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TRINITY EMS SYSTEM PREHOSPITAL GUIDELINES

HISTORY
- Type of bite/sting
- Description of creature or photograph for identification
- Time, location, size of bite/sting
- Previous reaction to bite/sting
- Domestic v. wild
- Tetanus and Rabies risk
- Immunocompromised patient

SIGNS AND SYMPTOMS
- Rash, skin break, wound
- Pain, soft tissue swelling, redness
- Blood oozing from the bite wound
- Evidence of infection
- Shortness of breath, wheezing
- Allergic reaction, hives, itching
- Hypotension or shock

DIFFERENTIAL
- Animal bite
- Human bite
- Snake bite (poisonous)
- Spider bite (poisonous)
- Insect sting/bite (bee, wasp, ant, tick)
- Infection risk
- Rabies risk
- Tetanus risk

HISTORY

SIGNS AND SYMPTOMS

DIFFERENTIAL

Universal Patient Care Protocol

Position patient supine
Immobilize area or limb
Apply ice/cold pack if appropriate

Animal Bite: Document County of Occurrence and Contact with Law Enforcement or Animal Control

Refer to appropriate protocols if necessary:
Pain Control
Allergic Reaction

Contact Medical Control and Notify Destination

PEARLS
- Recommended Exam: Mental Status, Skin, Extremities (Location of Injury), and a complete Neck, Lung, Heart, Abdomen, Back, and Neuro exam if system effects are noted
- Human bites have a higher infection rate than animal bites due to normal mouth bacteria
- Carnivore bites are much more likely to become infected and all have risk of Rabies exposure
- Cat bites may progress to infection rapidly due to specific bacteria (Pasteurella multifacta)
- Poisonous snakes in the area are rare, but are of the pit viper family: Timber rattlesnakes and water moccasins. If no pain or swelling, envenomation is unlikely
- Brown Recluse spider bites are minimally painful to painless. Little reaction is noted initially, but tissue necrosis at the site of the bite develops over the next few days (brown spider with fiddle shape on back)
- Evidence of infection: swelling, redness, drainage, fever, red streaks proximal to wound
- Immunocompromised patients are at increased risk for infection: diabetes, chemotherapy, transplant patients
- Consider contacting the Illinois Poison Control Center for guidance: 1 800 222 1222

TRINITY EMS SYSTEM PREHOSPITAL GUIDELINES 2012

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TRINITY EMS SYSTEM PREHOSPITAL GUIDELINES

TRINITY EMS SYSTEM PREHOSPITAL GUIDELINES 2012

BURNS: CHEMICAL & ELECTRICAL
TRAUMA PROTOCOL # 5 - 02

HISTORY
- Type of exposure (heat, gas, chemical)
- Inhalation injury
- Past medical history and medications
- Other trauma
- Loss of consciousness
- Tetanus/Immunization status

SIGN AND SYMPTOMS
- Burns, pain, swelling
- Dizziness
- Loss of consciousness
- Hypotension, shock
- Airway compromise/distress
- Singed facial hair or nasal hair
- Hoarseness/wheezing

DIFFERENTIAL
- Superficial (1st Degree) – red and painful
- Partial Thickness (2nd Degree) – blistering
- Full Thickness (3rd Degree) – painless/charred or leathery skin
- Thermal
- Chemical
- Electrical
- Radiation

PEARLS – CHEMICAL
- Do not contact the patient until you are certain the source of electric shock has been disconnected.
- Attempt to locate contact points (entry wound where the AC source contacted the patient, an exit at the ground point) both sites will generally be full thickness.
- Cardiac monitor, anticipate ventricular or atrial irregularity, to include V-tach, V-fib, heart blocks, etc.
- Attempt to identify the nature of the electrical source (AC v. DC), the amount of voltage, and the amperage the patient may have been exposed to during the electrical shock.

