

Pediatric SOPs

NWC EMSS Continuing Education October 2020

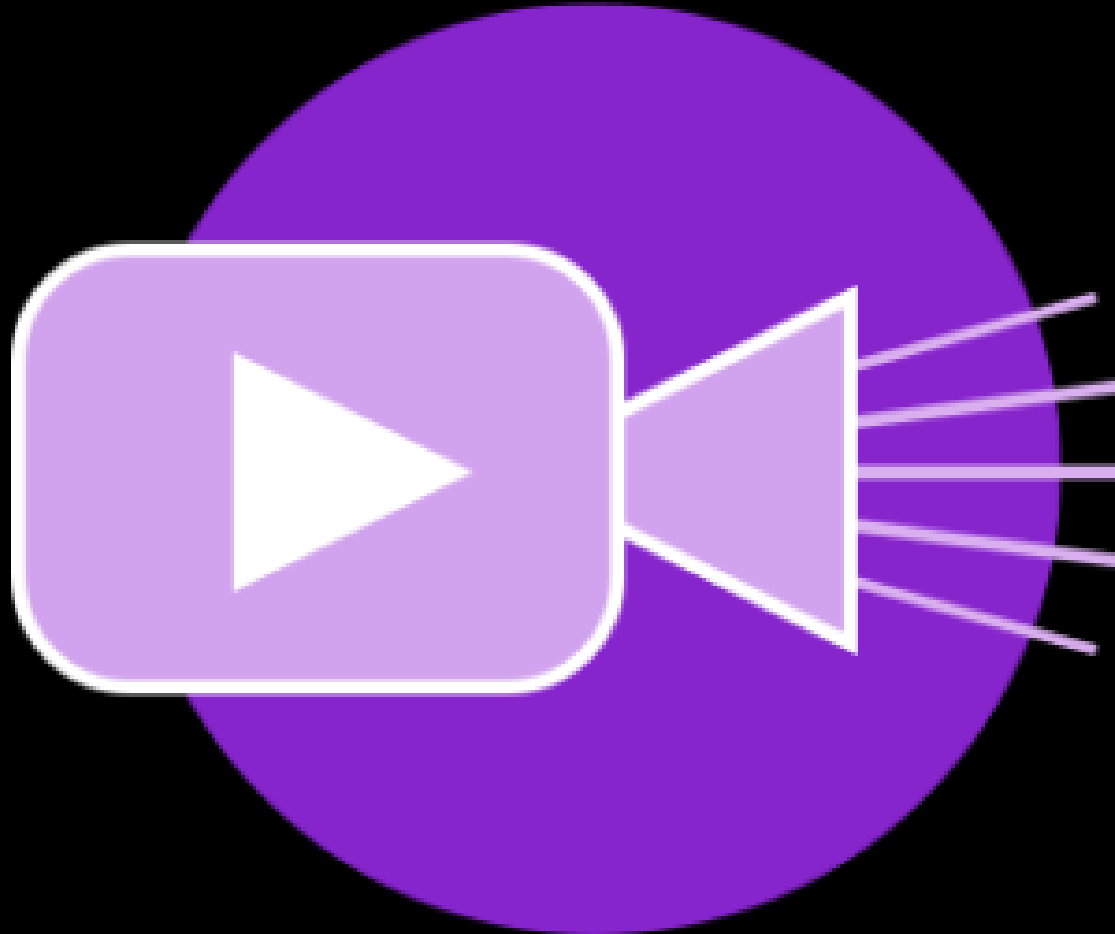


Please direct comments or inquiries to
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NWC EMS System

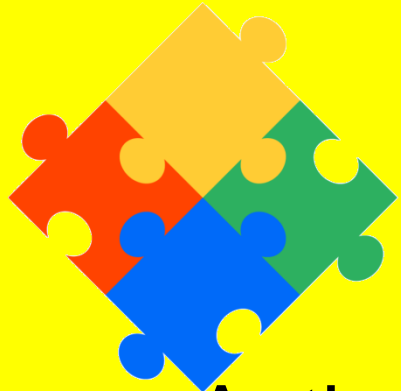
Objectives

1. Autism: common behaviors
2. Adjusted response: autistic patients
3. Pain assessment: pre- and nonverbal peds patients
4. Peds assessment emphasizing unique presentations, recognition of severity level
5. Venous access: site, catheter size, pain management, patient interaction
6. Peds med doses: calculations/cross-check; peds dose tables
7. Consent and refusal in pediatric-aged patients
8. Pediatric qSOFA
9. Review various Peds SOPs via scenarios
10. Acute flaccid myelitis
11. Multisystem inflammatory syndrome

Are you ready for this?



<https://www.youtube.com/watch?v=xCpARhCNsb4&list=PLBEgWw2V5-xM1IIeII00XJLK3zCOSvavO&index=3>



Autism Facts



Autism spectrum disorder (ASD) is the fastest-growing developmental disability, affecting about 1 in 54* children in the United States. On a global scale, approximately 1 percent of the world population has ASD.

ASD 7 x more likely to need svc of EMS than those w/o ASD!



The Take-away

EMS must be prepared to recognize and safely treat persons with ASD.



