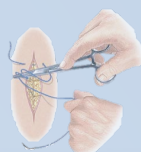
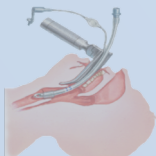


Diver Medic Technician

Skills Aid



TRAUMA TRAINING

Website: www.trauma-training.org

E-mail: info@trauma-training.org



Section		Page
1. Assessment		1
1.1	ATLS – A.B.C.D.E. Survey	1
1.2	ATLS – Trauma Teams	2
1.3	ATLS – TRIAGE	3
2. Respiratory		4
2.1	Compromised Airway	4
2.2	iGEL Insertion Technique	5
2.3	E.T. Insertion Technique	6
3. Cardiovascular		7
3.1	A.E.D. Algorithm	7
3.2	Venepuncture	8
3.3	Venous Cannulation	9
3.4	Subcutaneous Injection	10
3.5	Intramuscular Injection	10
3.6	Intravenous Infusion	11
4. Elimination		12
4.1	Catheterisation	12
5. Wound Closure		13
5.1	Interrupted Suture Pattern	13
6. Intra-Osseous		14
6.1	Fast-1 Intra-Osseous Insertion	14
6.2	B.I.G. Intra-Osseous Insertion	15
7. Gastric		16
7.1	Naso-Gastric Tube Insertion	16
8. Tension Pneumothorax		17
8.1	Needle Decompression	17
9. Rapid Sequence Induction (R.S.I.)		18
9.1	Rapid Sequence Induction (R.S.I.)	18



Website: www.trauma-training.org

E-mail: info@trauma-training.org



Advanced Trauma Life Support - ABCDE Assessment 1.1

Shout/ Signal / Send for help.
Approach with care.
Free from danger (extract from the area if needed).
Evaluate the casualty, what caused the injury.

First Look: Can the casualty talk ?
Rapid Inspection: Airway, Breathing, Cardiovascular & Neurological Implications.
Findings: Injuries, Shock & demeanor.

Be Systematic. The ATLS Principles MUST be adhered to. Manage catastrophic haemorrhage immediately, then conduct thorough ABCDE Survey.

Look: Any obstructions, See-saw breathing, choking.
Listen: Gurgling, Snoring.
Feel: Air Movement.
Top to Toe: Neck : Signs of T.W.E.L.V.E.

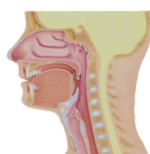
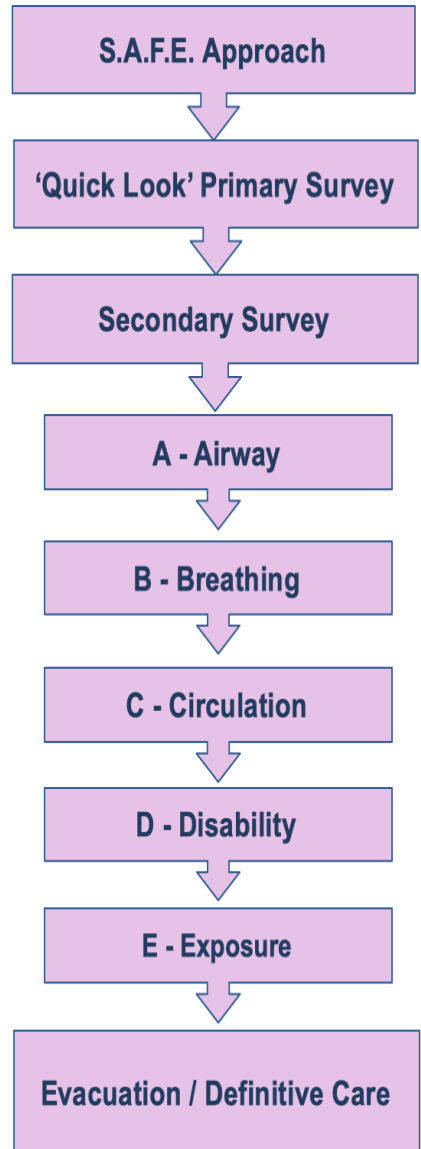
RISE 'n' FALL: Rate, Injuries, Symmetry, Effort of breathing. & Feel the chest, Assess resonance, Listen to both sides of the chest, Look at the back.
Top to Toe: Shoulders & Chest

Look: Sweaty / Clammy / Pale, blood loss.
Feel: Peripheral perfusion, Temperature.
Pulse : Rate, regular, weak, bounding.
Estimated B/P: No Radial Pulse = systolic <90mmHg.

Level Of Consciousness: A.V.P.U.: Alert, Voice, Pain, Unresponsive.
Pupil Assessment: Pupils Equal & reactive.
Top to Toe: Head

Top to Toe: Abdomen, Pelvis, Arms, Legs & Back
Check: For alert bracelets / medallions.
Maintain: casualty's dignity.
Avoid: casualty heat loss.

Give definitive care.
Continue to Monitor ABCDE's.
Prepare for evacuation.
Implement Tertiary Survey.
Document Care.



