PRACTICE GUIDELINE

Effective Date: **4-10-02** Manual Reference: **Deaconess Trauma Services**

TITLE: **ACTIVATION PROCESS FOR TRAUMA PATIENTS**

PURPOSE: To provide a uniform definition of the type of patient for which the trauma team will be activated.

GUIDELINES:

A. Deaconess Hospital is capable of providing Level II trauma care as defined by the American College of Surgeons. The trauma care will be available to treat and admit any seriously injured patient at high risk of dying or suffering morbidity of multiple and severe injuries.

B. Deaconess Hospital will be using the definitions proposed by the Committee on Trauma of the American College of Surgeons. In certain cases, the definition of trauma that it established by "mechanism" and "pre-existing conditions" have been altered.

RESPONSIBILITIES:

A. The Emergency Department physician, staff, and EMS providers will have the authority to define patients that meet trauma activation/alert criteria. Consultation with the trauma surgeon is always available to help make this decision. Additionally, if the patient deteriorates en route or after arrival to the Emergency Department, the status can be upgraded at any time from a Category II activation by ED MD, ED staff, trauma surgeon, or EMS providers. No activation can be downgraded or cancelled at any time for any reason.

DEFINITIONS:

A. Deaconess Hospital's definition of a trauma patient according to trauma Category I or II trauma activation/alert criteria is in this section.

B. Two Tiered Trauma System:

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Deaconess
REGIONAL TRAUMA CENTER

Category I Activation

To transfer a patient to DH:
1-812-450-1111

To contact Trauma Services Dept:
Office: 812-450-4879 or Fax: 812-450-5049

The "**Category I Activation**" will be activated through Deaconess Call Center for trauma team response **within 10 minutes** of patient arrival in ED. The trauma surgeon will be present in the Emergency Department upon patient arrival with proper field notification **OR within 15 minutes** after the trauma team is activated. The trauma patient will be admitted to the appropriate trauma surgical service.

- ☐ CONFIRMED blood pressure < 90 at any time in adults and children > 10 years of age (CONFIRMED=more than 1 reading)
- ☐ Age-specific hypotension for children up to ten years of age:
  - Birth to 6 months: SBP < 60 mm Hg
  - Infant (6 to 12 months): SBP < 70 mm Hg
  - Toddler/Preschool/School Age (1–10yrs): SBP < 80 mm Hg
- ☐ Respiratory compromise or obstruction, need for definitive or surgical airway placement
- ☐ Intubated patient coming from the scene or a referring hospital
- ☐ Chest wall instability or deformity (e.g., flail chest)
- ☐ Respiratory rate < 10 or > 29 bpm or < 20 bpm in infant < 1 year
- ☐ Trauma transfers receiving blood to maintain vital signs
- ☐ Trauma patient in cardiac arrest
- ☐ Penetrating wounds to the head, neck, abdomen, chest or groin
- ☐ GSW to extremities proximal to the elbow/knee
- ☐ Open or depressed skull fracture
- ☐ GCS 13 or less with mechanism attributed to trauma
- ☐ Two or more proximal long bone fractures
- ☐ Crush, degloved, pulseless or mangled extremity above wrist or ankle
- ☐ Pelvic fractures with hemodynamic instability
- ☐ > 20% TBSA burn with high suspicion for concomitant injuries, needing evaluation by surgeon prior to transfer out
- ☐ Amputation above wrist or ankle
- ☐ ≥ 2 life or limb threats
- ☐ Emergency physician's discretion (meets no criteria, but physician feels warrants activation to expedite care due to mechanism of injury or assessment)

F5241 (06-2019)

Deaconess REGIONAL TRAUMA CENTER

Category II Activation

To transfer a patient to DH:
1-812-450-1111

To contact Trauma Services Dept:
Office: 812-450-4879 or Fax: 812-450-5049

- ☐ Falls
  - Adults: > 20 feet
  - Children: > 10 feet or two times the height of the child
- ☐ Ejection from automobile
- ☐ Separation from a motorized device (e.g. scooter, motorcycle, ATV, etc. traveling > 10mph
- ☐ Death of another occupant in the same vehicle
- ☐ Elderly patient (65 yrs or >) with significant traumatic mechanism and one of the following:
  - CONFIRMED SBP < 100 mm Hg (CONFIRMED=more than one reading)
  - On anticoagulant (Plavix, Coumadin, Pradaxa, etc.)
- ☐ Pregnancy > 20 weeks with significant traumatic mechanism
- ☐ Transfer from referring hospital with diagnosed traumatic injury (requiring admission to trauma surgeon)
- ☐ Trauma Surgeon Needed—Sub-specialist unable/unwilling to admit or want trauma surgeon to examine patient and provide direction on ED disposition.
- ☐ Any burn patient requiring admission will be admitted to the trauma/plastic surgeon. Follow the American Burn Association's guidelines for transfer criteria.
- ☐ Emergency physician's discretion (meets no criteria, but physician feels warrants activation to expedite care due to mechanism of injury or assessment)
- ☐ Paralysis or suspected spinal cord Injury