But how?

The Challenge

People with
ASD cannot be
identified by appearance.
They are identified by their
behavior.



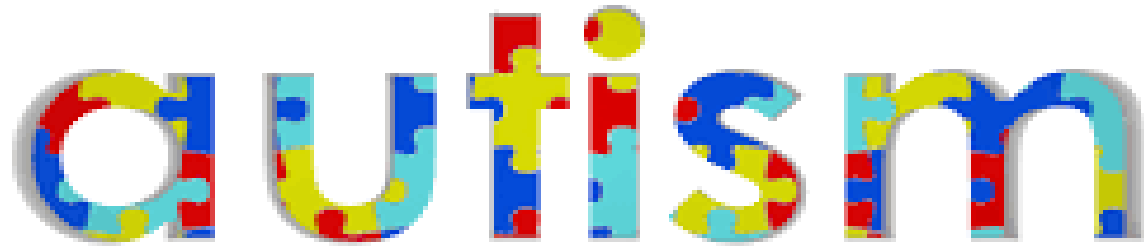
WhatCulture.com

Asperger's Disorder

The character, Sheldon Cooper, from The Big Bang Theory meets criteria in the DSM-IV for **Asperger's Disorder**. By assessing Sheldon's behavior across several episodes, the viewer can reevaluate Sheldon considering the new criteria.

[www.longdom.org › open-access › rethinking-asperger...](http://www.longdom.org/open-access/rethinking-asperger...) PDF

Understanding the DSM-5 Diagnosis by Introducing Sheldon ...



autism

In the autism community,
they have a saying.

If you've met one person with
autism, you've met one
person with autism.

Autism Spectrum Disorder (ASD)

Impaired social interaction

Impaired communication

Restrictive/repetitive interests & activities

One third have intellectual disability *



ASD - Unique and varied

Limited/no expressive ability, but highly intact receptive ability

May communicate visually by writing, typing, pointing/pictures

Those who are verbal may become nonverbal when stressed

Difficulty interpreting facial expression (Wong Baker will be inaccurate!)



ASD - Unique and varied

Responses slow/inappropriate

Literal, concrete thinking

May repeat what you say

May confuse pronouns (“you” instead of “I”)

May appear argumentative, blunt, tactless

Self-centered or controlling

Obsessed w/ an object or topic



ASD - Unique and varied

Repetitive movements (“stims, stimming”) increase when stressed/agitated

May have a “comfort” object (fidget; lpad; toy)

Hypo/hypersensitive to sound, touch, temp, pain. **RISK!!!**

- High pain threshold
- Valid exam?
- Band-aids, BP cuffs. ***Essential or not?***

Pain response-laughter, humming, singing, removing clothing



ASD - Unique and varied

Unaware of social in/appropriateness

Do not make appropriate eye contact

Odd body language

Do not understand symbols (PD; EMS) or know what is expected of them

Do not understand body language, gestures

May not appreciate personal space

May ignore you!



ASD - Unique and varied

Affinity for water → fearless regardless of ability, temp, depth

Affinity for “shiny” things (badge; gun)

Tendency to wander

Tendency to hide – do not seek help

Do not respond verbally when called

Don't understand consequences



ASD – Unique and varied

Home environment may appear abusive or neglectful

Others may misinterpret family interactions

Vulnerable-no sense of “good”/”bad” people

Rarely capable of intentionally harming or committing an illegal activity

Risk of being crime victims, bullied

Exceedingly honest-rarely lie



ASD – Unique and varied

Do not recognize danger

May be overwhelmed by light, noise, odors

“Meltdown” when overwhelmed

- Self-injurious
- Aggressive

Lack sense of appropriateness of behavior

- Look in windows, enter others' homes, cars
- Inappropriate touching
- Removing clothing



CHALLENGE
AHEAD

So how do
you adjust
your response,
while providing
the most
efficient yet
safest care
possible?

Adjust your response



- Find parent or caregiver –
your best source of information!
- Bring caregiver in patient compartment
- Allow them to ask the patient questions
 - Calming for patient
 - Source for best approach
- Expect the unexpected
- Check for medic alert, IDs

Adjust your response

What assessments/care are essential – what can be deferred safely?

Speak clearly, slowly

Use literal, direct language

Explain, demo your actions in advance

Assess starting w/ extremities, work proximally

Minimize stimulation, physical contact

- Lights and sirens
- Stretcher straps

PATIENCE!

**ADJ
UST**

Adjust your response

Firm-pressure touch preferable to light

Indirect touch with a blanket

Wrap in a blanket if need to move quickly

Ignore stimming unless it presents a threat

Do not underestimate strength, determination

Call OLMC ASAP! Need quiet environment!

Keep their “comfort item”!



