

	<b>COUNTY OF SACRAMENTO</b> EMERGENCY MEDICAL SERVICES AGENCY	Document #	8015.25
	<u>PROGRAM DOCUMENT:</u>  <b>Trauma</b>	Initial Date:	10/10/95
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 EMS Medical Director

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 EMS Administrator

**Purpose:**

- A. To serve as the treatment standard for adult patients who have received traumatic injuries.

**Authority:**

- A. California Health and Safety Code, Division 2.5
- B. California Code of Regulations, Title 22, Division 9

**Protocol:**

**BLS TREATMENT**

<p><b>ABC's / Routine Trauma Care</b> - Time on scene should not exceed 10 minutes under normal circumstances. Conditions requiring extended scene times shall be documented.</p> <ul style="list-style-type: none"> <li>• Administer supplemental O2 as necessary to maintain SpO2 ≥ 94%. EXCEPTION: Head injuries require 100% O2 by Non-Rebreather</li> <li>• Be prepared to support ventilation with appropriate airway adjuncts when indicated</li> <li>• Spinal immobilization if indicated</li> <li>• Prepare for immediate transport</li> </ul> <p><b>Amputations</b> – Dress stump with dry sterile dressing. Place amputated part in sterile, dry container or bag and close. Place first container in second container or bag and tie it closed. Place in melting ice. Amputated part should not direct contact ice or water.</p> <p><b>Evisceration</b>– Cover with large sterile saline soaked dressing. Do not replace abdominal contents.</p> <p><b>Flail Chest</b> – You may use your hand or a pillow to make the patient more comfortable by stabilizing the injured area. Remove the pressure if respirations deteriorate or if the pressure does not help the pain. Assist ventilation as needed.</p> <p><b>Hemorrhage Control</b> – The best method of control is direct pressure. If unable to control, see Hemorrhage Policy PD #8065</p> <p><b>Impaled Object</b> – Only to be removed when its presence interferes with CPR or impaled object interferes with the airway.</p>
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**Open Chest Wounds** – Cover with an occlusive dressing and tape on three sides loosely. If signs of tension pneumothorax develop (distended neck veins, cyanosis, tracheal shift, absent breath sounds on one side, falling BP, dyspnea), remove the dressing, allow air to escape and reapply dressing.

**Orthopedic Trauma** – Check for pulse before and after splinting and document.

- If angulated and NO pulse, then attempt to gently straighten, unless pain or resistance is met, and splint.
- If angulated, stable and GOOD pulse, splint in position unless transport would be compromised.
- Open fractures should be treated with moist sterile dressing and not reduced. The exception would be a traction splint to an open femur fracture. In this case, it is essential to notify hospital staff (as well as written documentation) of the presence of an open fracture.

**Eye Injuries** – Position patient, sitting upright if comfortable, unless spinal immobilization is indicated. Impaled objects should be stabilized, not removed. Embedded foreign bodies in eye-cover both eyes.

- Chemical: Acid or alkali irrigate with water or normal saline on all chemical injuries. Irrigate profusely until the patient reaches the hospital.
- Remove contact lenses
- Trauma: Cover both eyes loosely with protective dressing and avoid pressure to globe

**Head Trauma** – If in shock, treat according to shock protocol. 100% O<sub>2</sub> via Non-Rebreather Mask

- Scalp hemorrhage can be life-threatening dress with a pressure dressing  
Check for:
  1. Alertness
  2. Verbal response
  3. Pain response
  4. Unresponsiveness

## ALS TREATMENT

**Advanced airway adjuncts as needed** - Confirm Advanced Airway placement with continuous waveform capnography.

- Cardiac monitoring and SpO<sub>2</sub>
- Establish large bore Intravenous (IV) Access with Normal Saline (NS)/ titrate to a systolic blood pressure (SBP) of 90-100 mmHg for patients meeting Trauma Triage Criteria. If patient meets physiological criteria, start a second large bore IV.

**Decompression of Tension Pneumothorax** – Indications:

1. Severe respiratory distress
2. SBP less than 90 mmHg or loss of radial pulse due to shock
3. Unilateral decreased breath sounds with a history of chest trauma

**OR**

1. Traumatic arrest with evidence of chest trauma or suspicion that a tension pneumothorax is contributing to the arrest.

**If indication is present:** Decompression of a tension pneumothorax should be immediately accomplished with insertion of a 3.25" 14 gauge chest decompression needle in the 2<sup>nd</sup> intercostal space, midclavicular line.

Subsequently, if all the criteria are met for tension pneumothorax on the opposite side, needle decompression should be performed on that side.

Decompression of suspected pneumothorax in traumatic arrest should be performed bilaterally.

NOTE: If anatomical variation precludes access to the midclavicular line approach, decompression can be attempted by placing a needle on the affected side at the 3<sup>rd</sup> or 4<sup>th</sup> intercostal space, anterior axillary line.

**Orthopedic Trauma** – Patients presenting in severe pain from amputation and/or suspected extremity fracture(s), including hip or shoulder injuries or dislocations, consider administration of opiate pain medication per Pain Management Policy, PD #8066

Cross Reference:      Destination, PD#5050  
                                 Respiratory Distress, General, PD#8020  
                                 Spinal Immobilization, PD#8044  
                                 Trauma Destination, PD#5052  
                                 Trauma Triage Criteria, PD#5053  
                                 Hemorrhage, PD#8065  
                                 Pain Management, PD#8066