

# Trauma Care

## (Section TC)

### (TC-1) Amputations

- 1) Trauma assessment to include correcting life threats as found
- 2) Spinal Immobilization as indicated
- 3) O2, IV and cardiac monitor as appropriate
- 4) If amputation is incomplete try to splint the limb in physiological position as possible
- 5) With complete amputation follow these guidelines:
  - i) Wrap body part in sterile gauze moist with NS
  - ii) Place into bag or container
  - iii) Place bag of ice into container however don't let body part directly contact the ice
- 6) Support vital status and utilize pain control according to the pain management protocol

### (TC-2) Burn Emergencies

- 1) Scene safety (think about hazard for crew, patient, and bystanders)
- 2) Trauma assessment
- 3) O2, IV, and cardiac monitor
- 4) Think about spinal immobilization especially with electrical burns

#### Minor Burns

- 1) Cover burns of less than 10% BSA with sterile saline soaked dressing
- 2) Splint as indicated

#### Major Burns

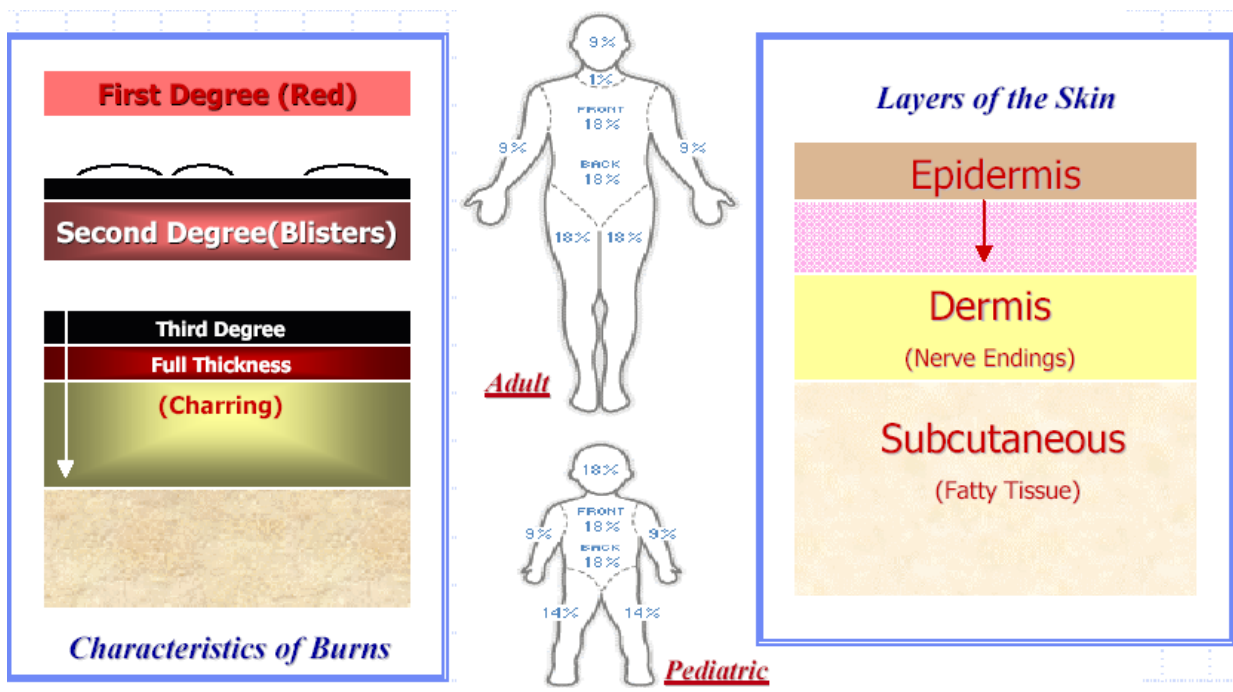
- 1) Fluid replacement
  - a) Aggressive fluid for major burns as follows
    - i) Parkland formula  $4\text{ml} \times \% \text{BSA} \times \text{kg} = \text{total in 24 hr}$
    - ii) One half total in first 8 hour
- 2) Contact medical control for Morphine 2-4mg q 5 minutes up to 10mg

#### General guidelines

Keep in mind that with electrical burns AC current causes V-fib and DC current causes Asystole. In lightning strikes try to get accurate time frame Asystole is not a good indicator in deciding survivability. With chemical burns make sure to decontaminate patient and avoid contaminating your unit and/or the ER.

#### Flight consideration

If the patient has an isolated burn and no underlying or potentially underlying trauma they can be flown directly to the burn center. The burn center is not a trauma center and patients who either have or potentially have underlying trauma must be cleared by a trauma center.



### (TC-3) Head Injury

- 1) Trauma assessment
- 2) O2 IV and cardiac monitor
  - a) Aggressive oxygenation helps reduce secondary brain injury
- 3) Spinal immobilization as indicated
- 4) Maintain a pressure of 90 systolic using fluid boluses of 10-20ml/kg
- 5) For restraining patient refer to restraint protocol

### (TC-4) Crush Injury

- 1) Trauma assessment
- 2) O2, IV, and cardiac monitor
- 3) Aggressive fluid prior to release of compression 20ml/kg of NS
- 4) Albuterol 5mg in HHN
- 5) Contact medical control for Morphine Sulfate for pain management 2-4mg IV push
- 6) For prolonged compression consider the following
  - a) Sodium Bicarbonate 1Meq/kg in 1000ml of NS run wide open

## **(TC-5) Sexual Assault**

- 1) Scene safety
- 2) Be sure law enforcement is notified
- 3) Medical assessment
- 4) Primary responsibility is emotional support
- 5) Handle environment as follows:
  - a) Do not examine genitalia
  - b) Attempt to have same sex EMT if possible
  - c) Save clothing and encourage patient not to defecate, urinate or douche.
- 6) Primary care as required.

## **(TC-6) Snakebite**

- 1) Trauma assessment
- 2) O2, IV, and cardiac monitor as indicated
- 3) Mark the edema with a pen
- 4) Place the effected extremity in a neutral dependent position below the heart
- 5) Support vital status, for hypotension see the hypotension protocol
- 6) Contact Medical control for Morphine 2-4mg up to 10mg for pain control

## **(TC-7) Spinal Injury**

- 1) Trauma assessment to include PMS before and after immobilization
- 2) Support vital status following appropriate protocol
- 3) Keep in mind that cord injury may cause vasomotor control problems. If applicable consider vasopressor after volume status ensured.
  - a) Fluid therapy **10-20ml/kg** of NS over 15-30 minutes
  - b) If unresponsive to fluid therapy and volume status is assured consider **Dopamine 5-20mcg/kg/min**. Maintain pressure of above 90 mm/hg

## Spinal Rule Out

- 1) Follow diagram below
- 2) If in doubt err in favor of the patient and immobilize

