Northwest Community EMS System
October 2020 CE Credit Questions: Peds SOPs

Name:	Date submitted:
EMS Agency/hospital:	Credit awarded (date):
EMSC/Educator reviewer:	Returned for revisions:
	Revisions received:

This packet earns you the equivalent of the 2 hours of live or Zoom CE class.

Sources: Oct 2020 CE handout; SOPs; CE PPT for Credit Qu posted to website; R-6 Policy.

1. According to slide # 8, what are 3 over-arching difficulties for most persons with autism?

2. According to slide 9, what should EMS consider about the patient with autism who has limited or no expressive ability, with regard to their ability to understand what is said to them?

3. "Stimming" is repetitive movement or verbalizations often demonstrated by persons with autism. This may take the form of hand flapping, finger flicking, blinking, twirling, rocking, pacing, or sounds. If EMS observes these actions, what does this signal?

4. Children with autism may be hypersensitive to stimuli. List 3 common ones.

5. The safety of children with autism is at risk as a result of what 4 tendencies and or affinities?

6. Who is EMS' best source of information and assistance with communication for the child with autism?

7. Describe 2 guidelines for giving instructions or explanations to the child with autism:

8. *When possible*, to increase the likelihood that the child with autism will not become agitated by your actions or interventions, what action should EMS take prior to proceeding?

9. Your pediatric patient with autism, who is safely secured to the cot, is rocking back and forth during transport. What is EMS' best response to this behavior?

10. What guideline should EMS follow if their pediatric patient with autism has a "comfort item"?

11. What 2 actions should EMS do in response to aggressive behavior in a person with autism?

12. Children with autism typically have weak trunk muscles. Respond to the following:

What positioning should be avoided?
What risk does this pose?

13. Read the scenario on slides 22-23. Then answer the following questions:

What approach would best allow you to apply stretcher straps, apply dressings to his cuts or splint his arm?

Should you attempt to get the patient to stop rocking?
OLMC should be contacted as early as possible. Why?

14. What are 3 signs of respiratory distress seen in young children, not typically seen in adults?

15. List **4** respiratory – related indicators that signal EMS to ensuing rapid deterioration of imminent resp arrest.

16. In addition to general appearance and breathing, and anterior fontanelle in infants, what 4 assessments are specific to hydration status in a pediatric – aged patient?

17. Peds GCS: Eye opening and Motor are the same as for adults. Verbal response has been modified for developmental age ranges. Calculate a Peds Glasgow Scale for the following patients:

2 year, 4 months old child			
E	**Eyes are open spontaneously**		**Total score:**
V	**Crying persistently**		
M	**Moves spontaneously / purposefully**		

18. What is a rapid formula to calculate for a child between 1 and 10 yrs of age?

19. A 2 yr 2 mo old child has a forearm fx and has just been casted. Review the FLACC pain scale on the back page of the SOPs. Then calculate a 0-10 pain score for her

Face: Grimace / frown (crying)	

Legs: restless, tense	
Activity: Squirming	
Crying: crying steadily	
Consolability: inconsolable	
FLACC Pain Score rating:	

Read the following scenario. Then answer questions the following questions.

An 18 mo old has been sick for 2 days w/ cough, fever (100.8), and runny nose. Tylenol was given 2 hrs ago (10 pm). Temp is 102. The child's breathing has become increasingly labored over the past 2 hrs. He is pale, and you note retractions, bilat wheezing, and rapid, shallow respirations. The child appears tired and does not seem upset with you touching and assessing him.

20. Determine the most likely cause / impression for this patient. Support your decision with your assessment findings / patient presentation for the following conditions.

Impression	Yes / No	Findings supporting or not supporting this impression
Asthma?		
Allergic reaction?		
Croup?		
Epiglottitis?		
RSV/bronchiolitis?		

21. This patient meets criteria for "critical" level of severity. Describe your interventions for this patient, including how to prepare the neb you will administer.

Read the following scenario and updates and answer the questions that follow.

A 9-yr old boy fell from the foundation wall into the basement of a house under construction approx 15 min ago. It is 55° outside. He is lying supine in rubble. He is unresponsive, makes no spontaneous movement. He does not open his eyes to stimuli. He makes incomprehensible sounds to pressure. He pulled his had away when your partner attempted an IV.

22. What is this patient's GCS? Specify each of the 3 components.

Scenario continued:

The pt is lying supine. He has a 3-4" Rt parietal head laceration oozing dk red, with a 6-inch puddle of same surrounding his head. You note + resp distress w/ snoring and gurgling. There are deformities to both his Rt upper arm and upper leg. 4X4s are secured over the head laceration. **Wt ~ 65# / 30 kg.**

23. What 2 interventions are needed immediately? Describe ***how you would accomplish*** these.

Scenario continued:

You suction 3 broken teeth and a mod amount of dark red blood and saliva. Breathing resumes, now only mildly labored. Breathing is shallow at 24/min. Lung sounds on the right are diminished. You expose his chest to see the Rt mid-lat chest wall moving in opposition to the rest of the chest. Pulse ox is 91%.

24. What injury does this patient have? What intervention is needed immediately for this injury?

Scenario continued:

The head lac continues to soak 4X4s. There is no instability / crepitus / depression in area of laceration. Carotid pulses are weak and rapid. Peripheral pulses are not palpable. Skin is pale and cool.