A	Alert
V	Responds to Voice
P	Responds to Pain
U	Unresponsive



Advanced Trauma Life Support - Trauma Teams 1.2

AIRWAY

Assess:

- The airway. (Look, Listen & Feel).
- Top to Toe: Neck (T.W.E.L.V.E).

Immediate Interventions:

- Airway suction if necessary.
- Chin lift / jaw thrust if necessary.
- Oral / nasal airway if necessary.
- Definitive airway insertion (Inform Leader, RSI is likely needed).

If Spinal Injury is Suspected:

Assume spinal injury in all multi-system trauma.

- C-spine immobilisation (applied immediately).
- C-spine collar (applied as soon as possible).
- Definitive immobilization (once assessment complete).

SECONDARY ROLE: The Disability Assessment :

- Assessing an A.V.P.U.
- Assessing pupil response.
- Top to Toe: head examination.

Immediate Interventions:

- As Above.

AIRWAY Assistant

Assess: The R.I.S.E. - F.A.L.L. assessment.

R - Breathing Rate

I - Injuries

S - Symmetry

E - Effort

F - Feel

A - Assess (Percussion)

L - Listen (Auscultate)

L - Look :At back / armpits

- Top to Toe: Shoulders & Chest examination.

- Apply a SpO₂ monitor (if available).

Immediate Interventions:

- Ventilate with 100% oxygen.
- Non-rebreather mask if RR > 9 Or < 43 (O₂ @ 15L/min).
- Ventilate with B.M.V. if RR < 8 Or > 44 (O₂ @ 15L/min).
- Needle decompression (if tension pneumothorax suspected).
- Occlusive / valve dressing (if sucking chest wound present).
- Assist with RSI Intubation (always ordered by leader):
 - o Applying cricoid pressure.
 - o Evaluating ETT / IGEL position.
 - o Securing tube.

Circulation

Assess:

- Take a Pulse Rate (and evaluating its character).
- Estimating Blood Pressure (Does the casualty have a Radial Pulse).

Immediate Interventions:

- Apply pressure to hemorrhages (Immediately if catastrophic).
- Applying tourniquet (Immediately if can't be controlled).
- Establish IV access.
 - o 2 large I.V. bore cannula's (18g minimum).
 - o intraosseous Device.
- Commencing I.V. fluid.
- 250mls of crystalloid (Hartmans / Saline 0.9%), then reassess.
- Assist with RSI:
 - o Giving sequential drugs (under direction of Team Leader).

SECONDARY ROLE (After casualties' initial stabilisation):

- Monitor Casualties Pulse & Blood Pressure.
- Apply of a cardiac monitor (if available).
- Administer I.V. Fluid as instructed.
- Administer I.V. Drugs as instructed.

Runner

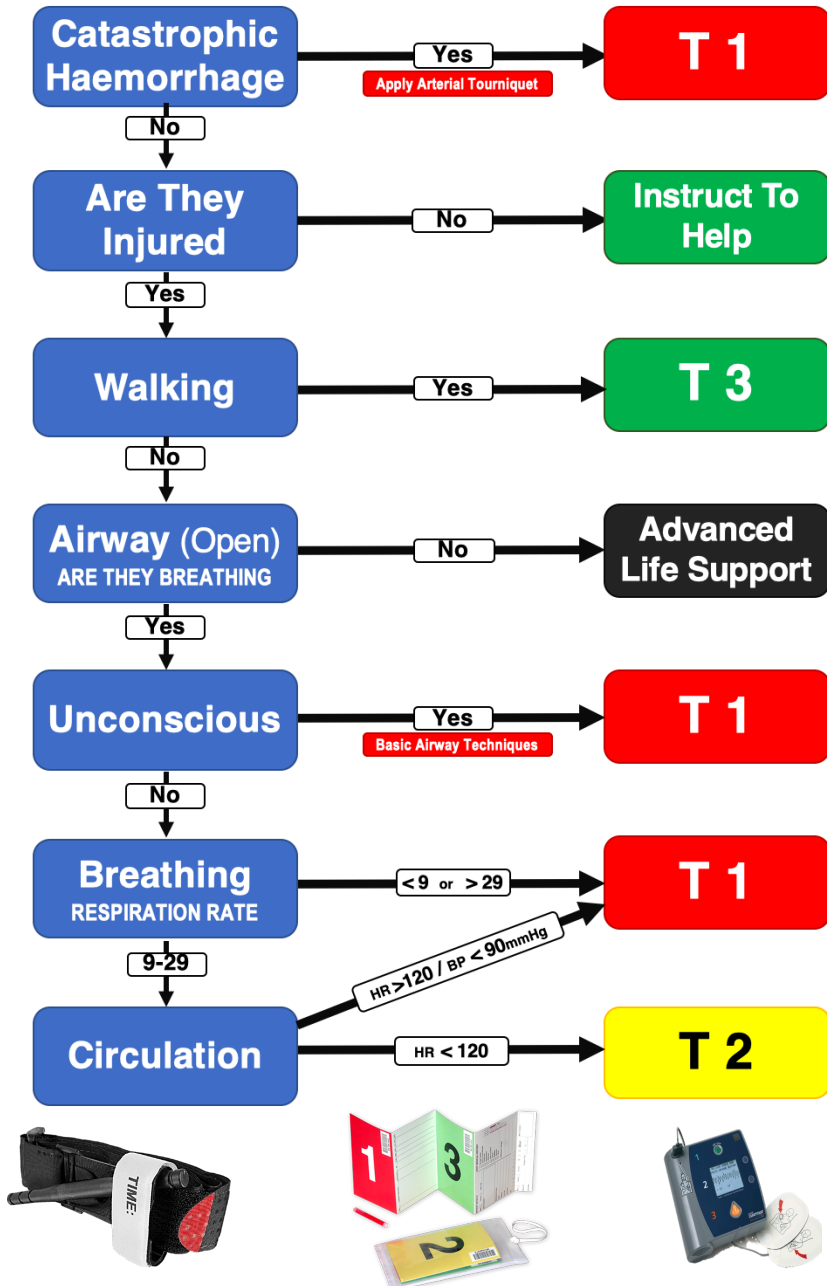
Assess:

