



General Trauma Management

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Approval: Victoria Pinette – Executive Director

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- Transport patients who meet trauma triage criteria (policy reference 860) as soon as possible. Scene time for patients meeting anatomical and/or physiological trauma triage criteria should not exceed 10 minutes.
- On scene procedures should be limited to the following:
 - Triage
 - Patient assessment
 - Airway management
 - Hemorrhage control
 - Immobilization/splinting
 - Spinal motion restriction

BLS

- Assess V/S, including SpO₂
- O₂ at appropriate rate if hypoxemic (SpO₂ < 94%) or short of breath
- Manage airway and assist ventilations as needed
- Provide hemorrhage control as needed (protocol reference T-8)
- Immobilize/splint injuries as needed
- Initiate spinal motion restriction (SMR) if indicated (see page 3)
- Maintain body temperature, keep warm

LALS

- Consider advanced airway for patients meeting any of the following criteria:
 - Apnea
 - Unconsciousness: GCS ≤ 8
 - Need for airway protection from aspiration (vomitus, bleeding, etc.)
 - Risk for airway obstruction (laryngeal/tracheal injury, inhalation injury, etc.)
- Consider application of a pelvic binder if indicated (see page 2)

Cardiac monitor (AEMT II ONLY)

Determine patient severity and transport destination (policy reference 860)

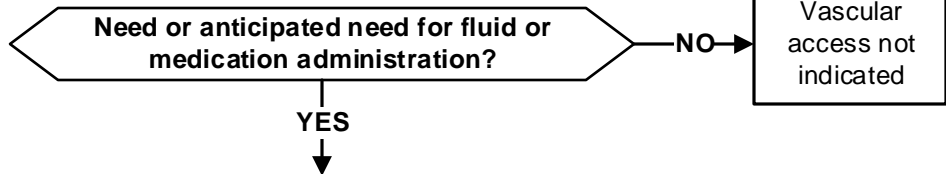
- Establish vascular access if indicated (see page 2)
- Consider pain management as necessary (protocol reference M-8 and P-34)

- Transport to appropriate destination
 - Transport patients with known or apparent third trimester pregnancy in left-lateral position.
- Notify receiving hospital of 'Trauma Alert' as soon as possible for patients who meet trauma triage criteria
- Monitor & reassess



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Vascular Access Procedures

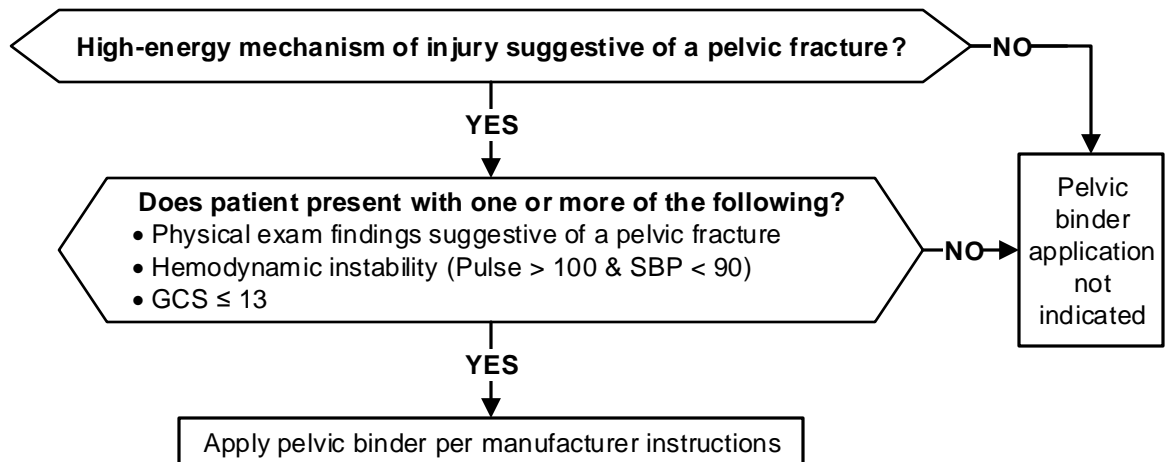


- IV/IO (IO approved for pediatric patients only) – Normal Saline or Lactated Ringers Solution**
- Initiate large bore vascular access via blood administration or macrodrip tubing on all patients meeting anatomic, physiologic, or mechanism of injury trauma triage criteria
 - Initiate second vascular access on adult patients with SBP < 90 or if thoracic/abdominal pain present
 - Fluid resuscitation guidelines:
 - Adult patients:
 - Administer 500 mL fluid boluses for signs of hypoperfusion/shock
 - Reassess hemodynamic parameters, respiratory status and lung sounds after each fluid bolus
 - Titrate fluid boluses to SBP of ≥ 90
 - Pediatric patients:
 - Administer 20 mL/kg fluid boluses for signs of hypoperfusion/shock
 - Reassess hemodynamic parameters, respiratory status and lung sounds after each bolus
 - Titrate fluid boluses to age appropriate SBP (max = 60 mL/kg)

Commercial Pelvic Binder Assessment/Utilization Procedures

Approved Commercial Pelvic Binders: 1) T-POD Pelvic Stabilization Device, 2) SAM Pelvic Sling 2

