

BLS

- Ensure patent airway, protecting C-spine
- Control obvious bleeding
- Spinal stabilization prn. (Except in penetrating trauma without neurological deficits.)
- O₂ Saturation prn
- O₂ and/or ventilate prn
- Keep warm
- Hemostatic gauze

Abdominal Trauma:

- Cover eviscerated bowel with saline pads

Chest Trauma:

- Cover open chest wound with three-sided occlusive dressing; release dressing if ?tension pneumothorax develops.
- Use of Chest seal

Extremity Trauma:

- Splint neurologically stable fractures as they lie. Use traction splint as indicated.
- Grossly angulated long bone fractures with neurovascular compromise may be reduced with gentle unidirectional traction for splinting per BHO
- Apply tourniquet in severely injured extremity when direct pressure or pressure dressing fails to control life-threatening hemorrhage.
- In Mass Casualty direct pressure not required prior to tourniquet application

Impaled Objects:

- Immobilize & leave impaled objects in place. Remove BHPO
- **Exception:** may remove impaled object in face/cheek or from neck if there is total airway obstruction.

Neurological Trauma (head and spine injuries):

- Ensure adequate oxygenation without hyperventilating patient. Goal: 6-8 ventilations/minute

Pregnancy of greater than or equal to 6 months:

- Where spinal stabilization precaution is indicated, tilt on spine board 30 degrees.

Blunt Traumatic Arrest: Consider pronouncement at scene
BHPO

ALS

- Monitor EKG
- IV/IO SO
- If MTV IV/IO en route SO
- 500ml fluid bolus IV/IO to maintain BP at 80
- Capnography SO prn

- Treat pain as per Pain Management Protocol (S-141)

Crush injury with extended compression > 2 hours of extremity or torso:

Just prior to extremity being released:

- 500ml fluid bolus IV/IO, then TKO SO
- CaCl₂ 500mg IV/IO over 30 seconds BHO
- NaHCO₃ 1mEq/kg IV/IO BHO

Grossly angulated long bone fractures

- Reduce with gentle unidirectional traction for splinting SO

Severe Respiratory Distress with unilateral diminished breath sounds and systolic BP < 90

- Needle thoracostomy SO

Blunt Traumatic Arrest:

- Consider pronouncement at scene*

Penetrating Traumatic Arrest:

- Rapid transport off scene

*Reference Policy S-402 Prehospital Determination of Death



SUBJECT: TREATMENT PROTOCOL -- TRAUMA

Date: 7/1/2015

TRANSPORT GUIDELINES:

Routine Disposition-Pediatric patients who meet criteria outlined in T-460 "Identification of the Pediatric Trauma Center Candidate" should be delivered to the Designated Pediatric Trauma Center, EXCEPT in the following situations:

1. Adult + Child:

- a. If there is a single ambulance (air/ground) with both a pediatric trauma center candidate AND an adult trauma center candidate, the ambulance should first deliver the more critical patient to the appropriate facility. If both patients are critical, or if there are other questions, both may be delivered to the designated adult trauma center.
 - b. Field personnel should consider splitting the team using additional ALS transport vehicles, or aeromedical resources to transport the pediatric patient to pediatric trauma facility and the adult to the catchment area trauma facility.
- 2. Bypass/Diversion:** If the designated pediatric trauma center is "on bypass", pediatric trauma candidates should be delivered to UCSD.
- 3.** A <15 year old pregnant patient should be delivered to the UCSD.

Document revised 7/1/2015

Approved:



EMS Medical Director