- Top to toe:
- Abdomen examination.
- Pelvis examination.
- Legs examination.
- Arms examination.
- Back examination. Using a logroll if spinal injury suspected with Airway to lead.
- Complete disrobing of casualty.
- Logistical support of team.

Immediate Interventions:

- Prime I.V. Fluid if I.V. access is being established.
- Limb splinting.
- Pelvis wrapping.
- Primary dressings.
- Logistical Support of other team members

Advanced Trauma Life Support - TRIAGE 1.3



Compromised Airway 2.1

Presentation of an Airway Obstruction

- Noise (stridor, snoring)
- Secretions
- Abnormal breathing pattern
- Patient pale or blue
- Looks distressed
- Cannot speak or difficulty in speaking



Clear And Support The Airway:

- Use simple actions first: suction, jaw thrust, chin lift
- Progress to simple adjuncts: NPA, OPA (as tolerated)
- Consider using a laryngoscope to improve view for suction (if available)
- Consider Magill forceps to remove solid debris (if available)

With suspected C-spine injury jaw thrust is preferred to chin lift

Support Ventilation:

- Give high concentration oxygen (by mask, or delivered by BVM)
- Aim for consistent ventilation between 10-20/min if RR >30 or < 8/min



Airway CLEAR

Maintain the Airway:

- Consider lateral, ¾ prone or head down positions
- If spinal immobilisation applied, suction should be available

Airway NOT CLEAR

Advanced Airway Skills:

- i-GEL
- Endo-Tracheal Intubation
- Surgical Airway (facial injury; airway burns; foreign body)



i-GEL Insertion Technique 2.2

iGel has a low failure rate. Even with difficult airways.

Head Tilt / Chin Lift. Position maintained by the **Airway Assistant** throughout intubation. Placing an IV bag under the neck can help maintain.

The **Airway Assistant** is responsible for all oxygenation / ventilation.

The **Airway** is responsible for intubation. If >45 sec's (or O₂ Sats <89%) reventilate for 60 sec's then re-attempt. If >3 attempts swop with **Airway Assistant**.

The **Airway Assistant** is responsible for oxygenation / ventilation.

The **Airway** confirms placement L & R lung (Apices & Bases) & epigastric. Readjust tube if poor air entry.

The **Airway** secures the iGEL with 1cm ribbon or purpose made fastening device. Avoid surgical tape.

Assess Airway

Mallampati Classification

Open Airway

Sniffing the morning air

Pre-oxygenate

At Least 60 Seconds

Intubation

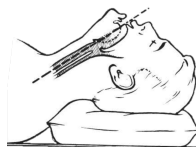
Within 45 Seconds

Ventilate

Confirm Placement

Both sides / stomach

Secure Tube



Endo-Tracheal Insertion Technique 2.3

E.T. Intubation has a high failure rate. Especially with difficult airways (Short necks, obesity & trauma).

Head Tilt / Chin Lift. Position maintained by the **Airway Assistant** throughout intubation. Placing an IV bag under the neck can help maintain.

The **Airway Assistant** is responsible for all oxygenation / ventilation.

The **Airway** stands at the head, gentle insert laryngoscope blade with left hand. Use suction as necessary with right hand. Visualize vocal cords.

The **Airway** is responsible for intubation. If >45 sec's (or O₂ Sats <89%) reventilate for 60 sec's then re-attempt. If > 3 attempts swop with **Airway Assistant**.

The **Airway Assistant** is responsible for oxygenation / ventilation.

The **Airway** confirms placement L & R lung (Apices & Bases) & epigastric. If only R, pull back 1cm. If epigastric, remove.

The **Airway** secures the E.T. tube with 1cm ribbon or purpose made fastening device. Avoid surgical tape.