- Utilization of a commercial pelvic binder is optional and only approved for AEMT/paramedic personnel. ALS/LALS provider agencies must ensure that their personnel are appropriately trained on the application/use of the device as misplacement of pelvic binders can significantly decrease the ability of the binder to reduce pelvic ring fractures.
- Physical exam findings which may indicate the presence of a pelvic ring fracture include, but are not limited to:
 - Crepitus when applying compression to the iliac crests
 - Perineal or genital swelling
 - Testicular/groin pain
 - Blood at the urethral meatus
 - Rectal, vaginal or perineal lacerations/bleeding
- When stabilizing a suspected pelvic ring fracture, care must be taken not to over-reduce the fracture. Over-reduction can be assessed by examining the position of the legs, greater trochanters and knees with the patient supine. The goal is to achieve normal anatomic position of the pelvis, so the lower legs should be symmetrical after stabilization.
- Pelvic binders should be placed directly to skin.
- When clinically indicated and logistically feasible, the pelvic binder should be placed prior to extrication/movement.
- Once applied, commercial pelvic binders should not be removed.
- If possible, avoid log-rolling patients with a suspected pelvic fracture.

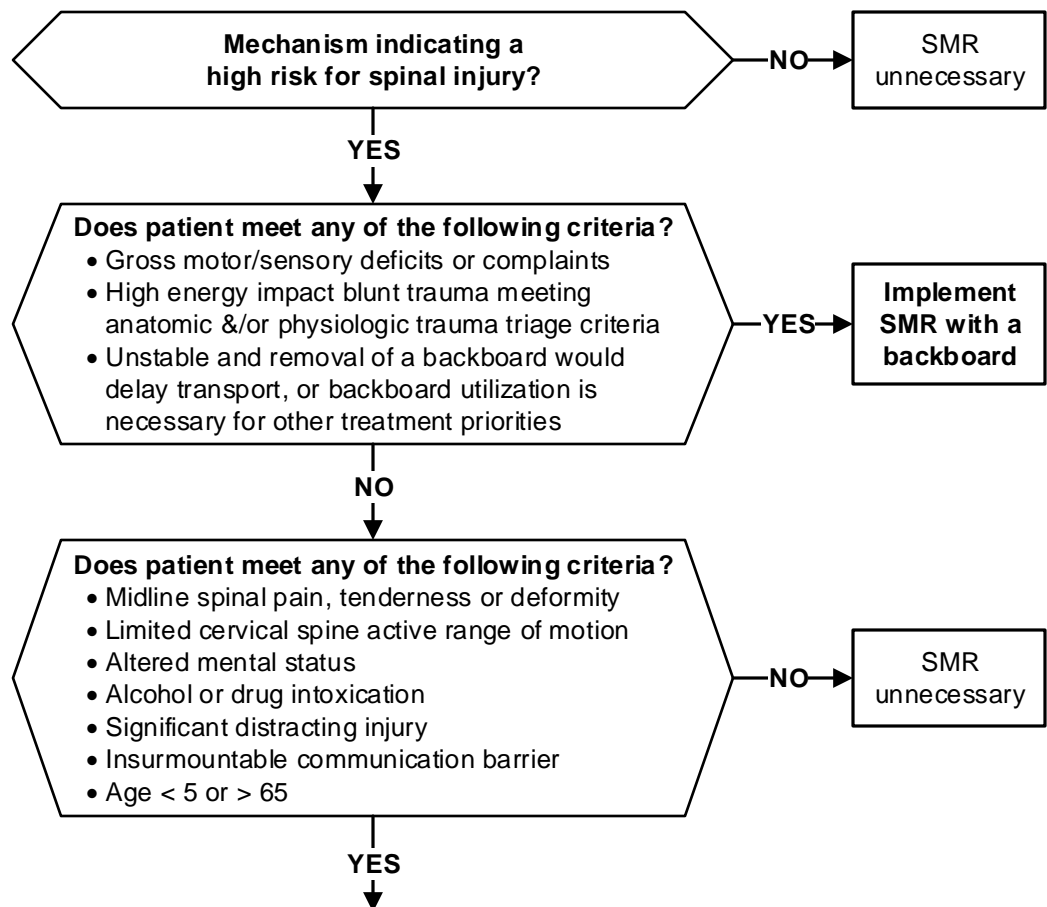




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Trauma Patient SMR Assessment/Utilization Procedures

- A backboard shall not be utilized for patients with penetrating trauma to the head, neck or torso without evidence of spinal injury.
- Helmet removal guidelines:
 - For patients who meet criteria for SMR with a backboard, football helmets should only be removed if they prevent adequate SMR or under the following circumstances:
 - If the helmet and chin strap fail to hold the head securely or prevent adequate airway control.
 - If the facemask cannot be removed.
 - Football helmets should be carefully removed to allow for appropriate SMR of patients who do not meet criteria for backboard utilization.
 - All other types of helmets (bicycle, motorcycle, etc.) should be carefully removed to allow for appropriate SMR.



- Implement SMR without a backboard as follows:**
- Apply a cervical collar
 - Allow ambulatory patients to sit on the stretcher and then lie flat (no 'standing take-down")
 - If necessary, move patient from the position found to the ambulance stretcher utilizing a device such as a KED, scoop stretcher, backboard, or if necessary, by having the patient stand and pivot to the stretcher – do not permit the patient to struggle to their feet from a seated or supine position
 - Once on the ambulance stretcher, remove any hard backboard device & instruct the patient to lie still
 - The head of the stretcher may be elevated 20-30° in a position of comfort
 - Secure cross stretcher straps and over-the-shoulder belts firmly
 - Patients with nausea &/or vomiting may be placed in the lateral recumbent position maintaining the head in a neutral position using manual stabilization, padding, pillows, &/or the patient's arm