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TRAINING THE WORLD'S **FIRST** FIRST RESPONDERS™

Handling Trauma Calls

Trauma is generally defined as "physical injury caused by an accident or violence." The proper EMS response and pre-arrival instructions involved in calls of traumatic incidents rely heavily on the Emergency Medical Dispatcher's (EMD's) ability to gather several key points of information regarding the nature of the incident, extent and location of injuries and the identification of priority symptoms.

With trauma calls, the chief complaint is typically reported, by the caller, in the form of a mechanism of injury. The mechanism of injury is how the patient received the injury. Examples of this can be reports of a pedestrian struck by a vehicle or a person that has fallen off the roof.

Traumatic incident calls will be assessed differently, by the EMD, than calls with chief complaints of a medical nature. This is due in part to the factors used to determine response levels, which are different with traumatic injuries. The primary determining factors in response to traumatic incidents are mechanism of injury, location of the injury on the body (central or peripheral, torso or arms and legs) and the presence of any significant critical symptoms.

Significant critical symptoms can include altered levels of consciousness which can indicate the onset of shock, a head injury, an underlying medical problem, severe hemorrhage or breathing problems associated with injuries to the central core.

Pre-arrival instructions for traumatic incidents vary widely based on the situation and complaint type reported. They include the same instructions in many cases as the medical chief complaints, especially in dealing with airway control. However, traumatic incident guidecards include more specific injury-related instructions. These pre-arrival instructions are designed to protect the patient from further injury from a well-meaning, but untrained, bystander who attempts to help.

Pre-arrival instructions in these cases relate primarily to ensuring the safety of the scene for patients, bystanders and responders. Instructions are provided for the control of external bleeding, ensuring the patient's airway is

clear, advising the caller when it may be best to do nothing, advising the caller to guide the responding units to the patient and advising the caller to call back if the patient's condition worsens.

There are some additional considerations when dealing with traumatic incidents involving pediatric patients. Traumatic incident types are by far the most common chief complaint group used to report incidents involving children. With regard to CPR and obstructed airway interventions, "children" are defined as aged one to eight years. People who are older than eight years old are considered adults for CPR purposes.

In cases of traumatic injury, children should not be moved unless in danger. A common error is for the caller or bystander to move or pick up the child, run into the house or shelter and hold the child to comfort them. This can lead to further injuries in patients with spinal injuries. If the child moves on their own, they should be made to lie down on a flat surface and be encouraged to remain still until responders arrive on scene. Bystanders should be instructed to keep the child calm and reassured until help arrives.

Injuries to the spinal cord should be suspected if there is any indication of severe facial or head injuries, unconsciousness associated with the incident, numbness, tingling or loss of sensation in any extremities, paralysis or inability to move any extremities, pain in the back upon movement or attempted movement or any motor dysfunction reported by the caller.

Children may have critical injuries but the symptoms may remain hidden until the child reaches a point of rapid deterioration. Critical symptoms such as low blood pressure do not appear as rapidly in children as they do in adults. Other symptoms like breathing and pulse may be difficult to interpret in a child who is hurt or frightened. If priority symptoms are present, then time is critical and the child must be taken immediately for care.

Conscious injured children require extra attention. It will be necessary to support the child emotionally and reassure them. This should be constant and, preferably, from a single consistent bystander. This must be communicated through the EMD to the bystanders.

Remember, the emotional condition of the patient and/or the caller should not be used as an indicator of the severity of the problem. Bystanders and children may be distraught from witnessing the incident, reacting to the sight of blood or limbs bent at unnatural angles. Never allow a caller's emotional status to dictate a response mode. Different people react to emergency situations in different ways. One person may be calm and the next may immediately become hysterical in the same situation. Just because the caller is emotionally upset and hysterical do not assume the incident is more serious than it sounds.

At the same time, be careful of the opposite – do not assume that an incident is less severe because the caller sounds calm. This is especially true if the caller is a child. Children sometimes cannot grasp the severity of a situation or the grave danger involved and this lack of experience and knowledge may cause the child to be relatively calm despite the critical nature of the situation.

Prevention is the most powerful treatment for most childhood injuries. The EMD can play a role in injury prevention by recognizing and reporting traffic, playground or other hazards as they are identified in calls relating to childhood injuries.

As always, these are just some of the suggested methods for handling traumatic incident calls. Refer to your supervisor, your agency's operating guidelines and your APCO Institute EMD Guidecards and MEDS™ software for assistance and further information.

By Bob Smith, APCO Institute EMD Program/Operations Manager

Resources and Helpful Websites

* www.apcoinstitute.org APCO Institute Website
* www.amtrauma.org American Trauma Society Website
* Basic Emergency Medical Dispatch 5th Edition, APCO Institute
* Public Safety Telecommunicator 1 textbook, APCO Institute

Quiz

CDE Article – Handling Trauma Calls

Name: ______________________________________ Date: ________________

Agency: ____________________________________

Address: ____________________________________

____

____

Phone: _____________________________________

Fax: _______________________________________

Email: ______________________________________

1. Trauma is defined as:
   a. Emergency situations involving children
   b. physical injury caused by an accident or violence
   c. all non-medical calls
   d. calls received from children callers

2. The chief complaint in trauma calls is usually reported how?
   a. When the caller provides the time of the incident
   b. When the caller gives their name
   c. When the caller describes the mechanism of injury
   d. When the caller hangs up

3. Mechanism of injury is how the patient received the injury.
   a. True
   b. False

4. A key consideration for trauma calls is scene safety.
   a. True
   b. False

5. Symptoms of critical injuries in children are always obvious.
   a. True
   b. False

6. A telecommunicator should always use the emotional condition of the patient as an indicator of the severity of the problem.
   a. True
   b. False

7. Injuries to the spinal cord should be suspected if there is any indication of which of the following?
   a. Severe head injuries
   b. Numbness, tingling or loss of sensation in extremities
   c. Paralysis in any extremities
   d. All of the above

8. In cases of traumatic injury, children should not be moved unless in danger.
   a. True
   b. False