Assess Airway
Mallampati Classification

Open Airway
Sniffing the morning air

Pre-oxygenate
At Least 60 Seconds

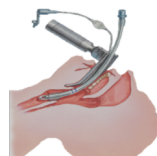
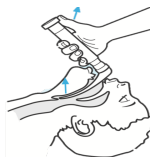
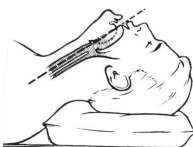
Laryngoscopy
Left Hand. View Vocal Cords

Intubation
Within 45 Seconds

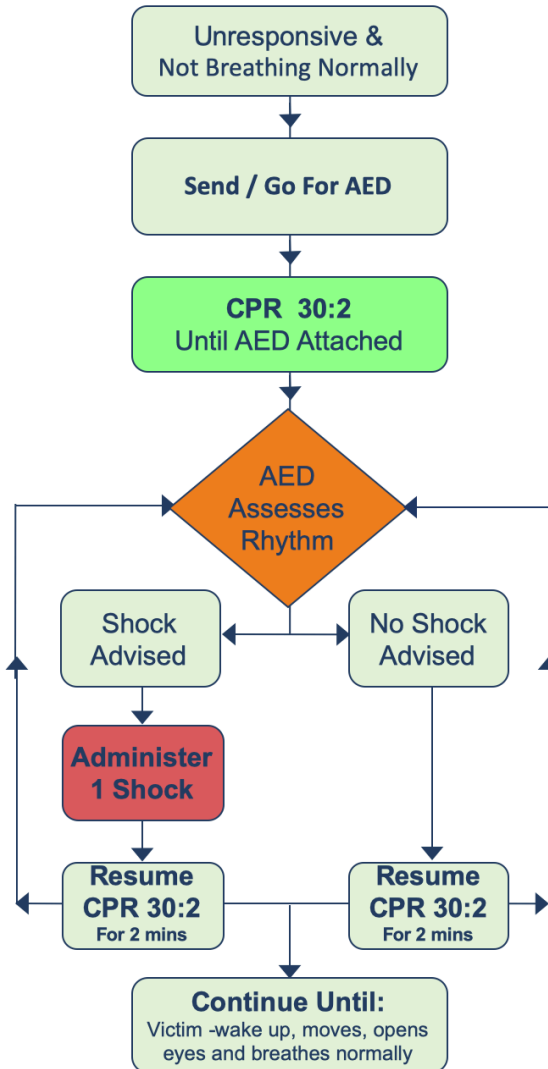
Ventilate

Confirm Placement
Both sides / stomach

Secure Tube



A.E.D. Algorithm 3.1



Venepuncture 3.2

Position arm below heart level of heart. 'Lock' arm in place to ensure no movement. Place tourniquet 4 cm above puncture site, wait 2 minutes before puncturing.

Use 21-23g needle. Be systematic. Assemble all equipment in order of use, screw barrel onto needle assembly. Apply close fitting clinical gloves.

The medial / anti-cubital Fossa are best. Use a sterilising swab in all directions to saturate skin. Allow 60 seconds to evaporate.

Practice holding the venepuncture set while spreading the surface skin above the puncture site.

Do Not 'search' for a vein. Insert bevel up at a shallow angle, feel the layers (Dermal, fat & vessel wall). Feel the 'pop' as it enters vessel, look for flash of

Once you see the 'flashback', slide the needle 1-2mm into the middle of the vessel.

Hold by barrel. Remove tourniquet. Sequentially insert vacutainer bottles and allow to fill (2-5 seconds).

Simultaneously remove needle & apply pressure on puncture site with gauze. Needle in sharps bin. Clean area & dispose of needle in sharps bin.

Position Arm

Apply venous tourniquet

Assemble Equipment

Select Appropriate Cannula Size

Select site / Serilise

Appropriate to casualties needs

Anchor Vein

Using non dominant hand

Insert Needle

Bevel Up 15 - 25°

Flashback

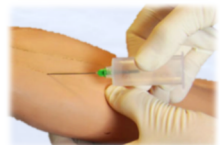
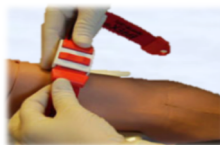
Level Needle & Advance 1mm

Take Samples

Release Tourniquet

Dispose Of Needle

Apply Pressure 1 Min, Dress



Venous Cannulation 3.3

Position arm below heart level of heart. 'Lock' arm in place to ensure no movement. Place tourniquet 4 cm above puncture site, wait 2 minutes before puncturing.

A 20-22g cannula for IV drugs, 18-14g for IV Fluid. Be systematic. Assemble all equipment in order of use, have gauze & position cannula bung for later use. Apply close fitting clinical gloves.

Metacarpals for 20-22g, Basilic or Cephalic for IV fluid. Use a sterilising swab in all directions to saturate skin. Allow 60 seconds to evaporate.

Practice holding the cannula while spreading the surface skin above the puncture site. 3 points of contact is essential.

