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TRAUMATIC CARDIAC ARREST

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as the treatment standard for EMT-Is and EMT-Ps in treating patients.
- III. PROTOCOL

STANDING ORDERS

ABC's

CPR Do not delay transport even if CPR has to be interrupted. Minimize interruptions in compressions as much as possible.

MONITOR For V-Fib or Pulseless V-Tach: defibrillate once at 360J or equivalent biphasic energy setting. Complete this protocol before referring to cardiac protocols.

SECURE AIRWAY-INTUBATE Use the simplest effective method while maintaining c-spine. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Consider intubation while en route. Confirm placement, if intubated, with end-tidal CO₂ detector and esophageal detector device. **Continuous waveform capnography should be used in all intubated patients, if available.**

OXYGEN Ventilate with bag-valve or approved ventilator and 100% oxygen.

STOP BLEEDING Apply and maintain direct pressure to wounds with evidence of active bleeding.

SPINE IMMOBILIZATION If indicated, refer to ALS Introduction

IV/IO ACCESS Two 14-16 gauge catheters, macro drip or blood-Y administration sets, wide-open.

CONSIDER

NEEDLE THORACOSTOMY For tension pneumothorax: On affected side in second intercostal space in midclavicular line. Perform on other side if no response to treatment and tension pneumothorax physiology persists. Secure catheter to chest.

Code 3 transport is only appropriate if in paramedic judgment special circumstances exist such as: third trimester pregnancy, witnessed arrest, penetrating trauma.

BASE PHYSICIAN ORDERS

DECLARATION OF DEATH Refer to Determination of Death policy 570.20