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Trauma Activation

Background:

The trauma program must involve multiple disciplines and transcend normal departmental hierarchies. Because optimal care extends from the scene of an injury through the acute care setting to discharge from a rehabilitation center, the trauma program should have appropriate representation from all phases of care. The trauma resuscitation team consists of physicians, nurses, and allied health personnel.

Purpose:

This policy is intended to provide the framework for trauma activations in the Emergency Department or during the screening and stabilization process of the trauma patient. This policy does not cover pre-hospital care of the trauma patient according to the National Guideline for the Field Triage of Injured Patients rules.

The purpose of activating trauma is to standardize the response of the hospital to incoming trauma patients enabling them to receive high quality care with smooth transitions.

Deaconess Memorial Medical Center will utilize a two-tiered system for trauma activations. Using a defined multidisciplinary approach to care will limit the waste of resources caused by excessive team mobilization (over-activation) while ensuring resources are available to prevent delays in care (under-activation.) Activation considerations should include prehospital physiological parameters, anatomical injuries, mechanism of injury, along with comorbid conditions. *Resources for the Optimal Care of the Injured Patient – 2022 Standards.*

Guidelines:

See Trauma Team Activation (TTA) Criteria flowchart for detailed criteria

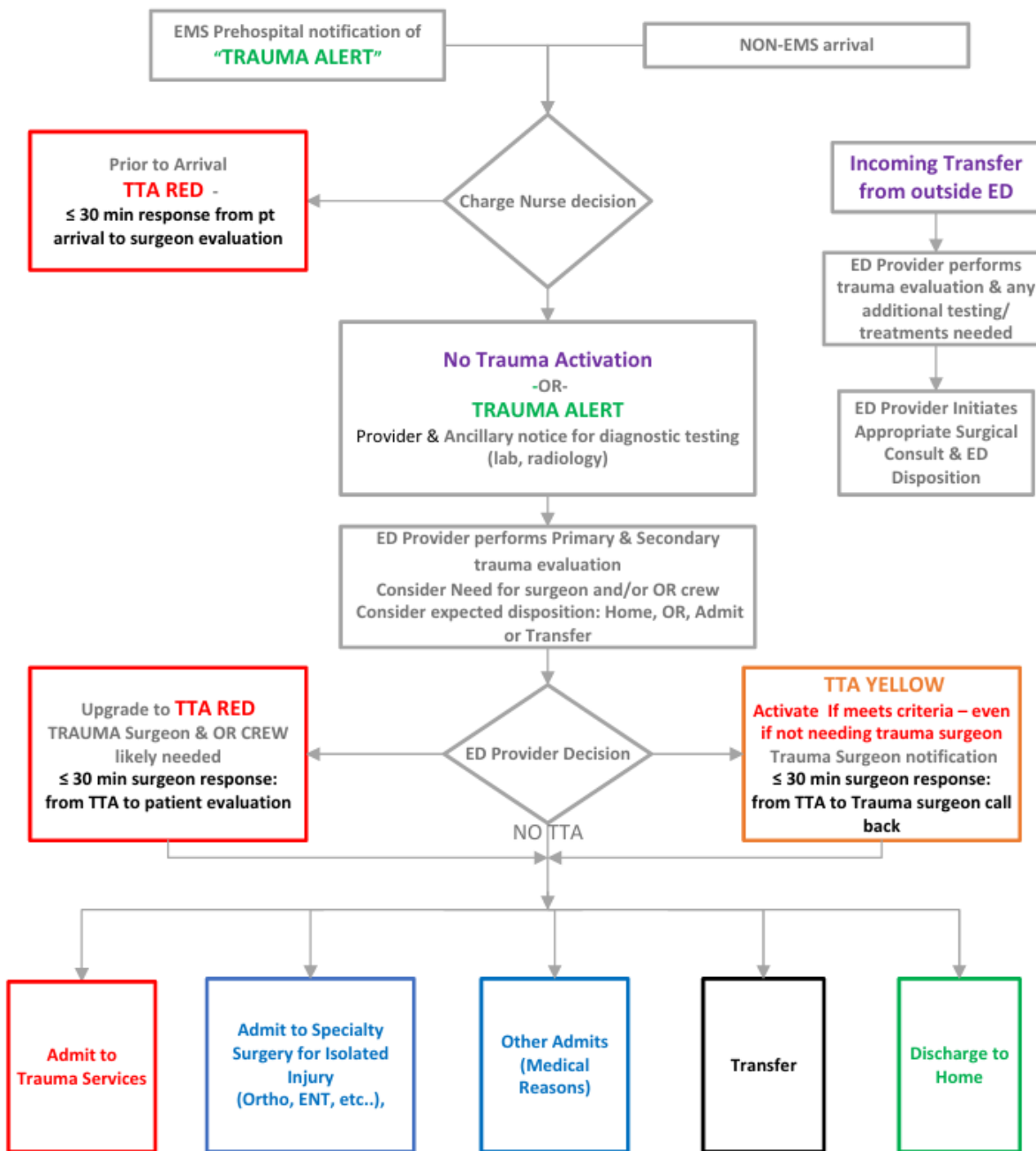
TRAUMA TEAM ACTIVATION (TTA) CRITERIA		
Must have a Traumatic Mechanism of Injury (MOI)		
Should activate if meeting criteria to collaborate care and/or disposition with the Trauma Surgeon (TS)		
	CAT I Activated Prior to Arrival or Immediately once meeting criteria	CAT II Activated Prior to Arrival or Immediately once meeting criteria