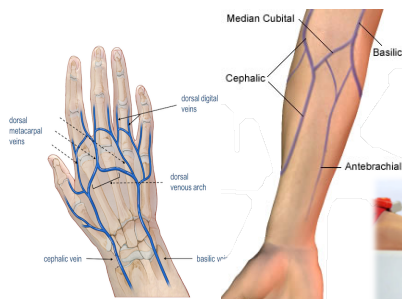
Do Not 'search' for a vein. Insert bevel up at a shallow angle, feel the layers (Dermal, fat & vessel wall). Feel the 'pop' as it enters vessel, look for flash of blood.

Once you see the 'flashback', slide the cannula 1-2mm into the middle of the vessel, whilst holding trocar. Remove tourniquet.

Hold Trocar. Slide cannula up the vein (witness cannula flashback). Place gauze under wings, rapidly remove trocar (**place in sharps bin**) & apply bung.

Place surgical tape on wings, and apply sterile cannula dressing over puncture site. Document time & date. Flush the cannula with sterile saline 0.9%.

Bleeding, Infiltration, infection. Remove and report to medic.



Colour	Gauge	Crystalloid	Plasma	Blood
Orange	14G	16.2	13.5	10.3
Grey	16G	10.8	9.4	7.1
Green	18G	4.8	4.1	2.7
Pink	20G	3.2	2.9	1.9
Blue	22G	1.9	1.7	1.1



Position Arm

Apply venous tourniquet

Assemble Equipment

Select Appropriate Cannula Size

Select site / Serilise

Appropriate to casualties needs

Anchor Vein

Using non dominant hand

Insert Cannula

Bevel Up 15 - 25°

Flashback

Level off & Advance 1mm, release tourniquet

Insert Cannula

Rail road off trocar, attach bung, **SHARPS**

Secure Cannula

Apply dressing, securely fix, flush

Look for complications

Subcutaneous Injection 3.4

Prepare medication in appropriate syringe & attach 25g Orange needle.

Select fat deposit (Tummy, thigh or forearm). Sterilise area & allow to evaporate for 60 secs.

Pinch sterilised section of fat.

Stab needle. Aspirate, if blood present, abort injection.

Steadily inject over 10 secs. Release the pinch on the fat. Pull out. Apply pressure 30 secs.

Clean equipment and dispose of needle in sharps bin.



Equipment

INSULIN SYRINGE OR 25G (ORANGE.)

Select Site

STERILISE AREA

Pinch Skin

LIFT AWAY FROM UNDERLYING MUSCLE

Insert Needle

45° - 90° ANGLE

Inject

1 -2 ML FLUID

Dispose Of Needle

OBSERVE INFLAMMATION / SWELLING

Intramuscular Injection 3.5

Prepare medication in appropriate syringe & attach 21g / 23g Green / Blue needle.

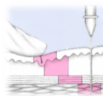
Select muscle (gluteal, deltoid or thigh). Sterilise area & allow to evaporate for 60 secs.

Pull firmly away from insertion site. The Z track disrupts any leakage post injection.

Slide needle to muscle layer (feel dermal, fat & muscle). Aspirate, if blood present, abort injection.

Steadily inject over 60 secs. Release z track pressure. Pull out. Apply pressure 30 secs.

Clean equipment and dispose of needle in sharps bin.



Equipment

21G NEEDLE (GREEN.)

Select Site

STERILISE AREA

Manipulate Skin

Z TRACK TECHNIQUE

Insert Needle

90° ANGLE, ASPIRATE & CHECK FOR BLOOD

Inject

1 ML FLUID EVERY 10 SECS

Dispose Of Needle

OBSERVE INFLAMMATION / SWELLING

Intravenous Infusion 3.6

Wash hands, remember, if you don't touch it, you can't infect it.

Try and hang IV bag. When tearing off administration port, avoid touching with your hand.

Move the roller-clamp from 6-10cm below the drip chamber and close. This prevents air mixing with IV fluid when primed. Secure bunged end to roller clamp.

Using a firm left & right movement, insert the spike in a single movement into the IV bag.

Pump the drip chamber until half full. If it over-fills you can invert the bag and empty into IV bag.

The fluid will not pass through the air-filter in the bung.

If the process has been followed, there should be no bubbles. However, a small amount is insignificant. If large amount present, repeat priming process.

It is vital that the IVI is looped & secured with surgical tape. This prevents it being dislodged & reduces the risk of infection.

Open Giving Set
Using Aseptic No Touch Technique

Prepare I.V. Fluid
Check type, date & clarity. Then open.

Close The Roller Clamp
Secure the end of set to roller clamp

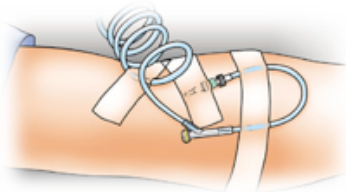
Unsheathe Spike
Using ANTT. Push into port of the fluid

Half Fill The Chamber
Gently pump the walls of the chamber

Open The Roller Clamp
Slowly. Let the fluid flow through the set

Observe Set For Bubbles
Agitate giving set to remove bubbles

Secure The Giving Set
Using ANTT. Administer IVI at set rate



Catheterisation 4.1

Preparation is the key to sterility, use ANTT & place all sterile equipment on sterile field. Disrobe casualty, wash groin. Place on **two** sets of sterile gloves.

