Adult BLS Standing Orders

- **Universal Patient Protocol**
- Control patient airway and breathing per **Airway Policy**
- **Hemorrhage Control Protocol**
- Keep patient warm
- **Immediate transport (goal < 10 minutes on scene) if patient is critical or mechanism of injury is significant**
- Consider on scene helicopter rendezvous protocol
- Continuous heartrate, pulse oximetry, blood pressure, and capnography (if ALS present) PRN

TRAUMATIC ARREST – See Traumatic Arrest Protocol

CHEST TRAUMA

- See **Needle Thoracostomy Procedure** if tension pneumothorax suspected
- Cover open chest wound with three-sided occlusive dressing following needle thoracostomy
- Release or "burp" dressing if suspected tension pneumothorax redevelops

ABDOMINAL TRAUMA

- Cover eviscerated bowel with saline soaked pads
- NEVER attempt to reduce eviscerated bowel

EXTREMITY TRAUMA

- Place tourniquet for uncontrolled bleeding (see **Hemorrhage Control Protocol**)
- Splint fractures as they lie, if no neurovascular impairment
- Fractures with neurovascular impairment may be realigned, per **BH** with gentle, unidirectional traction before splinting
- If circulation in not restored after two attempts at straightening, splint as it lies and transport immediately
- Splint dislocations in position found
- Immobilize joints above and below injury, if possible
- Pelvic wrap for unstable patients with concern for pelvic fractures

AMPUTATED PARTS

- Place in plastic bag if possible and keep cool during transport
- Do not place in water or directly on ice
- Place avulsed teeth in milk if possible. Avoid touching root of tooth

IMPALED OBJECTS

- Immobilize object
- May remove object if in face, neck or chest if airway ventilation is compromised, or interferes with CPR

OPEN NECK WOUNDS

- Cover with occlusive dressing

HEAD TRAUMA

- Always consider spinal injury and see **Spinal Motion Restriction Protocol**

- Always consider traumatic brain injury, and consider patient impairment if patient is altered, argumentative, or attempting care refusal, see **Patient Refusal Policy**
- **Avoid hypotension and hypoxia.** Single episodes of either can result in permanent damage in head injured patients
- DO NOT HYPERVENTILATE PATIENTS

Adult LALS Standing Order Protocol

- Establish IV (2 large bore if massive blood loss or suspected internal injury)
- **NS 0.9% 500-1,000 mL IV** bolus – for BP < 90 mmHg systolic, target BP > 90 mmHg systolic. May repeat per **BH**

HEAD TRAUMA

- **NS 0.9% 500-1,000 mL IV** – if GCS ≤ 14, maintain BP ≥ 90 mmHg
- Avoid hypotension, hypoxia and hypercarbia

CRUSH INJURY (with extended compression >2 hours of extremity or torso)

- Administer **NS 0.9% - 500 mL IV** bolus just prior to extremity or torso release

Adult ALS Standing Order Protocol

- Insert supraglottic airway or endotracheal tube with in-line stabilization if indicated per **Airway Policy**
- **Ondansetron – 4mg** ODT/IV/IM/IO for nausea and vomiting
- **Pain Medication Protocol PRN**
- Establish IO PRN
- Airway control per **Airway Policy**
- Continuous heartrate, pulse oximetry, blood pressure, and capnography
- Consider TXA for hypotensive patients per **Hemorrhage Control Protocol**

HEAD TRAUMA

- **NS 0.9% 500-1,000 ml/kg IO** – if GCS ≤ 14, maintain normal blood pressure for age
- Avoid hypotension, hypoxia and hypercarbia

Adult Base Hospital Orders

CRUSH INJURY (with extended compression >2 hours of extremity or torso)

- BH - Calcium Chloride – 500 mg IV/IO over 30 seconds just prior to release of extremity or trunk
- BH – Sodium Bicarbonate **–** 1 ampule IV/IO

PERSISTENT HYPOTENSION (systolic BP < 90, in spite of 1,000 mL IV)

- BHP - Consider TXA if indicated per **Hemorrhage Control Policy**
- BHP – Consider Push Dose Epinephrine

A. Take Epinephrine 1 mg of 0.1 mg/ml preparation (Cardiac 1:10,000 Epinephrine) and waste 9 ml of Epinephrine

B. In that syringe, draw 9 ml of normal saline from the patient's IV bag and shake well Mixture now provides 10 ml of Epinephrine at a 0.01 mg/ml (10 mcg/ml) concentration

C. If patient fulfill indications, and has approval from Base Hospital Physician, administer **Epinephrine** 0.5 mL (5 mcg) IV/IO, every 3 minutes, titrate to a SBP > 90 mmHg
Notes:
It is critical to transport ill trauma patients to definitive care as soon as possible. Consider early activation of air ambulance if patient fulfills criteria for **Air Ambulance Activation #4240.**

APPROVED:

Signature on File

Katherine Staats, M.D.

EMS Medical Director