

SECTION: T-1

PROTOCOL TITLE: GENERAL TRAUMA CARE

REVISED: April 01, 2023

GENERAL COMMENTS: When possible, this protocol should supplement other, more specific protocols based on clinical assessments and judgment.

BLS SPECIFIC CARE:

- Basic BLS care and assessments and v/s every 5 minutes
- Follow *Appendix 17: Selective Spinal Immobilization* protocol in regard to spinal care.
- Follow *Hospital Destination Protocol (G-3)*
- Oxygen administration titrated for SpO₂ < 92%, with a goal 92-96%, or for those patients who are at risk for decompensation.
- Maintain patent airway as necessary and assist ventilations as needed
- Open injuries to the neck, chest, upper abdomen or deep vascular structures should be covered with an occlusive dressing when possible . Apply occlusive dressings to sucking chest wounds
 - Seal on either 3 or 4 sides is acceptable.
- Coordinate resources to insure prompt arrival of ALS care to the patient. Update responding ALS and receiving hospital as needed
- Pregnant trauma patients: Transport in left lateral recumbent, or tilt backboard as needed
- Control bleeding aggressively, including the use of pressure dressings, wound packing, and tourniquets as needed
- Stabilize impaled objects and leave in place unless compromising the airway
- Assess blood glucose level as indicated
- Splint extremity injuries as needed
 - Traction (Sager) splint as needed for suspected fractures to the mid-shaft of femur
 - Splints, sling and swath, etc., where applicable, for other long-bone fractures and joint dislocations
 - Assess neuromuscular function **before and after** splinting
- Provide pelvic stabilization and splinting as needed for suspected pelvic fractures.
- Conserve body heat /Prevent hypothermia

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AEMT/O.M. Specific Care:

Vascular Access

- IV access (to a max of 3 attempts) or IO access if needed due to severity of underlying injury or illness, otherwise consider deferring until arrival of ALS providers
 - IV: Crystalloid solution at a TKO rate. May administer 200-500 ml if S/S of dehydration are present, repeat as needed to a maximum of 2 liters
 - Withhold fluids and maintain IV at TKO rate if patient is hemo-dynamically stable or signs and symptoms of fluid overload are present
 - 2-3 Large bore lines are indicated with major trauma patient's

Respiratory Support (if appropriate and available)

- Consider Assisted/Intermittent Positive Pressure Ventilation
- Consider Placement of SGA

ALS SPECIFIC CARE:

Airway Management: Secure the airway using means best determined by good clinical decision making.

- See "Appendix 2: Advanced Airway Support Supplement" for guidelines for current and anticipated clinical needs

Suspected Tension Pneumothorax

- Needle chest decompression

Ocular Trauma

- Tetracaine 1-3 gtts (hold for penetrating or open globe injury)

Severe Blood Loss for non-compressible/refractory bleeding with SBP \leq 90 mm Hg (or age specific blood pressure for pediatrics) and/or HR \geq 110/min, and/or suspected blood loss \geq 500 cc.

- Tranexamic Acid (TXA) if within 3 hours of injury:
- Adults:
 - IV/IO: 2 gram/250 cc over 10 minutes. Does not need a pump
- Pediatrics
 - IV/IO: 15 mg/kg in 250 cc over 10 minutes. Does not need a pump. 1 GM max.

Post Tonsillectomy Hemorrhage

- Adults:
 - NEB: 500 mg Nebulized. Repeat once PRN
- Pediatrics
 - NEB: 10 mg/kg Nebulized

PHYSICIAN PEARLS:

Early Notification: Early notification of the receiving hospital is *essential* in priority trauma patients.

Basics of Trauma Care: While not specifically mentioned above, aggressive management of the airway, respiratory functions, and prevention of shock/ hypothermia are cornerstones of solid trauma care.

In addition, rapid transport, good scene management with minimized scene times (ideally < 10 minutes), and coordination with receiving trauma center are also important.

Trauma destination: See *G-03 Hospital Destination Protocol and Appendix 16: Trauma Priority Criteria*

Hypothermia: Heat loss and hypothermia is one of the most often neglected parts of prehospital trauma care. Prevent accordingly.

Post Tonsillectomy Hemorrhage: Hemorrhage after tonsillectomy can be classified as primary (within 24 hours – 2 weeks of surgery) or secondary (24+ hours after surgery). Hemorrhage is rare, occurring in about 1-4 % of surgeries, and is more common in older teens and adults than in children. It is considered significant if it is active/diffuse bleeding, is bright red, causes hypotension or causes *any* respiratory distress. Significant post-tonsillectomy hemorrhage is considered both an airway *and* a surgical emergency.

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