In the trauma patient, time is critical. Only initial assessment and treatment of life-threatening injuries should be performed on-scene. For severely injured patients, after appropriate airway management, “load and go” is more appropriate.

If dispatch information gives the responding ambulance reason to suspect the possibility of a significant accident situation (multiple vehicles, etc.), alert Medical Command prior to arrival at scene and consider aeromedical standby.

A. Scene evaluation.

1. Note potential hazard to rescuers and patient.

2. Identify number of patients; organize triage operations, if needed.

3. Observe patient position and surroundings.

4. Consider need for aeromedical evacuation.

B. Consider mechanism of injury.

1. Cause, precipitating factors, and weapons used.

2. Trajectories and forces involved to patient.

3. For vehicular trauma: condition of vehicle, windshield, steering wheel, compartment intrusion, car seat, type and use of seatbelts. Specific description of mechanism, i.e. auto-pole, rollover, auto-pedestrian, etc.

4. Helmet use?

C. Patient assessment.

1. Determine responsiveness.

2. Establish and maintain airway.

   a. Maintain C-spine.

   b. Perform **Airway Management Protocol 5901** as indicated.

3. Breathing.

   a. If adequate, oxygen 15 LPM non-rebreather mask to maintain pulse oximeter >94%. If patient cannot tolerate mask, oxygen 6 LPM by nasal cannula to maintain pulse oximeter >94%.

   b. If inadequate, ventilate with 100% oxygen and perform **Airway Management Protocol 5901** as indicated.

4. Circulation.

   a. Control bleeding.

   b. Assess perfusion status.

5. Neurological status.

   a. Determine level of consciousness using AVPU or GCS.

   b. Check pupils.

6. Limit on-scene time. Unless unusual circumstances, the goal should be:

   a. Not trapped - 10 minutes or less.

   b. Entrapped - within 5 minutes of extrication.

7. In **consultation with Medical Command**, establish mode (ground vs. air) and destination of transport.

D. Treatment.

1. Immobilize patient on long spine board or as indicated in **Spinal Trauma Protocol 5103**.

   Note: All multiple trauma patients are considered to have a significantly distracting painful injury.

2. Transport.

3. Monitor vital signs, ECG, pulse oximeter.

4. At least one large bore IV normal saline.

   a. If hypotensive (BP <90 systolic) **or** other signs and symptoms of shock such as tachycardia or delayed capillary refill, **or** high suspicion of major blood loss, administer 20 ml/kg normal saline IV up to 2 liters and reassess (refer to **Shock Protocol 5108**).

   b. If BP >90 systolic and patient has no other signs or symptoms of shock, administer 100 ml/hour normal saline IV.

5. Prevent heat loss.

6. In **consultation with Medical Command**, consider nasogastric tube placement if patient intubated and no facial trauma suspected.

7. Refer to **Pain Management Protocol 5902** if indicated.

8. Notify Medical Command.

Special Notes:

1. Pregnant patients - tilt backboard to left.