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

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

1. Prioritize rapid transport for patients who do not meet *Ref. 814* ❷
2. Immediately control major bleeding *(MCG 1370)*
   Apply tourniquet prn
3. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302; 1309)* ❸
   Ventilate with **high flow Oxygen 15L/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, dose per *MCG 1309*

   For penetrating trauma: ❹
   Defibrillate while prioritizing immediate transport

   For blunt trauma: ❺
   Initiate resuscitation on scene
   If organized rhythm is not restored after defibrillation x3 or patient converts to nonshockable rhythm
   CONTACT BASE 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)*
   Establish IO if unable to establish IV access
10. **Normal Saline 20mL/kg IV/IO rapid infusion** per *MCG 1309* x2**,** maximum 2L
    Administer through two sites simultaneously if possible
11. Hanging/asphyxia should be transported to the nearest Pediatric Medical Center (PMC) if transport is ≤30 mins or Emergency Department Approved for Pediatrics (EDAP) if > 30 minutes, not trauma center, unless other evidence of trauma

SPECIAL CONSIDERATIONS

❶ EMS Personnel are mandated reporters of child abuse and neglect, and a report should be made when suspected as per *Ref. 822*. Communicate suspicion for child abuse and/or neglect to accepting ED staff when home suggests children could be at risk for harm (e.g., unkept home, evidence of drug or alcohol abuse, unsafe living conditions, known or suspected domestic violence), when the history does not match with the severity of physical findings (e.g., child posturing after a roll off the couch), when patterned injury or burns or noted (e.g., circular burns as from a cigarette, whip marks on the skin, burns of both hands or feet), or when child reports physical or sexual abuse. Children < 3 years of age and those with developmental delay are at increased risk of abuse. This must also be accompanied by notification to the Department of Children and Family Services (DCFS).

❷ 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.

❸ Bag-mask ventilation (BMV) with a viral filter is the preferred initial method of airway management. An advanced airway may be placed during transport or if BMV is difficult or ineffective as authorized per *MCG 1302*; supraglottic airway (sizing per MCG 1309) is preferred unless contraindicated. Paramedics should use judgment based on patient characteristics, circumstances, and skill level when selecting the advanced airway modality for pediatric patients in whom multiple modalities are authorized.

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

❺ Sudden cardiac death can result from blunt cardiac injury (commotio cordis) triggering V-fib/V-tach. Unlike major trauma resulting in hemorrhagic shock, patients with this mechanism typically have **minimal external trauma** and should be treated with immediate defibrillation on scene. Patients with multisystem blunt trauma in persistent cardiac arrest without organized rhythm should generally not be transported. If commotio cordis is the suspected mechanism with minimal external trauma and the patient remains in V-fib/V-tach after three defibrillations, contact Base to discuss timing of transport versus termination for futility.

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.