PEDS TRAUMA: TRAUMA ARREST

E	EMT	E
A	AEMT	A
P	PARAMEDIC	P
M	MED CONTROL	M

UNIVERSAL PATIENT CARE PROTOCOL

SPINAL MOTION RESTRICTION -SMR

PEDIATRIC AIRWAY PROTOCOL

CAPNOGRAPHY PROCEDURE

Consider
BILATERAL NEEDLE DECOMPRESSION
Use appropriate sized catheter for age or commercial device

Consider
DOA / Termination of Efforts

IV / IO PROCEDURE

Apply Cardiac Monitor

Appropriate Protocol based on Signs and Symptoms

INITATE TRAUMA ALERT

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated

PEDS TRAUMA: TRAUMA ARREST-Cont.

PEARLS and KEY POINTS

HISTORY	SIGNS AND SYMPTOMS	DIFFERENTIAL DIAGNOSIS
• Time of injury • Mechanism: blunt / penetrating • Loss of consciousness • Bleeding • Medications • Evidence of multi-trauma	• Excessive bleeding • Unresponsive; not breathing • Cardiac arrest • Significant mechanism of injury	• **Obvious DOA** • **Death**

- Immediately transport traumatic cardiac arrest patients.
- With the exception of airway management, traumatic cardiac arrests are “load and go” situations.
- Resuscitation should not be attempted in cardiac arrest patients with spinal transection, decapitation, or total body burns, nor in patients with obvious, severe blunt trauma that are without vital signs, pupillary response, or an organized or shockable cardiac rhythm at the scene. Patients in cardiac arrest with deep penetrating cranial injuries and patients with penetrating cranial or truncal wounds associated with asystole and a transport time of more than 15 minutes to a definitive care facility are unlikely to benefit from resuscitative efforts.
- Extensive, time-consuming care of trauma victims in the field is usually not warranted. Unless the patient is trapped, they should be enroute to a medical facility within 10 minute after arrival of the ambulance on the scene.