ROUTINE MEDICAL CARE PEDIATRIC

Effective: January 1, 2024
Replaces: January 1, 2023

1. Scope of Practice

1.1. The descriptions of treatments prescribed in the following treatment protocols are intended to call special attention to the uniqueness of Santa Clara County, and are in no way meant to replace the standard of medicine that providers are held in the nation, the state, or the region. The default to all treatment otherwise not noted in these protocols is the national and state standard.

2. Pediatric Patient Defined

2.1. **Neonate** is considered between 0-4 weeks of age
2.2. **Infant** is considered between 1 month to 1 year of age
2.3. **Child** is considered older than 1 year of age
2.4. **Pediatric** is defined as under 15 years of age

3. Baseline Vital Signs

3.1. **Glasgow Coma Scale** on every patient and every reassessment
3.2. **Blood Pressure** on every patient and every reassessment (except for neonates)
3.2.1. First obtained blood pressure will be obtained manually by provider. Subsequent blood pressures may then be obtained by non-invasive blood pressure (NIBP) if unit is equipped
3.3. **Respiratory Rate o**n every patient and every reassessment
3.4. **Pulse Rate** on every patient and every reassessment
3.4.1. First pulse rate will be obtained by palpation. Only after assuring the mechanical correlation of cardiac ECG to the physical pulse will the rate on the cardiac monitor be acceptable for subsequent assessments
3.5. **Pulse Oximetry** on every patient and every reassessment if the unit is equipped
3.6. **Temperature** on every initial assessment
3.7. Baseline vitals, except for temperature, will be assessed every ten (10) minutes on stable patients and every five (5) minutes on unstable patients
3.8. **Blood Glucose Level** on assessment of ALOC and suspected diabetics
3.8.1. Obtained with intravenous access (IV) start or heal stick with lancet
3.8.2. Readings of less than 60mg/dl along with symptoms of hypoglycemia or altered requires intervention **(700-P03)**

4. Advanced Vital Signs

4.1. **Cardiac Monitoring (ECG)** on every ALS patient and every reassessment
4.2. **Capnography** on every patient that received an airway adjunct BLS or ALS
4.2.1. No airway, BLS or ALS, will be deemed patent and/or sufficient unless there is the development of a capnographic wave form, if unit is equipped

5. 5. Airway

5.1. **Airway Management** pediatric intubation is contraindicated if patient fits on length-based resuscitation tape
5.1.1. If patient is larger than length-based tape, intubation may be performed

5.2. **Oxygen Administration** will be titrated to achieve a pulse oximetry saturation between 94 –100%
5.2.1. The provider will select the most appropriate way to deliver the oxygen by either blow by method, nasal cannula, non-rebreather mask (NRB), or bag valve mask (BVM)
5.2.2. Responders not equipped with pulse oximetry will titrate oxygen to the patient's relief of symptoms
5.3. **Assisted Ventilations** will be delivered by a bag valve mask (BVM) and supplemental oxygen to the rate and volume specified in the treating protocol

6. Circulation

6.1. **CPR** is defined under **(700-S01)**
6.2. **Fluid Administration** will be titrated on patient condition
6.2.1. IV starts where there is no or minimal need for fluid administration TKO or a saline lock is acceptable
6.2.2. If the patient needs fluid resuscitation, the amount of fluid and interval of reassessment will be outlined in the treating protocol
6.3. **Fluid Bolus** will be prescribed as:
6.3.1. Neonates:10ml/kg
6.3.2. Child: 20ml/kg to a max single dose of 250ml
6.3.3. If the treating protocol prescribes a different amount or frequency, the treating protocol will always take precedence

7. Medication Administration

7.1. All medication dosages will be obtained or calculated from a length-based resuscitation tape. If patient is taller than the length-based tape, refer to adult protocols

8. Patient Medications

8.1. Field personnel must either bring all prescribed medications with the patient to the receiving facility or document the medications along with dosage and frequency
8.2. Field personnel may assist patients with administration of physician prescribed devices including but not limited to, patient operated medication pumps, sublingual nitroglycerin and self-administer emergency medications devices

9. Medication Administration

9.1. Unless otherwise specified, pharmacological intervention indicates a need for transport to a hospital and further evaluation by a physician
9.2. Prior to administering any medication, ensure the right drug, right dose, right patient, and right route
9.3. Assess medication for expiration date, clarity, color, and intact seal PRIOR to administering the drug
9.4. Multi-dose vials of injectable medications are intended for multiple use on a single patient, not for use on multiple patients. They are multi-DOSE, not multi-PATIENT vials
9.5. Documentation shall include, at a minimum, medication name, dose, route, time of administration, and patient response (including vital signs)

10. Rapid Transportation Decisions

10.1. Responders should not delay the transport of a patient(s) to complete non-critical prehospital care if applicable