Aggressive behavior

Increases when stressed, ill, uncomfortable

Not planned, purposeful violent behavior

Try to determine cause

Best response if possible:

- Back away
- State “Stop” in a clear, authoritative voice

Restraint only if imminent danger

Restraint

Will likely increase agitation

Geographic containment preferable

**Weak trunk muscles - AVOID chest
down/face down - risk positional asphyxia**



Scenario: The boy

You are a 6 y/o boy with autism. You were on your way to school, and something happened. You can't move your left arm or leg. There's something sticky running down your left arm and leg. Your mom is in the front, but she's not moving, and she's moaning. A stranger is looking at you thru the window. People are yelling and asking you a lot of questions. Now you hear sirens, and they're getting really loud. You wish they would stop-you are getting anxious. You need to rock, but you can't move. You are glad when you feel your squishy still in your right hand. A stranger has opened the door and grabbed your head, and they won't let you move it.

Scenario: The Paramedic

You are in the process of extricating a young boy from the back seat. He has arm and leg lacerations that is slowly bleeding and you note a deformity to his left upper arm. He is clutching a warm gel ice pack in his right hand. He is screaming and struggles away from you and out onto the road. He does not respond to your instructions to come back, warnings of danger, or explanations of what's happening. Amazingly, he is moving his left arm w/o any hint of discomfort, and covering his ears with his hands.

The Lt. on the engine hurries over and informs you that the boy has autism and is nonverbal.

Adjusting your response

- 1. What method might you use to get this boy out of traffic to safety?**
- 2. What is the optimal size team to care for this patient? Why?**

More of the story

The boy is secured on the stretcher, sitting upright. He does not look at you when you speak to him. He intently squeezes the gel pack over and over. He is gently rocking back and forth and making humming noises. His color and breathing appear normal, and he is alert. He shows no obvious signs of discomfort.

Adjusting your response

1. Should you try to replace the boy's warm gel cold pack with a new, cold one? Why?
2. Would you expect cold applied to the arm deformity to be soothing to this patient?
3. Would light or firm touch likely be better tolerated?
4. Is it essential that you obtain a set of VS?
Why or why not?
5. Should you bandage the cuts on his arm and leg? Why or why not?

Adjusting your response

1. The Wong-Baker faces pain scale is ideal for this age group. Would you expect this patient to rate his pain using this tool?
2. Should you attempt to get patient to stop rocking? Why or why not?
3. If the patient was critical, what would guide your choice whether to use lights/sirens?
4. Benefits to early OLMC contact?

**Thanks to Bram Hornstein, FF/PM for
Palatine FD, retired, for sharing insights from
his journey with son Brenen, who has ASD.**



BHARE

means

Brenen Hornstein Autism
Research Education

by acronymsandfong.com

Pediatric Assessment



Airway

Abnormal sounds?

- Reposition.
- Suction * Limit 5 sec *
- Adjuncts

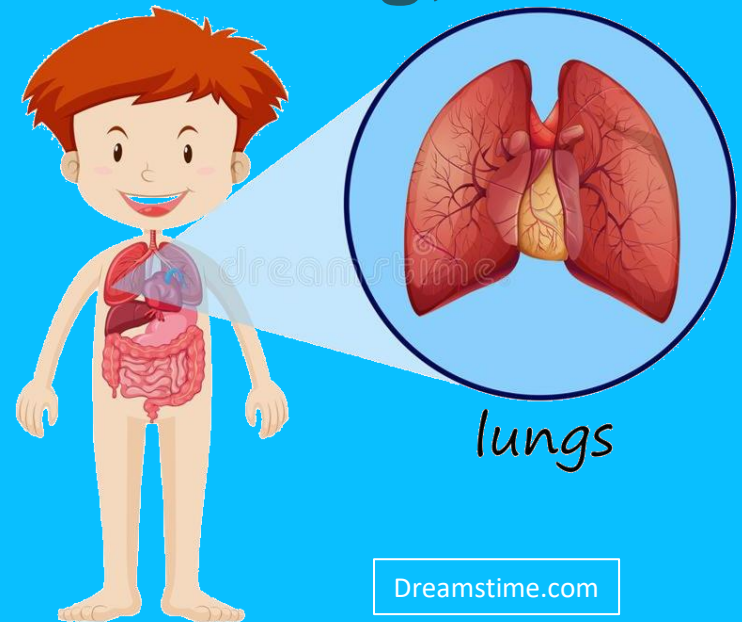
Patent? Obstructed?

Be alert to bradycardia!



Breathing

- WOB
- Gen rate, depth, chest expansion
- Lung sounds / air movement
- Accessory muscles, nasal flaring, head bobbing, exp grunting
- Position
- SpO₂ and ETCO₂



Breathing: Danger signs

- ↑ or ↓ RR – esp if S&S of distress
- Increased effort
- Poor chest excursion
- ↓ peripheral lung sounds
- Gasping, grunting
- ↓ LOC or response to pain
- Poor muscle tone
- Cyanosis



Hypoxia & inadequate ventilation

What if ...