Retract foreskin, Clean glans with sterilising solution. Place penis through Fenestrated sterile towel, wrap penis shaft in sterile gauze, remove outer gloves.

Hold the shaft vertically (using gauze) gently dispense anaesthetic gel at tip & massage down the urethra. Allow 2 minutes to work, organise supplies.

Tear tip of catheter package off. Insert tip in end of Urethra, slowly insert, tear outer package as you go. Insert till 25mm of bifurcation.

Urine should drain from the catheter into receiver / drainage bag (if prior attached, this is preferred).

Use syringe of sterile water, insert firmly into port, inflate balloon with recommended volume (10-30 mls, this info will be on packaging).

Gently retract catheter, If urine leaks, emptying a few mls can create a better seal in the bladder.

Wipe groin clean, tear fenestrated drape clear, **retract foreskin to prevent paraphimosis**. Tape drainage bag to leg, do not allow a taut catheter.

Clean away all equipment into clinical waste. Observe for complications. Monitor & record urine output accurately.

Assemble Equipment

Clean Urethra

REMOVE OUTER GLOVES

Apply Anaesthetic Jelly

MASSAGE GEL'S PASSAGE

Insert Catheter

UP TO 1" BELOW THE BIFURCATION

Observe Urine Drainage

Inflate Balloon

WITH 10 ML OF STERILE WATER

Retract Catheter

GENTLY

Secure Catheter

ATTACH DRAINAGE BAG & TAPE TO LEG

Equipment Disposal



Interrupted Suture Pattern 5.1

Use strict asepsis. Use needle holder to grasp suture in flat portion.

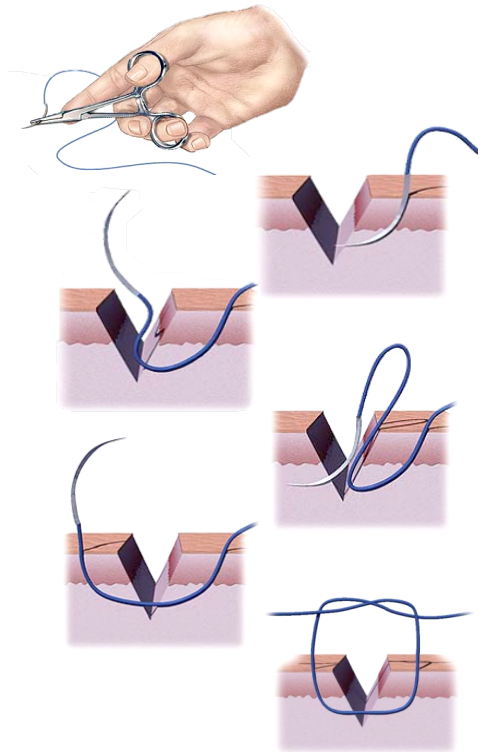
Grip the needle with the needle holder at a 90° angle $\frac{1}{3}$ down the body.

Push the needle through the skin and into the base of the wound. Then pull the suture through the first side of the wound.

When the suture is properly in place, it should form a U-shape.

To tie a suture, first loop it around the needle driver twice. Next, grab the short end of the suture with the needle driver.

Start by creating the first knot of a loop. Next, make a second single loop in the opposite direction. This completes the square knot.



SUTURE RE-CAP

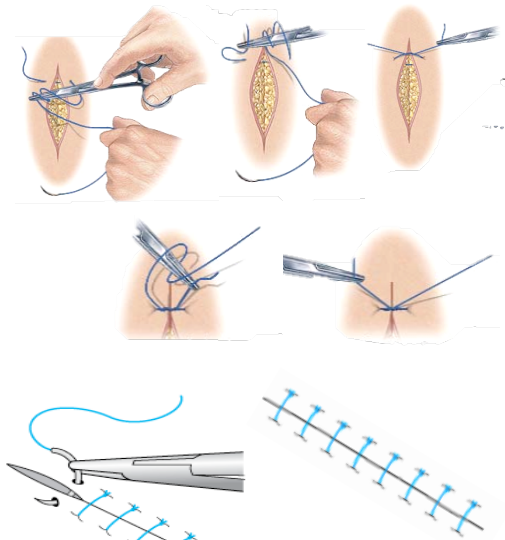
Lay down first loop of knot. As described above.

Create second double loop around body of needle holder in opposite direction, using needle holder, grasp short end and pull.

Repeat this process for a third time in the opposite (original) direction. Place knot 3-5mm from edge of suture line. Cut end of sutures to 2-3mm.

Place following sutures at distal end of the sutures. Subsequent sutures should be placed to fill in gaps. Eventually there should be no more than 5mm gaps between each suture with all the suture knots in the same direction.

Place a sterile dressing over the sutures.



Fast-1 Intra-Osseous Insertion 6.1

Use the target patch, locate sternal notch. Place half-moon cut-out, insertion site is in the circular cut-out.

With traumatic / distracting injuries local anaesthesia is often unnecessary. Clean area with sterilising swab and allow to evaporate.

