Treatment Protocol: TRAUMATIC ARREST **Ref. No. 1243**

Base Hospital Contact: Contact the Trauma Center for patients not meeting criteria for determination of death per *Ref 814*.

1. Prioritize rapid transport for patients who do not meet *Ref. 814* ❶

2. Immediately control major bleeding *(MCG 1370)*
   Apply tourniquet prn

3. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)* ❷
   Ventilate with **high flow Oxygen 15 L/min**

4. Begin chest compressions

5. Perform bilateral needle thoracostomy for suspected tension pneumothorax *(MCG 1335)*

6. Initiate cardiac monitoring *(MCG 1308)*
   Assess cardiac rhythm

7. If shockable rhythm (V-Fib/V-Tach) identified:
   Defibrillate V-Fib/V-Tach at 200J or per manufacturer's instructions

   For penetrating trauma: ❸
   Defibrillate while prioritizing immediate transport

   For blunt trauma: ❹❺
   Initiate resuscitation on scene
   If organized rhythm is not restored after defibrillation x3 or patient converts to nonshockable rhythm, refer to *Ref. No. 814* for determination of death
   CONTACT BASE if needed for guidance on continued resuscitation or transport

8. Provide spinal motion restriction (SMR) if indicated *(MCG 1360)*
   Do not delay transport for SMR ❻

9. Establish vascular access en route *(MCG 1375)*
   Two large bore IV catheters (16 or 18 gauge) preferred
   Establish IO if unable to establish IV access

10. **Normal Saline 2L IV/IO rapid infusion**
    Administer through two sites simultaneously if possible

SPECIAL CONSIDERATIONS

❶ Rapid transport after hemorrhage control is the priority for all patients with severe trauma. With the exception of hemorrhage control, needle thoracostomy, and initiation of CPR, all other procedures may be deferred for immediate ambulance loading of patient and performed en route.

❷ Bag-mask ventilation (BMV) is the preferred initial method of airway management. An advanced airway may be placed once initial resuscitation priorities are complete, and preferably during transport, unless BMV is ineffective. Supraglottic airway is preferred unless contraindicated. Paramedics should use judgment based on patient characteristics, circumstances, and skill level when selecting the advanced airway modality.

❸ Patients with penetrating trauma should receive defibrillation while still prioritizing early transport.

❹ Patients in cardiac arrest with hanging or submersion mechanisms are asphyxial in the large majority of cases and should be considered a medical cardiac arrest, and therefore managed in accordance with TP-1210-Cardiac Arrest with transport destination per Ref. No. 516. Trauma center destination in cases with ROSC should only be considered if there is strong evidence of cervical spine injury.

❺ Sudden cardiac death can result from blunt cardiac injury (commotio cordis) triggering V-fib/V-tach. Patients in cardiac arrest due to commotio cordis typically have **minimal external trauma** and should be treated as a medical cardiac arrest, with immediate defibrillation on scene. If the patient with suspected commotio cordis remains in V-fib/V-tach after two defibrillations, consider transport to an ECPR center if criteria are met, or contact Base to discuss transport versus continued on-scene resuscitation. Patients with **multisystem** blunt trauma in persistent cardiac arrest and without organized rhythm are generally not transported.

❻ For patients in traumatic arrest, spinal motion restriction (SMR) using a backboard causes harmful delays in care. However, a backboard may be helpful to assist in patient movement and to support chest compressions.