**Traumatic Cardiac Arrest**

**TRAUMATIC CARDIAC ARREST IDENTIFIED**

- **AIRWAY MANAGEMENT**: with c-spine control (basic interventions only)
  - Insert Oropharyngeal / Nasopharyngeal Airway (OPA / NPA)
  - Insert Supraglottic Airway (SGA)

- **BREATHING**: BVM ventilations x2, maximising oxygenation
  - Bilateral chest decompression in suspected pneumothorax / chest trauma

- **CIRCULATION**: stop any life-threatening haemorrhage
  - Consider Combat Application Tourniquet (CAT)
  - Consider pelvic binder (T-POD)
  - Establish IV/IO Access (limited to 1x attempt)

- **DEFIBRILLATION**: apply therapy pads
  *Remember*: only 7.5% of traumatic cardiac arrest are initially in a shockable rhythm

- **COMPRESSIONS**: chest compressions should not delay the treatment of reversible causes listed above or transportation. In cardiac arrest caused by hypovolaemia, cardiac tamponade or tension pneumothorax, chest compressions are unlikely to be as effective as in normovolaemic patients.

- Prepare for immediate and rapid **EXTRICATION**;
  Secure patient to scoop or spine-board or load onto stretcher

- **NOTIFY RECEIVING HOSPITAL**

- **TRANSPORT** immediately to appropriate hospital
  Perform only life-saving interventions (e.g. CPR, vascular access, fluids, adrenaline)

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**BLUNT TRAUMA**

Prolonged CPR in BLUNT trauma cardiac arrest after reversible causes have been addressed is almost never associated with a good outcome. If delivery to an Emergency Department cannot be achieved within 25 minutes from arrival on scene, it is reasonable to terminate resuscitation if no ROSC after 10 minutes of resuscitation post correction of reversible causes / damage control measures and termination criteria are met.

- **Termination of Resuscitation**