

	<b>COUNTY OF SACRAMENTO</b> EMERGENCY MEDICAL SERVICES AGENCY	Document #	8015.27
	<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 establish the treatment standard for adult patients who have traumatic injuries.

**Authority:**

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

**Protocol:**

<b>BLS</b>
<ol style="list-style-type: none"> <li>1. ABC's / Routine Trauma Care - Time on scene for critical trauma should not exceed 10 minutes under normal circumstances. Conditions requiring extended scene times shall be documented.</li> <li>2. Administer supplemental O<sub>2</sub> as necessary to maintain SpO<sub>2</sub> ≥ 94%. EXCEPTION: Head injuries require 100% O<sub>2</sub> by non-rebreather</li> <li>3. Be prepared to support ventilation with appropriate airway adjuncts when indicated</li> <li>4. Spinal Motion Restriction (SMR) if indicated</li> <li>5. Prepare for immediate transport</li> <li>6. Amputations:           <ul style="list-style-type: none"> <li>• Dress stump with a dry sterile dressing. Place amputated part in a sterile, dry container or bag and close. Place the first container in the second container or bag and tie it closed. Place in melting ice. Amputated part should not come in direct contact with ice or water.</li> </ul> </li> <li>7. Evisceration:           <ul style="list-style-type: none"> <li>• Cover with large sterile saline-soaked dressing. Do not replace abdominal contents.</li> </ul> </li> <li>8. Hemorrhage Control:           <ul style="list-style-type: none"> <li>• The best method of control is direct pressure. If unable to control with direct pressure, see PD# 8065 – Hemorrhage.</li> </ul> </li> <li>9. Impaled Object:           <ul style="list-style-type: none"> <li>• Only to be removed when its presence interferes with CPR or impaled object interferes with the airway.</li> </ul> </li> <li>10. Open Chest Wounds:           <ul style="list-style-type: none"> <li>• 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.</li> </ul> </li> </ol> <p><b>NOTE:</b> A third-party vendor dressing specifically designed for use with open chest wounds, which allows ventilation of air, is acceptable for use.</p>

11. Orthopedic Trauma:

- Check for a 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 a 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.

12. Eye Trauma:

- 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 loosely with protective dressing and avoid pressure to the globe.

13. 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

14. 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 and will be dressed with a pressure dressing for signs of significant bleeding or active brisk/heavy bleeding. Check for:
  - a. Alertness
  - b. Verbal response
  - c. Pain response
  - d. Unresponsiveness

15. Prepare for immediate transport.

**ALS**

1. Advanced airway adjuncts as needed - confirm advanced airway placement with continuous waveform capnography.
2. Cardiac monitoring and SpO<sub>2</sub>
3. Establish large-bore Intravenous (IV) access with normal saline (NS)/ titrate to a Systolic Blood Pressure (SBP)  $\geq$  90mmHg for patients meeting Trauma Triage Criteria. If patient meets physiological criteria, start a second large bore IV.
4. Decompression of Tension Pneumothorax:
  - a. Indications:
    - Unilateral decreased breath sounds with a history of chest trauma and:
    - Severe respiratory distress and/or
    - SBP  $\leq$  90 mmHg or loss of radial pulse due to shock
  - OR**
  - b. Traumatic arrest with evidence of chest trauma or suspicion that a tension pneumothorax is contributing to the arrest.
  - c. If an 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 3<sup>rd</sup> or 4<sup>th</sup> intercostal space, midaxillary line.
  - d. Subsequently, if all the criteria are met for tension pneumothorax on the opposite side, needle decompression should be performed on that side.

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

**NOTE:** If conditions preclude access to the midaxillary approach, decompression can be attempted by placing a needle on the affected side at the 2<sup>nd</sup> intercostal space, midclavicular line.

5. 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 pain medication per PD# 8066 – Pain Management.

**Cross Reference:** PD# 5050 – Destination  
PD# 8020 – Respiratory Distress: Airway Management  
PD# 8044 – Spinal Motion Restriction (SMR)  
PD# 5052 – Trauma Destination  
PD# 5053 – Trauma Triage Criteria  
PD# 8065 – Hemorrhage  
PD# 8066 – Pain Management  
PD# 8032 – Traumatic Full Arrest