



EMS System for Metropolitan Oklahoma City and Tulsa 2017 Medical Control Board Treatment Protocols



Approved 11/9/16, Effective 2/1/17, replaces all prior versions

1A – MEDICAL GENERAL ASSESSMENT ADULT & PEDIATRIC

TREATMENT PRIORITIES

1. Assessment:
 - > SCENE SAFETY
 - > PROTECTIVE EQUIPMENT
 - > Primary Survey
 - > Secondary Survey (when appropriate)
2. Primary Survey Care:
 - > Initiate cardiopulmonary resuscitation if indicated
 - > Open airway
 - > Support oxygenation/ventilation
 - > Support circulation – Dysrhythmia care? Rate control? Hypotension care?
3. Minimize scene time in critical case unless working cardiac arrest
4. Enroute Care:
 - > Reassess all primary care
 - > Support oxygenation/ventilation
 - > Vascular access
 - > Secondary Survey (if able)
 - > Keep patient warm/avoid hypothermia
5. Hospital per destination protocol..

In general, approach the assessment of medical (non-trauma) patients, in A-B-C order:

Airway: Evaluate the patency and mechanics of the airway. Is the patient able to oxygenate and ventilate? Rapid intervention may be required during the assessment phase if airway patency and protection is compromised.

Breathing: Expose the chest as required to accurately assess the mechanics of respiration (taking into account patient privacy/modesty if in public location). Note the rate, depth, and pattern of respirations and if any degree of respiratory distress or effort. Auscultate breath sounds bilaterally.

Liberal obtain pulse oximetry readings and in patients with respiratory difficulties, waveform capnography readings (if equipped, **Mandatory use if the patient is intubated).

Circulation: The adequacy of a patient's circulation is best assessed first by evaluating their level of consciousness and mental status. Next assess the location, rate, and character of the pulse. Then check a blood pressure – preferably, manually for at least the first reading. Apply the cardiac monitor (if equipped) liberally.

Cardiac Arrest is an exception to the above order. Aggressively initiate chest compressions and search for shockable rhythms at the appropriate intervals per Section 4 protocols.



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Protocol 1A: Medical General Assessment – Adult & Pediatric, cont.

Many treatment decisions regarding airway management involve calculating the adult patient's Glasgow Coma Scale score using the following table:

Eyes Open		Best Motor Response		Best Verbal Response	
Spontaneously	4	Obeys verbal orders	6	Oriented, conversant	5
To command	3	Localizes painful stimuli	5	Disoriented, conversant	4
To pain	2	Withdraws	4	Inappropriate words	3
No response	1	Painful stimulus, flexion	3	Inappropriate sounds	2
		Painful stimulus, extension	2	No response	1
		No response	1		

Maximum 15 points

After addressing the A-B-C order in most medical patients, including evaluating and addressing any life-threatening conditions, minimize scene time and initiate timely transport to an appropriate emergency department in any setting of a time-sensitive medical condition.

Complete a head-to-toe assessment of the patient if the patient is relatively medically stable. Obtain relevant history of past and current medical problems, medications, allergies, and physicians/hospitals used in care plans to help guide further assessment.

Reassess patients frequently, typically at least every 10 minutes, and more often if critical illness is discovered and being treated. In the situations of an unstable patient, vital signs should be assessed every 5 minutes, especially if hemodynamic changes are occurring.

Assess and treat per symptom or illness specific protocols that follow in this protocol set.

Pediatric Assessment Comments:

1. Pediatric respiratory distress may look just like adult respiratory distress, presenting with:
 - slowing respirations
 - accessory muscle use
 - nasal flaring
 - retractions – intercostal or subcostal
 - tachypnea
 - mottling
 - cyanosis
 - pallor
 - lethargy/listlessness
 - irritability
 - stridor
 - grunting



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2. Vital signs vary with age. In general, the younger the patient, the faster the respiratory rate, the faster the heart rate, and the lower the blood pressure:

AGE	HEART RATE (BPM)	RESP. RATE (BPM)	SYSTOLIC BP (mmHg)
Premature	100-190	40-60	
Neonate	90-190	30-60	50-70
6 months	80-180	25-40	60-110
1 year	80-150	20-40	70-110
3-4 years	80-140	20-30	80-115
5-6 years	70-120	20-25	80-115
7-8 years	70-110	20-25	85-120
11-12 years	60-110	15-20	95-135

The average normal systolic BP can also be estimated by: $80 + (2 \times \text{age})$ in years.
Lower limits of normal systolic BP can also be estimated by: $70 + (2 \times \text{age})$ in years.

3. The following table can be used to calculate Glasgow Coma Scale scores in pediatric patients, especially those under 4 years of age. Most pediatric patients above the age of 4 years will be able to be assessed for Glasgow Coma Scale scores using the adult table.

Pediatric Glasgow Coma Scale Scores

Points*	Best eye	Best verbal		Best Motor
6	--	--		obeys
5	--	smiles, oriented to sound, follows objects, interacts		localizes pain
4	spontaneous	Crying	Interaction	withdraws to pain
		consolable	inappropriate	
3	to speech	inconsistently consolable	moaning	flexion (decorticate)
2	to pain	inconsolable	restless	extensor (decerebrate)
1	none	none	none	none

* Range of total points:
3 (worst) to 15 (normal)