The "**Category II Activation**" will be activated through Deaconess Call Center for trauma surgeon response within 6 hours of patient arrival to the ED provided the patient meets any of the above-listed criteria. If the patient needs to be seen sooner than 6 hours, these instances should be identified by discussion between the ED physician and the trauma surgeon. Trauma consults will be activated within **2 hours** of patient arrival in the ED. Prompt call back to the ED physician by the trauma surgeon ***is essential.*** The trauma patient will be admitted to the appropriate trauma surgical service. Any injured patient being admitted to the hospital who does not meet any other trauma activation criteria should be discussed with the trauma surgeon to determine if a trauma surgery consult is necessary. (Patients do not have to be seen by trauma surgeon if determination is made by trauma surgeon and ED physician that a surgical service will admit for single system injury. This determination must be documented in Epic by the ED physician.) If at any time the patient status deteriorates, the patient must be upgraded to the higher activation level.

* Trauma activations may not be canceled or downgraded despite changes in patient assessment or findings.

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PROCEDURES:

A. When the Emergency Department receives notification that a trauma patient is en route to the hospital, the Emergency Department physician and staff will determine whether the patient meets the requirements for a trauma activation Category I or a Category II. Patients who are not classified as trauma prior to arrival shall be evaluated to assess whether they should be classified as a trauma patient within 10 minutes after arrival.

B. Within the above 10 minute evaluation period, the patient must be determined to be Category I or Category II activation per criteria with appropriate stabilization and management, specialty consultation and/or need for transfer identified and initiated.

C. Decision time for transfer for Trauma patients being transferred out from the ED to a higher level of care should be within two hours (ED LOS per NTDB definition) when stabilized within the capabilities of the referring institution (Deaconess Hospital).

D. All activated trauma patients must be evaluated by the trauma surgeon with a corresponding dictation.

E. The Emergency Department staff will recognize trauma activation criteria via EMS/telephone report and will call the dedicated trauma activation line at extension 3700 to activate the system. The information below is required to be given to the Call Center staff by the ED caller in order to be able to activate the system appropriately.

LEVEL:	Category I or Category II
Criteria:	Specific activation criteria taken from activation card
AGE:	Patient age in years – required d/t pediatric needs
VS:	Stable or Unstable
INJURIES	Obvious patient injuries
ETA:	Estimated time of arrival
FROM:	Scene or Referring Hospital – name of Hospital or Scene location

F. The process to follow if the trauma team does not respond via telephone within 3 minutes of first activation:

1. Call the Call Center (ext. 3700) to have them repage the trauma surgeon since he/she has not responded. Document reactivation time on the activation record.
2. If within 3 minutes the surgeon does not return the call after second attempt, ED staff will attempt to contact surgeon via cell phone number and/or call room phone number posted at ED secretary's desk.

G. The Call Center is responsible for trouble shooting the activation system to ensure all trauma pagers are transmitted and received. In the event that the primary activation source is not operating, a secondary backup system will be utilized by the Call Center.

H. Under activation and Over activation/triage process will be monitored on a daily basis by the Trauma Performance Improvement RN and the Trauma Data Quality Coding Coordinator.

1. Any variances in this process will be reviewed by the Trauma Medical Director and the multidisciplinary Operational Committee.
2. PI letters will be sent to the responsible Emergency Department Physician and/or ED staff for education.
3. This information is tracked in the registry as an ongoing performance improvement indicator and reported monthly to the Trauma Operational Committee.
4. Trauma Service's benchmark for undertriage is 10%, while overtriage is 50%. This is calculated based on Cribari Grid and evaluated on a quarterly basis.
5. Please note definitions below:
   - Over Activation – A Category I activation that met Category II criteria or a Category II activation that met no criteria.
   - Under Activation – A Category II activation that met Category I activation criteria or a Category II activation that was not activated, or isolated injury that met Category I or II criteria.

REFERENCES:

- Trauma Services Department Guideline "DEFINITION OF TRAUMA PATIENT".
- Trauma Service Department Guideline "TRAUMA TEAM ROLES & RESPONSIBILITIES".

REVIEWED DATE	REVISED DATE
JAN 03	Previous revision dates on file
JAN 04	11-7-11
JAN 05	10-4-12
JAN 06	4-1-13
JAN 07	3-4-16
11-19-09	7-1-17
AUG 2014	8-1-18
JAN 2019	7-3-19