline: \_\_\_\_\_

Time of symptom onset: \_\_\_\_\_

Onset Witnessed or reported by: \_\_\_\_\_

Symptoms (circle abnormal findings)

### **ANY ONE FINDING = POSSIBLE STROKE**

FACIAL DROOP:                      R                      L

ARM DRIFT:                      R                      L

SPEECH:                      slurred                      wrong words                      mute

Possible Contraindications (check all that apply)

Current use of anticoagulants (e.g., warfarin sodium)	Yes	No	?
Has blood pressure consistently over 180/110 mm Hg	Yes	No	?
Witnessed seizure at symptom onset	Yes	No	?
History of intracranial hemorrhage	Yes	No	?
History of GI or GU bleeding, ulcer, varices	Yes	No	?
Is within 3 months of prior stroke	Yes	No	?
Is within 3 months of serious head trauma	Yes	No	?
Is within 21 days of acute myocardial infarction	Yes	No	?
Is within 21 days of lumbar puncture	Yes	No	?
Is within 14 days of major surgery or serious trauma	Yes	No	?
Is pregnant	Yes	No	?
Abnormal blood glucose level (<50 or >400): FSBS (if done): _____	Yes	No	?

Have you identified any contraindications to thrombolytic therapy?    ☐ YES ☐ NO

Receiving Site/Physician: \_\_\_\_\_ Time \_\_\_\_\_

EMT

# \_\_\_\_\_ Signature \_\_\_\_\_



## Georgia Designated Trauma & Specialty Care Centers

<u>Facility</u>	<u>County</u>	<u>Number</u>
<b><u>LEVEL I</u></b>		
Atlanta Medical Center/ Atlanta	FULTON	404-265-6577
Grady Memorial Hospital Atlanta	FULTON	404-616-6200
Medical Center of Central Ga. Inc. /Macon	BIBB	478-633-1584
GA Regents Medical Center /Augusta	RICHMOND	706-721-3153
Memorial Health Univ. Medical Center/Savannah	CHATHAM	912-350-8861
<b><u>LEVEL II</u></b>		
Athens Regional Medical Center /Athens	CLARKE	706-475-3020
Floyd Medical Center/ Rome	FLOYD	706-509-5000
Gwinnett Medical Center/ Lawrenceville	GWINNETT	678-312-4321
Hamilton Medical Center/ Dalton	WHITFIELD	706-272-6150
John D. Archbold Memorial Hospital/Thomasville	THOMAS	229-228-2834
Midtown Medical Center-Columbus/Columbus	MUSCOGEE	706-571-1901
Northeast GA Medical Center /Gainesville	HALL	770-219-1200
North Fulton Hospital/ Roswell	FULTON	770-751-2559
Wellstar Kennestone Hospital /Marietta	COBB	770-793-5000
<b><u>LEVEL III</u></b>		
Clearview Regional Medical Center/ Monroe	WALTON	770-267-1781
Doctors Hospital of Augusta /Augusta	RICHMOND	706-651-3232
Redmond Regional Medical /Center Rome	FLOYD	706-291-0291
Taylor Regional Hospital/ Hawkinsville	PULASKI	478-783-0369
Trinity Hospital of Augusta/ Augusta	RICHMOND	706-481-7513

<b><u>Facility</u></b>	<b><u>County</u></b>	<b><u>Number</u></b>
<b><u>LEVEL IV</u></b>		
Crisp Regional /Cordele	CRISP	229-276-3100
Effingham Health System /Springfield	EFFINGHAM	912-754-6451
Emanuel Medical Center/ Swainsboro	EMANUEL	478-289-1100
Meadows Regional Medical Center/ Vidalia	TOOMBS	912-535-5555
Morgan Memorial Hospital/ Madison	MORGAN	706-752-2261

## **Specialty Care Centers**

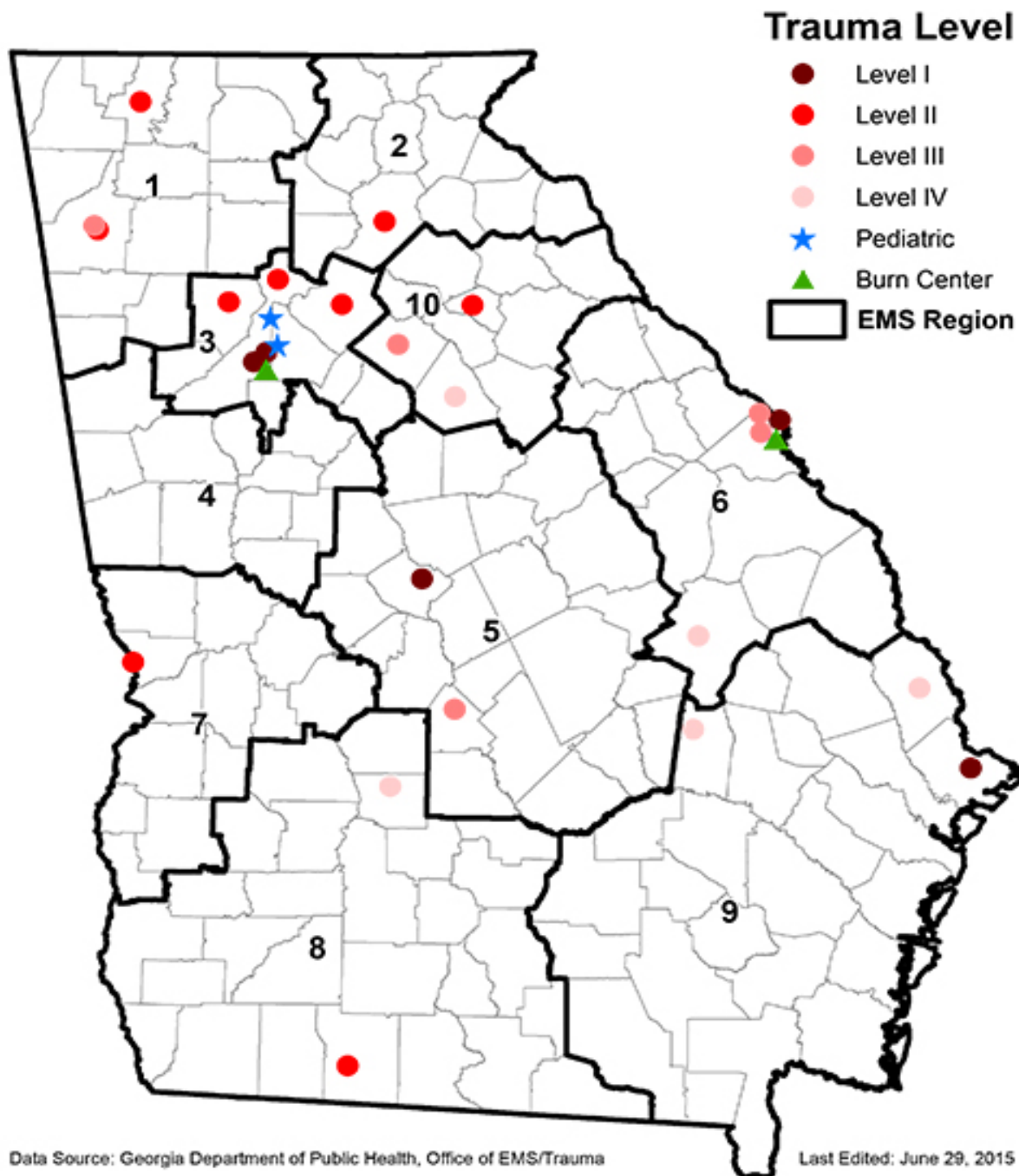
### **Pediatric Trauma Centers**

Childrens Healthcare of Atlanta@ Atlanta	DEKALB	404-785-6405
Egleston (Level I)		
Childrens Healthcare of Atlanta @ Atlanta	FULTON	404-785-2275
Scottish Rite (Level II)		

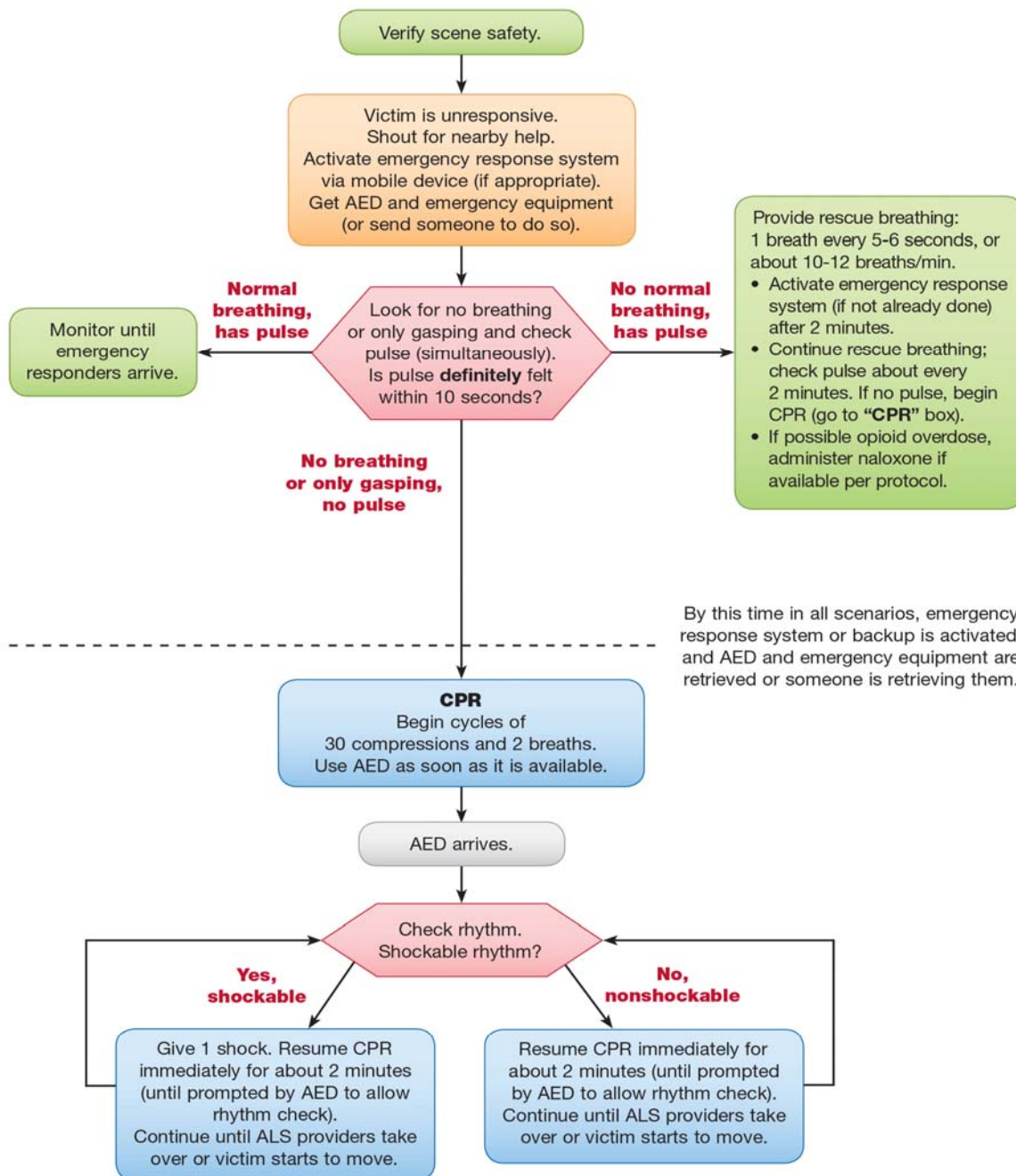
### **Designated Burn Centers**

Joseph M. Still Burn Center /Augusta	RICHMOND	706-651-6399
Grady Burn Center /Atlanta	FULTON	404-616-6178

# Georgia Designated Trauma Centers

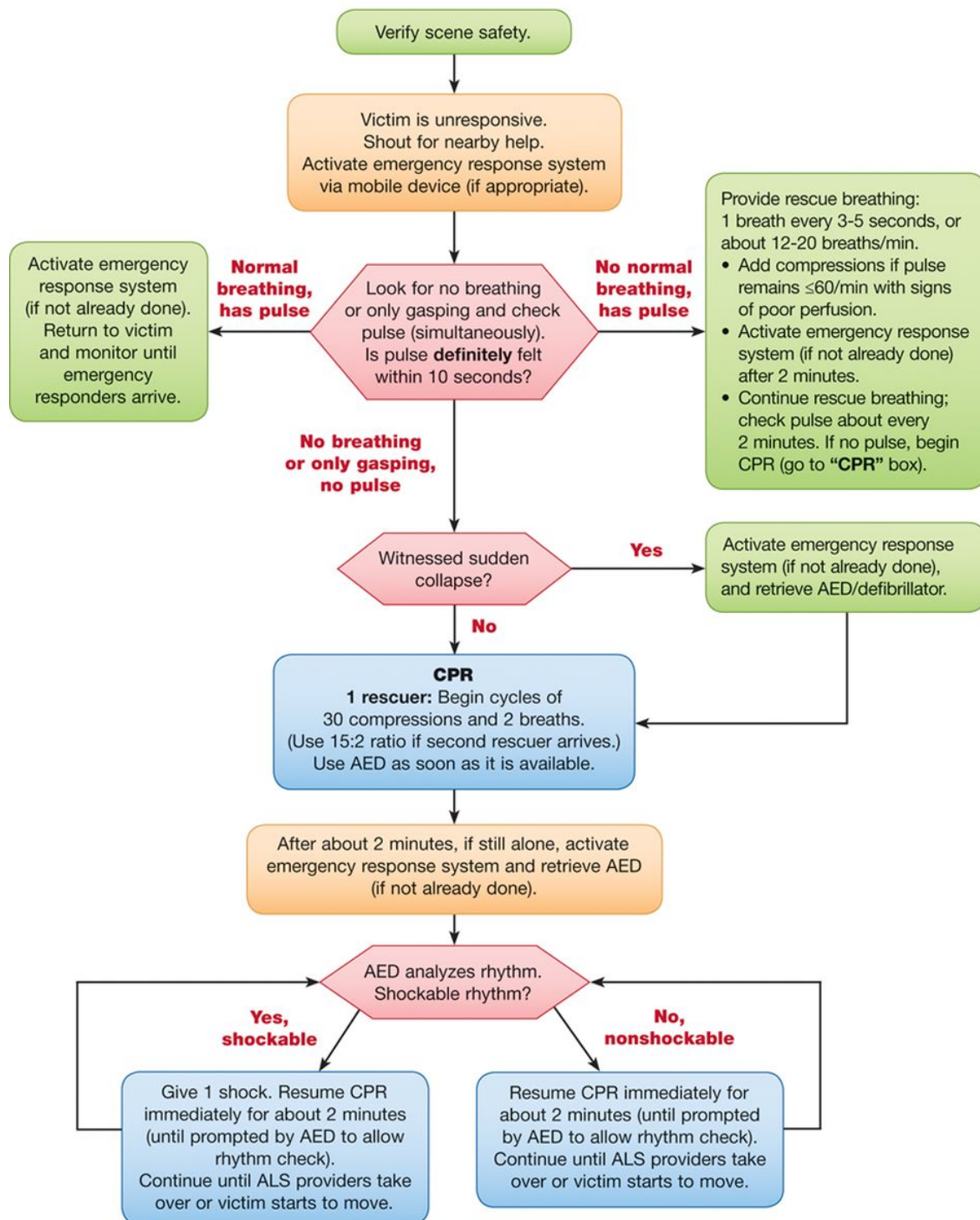


## BLS Healthcare Provider Adult Cardiac Arrest Algorithm—2015 Update



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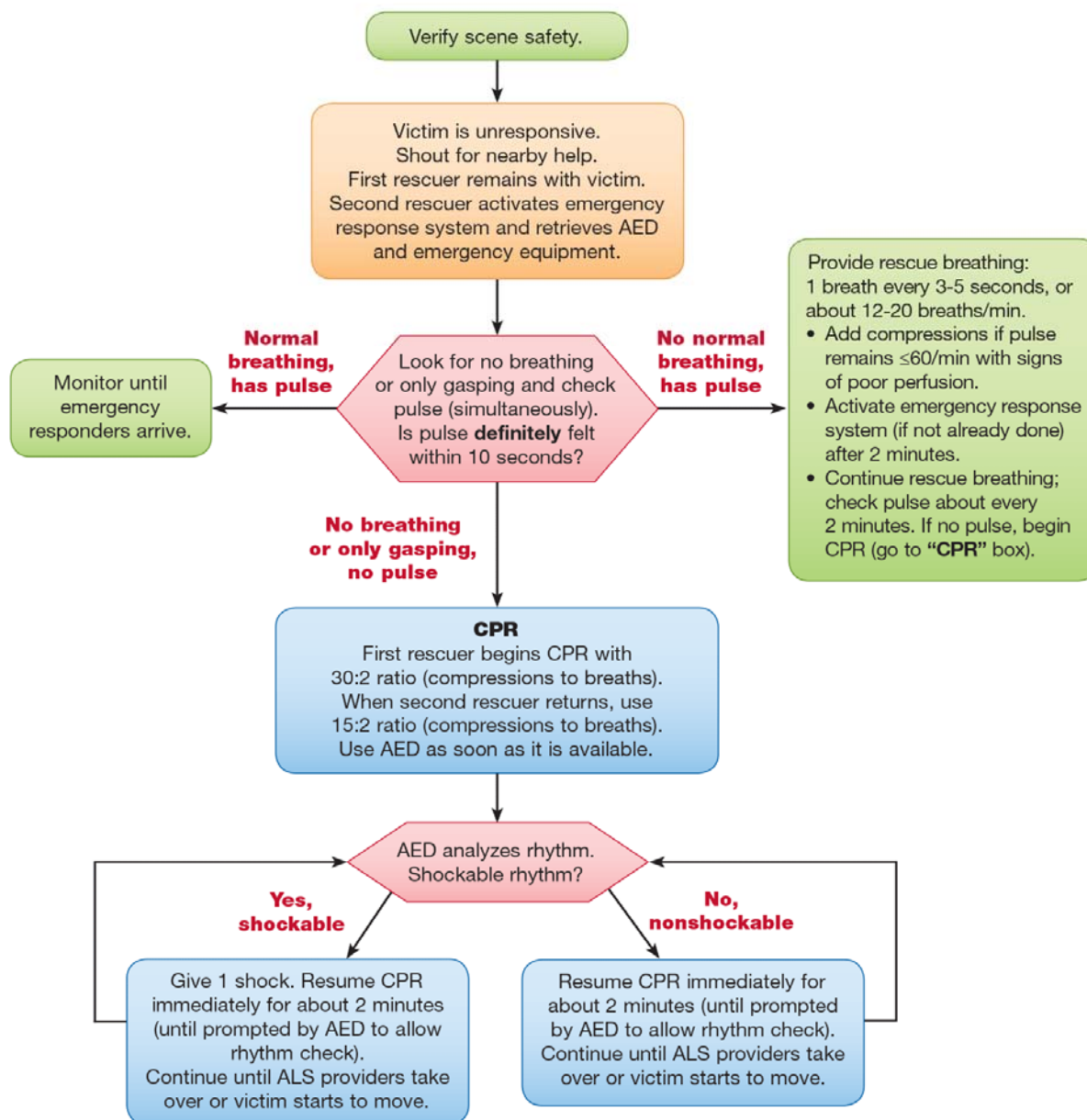
## BLS Healthcare Provider Pediatric Cardiac Arrest Algorithm for the Single Rescuer—2015 Update



