

EL DORADO COUNTY EMS AGENCY PREHOSPITAL PROTOCOLS

Effective: July 2008

Reviewed: July 2009, February 2010

Revised: **July 1, 2016**

Scope: BLS/ALS – Adult/Pediatric



EMS Agency Medical Director

HEAD TRAUMA

ADULT

BLS TREATMENT

ABCs / ROUTINE MEDICAL CARE :

- Be prepared to support ventilation with appropriate airway adjuncts.
- Administer oxygen if indicated at an appropriate flow rate
- Spinal Precautions as indicated.
- For eye injuries consider covering both eyes to prevent further trauma of injured eye.
- Consider possible non-traumatic etiology of ALOC: shock, toxic exposure, insulin shock, or seizures. Refer to appropriate protocol.

PROTOCOL PROCEDURE: Flow of protocol presumes patient has, or has the potential for, a significant head injury. Rapid transport with IV(s) established en route is a standard. Early notification to the hospital is essential for proper triage and notification of surgical personnel.

ALS TREATMENT

CONTACT BASE STATION - Early notification of destination and surgical personnel.

RAPID TRANSPORT - ASAP - Ideally, scene times for critical trauma should not exceed 10 minutes.

NORMAL SALINE - Establish 2 large bore IVs via macro drip tubing. Place IO if unable to establish IV. If patient is in shock or is compensating for impending shock, refer to SHOCK protocol.

Hypotensive patients with head injuries should have IV fluid resuscitation to maintain appropriate systolic BP.

BLOOD SAMPLE/GLUCOSE LEVEL ASSESSMENT - Obtain blood sample via venipuncture. Rule out diabetic emergency. **Use caution when administering Dextrose/Glucagon to head injured patients, consider contacting base station if blood sugar is borderline or patient is not a known diabetic.**

REFER TO ALTERED LEVEL OF CONSCIOUSNESS OR SEIZURE PROTOCOLS AS APPROPRIATE.

LIDOCAINE 2%* (PRE-INTUBATION ONLY) - 1.5 mg/kg IV push (Max. total dose 100 mg). Administer 2 minutes prior to intubation attempt when feasible, to blunt increased ICP.

AVOID HYPERVENTILATION OF HEAD INJURED VICTIMS.

PEDIATRICBLS TREATMENT**ABCs / ROUTINE MEDICAL CARE :**

- Be prepared to support ventilation with appropriate airway adjuncts.
- Administer oxygen if indicated at an appropriate flow rate
- Spinal Precautions as indicated.
- For eye injuries consider covering both eyes to prevent further trauma of injured eye.
- Consider possible non-traumatic etiology of ALOC: shock, toxic exposure, insulin shock, or seizures. Refer to appropriate protocol.

PROTOCOL PROCEDURE: *Flow of protocol presumes patient has, or has the potential for, a significant head injury. Rapid transport with IV(s) established en route is a standard. Early notification to the hospital is essential for proper triage and notification of surgical personnel.*

ALS TREATMENT

CONTACT BASE STATION – Early notification of destination and surgical personnel.

RAPID TRANSPORT – ASAP, Ideally, scene times for critical trauma should not exceed 10 minutes.

NORMAL SALINE – Establish 2 large bore IVs via macro drip tubing. Place IO if unable to establish IV. If patient is in shock or is compensating for impending shock, refer to SHOCK protocol.

Hypotensive patients with head injuries should have IV fluid resuscitation to maintain appropriate systolic BP. [70 + (2 x age in Yrs)]

BLOOD SAMPLE/GLUCOSE LEVEL ASSESSMENT - Obtain blood sample via venipuncture. Rule out diabetic emergency. **Use caution when administering Dextrose/Glucagon to head injured patients, consider contacting base station if blood sugar is borderline or patient is not a known diabetic.**

REFER TO ALTERED LEVEL OF CONSCIOUSNESS OR SEIZURE PROTOCOLS AS APPROPRIATE.

LIDOCAINE 2% (PRE-INTUBATION ONLY) – 1 mg/kg IV/IO (Max. total dose 50 mg).

Administer 2 minutes prior to intubation attempt when feasible, to blunt increased ICP.

AVOID HYPERVENTILATION OF HEAD INJURED VICTIMS.