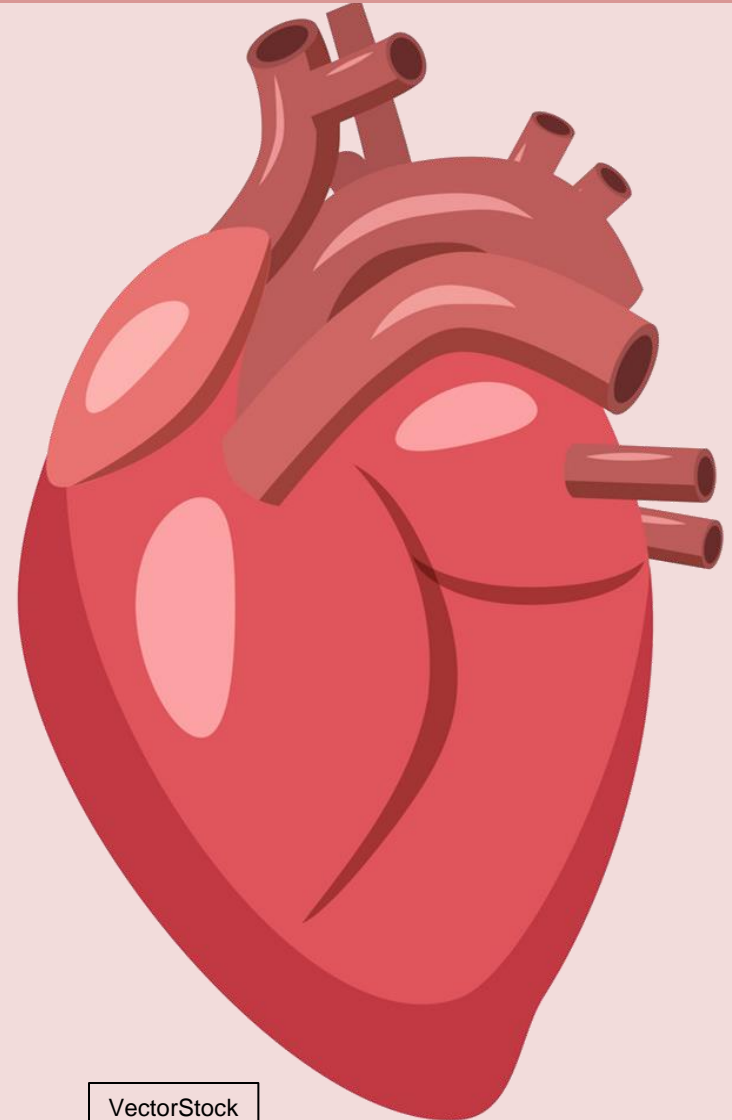


[pngtree.com](https://www.pngtree.com)

- Adeq rate/depth, minimal distress, 92-95%?
- Adeq rate/depth, mod-severe distress, <92%?
- Shallow or apnea, inadeq rate/depth, mod – severe distress?

Circulation/Perfusion/Hydration

- **Pulse**
 - Rate, quality, regularity
 - Central vs peripheral
- **Perfusion**
 - LOC
 - Skin
 - Cap refill ***IF WARM***
- **Hydration**
 - Fontanelles
 - Mucous membranes
 - Turgor
 - Tears; urine output (# diapers)



Vascular access

- Indications?
- Limit time spent if critical
- Elective IV for time-sensitive pt? Enroute!
- IO if unresponsive
- Hypovolemic?
 - NS 20 mL/kg in < 20 min
 - May repeat X 2
 - Monitor lung sounds

Vascular access tips

- Goal: minimize anxiety & pain
- Distraction techniques
 - Neonates/infants: sucking, swaddling, rocking
 - Ages 3-7: iphone, Ipad, toys, movies, books
 - Pre-school & school age: blowing, singing or counting
 - Adolescent: music, phone apps, controlled breathing, coaching, talking
 - Special needs: sensory / touch and feel toys
- Buzzy!

The word "DISTRACTION" is displayed in large, bold, 3D block letters. Each letter is a different color: D (red), I (green), S (orange), T (blue), R (pink), A (green), C (blue), T (red), I (green), O (orange), and N (blue). The letters have a slight shadow, giving them a three-dimensional appearance.

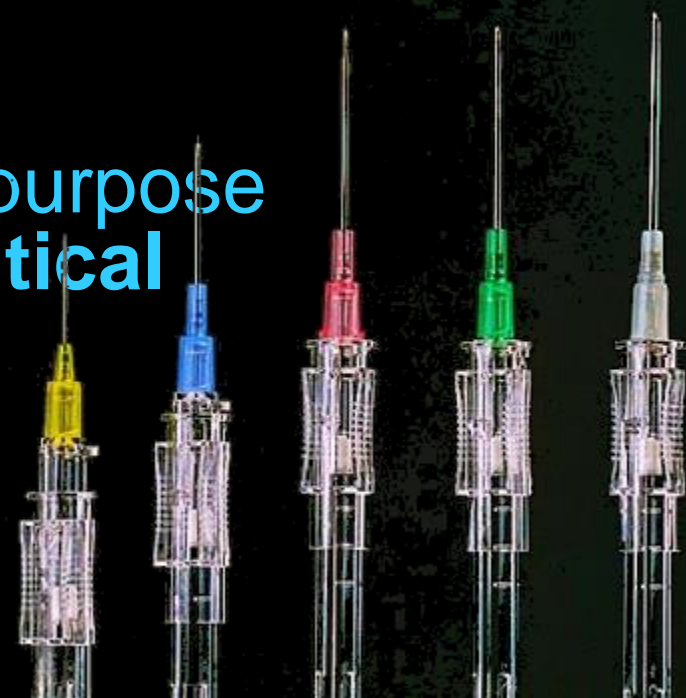
Vascular access tips

- Tourniquet

- Position several inches above site
- Too tight - red or purplish skin.
- Distend veins but still feel a pulse
- Tie over a sleeve or gauze