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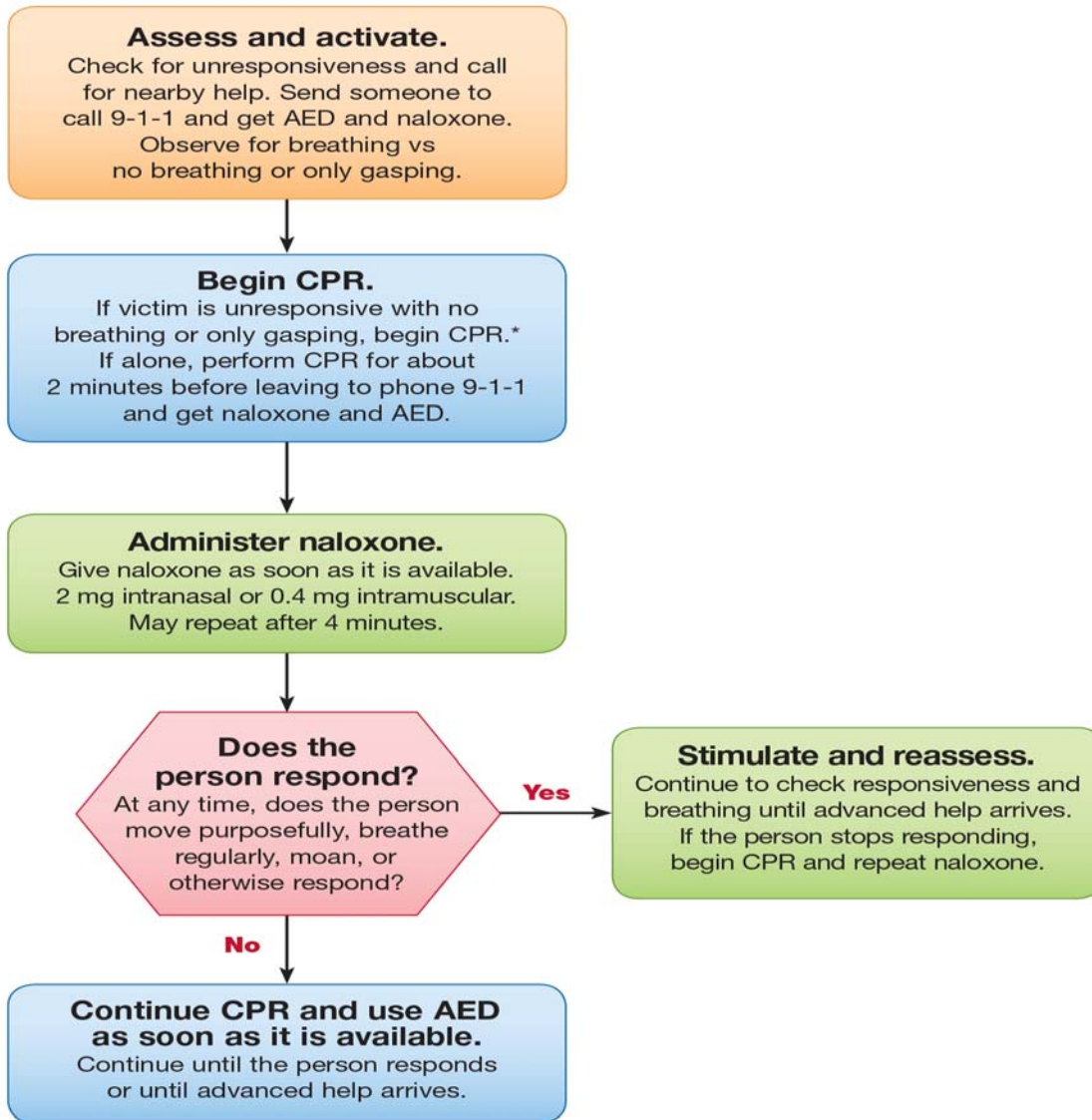


## BLS Healthcare Provider Pediatric Cardiac Arrest Algorithm for 2 or More Rescuers—2015 Update



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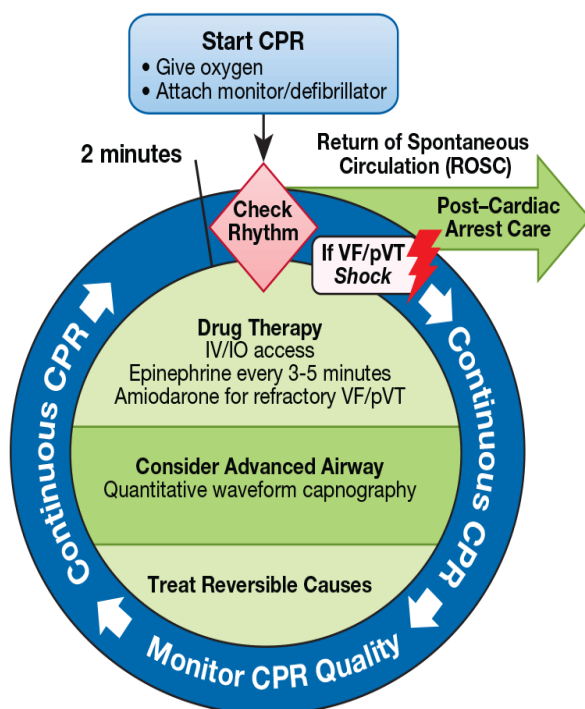
## Opioid-Associated Life-Threatening Emergency (Adult) Algorithm—New 2015



\*CPR technique based on rescuer's level of training.

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## Adult Cardiac Arrest Circular Algorithm—2015 Update



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### CPR Quality

- Push hard (at least 2 inches [5 cm]) and fast (100-120/min) and allow complete chest recoil.
- Minimize interruptions in compressions.
- Avoid excessive ventilation.
- Rotate compressor every 2 minutes, or sooner if fatigued.
- If no advanced airway, 30:2 compression-ventilation ratio.
- Quantitative waveform capnography
  - If PETCO<sub>2</sub> <10 mm Hg, attempt to improve CPR quality
- Intra-arterial pressure.
  - If relaxation phase (diastolic) pressure <20 mm Hg, attempt to improve CPR quality.

### Shock Energy for Defibrillation

- **Biphasic:** Manufacturer recommendation (eg, initial dose of 120-200 J); if unknown, use maximum available. Second and subsequent doses should be equivalent, and higher doses may be considered.
- **Monophasic:** 360 J

### Drug Therapy

- **Epinephrine IV/IO dose:** 1 mg every 3-5 minutes
- **Amiodarone IV/IO dose:** First dose: 300 mg bolus. Second dose: 150 mg.

### Advanced Airway

- Endotracheal intubation or supraglottic advanced airway
- Waveform capnography or capnometry to confirm and monitor ET tube placement
- Once advanced airway in place, give 1 breath every 6 seconds (10 breaths/min) with continuous chest compressions

### Return of Spontaneous Circulation (ROSC)

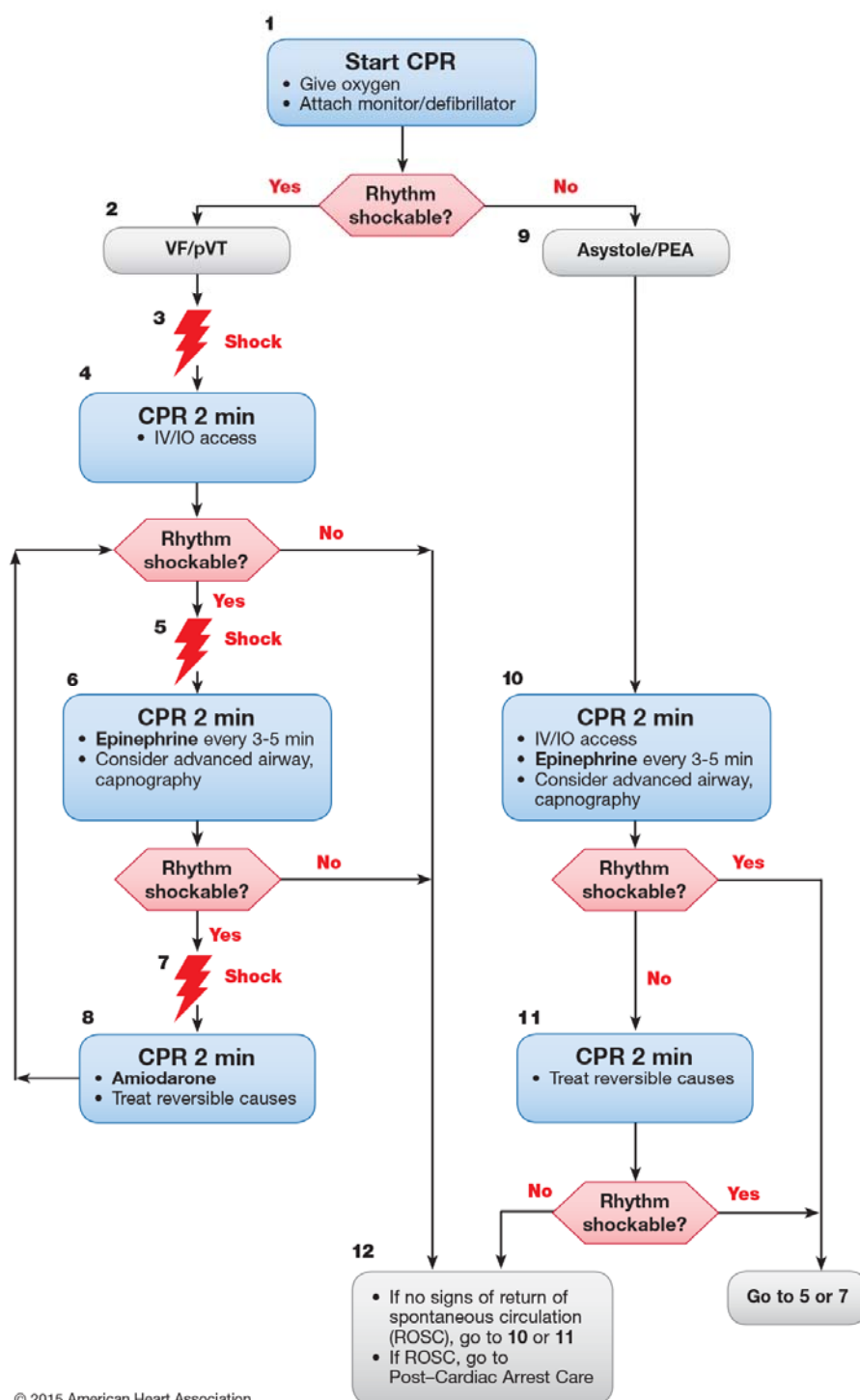
- Pulse and blood pressure
- Abrupt sustained increase in PETCO<sub>2</sub> (typically ≥40 mm Hg)
- Spontaneous arterial pressure waves with intra-arterial monitoring

### Reversible Causes

- |                           |                         |
|---------------------------|-------------------------|
| • Hypovolemia             | • Tension pneumothorax  |
| • Hypoxia                 | • Tamponade, cardiac    |
| • Hydrogen ion (acidosis) | • Toxins                |
| • Hypo-/hyperkalemia      | • Thrombosis, pulmonary |
| • Hypothermia             | • Thrombosis, coronary  |



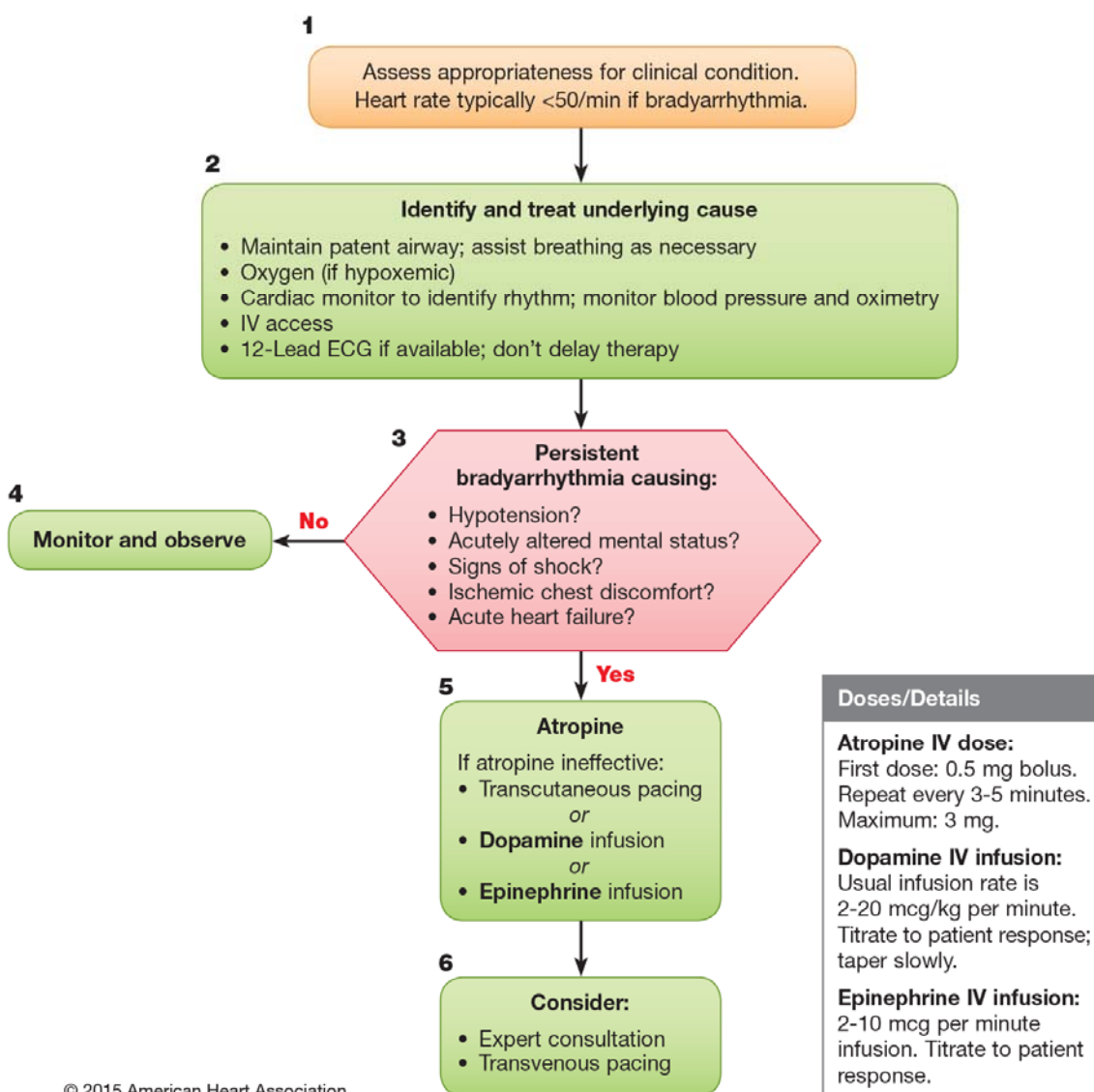
## Adult Cardiac Arrest Algorithm—2015 Update



