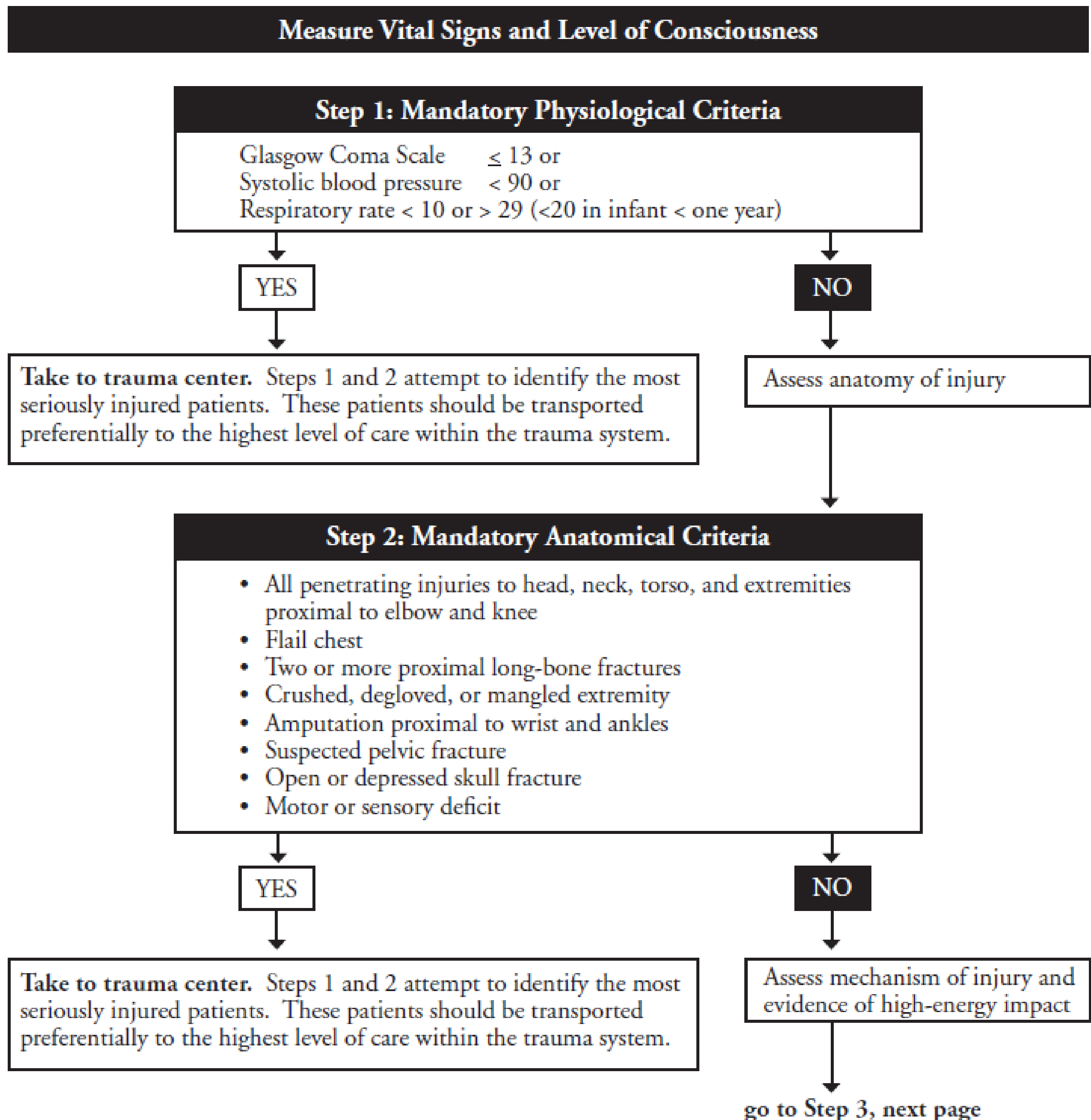
