

TRAUMATIC ARREST

***When trauma is insufficient to explain cardiac arrest, refer to CCR/ACLS Protocol.

Do Not Resuscitate

- Decapitation
- Hemicorpectomy
- Rigor Mortis/Dependent Lividity
- Decomposition
- GSW Head
- Drowning- >1 hour submerged. Resuscitate more aggressively pediatric cold-water drowning.

Resuscitate - if any of the following signs of life are present

- EMS witnessed arrest
- Any Electrocardiographic Activity
- Any spontaneous respirations
- Movement
- Pupillary reaction
- Electrocutation or Lightning Strikes

BASIC EMT

1. Airway
 - Follow Trauma Management Airway:
 - Trauma patients and pediatric patients airway should be maintained by BLS means if possible.
 - Evaluate the airway. Take into account the possibility of cervical injury. Secure the airway by positioning, oropharyngeal airway, or nasopharyngeal airway if possible.
 - Place supraglottic airway if necessary.
 - Provide continuous waveform ETCO₂ (if available)
 - Consider cervical spine stabilization
2. Breathing
 - Assist with high flow oxygen.
3. Circulation
 - Control severe bleeding per BLS standards.
 - Direct Pressure
 - Tourniquet for extremity bleeding
 - Wound packing for significant external bleeding where tourniquet cannot be used or is ineffective utilizing gauze or hemostatic agents (preferred if available)
4. Initiate chest compressions

TRAUMATIC ARREST cont.

ADVANCED EMT

5. Establish two (2) large bore IV's or IO
 - 1000 ml Normal Saline bolus

PARAMEDIC

6. Consider intubating patients who are unable to be adequately oxygenated by BLS means. Endotracheal intubation should not significantly delay transport. If an endotracheal tube (ETT) is not passed after a total of two attempts at visualization and/or ETT passage, a non-visualized airway should be placed. "Attempt" is defined by the National Association of EMS Physicians as: "Insertion of laryngoscope blade into mouth (for orotracheal methods)".
 - EMS personnel are required to confirm endotracheal tube placement on every intubation with:
 - e. visualization
 - f. 5-point auscultation
 - g. chest rise
 - h. continuous waveform ETCO₂
7. Tidal volume 500 – 600 ml and rate 8 – 10 with cardiac arrest.
8. When all reasonable attempts to provide an adequate airway by less invasive means have failed, consider performing an invasive airway procedure:

Surgical Cricothyrotomy (age greater than or equal to 5 years)

1. Make a vertical, midline incision through the skin over the cricothyroid membrane
2. Carefully incise through the cricothyroid membrane.
3. Spread tracheal incision with scalpel handle.
4. Assess and maintain opening with finger or other device.
5. Consider ET introducer (bougie)
6. Insert tube through the incision and advance caudally (toward the feet).
7. Secure tube and dress incision site with 4x4's.
8. Continue to ventilate the patient via bag-valve-mask during the procedure if able.
9. Reassess airway and ventilatory status frequently.
10. CONFIRM TUBE PLACEMENT
 - EMS personnel are required to confirm cricothyrotomy tube placement on every surgical airway:
 - d. 5-point auscultation
 - e. chest rise
 - f. continuous waveform ETCO₂.

TRAUMATIC ARREST cont.

Needle Cricothyrotomy (age less than 5 years)

1. Locate the Cricothyroid membrane.
 2. Puncture cricothyroid membrane with a catheter over the needle and saline filled
 3. syringe. Direct the needle toward the feet and aspirate for air. Once in the trachea advance the catheter.
 4. Attach a 3.0 mm endotracheal adapter to the catheter and ventilate.
9. Needle chest decompression bilaterally if known or suspected chest injury
10. If ROSC
- **Tranexamic Acid (TXA)** 1 gram in 100 ml NS over 10 minutes IV / IO
11. When trauma insufficient to explain cardiac arrest, refer to CCR/ACLS Protocol.

TERMINATE RESUSCITATION

Contact medical control after 15 minutes of resuscitation efforts to discuss the need to continue active resuscitation efforts.

- If already enroute and further efforts are felt to be futile, consider transporting quietly to the hospital without active resuscitation efforts after contacting OLMC during transport.