With your finger in sternal notch slide the half-moon cut-out around finger. Pull off adhesive strips and secure patch to chest wall.

At a 90° angle place needles against skin. Using ever-increasing force to activate the device. **Do not** stab or twist device. Once spring deploys, cease pressure.

Gently pull device away. Throw in sharps bin or push in the needle receptor and place the cap over the end of the device.

Use ANTT to connect IVI, connecting a 3-way tap can increase the use of the device. Connect to end of I.O. device. Flush with Saline 0.9%.

Place the clear plastic dome over the device.

Administer fluid / I.V. Drugs as needed. Look for potential complications. I.O. devices should be removed as soon as an IV cannula can be inserted.

Locate Penetration Site

Perpendicular On The Surface Of Manubrium

Prepare The Site

Clean Sternum / Local Anaesthetic

Place Target Patch

Locate Sternal Notch With Index Finger

Insert Introducer

90° To Sternum, Push Firmly Until Release

Expose Infusion Tube

Dispose Of In Sharps Bin

Connect Infusion Tube

Using Leur Slip, Flush With 10ml NACL

Secure Protector Dome

Press Firmly To Engage Velcro™

Administer IV Fluid

Confirm Placement, Aspirate & Flush



B.I.G. Intra-Osseous Insertion 6.2

Locate the protrusion below the Knee. The Tibial Plateau is located 1" horizontally towards the groin & 1/2" vertical. A small depression is felt.

Sterilise the Tibial Plateau. Hold the blue barrel firmly and press gently into the Plateau.

Pinch and pull the red pin. Place the pin inside the sterile packaging for later use.

Keep hold of the blue barrel, maintain the BIG at a 90° angle, press firmly on top of the device with palm until the spring deploys.

Using a 'wiggling motion' remove the BIG. **Beware**, there is a risk of pulling out the I.O. needle whilst doing this.

Take the red clip and slide around the base of the I.O. cannula. This acts as a securing depth gauge and the bright red clip makes it easier to identify the device.

Grip the trocar and remove. Place in sharps container. It is possible that blood / bone marrow leaks, therefore go rapidly to next section.

Take a pre-primed IVI with a 3way adaptor and connect to I.O. Flush with 5mls of 0.9% saline and secure the IVI / red clip with surgical tape.

Locate Penetration Site

Tibial Tuberosity 25mm Medial, 12mm Prox

Hold Bottom Firmly

90° Angle To The Bone

Squeeze & Pull Red Pin

Firmly

Apply Pressure To Top

Firmly, With Palm Of Hand

Remove The B.I.G.

Pull Up, Side To Side Motion

Clip & Secure Needle

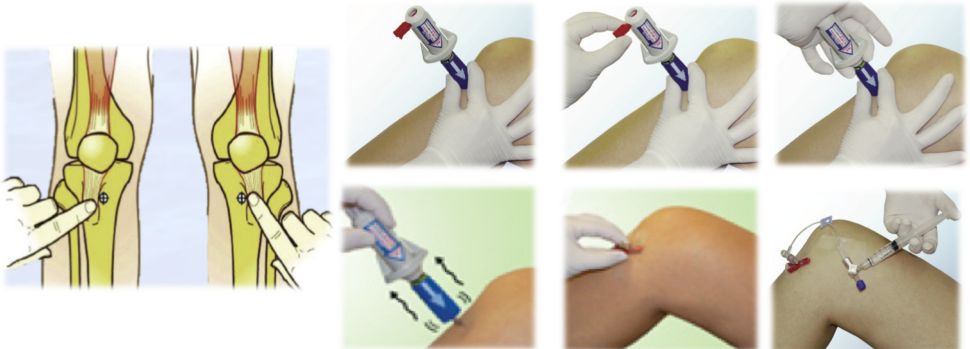
Using Red Safety Latch & Tape

Remove The Trocar

Dispose Of In Sharps Bin

Connect IV Extension

Confirm Placement, Aspirate & Flush



Naso-Gastric Insertion 7.1

NG tube insertion is a clinically clean procedure. It helps if the tube is cold before insertion. Place ph indicator in the barrel of a 50ml catheter tip syringe.

The left nostril is the preferred route for insertion. The Fowlers position is a sitting 66°angle.

Place the tip of the NG tube at the epi-gastric region & trace its path to the left nostril. Measure the length & make a note or mark with tape on tube.

Use a water-based lubricant, such as KY Jelly.

Place the tip of the NG tube in the left nostril. Gently insert 10-15cm. Stop. Use a straw to give the casualty a mouthful of water to hold in their mouth.

Instruct to "SWALLOW". Insert tube as they gulp. Keep giving them a bolus of water & repeating process until the measured depth reached.

Flush with air & auscultate for gastric sounds. Aspirate syringe, look for green gastric content, if it is gastric fluid, it will turn indicator red.

Tape the tube to the nostril. Attach a drainage bag and ensure it is not taugt.