PEARLS – ELECTRICAL
- Do not contact the patient until you are certain the source of electric shock has been disconnected.
- Attempt to locate contact points (entry wound where the AC source contacted the patient, an exit at the ground point) both sites will generally be full thickness.
- Cardiac monitor, anticipate ventricular or atrial irregularity, to include V-tach, V-fib, heart blocks, etc.
- Attempt to identify the nature of the electrical source (AC v. DC), the amount of voltage, and the amperage the patient may have been exposed to during the electrical shock.

Universal Patient Care Protocol
- Cardiac Monitor
- Pain Control Protocol
- IV Access Protocol

Chemical and Electrical Burn patients must be triaged using the guidelines below and their care must conclude in the Thermal Burn Protocol

Rule of 9’s

Eye involvement? Continuous saline flush in affected eye. Flush with water or Normal Saline for 10-15 minutes
Remove rings, bracelets, and other constricting items.
Remove clothing or exposed area.
Identify entry and exit sites. Apply sterile dressings.

FIRST RESPONDER
EMT-BASIC
EMT-INTERMEDIATE
PARAMEDIC
MEDICAL CONTROL
**BURNS: THERMAL**

**TRAUMA PROTOCOL #5-03**

**HISTORY**
- Type of exposure (heat, gas, chemical)
- Inhalation injury
- Time of injury
- Past medical history
- Medications
- Other trauma
- Loss of consciousness
- Tetanus/Immunization status

**SIGNS AND SYMPTOMS**
- Burns, pain, swelling
- Dizziness
- Loss of consciousness
- Hypotension/shock
- Airway compromise/dyspnea
- Singed facial hair or nasal hair
- Hoarseness/wheezing

**DIFFERENTIAL**
- Superficial (1st Degree) – red and painful
- Partial Thickness (2nd Degree) – blistering
- Full Thickness (3rd Degree) – painless/charred or leathery skin
- Thermal
- Chemical
- Electrical
- Radiation

**UNIVERSAL PATIENT CARE PROTOCOL**

**CRITICAL (RED)**
- >15% TBSA 2nd/3rd Degree Burn
- Burns with multiple trauma
- Burns with definitive airway compromise

**SERIOUS (YELLOW)**
- 5-15% TBSA 2nd/3rd Degree Burn
- Suspected inhalation injury or requiring intubation for airway stabilization
- Hypotension or GCS<14

**MINOR (GREEN)**
- <5% TBSA 2nd/3rd Degree Burn
- No inhalation injury
- Not intubated
- Normotensive
- GCS>14

**NORMAL SALINE**
- 2 large bore IVs
- Infuse total of 0.25 x kg body weight x %TBSA per hour for first 8 hours

**AIRWAY PROTOCOL (Adult or Peds)**
- Cover burn with dry, sterile sheet or dressings

**COOL DOWN THE WOUND WITH NORMAL SALINE**
- Cover burn with dry, sterile sheet or dressings

**PAIN CONTROL PROTOCOL (Adult or Peds)**
- Infuse total of 0.25 x kg body weight x %TBSA per hour for first 8 hours
- Contact Medical Control and Notify Destination

**CRITICAL OR SERIOUS BURNS**
- > 5 – 15% TBSA; 2nd or 3rd degree burns, or
- 3rd degree burns > 5% TBSA for any age group, or
- Circumferential burns of extremities or
- Suspicion of abuse or neglect, or
- Inhalation injury, or
- Chemical burns, or
- Burns of face, hands, perineum, or feet, or
- Any burn requiring hospitalization

**PEARLS**
- Burn patients are trauma patients! Evaluate for multisystem trauma
- Assure whatever has caused the burn is no longer contacting the injury (STOP THE BURNING PROCESS)
- Recommended Exam: Mental Status, HEENT, Neck, Heart, Lungs, Abdomen, Extremities, Back and Neuro
- Early intubation is required when the patient experiences significant inhalation injuries
- Potential CO exposure should be treated with 100% oxygen
- Circumferential burns to extremities are dangerous due to potential vascular compromise secondary to soft tissue swelling
- Burn patients are prone to hypothermia – never apply ice or cool burns; must maintain normal body temperature
- Evaluate the possibility of child abuse with children and burn injuries

