Level 4- 1 Activation level

[redacted]

Trauma Service Activation

PURPOSE

Trauma is the leading cause of death for persons age 45 and under and the third leading cause of death among people of all ages. It has been proven that initial treatment at a basic level trauma center can improve survival chances for trauma victims. It is the desire of [redacted]nd the medical staff to provide this service to our community in keeping with our Core Values of Reverence, Integrity, Compassion, and Excellence in our service to the community.

POLICY STATEMENT

A. The Trauma Team will be activated, in the opinion of the emergency provider,nurse,or EMS, when there is the presence or potential of severe injury with multiple system involvement, which may threaten the trauma patient's life.

B. The team consists of the emergency provider, Emergency Department (ED) nurse, staff nurse, CRNA, CT technician, imaging technicians, and Lab personnel.

C. The ED staff has the ability to notify other providers to join the team as needed; i.e., back-up physicians, ER techs, respiratory therapist (when in-house), and pharmacist (when in-house) .

D. The minimum response time for team members is 20 minutes for all staff, and 30 minutes for physicians.

    1. Respiratory therapists will automatically respond when in-house only.

E. When the emergency provider is an advanced practice provider, they will contact their back-up physician at their discretion if they feel the back-up physician is needed.

F. The physician will be available to respond to a Full Trauma Activation at the discretion of the advanced practice provider or ED nurse.

    1. The emergency provider may direct transfer to a higher level of care at any time

during the resuscitation of the trauma patient.

2. All EMTLA procedures will be followed in transferring this patient to the next facility.

EQUIPMENT

A. Equipment needs for the treatment of the trauma patient are found in the Emergency Services Department, in each room designed for care of the trauma patient.

B. The equipment chosen for availability was based on the State Health Department recommendations for basic trauma centers.

PROCEDURE

A. Information gained from a referral source pre-hospital ,or on assessment of the patient to the ED will be used to judge severity of injury and need for activation of Trauma Team which include:

1. Abnormal physiologic signs
2. Obvious anatomic injury
3. Mechanism of injury
4. Co-morbidity factors; i.e., age <5 or >65, pregnancy, history of cardiac or respiratory disease, diabetes, or morbid obesity etc.

B. The emergency provider will determine need of Trauma Activation.

1. The ED nurse or EMS may activate the Trauma Team, in the absence of provider.

C. The emergency provider and nurse will be Team Leaders, collaborating in directing the team.

1. Any time a Full Trauma Activated patient leaves the ED (i.e., CT Scan), a nurse must accompany the patient for continued monitoring.

D. Full Trauma Activation

1. The back-up physician and CRNA will be called in based on ED provider and ED nurse discretion.
2. The goal is to have the team present by the time of arrival of patient.
    a. The members of the Trauma Team will be called in based on ED provider and ED nurse discretion.
3. Trauma orders activated unless requested otherwise by emergency provider; emergency provider and Nursing staff will make arrangements for transfer to a trauma center.
4. These patients may be admitted, discharged, or transferred after appropriate evaluation and observation; consultations may be utilized.
5. Full Trauma Criteria
    a. Physiologic
        1. Unable to adequately ventilate, intubated, or requiring assisted

ventilation

2. Respiratory rate <10 or >29 per minute; any sign of respiratory compromise/ obstruction and/or intubation
3. SBP <90 mmHg perfusion; (pediatric hypotension: SBP <70 mmHg +[2 x age in yrs])
4. GCS ≤13

b. Anatomic

1. Penetrating injuries to the head, neck, torso, groin, or extremities proximal to the elbow/knee
2. Open or depressed skull fracture
3. Suspected spinal cord injury/ paralysis
4. Flail chest
5. Unstable pelvic fracture
6. Amputation proximal to the wrist or ankle
7. Two or more proximal long bone fractures (humerus or femur)
8. Crushed, degloved, mangled or pulseless extremity
9. Uncontrolled external bleeding

c. Mechanism of Injury

1. Falls: Adult >20 feet, Child >10 feet, or 3x height
2. Fall from any height (>65 y/o on anticoagulants w/ signs of injury)
3. Traumatic injury on anticoagulation (except for aspirin)
4. High-risk auto/motorcycle/ ATV crash with:
    a. Intrusion of vehicle ≥12 inches
    b. Ejection/separation from automobile (partial or full)
    c. Rollovers - unrestrained
    d. Death of same car occupant
5. Auto vs. pedestrian/cyclist thrown, run over, or with significant (>20 mph) impact
6. High energy dissipation or rapid decelerating incidents, for example:
    a. Ejection from motorcycle, ATV, animal, etc.
    b. Striking fixed object with momentum
    c. Blast or explosion
7. Prolonged extrication ≥20 minutes

8. High energy electrical injury
9. Burns of >10% TBSA and/or significant burns of face/airway, to include inhalation injury
10. Suspicion of hypothermia, drowning, or hanging
11. Suspected non-accidental trauma
12. Mass casualties (disaster scenario) that exceeds ER capabilities at a given time
13. All pregnant trauma patients ≥20 weeks gestation after trauma
14. EMS/provider discretion based on Mechanism of Injury

REFERENCES

A. State of Nebraska Basic Level Trauma Center Guidelines

B. Resources for Optimal Care of the Injured Trauma Patient from the American College of Surgeons

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Approval Signatures

Step Description	Approver	Date
	[redacted] DOCUMENT CONTROL COORD	
	[redacted] CARE SERVICES	
	[redacted] CLINICAL COORDINATOR	