

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	9017.21
	<u>PROGRAM DOCUMENT:</u> PEDIATRIC Trauma	Initial Date:	11/21/95
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Signature on File

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 EMS Medical Director

 EMS Administrator

Purpose:

- A. To serve as the treatment standard for pediatric patients (age ≤ 14 yrs.) who have received traumatic injuries.
- B. To serve as the treatment standard for pediatric orthopedic injuries, eye injuries and head trauma.

Authority:

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

Protocol:

- A. **TRAUMA:** Time on scene should not exceed 10 minutes under normal circumstances. Conditions requiring more than 10 minute scene times must be documented.

BLS TREATMENT

Supplemental O2 as necessary to maintain SpO2 ≥ 94%. Use the lowest concentration and flow rate of O2 as possible.

Airway adjuncts as needed.

Spinal precautions when indicated.

Amputations:

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 directly contact ice or water.

Evisceration of Abdomen:

Cover with large saline soaked dressing. Do not replace abdominal contents.

Flail Chest:

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.

Hemorrhage Control:

The first method of control is direct pressure. If unable to control see Hemorrhage Policy #8065

Impaled Object:

Only to be removed when its presence interferes with CPR or impaled object interferes with the airway.

Open Chest Wounds:

Cover with Vaseline impregnated gauze 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.

Prepare for immediate transport.

ALS TREATMENT

ADVANCED AIRWAY ADJUNCTS as needed. Airway management per Pediatric Airway Management PD# 8837.

Transport as soon as possible.

Establish Intravenous (IV). If hypotensive, administer 20 ml/Kg bolus of normal saline (NS) and reassess after each bolus. If unable to establish IV and patient is in extremis, then establish Intraosseous (IO) Access. If hypotensive, administer 20 ml/Kg bolus of NS and reassess after each bolus. Titrate to a minimal Systolic Blood Pressure (SBP) for patient's age.

If all the following are present in a patient:

1. Unilateral decreased breath sounds with a history of chest trauma and:
 - a. Severe respiratory distress and/or
 - b. Hypotension per pediatric BP parameters or loss of radial pulse due to shock

OR

2. 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 2ND INTERCOSTAL SPACE, MIDCLAVICULAR LINE.

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 3rd or 4th intercostal space, anterior axillary 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.

B. Orthopedic Trauma:

BLS TREATMENT

Supplemental O2 as necessary to maintain SpO2 \geq 94%. Use the lowest concentration and flow rate of O2 as possible.

Airway adjuncts as needed.

Spinal Motion Restriction (SMR) when indicated.

Splinting:

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.

If severely angulated, may gently straighten. Check pulse before and after positioning.

Open fractures should be treated with moist sterile dressings 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.

ALS TREATMENT

Any patient receiving Advanced Life Support interventions for Trauma shall be placed on ECG and SPO2 when available.

For patients presenting in severe pain from amputations and/or suspected extremity fracture(s) including hip injuries or dislocations, consider administration of opiate pain medication per PEDIATRIC Pain Management policy, PD# 9018.

C. Eye Injuries:

BLS TREATMENT

Chemical:

Irrigate with water or normal saline on all chemical injuries. Irrigate profusely until the patient reaches the hospital.

Remove contact lenses if present.

Trauma:

Cover both eyes loosely with protective dressing and avoid pressure to globe.

Spinal immobilization when indicated.

Position patient, sitting upright if comfortable.

Note: Impaled objects should be stabilized, not removed. Embedded foreign bodies in eye - cover both eyes.

D. Head Trauma:

BLS TREATMENT

Supplemental O2 100% by Non-Rebreather.

Airway adjuncts as needed.

Spinal immobilization - Transport well immobilized with backboard on side if airway problems occur.

If in shock, treat according to shock protocol.

Further assessment - check for:

1. Alertness.
2. Verbal response.
3. Pain response.
4. Unresponsiveness.

CROSS REFERENCE: Destination, PD#5050
 Trauma Destination, PD# 5052
 Trauma Triage Criteria, PD# 5053
 Respiratory Distress, General, PD# 8020
 Spinal Immobilization, PD# 8044
 Pediatric Pain Management, PD# 9018
 Hemorrhage in Trauma, PD# 8065
 Pediatric Airway Management PD# 8837
 Pediatric Parameters PD# 9016