

chest rise. Place a supraglottic airway as soon as possible and follow the airway management guidelines (8.02 A.1.d.)

7. Any and all pulse checks should take no more than 10 seconds, and if a pulse is not definitely felt within 10 seconds, chest compressions should be restarted.
8. If there is a pulse, continue with rescue breaths at a rate of 15-20 per minute with frequent checks to ensure pulse remains.
9. Once an advanced airway is placed (ET Tube or Supraglottic Airway), convert to continuous chest compressions at a rate of 100/minute without pauses for ventilations. Ventilations should be provided at a rate of 15-20 per minute (every 3-4 seconds) on the upstroke of a chest compression.

D. Adolescent (8 years of age to <16 years) / Adult CPR (16 years of age or greater)

1. Assess unresponsiveness – shout loudly and attempt to stimulate patient. If unresponsive, make certain the appropriate resources are responding.
2. Position the patient face-up on a flat, firm surface and open the airway using a gentle head tilt-chin maneuver. If trauma is suspected, use the jaw thrust maneuver.
3. Assess breathing - is there no breathing visible or no normal breathing (only gasping)?
4. If the patient is unresponsive with no breathing or no normal breathing (only gasping), immediately begin CPR with chest compressions first.
5. Begin chest compressions.
  - a. Compress in the center of the chest midline at the nipple line with the heel of one hand and the other hand on top.
  - b. Compress the sternum at least 2 inches deep for each compression.
  - c. Provide 30 chest compressions (at a rate of 100 per minute) to 2 ventilations.
  - d. “Push hard, push fast.” Allow complete recoil of the chest wall between compressions and minimize interruptions of chest compressions.
6. To ventilate, maintain a patent airway and deliver 2 breaths with an adult BVM. Maintain a seal using the appropriate sized facemask around the patient’s nose and mouth. Deliver each rescue breath over 1 second and give a sufficient volume to just produce visible chest rise. Place a supraglottic airway as soon as possible and follow the airway management guidelines (8.02 A.1.d.)
7. Any and all pulse checks should take no more than 10 seconds, and if a pulse is not definitely felt within 10 seconds, chest compressions should be restarted.
8. If there is a pulse, continue with rescue breaths at a rate of 8-10 per minute with frequent checks to ensure the pulse remains.
9. Once an advanced airway is placed (ET Tube or Supraglottic Airway), convert to continuous chest compressions at a rate of 100/minute without pauses for ventilations. Ventilations should be provided at a rate of 8-10 per minute (every 6-8 seconds) on the upstroke of a chest compression.

7.06 Hemorrhage Control [BLS/ALS]

A. Direct Wound Care

1. Use proper body substance isolation precautions.
2. Remove any sharp, loose fragment of glass or other foreign substance which, if pressed upon, could result in further injury to the patient or rescuer.
3. Impaled objects should not be removed, but should be stabilized in place to prevent further movement or deeper insertion.
4. Cover the bleeding site with several gauze dressings so that their edges extend at least slightly beyond the edges of the wound.

5. While firmly holding the limb/body with one hand so that it will not move, apply firm pressure directly over the wound with the palm of the other hand. To be most effective, pressure should be directed so that the injured vessels lie between where the pressure is applied and an underlying bone.
6. Elevate the limb such that the wound is above the level of the heart.
7. For wounds over the thorax, cover the wound with a chest seal or 3-sided semi-occlusive dressing.

#### B. Tourniquet Use

1. Use of a tourniquet should be considered in the setting of life threatening exsanguination from an extremity when direct pressure and elevation have failed to quickly control the bleeding.
2. Use a commercially produced tourniquet or a blood pressure cuff as the tourniquet if a standard one is not available. The tourniquet should be placed proximal to the wound “high and tight”, leaving at least two inches of uninjured skin between the tourniquet and the wound. For upper extremity injuries, preferred placement is around the upper humerus. For lower extremity, the preferred placement is around the upper femur. Do not place over the knee or elbow.
3. If one tourniquet does not stop the bleeding sufficiently, place a second tourniquet proximal to the first tourniquet.
4. If using a blood pressure cuff, inflate the cuff sufficiently to stop the hemorrhage. Wrap 2 strips of one-inch tape all the way around the cuff to secure the cuff.
5. Mark the time the tourniquet was applied on a piece of tape, placed on the patient. Use ‘TK’ to indicate the significance of the time. Example: TK 1330 hrs.

#### C. Wound Packing

1. Wound packing should be considered in the setting of junctional hemorrhage in which direct pressure has failed to control the bleeding and tourniquet application is not possible due to wound location. Wound packing shall only be performed in junctional hemorrhage (wounds to the groin, axilla, or neck) and SHALL NOT be performed in wounds to the chest or abdomen.
2. Removing clothing from around the wound and clear away excess blood while preserving any clots already formed in the wound. Locate the source of the most active bleeding.
3. Using either roller gauze or hemostatic gauze (if available), pack the wound tightly with gauze, focusing on the area of the most active bleeding. More than one roll of gauze may be required to fill the wound cavity and stop the bleeding.
4. Apply direct pressure to the packed wound, focusing on the area of the most active bleeding. Hold pressure for a minimum of three (3) minutes.
5. After three minutes, reassess the wound for hemostasis. **DO NOT REMOVE THE PACKING FROM THE WOUND!** If bleeding continues, continue to apply direct pressure and rapidly transport the patient to the appropriate facility.
6. If the bleeding appears to be controlled on reassessment, secure the packing with a pressure dressing and initiate rapid transport to the appropriate facility. Reassess the wound frequently for continued bleeding. If more bleeding is observed, reapply direct pressure.

### 7.07 Extremity Splinting Skills [BLS/ALS]

#### A. Repositioning Injured Extremities

1. Injured extremities with apparent fractures should be repositioned only if there is loss of signs of circulation, loss of sensation distal to the deformity, or if it is necessary in order to otherwise care for and transport the patient.