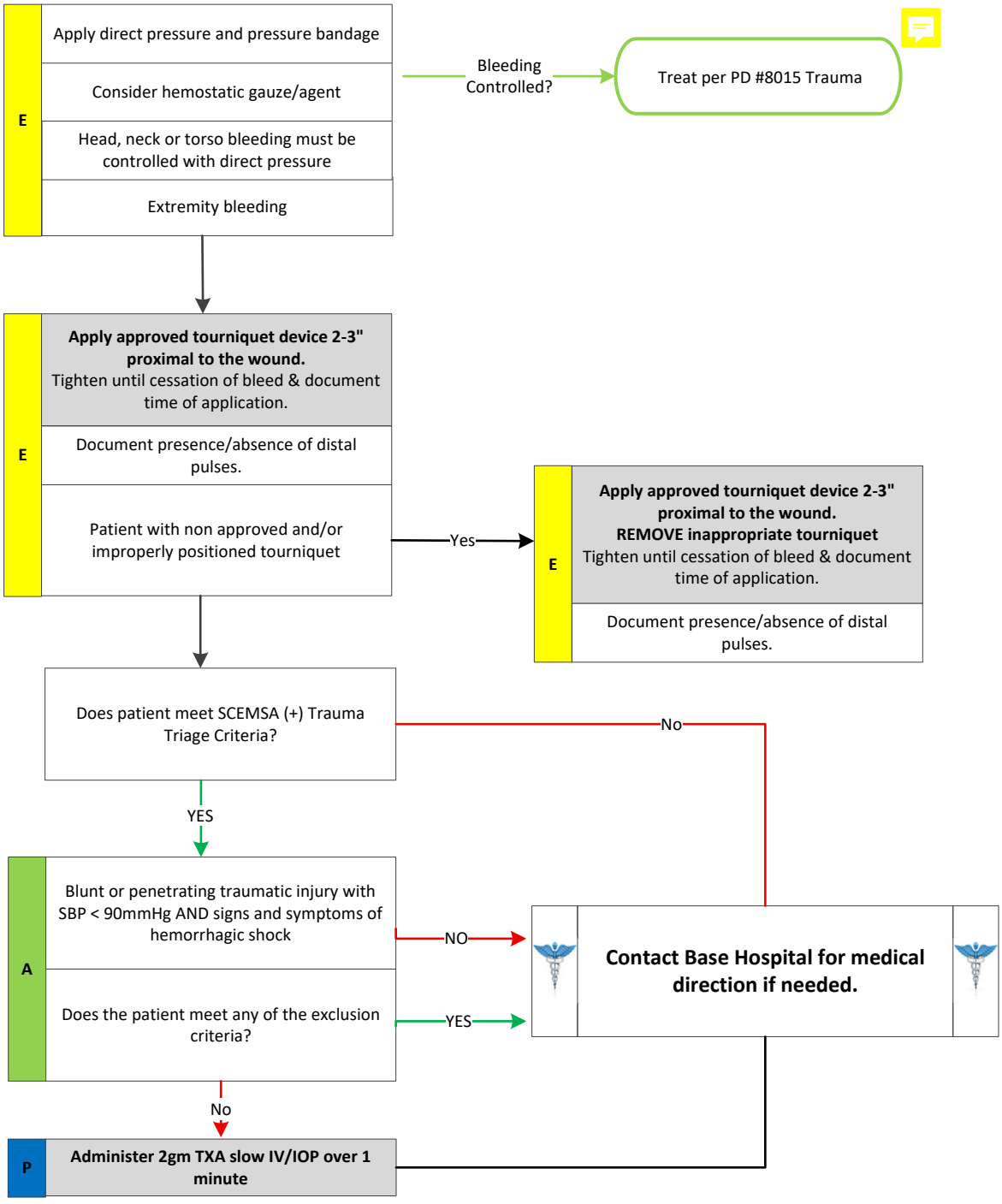
Hemorrhage

EMS Medical Director:
Signature on File
EMS Administrator:
Signature on File



E	EMT
A	AEMT
P	Paramedic

Adult Medical Treatment Protocol

DRAFT

Document: 8065.14
Approved: 06/13/24
Effective: 11/01/26
Next Review: 06/01/26

Hemorrhage – Epistaxis/Oral Hemorrhage

EMS Medical Director:
Signature on File
EMS Administrator:
Signature on File

E	Assess C-A-B
	Secure airway
	Position of comfort, reduce anxiety
	Suction as needed
	Apply ice and direct pressure across the bridge of nose
	SpO2 with supplemental O2 as needed
A	Cardiac monitoring and ETCO2 measurement as available
	Vascular access, but do not delay airway management
P	Consider intubation for significant hypoxia, dyspnea, or impending airway loss

Additional TXA use

Epistaxis

P	**Contraindication:** Known Allergy, severe local tissue injury or patient unstable.
	Preparation: 500mg of TXA in 5mL. Soak a cotton pledget in the solution.
	Application: Insert the TXA-soaked pledget into the bleeding nostril. Leave in place for 10-15 minutes. Do not remove pledget once placed.

Oral Hemorrhage

P	**Contraindication:** Known Allergy, severe local tissue injury or patient unstable.
	Preparation: 500mg of TXA in 5mL via standard nebulizer.
	Application: Deliver via face mask nebulizer with patient sitting upright.
	Adjuncts: Combine with direct pressure via gauze to discrete bleeding site. Alternatively a TXA soaked cotton pledget can be used for this purpose – prepared as in epistaxis protocol.

Contact Base Hospital for medical direction if needed.

E	EMT
A	AEMT
P	Paramedic

DRAFT

Adult Medical Treatment Protocol

Document: 8065.14
Approved: 06/13/24
Effective: 11/01/26
Next Review: 06/01/26

Hemorrhage

NOTES:

A. Life-threatening hemorrhage to a limb is best managed with splinting or stabilization of the limb to reduce movement and progress rapidly through the hemorrhage control algorithm below until bleeding is controlled.