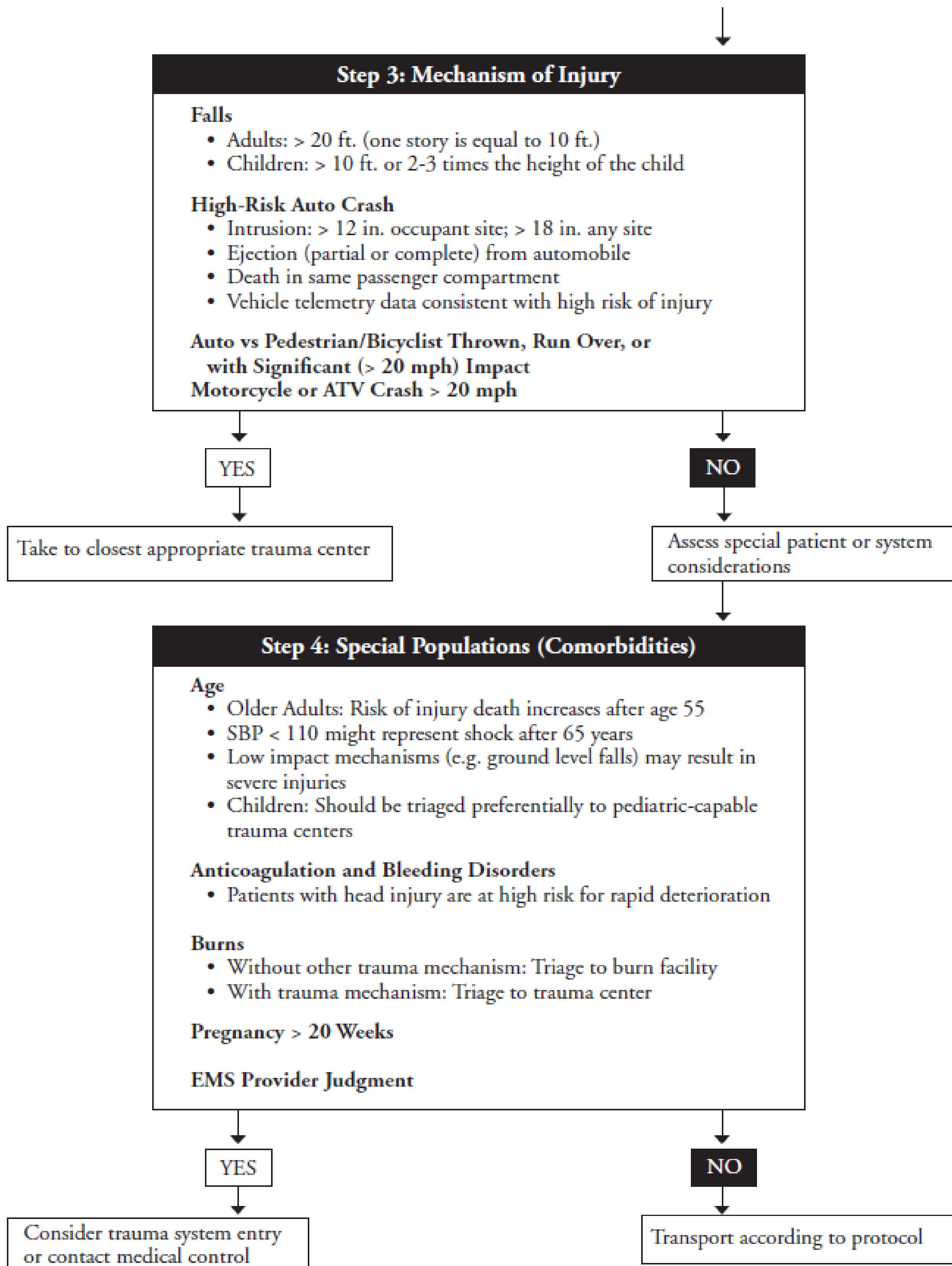
Trauma System

