## 4.02 TRAUMATIC CARDIAC ARREST Assess patient by history and exam Do **NOT** use Pulseless? Traumatic cause of arrest NO this protocol suspected? YES Are any of the following true? Do **NOT** initiate 1. Injuries incompatible with life? (See policy 4049) 2. Evidence of prolonged cardiac arrest? (See policy 4049) resuscitation 3. Valid DNR (See policy 4051) NO Initiate/Continue resuscitation Perform and prioritize life saving intervention, if clinically indicated: 1. Hemorrhage control (e.g. direct pressure, wound packing, tourniquets etc.) 2. Airway management (e.g. remove airway obstruction, reposition airway, advanced airway etc.) 3. Needle decompression, if concern for tension pneumothorax Immediate ROSC? Transport to trauma center NO

## **OPTIONS**

- 1. Discontinue resuscitative efforts (Policy 4049 section
- 3.1.3)
- 2. Transport to trauma center
- 3. Contact Base Hospital as needed (should not delay care)

## **COMMENTS**

- If there is any suspicion of a medical cause for cardiopulmonary arrest (e.g. older patient with low mechanism), refer to medical cardiac arrest protocol.
- If transporting, minimizing scene time is a priority. All interventions, EXCEPT hemorrhage control, management of airway obstruction and needle decompression should be done en route to hospital as appropriate.
- External chest compressions may be considered but only secondary to other life-saving interventions. LUCAS is NOT indicated in traumatic cardiac arrest.
- Epinephrine is NOT recommended in traumatic cardiopulmonary arrest.
- If patient remains pulseless after attempted life-saving, there is a very low possibility of survival especially for blunt trauma.
- Unsafe scene may warrant transport or alternative treatment despite low potential for survival.
- Minimal disturbance of possible crime scene.

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