GUIDELINES FOR ASSESSING AND MANAGING A POLYTRAUMA PATIENT.

<table>
<tr><th>Sl No.</th><th>Activity</th><th>Remarks</th></tr>
<tr><td>1</td><td>Airway</td><td>Check 1) patency of the airway 2) clear the secretions 3) Suck nose & mouth.
Endotracheal Intubation if necessary.
If there is a delay then needle tracheostomy can be done.</td></tr>
<tr><td>2</td><td>Breathing</td><td>Check whether the mechanical act of ventilation is normal (chest movements and bilateral air entry). If saturation is < 94%, then start on O_2 @ 4L/min by mask or prongs.</td></tr>
<tr><td>3</td><td>Circulation</td><td>Monitory pulse rate and BP.
<table>
<tr><td>PR</td><td>BP</td><td>Clinically</td><td>Blood loss</td></tr>
<tr><td>>140</td><td><90 systolic</td><td>Cold and clammy</td><td>>40%</td></tr>
<tr><td>>100</td><td><90</td><td>Oriented</td><td>>20-<40%</td></tr>
<tr><td>>20/min</td><td><10mm</td><td>After sitting up for 5 min</td><td><20%</td></tr>
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Start 2 IV lines 18Guage and RL and DNS @ 120 ml/hr for every patient.
For shock cases
a) 2L of RL over 30 minutes (monitor for pulmonary edema)
b) Followed by a maximum of 1 litre of Colloid (Dextran/Hemaccel)
c) Start blood after cross matching and typing, only after crystalloids.</td></tr>
<tr><td>4</td><td>Dysfunction</td><td>a) GCS monitoring (every30 min for head injury/ every 2 hrs for other patients)
b) Pupils, Pulse rate, Blood Pressure (every 30 minutes)
c) Chest movements and expansion, rib cage.
d) Per abdomen – distention, bowel sounds, percussion
e) Pelvis – Compression/distraction
f) 4 limbs for fracture/dislocation
g) Major wounds to be attended to (lacerations to be sutured, compound fractures to be lavaged first and then splinted. Abrasions dressed)</td></tr>
<tr><td>5</td><td>Exposure</td><td>Expose the whole body to look for wounds and manage them as soon as possible.
Avoid causing hypothermia !</td></tr>
<tr><td>6</td><td>Fluids</td><td>As explained to combat shock. Blood may be started earlier – Follow consultant’s orders.</td></tr>
<tr><td>7</td><td>Investigations</td><td>FOR ALL PATIENTS:
Hb, TC, DC, PCV, Na+, K+, Blood group, cross matching
Chest Xray PA Erect, AXR AP Erect, Pelvis AP
Depending on site
Head injury – Skull and Cervical spine AP and Lat
Long bones – AP and lateral (include joint above and below)
Hand and foot – AP and oblique views</td></tr>
<tr><td>10</td><td>Treatment</td><td>Blanket for all patients
NPO
Inj TT 0.5ml im stat
Inj Diclo 75mg im stat and Q8H
Inj Rantac 50mg iv stat and Q8H
Inj Ceftriaxone 1g iv stat and Q12H
Inj Metrogyl 500mg iv stat and Q8H
Pass Foley’s catheter</td></tr>
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		Inj Genta 80mg iv stat and Q8H (for Ortho cases) IV fluids – after stabilization at 120ml/hr. (prevent hypotension and overfilling) Head injury patients Intubate and ventilate to maintain sPO_2 of 100. Inj Epsolin 500mg iv stat and 100mg Q8H (to prevent convulsions) AVOID INJ MANNITOL
11	Command structure, depending on the type of case.	Nurses – Nurses In-Charge Doctors – Medical Officer In-Charge Ventilator – Anesthetist Orthopedic cases – Orthopedic surgeon Surgical cases – General surgeon Doctor: Nurse: patient ratio = 1:3:1 for serious cases/ 1:2:1 for other accident cases
12	If to be transferred	a) Stabilize the patient b) Contact IGMH and discuss c) Prepare – Discharge summary/Referral letter/medical report/Medform d) Ascertain – Medical escort – doctors and nurses (relieve in advance so that they can be to be ready to travel) e) Inventory to be taken while shifting – Medical paraphernalia and In-transit instructions.