I. PATIENT ENTRY:




Step 3: Mechanism of Injury
Falls
• Adults: > 20 ft. (one story is equal to 10 ft.)
• Children: > 10 ft. or 2-3 times the height of the child
High-Risk Auto Crash
• Intrusion: > 12 in. occupant site; > 18 in. any site
• Ejection (partial or complete) from automobile
• Death in same passenger compartment
• Vehicle telemetry data consistent with high risk of injury
Auto vs Pedestrian/Bicyclist Thrown, Run Over, or with Significant (> 20 mph) Impact
Motorcycle or ATV Crash > 20 mph
YES
NO
Take to closest appropriate trauma center
Assess special patient or system considerations
Step 4: Special Populations (Comorbidities)
Age
• Older Adults: Risk of injury death increases after age 55
• SBP < 110 might represent shock after 65 years
• Low impact mechanisms (e.g. ground level falls) may result in severe injuries
• Children: Should be triaged preferentially to pediatric-capable trauma centers
Anticoagulation and Bleeding Disorders
• Patients with head injury are at high risk for rapid deterioration
Burns
• Without other trauma mechanism: Triage to burn facility
• With trauma mechanism: Triage to trauma center
Pregnancy > 20 Weeks
EMS Provider Judgment
YES
NO
Consider trauma system entry or contact medical control
Transport according to protocol

II. MEDICAL DIRECTION:

A. Off-line medical direction for trauma patients is controlled by the Treatment Protocols and Procedures section.
B. OLMC is provided by the receiving hospital. OLMC may override off-line medical direction. Any instances where this occurs will be documented in the pre-hospital care report.

III. COMMUNICATIONS:

A. The following information will be provided to receiving hospital:
   1. Unit number and the location of the incident.
   2. Number of patients.
   3. Age and sex of the patients.
   4. Trauma system entry criteria and vital signs.
   5. Glasgow Coma Scale.
   6. ETA to Trauma Center.
   7. Patient destination based on incident location or request.

IV. TRAUMA CENTER DESTINATION:

A. **St. Charles Medical Center- Bend** is the only Level 2 in Central Oregon.
B. **Patients or Guardians Request:** If the alert, competent patient or his/her competent guardian demands transport to a specific hospital, the EMS provider will try to honor that request and notify the receiving hospital immediately.
C. Multiple Patients: Follow ATAB 7 MCI Plan.
D. **Diversion To Local Hospital:** If the paramedic is unable to establish an airway, the patient should be transported to the nearest acute care facility

V. MODE OF TRANSPORT:

An air ambulance may be used when it would reduce total pre-hospital time by 15 minutes or greater. This is usually achieved whenever the ground transport time will exceed 30 minutes (Scene is > 15 miles from Level 2 hospital, or other circumstances exist).