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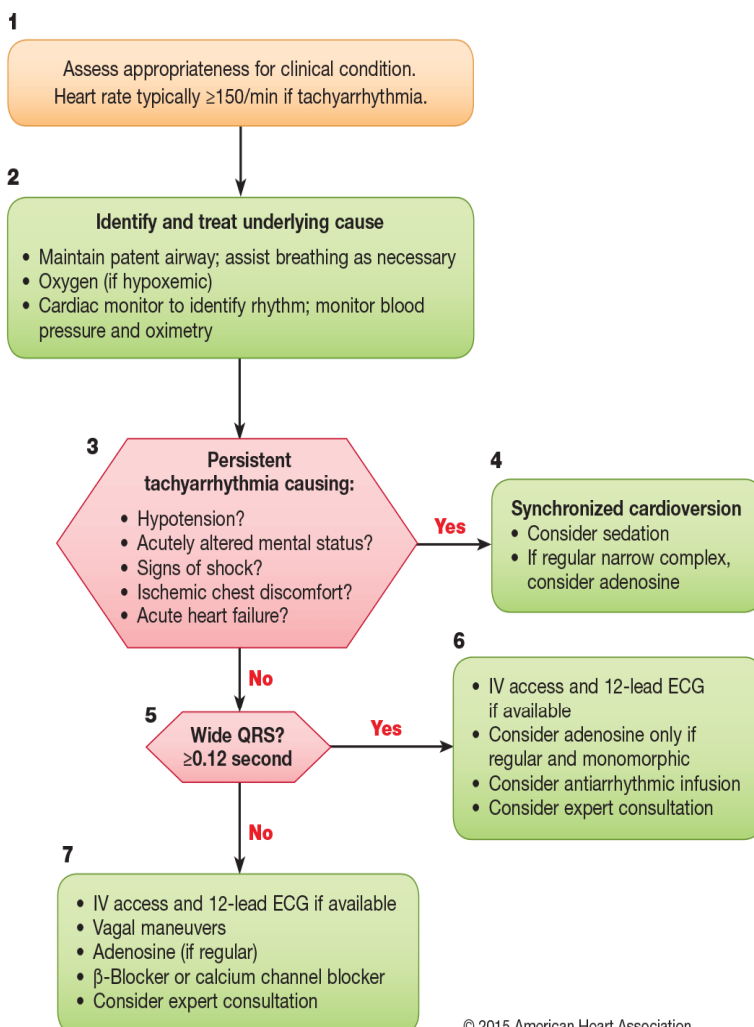
CPR Quality
<ul style="list-style-type: none"> <li>Push hard (at least 2 inches [5 cm]) and fast (100-120/min) and allow complete chest recoil.</li> <li>Minimize interruptions in compressions.</li> <li>Avoid excessive ventilation.</li> <li>Rotate compressor every 2 minutes, or sooner if fatigued.</li> <li>If no advanced airway, 30:2 compression-ventilation ratio.</li> <li>Quantitative waveform capnography <ul style="list-style-type: none"> <li>If PETCO<sub>2</sub> &lt;10 mm Hg, attempt to improve CPR quality.</li> </ul> </li> <li>Intra-arterial pressure <ul style="list-style-type: none"> <li>If relaxation phase (diastolic) pressure &lt;20 mm Hg, attempt to improve CPR quality.</li> </ul> </li> </ul>
Shock Energy for Defibrillation
<ul style="list-style-type: none"> <li><b>Biphasic:</b> Manufacturer recommendation (eg, initial dose of 120-200 J); if unknown, use maximum available. Second and subsequent doses should be equivalent, and higher doses may be considered.</li> <li><b>Monophasic:</b> 360 J</li> </ul>
Drug Therapy
<ul style="list-style-type: none"> <li><b>Epinephrine IV/IO dose:</b> 1 mg every 3-5 minutes</li> <li><b>Amiodarone IV/IO dose:</b> First dose: 300 mg bolus. Second dose: 150 mg.</li> </ul>
Advanced Airway
<ul style="list-style-type: none"> <li>Endotracheal intubation or supraglottic advanced airway</li> <li>Waveform capnography or capnometry to confirm and monitor ET tube placement</li> <li>Once advanced airway in place, give 1 breath every 6 seconds (10 breaths/min) with continuous chest compressions</li> </ul>
Return of Spontaneous Circulation (ROSC)
<ul style="list-style-type: none"> <li>Pulse and blood pressure</li> <li>Abrupt sustained increase in PETCO<sub>2</sub> (typically ≥40 mm Hg)</li> <li>Spontaneous arterial pressure waves with intra-arterial monitoring</li> </ul>
Reversible Causes
<ul style="list-style-type: none"> <li>Hypovolemia</li> <li>Hypoxia</li> <li>Hydrogen ion (acidosis)</li> <li>Hypo-/hyperkalemia</li> <li>Hypothermia</li> <li>Tension pneumothorax</li> <li>Tamponade, cardiac</li> <li>Toxins</li> <li>Thrombosis, pulmonary</li> <li>Thrombosis, coronary</li> </ul>

## Adult Bradycardia With a Pulse Algorithm



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## Adult Tachycardia With a Pulse Algorithm



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### Doses/Details

#### Synchronized cardioversion:

Initial recommended doses:

- Narrow regular: 50-100 J
- Narrow irregular: 120-200 J biphasic or 200 J monophasic
- Wide regular: 100 J
- Wide irregular: defibrillation dose (not synchronized)

#### Adenosine IV dose:

First dose: 6 mg rapid IV push; follow with NS flush.

Second dose: 12 mg if required.

#### Antiarrhythmic Infusions for Stable Wide-QRS Tachycardia

##### Procainamide IV dose:

20-50 mg/min until arrhythmia suppressed, hypotension ensues, QRS duration increases >50%, or maximum dose 17 mg/kg given. Maintenance infusion: 1-4 mg/min. Avoid if prolonged QT or CHF.

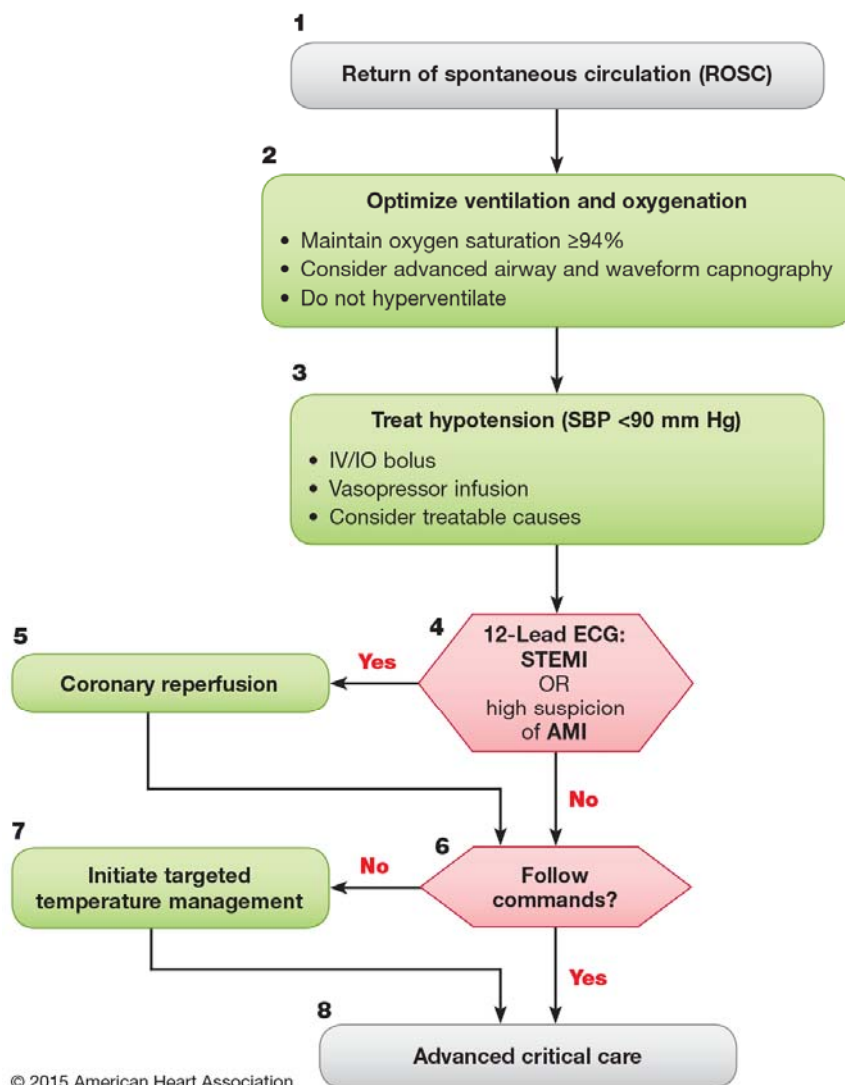
##### Amiodarone IV dose:

First dose: 150 mg over 10 minutes. Repeat as needed if VT recurs. Follow by maintenance infusion of 1 mg/min for first 6 hours.

##### Sotalol IV dose:

100 mg (1.5 mg/kg) over 5 minutes. Avoid if prolonged QT.

## Adult Immediate Post-Cardiac Arrest Care Algorithm—2015 Update



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### Doses/Details

**Ventilation/oxygenation:**  
Avoid excessive ventilation. Start at 10 breaths/min and titrate to target PETCO<sub>2</sub> of 35–40 mm Hg. When feasible, titrate FIO<sub>2</sub> to minimum necessary to achieve SpO<sub>2</sub>  $\geq 94\%$ .

**IV bolus:**  
Approximately 1–2 L normal saline or lactated Ringer's

**Epinephrine IV infusion:**  
0.1–0.5 mcg/kg per minute (in 70-kg adult: 7–35 mcg per minute)

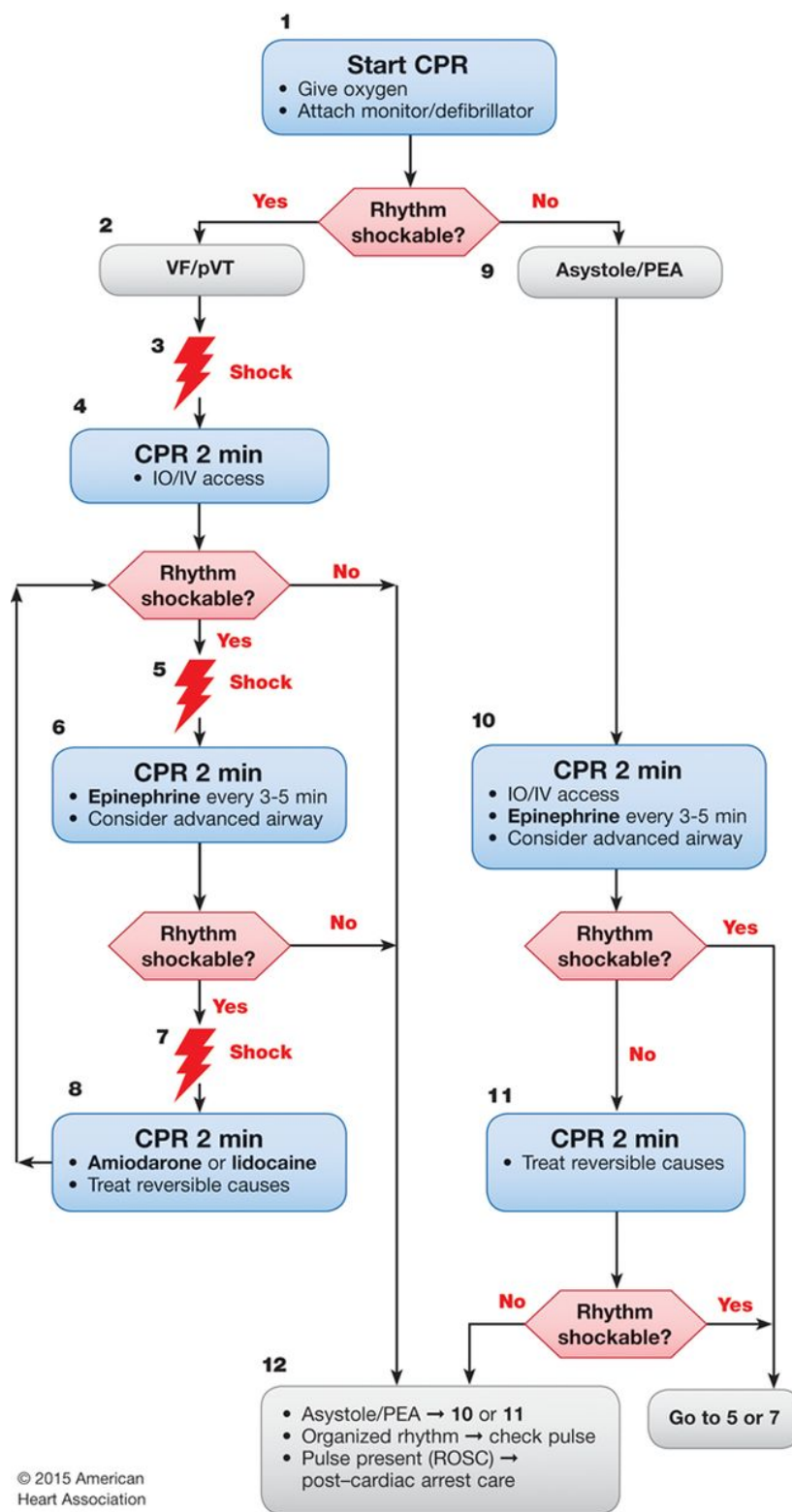
**Dopamine IV infusion:**  
5–10 mcg/kg per minute

**Norepinephrine IV infusion:**  
0.1–0.5 mcg/kg per minute (in 70-kg adult: 7–35 mcg per minute)

### Reversible Causes

- Hypovolemia
- Hypoxia
- Hydrogen ion (acidosis)
- Hypo-/hyperkalemia
- Hypothermia
- Tension pneumothorax
- Tamponade, cardiac
- Toxins
- Thrombosis, pulmonary
- Thrombosis, coronary

## Pediatric Cardiac Arrest Algorithm—2015 Update

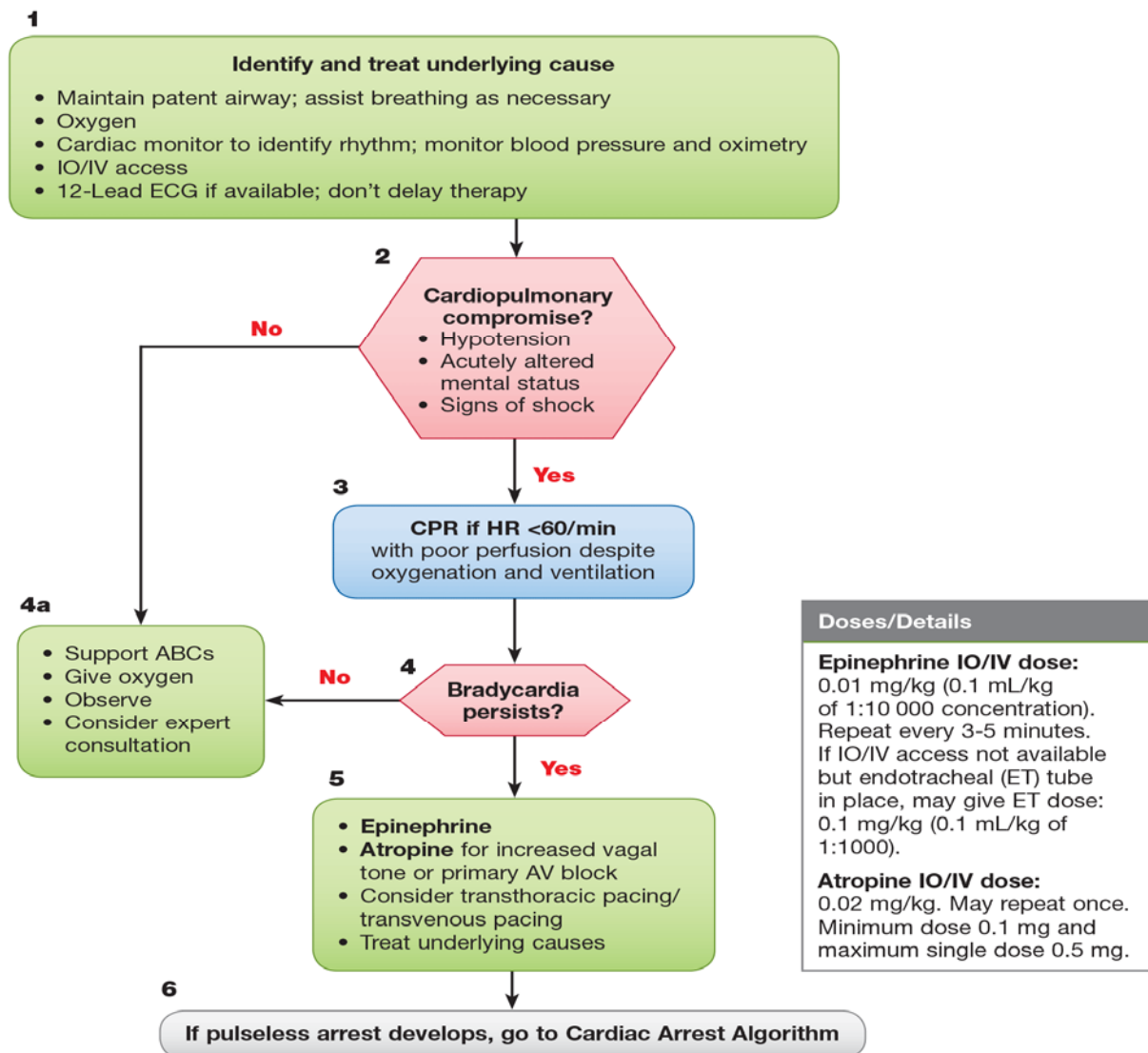


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CPR Quality
<ul style="list-style-type: none"> <li>Push hard (<math>\geq \frac{1}{3}</math> of anteroposterior diameter of chest) and fast (100-120/min) and allow complete chest recoil.</li> <li>Minimize interruptions in compressions.</li> <li>Avoid excessive ventilation.</li> <li>Rotate compressor every 2 minutes, or sooner if fatigued.</li> <li>If no advanced airway, 15:2 compression-ventilation ratio.</li> </ul>
Shock Energy for Defibrillation
First shock 2 J/kg, second shock 4 J/kg, subsequent shocks $\geq 4$ J/kg, maximum 10 J/kg or adult dose
Drug Therapy
<ul style="list-style-type: none"> <li><b>Epinephrine IO/IV dose:</b> 0.01 mg/kg (0.1 mL/kg of 1:10 000 concentration). Repeat every 3-5 minutes. If no IO/IV access, may give endotracheal dose: 0.1 mg/kg (0.1 mL/kg of 1:1000 concentration).</li> <li><b>Amiodarone IO/IV dose:</b> 5 mg/kg bolus during cardiac arrest. May repeat up to 2 times for refractory VF/pulseless VT.</li> <li><b>Lidocaine IO/IV dose:</b> Initial: 1 mg/kg loading dose. Maintenance: 20-50 mcg/kg per minute infusion (repeat bolus dose if infusion initiated &gt;15 minutes after initial bolus therapy).</li> </ul>
Advanced Airway
<ul style="list-style-type: none"> <li>Endotracheal intubation or supraglottic advanced airway</li> <li>Waveform capnography or capnometry to confirm and monitor ET tube placement</li> <li>Once advanced airway in place, give 1 breath every 6 seconds (10 breaths/min) with continuous chest compressions</li> </ul>
Return of Spontaneous Circulation (ROSC)
<ul style="list-style-type: none"> <li>Pulse and blood pressure</li> <li>Spontaneous arterial pressure waves with intra-arterial monitoring</li> </ul>
Reversible Causes
<ul style="list-style-type: none"> <li>Hypovolemia</li> <li>Hypoxia</li> <li>Hydrogen ion (acidosis)</li> <li>Hypoglycemia</li> <li>Hypo-/hyperkalemia</li> <li>Hypothermia</li> <li>Tension pneumothorax</li> <li>Tamponade, cardiac</li> <li>Toxins</li> <li>Thrombosis, pulmonary</li> <li>Thrombosis, coronary</li> </ul>