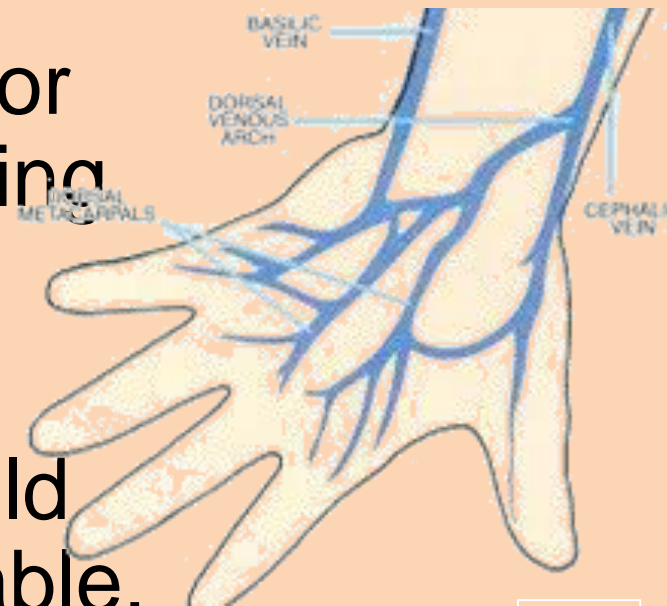
- Catheter size

- Smallest size to serve the purpose
UNLESS unstable and critical
- Neonates - 24 or 26
- Infants – 22 g
- Children – 20g



Choosing a site

- Dorsal venous plexus (hand) preferred.
- Forearm / upper arm may be difficult in infants and toddlers
- Avoid child's dominant hand or hand favored for thumb sucking
- Arm sites allow larger catheters, hand mobility
- Antecubital suitable but should not be 1st choice: uncomfortable, requires immobilizing, renders unavailable for phlebotomy



Disability

- LOC (Peds GCS)
- Pupils
- Gross motor – moving all extremities?
- Glucose if AMS, arrest

PEDIATRIC GLASGOW COMA SCORE

Eye Opening		Best Verbal Response				Best Motor Response	
Spontaneously	4	> 5 years	5	2-5 years	5	< 2 years	6
		Oriented/ converses		Oriented, appropriate words/phrases		Coos, <u>babbles</u> Appropriate words	
		Disoriented/ Converses		Confused		Irritable; cries but consolable	
		Inappropriate words		Inappropriate words/ Persistent cry		Cries to pressure, inconsolable	
To speech	3	Incomp. sounds	2	Incomprehensive snds	2	Moans/grunts to pain	2
		None		None		None	
To pressure	2		1		1		1
None	1						

Peds GCS

Eye Opening and Motor same as for adult GCS
Verbal adapted for developmental age

PEDIATRIC GLASGOW COMA SCORE							
Eye Opening		Best Verbal Response				Best Motor Response	
Spontaneously 4	4	<u>> 5 years</u> Oriented/ converses	5	<u>2-5 years</u> Oriented, appropriate words/phrases	5	<u>< 2 years</u> Coos, <u>babbles</u> Appropriate words	5
		Disoriented/ Converses	4	Confused	4	Irritable; cries but consolable	4
		Inappropriate words	3	Inappropriate words/ Persistent cry	3	Cries to pressure, inconsolable	3
		Incomp. sounds	2	Incomprehensive snds	2	Moans/grunts to pain	2
None 1	1	None	1	None	1	None	1
						Abnormal flexion	3
						Abnormal extension	2
						None	1

Peds GCS

	9 mo	2 yr	6 yr
E	pressure / touch	spontaneous	pressure
V	irritable; cries, consolable	crying persistently	incomprehensible sounds
M	withdraws to touch	moves spontaneously	Localizes/withdraws

Calculate Peds GCS for each of these

Peds Vital Signs

Age	Normal Systolic BP Ages 1-10 $90 + (2 \times \text{age in yrs})$	Diastolic BP	Hypotension	Heart rate	Resp rate
Premature; neonate	55-75	35-45	<60	110-170	40-70
0-3 month	65-85	45-55	<70	110-160	35-55
Infant 4-6 mos	70-90	50-65		110-160	30-45
Infant 7-12 mos	80-100	55-65		90-160	22-38
1-3 years	90-105	55-70	1-10 years: $<70 + (2 \times \text{age in yrs})$	80-150	22-30
4-6 years	95-110	60-75		70-120	22-34
7-12 yr	100-120	60-75		60-110	16-22
>12	110-130	65-80	<90	60-100	12-20

**Great reference for the question
“Is my patient hypotensive?”**

Pre- or Non-verbal pain assessment

FLACC Pain Scale - Children 2 mos to 7 yrs or unable to communicate their pain. Scored range: 0–10 (0 represents no pain) Each criteria scored at 0, 1 or 2.				Score
Category	0	1	2	
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw	
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up	
Activity	Lying quietly, moves easily	Squirming, shifting back & forth, tense	Ached, rigid, or jerking	
Cry	No cry (awake or asleep)	Moans or whispers, occasional complaint	Crying steadily, screams or sobs, frequent complaints	
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort	
TOTAL				

Score 0-10 by evaluator
Each category scored 0 – 1 – 2
2 mo – 7 yrs or non-verbal

FLACC pain assessment

Face

13 kg 2 year old

Legs (tense)

Activity (tense? rigid?)