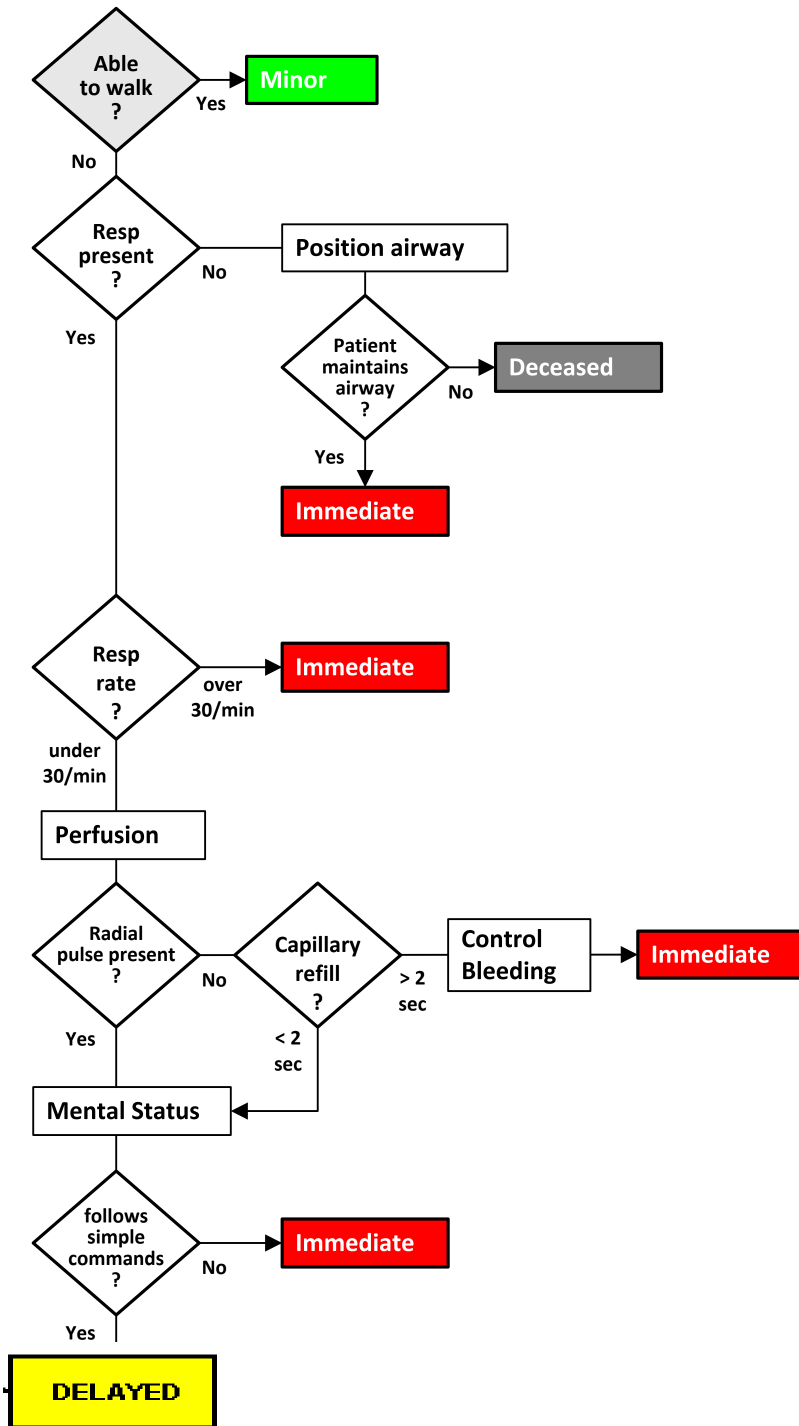
VI. PATIENT EVALUATION PROTOCOL:

A. Treatment Priority Should Be Approached In This Order:
   1. Airway Maintenance (Including control of the cervical spine).
   2. Breathing.
   3. Control of circulation and hemorrhage.
   4. Treatment of shock.
   5. Neurological examinations.
   6. Complete secondary survey.
   7. Splinting of fractures.

