

SECTION: T-01

PROTOCOL TITLE: GENERAL TRAUMA CARE

REVISED: November 1, 2017

GENERAL COMMENTS: When possible this protocol should supplement other, more specific protocols based on clinical assessments and judgment. While not specifically mentioned below, aggressive management of the airway, respiratory functions, and prevention of shock are cornerstones of solid trauma care. In addition, rapid transport, good scene management with minimized scene times, and coordination with receiving trauma center are also important.

BLS SPECIFIC CARE:

- Basic BLS care and assessments and v/s every 5 minutes
- Patients with respiratory related complaints in the setting of major trauma should receive high flow oxygen, regardless of oxygen saturation. 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.
- Follow *Appendix 17: Selective Spinal Immobilization* protocol in regard to spinal care *when in doubt, immobilize*.
- 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
- Follow *Hospital Destination Protocol (G-3)*
- Maintain patent airway as necessary
- Supplemental high flow oxygen as tolerated
- Assist ventilations if necessary to maintain adequate SpO₂
- 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

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- Splint extremity injuries as needed
 - Traction (Sager) splint as needed for fractures to the proximal third and mid-shaft of femur
 - Splints, sling and swath, etc., where applicable, for other long-bone fractures and joint dislocations
- Provide pelvic stabilization and splinting as needed for suspected pelvic fractures.
- Assess neuromuscular function **before and after** splinting
- Conserve body heat

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 6: Medication Assisted Intubation" 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)

PHYSICIAN PEARLS:

Trauma patients: All patients shall be stabilized and transported as rapidly and efficiently as possible. "Trauma Priority" patients and patients who may benefit from specific interventional therapy (surgery, thrombolytic, cath lab) should have a goal of less than ten minutes on scene, within the bounds of quality patient care (such as pain management) . See *Appendix 16: Trauma Priority Criteria*

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

**EARLY NOTIFICATION OF THE RECEIVING FACILITY IS
ESSENTIAL IN SIGNIFICANT TRAUMA CASES.**

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