**LEGEND**
- F FIRST RESPONDER
- B EMT-BASIC
- I EMT-INTERMEDIATE
- P PARAMEDIC
- M MEDICAL CONTROL

**RULE OF 9’S**

**TRINITY EMS SYSTEM PREHOSPITAL GUIDELINES 2012**
Universal Patient Care Protocol

Consider the 5 Ps:
- Pain
- Pallor
- Paresthesia
- Poikilothermia
- Pulselessness

Ensure airway
Oxygen 15L NRB

Vital Signs

Albuterol 2.5 mg Nebulized

Normal Saline Bolus

Sodium Bicarbonate 50 mEq in 1L NS
Administer entire 1L Normal Saline

Calcium Chloride 1 gram IV with 20 ml flush

PEARLS
- EKG changes of hyperkalemia include peaked T waves, loss of P waves, wide QRS
- Crush injuries lead to rapid release of potassium from cells. Overload of potassium leads to cardiac dysrhythmias
- Patients who have been trapped can appear hemodynamically stable until released. After release, patient can become unstable very quickly. Do not delay life saving measures for ALS if immediate threat to life exists
- ALS should be on scene prior to release of any crush injury
- Monitor lung sounds, patient is at risk for pulmonary edema

CONTACT MEDICAL CONTROL UPON ARRIVAL TO SCENE

Apply tourniquets to affected extremity/extremities prophylactically if appropriate

ALS MUST BE CALLED FOR CRUSH INJURY. IF POSSIBLE, ALS SHOULD BE PRESENT BEFORE RELEASE OF CRUSH INJURY

Maintain systolic BP > 100

Rapid Transport and Contact Medical Control
TRINITY EMS SYSTEM PREHOSPITAL GUIDELINES

DROWNING
TRAUMA PROTOCOL # 5 - 05

HISTORY
- Submersion in water regardless of depth
- Possible trauma to cervical spine
- Possible history of trauma, e.g., diving board
- Duration of immersion
- Temperature of water or possibility of hypothermia

SIGNS AND SYMPTOMS
- Unresponsive
- Mental status changes
- Decreased or absent vital signs
- Vomiting
- Coughing
- Apnea
- Stridor
- Wheezing
- Rales

DIFFERENTIAL
- Trauma
- Pre-existing medical problem
- Pressure injury (diving)
- Barotrauma
- Decompression sickness
- Post-immersion syndrome

Universal Patient Care Protocol

Spinal Immobilization Procedure

Pulse Oximetry

12 Lead EKG if available

Cardiac Monitor

IV Access Protocol

Consider Albuterol 2.5 mg Nebulized for respiratory distress

Consider CPAP for respiratory distress

Monitor and reassess

Appropriate Protocol Based on symptoms

Contact Medical Control and Notify Destination

PEARLS
- Recommended Exam: Trauma Survey, Head, Neck, Chest, Abdomen, Pelvis, Back, Extremities
- Have a high index of suspicion for possible spinal injuries
- There is no time limit on cold water drownings. Resuscitate all cold water drownings. Patients have increased chance of survival
- Some patients may develop delayed respiratory distress
- All victims may develop delayed respiratory distress
- Drowning is a leading cause of death among would-be rescuers
- All appropriately trained and certified rescuers to remove victims from areas of danger
TRINITY EMS SYSTEM PREHOSPITAL GUIDELINES

EXTREMITITY TRAUMA PROTOCOL # 5 - 06

HISTORY
- Type of injury
- Mechanism: crush/penetrating/amputation
- Time of injury
- Open vs. closed wound/fracture
- Wound contamination
- Medical history
- Medications

