SUBJECT: 1000.01
PEDIATRICS:
GENERAL GUIDELINES

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General Guidelines:

- **Patient Consent and Refusal:** A minor's (less than 18 years of age) parent or legal guardian must give consent or refusal of treatment/transport. Although less desirable, consent or refusal may be given by a responsible adult caretaker (over age 18) if the parent has deliberately left the minor in the care of this adult, and the adult is competent and capable. If unsure whether it is appropriate to allow someone to give consent or refuse treatment of a minor, a medical control physician should be consulted.

- Parents should be allowed to stay with children during evaluation and transport, if appropriate. The parent's lap is usually the best place for the examination of a stable patient.

- Follow dosage and equipment recommendations on Broselow tape.

Airway Management:

- Do not hyperextend the neck of newborns and infants.

- Do not use a positive pressure valve on patients less than 6 years of age.

- If epiglottitis is a possibility, **do not** attempt to visualize the throat or pharynx. However, if a patient with an airway obstruction has a respiratory or cardiac arrest, the airway may be visualized with a laryngoscope to rule out a foreign body airway obstruction.

Airway Devices:

- Consider an oropharyngeal airway of appropriate size on all unconscious pediatric patients for initial airway maintenance.

- When attempting endotracheal intubation it should be remembered that the pediatric airway differs from the adult airway in that:

    - The pediatric airway is more anterior.

    - The pediatric airway is smaller than an adult and is more easily obstructed.

    - A child's tongue is large in relation to jaw size, making obstruction more likely.

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Pediatric Oxygen Therapy:

Pediatric oxygen therapy should be administered in accordance with the following guidelines:

- High flow O2. If agitated, use high flow blow-by O2.
- Do not hyperextend the neck in newborns and infants.
- Consider oral airway of appropriate size for all unconscious patients.
- Ventilate using BVM with pediatric mask when ventilation must be assisted.
- Do not use a positive pressure valve on patients less than 6 years of age.
- If epiglottitis is a possibility, do not attempt to visualize the throat or pharynx. However, if a patient with an airway obstruction has a respiratory or cardiac arrest, the airway may be visualized with a laryngoscope to rule out a foreign body.
- Endotracheal intubation as needed.

Pediatric IV Therapy:

Pediatric intravenous therapy should be administered in accordance with the following guidelines:

- For trauma and shock of other etiology, start IV's en route.
- Use minidrip IV infusion sets for non-traumatic emergencies and macrodrip sets for trauma or hypotensive patients.
- If IV access cannot be established at the scene in two attempts for patients with nontraumatic problems, begin transport to the hospital. There should be no delay at the scene for IV attempts on children with trauma or in shock - these IV's should be started during transport.
- Consider intraosseous infusion for use in children under the age of seven years in critical condition when IV access is unobtainable.

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Pediatric Medication Administration via the Endotracheal Tube (ETT):

- Medications that may be administered via the tracheobronchial tree by injection into an endotracheal tube:
    - Narcan
    - Atropine
    - Epinephrine
    - Lidocaine
- This drug administration route should only be used in cardiac arrest whenever an endotracheal tube has been placed, venous access is significantly delayed, or attempts at venous access have failed.
- Drugs may be administered full strength or diluted in 1-2 ml of normal saline.

Pediatric Pain Management: Must call Medical Control

Medical Direction Options:

- Morphine Sulfate x 1 at 0.05 mg/kg - 0.1 mg/kg IV (up to maximum dose of 5 mg).
- Inhaled Nitronox may be used as an alternative if available (adolescents only)

Pre-Hospital Actions:

- Monitor vital signs. If respiratory depression or hypotension occurs after administration of Morphine Sulfate, ventilate patient as necessary and administer Narcan/Naloxone 0.1 mg/kg IV (up to a maximum dose of 2 mg). Narcan/Naloxone may also be administered using the Mucosal Atomization Device (MAD). When using the MAD, half of the age appropriate dose should be sprayed into each nostril. The MAD device may be used as the primary delivery mechanism for Narcan/Naloxone, but additional doses should be given IV.