Cry

Consolability (not)



FLACC pain assessment

Face

18 kg 4 y/o

Legs (drawn up)

Activity (tense)

Cry (whispers)

Consolability

(reassured; distractible)



Your first sick kid

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.

What are your thoughts?

Asthma?

Allergic reaction?

Foreign body aspiration?

Croup / Epiglottitis / RSV / Bronchiolitis?



Provide rationale for your answers.

How will you treat this patient?

CROUP / EPIGLOTTITIS / RSV / Bronchiolitis

1. IMC special considerations:

- **Asses level of consciousness:** alert, tired, restless to lethargic, unresponsive
- **Assess air entry** (normal, mild delay, diminished); **lung sounds** (clear, wheezes, crackles, diminished)
- **Signs of distress:** (grunting, nasal flaring, retracting, stridor); weak cry or inability to speak full sentences
- **Color** (pallor, cyanosis, normal)
- **Hydration status** (+/- sunken eyes, delayed cap refill, moisture of mucus membranes, fontanelles)
- **If airway/ventilatory distress:** Prepare airway/suction equipment; O₂ 15 L/peds NRM; assess tolerance to O₂ administration; if inadequate ventilations: O₂ per Peds BVM
Do NOT attempt NPA/OPA, intubation, glottic visualization, or vascular access unless CR collapse.
- **Avoid agitation.** Hold upright in position of comfort until transport. Transport in sitting position if possible.
- **Monitor SpO₂** for hypoxia and **ETCO₂** for ventilatory, perfusion, & metabolic deficits *if sensors available*
- **Monitor ECG** for changes in heart rate. Bradycardia signals deterioration.

When at ***critical level***, pts are treated w/ nebulized Epi 0.5 mg w/ 6L O₂ by HHN/mask/BVM.

How do you prepare that?

5 mL of 1 mg/10 mL

Next challenging patient

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 the arm away in which his IV was started.

What is his GCS?



Assessment

Gen impression:

Supine; 3-4" Rt parietal head lac; oozing dk red; 6-inch puddle of same; + resp distress w/ snoring; deformities to Rt upper arm, leg. **Wt ~ 65#**

? Any life threats or actions needed ?

Airway:

Blood & 3 teeth in oropharynx; gurgling.

? Any actions needed ?



Assessment

Breathing

Breathing resumes; mildly labored, shallow.

RR 24. Lung sounds on Rt diminished.

Rt mid-lat chest wall moves in opposition to rest. RA SpO₂ 91%. ETCO₂ 45.

? Actions needed now ?



Assessment

Circulation

Head lac continues to soak 4X4s. (No instability in area of lac.) Carotids weak, rapid; peripheral pulses – unable. Skin pale, cool.

? Actions needed now ?

Provide rationale for your actions.

Would you assess cap refill on this pt?



Assessment

Disability

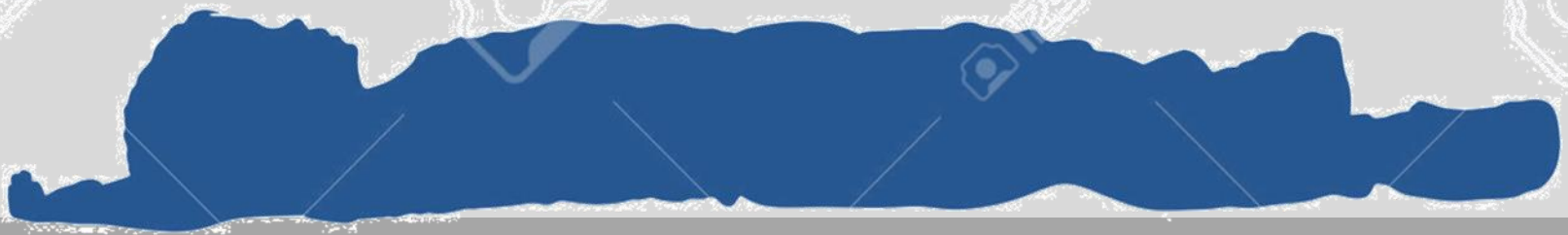
**GCS 7. Pupils 7 mm, equal, react.
Glucose 104.**

? Actions needed now ?

? Transport decision ?

What assessments did you not get yet?

Provide rationale for your actions.



The boy who wouldn't go

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 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.





Indivisible Lambertville/New Hope

Seat-belted; airbag did not deploy

Damage limited to front bumper

Patient calm, cooperative, A&O X 4, meets decisional capacity requirements; no impairment

No injuries found; no complaints.

VS, glucose, SpO2 all WNL

Adolescent age 17

Wants to refuse; parent cannot be contacted @ scene

Refusal of Service.