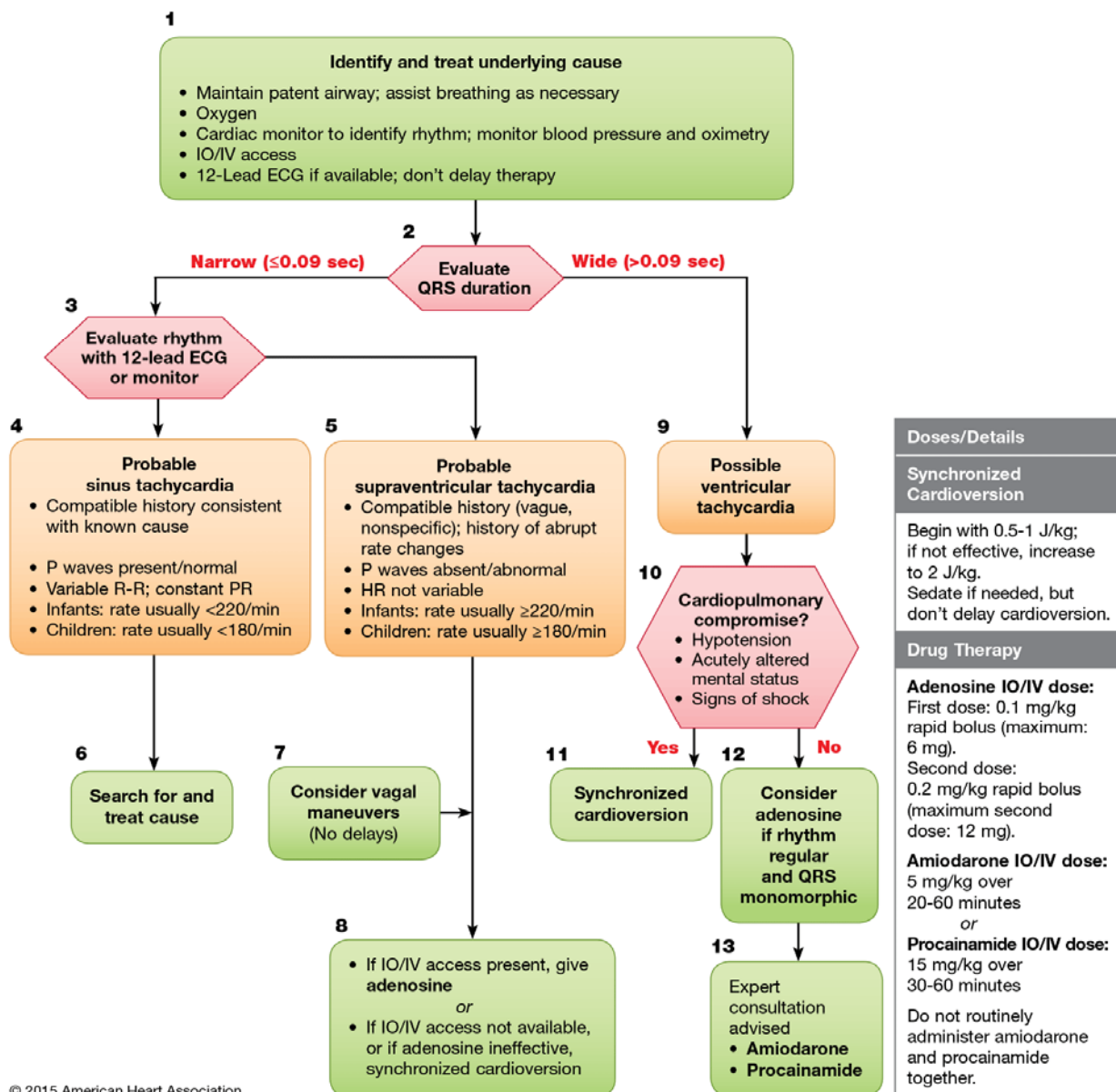


## Pediatric Bradycardia With a Pulse and Poor Perfusion Algorithm



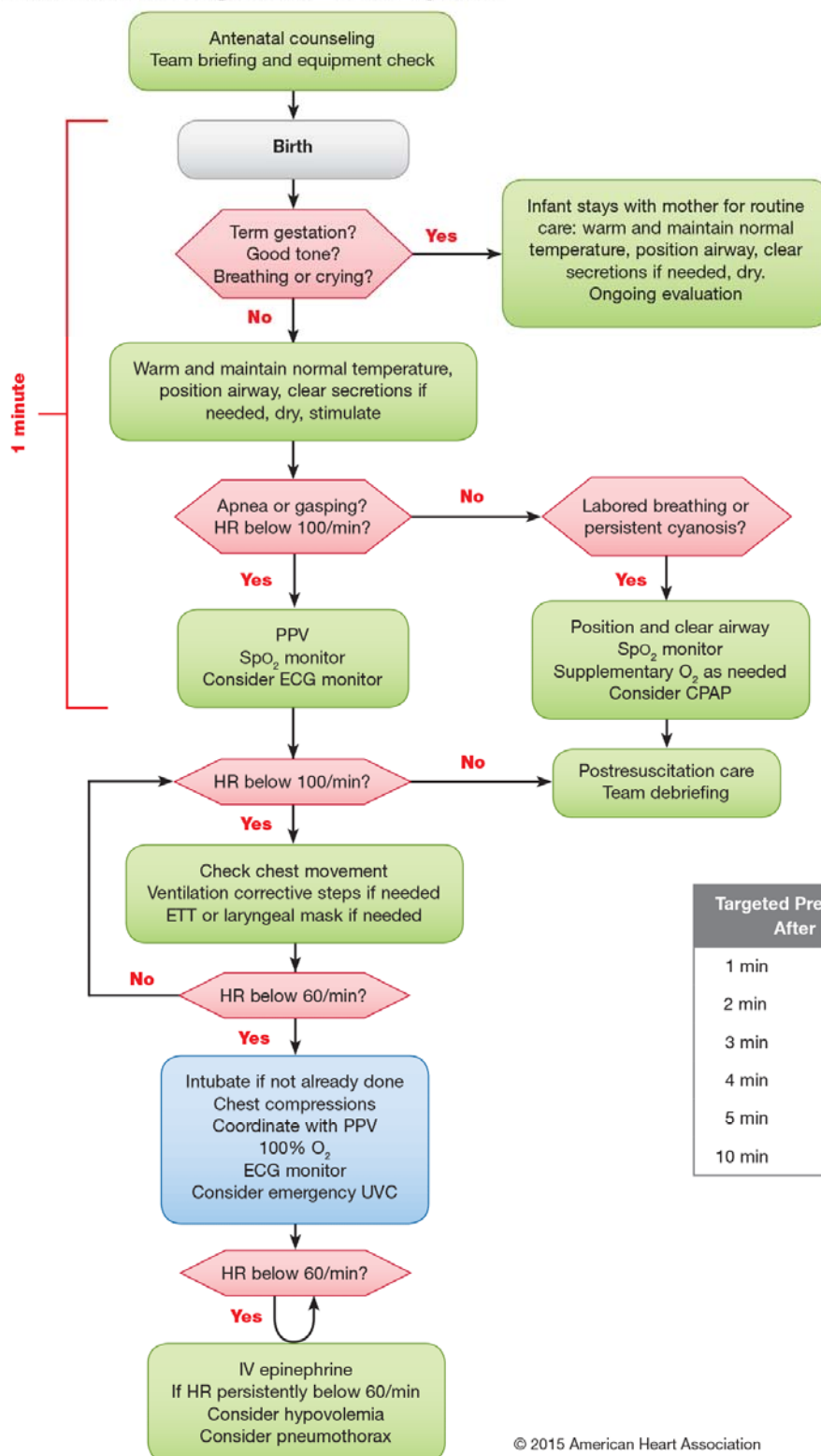
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## Pediatric Tachycardia With a Pulse and Poor Perfusion Algorithm



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## Neonatal Resuscitation Algorithm—2015 Update



Targeted Preductal SpO <sub>2</sub> After Birth	
1 min	60%-65%
2 min	65%-70%
3 min	70%-75%
4 min	75%-80%
5 min	80%-85%
10 min	85%-95%

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## VEHICLE INSPECTION FORM FOR REGISTERED AMBULANCES

<b>SERVICE NAME:</b>				<b>DATE:</b>	
<b>UNIT VID NUMBER:</b>			<b>UNIT VIN NUMBER:</b>		
<b>RESPIRATORY EQUIPMENT</b>					
QTY	COMPLIANT			PRI	ITEM / DESCRIPTION
	Y	N			
1	<input type="radio"/>	<input type="radio"/>	1		Mounted Electric or Manifold Operation Suction Aspirator
1	<input type="radio"/>	<input type="radio"/>	1		Portable Suction Aspirator – as approved by the Department
4	<input type="radio"/>	<input type="radio"/>	1		Sterile Suction Catheters, assorted sizes
2	<input type="radio"/>	<input type="radio"/>	3		Irrigation Liquids, 1000 ml each or equivalent
2	<input type="radio"/>	<input type="radio"/>	1		Bag-Valve-Mask Resuscitator, disposable, with transparent adult mask. The valve must operate in cold weather, and the unit must be capable of use with an oxygen supply. The unit must be capable of delivering approximately 100% oxygen.
2	<input type="radio"/>	<input type="radio"/>	1		Pediatric Bag-Valve-Mask Resuscitator, disposable, with transparent child and infant mask. The valve must operate in cold weather, and the unit must be capable of use with an oxygen supply. The unit must be capable of delivering approximately 100% oxygen.
4	<input type="radio"/>	<input type="radio"/>	1		Adult Oxygen Mask with Reservoir
2	<input type="radio"/>	<input type="radio"/>	3		Adult Oxygen Mask
3	<input type="radio"/>	<input type="radio"/>	1		Pediatric Oxygen Mask with Reservoir
3	<input type="radio"/>	<input type="radio"/>	3		Pediatric Oxygen Mask
3	<input type="radio"/>	<input type="radio"/>	3		Nasal Cannula
3	<input type="radio"/>	<input type="radio"/>	3		Oxygen Supply Tubing
1	<input type="radio"/>	<input type="radio"/>	1		Oropharyngeal Airways, with adult, child and infant sizes
1	<input type="radio"/>	<input type="radio"/>	1		Nasopharyngeal Airways, with adult, child and infant sizes
1	<input type="radio"/>	<input type="radio"/>	1		Tracheal / Pharyngeal Airway Adjunct (device not intended to be placed into the trachea)
1	<input type="radio"/>	<input type="radio"/>	1		Oxygen: fixed system with at least two wall-mounted oxygen outlets and one flowmeter. The system shall also include a yoke, pressure reducer gauge and an approved cylinder-retaining device that meets DOT standards. The system shall be capable of delivering an oxygen flow of at least 15 liters per minute. If the oxygen source is of a size less than "M" cylinder or equivalent, an additional full spare cylinder for the fixed system shall be carried in the ambulance
1	<input type="radio"/>	<input type="radio"/>	1		Oxygen: portable unit consisting of at least a "D" cylinder or equivalent, yoke, pressure gauge, flowmeter and cylinder wrench or hand wheel. The unit shall be capable of delivering an oxygen flow of at least 15 liters per minute. Cylinder holders with a quickrelease fitting shall be furnished to allow the use of the portable unit outside the vehicle. Ambulances manufactured 12 months after adoption of these rules must meet Ambulance Manufacturers Division (AMD) Oxygen Tank Retention Standard 003.
1	<input type="radio"/>	<input type="radio"/>	1		Oxygen: full spare cylinder for use with the above portable oxygen unit. In all ambulances manufactured 12 months after adoption of these rules, the oxygen unit must be secured in a manner that meets Ambulance Manufacturers Division (AMD) Oxygen Tank Retention Standard 003.

### BANDAGES / DRESSINGS

QTY	COMPLIANT			ITEM / DESCRIPTION
	Y	N	PRI	
2	<input type="radio"/>	<input type="radio"/>	3	Triangular Bandages
2	<input type="radio"/>	<input type="radio"/>	3	Universal Dressings, approximately 10 inches by 30 inches
12	<input type="radio"/>	<input type="radio"/>	3	Gauze Pads, 4 inches by 4 inches
4	<input type="radio"/>	<input type="radio"/>	3	Bandages, soft roller, self-adhering type, 2 inches to 4 inches by 5 yards
2	<input type="radio"/>	<input type="radio"/>	3	Bandages, soft roller, self-adhering, 6 inches by 5 yards
4	<input type="radio"/>	<input type="radio"/>	3	Bandages, elastic, of assorted sizes
4	<input type="radio"/>	<input type="radio"/>	3	Petroleum gauze pads, sterile, individually wrapped, 4 inches by 3 inches or 9 inches by 3 inches
4	<input type="radio"/>	<input type="radio"/>	3	Rolls of adhesive tape

### DIAGNOSTIC EQUIPMENT

QTY	COMPLIANT			ITEM / DESCRIPTION
	Y	N	PRI	
1	<input type="radio"/>	<input type="radio"/>	2	Aneroid Sphygmomanometer, with pediatric, adult, and obese size cuffs
1	<input type="radio"/>	<input type="radio"/>	1	Stethoscope
1	<input type="radio"/>	<input type="radio"/>	3	Glucose Monitoring Instrument

### IMMOBILIZATION DEVICES

QTY	COMPLIANT			ITEM / DESCRIPTION
	Y	N	PRI	
4	<input type="radio"/>	<input type="radio"/>	3	Extremity Immobilization Devices: 2 full arms and 2 full legs, or equivalent
1	<input type="radio"/>	<input type="radio"/>	1	Short Spinal Extrication Device (KED or equivalent)
1	<input type="radio"/>	<input type="radio"/>	1	Pediatric Immobilization Device ( <b>must be manufactured for pediatric use only</b> )
2	<input type="radio"/>	<input type="radio"/>	1	Spine Boards, long, at least 16 inches wide by 72 inches in length, with 3 straps for each board or equivalent
2	<input type="radio"/>	<input type="radio"/>	1	Lateral Cervical Immobilization Devices, commercial devices, foam blocks, or sheet / blanket rolls
6	<input type="radio"/>	<input type="radio"/>	1	Cervical Immobilization Collars, hard type, 2 adult, 2 medium, 2 child
1	<input type="radio"/>	<input type="radio"/>	3	Traction Splint, adult, lower extremity, adjustable
1	<input type="radio"/>	<input type="radio"/>	3	Traction Splint, pediatric, lower extremity, adjustable
1	<input type="radio"/>	<input type="radio"/>	3	Equipment for the safe transport of pediatric patients, as approved by the local EMS medical director with guidelines provided by the department

### MISCELLANEOUS EQUIPMENT

QTY	COMPLIANT			ITEM / DESCRIPTION
	Y	N	PRI	
1	<input type="radio"/>	<input type="radio"/>	1	Automatic External Defibrillator when only EMT-Is and/or EMT-B is on the ambulance or 1 cardiac monitor / defibrillator when Cardiac Technicians and/or EMT-Paramedics are on the unit
1	<input type="radio"/>	<input type="radio"/>	3	Pillow, disposable, or pillow with vinyl cover. Rolled sheets are acceptable substitutes.
1	<input type="radio"/>	<input type="radio"/>	1	Multi-Level Stretcher with at least one pair of shoulder / chest straps and one set of straps for the lower extremities, capable of securing adult and pediatric patients
2	<input type="radio"/>	<input type="radio"/>	3	Blankets
2	<input type="radio"/>	<input type="radio"/>	3	Waterproof Patient Covers (e.g. plastic sheets) or Rescue Blanket

MISCELLANEOUS EQUIPMENT... continued				
QTY	COMPLIANT			ITEM / DESCRIPTION
	Y	N	PRI	
1	<input type="radio"/>	<input type="radio"/>	2	Flashlight
1	<input type="radio"/>	<input type="radio"/>	1	Fire Extinguisher, 10 pound ABC type or functional equivalent, charged
2	<input type="radio"/>	<input type="radio"/>	3	Emesis Basins or Emesis Bags or equivalent
1	<input type="radio"/>	<input type="radio"/>	3	Bedpan
1	<input type="radio"/>	<input type="radio"/>	3	Urinal
4	<input type="radio"/>	<input type="radio"/>	3	Restraints, 2 ankle and 2 wrist, leather or nylon
1	<input type="radio"/>	<input type="radio"/>	3	Shears
2	<input type="radio"/>	<input type="radio"/>	3	Clean Wrapped Sheets or Burn Sheets
1	<input type="radio"/>	<input type="radio"/>	3	Nonporous Infant Insulating Device, foil swaddler or equivalent
1	<input type="radio"/>	<input type="radio"/>	2	Obstetrical Kit: Receiving blanket, sterile bulb aspirator, wrapped sanitary napkin, sterile scissors or scalpel blade, 4inch gauze pads, one pair of sterile gloves, 2 cord clamps and plastic bag for placenta. All items are to be in a container with identifying label showing contents.
1	<input type="radio"/>	<input type="radio"/>	1	IV Solution Kit with the list of contents, to include expiration dates, affixed to the outside of the sealed kit established and approved by the local or regional medical director
1	<input type="radio"/>	<input type="radio"/>	3	Sharps Container
1	<input type="radio"/>	<input type="radio"/>	3	U. S. Department of Transportation Emergency Response Guidebook, current edition
1	<input type="radio"/>	<input type="radio"/>	3	Resource Handbook providing information on chemical, biological, and nuclear agents
1	<input type="radio"/>	<input type="radio"/>	2	Mark I Plus Kit (CHECK IF PRESENT, BUT NOT REQUIRED)
2	<input type="radio"/>	<input type="radio"/>	2	Escape Hoods, SCBA, or equivalent / higher (CHECK IF PRESENT, BUT NOT REQUIRED)
2	<input type="radio"/>	<input type="radio"/>	2	N-95 or > Particulate Mask
20	<input type="radio"/>	<input type="radio"/>	1	Exam Gloves, assorted sizes
2	<input type="radio"/>	<input type="radio"/>	2	Disposable Splash Protection (gowns, EMS turnout gear, etc.)

