PEDIATRIC - 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 with 2 J/kg. Complete this Protocol.
SECURE AIRWAY	Using 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 CO_2 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
TRANSPORT	Code 3 transport is only appropriate if in paramedic judgment special circumstances exist such as: witnessed arrest, penetrating trauma.
IV/IO ACCESS	Start two large-bore cannulas with volume control chambers. Give 20 ml/kg fluid boluses. Repeat x 2. Reassess the patient after each bolus administration.
	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.
BASE PHYSICIAN ORDERS	
DECLARATION OF DEATH	Refer to Determination of Death policy 570.20 for obvious death criteria.