SIGNS AND SYMPTOMS
- Pain, swelling
- Deformity
- Altered sensation/motor function
- Diminished pulse/capillary refill
- Decreased extremity temperature

DIFFERENTIAL
- Abrasion
- Contusion
- Laceration
- Sprain
- Dislocation
- Fracture
- Amputation

DIFFERENTIAL
- Abrasion
- Contusion
- Laceration
- Sprain
- Dislocation
- Fracture
- Amputation

PEARLS
- Recommended Exam: Mental Status, Extremity, Neuro
- Peripheral neurovascular status is important
- In amputations, time is critical. Transport and notify medical control immediately, so that the appropriate destination can be determined
- Dislocations/fractures of hip, knee, or elbow have high incidence of vascular compromise
- Urgently transport any injury with vascular compromise
- Blood loss may be concealed or not apparent with extremity trauma
- Lacerations must be evaluated for repair within 6 hours of injury

Legend:
- F FIRST RESPONDER
- B EMT-BASIC
- I EMT-INTERMEDIATE
- P PARAMEDIC
- M MEDICAL CONTROL

Universal Patient Care Protocol

Wound care
Control hemorrhage with pressure
Splinting as required

If hemorrhage cannot be controlled by direct pressure and is life-threatening, consider Tourniquet Procedure

IV Access Protocol

Pain Control Protocol (Adults or Peds)

If amputation is clean, wrap amputated part in sterile dressing soaked in normal saline and place in air tight container. Place container on ice if available.

Contact Medical Control and Notify Destination
TRINITY EMS SYSTEM PREHOSPITAL GUIDELINES

Approved by EMS Medical Director 2012

HEAD TRAUMA
TRAUMA PROTOCOL # 5 - 07

HISTORY
• Time of injury
• Mechanism (blunt v. penetrating)
• Loss of consciousness
• Bleeding
• Past medical history
• Medications
• Evidence for multi-trauma

SIGNS AND SYMPTOMS
• Pain, swelling, bleeding
• Altered mental status
• Unconsciousness
• Respiratory distress/failure
• Vomiting
• Major traumatic mechanism of injury
• Seizure

DIFFERENTIAL
• Skull fracture
• Brain injury (concussion, contusion, hemorrhage, or laceration)
• Epidural hematoma
• Subdural hematoma
• Subarachnoid bleed
• Spinal injury
• Abuse

Universal Patient Care Protocol

Adult Multiple Trauma Protocol

Isolated Head Trauma?

Spinal Immobilization Procedure

IV Access Protocol

Obtain GCS

GCS <8

Can patient cough or speak?

YES

F

Basic airway maneuvers with BVM
Maintain pulse ox >90%

F

Seizure

NO

<60

B

Blood Glucose

>60

Monitor and reassess

M

Contact Medical Control and Notify Destination

PEARLS
✓ Recommended Exam: Mental Status, HEENT, Heart, Lungs, Abdomen, Extremities, Back, Neuro
✓ If GCS <12 consider air/rapid transport
✓ In the absence of capnography, hyperventilate the patient (adult: 20 breaths/minute; child: 30; infant: 35) ONLY if ongoing evidence of brain herniation (blown pupil, decorticate or decerebrate posturing, or bradycardia)
✓ Increased intracranial pressure (ICP) may cause hypertension and bradycardia (Cushing’s Response)
✓ Hypotension usually indicates injury or shock unrelated to the head injury and should be aggressively treated
✓ The most important item to monitor and document is a change in the level of consciousness
✓ Consider restraints if necessary for patient’s and/or personnel’s protection per the Restraint Procedure
✓ Limit IV fluids unless patient is hypotensive
✓ Concussions are periods of confusion or LOC associated with trauma which may have resolved by the time EMS arrives. Any prolonged confusion or mental status abnormality which does not return to normal within 15 minutes or any documented loss of consciousness should be evaluated by a physician ASAP
✓ In areas with short transport times, RSI/Drug-Assisted Intubation is not recommended for patients who are spontaneously breathing and who have oxygen saturations > 90% with supplemental oxygen