Policy R-6

Policy Title: REFUSAL OF SERVICE (Elements of granting & withholding consent)			No. R - 6
Board approval: 1/11/18	Effective: 3/9/18	Supersedes: 2/1/18	Page: 4 of 11

C. Refusal contraindications - Instances when EMS personnel should not accept a refusal from an adult, adolescent, or a surrogate:

1. Patient is homicidal, suicidal, meets one of the criteria above under persons with mental illness, has altered mental status (AMS), drug altering behavior, or is hypoglycemic, hypotensive, or hypoxic.
2. Adolescents may not refuse an assessment to determine if they are ill or injured or care if they are ill or injured.
3. Refusal of care for a minor, adolescent, or non-decisional adult by a parent, guardian, agent, or surrogate is not *necessarily* valid. The welfare of the patient is the EMS System's primary consideration. If EMS personnel believe that the patient's health and welfare could be compromised by the refusal, they must contact OLMC before accepting and executing a refusal of service. Each case must be evaluated on its own merits to determine a proper course of action.

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; capnography 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.
3. EMS personnel have a duty to attempt to convince a patient to receive needed assessment, care, and/or transportation.

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.
 - (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.



What do you do?

Policy R-6, p. 6

What steps must you take now?

- ▶ Contact OLMC **PHYSICIAN** – explain the situation incl your findings
- ▶ Attempt to contact parent again
- ▶ Execute refusal
- ▶ Document circumstances thoroughly
- ▶ Confirm witness signatures on release
- ▶ Attempt parent contact upon return to quarters
- ▶ If no contact made, send follow-up letter
- ▶ Scan copy of letter as attachment to PCR

Acute Flaccid Myelitis: Awareness

Uncommon but life-threatening

Mostly children (avg 4-5 yrs)

Cyclic peaks every 2 yrs (last 2018)

Most between August and November

Enterovirus likely cause

Fever or URI ~ 6 wks prior

Onset is usually sudden!

Acute Flaccid Myelitis: Awareness

Most severe symptom: resp failure

May require ventilatory assistance

Stats:

98% hospitalized

54% required ICU

23% required mechanical ventilation

Look out for AFM signs and symptoms

Onset usually
sudden

Limb weakness and paralysis

The most common symptom of AFM



Some people may experience



Recent or current
respiratory illness



Fever



Pain or numbness
in the limb(s)



Gait
difficulty



Headache



Back or
neck pain



Difficulty talking
or swallowing



Neck or facial
weakness

MIS-C

2-4 wks after COVID

Common S&S:

Fever (100%)

Abdominal pain

Diarrhea, Vomiting
Rash

*** Shock

Over half require ICU

Majority in ICU require
mechanical ventilation

Reporting Multisystem Inflammatory Syndrome in Children (MIS-C)

Accessible version: <https://www.cdc.gov/mis-c/hcp/index.html>

Clinical Presentation

Patients with MIS-C have presented with a persistent fever, fatigue, and a variety of signs and symptoms, including multiorgan (e.g., cardiac, gastrointestinal, renal, hematologic, dermatologic, neurologic) involvement and elevated inflammatory markers. Not all children will have the same signs and symptoms, and some children may have symptoms not listed here.

MIS-C may present weeks after a child is infected with SARS-CoV-2. The child may have been infected from an asymptomatic contact and, in some cases, the child and their caregivers may not even know they had been infected.

Case Definition

- An individual aged <21 years presenting with fever*, laboratory evidence of inflammation**, and evidence of clinically severe illness requiring hospitalization, with multisystem (>2) organ involvement (cardiac, renal, respiratory, hematologic, gastrointestinal, dermatologic or neurological); AND
- No alternative plausible diagnoses; AND
- Positive for current or recent SARS-CoV-2 infection by RT-PCR, serology, or antigen test; or exposure to a suspected or confirmed COVID-19 case within the 4 weeks prior to the onset of symptoms

*Fever >38.0°C for ≥24 hours, or report of subjective fever lasting ≥24 hours

Report possible cases of MIS-C to your local, state, or territorial health department.

Visit cdc.gov/mis-c/hcp for more information and a case report form.

Questions? Contact CDC's 24-hour Emergency Operations Center at 770-488-7100.

**Including, but not limited to, one or more of the following: an elevated C-reactive protein (CRP), erythrocyte sedimentation rate (ESR), fibrinogen, procalcitonin, d-dimer, ferritin, lactic acid dehydrogenase (LDH), or interleukin 6 (IL-6), elevated neutrophils, reduced lymphocytes and low albumin

Additional comments:

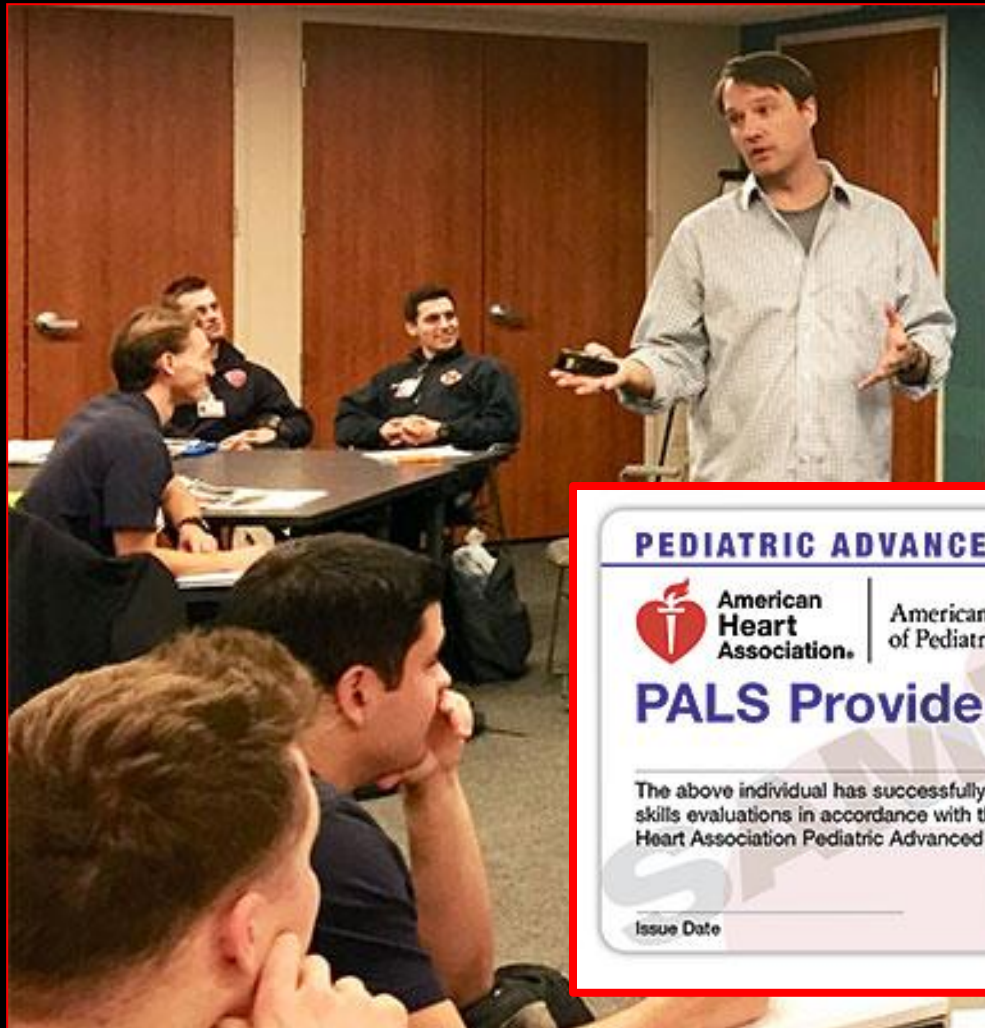
- Some individuals may fulfill full or partial criteria for Kawasaki disease but should be reported if they meet the case definition for MIS-C.
- Consider MIS-C in any pediatric death with evidence of SARS-CoV-2 infection.

Visit [Information for Healthcare Providers about Multisystem Inflammatory Syndrome in Children \(MIS-C\)](https://cdc.gov/mis-c/hcp) for more information about MIS-C.



cdc.gov/coronavirus

Competence breeds confidence



2019	Region IX STANDARD OPERATING PROCEDURES/ STANDING MEDICAL ORDERS	2019
NORTHWEST COMMUNITY EMS SYSTEM EDITION		

Healthcare delivery requires structure (people, equipment, education) and process (policies, protocols, procedures) that, when integrated, produce a system (programs, organizations, cultures) that leads to optimal outcomes (patient survival and safety, quality, satisfaction). An effective system of care comprises all of these elements -structure, process, system, and patient outcomes -in a framework of continuous quality improvement (AHA, 2015).

These protocols have been developed and approved through a collaborative process involving the Advocate Lutheran General; Greater Elgin Area, McHenry Western Lake County, Northwest Community, Saint Joseph, and Southern Fox Valley EMS Systems to reduce variation in practice and establish a Region-wide System of care.

They shall be used:

- as the written practice guidelines/pathways of care approved by the EMS Medical Directors (EMS MDs) to be initiated by System EMS personnel for off-line medical control.

be used by Emergency Communications Registered on-line medical control (OLMC).

patient incidents, given that the usual and customary indicated as specified in the Region IX disaster plan.

to implement these orders to their scope of practice, be established without endangering the patient.

any prehospital care be delayed while attempting to

not be established, EMS personnel shall continue to be provided by their license, these protocols, drugs/equipment granted by the EMS MD.

ble. In all circumstances, on line physicians have the privilege if it is believed that deviation is in the best interest of the patient in no way detract from the high level of patient care

by these standing orders, initiate Initial Medical or Initial hospital with OLMC privileges for the NWC EMSS as soon as

W. T. Jordan M.D.

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Northwest Community EMSS

PEDIATRIC ADVANCED LIFE SUPPORT



American
Heart
Association.

American Academy
of Pediatrics



PALS Provider

The above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Pediatric Advanced Life Support (PALS) Program.

Issue Date

Recommended Renewal Date



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