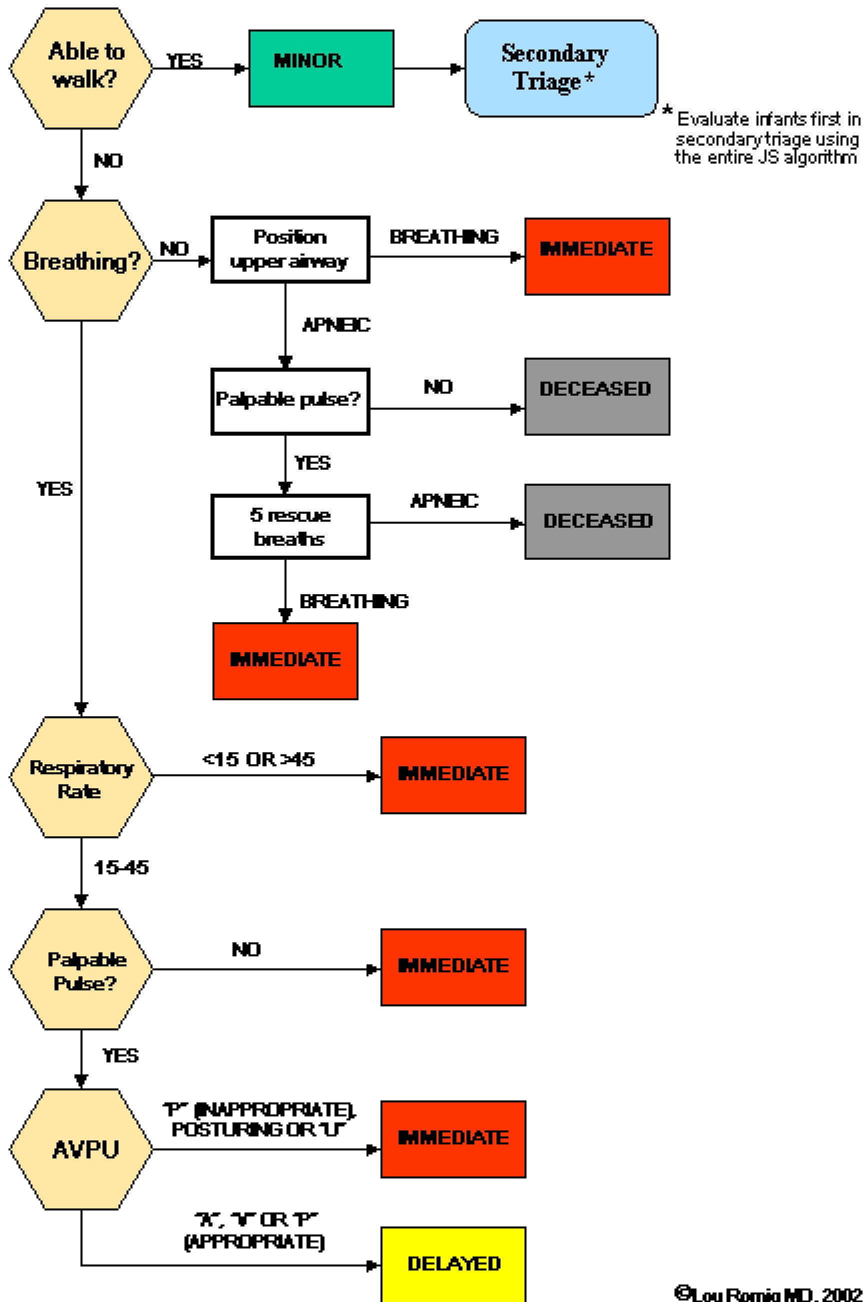
VII. SCENE TIME:

After gaining access to the patient, scene time should not exceed ten minutes for any patient who is entering the Trauma System. Plan to start IV/IOs and initiate other care once en-route to the hospital if necessary.

START Triage



Jump Start Pediatric Triage



The National Incident Management System (NIMS) will be used to manage all incidents.

1. Incident Command (IC) is the responsibility of the agency having jurisdiction (AHJ).

2. Each assisting agency shall retain full authority to operate within the scope of its agency operational and administrative protocols and procedures.

3. Agencies that are assisting in the support of a single jurisdiction will function under the direction of that jurisdiction's designated Unified Incident Command.

4. Incident Command of a multi-discipline event should be predicated on the "Primary Hazard" of the event.

5. In a Unified Command, the "Lead Agency" may change as priorities change.

The **Mass Casualty Incident ATAB 7 Plan** is a tool that may be used in part or whole as determined by the on-scene Incident Commander in situations where the number of patients exceeds the resources of the on-scene responders. There is no set number of patients that will automatically initiate this protocol. If the Incident commander determines that additional resources or incident structure is needed to better manage due to the complexity of the incident, he/she shall announce to dispatch that an MCI is being declared. This may be done upon arrival or at any time during the incident.

- If the incident involves multiple asymptomatic patients (HazMat exposure) set up secure evaluation area.
- During a declared MCI, the Trauma System is not in effect.
- "Licensed ambulances" are not needed for transport.
- If transport resources are limited, more than one critical patient may be placed in an ambulance.