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TRINITY EMS SYSTEM PREHOSPITAL GUIDELINES 2012
HYPERTHERMIA

TRAUMA PROTOCOL # 5 - 08

HISTORY
- Age
- Exposure to increased temperatures and/or humidity
- Past medical history
- Medications
- Extreme exertion
- Time and length of exposure
- Poor PO intake
- Fatigue/muscle cramping

SIGNS AND SYMPTOMS
- Altered mental status or unconsciousness
- Hot, dry, or sweaty skin
- Hypotension or shock
- Seizures
- Nausea

DIFFERENTIAL
- Fever (infection)
- Dehydration
- Medications
- Hyperthyroidism (Storm)
- Delirium Tremens (DT’s)
- Heat cramps
- Heat exhaustion
- Heat stroke
- CNS lesions or tumors

PEARLS
- Recommended Exam: Mental Status, Skin, HEENT, Heart, Lungs, Neuro
- Extremes of age are more prone to heat emergencies
- Predisposed by use of: tricyclic antidepressants, phenothiazines, anticholinergic medications
- Cocaine, amphetamines, and salicylates may elevate body temperature
- Sweating generally disappears as body temperature rises above 104°F (40°C)
- Intense shivering may occur as patient is cooled
- Heat cramps consist of benign muscle cramping secondary to dehydration and is not associated with an elevated temperature
- Heat exhaustion consists of dehydration, salt depletion, dizziness, fever, mental status changes, headache, cramping, nausea, and vomiting. Vitals signs usually consist of tachycardia, hypotension, and an elevated temperature
- Heat stroke consists of dehydration, tachycardia, hypotension, temperature >104°F (40°C) and an altered mental status

Universal Patient Care Protocol
- Document patient temperature
- Remove clothing
- Remove from heat source
- Apply room temperature water to skin and increase air flow around patient
- Cardiac Monitor
- 12 Lead EKG if available
- IV Access Protocol
- Normal Saline Bolus (may repeat)
- Monitor and reassess

Appropriate Protocol
- Based on Patient’s symptoms

Contact Medical Control and Notify Destination

LEGEND
F FIRST RESPONDER
B EMT-BASIC
I EMT-INTERMEDIATE
P PARAMEDIC
M MEDICAL CONTROL

TRINITY EMS SYSTEM PREHOSPITAL GUIDELINES

Approved by EMS Medical Director 2012
HYPOTHERMIA

TRAUMA PROTOCOL # 5 - 09

HISTORY

- Past medical history
- Medications
- Exposure to environment even in normal temperatures
- Exposure to extreme cold
- Extremes of age
- Drug use: alcohol, barbiturates
- Infections/Sepsis
- Length of exposure/Wetness

SIGNS AND SYMPTOMS

- Cold, clammy
- Shivering
- Mental status changes
- Extremity pain or sensory abnormality
- Bradycardia
- Hypotension or shock

DIFFERENTIAL

- Sepsis
- Environmental exposure
- Hypoglycemia
- CNS dysfunction
- Stroke
- Head injury
- Spinal cord injury

PEARLS

- Recommended Exam: Mental Status, Heart, Lungs, Abdomen, Extremities, Neuro
- NO PATIENT IS DEAD UNTIL WARM AND DEAD (core temperature >95º)
- Extremes of age are more susceptible to hypothermia
- With temperatures less than 86º F (30º C), ventricular fibrillation is common cause of death. Handling patients gently may help prevent this
- If the temperature cannot be measured, treat the patient based on suspected temperature
- Hypothermia may produce severe bradycardia so take at least 45 seconds to palpate a pulse
- Hot packs can be activated and placed armpit and groin area if available. Care should be taken not to place packs directly against patient’s skin
- Consider withholding CPR if patient has organized rhythm or other signs of life. Contact Medical Control
- Intubation can cause ventricular fibrillation; the most proficient person should perform this skill gently
- Do not hyperventilate the patient as this can cause ventricular fibrillation
- If the patient is below 86ºF (30ºC), then defibrillate 1 time if defibrillation is required. Normal defibrillation procedure may resume once patient reaches 86ºF (30ºC)
- Anti-arrhythmics may not work below 86ºF (30ºC), and if given, should be administered at reduced intervals. Contact Medical Control before administering
- Pacing should not be done below 86ºF (30ºC)