AIRWAY	<ul style="list-style-type: none"> Compromised Airway Intubated or Assisted Ventilations 	<ul style="list-style-type: none"> Chest Wall instability (i.e. flail chest) without respiratory compromise Hanging or Drowning
BREATHING	<ul style="list-style-type: none"> Respiratory Distress or Compromise 	
CIRCULATION	AGE	Systolic Blood Pressure *confirmed with 2 nd reading
	< 1 year	< 60 mmHg
	1-10 years	< 70 mm Hg plus (2 X age in years) mmHg
	≥11-years	< 90 mmHg -or- HR >SBP (shock index > 1.0)
	<ul style="list-style-type: none"> Receiving blood to maintain Vital Signs Unstable pelvic fractures 	
DISABILITY	<ul style="list-style-type: none"> GCS < 9 (attributed to trauma) Acute Paraplegia or quadriplegia 	<ul style="list-style-type: none"> *Focal neuro deficits (traumatic) suspect CNS trauma Anti-coagulated (excluding ASA) patients with +LOC, including ground level falls GCS 9-12 with GCS motor Score ≤ 5
OTHER	<ul style="list-style-type: none"> Gunshot wound to head, neck, chest, or abdomen Other penetrating Injury with confirmed hypotension Skull deformity Mangled extremity or amputation proximal to wrist or ankle Deterioration of previously stable patient Emergency Provider discretion 	<p style="background-color: #ffff00; display: inline-block; padding: 2px;">NOT AN ALL-INCLUSIVE LIST</p> <ul style="list-style-type: none"> Falls > 20 ft (Adults); >10 ft or 2 X height (Peds ≤14) Ejection from automobile or death in same vehicle Vehicle vs Pedestrian or Cyclist Thrown from personal transport device/animal Pregnancy >20 weeks with significant MOI Emergency Provider discretion- may activate, even if not meeting criteria (should document reason for activation)

*A focal neurologic deficit can affect any of these functions: Movement changes, including loss of muscle control, increased muscle tone, loss of muscle tone, or movements a person cannot control (involuntary movements, such as tremor); or loss of sensation

Procedure:

See Trauma Team Activation (TTA) Flowsheet for activation procedure

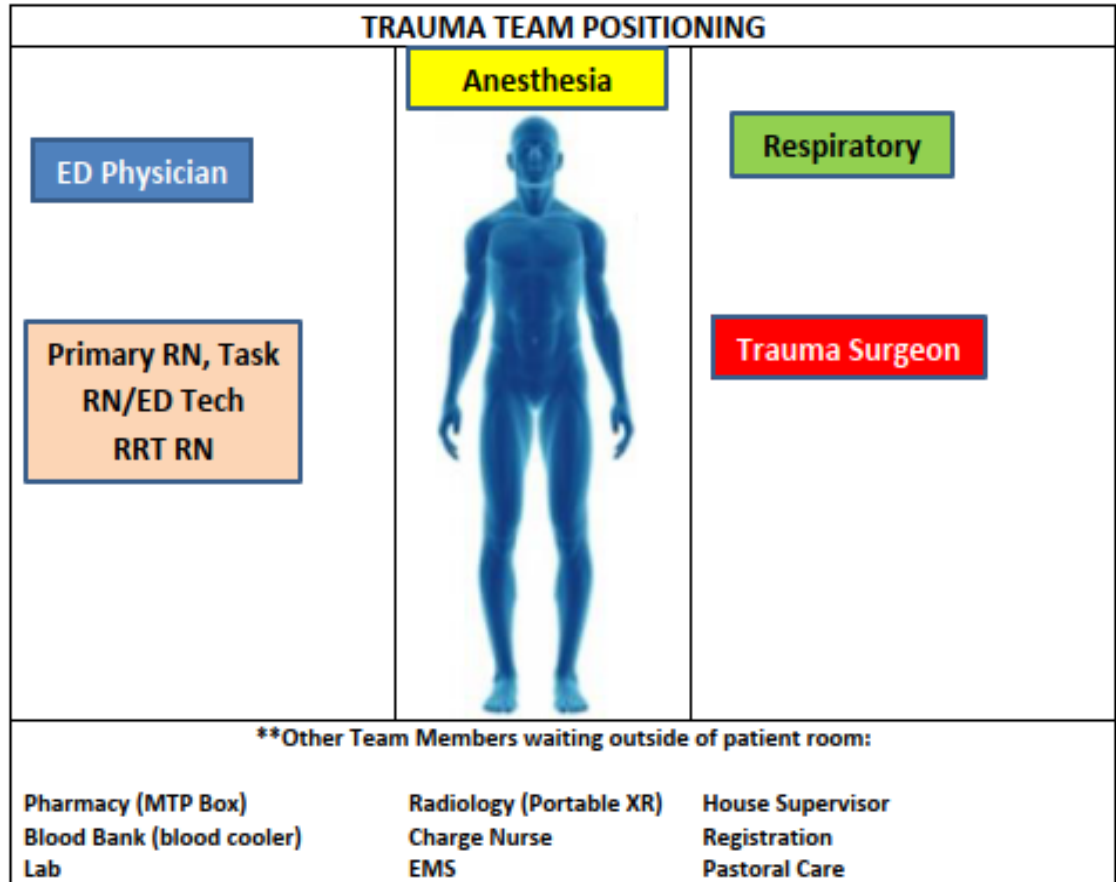
TRAUMA TEAM ACTIVATION (TTA) FLOWSHEET



A. Patients arriving via Emergency Medical Services (EMS)

1. When calling report to the hospital, EMS will indicate that a trauma patient is enroute with their ETA.
2. Emergency Department charge nurse will take the report. If the charge nurse is unavailable, ED physician or other RN can take report.

3. Upon receiving EMS notification for a Trauma Alert, the nurse or physician should ensure that the appropriate activation is initiated via the alert call system. The Emergency Department secretary will activate the appropriate trauma team and mark the activation time and designated trauma level on the trauma sign-in form.
4. During trauma activation, the Trauma Team Positioning diagram should be followed:



ED Physician –Team Leader until Trauma Surgeon arrival <ul style="list-style-type: none"> Completes FAST exam Identifies & implements interventions for life threatening issues Assists with interventions as directed by trauma surgeon
Trauma Surgeon – assumes Team Leader upon arrival <ul style="list-style-type: none"> Completes primary & secondary survey Determines priority of procedures, tests and additional orders Responsible for ongoing critical care, intra-operative, and post-operative care
Anesthesia – Airway management & IV/central line access
Respiratory – Airway and ventilatory management
*** RN positioning adapts to patient and intervention needs Primary RN – Primary/secondary assessment & interventions Task RN/Tech – Removes clothing; Applies monitor; Obtains EKG RRT RN – Assists as needed Scribe Nurse – Maintains all care documentation (sits at computer in room)

5. Surgical Services Response Times

- a. Trauma Activation **Category I (CAT I)** Notification (Highest Level)
 - i. Trauma Surgeon – must be at the patient’s bedside within 30 minutes of patient arrival at least 80% of the time (Std 5.4)
 - ii. Anesthesia Services– must be available within 30 minutes of trauma activation notification (Std 4.13)
 - iii. Operating Room - must be staffed and available within 30 minutes of trauma activation notification (Std 3.1)
- b. Trauma Activation **Category II (CAT II)** Notification (Level below highest)
 - i. Trauma Surgeon – must respond by phone within 30 minutes of trauma activation notification. The Trauma Surgeon must be at patient bedside within 30 minutes of ED physician request (Std 5.5)
 - ii. Anesthesia Services– must be available within 30 minutes of request (Std 4.13)
 - iii. Operating Room - must be staffed and available within 30 minutes of request (Std 3.1)
- c. Orthopedic Surgeon must be at bedside within 30 minutes of request for the following: (Std 5.21)
 - i. hemodynamically unstable, secondary to pelvic fracture
 - ii. suspected extremity compartment syndrome
 - iii. fractures/dislocations with risk of avascular necrosis (e.g., femoral head or talus)
 - iv. vascular compromise related to a fracture or dislocation
 - v. trauma surgeon discretion

6. Trauma Activation Notifications

- a. Trauma Alert **CAT I** team
 - i. House supervisor (during applicable times)
 - ii. ED physician
 - iii. Trauma / General Surgeon on call

- iv. Anesthesia on call
- v. Surgery Call Team
- vi. Trauma Program Director/Manager (notification)
- vii. Minimum of two nurses from the Emergency Department
- viii. Critical Care Services Charge Nurse
- ix. Respiratory Therapy
- x. EMT (if available)
- xi. Radiology Technologist
- xii. Laboratory personnel with blood cooler
- xiii. Chaplain
- xiv. Security

b. Trauma Alert **CAT II** team (may upgrade to RED, if warranted)

- i. House supervisor (during applicable times)
- ii. ED physician
- iii. Trauma / General Surgeon on call **via phone**
- iv. Trauma Program Director/Manager (*Notification*)
- v. Minimum of two nurses from the Emergency Department
- vi. EMT (if available)
- vii. Radiology Technologist
- viii. Laboratory personnel
- ix. Security

7. All Trauma Team members responding to the Trauma Activation CAT I or CAT II are responsible for signing in with time of arrival at designated sign in place. Times of response for trauma team members will be charted by the primary nurse in the appropriate place of the electronic medical record. All cases of over and under triage as well as instances where response time of trauma team members is greater than expected will be reviewed in the Trauma PIPS program
8. Emergency department physicians, after consulting with the nurse taking report, may make the determination if the Trauma Level should be upgraded from NO activation to a CAT I or CAT II activation or a CAT II activation upgraded to a CAT I activation.
9. Once trauma activation has been initiated, it can be upgraded, but it cannot be "canceled" except in the case that the patient was NOT a trauma patient

(i.e. activating trauma for a stroke patient). As the trauma activation case develops, specific members of the trauma team, not needed, may be called off the case, but must be documented along with any staff names and times that do report. Also, include surgeon name and call in time.

B. Patient arriving via private vehicle

1. Procedure is same as above except:

- a. Upon arrival at the Emergency Department, triage nurse will notify the physician or charge nurse of patient. The Emergency department physician will determine the level (if any) of trauma activation.

References:

Committee on Trauma American College of Surgeons. *Resources for the optimal care of the injured patient.* (2022 Standards)