Appendix A

BCH OAKLAND TRAUMA TRIAGE/ACTIVATION CLINICAL CRITERIA GUIDELINE

Level 1- Trauma Full	***Level 2- Trauma Partial***	***Level 3-Trauma Consult***
"Unstable"	**"Major Injury"**	**"Minor Injury"**
SCOPE: Likely requires emergent intervention. **Category Note:** All significant aberrations in vital and GCS will automatically initiate a Level 1 activation.	**SCOPE:** Requires trauma surgical evaluation **Category Note:** A level 2 activation is the minimum expected call for the injuries and circumstances listed below. **Physiologic aberrations along with any of these would be a level 1 activation.**	**SCOPE:** Any injury with anticipated admission but is clinically stable. **Category Note:** A level 3 consult is called at the discretion of the ED attending for any injury. The following are recommended to minimally receive a Level 3 Consult.
Criteria Include:	**Examples Include:**	**Examples Include:**
▪ Age appropriate hemodynamic instability (hypotension, tachycardia, poor perfusion) ▪ Required blood or >2 crystalloid boluses ▪ GCS less than 13 or Deteriorating GCS ▪ Neurologic deficit concerning for spinal cord injury ▪ Respiratory distress/compromise; definitive airway needed or present ▪ Penetrating wound to head, neck, chest or abdomen ▪ Major amputation or near amputation, or degloving injuries ▪ Presence of a tourniquet (for hemorrhage control) ▪ Significant burns that compromise physiologic stability (or 2nd degree > 20% TBSA) ▪ **Anticipated emergent surgery** ▪ emergency (911) re-triage - if meets above criteria ▪EM Attending discretion	***Injuries*** ▪ Motor / sensory neurologic symptoms ▪ Multiple extremity fractures ▪ rib fractures ▪ Suspected pelvic fracture ▪ open fractures ▪ Penetrating eye injury ▪ Burns (2nd degree) that are >10% TBSA ▪ Suspected NAT w/ acute injury ▪ Injured limb w compromised perfusion ▪ Interfacility transfers with known injury ▪ Polytrauma (multiple injuries) ▪ Closed head injury with LOC (Grade III) or PECARN Box 2 w decision to CT head + mechanistic critieria ***Mechanisms:*** ▪ Stuck by high impact object ▪ Rollover MVA ▪ Ejected from Vehicle ▪ Auto vs Pedestrian ▪ + Seatbelt sign ▪ GSW/stab wound ▪ Auto vs bicyclist ▪ Drowning ▪ dog mauling ▪ Fall greater than 10 feet (or > 2 times height)	▪ Suspected NAT (old or incidental finding) ▪ Long bone fracture requiring admission ▪ Closed head injury meets PECARN Box 2 & decision to CT head (no machanistic criteria) → upgrade in pt w bleeding dx /anticoagulation rx ▪ Animal/human bite requiring Operative intervetnion or admission ▪ Delayed presentations ▪ Interfacility transfers with known isolated injury ▪Lacerations requiring admission
Respondents -Trauma Page	**Respondents - Trauma page**	**Respondents - Page individually as needed**
Attending surgeon (team leader), surgical resident/APP, anesthesiology attending or senior resident, ED attending, pediatric resident (from the ED), RNs - bedside, scribe, and Circulating, R.T., pharmacist, security, social worker, laboratory technologist (with O-neg. blood), radiology tech. **The neurosurgeon & orthopaedic surgeon on call will be paged if her/his services are needed.*	ED attending (trauma team leader), pediatric resident, bedside RN, scribe RN, R.T., security, social worker. **The senior surgical resident/APP is expected within 1/2 hour of the patient's arrival.*	ED attending (leadership role), ED fellow and/or pediatric resident, surgical resident within 1/2 hour, bedside RN, social worker . **Critical Care flow sheet may be used but is not required (if used 2nd RN needed to scribe).*

*Suspected NAT without admission- consult CCP