25. What interventions are indicated now with regards to hemorrhage control?

26. What intervention is indicated with regards to this patient's perfusion (shock)? Include volume, dose etc.

27. What systolic BP signals "hypotension" for this patient?

28. What level of trauma care does this patient require? List at least 2 assessment findings that qualify the patient for the level of care you chose.

Trauma Level:

The following questions relate to the scenario below.

A 17/M was involved in a low speed rear-end collision. There is minor damage to his vehicle and some paint transfer on the other's bumper. He is sitting on the curb, trying to contact his mom. He is calm and cooperative, and denies any discomfort. He allows you to assess him and you find no evidence of injury. He insists he is fine and wants to go get an estimate on a repair immediately.

The patient and EMS are unable to reach the mom (no father) – the boy explains "She had a big case today" and he does not expect her to be "out" until after 4pm.

Consult slide 55 ("*Get the Facts*") and the following excerpt from the R-6 policy to answer the following questions. Document your findings to support each requirement as follows:

V. **PROCEDURE**

A. If a mechanism of illness/injury exists or a request has been made on an individual's behalf for examination and treatment, **each person must be provided** an **appropriate screening exam**, to the extent authorized in an attempt to determine whether an emergency medical condition exists.

1. Before executing a refusal, assess and document the following unless impossible to obtain:
   a. Decisional capacity; mental status; lack of impairment from alcohol, drugs, disease
   b. Vital signs
   c. Past medical history
   d. Physical exam findings: glucose level, pulse oximetry; capnopgraphy number & waveform, ECG if indicated
2. Consider medical causes for their uncooperative behavior. Normal findings on the mental status assessment without evidence of diminished mental capacity from closed head injury, severe pain, hypoxia, hypotension or developmental delays are first steps in assessing capacity.

29. Did the patient allow EMS to do a physical exam? If so, what were the results?

30. Decisional capacity, mental status, presence or absence of impairment:

31. Vital signs, including glucose level, pulse ox, ECG and ETCO2 if indicated

32. Repeated attempts have been made unsuccessfully to contact the patient's mother from the scene. EMS contacts OLMC. Refer to the following the R-6 policy excerpt to answer the following questions.

Board approval: 1/11/18	**Effective:** 3/9/18	**Supersedes:** 2/1/18	**Page:** 6 of 11

4. **Parent/guardian/surrogate NOT on scene:** If the parent or a responsible adult is not present, EMS personnel must attempt to contact them by phone from the scene BEFORE treatment is begun (unless emergency doctrine applies) or the adolescent is released.

   a. **If phone contact is established and treatment appears necessary**, the responsible adult should be informed about the adolescent's condition and verbal consent for treatment solicited from them.

   b. **If phone contact is established and treatment/transportation appears unnecessary,** the adult may give verbal authorization for refusal of service on behalf of the adolescent. This refusal of service must be thoroughly documented on the ePCR and the refusal confirmed with OLMC.

   c. **If unable to establish contact from the scene,** and an adolescent appears to be exhibiting rational behavior with decisional capacity, and based on the EMS assessment there is **no apparent illness or injury**, and EMS believes that no foreseeable harm will come to the adolescent as a result of not receiving immediate care and/or transportation, EMS shall seek OLMC authorization to honor the adolescent's refusal of service and release them to the circumstances in which EMS personnel found him or her, unless releasing the individual would place them at risk of harm.

      (1) EMS must contact an ED OLMC physician at the nearest System Hospital from the scene BEFORE the adolescent is released. Describe the situation and determine a course of action.

      (2) OLMC shall consider allowing the adolescent to be released on their own signature. The circumstances of the call must be thoroughly documented on the patient care report (PCR) and Communications Log, and must be verified by witnesses.

What information must be presented by EMS to OLMC?

33. Who *specifically* must receive the above information, and ultimately decides to allow the refusal?

34. According to the R-6 policy below, what 2 steps (brief answers are sufficient) must be taken upon return to quarters?

(3) EMS shall **attempt to contact the parent/guardian again, as soon as possible after return to the ambulance quarters.**

(4) **Follow up notice**: If no contact can be made with a parent or guardian during that shift, a follow-up letter, on a form created by the NWC EMSS, must be sent to the parent/guardian immediately thereafter, describing the circumstances of the call, the nature of the evaluation, including any other information that the scene personnel deem significant so the parent/guardian is aware of an EMS response for their adolescent. A copy of this letter should be scanned and added as an attachment to the electronic PCR.

Consult the CDC Vital Signs document in the class handout to answer questions 35, 36 and 37.

35. What prior medical history is common in children who develop AFM?

36. What is the most common symptom these patients present with?

37. Should symptoms progress rapidly in a patient with AFM, what medical emergency could EMS expect?

Consult slide 62 and the CDC MISC-C document to answer questions 38, 39 and 40.

38. What recent, prior medical history is commonly found with patients who present with symptoms of MIS-C?

39. List one sign/symptom that is present in nearly 100% of children with MIS-C

40. What life-threatening condition might EMS encounter in children whose illness has progressed to involve multiple organ systems?