EXTRICATION EQUIPMENT				
The following extrication equipment is required to be on each vehicle except where the provider has written verification from the Regional EMS Program Director that this equipment is immediately available from sources within the zone.				
QTY	COMPLIANT			ITEM / DESCRIPTION
	Y	N	PRI	
1	<input type="radio"/>	<input type="radio"/>	1	Spring Loaded Center Punch
1	<input type="radio"/>	<input type="radio"/>	1	Rescue Ax or Halligan Tool, able to pry, cut, remove sheet metal
1	<input type="radio"/>	<input type="radio"/>	1	Flathead Screwdriver, minimum 6 inches
1	<input type="radio"/>	<input type="radio"/>	1	3 Pound Hammer
1	<input type="radio"/>	<input type="radio"/>	1	Hacksaw with extra Bimetal-type Blades
1	<input type="radio"/>	<input type="radio"/>	1	Roll Duct Tape
1	<input type="radio"/>	<input type="radio"/>	1	One Ton Come-A-Long and 2 Rescue-Rated Chains or Straps
2	<input type="radio"/>	<input type="radio"/>	1	Helmets with Face Shields
2	<input type="radio"/>	<input type="radio"/>	1	Gloves, work gloves or leather gloves

## ADVANCED LIFE SUPPORT (ALS) EQUIPMENT

**The ambulance, staffed by at least one Cardiac Technician or Paramedic, must have all the above required equipment and additional equipment as follows:**

QTY	COMPLIANT			ALS AIRWAY EQUIPMENT
	Y	N	PRI	
1 Kit	○	○	1	ALS Airway Kit with endotracheal tubes (assorted sizes, adult, child, and infant), 10 ml syringes, stylette, appropriately sized laryngoscope handles, blades (assorted sizes, small, medium, and large) and Magill Forceps
QTY	COMPLIANT			ALS CARDIAC EQUIPMENT
	Y	N	PRI	
1	○	○	1	Cardiac Monitor / Defibrillator (with print-out), configuration and supplies such that one is capable of delivering defibrillation to pediatric and adult patients
QTY	COMPLIANT			ALS PHARMACOLOGICAL EQUIPMENT
	Y	N	PRI	
1 Kit	○	○	1	Drug Kit containing appropriate medications with the list of contents established and approved by the local or regional medical director. The list of contents and earliest expiration dates shall be affixed to the outside of the sealed kit. Drug kits must be maintained in a temperature-controlled environment and must not be left unsecured.

**Priority 1 (1):** Critical Essential Equipment - Item must be on the unit at the time of the inspection or the unit will be taken out of service. DHR window decal will not be applied. The only exception is EXTRICATION EQUIPMENT where the provider has written verification from the Regional EMS Program Director that this equipment is immediately available from sources within the zone or county.

**Priority 2 (2):** Item must be on the unit at re-inspection in five (5) business days. Deficiencies will be noted as minor deficiencies in the inspection report.

**Priority 3 (3):** Item must be on the unit upon the next routine re-inspection. Deficiencies will be noted as minor deficiencies in the inspection report.

OOS (out-of-service): If the unit is marked OOS, the vehicle will be immediately taken out of service and will remain out-of-service until re-inspected within two (2) business days. DHR window decal will be removed from the vehicle. This will include the mechanical / safety condition of the vehicle.

**COMMENTS:**

[illegible]

## **EXHIBIT 4**

### **COMMUNICATIONS EQUIPMENT SPECIFICATION**

#### **Mobile Data Terminal (MDT) and Radio Specifications**

##### **Mobile Data Terminals**

Brand: Panasonic

Model: FZ-G1 or CF-53/54

Minimum configuration:

CPU: One (1) 1.06 GHz or faster processor

RAM: 4GB

Disk Space: 20GB

GPS: GPS capable

Wifi: 4G Wifi capable

Operating System:

Windows 10, 64-bit, Pro CBB (Current Branch for Business) November 2015 Release

Windows 10, 64-bit, Enterprise CBB (Current Branch for Business) version 5.7.25 and above


##### **Radios**

###### **SPECIFICATIONS**

###### **RF BANDS**

- 700/800 MHz, VHF, UHF Range 1 & UHF Range 2
- 9600 Baud Digital APCO P25 Phase 1 FDMA and Phase 2 TDMA Trunking
- 3600 Baud SmartNet®, SmartZone®, SmartZone, Omnilink Trunking
- Digital APCO 25, Conventional, Analog MDC 1200, Quick Call II System Configurations Narrow and Wide Bandwidth Digital Receiver (6.25 kHz Equivalent/25/20/12.5 KHz)

## EXHIBIT 5

	<b>DeKalb County Innovation &amp; Technology Information Security Policy</b>	<b>Effective Date: 07-01-2016 Revised:</b>
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**Hardcopies are considered to be “UNCONTROLLED DOCUMENTS”  
User must verify latest version by accessing online document before use**

### 1. PURPOSE

DeKalb County recognizes that information and information systems are valuable assets which play a major role in supporting the County’s strategic objectives. Information security is important to the protection of the County’s reputation and the success of all activities. It is also an integral part of the information sharing which is essential to providing services to our citizens and constituents. The management of data has important implications, and is subject to legal obligations. The consequences of information security failures can be costly and time-consuming.

The Information Security Policy sets out appropriate measures through which the County will facilitate the secure and reliable flow of computer based information, both within the County and in external communications. It comprises this document, which sets out the principles and framework, and other specific policies and guidelines. The approach is based on recommendations set forth by the National Institute of Standards and Technologies (NIST) and in compliance with the Department of Homeland Security and incorporates IT best practices.

This document covers IT Information Security and does not include paper / non-IT based information.

### 2. OBJECTIVE

The objective of the Information Security Policy is to ensure that all computerized information and information systems upon which the County depends are protected. It also serves as a manifesto by which all Information Security Officers and Information Technology employees adhere to and enforce.

### 3. SCOPE

The Information Security Policy applies to computerized information in all its forms, but excludes paper, oral, film, microfiche or other media that does not traverse a network or resides on a computer, server or switching device. It covers all information transmitted by electronic means. It applies throughout the lifecycle of the information from creation through storage and utilization to disposal. Appropriate protection is required to ensure business continuity and to avoid breaches of the law and statutory, regulatory or contractual obligations.

The policy applies to all departments, staff and contractors of the County and to other users associated with the County. With regard to electronic systems, it applies to use of County owned facilities and

privately/externally owned systems when connected to the County network directly or indirectly. ('Owned' is deemed to include leased, rented or on-loan).

The policy applies to all county owned/licensed data and software, whether being used on County systems or privately/externally owned systems, and to all data and software provided to the County by sponsors or external agencies.

#### **4. POLICY STATEMENT**

The County is committed to protecting the security of electronic information through the preservation of:

- confidentiality: protecting information from unauthorized access and disclosure
- integrity: safeguarding the accuracy and completeness of information and processing methods
- availability: ensuring that information and associated services are available to authorized users when required

The County will develop, implement and maintain policies and procedures to achieve appropriate levels of information security. These will cover the range of elements that need to be addressed in the management of information security, in particular the following areas:

##### **4.1 Authorized Use**

County information systems are provided to support the County's activities. Only staff, contractors and other persons authorized by appropriate County authority are entitled to use the County's information systems.

Request for exceptions to any policy must be submitted to the Innovation & Technology Director / CIO in writing for review. All requests must be submitted by Department Heads or Elected Officials and a response will be submitted back in writing. All requests must adhere to security best practices to be considered.

##### **4.2 Acceptable Use**

All users have an obligation to use information and information systems responsibly. Rules for the latter are defined in the "DeKalb County Government Utilization of Technologies Policy."

##### **4.3 Malicious Code Control**

It is an offense to knowingly introduce a virus, Trojan, other malicious code or take deliberate action to circumvent precautions taken to prevent the introduction of malicious code or other internal or

external threats. This includes, but not limited to the downloading of, or the installation of unauthorized applications.

#### **4.4 Business Continuity**

The County will implement, and regularly update, a business continuity management process to counteract interruptions to normal County activity and to protect critical processes from the effects of failures or damage to vital services or facilities.

#### **4.5 Transmission of Information to Third Parties**

All staff has a responsibility to ensure adequate data security when transmitting sensitive information to third parties electronically. "Sensitive data" comprises information about individuals and business information relating to the County. Where transmission is compulsory through external regulations, users must supply information in accordance with definitions set out by the third party. Where the third party has not defined the means of transmission, users must ensure the method they chose to supply the information is secure. Users requiring advice on best practices are asked to contact the office of CIO or the IT Security Manager.

### **5. RESPONSIBILITY**

IT Security Operations are responsible for minimizing risks associated with the information infrastructure of DeKalb County, which includes, but not limited to networks, its demilitarized areas and server farms. This includes, but not limited to filtering, blocking, redirecting and termination of connections that are not approved or harmful to County systems.

#### **5.1 Managerial**

The IT Security Manager/Chief Information Security Officer, under the auspices of the Office of the CIO will oversee the Information Security Policy. To assist in this task, the DeKalb County Security Incident Response Team (DCSIRT) has been established, consisting of a Security Operations (SecOPS) Officers, Network Manager, Server Manager, Field Service Support Manager, Web Development & Integration Manager, ERP Solutions Manager and Business Systems Manager. IT will be responsible for development of the policies, will coordinate implementation and dissemination, and will monitor operation. They will work in collaboration with remote DeKalb IT personnel and other administrators as appropriated to ensure the protection of DeKalb County information infrastructure and integrity.

Director(s) and other Department Leaders with support from IT are responsible for ensuring that information and information systems used within their areas of responsibility are managed and used in accordance with information security policies.

#### **5.2 Individual**



Everyone granted access to County information systems has a personal responsibility to ensure that they, and others who may be responsible to them, are aware of and comply with the policies, codes of conduct and guidelines.

Each individual is responsible for protecting the County's information assets, systems and infrastructure, and will protect likewise the information assets of third parties whether such protection is required contractually, legally, ethically or out of respect for other individuals or organizations.

It may be necessary for some individuals to sign confidentiality agreements as part of their terms and conditions of employment. This may also apply to contracted or agency staff.

### **5.3 Reporting of Incidents and Breaches**

All staff, contractors and other users must report immediately any observed or suspected security incidents where, any security weaknesses in, or threats to, systems or services of the County's security policies has occurred. Reports must be sent to the relevant Director, the owner of the information, and, where the IT infrastructure is involved, the IT Security Manager / CISO. Incidents of a critical nature must be reported *immediately* to the IT SecOps staff.

Those responsible for information or information systems, for example database and IT systems administrators, must ensure that appropriate security arrangements are established and maintained.

## **6. POLICY AWARENESS AND DISCIPLINARY PROCEDURES**

The Information Security Policy will be made available to all staff and contractors via the web and maintained by IT. Staff, contractors and authorized third parties given access to the County information systems will be advised of the existence of relevant policies, codes of conduct and guidelines.

Failure to comply with the Information Security Policy may lead to suspension or withdrawal of an individual's access to information systems.

Failure by a member of staff to comply with the Information Security Policy may lead to disciplinary action under the County's merit rule disciplinary procedures.

Failure of a staff member and authorized third parties to comply with the Information Security Policy may lead to the instigation of the disciplinary procedures and, in certain circumstances, legal action may be taken.

Failure of a contractor to comply could lead to the cancellation of a contract and, in certain circumstances, legal action may be taken.

Compromises of a system or services due to failed security practices are subject to be separated from the County's network infrastructure in an effort to protect the County. Systems and services are only

restored when the DCSIRT has cleared the threat of compromise and has communicated all facts to the Security Manager and/or the CIO.

## **7. MAINTENANCE**

The Information Security Policy and Procedures will be monitored by IT CIO and the IT Security Manager and reviewed annually by DCSIRT. Revisions will be subject to appropriate consultation and will be approved by the CIO. DCSIRT will report all major incidents and breaches to the Security Manager. Departments and Directors may be required to carry out periodic risk assessments and establish and maintain effective contingency plans. They are also required to carry out regular assessments of the security arrangements for their information systems.

Those responsible for information or information systems must carry out periodic risk assessments of their information and the security controls in place. They must take into account changes in business requirements, changes in technology and any changes in the relevant legislation and revise their security arrangements accordingly.

## **8. PHYSICAL AND ENVIRONMENTAL SECURITY**

The County recognizes the need to place all centrally used information storage systems in secure, environmentally controlled areas with adequate fire protection. Business critical hardware will be provided with Uninterrupted Power Suppliers (UPS). The equipment will be regularly maintained and upgraded. IT has the responsibility to ensure this occurs.

Departments are required to ensure all information storage devices (PC's, Storage Devices, Cabinets, etc.) in their ownership are adequately protected against theft and environmental damage. It is the responsibility of the relevant Department Director to ensure this occurs. In the event of theft or loss of an asset, the IT Security Manager must be advised in tandem with filing a report with the Police or Sheriff Departments. The latter allows the CIO or IT Security Manager to activate safeguards such as, data wiping or GPS tracking, which may be integrated with the asset. The IT Security Manager will advise Risk Management of any potential risk as a result of the loss.

## Exhibit 6

### Incident Command

- The System Status Manager must have exceptional skills in organizing and prioritizing in order to orchestrate multiple tasks simultaneously for an extended time while operating in a demanding environment.
- The System Status Manager must have excellent skills in verbal communications.
- The System Status Manager must have the ability to show professional rapport and diplomacy when interfacing with personnel, hospital staff, or citizens who may be requiring emergency services.
- The System Status Manager must be able to maintain appropriate and respectful radio communications under stressful conditions.
- The System Status Manager must show proficiency in the current dispatch CAD functions, in order to utilize the system for reviewing and retrieval of information or any other functions that may become necessary.
- The System Status Manager must have a working knowledge of the operations of the MDT and other computer functions that units use on a daily basis.
- The System Status Manager must be willing to commit to this position for a minimum of 2 years unless previous arrangements have been agreed upon.
- The System Status Manager must employ teamwork ethics with communications center personnel. Continual interfacing with these employees is essential and workloads may need to be shared to complete priority tasks between these positions in an expeditious manner.

iii. Experience:

The System Status Manager must have a minimum of 3 years experience employed with DeKalb County Fire Rescue. It is a positive if the System Status Manager has previous teaching experience.

d. Work Environment and Logistics:

- i. The System Status Manager will work at a dispatch console in the communications center located as close to the Fire Rescue Dispatch Operators as possible.
- ii. The System Status Manager will have a continual exposure to stress while working to manage emergency situations.
- iii. The System Status Manager will have to work a total of 40 hours per week - the assigned day/evening/night will be scheduled for day or overnight shifts depending upon the needs of the County – shifts may vary between 8 – 10 or 13.5 hour assignments.

#### C. TACTICAL OPERATIONS

##### 1. INCIDENT COMMAND

The objective of Fire Rescue is to:

Prevent disastrous incidents from occurring to life and property, and to maximize the saving of life and property when disastrous incidents occur.

