

TRAUMA ARREST

3-5 kg	6-7 kg	8-9 kg	10-11 kg	12-14 kg	15-18 kg	19-23 kg	24-29 kg	30-36 kg
6-11 lbs	13-15 lbs	18-20 lbs	22-24 lbs	26-31 lbs	33-40 lbs	42-51 lbs	53-64 lbs	66-81 lbs
18-24 in	24-26 in	26-29 in	29-33 in	33-38 in	38-43 in	43-48 in	48-52 in	52-57 in

HISTORY	SIGNS AND SYMPTOMS	DIFFERENTIAL DIAGNOSIS
<ul style="list-style-type: none"> Time of injury Mechanism: blunt / penetrating Loss of consciousness Bleeding Medications Evidence of multi-trauma 	<ul style="list-style-type: none"> Excessive bleeding Unresponsive; not breathing Cardiac arrest Significant mechanism of injury 	<ul style="list-style-type: none"> Obvious DOA Death

UNIVERSAL PATIENT CARE PROTOCOL

BEGIN RESUSCITATION

CONSIDER SPINAL MOTION RESTRICTION PROCEDURE

PEDIATRIC AIRWAY PROTOCOL

CAPNOGRAPHY PROCEDURE

BILATERAL TRAUMATIC NEEDLE CHEST DECOMPRESSION

IV / IO PROCEDURE

Apply Cardiac Monitor

Appropriate Protocol based on Signs and Symptoms

INITIATE TRAUMA ALERT

TRANSPORT to appropriate facility

CONTACT receiving facility

CONSULT Medical Control where indicated

APPROPRIATE transfer of care

Consider

DOA / Termination of Efforts

KEY POINTS

- 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 patients 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 minutes after arrival of the ambulance on the scene.

EMT Intervention

AEMT Intervention

PARAMEDIC Intervention

Online Medical Control

P E D I A T R I C P R O T O C O L

GLASGOW COMA SCALE

EYE OPENING	Spontaneous	Spontaneous	4
	To voice	To voice	3
	To pain	To pain	2
	None	None	1
VERBAL RESPONSE	Oriented	Coos, babbles	5
	Confused	Irritable cry, inconsolable	4
	Inappropriate	Cries to pain,	3
	Garbled speech	Moans to pain	2
	None	None	1
MOTOR RESPONSE	Obeys commands	Normal movements	6
	Localizes pain	Withdraws to touch	5
	Withdraws to pain	Withdraws to pain	4
	Flexion	Flexion	3
	Extension	Extension	2
	Flaccid	Flaccid	1

* NOTE: MOTOR RESPONSE IS MOST INDICATIVE OF LEVEL OF INJURY

P E D I A T R I C P R O T O C O L

NORMAL VITAL SIGNS

AGE	HEART RATE	RESPIRATIONS	SYSTOLIC BLOOD PRESSURE
Preterm, 1 kg	120-160	30-60	36-58
Preterm 1 kg	120-160	30-60	42-66
Preterm 2 kg	120-160	30-60	50-72
Newborn	126-160	30-60	60-70
Up to 1 yo	100-140	30-60	70-80
1-3 yo	100-140	20-40	76-90
4-6 yo	80-120	20-30	80-100
7-9 yo	80-120	16-24	84-110
10-12 yo	60-100	16-20	90-120
13-14 yo	60-90	16-20	90-120
15 + yo	60-90	14-20	90-130

Blood pressure is a late and unreliable indicator of shock in children