B. Patients with major arterial bleeding can bleed to death in as little as two to three minutes. It is important to control external bleeding before the patient is in shock.

C. Any patient who requires a tourniquet is considered to have a time-dependent injury and should be transported immediately to an appropriate trauma center per Trauma Destination Policy, PD# 5052.

1. Pediatric patients ≤ fourteen (14) years of age who require a tourniquet shall be transported to the University of California Davis Medical Center (UCDMC), with the following exceptions:

a. Pediatric patients without an effective airway may be transported to the nearest available facility for emergent airway establishment.

b. Pediatric trauma patients under Cardiopulmonary Resuscitation (CPR) shall be transported to the time closest trauma facility.

D. It is critical that the time of tourniquet application be documented in the PCR, on the tourniquet when possible, and communicated to all providers.

E. The use of approved Hemostatic Agents shall be documented in the PCR and communicated to all providers.

F. While most life-threatening bleeding is a result of trauma, hemorrhage control strategies and sections of this policy also apply to non-traumatic hemorrhage, including but not limited to bleeding AV-shunts and non-traumatic bleeding in patients on anticoagulants. TXA is only indicated by the protocol below for traumatic bleeding, epistaxis, and oral bleeding.

- **TXA EXCLUSION CRITERIA FOR TRAUMATIC HEMORRHAGE**

  Does patient meet any of the following exclusion criteria?

  - Time since injury > 3 hours
  - Isolated neck or extremity trauma
  - Thromboembolic event (i.e. stroke, MI, PE) in last 24 hours
  - Traumatic arrest with > 5 minutes of CPR without ROSC
  - Hypotension secondary to suspected cervical cord injury with motor deficit or spinal shock
  - Pediatric Patients ≤ fourteen (14) years of age
  - Head injury with GCS < 9 OR unreactive pupils.

Cross Reference:

PD# 5052 –Trauma Destination Policy
PD# 5053 –Trauma Triage Criteria Policy
PD# 8015 – Trauma Policy
PD# 9017 – Pediatric Trauma