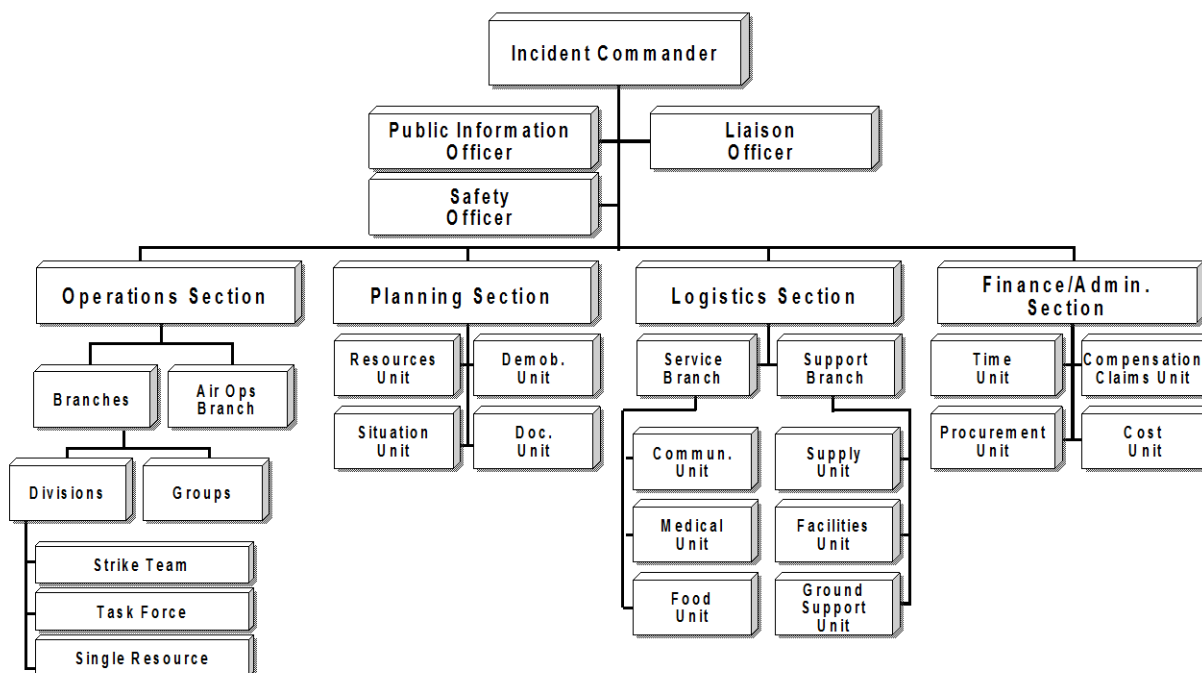
a. In order to fulfill these objectives, two (2) functions must be accomplished.

- i. One is the task functions of engine work, truck work, and rescue work.
- ii. The second is the command functions of communication, coordination and control of an incident.

- b. When the command function is carried out, it creates a practical framework for incident operations and effectively integrates and manages the efforts of all resources deployed and available.
- c. DeKalb County Fire Rescue adopts the National Incident Management System (NIMS) to provide a systematic approach for the Incident Commander to manage all types of incidents.
- d. The effective functioning of Units, personnel and outside agencies at incidents requires clear decisive action on the part of an Incident Commander. This procedure identifies the guidelines to be employed in establishing and maintaining command. It also fixes responsibility for the command function and its associated duties on one individual. Command/Incident Management Procedure Functions are designed to accomplish the following:
  - i. Fix the responsibility for command on a certain individual through a Standard Identification System depending on the arrival sequence of members, companies and Officers.
  - ii. Ensure that strong direct and visible command will be established as early as possible during the incident.
  - iii. Provide an effective framework utilizing the Rudiments of Command to manage the incident.
  - iv. Provide a system for the orderly transfer of command to subsequent arriving Officers.
- e. Rudiments of Incident Command  
To accomplish the command function the following Rudiments of Command must be accomplished:
  - i. Establish or Assume Command
    - Communications
    - Coordination
    - Control
  - ii. Determine Critical Factors by conducting a size up and 360° walk around of location.
  - iii. Determine Priority/Mode of Operation
    - Priority
      - Rescue
      - Confine/Control
      - Property Conservation
      - Terminate
    - Mode
      - Offensive
      - Marginal
      - Defensive
  - iv. Sections
    - Branches
    - Divisions
    - Groups
  - v. Determine/request resources needed
  - vi. Deploy Resources
  - vii. Reevaluate/reinforce actions taken

- viii. Give Progress report-Progress reports are to be given periodically throughout the incident.

f. Organizational Chart



g. Position Titles

Organizational Level	Title	Support Position
Incident Command	Incident Commander	Deputy
Command Staff	Officer	Assistant
General Staff (Section)	Chief	Deputy
Branch	Director	Deputy
Division/Group	Supervisor	N/A
Unit	Leader	Manager
Strike Team/Task Force	Leader	Single Resource Boss

- **Command Staff**-The Command Staff consists of the Public Information Officer, Safety Officer, and Liaison Officer. They report directly to the Incident Commander.
- **Section**-The organization level having functional responsibility for primary segments of incident management (Operations, Planning, Logistics, Finance/Administration). The Section level is organizationally between the Incident Commander and a Branch.
- **Branch**-That organizational level having functional, geographical, or jurisdictional responsibility for major parts of the incident operations. The Branch level is organizationally between Section and Division/

Group in the Operations Section, and between Section and Units in the Logistics Section. Branches are identified by the use of Roman Numerals, by function, or by jurisdictional name.

- **Division**-That organizational level having responsibility for operations within a defined geographic area. The Division level is organizationally between the Strike Team and the Branch.
- **Group**-Groups are established to divide the incident into functional areas of operation. Groups are located between Branches (when activated) and Resources in the Operations Section.
- **Unit**-That organization element having functional responsibility for a specific incident planning, logistics, or finance/administration activity.
- **Task Force**-A group of resources with common communications and a leader that may be pre-established and sent to an incident, or formed at an incident.
- **Strike Team**-Specified combinations of the same kind and type of resources, with common communications and a leader.
- **Single Resource**-An individual piece of equipment and its personnel complement, or an established crew or team of individuals with an identified work supervisor that can be used on an incident.

h. Establishing Command

The first unit to arrive at the dispatched location shall establish Command and remain in Command until relieved by a ranking Officer or until the incident is terminated. The Incident Commander is provided the Fire Rescue Incident Management Worksheet to manage resources and tactics.

i. Initial Report/Size Up

The person establishing incident command transmits a brief initial radio report including:

- Unit identification on the scene, confirming the establishment of Command and location (address). If the exact address cannot be found the Officer/AOIC shall establish Command at the location to which they were dispatched and request additional information from the communications center.
- Building or incident description (size, construction, occupancy).
- Obvious incident conditions.
- Action to be taken. Carry out and Verbalize 360 then assign task to specific units. (Investigating, attempting to locate). If the structure is of excessive size or dimensions the IC may assign individuals or Unit(s) to assist in the 360.
- Any obvious safety concerns.
- For example: "Radio from Engine 1, (acknowledgement from Radio) onscene, 100 Skyland Drive, two (2) story brick, commercial building, medium smoke and Fire conditions showing, side (A, B, C or D), down 2- 1 3/4" lines. Engaged in offensive, rescue operation. Engine one is "Skyland COMMAND".
- When communicating it will be necessary to use the street name before COMMAND. For example: "SKYLAND COMMAND from roof Branch" or "Radio from Engine 1, (acknowledgement from Radio) In

Area or at Dispatched Location, establishing Redan High Command, attempting to locate, radio do you have any further updates?

- The individual in charge of the incident shall be designated COMMAND.

i. Command Options

In cases when the initial arriving Officer is a Chief Officer, efforts should automatically be directed towards establishing a Command Post and following the Rudiments of Command. When Command is initially assumed by a Company Officer, that Officer must decide on an appropriate commitment for his/her company which will usually fall into one of three (3) modes: Nothing Showing Mode, Fast Attack Mode and Command Mode.

- i. Nothing Showing Mode: These situations generally require investigation by the first arriving engine, rescue and/or Truck Company, while holding other arriving units at Level 1 Staging. Normally, the Officer should go with the company to check critical factors while utilizing a portable radio to Command the incident. This shall be accomplished by physically examining the structure from a 360 degree view. This company may act as a "Recon" Unit, if Command is first passed to another Unit.
- ii. Fast Attack Mode: Situations that require immediate action to stabilize the incident where a fast interior attack is critical; utilization of the portable radio will permit the necessary involvement in the attack without neglecting command responsibilities. This Fast Attack Mode will conclude rapidly with one of the following outcomes:
  - Incident is stabilized
  - Command is passed to next arriving Officer or a Chief Officer arrives and command is transferred to him or here, thereby moving into Command Mode.
  - Incident is not stabilized and the Officer must withdraw to the exterior and establish a Command Post thereby moving into Command Mode.
- iii. Command Mode:
  - Situations that require a strong command by virtue of the incident, the complexity or potential of the incident or the possibility of expansion require strong, direct, overall command from the outset. In such cases, the Officer will initially assume a Command position and maintain that position until relieved by a Command Officer. The "critical factor" and "Branches assign" boards should be utilized to assist in managing these situations.
  - If a Company Officer assumes Command he or she may assign the remaining crewmembers in one of the following ways:
    - When applicable, the Officer of a four person crew may designate an Acting Officer to operate a three person company.
    - The Officer may elect to assign company members to perform staff functions to assist Command.
    - The Officer may assign the crew members to another company, to work under the supervision of the Officer of that company. In such cases, the Officer must communicate with

the receiving Officer and indicate the assignment and accountability of those personnel.

- The Company Officer assuming Command has a choice of modes and degrees of personal involvement in the attack, but continues to be fully responsible for the identified tasks assigned to the command/management function. In all cases, the initiative and judgment of the Officer are of great importance. The modes identified are not strict rules, but general guidelines to assist the first arriving Officer in planning appropriate actions.

iv. Passing Command

In certain situations it may be advantageous for the first arriving Company Officer to "Pass Command" to the next arriving Company Officer or to a Command Officer. This is indicated when the initial commitment of the first arriving company requires a full crew (i.e., a high-rise building or an immediate rescue situation) and the next arriving company or Command Officer is on the scene or close behind. The initial arriving Officer will give an initial on the scene radio report and advise that Command will be passed. The initial arriving Company Officer retains responsibility for Command until the next unit arrives and acknowledges the transfer. Radio will confirm that the next unit has assumed Command.

- Transfer of Command

The First Fire Rescue Unit to arrive at the dispatched location shall assume and retain Command until relieved by a ranking Officer within the following guidelines:

- The first arriving Company Officer will automatically assume Command except as noted below.
  - The first arriving Chief Officer will assume Command after transfer of command procedures have been completed. A secondary 360 by the Chief Officer may be completed at their discretion.
  - Complex situations that have not been declared under control may require the Battalion Chief or Assistant Chief to take command. Assumption of Command by Chief Officers is discretionary. If the Battalion Chief or Assistant Chief does not assume Command but remains on the scene, they shall actively monitor the progress of the incident. The decision not to take command will not relieve a Chief Officer of responsibility while on scene.
  - The first due Battalion Chief or Acting Battalion Chief shall arrive at the location of all reported structure fires. The Incident Commander may cancel resources prior to the arrival of the Chief Officer, but the IC must remain on scene until all critical factors are reviewed with the first due Battalion Chief and the incident is terminated.
  - Assumption of Command is discretionary for the Fire Chief or Deputy Chief of Operations.



- The Officer assuming Command will communicate with the Incident Commander face-to-face on arrival or by radio if face-to-face is not possible.
- The Incident Commander will brief the Officer assuming Command on the following:
  - General Situation Status
    - ✧ Priority/Mode of Operation
    - ✧ Critical Factors/Branches assigned (Command Boards)
    - ✧ Resources deployed/requested (Command Boards)
    - ✧ Any special hazards or problems
- Chief Officers should discourage unnecessary radio traffic while responding. This requires the person initially in Command to give a clear on-the-scene report to include 360 results and continue to give updated progress reports as needed.
- There is no automatic transfer of command. The arrival of a Chief Officer on the fire ground does not necessarily mean command has been transferred to that Officer. Command is transferred only when the outlined communication functions have been completed.
- The response and arrival of ranking Officers and Chief Officers on the incident strengthens the overall command function. All Officers will exercise their command prerogative in a supportive manner that will ensure a smooth transition and the effective on-going function of command.
- The Officer assuming Command will utilize the person relieved of Command to best advantage.
- In cases where Command is effectively handling an incident and is completely aware of the situation, it may be desirable for that Incident Commander to continue to be in Command. In such cases, the ranking Chief Officer may return to service or if he/she wishes, may continue to stay on the scene. In cases of complex situations, the ranking Chief Officer, upon arrival, will complete the transfer of Command procedures and assume Command. The Officer assuming Command will utilize the Officer relieved of Command to best advantage.

j. Command Structure

- i. It is the responsibility of Command to develop an organizational structure, using Standard Operating Procedures to effectively manage Incident Operations through a number of phases, depending on the size and the complexity of the particular situation. The objective must be to develop the command organization at a pace, which stays ahead of, or even with the tactical deployment of companies.
- ii. The basic configuration of a Command Structure includes three (3) levels:
  - Strategic Level - Overall Incident Command

The Strategic Level involves the overall Command of the incident and includes establishing major objectives, setting priorities, allocating resources, predicting outcomes, determining the appropriate mode of operations (offensive or defensive) and assigning specific objectives to Tactical Level Units.

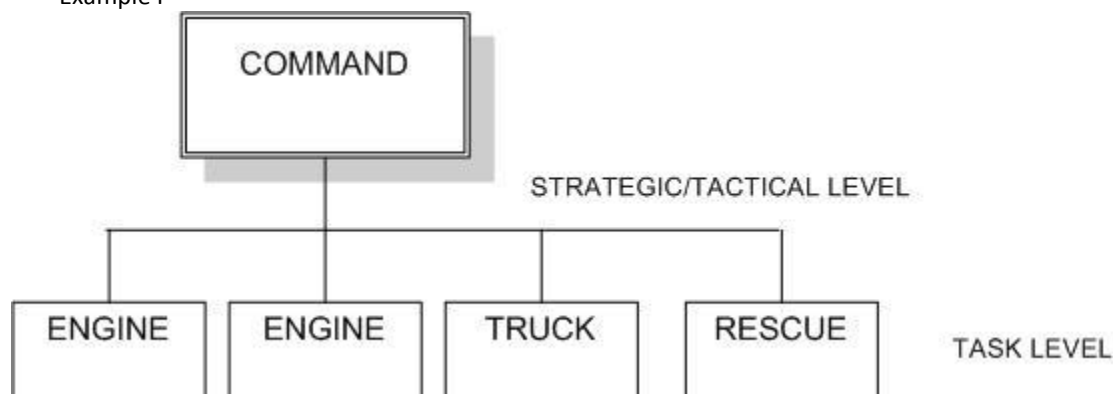
- Tactical Level - Direction of Branches and functions

The Tactical Level includes intermediate level Officers directing activities toward specific objectives. Tactical Level Officers include Branch, Division, and Group Officers, in charge of grouped resources operating in assigned areas or providing special functions at the scene of an incident. The accumulated achievement of tactical objectives should accomplish strategic level objectives.

- Task Level - Company activities

The Task Level includes activities by companies, involving the evolution-oriented functions needed to produce task-level outcomes. The most basic structure for a routine incident involving a small number of companies involves only two levels. The role of Command combines the Strategic and Tactical Levels. Companies report directly to Command or operations as required and operate at the Task Level.

Example I

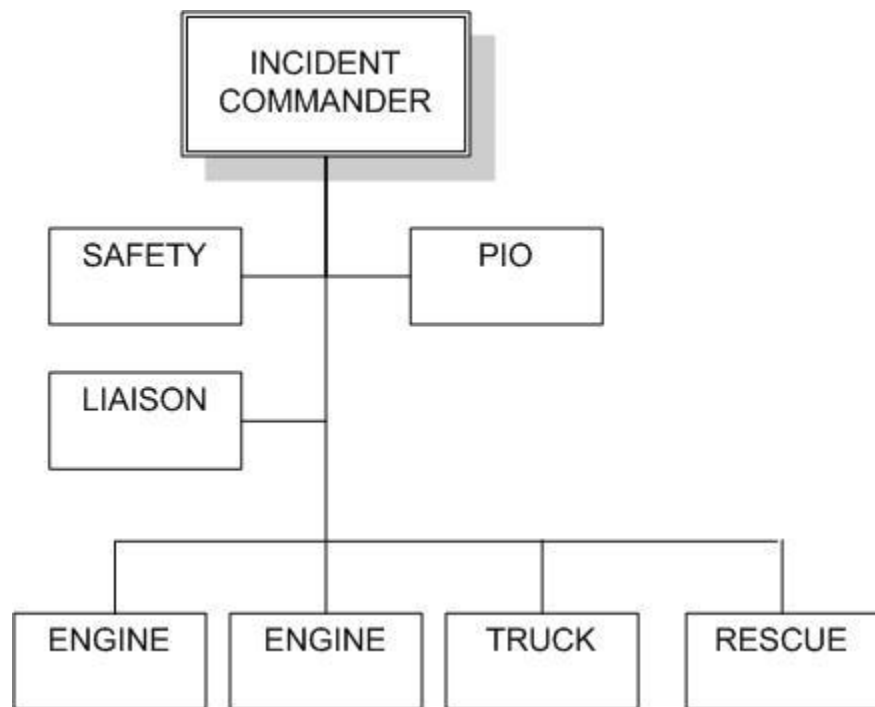


- iii. In more complex situations, Command shall group companies to work in sections. The Branch, Division, Group Officers operate at the Tactical and Task Level, directing the work of several companies or performing specialized functions as requested by Command. Command continues to operate at the Strategic Level, determining and directing the overall strategy to deal with the incident.