LEGEND

- F FIRST RESPONDER
- B EMT-BASIC
- I EMT-INTERMEDIATE
- P PARAMEDIC
- M MEDICAL CONTROL

Universal Patient Care Protocol

Cardiac Monitor

Temperature < 95º F (35º C)

YES

Handle very gently
Remove wet clothing
Hot packs and blankets

BLOOD GLUCOSE

If glucose <60
D50 IV/IO (Adult)
D25 IV/IO (Pediatric)

Consider Narcan 0.4 - 2 mg IV

Appropriate Protocol
based on patient’s symptoms

Contact Medical Control and Notify Destination
**MULTI-SYSTEM TRAUMA**

**TRAUMA PROTOCOL # 5 - 10**

---

**PEARLS**

- Recommended Exam: Mental Status, Skin, HEENT, Heart, Lung, Abdomen, Extremities, Back, Neuro
- Transport Destination is based on the EMS System Trauma Plan with EMS pre-arrival notification
- Geriatric patients should be evaluated with a high index of suspicion. Often occult injuries are more difficult to recognize
- Mechanism is the most reliable indicator of serious injury
- In prolonged extrications, serious multi-system trauma, or traumatic brain injury, consider air transport
- Early administration of TXA (less than 1 hour from injury) provides increased benefit, and must be given within 3 hours of injury
- Excessive rapid administration of the TXA 1 gram bolus may cause hypotension
- Scene times should not be delayed for procedures and should be performed en route when possible
- Rapid transport of the unstable trauma patient is the goal
- BVM is an acceptable method of managing the airway if pulse oximetry can be maintained >90%

---

**HISTORY**

- Time and mechanism of injury
- Damage to structure or vehicle
- Location in structure or vehicle
- Others dead or injured
- Speed and details of MVC
- Restraints and protective equipment
- Past medical history
- Medications

**SIGNS AND SYMPTOMS**

- Pain, swelling
- Deformity, lesions, bleeding
- Altered mental status or unconscious
- Hypotension or shock
- Arrest

**DIFFERENTIAL (LIFE THREATENING)**

- Chest: Tension pneumothorax, Flail chest, Cardiac tamponade, Open chest wound, Hemotherax
- Spine Fractures/Spinal Cord Injury
- Intra-abdominal bleeding
- Pelvis/femur fracture
- Head injury (see Head Trauma)
- Laryngeal fracture/ airway obstruction
- Hypothermia

---

**Universal Patient Care Protocol**

**Spinal Immobilization Procedure**

**Airway Protocol**

**Vital signs including GCS**

**VITAL SIGNS**

**P**

- Pain, swelling
- Deformity, lesions, bleeding
- Altered mental status or unconscious
- Hypotension or shock
- Arrest

---

**Rapid Transport to appropriate destination using**

**TRAUMA FIELD CRITERIA DESTINATION PROTOCOL**

**LIMIT SCENE TIME TO 10 MINUTES PROVIDE EARLY NOTIFICATION**

**LEGEND**

- **F** First Responder
- **B** EMT-Basic
- **I** EMT-Intermediate
- **P** Paramedic
- **M** Medical Control

---

**APPLEMEDICAL**

**TRINITY EMS SYSTEM PREHOSPITAL GUIDELINES 2014**
HISTORY
- Complaint of sexual assault
- Drugs or alcohol – patient may not be able to recall the assault or events preceding the assault