Assemble Equipment Appropriate Sized NG Tube

Position Patient High Fowlers Position / Examine Nose

Measure NG Tube Tip of the nose - xyphoid process

Lubricate NG Tube Distal End

Instruct Casualty Hold A Bolus of Water In Their Mouth

Insert NG Tube Patient Should Swallow During Insertion

Check For Placement AUSCULTATION, IMMERSION, LITMUS

Secure Tube Adhesive Elastoplast



Needle Decompression / Tension Pneumothorax 8.1

Purpose made chest deco kits are available. However, 14g Orange cannula's are usually used. DMAC 14 includes a Heimlich valve.

You cannot feel the first rib. The site is above the 3rd rib (to avoid neuro-vascular bundle). MCL is about 1" in from nipple line.

Clean the area well with sterilisation pad and allow to evaporate.

Use a 5-10ml syringe half filled with saline. Connect to end of cannula with all bungs removed. Use firm pressure Feel: Skin, fat, muscle & pleural layer.

As you feel the 'pop' of pleural layer penetration **STOP** pushing. You will get bubbling air into the

Remove the cannula needle and place in sharps bin. Observe for air & symptom relief.

Attach Heimlich valve. A finger of a latex glove may be used if its unpowdered.

Secure Heimlich valve with surgical tape.

A chest drain needs to be inserted. 1-2 hrs post needle decompression is acceptable.

Assemble Equipment

Identify Insertion Site

2ND ICS ANTERIOR CHEST WALL, MCL.

Decontaminate Area

Insert Cannula

90° ANGLE OVER THE 3RD RIB.

Observe Hiss Of Air

OR BUBBLES IF USING SYRINGE TECHNIQUE

Remove Needle

LEAVING CANNULA INSITU

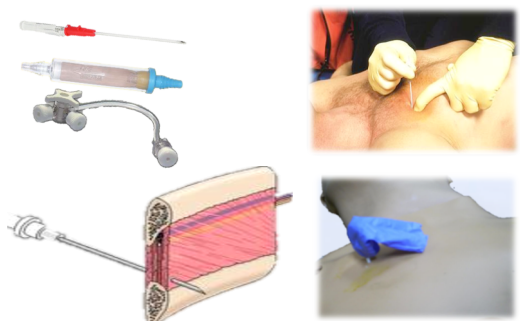
Attach Heimlich Valve

OR GLOVE FINGER TECHNIQUE

Secure Catheter

OBSERVE IF FURTHER DECOMPRESSION NEEDED

Refer For Chest Drain



Rapid Sequence Induction (R.S.I.) 9.1

Leader: Allocate Team Tasks.

Airway: Suction, Position patient, Evaluate for difficult airway, Check and prep equipment.

Airway Assistant: B.M.V. Ventilation, SpO₂ probe.

Circulation / Runner: Venous access, I.V. Infusion, Draw up and label drugs.

Airway Assistant: Give 100% O₂ via Non-rebreather mask / BIBS or B.M.V. Ventilation (if necessary).

Circulation / Runner: Give Fentanyl (as instructed).

Airway: Suction, Reposition patient.

Circulation / Runner: Give sedation agent (as instructed), Give paralysis agent (as instructed).

Airway Assistant: B.M.V. Ventilation, Apply cricoid pressure.

Airway: Insert laryngoscope, Pass E.T. tube between cords. If SpO₂ < 90% STOP! (Provide PPV until SpO₂ > 90%).

Airway Assistant: B.M.V. Ventilation with O₂

Circulation / Runner: Monitor H.R. & B/P, Give I.V. fluids (as instructed).

Airway: Confirm placement, Detect ETCO₂, Inflate cuff, Secure tube.

Airway Assistant: Cease cricoid pressure, B.M.V. Ventilation, Reassess O₂ needs.

Circulation / Runner: Monitor H.R. & B/P, Bolus sedation (as instructed).

Airway: Maintain tube patency, Insert gastric tube.

Airway Assistant: IPPV ventilation therapy, Transfer ventilation to Airway.

Circulation: Monitor H.R. & B/P, Maintain sedation to -2 / -3 level, Continue sedation (as prescribed).

Runner: Insert urinary catheter.

PREPARATION

T minus 10 min
(unless CRASH INDUCTION)

PREOXYGENATION

T minus 5 min

PRE-MEDICATION

T minus 2 min

PARALYSIS

T = ZERO

Passage of E.T. / iGel Tube

T plus 30 – 45 sec

POST INTUBATION CARE

T plus 45 sec



RASS	RASS Description
+4	Combative, violent, danger to staff.
+3	Pulls at tube(s) or catheters; aggressive
+2	Nonpurposeful movement, fights ventilator
+1	Anxious, apprehensive , but not aggressive
0	Alert and calm
-1	Awakens to voice (eye opening) >10 sec
-2	Light sedation, briefly awakens to voice (eye opening) <10 sec
-3	Moderate sedation, movement or eye opening.
-4	Deep sedation, no response to voice, movement or eye opening to stimulation.
-5	Unarousable, no response.

Website: www.trauma-training.org

E-mail: info@trauma-training.org





Website: www.trauma-training.org

E-mail: info@trauma-training.org