

**Treatment Protocols****Date: 07/01/2023****Traumatic Cardiac Arrest - Adult****Policy #9240A****Adult BLS Standing Orders**

- Universal Patient Protocol
- Apply Spinal Motion Restriction (SMR) as indicated per policy
- High quality uninterrupted CPR (See CPR Policy)
- Manage airway and ventilation per **Airway Policy** and **BVM Policy**
- Apply AED and follow device instructions (**See Defibrillation Policy**)
- Address any areas of significant blood loss prior to arrest with hemorrhage control measures, **regardless if the wound or laceration is actively bleeding**
- Apply tourniquet(s) proximal to any large wound, laceration or amputation of the extremities, **regardless of any active bleeding or hemorrhage.**

If applicable:

- **Determination of Death in the Field Policy**
- **Do Not Resuscitate Policy**
- **Termination of Resuscitation Policy**
- **Hemorrhage Control Policy**

**Adult LALS Standing Orders**

- Establish IV
- NS 500-1,000 mL IV MR x 1 to a max of 2,000 mL to maintain a SBP of  $\geq 90$  mmHg

**Adult ALS Standing Orders**

- If non traumatic cardiac arrest is suspected as the cause of the traumatic event, treat the patient as a medical source for cardiac arrest (ex: single car accident, or found down with pill bottles nearby)
- If the traumatic arrest patient is asystolic on initial contact of EMS, do not attempt resuscitation.
- If rhythm besides asystole: provide high quality uninterrupted CPR

\*\*\* Mechanical CPR devices are prohibited on traumatic arrests \*\*\*

- Monitor EKG
- Establish IV/IO
- Capnography
- ETT
- 12 Lead ECG
- If ETT attempt(s) fail:
  - Supraglottic airway device
- If both ETT and Supraglottic airway attempts fail:
  - Oropharyngeal airway (OPA) with BVM
- EtCO<sub>2</sub> continuous numeric and waveform monitoring on every airway adjunct
- BVM, ventilate once every six (6) seconds to a total of 10 respirations a minute.
- Initiate Transport to closest receiving hospital, if within 15 minute transport time, all remaining care to be completed en-route to nearest hospital

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- **If hospital distance is > 15 minutes following a Traumatic Cardiac Arrest, call Base Station for potential Termination of Resuscitation**
- Vascular Access (IV) or (IO), (large bore, bilateral access preferred if available), wide open (WO)
- If Return of Spontaneous Circulation (ROSC) occurs after any intervention, titrate fluids to maintain a systolic blood pressure of 90 mmHg, obtain 12 Lead ECG (if it doesn't delay transport) and continue transport to nearest hospital.

**Ventricular Fibrillation or Pulseless Ventricular Tachycardia**

- Note: Epinephrine is not indicated in traumatic cardiac arrest. If suspected medical cause for arrest, go to medical cause cardiac arrest algorithm.
- Defibrillation at manufacturer's suggested values (example: 200 joules for adult patients)
- Administer amiodarone 300 mg IV/IO or Lidocaine 1-1.5 mg/kg IV/IO
  - If after 5 minutes rhythm remains refractory:
    - Amiodarone 150 mg IV/IO, for a max cumulative dose of 450 mg or Lidocaine 0.5 mg/kg IV/IO up to 3 mg/kg

**Asystole and Pulseless Electrical Activity**

**\*\*\* Note: Epinephrine is not indicated in traumatic cardiac arrest. \*\*\*\***

- Identify and treat any reversible causes:
  - **Hypovolemia:** Reassess any hemorrhage control interventions to ensure they are adequately addressing blood loss and reapply if necessary. Consider a rapid **500-1,000 ml fluid infusion**
    - Consider TXA if considering hemorrhagic shock SO
  - **Hypoxia:** Ensure that the patient is adequately ventilated and airway maintained
  - **Tension Pneumothorax:** If tension pneumothorax is suspected or the patient has a traumatic injury to the chest, perform bilateral pleural decompression if not already completed **SO**
  - **Hypothermia:** Consider rewarming measures
    - Patients that are hypothermic can be unresponsive to pharmaceutical therapy and electrical therapy
- Ensure proper chest rise and fall with respirations
- Reassess any sucking chest wounds or flail segment interventions
- Reassess endotracheal tube position for dislodgment, occlusion or mainstem bronchus location
- Treat any rhythm changes according to correct treatment protocol

Reversible Causes:

<p><b>H's &amp; T's</b></p> <ul style="list-style-type: none"> <li>• Hypovolemia</li> <li>• Hypoxia</li> <li>• Hydrogen ion excess (acidosis)</li> <li>• Hypoglycemia</li> <li>• Hypokalemia</li> <li>• Hypothermia</li> </ul>	<ul style="list-style-type: none"> <li>• Tension pneumothorax</li> <li>• Tamponade – cardiac</li> <li>• Toxins</li> <li>• Thrombosis (pulmonary embolus)</li> <li>• Thrombosis (myocardial infarction)</li> </ul>
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APPROVED:

Signature on File

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