TRAUMATIC CARDIOPULMONARY ARREST – PEDIATRIC

✱✱✱ BASE HOSPITAL CONTACT REQUIRED ✱✱✱

ALS STANDING ORDERS:

1. Initiate and maintain uninterrupted CPR
2. Initiate or maintain spinal motion restriction as appropriate.
3. Make early base contact for destination determination when transport indicated.
4. Maintain open airway, assess for upper airway obstruction:
   - ► *Assist ventilation/oxygenation with BVM and high flow supplemental oxygen.*
5. Monitor cardiac rhythm:
   - ► *For bradycardia, ensure airway is open and provide high flow oxygen by mask, nasal cannula, or blow-by as is indicated and tolerated.*
6. IV/IO access; if unable to place IV, establish IO access (do not delay transport to establish IV or IO):
   - ► *Infuse 20 mL/kg normal saline (maximum 250 mL) IV/IO fluid bolus and make BH contact. May repeat same dose twice for total of three boluses as a standing order.*
7. If chest injury and suspected tension pneumothorax:
   - ► *Place Needle Thoracostomy to side of chest with absent breath sounds.*
   - ► *Place bilateral Needle Thoracostomy when bilateral chest trauma observed.*
8. Transport to Trauma Center as directed by Base Hospital (CCERC base preferred).
9. If trauma is clearly the cause of cardiopulmonary arrest (gunshot wound to the chest, pedestrian hit by a car at high speed, etc), administration of epinephrine is not indicated.

TREATMENT GUIDELINES:

- Trauma arrest patients for who resuscitation and transport is pursued should be triaged as follows:
  - Unmanageable airway - Base Hospital triage to closest appropriate Trauma Center
  - Penetrating or blunt traumatic cardiopulmonary arrest (including pregnant women) - Base Hospital triage to closest appropriate Trauma Center.
- Transport of trauma victims should be rapid with treatment enroute when possible.

Approved: Carl Schultz, MD.

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