Adult BLS Standing Orders

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

TRAUMATIC ARREST – See Traumatic Arrest Protocol

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 Policy**)
- Splint fractures as they lie if no neurovascular impairment
- Fractures with neurovascular impairment may be realigned. Provide gentle, unidirectional traction before splinting
- If circulation in not restored after two (2) 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 Orders

- Establish IV (2 large bore if massive blood loss or suspected internal injury)

For SBP < 90 mmHg, target BP > 90 mmHg systolic

- NS 500-1,000 mL IV MR x 1 to a max of 2,000 mL to maintain a SBP of ≥ 90 mmHg

HEAD TRAUMA

- **Avoid hypotension, hypoxia and hypercarbia**
- **If GCS ≤ 14, maintain SBP ≥ 90 mmHg**
- NS 500-1,000 mL IV MR x 1 to a max of 2,000 mL to maintain a SBP of ≥ 90 mmHg

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

- NS 500-1,000 mL IV**,** just prior to extremity or torso release

Adult ALS Standing Orders

- Monitor EKG
- Establish IV/IO
- Capnography
- 12 Lead ECG
- **Pain Medication Protocol PRN**

Nausea and Vomiting

- Ondansetron 4 mg IV/IO/IM/ODT PRN, MR x1, total 8 mg

For SBP < 90 mmHg, target BP > 90 mmHg

- NS 500-1,000 mL IV/IO MR x 1 to a max of 2,000 mL to maintain a SBP of ≥ 90 mmHg
- Consider TXA for hypotensive patients ≥ 15 years old per **TXA Administration Policy**

HEAD TRAUMA

- **Avoid hypotension, hypoxia and hypercarbia**
- **If GCS ≤ 14, maintain SBP ≥ 90 mmHg**
- NS 500-1,000 mL IV/IO MR x 1 to a max of 2,000 mL to maintain a SBP of ≥ 90 mmHg

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

- NS 500-1,000 mL IV/IO**,** just prior to extremity or torso release
- Calcium Chloride 500 mg IV/IO over 30 sec just prior to release of extremity or trunk **BH**
- Sodium Bicarbonate **–** 1 ampule IV/IO **BH**

CHEST TRAUMA

- **Needle Thoracostomy Procedure** if tension pneumothorax suspected

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 (SBP < 90 mmHg, in spite of 1,000 mL IV)

- BH – Consider Push Dose Epinephrine

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 Policy.** • Cover open chest wound with three-sided occlusive dressing following needle thoracostomy • Release or "burp" dressing if suspected tension pneumothorax redevelops • **Prioritize scene and provider safety. Ensure patient does not have any weapons, contact PD if assistance required.**

APPROVED:
Signature on File
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