



BLS

ALS

- Ensure patent airway
- Protect C-spine
- Control obvious bleeding
- Spinal motion restriction per Skills List (S-104) except in penetrating trauma without neurological deficits
- O₂ saturation. Maintain SpO₂ at 94% to 98%
- O₂ and/or ventilate at a rate of 10/min 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.
- Chest seal PRN

Extremity trauma

- Splint neurologically stable fractures in position as presented. Traction splint PRN.
- Reduce grossly angulated long bone fractures with no pulse or sensation PRN BHO
- Direct pressure to control external hemorrhage
- Apply gauze or hemostatic dressing PRN
- Tourniquet PRN
- In MCI, direct pressure not required prior to tourniquet application

Impaled objects

- Immobilize and leave impaled objects in place
- Remove object impaled in face, cheek, or neck if there is total airway obstruction SO

Any suspicion of neurological injury (mechanism, GCS, examination)

- High-flow O₂ PRN
- Monitor SpO₂, BP, and HR q3-5 min
- If SpO₂ <90% **or** hypoventilation (despite high-flow O₂), assist ventilations with BVM

- Monitor/EKG
- IV/IO SO
- Capnography SO. Maintain EtCO₂ 35-45 mmH₂O SO PRN.
- Treat pain per Pain Management Protocol (S-141)

SBP <80 mmHg or signs of shock

- 500 mL fluid bolus IV/IO SO, MR x3 q15 min to maintain SBP ≥80 mmHg

Crush injury with compression of extremity or torso ≥2 hours

Just prior to extremity being released

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

Grossly angulated long bone fractures

- Reduce with gentle unidirectional traction for splinting SO

Severe respiratory distress with diminished or absent breath sounds (unilaterally or bilaterally), and SBP <90 mmHg, and suspected pneumothorax

- Needle thoracostomy SO

**San Diego County Emergency Medical Services Office
Policy / Procedure / Protocol**

<p>Pregnancy ≥6 months</p> <ul style="list-style-type: none">• Where spinal motion restriction indicated, tilt patient to the left 30° <p>Blunt traumatic arrest</p> <ul style="list-style-type: none">• Consider request for pronouncement at scene BHPO per Prehospital Determination of Death Protocol (S-402) <p>Penetrating traumatic arrest</p> <ul style="list-style-type: none">• Rapid transport• Consider pronouncement at scene BHPO	
---	--

Transportation and Destination Guidelines

Pediatric patients who meet criteria outlined in T-460 (Identification of the Pediatric Trauma Center Patient) should be transported to the Designated Pediatric Trauma Center, **except** in the following situations.

1. Adult with child

- a. If there is a single ambulance (air/ground) with both a pediatric trauma center patient **and** an adult trauma center patient, the ambulance should first transport the more critical patient to the appropriate facility. If both patients are critical, or if there are other questions, both may be transported 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 the pediatric trauma facility and the adult patient to the catchment area trauma facility.

2. Trauma center diversion

The pediatric patient who is identified as a trauma patient shall be transported to the designated pediatric trauma center. When the pediatric trauma center is on diversion, including age-specific diversion, the pediatric patient shall be transported to the county-designated backup pediatric trauma center, the University of California, San Diego (UCSD).

3. Pregnant pediatric patient

A pediatric pregnant trauma patient shall be transported to UCSD.