- k. Command Post Organization

- i. The responsibilities assigned to Command often require the involvement of more than one individual to manage command functions. The Officer in Command of a working incident is routinely assisted by personnel in managing information, gathering information by reconnaissance (360), assisting with communications and providing liaison. The Command Post organization may be expanded through the involvement of Command Officers and staff personnel to provide Incident Planning and/or Technical Support. The roles of the individuals performing these functions may vary, depending on the situation.

- ii. As the incident organization grows in complexity, the Incident Commander may implement an additional intermediate level within the Command Post. The Control Level involves Function Officers who provide direct supervision over Section Officers and handle radio communications for the Incident Commander. This allows the Incident Commander to be removed from the immediate pressures of radio traffic and to focus on the strategic aspects of the overall situation and management of the organization.
- Strategic Level - Incident Commander
  - Control Level - Function Officers
  - Tactical Level - Branch, Division, Group Officers
  - Task Level - Companies
- iii. There are four functions to which the Incident Commander may assign an Officer to assist Command.
- Finance
  - Operations
  - Logistics
  - Planning
- (Operations will control the majority of the personnel and resources, but other functions are no less important.)
- iv. In addition to the Command Functions there are three assigned positions identified as Command Staff.
- Safety Officer
  - Public Information Officer
  - Liaison Officer



## I. Command Boards

When utilizing the Command Boards, it is important for them to be standardly formatted in order to facilitate their use and so that they can be systematically reviewed by later responding command personnel.

### i. Incident Status Report Board

The first Command Board function is the "Incident Status Report" board. This board contains the information needed in order to describe the scene. The Incident Commander should transmit an initial report including as much of the information as is known that is contained on the progress report board. As more of the information on the board is ascertained, it should also be transmitted. The progress report also can be used to measure the progress of the operation. This is done by monitoring the "Priority/Mode of Operation." All changes in the Priority/Mode of Operation mandate an updated progress report. The status report also lists units dispatched to the scene, the order in which they were dispatched to the scene, and the time they were dispatched.

- **Mode of Operation**

The "Mode of Operation" concerns itself with offensive, defensive, and marginal.

- **Priority/Mode of Operation:** The paramount function of Incident Command is to accomplish the objectives of Fire Rescue with the utmost consideration for the safety of the personnel operating at the incident. The "Priority/Mode of Operation" is a realistic, practical, and efficient way of accomplishing this function along with monitoring the progress of the incident.
  - **Offensive Mode:** The "Offensive Mode of Operation" means that personnel and equipment are deployed in a manner that overwhelms the situation and brings it to a quick and successful conclusion. If at any time the situation becomes an equal match for the resources deployed, Command simply adds more resources. Offensive and aggressive modes of operation are synonymous.
  - **Defensive Mode:** Contrary to the Offensive Mode is the "Defensive Mode of Operation". The Defensive Mode is when Command draws a line at a safe distance, sets up its defensive resources at that line, and maintains that position until conditions change so that the mode of operation can change or until the incident is terminated. When a Defensive Mode of Operation is being utilized, the area of danger shall be known as the "hot zone" and shall not be entered by personnel operating under the Defensive Mode of Operation.
  - **Marginal Mode:** The "Marginal Mode of Operation" means that conditions do not clearly indicate that the mode of operation should be offensive or defensive. When a Marginal Mode of Operation is being utilized, all personnel operating under the

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Marginal Mode should take a cautious but aggressive approach to the functions they are working to accomplish.

- Priority of Operation: The "Priority of Operation" concerns itself with rescue, confine/control, property conservation, and termination. The changing from one priority to another can be in any order and does not have to involve all four priorities of operation at all incidents.
  - Rescue Priority: The "Rescue Priority" is the MOST IMPORTANT PRIORITY because it concerns itself with saving life. Once primary search is completed, the priority of operations can be changed to one of the other priorities. It is also permissible for Command to forego the rescue priority if conditions warrant.
  - Confine/Control Priority: When keeping the event from becoming larger is the priority of action on scene
  - Property Conservation Priority: Property Conservation: The mitigation and reduction of any further property loss.
  - Terminate Priority: The final priority is the "Terminate Priority". This priority concerns itself with demobilization. It can be as simple as returning equipment to service verbally or as complicated as to cause a need for a section to be established to handle the demobilization of the resources deployed.

General Comments-Priority/Mode of Operation: It shall be the responsibility of all personnel to know the Priority/Mode of Operation that they are operating under, at all times. If any information or conditions exist that are contrary to the mode selected, this information or condition should be passed to Command for assessment. All operations upon arrival are assumed to be in a Rescue/Offensive Mode and Priority of Operation. When indications are present that justify a change in the Priority/Mode of Operation, Command is mandated to make the change. When Command makes a change, it is incumbent upon Command to announce this change to all personnel operating at the incident and conduct a PAR. When change is made from an Offensive Mode to a Defensive Mode, regardless of the priority, three (3) levels of command must concur. The three (3) levels of command are:

- Strategic Level
- Tactical Level
- Task Level

In most incidents, the Strategic Commander and the Tactical Commander are one and the same. As a matter of fact, when one Unit is operating on an alarm, the Officer in Command of the Unit, is the Strategic, Tactical and Task Commander. The

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importance of this statement is the fact that all three levels of command have to be brought together in all operations and this responsibility lies with Command even if it is only one person. It must be understood that the Priority/Mode of the Operation can be different for different Branches and/or Personnel. In some cases (as an example, weak walls), the Defensive Mode would apply to all personnel. In other cases (an example being a vapor cloud), personnel specially equipped would be operating in an Offensive Mode.

ii. Critical Factor Board

- The second command board function is the Critical Factor Board. The Critical Factor Board identifies important considerations across a broad spectrum of possible response types. Not all critical factors will apply to all incidents. In theory, once all of the critical factors have been identified and resources have been deployed to eliminate them, there is no longer an incident. The Command System is designed to help the Incident Commander to perform without emotion, thereby preventing oversights, which are common under stressful conditions. The Critical Factors board is a prime example of how the Command System does this.
- What has happened by creating the critical factor board has proven to be phenomenal. By taking every type of incident and listing the points to be considered, a checklist is developed that is all encompassing. Once this list has been established for all the many imaginable incidents, one soon can see that some of the critical factors, like accessibility, apply to literally every incident. On the other hand, critical factors, like stack effect, only apply to high-rise incidents.
- The Critical Factors are:
  - Accessibility
  - Address
  - Call Back Number
  - Call Help
  - Collapse
  - Communications
  - Confine
  - Construction
  - Contents
  - Crowd Control
  - Drainage
  - Elevators
  - Evacuation
  - Exposures
  - Extinguish
  - Fire Load
  - Fire Phase
  - Fire Walls
  - HVAC
  - Hazardous Materials

- Information on MDT
- Lobby Control
- Locate
- Location of Incident
- Medical Occupancy
- Overhaul
- Primary Search
- Radiation
- Rescue
- Run Off
- Run On
- Safety
- Secondary Search
- Sewer System
- Size Up
- Sprinklers
- Stack Effect
- Standpipe
- Time
- Traffic
- Ventilation
- Vertical Openings
- Water Supply
- Waterway
- Weather
- Wind
- 360 Views

iii. Section Assignment Board

- The third command board function is the "Section Assigned" area. When resources are assigned to a section, they are listed on this board under the section to which they are assigned. This provides accountability and also provides continuity in command over long incidents.
- The Department resources and the Sections (Branch, Division, Group) not being utilized remain on their respective boards and are placed above the section assigned board as a reminder to the Command team as to what is available.
- Sections are an efficient way of dividing incidents into smaller Command units or areas. Complex incidents soon exceed the capability of one person to effectively manage. There are two (2) types of assignments, Geographical and Functional. Geographical assignments are responsible for all general activities in an assigned area. Functional assignments are assigned to perform specialized tasks or activities, which do not necessarily coincide with geographic divisions. Sections reduce the span of control of the overall incident to a more manageable sized area. This allows Command to communicate with assigned Officers rather than many individuals or companies.

- Divisions provide a system for Command to divide large-scale operations geographically into effectively sized units. Groups also provide a system for Command to divide large-scale operations into functions. This places responsibility for the details and execution of the objective on a Branch Officer, thereby removing it from the Incident Commander's attention.
- When effective sections have been established, Command can concentrate on overall strategy and resource allocation. Each Commander is responsible for the tactical deployment of the resources at his/her disposal and for communicating needs and progress reports to Command.
- Command determines strategic objectives and assigns available resources to Branches where they are most needed.
- Assigning sections reduces the overall amount of incident ground radio communication. Most routine communication is conducted inside the assigned area in a more effective face-to-face manner between the Fire Companies and their assigned Officer. This process eliminates many of the details of company operations from radio communications. The Officer leading a Section shall provide Command with pertinent updates via radio.
- Safety of firefighting personnel represents a major reason for subdividing an incident. Each Section Commander must maintain the capability to communicate with personnel under his command so that he can control both the position and function of his assigned resources.
- Command assigns sections based on the following:
  - A situation where Command can no longer cope with the number of companies operating.
  - A situation where Command cannot determine the needs without sending someone to the area in question to determine them.
  - A situation where close control is required.
- The number of companies assigned to a section will depend upon conditions within that area. Four to six companies represent the ideal span of control.
- Section Command- Area Commanders will command Sections and these Officers can be Chief Officers, Company Officers, or any other persons designated by Command.
- Division A, B, C and D are identified by assigning the front, facing the building, as side A; The area to the left, side B; The rear, side C; The area to the right, side D. Exposures to the fire are numbered in the same manner. For example an exposure to the left of the fire would be exposure B. This can also be stated as exposure-side B. The top and bottom Divisions (or exposures) are addressed by using their names. If there are multiple exposures to any side of the fire the exposure closest to the fire will use the Division designator and a number. Additional exposures to the same side will use the Division designator letter plus a number. For example: if the fire building has three (3)



exposures to side B, the one closest to the fire would be exposure number B1, the next would be exposure number B2, and the third would be exposure B3.

- This will give everyone on the incident scene the same point of reference. Generally, side A will be the side facing the street. However, sometimes because of the way structures are situated on their lots it is not easy to determine which is the street side. This is a situation in which it will be important for Command to designate side A and ensure that all operating personnel understand this designation.
- The Division Commander will use the Division designation in radio communications. For example:
  - If Engine 4 is assigned to be in charge of the interior Division; he will communicate with Command in the following manner.  
"(Name of street) Command from Interior Division".  
Conversely, Command will communicate with Engine 4 as follows: "Interior Division from (name of street) Command".
- In many cases, the initial division assignment will be given to the Company Officer that receives the initial assignment to a basic tactical position. Command will indicate to such companies that they will be operating as both a division and an operating company. Command may, in such cases, assign a Command Officer to relieve the Company Officer as Division Commander.
- Division Officers will be in command of all assigned functions within their areas. In accomplishing this, they will be responsible for the following:
  - Monitoring welfare and safety of Division Personnel. A Safety Officer dedicated to a specific division can be utilized if needed.
  - Monitoring work progress
  - Directing activities as necessary
  - Coordinating with related activities
  - Requesting additional resources as needed
  - Communicating with Command as necessary
- When a Company is assigned to an operating section, the Company will be told to which Branch, Division, Group and which Section Commander the assignment is made. The Section Commander will be informed which particular Company has been assigned to him/her by Command. It is then the responsibility of the Section Commander to contact the Company to give them specific instructions. The Section Commander shall be able to provide a PAR for all Companies assigned to him/her.
- Section Commanders must be sufficiently mobile to be able to supervise the work of their assigned Companies. This may mean going into interior operation positions to monitor progress while maintaining radio communications. The Section Officer should be readily identifiable and maintain a visible position as much as possible. All protective clothing should be utilized when functioning in unsafe environments.

- The primary function of the Company Officer working within a section is to direct the operations of his/her crew in performing assigned tasks. Company Officers will advise their Section Commander of work progress and if a Company Officer determines the need for assistance on assigned work tasks, they will request such assistance from the Area Commander.
- Companies assigned to a section will direct routine communications to their Area Commander and should utilize non-radio modes whenever possible. This does not preclude the use of radio communications within sections. The use of an additional TAC channel should be utilized when needed for incident of greater complexity.
- Routine communications from a Company to Command if the Company is assigned to a section will be re-directed to the Area Commander. The Area Commander will conduct radio communications with Command and with other assigned Officers. This procedure will apply only to routine communications. Emergency traffic may be initiated by anyone at any time.
- The following is a list of the predetermined geographical and functional Branches already established:
  - Air Supply
  - Air Support
  - Command
  - Damage Assessment
  - Decontamination
  - Demobilization
  - Dive Team
  - Employee Benefits
  - Evacuation
  - Exposure/Side A
  - Exposure/Side B
  - Exposure/Side C
  - Exposure/Side D
  - Exposure Bottom
  - Exposure Top
  - Flying Brand
  - Interior
  - Investigation
  - Lighting
  - Lobby Control
  - Maintenance (Fleet)
  - Medical
  - Operations
  - Photo
  - Police
  - Public Relations
  - Radiation
  - Rehabilitation
  - Resource

- Roof
- Run Off
- Run On
- Safety
- Salvage
- Staging
- Tactical Rope
- Transportation
- Treatment
- Triage (Field)
- Unsolicited Help
- Water Supply

iv. Agencies List

- The forth command board function is the "Agencies" list, which is a checklist to prevent Command from overlooking important agencies that need to be considered for utilization. The agencies are:
  - Animal Control
  - Arson
  - Board of Education
  - Bomb Squad
  - C.D.C.
  - Chaplain
  - Chemtrec
  - Clean Up Co
  - Corps of Engineers
  - D.O.T.
  - E.M.A.
  - E.P.A. (Federal)
  - E.P.D. (State)
  - Engineering Dept.
  - F.A.A.
  - Fire Prevention
  - Forestry
  - Gas Companies
  - Maintenance (Fleet)
  - Media
  - Medical
  - Medical Examiner
  - Mutual Aid
  - N.R.C.
  - N.T.S.B.
  - National Guard
  - National Weather
  - O.S.H.A.
  - Phone Company
  - Poison Control
  - Police
  - Pollution Control
  - Power Company

- Railroad
- Red Cross
- Technical Advisor
- U.S.C.G.
- Water Works

Other command paraphernalia includes hazardous materials reference materials, tactical data sheets, water system maps, evacuation maps, binoculars, compass, and a book that explains the specifics of the critical factors, the sections, and the agencies.

m. Staging

The purpose of the Staging Guideline is to effectively manage resources assigned to an incident and to help keep the Incident Commander from being overwhelmed with equipment before he/she is ready to assign it for operation.

i. Level 1

- Level 1 staging will automatically apply to all multiple unit responses unless otherwise directed by Command. Command must be established for staging to take place. Level 1 staging involves the following:
  - The first arriving Engine Company will respond directly to the dispatched location and will operate to best advantage.
  - The first arriving Truck Company will respond directly to the dispatched location and will place themselves to best advantage, generally at the front of the building and report their action by radio.
  - The first arriving Rescue Unit will go directly to the dispatched location and place their apparatus in a location that will provide maximum access for medical/rescue support and not impede the movement of other units and indicate their action by radio.
  - All other units will stage uncommitted, approximately one (1) block from the dispatched location until assigned by Command. A position providing a maximum of possible tactical options with regard to access, direction of travel, water supply, etc., should be selected.
- Staged Companies or Units will, in a normal response situation, report Company designation, standing by and their location (Engine #1, Staging, Lawrenceville Highway at Montreal Circle). An acknowledgement is not necessary from Radio or Command. Staged Companies will stay off the air until orders are received from Command. If it becomes apparent Command has forgotten the Company is in a staged position, the Company Officer shall contact Command and re-advise him of their standby status. These staging procedures attempt to reduce routine radio traffic, but in no way should reduce effective communication or the initiative of Officers to communicate. If staged Companies observe critical tactical needs, they will advise Command of such critical conditions and their actions. Staged Units are not exempt from the responsibility of Command and

Safety if other Units are neglecting their duties. However, the Incident Commander bears overall responsibility for managing the incident.

ii. Level 2 staging

- Staging is used when an on-scene reserve of companies is required. These companies are placed in a Staging Area at a location designated by Command. When Command announces "Level 2 staging", all 2nd alarm and greater companies will report to Staging and remain in the Staging Area until assigned. First alarm Companies will continue with Level 2 staging unless instructed otherwise. When going to Level 2 staging, Command will give an approximate location for the Staging Area. Companies which are already staged (Level 1) will stay in Level 1 staging unless advised otherwise by Command. All other responding Units will proceed to the designated Level 2 staging Area.
- The Staging Area should be away from the Command Post and the emergency scene in order to provide adequate space for assembly and for safe effective apparatus movement.
- When calling for additional resources, Command should consider Level 2 staging at the time of the call. This is more functional than calling for Level 2 staging while units are enroute. The additional Units will be dispatched to the Staging Area.
- Command may designate a Staging Area and Staging Officer who will be responsible for the activities outlined in this Guideline. In the absence of such an assignment, the first Fire Rescue Units Officer to arrive at Staging will automatically become the Staging Officer and will notify Command upon arrival.
- Due to the limited number of Truck Companies, a Truck Officer will transfer responsibility to the first arriving Engine Company Officer. Staging Officers will assign their Company members to best advantage.
- In some cases, Command may ask the Staging Officer to scout the best location for the Staging Area and report back to Command.
- The radio designation for the Staging Officer will be-"Staging". All communications involving Staging will be between Staging and Command. All responding companies will stay off the air; respond directly to the designated Staging Area, and report, in person, to the Staging Officer. They will stand by their unit with crew intact and warning lights off (unless a traffic hazard dictates otherwise). The Staging Officer shall keep track of all Units either in or enroute to Staging. If directed to do so by Command, the Staging Officer shall call radio for additional Units to replenish Staging.

n. Incident Command Report

- i. An Incident Command Report shall be completed when it meets the following guidelines.
- All type fire incidents larger than a single-family occupancy.
  - All type fire incidents where additional equipment is requested.
  - Any unusual or complex incidents such as working hazardous material incidents, mass casualty incident, trench rescues, swift water rescues, confined space rescues, tactical rope rescues, complex medical incidents.