SIGNS AND SYMPTOMS
- Unable to recall events
- Physical signs may or may not be present on initial exam
- Emotional stress
- Flat affect

DIFFERENTIAL
- PTSD/Anxiety
- Multisystem Trauma
- Sexually Transmitted Diseases

PEARLS
- Early notification to trauma center ensures timely notification of Sexual Assault Nurse Examiner
- Discouraging patient from changing clothes, showering, going to the bathroom, brushing teeth, or drinking fluids helps ensure the quality of evidence
- Collaborate with the police to determine what articles will be transported with the patient. Police may package evidence on scene or in the ED
**TRAUMATIC ARREST**  
**TRAUMA PROTOCOL # 5 - 12**

**HISTORY**  
✓ Patient who has suffered traumatic injury and is now pulseless

**SIGNS AND SYMPTOMS**  
✓ Evidence of penetrating trauma  
✓ Evidence of blunt trauma

**DIFFERENTIAL**  
✓ Medical condition preceding traumatic event as cause of arrest  
✓ Tension pneumothorax  
✓ Hypovolemic shock  
  - External hemorrhage  
  - Unstable pelvic fracture  
  - Displaced long bone fracture(s)  
  - Hemothorax  
  - Intra-abdominal hemorrhage  
  - Retroperitoneal hemorrhage

**PEARLS**  
✓ Injuries obviously incompatible with human life include decapitation, massively deforming head or chest injuries, or other features of a particular patient encounter that would make resuscitation futile. If in doubt, place patient on monitor and contact Medical Control  
✓ Consider using cardiac arrest protocols if uncertainty exists regarding medical or traumatic cause of arrest  
✓ As with all major trauma patients, transport should not be delayed  
✓ Where use of spinal immobilization interferes with quality CPR, make reasonable efforts to manually limit patient movement

**DIFFERENTIAL**
- Medical condition preceding traumatic event as cause of arrest
- Tension pneumothorax
- Hypovolemic shock
  - External hemorrhage
  - Unstable pelvic fracture
  - Displaced long bone fracture(s)
  - Hemothorax
  - Intra-abdominal hemorrhage
  - Retroperitoneal hemorrhage

**SIGNS AND SYMPTOMS**
- Evidence of penetrating trauma
- Evidence of blunt trauma

**HISTORY**
- Patient who has suffered traumatic injury and is now pulseless

**PEARLS**
- Injuries obviously incompatible with human life include decapitation, massively deforming head or chest injuries, or other features of a particular patient encounter that would make resuscitation futile. If in doubt, place patient on monitor and contact Medical Control.
- Consider using cardiac arrest protocols if uncertainty exists regarding medical or traumatic cause of arrest.
- As with all major trauma patients, transport should not be delayed.
- Where use of spinal immobilization interferes with quality CPR, make reasonable efforts to manually limit patient movement.

**LEGEND**
- **F** FIRST RESPONDER
- **B** EMT-BASIC
- **I** EMT-INTERMEDIATE
- **P** PARAMEDIC
- **M** MEDICAL CONTROL

**EARLY NOTIFICATION TO TRAUMA CENTER IF POSSIBLE**

**RETURN OF SPONTANEOUS CIRCULATION?**
- YES
- NO

**CONTINUE NORMAL SALINE BOLUS**
- YES
- NO

**CONTACT MEDICAL CONTROL AND NOTIFY DESTINATION**
- YES
- NO

**ITP**
- Return of Spontaneous Circulation?
- YES
- NO

**IV PROTOCOL**
- Normal Saline bolus

**SPINAL IMMobilIZATION PROCEDURE**

**BILATERAL CHEST DECOMPRESSION**

**P**

**PEND**

**FIRST RESPONDER**
- EMT-BASIC
- EMT-INTERMEDIATE
- PARAMEDIC
- MEDICAL CONTROL