- Any unusual injuries or fire related deaths to Department Personnel or Civilians.
- ii. Rudiments of an Incident Command Report-In order to learn from our experiences associated with emergency incidents, it is important that we standardize our method of communicating what took place during these incidents. It will be the responsibility of the Incident Commander to see that the Incident Command Report is filled out appropriately and completely following the Rudiments of an Incident Report. There are five (5) components to an Incident Report. These are:
  - Conditions upon arrival to include 360 evaluation of building.
  - Critical factors and actions taken
  - Outside agencies utilized
  - Lessons learned/reinforced
  - Conclusion
- iii. Conditions upon Arrival-This part of the report deals with but not limited to the location and environmental conditions of the incident; what type structure is involved; the construction of the building or characteristics of the situation; the specific equipment dispatched on the initial alarm; and also the immediate conditions faced by the first arriving unit. This information paints a picture of the incident initially.
- iv. Critical Factors and Actions Taken-This section describes critical factors that were encountered and identified, which sections and actions were taken to alleviate these critical factors and how the situation was handled overall. Included in this part of the report are priority and mode of the operation (and if they changed during the incident) Command Post locations, exposure problems and additional equipment requested. All of the intricate parts that go into the operation/incident should be discussed. All "in-house" resources that were called for should be accounted for here.
- v. Outside Agencies Utilized-As all of us are aware, the Department can no longer efficiently handle many of the incidents that we encounter without the utilization of outside agencies. In this section of the report, all agencies other than DeKalb County Fire Rescue Units shall be listed and the role they played in combating critical factors identified. (Gas Company, Power Company, E.P.A.)
- vi. Lessons Learned and Reinforced-Perhaps this section could also be called the Educational Section of the report. This is often the most interesting and important part of an incident report. We can often learn by the actions that were taken at an incident, as to whether we should change a particular tactic or strengthen a particular tactic. This is an area where the Incident Commander should put his critical thoughts that represent both the positive and the negative of a particular incident. This will only serve to better our Department in future incidents.
- vii. Conclusion-This area is used for "summing up" the incident and presenting any changes in procedure/policy or thoughts that the Incident Commander would like brought out concerning the incident.
- o. Incident Management Terminology
  - i. Action Plan-(See Incident Action Plan)
  - ii. Branch-The organizational level having functional control or geographic responsibility for major parts of incident operations. The Branch level is

organizationally between Section and Division/Group in the Operations Section.

- iii. Cache-A pre-determined complement of tools, equipment, and/or supplies stored in a designated location, available for incident use.
- iv. Chain of Command-A series of management positions in order of authority.
- v. Clear Text-The use of plain english in radio communications transmissions.
- vi. Command-The act of directing and/or controlling resources by virtue of explicit legal, agency or delegated authority. May also refer to the Incident Commander.
- vii. Command Staff-The Command Staff consists of the Information Officer, Safety Officer, and Liaison Officer. They report directly to the Incident Commander.
- viii. Division-Divisions are used to divide an incident into geographical areas of operation. A Division is located within the IMS Organization between the Branch and the Task Force. Divisions are identified by alphabetical characters for horizontal applications and by floor numbers when used in buildings.
- ix. Documentation Unit-Functional unit within the Planning Section responsible for collecting, recording and safeguarding all documents relevant to the incident.
- x. Dispatch Location-The location of a reported incident that is verbally and electronically transmitted to emergency response units.
- xi. Area Command Center-A pre-designated facility established to coordinate the overall response and support to an emergency.
- xii. Emergency Operations Plan-The plan that each jurisdiction has and maintains for responding to appropriate hazards.
- xiii. Finance/Administrations Section-The Section responsible for all incident costs and financial considerations. Includes the Time Unit, Procurement Unit, Compensation/Claims Unit and Cost Unit.
- xiv. Group-Groups are established to divide the incident into functional areas of operation. Groups are composed of resources assembled to perform a special function not necessarily within a single geographical division. Groups are located between Branches (when activated) and Resources in the Operations Section.
- xv. Incident Action Plan- An oral or written plan containing general objectives reflecting the overall strategy for managing an incident. It may include the identification of operational resources and assignments. It may also include attachments that provide direction and important information for management of the incident during one or more operational periods.
- xvi. Incident Commander-The individual responsible for the management of all incident operations at the incident site/dispatched location. May also be referred to as "Command".
- xvii. Initial Action-The actions taken by resources, which are the first to arrive at an incident.
- xviii. Operations Section-The Section responsible for all tactical operations at the incident. Includes Branches, Divisions, and/or Groups.
- xix. Section-The organizational level with responsibility for a major functional area of the incident, i.e. Operations, Planning, Logistics, and Finance/Administration. The Section is organizationally between the Branch and Incident Commander.

- xx. Size Up-The process of evaluating an emergency situation to determine what actions need to be taken. Effective size up depends on a combination of training, experience and good judgment.
- xxi. Staging Area-Staging Areas are locations set up at an incident where resources can be placed while awaiting a tactical assignment. The Operations Section manages Staging Areas.
- xxii. START-Acronym for Simple Triage and Rapid Transport. This is the initial triage system that has been adopted for use by the Georgia EMS Region III Council.
- xxiii. Strategy-The general plan or direction selected to accomplish incident objectives.
- xxiv. Tactics-Deploying and directing resources on an incident to accomplish the objectives designated by strategy.
- xxv. Triage-The screening and classification of sick, wounded, or injured persons to determine priority needs in order to ensure the efficient use of personnel, equipment and facilities.
- xxvi. START Tag-A tag used by triage personnel to identify and document the patient's medical condition.
- xxvii. Unified Command-A unified team effort which allows for all agencies with responsibility for the incident, either geographical or functional, to manage an incident by establishing a common set of incident objectives and strategies. This is accomplished without losing or abdicating agency authority, responsibility, or accountability.
- xxviii. Unity of Command-The concept by which each person within an organization reports to one and only one designated person.
- xxix. 360-The Incident Commanders check of critical factors while utilizing a portable radio as they view all four sides of a structure.

## 2. STANDARD COMPANY OPERATIONS

- a. Standard company operations assign basic fireground functions and activities to companies based upon the capability and characteristics of each type of unit.
- b. Standard company operations assign major fireground functions to the particular company who can best accomplish the operation.
- c. Standard company operations integrate the efforts of engine, ladder, Mobile Medical Officers and Rescues to achieve effective rescue, fire control, and loss control activities.
- d. Standard company operations increase the awareness and confidence of company members in the standard performance of other companies operating on the fireground.
- e. Standard company operations reduce the amount and detail of orders required to get companies into action on the fireground.
  - i. Responsibilities
 

The following items represent the standard operations that will normally be performed by Engine, Ladder, Rescue apparatus and Mobile Medical Officers. These basic functions will provide the framework for field operations for these apparatus; however the Incident Commander has the authority to utilize personnel as necessary:

    - Engine Functions
      - Search, rescue and treatment
      - Establish Command
      - Stretch hose lines
      - Operate nozzles
      - Pump hose lines



- Water Supply
- Loss control
- Support fire protection systems
- Rapid intervention duties
- Truck Functions
  - Search, rescue, and treatment
  - Establish Command
  - Ventilate
  - Forcible entry
  - Raise ladders
  - Provide access/check fire extension
  - Utility control
  - Provide lighting
  - Operate ladder pipes
  - Perform overhaul
  - Extrication
  - Loss control
  - Salvage Operations
  - Rapid intervention duties
- Rescue Functions
  - Establish Command
  - Exterior ventilation
  - Assist with water supply
  - Building evacuation
  - Utility shutdown
  - Exposure protection
  - Rapid intervention duties
  - Establish Rehab
  - Establish Medical Branch

When Rescue Personnel are engaged in interior firefighting operations, Command should consider requesting a second Rescue response for immediate transport responsibility.

- Mobile Medical Officer Functions
 

Mobile Medical Officers will only be dispatched on the following fire suppression assignments. MMO's will check with the on duty Assistant Chief and request permission to respond to all other reported structure fires.

  - Second alarm assignments
  - Multiple Casualty Incidents
  - Any incident with a DCFR injury
  - 1<sup>st</sup> Alarm with reported entrapment

## ii. Operations

- The first arriving Engine, Truck and Rescue will perform these functions as required and ordered by Command. These crews will advise Command on the type of function they are performing.
- Officers will determine, based upon conditions, the priority of the functions for their crews unless otherwise ordered by Command. This does not limit a crew to only its listed functions. Every type apparatus

crew will be expected to perform all basic functions safely within the limits of their capability, and it will be the on-going responsibility of Command to integrate tasks and functions as required with the on-scene units.

- In the absence (or delay) of a Truck response, Command should assign Truck functions to an Engine Company: "Engine 11, perform truck functions." In such cases, engine crews will perform all truck functions within the capability of their crew.
- The assignment of these basic operations represents a standard fireground plan for tactical operations designed to improve the effectiveness and safety of all units working together. This plan should in no way limit the initiative of any Officer and should enhance the decision making process of all Officers by establishing a standard operational framework.
- Fire alarms or any dispatch which presents the possibility of physical injury to the responder such as structure fires, Haz mat incidents, motor vehicle accidents, etc., require the following:
  - Within the immediate perimeter, as defined by the Incident Commander, all personnel shall wear:
    - Helmet with chinstrap secured to the chin and eye shield (or safety glasses) when required.
    - Turnout coat with all snaps and buckles fastened.
    - Turnout pants w/boots fully on, all closures fastened.
    - Gloves
    - SCBA according to the SCBA operating guideline.
    - Nomex hood
    - Activated PASS device
    - Personal Flotation Devices (PFD) when operating within 25' of any open water.
  - Exceptions
    - Exceptions will only be permitted when the incident is declared under control, and then only upon specific direction from the Incident Commander.
    - Only the PFD is required during water rescue operations. All other personal protective equipment is optional at the Incident Commander's discretion.
    - Seat belts may be temporarily loosened only when necessary to operate mobile radios.
    - Outside of the immediate perimeter
    - Personnel assigned to the Command Post should wear the helmet and the appropriate vest identifying their position in the Command Structure.
    - Personnel exposed to other dangers such as vehicular traffic shall wear the helmet, and turnout coat/reflective vest.

- Personnel not exposed to any other dangers are not required to wear PPE unless otherwise directed by the Incident Commander.
- Medical/Trauma incidents where the potential of contamination by splashes, sprays, spatter, blood or other body fluids exists require the following:
  - Plastic eye shields
  - N-95 respirator mask
  - Exam gloves
  - Gown

### 3. APPARATUS OPERATIONS

This document provides guidelines required to support the safe and effective operation of all fire rescue vehicles; this includes fire rescue apparatus, command, and support units, operated by fire rescue department personnel in the performance of their duties.

#### a. Responsibilities

- i. It is the responsibility of all Department personnel to adhere to the procedures and policies of this guideline.
- ii. The officer or AOIC on the apparatus will have overall charge and responsibility for the safe operation of the vehicle.
- iii. Before any Department vehicle is moved, the driver shall ensure the immediate path of the vehicle is clear of all obstructions.

#### b. Vehicle Operations

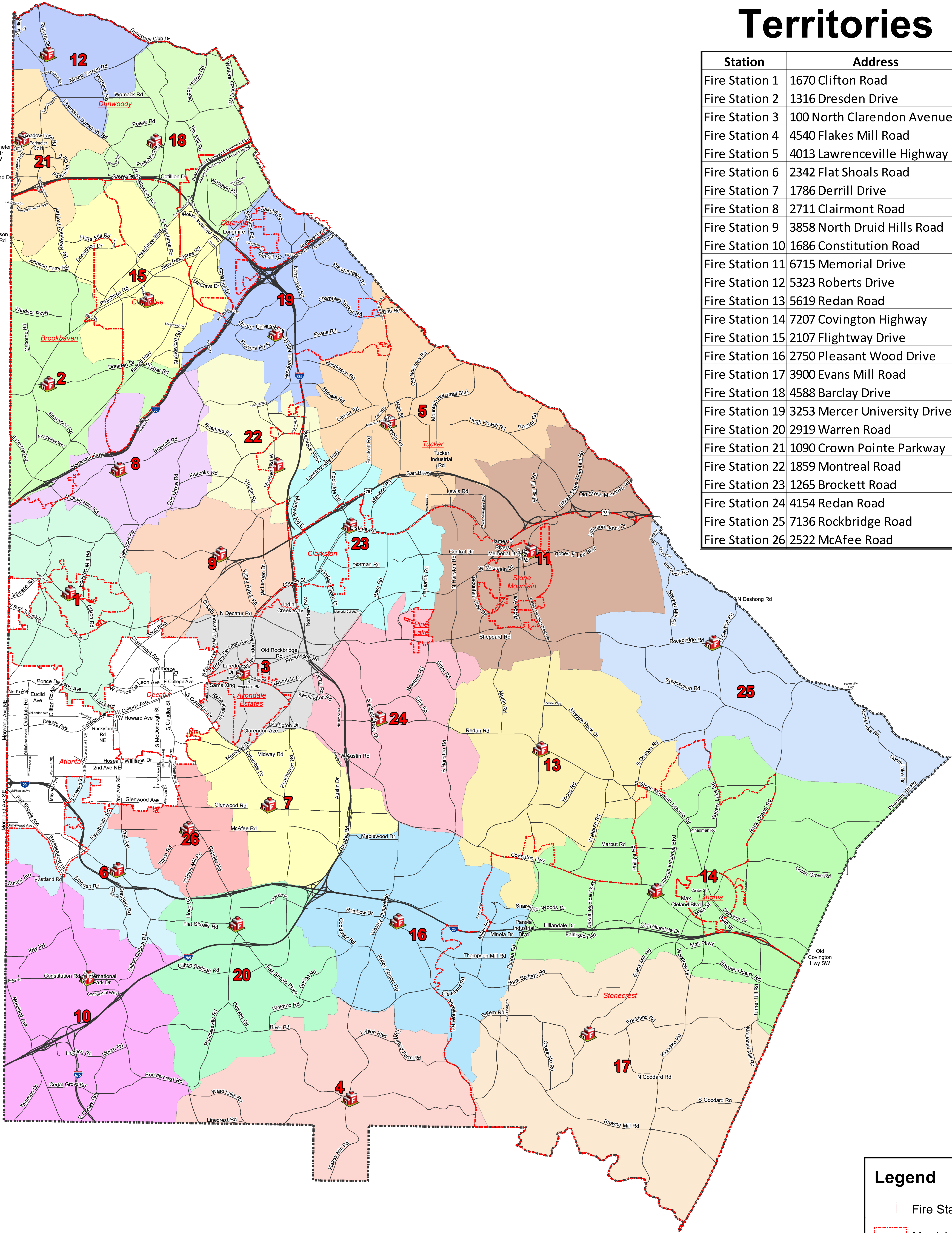
##### i. Safety

- All persons driving or riding in Fire Rescue Department vehicles shall be seated in approved riding positions with seatbelts or safety restraints fastened at all times when the vehicle is in motion. Tailboards, running boards etc. are not approved riding positions. Personnel will be permitted to ride on the tailboard while inspecting hydrants when the speed is 10 mph or less. Helmets, gloves, safety glasses and safety vest shall be worn when riding on the tailboard.
- The driver shall not begin to move the vehicle until all passengers are seated and properly secured. All passengers shall remain seated and secured as long as the vehicle is in motion. Seatbelts shall not be loosened or released while responding to dress or don equipment.
- Personnel shall not attempt to mount or dismount from a moving vehicle under any circumstances. *Exception: Fire Rescue personnel who are providing direct patient care inside an ambulance shall be permitted to release the seat belt momentarily while the vehicle is in motion – if it is essential to provide patient care. When the procedure has been completed, the Fire Rescue Department member shall refasten the seatbelt. Time without the protection of a seat belt shall be minimized.*
- Prior to entering the cab and starting the vehicle, the driver shall make a visual inspection around the vehicle to see that all equipment and all compartment doors are secured. Additional responders shall also inspect their surroundings for obstructions and security of equipment. This inspection shall include all four sides as well as the top of the vehicle. In the event that clearance is questionable all riders, unless



# Fire Stations and Territories

Station	Address
Fire Station 1	1670 Clifton Road
Fire Station 2	1316 Dresden Drive
Fire Station 3	100 North Clarendon Avenue
Fire Station 4	4540 Flakes Mill Road
Fire Station 5	4013 Lawrenceville Highway
Fire Station 6	2342 Flat Shoals Road
Fire Station 7	1786 Derrill Drive
Fire Station 8	2711 Clairmont Road
Fire Station 9	3858 North Druid Hills Road
Fire Station 10	1686 Constitution Road
Fire Station 11	6715 Memorial Drive
Fire Station 12	5323 Roberts Drive
Fire Station 13	5619 Redan Road
Fire Station 14	7207 Covington Highway
Fire Station 15	2107 Flightway Drive
Fire Station 16	2750 Pleasant Wood Drive
Fire Station 17	3900 Evans Mill Road
Fire Station 18	4588 Barclay Drive
Fire Station 19	3253 Mercer University Drive
Fire Station 20	2919 Warren Road
Fire Station 21	1090 Crown Pointe Parkway
Fire Station 22	1859 Montreal Road
Fire Station 23	1265 Brockett Road
Fire Station 24	4154 Redan Road
Fire Station 25	7136 Rockbridge Road
Fire Station 26	2522 McAfee Road



Legend

Fire Station

Municipal Boundary

County Boundary