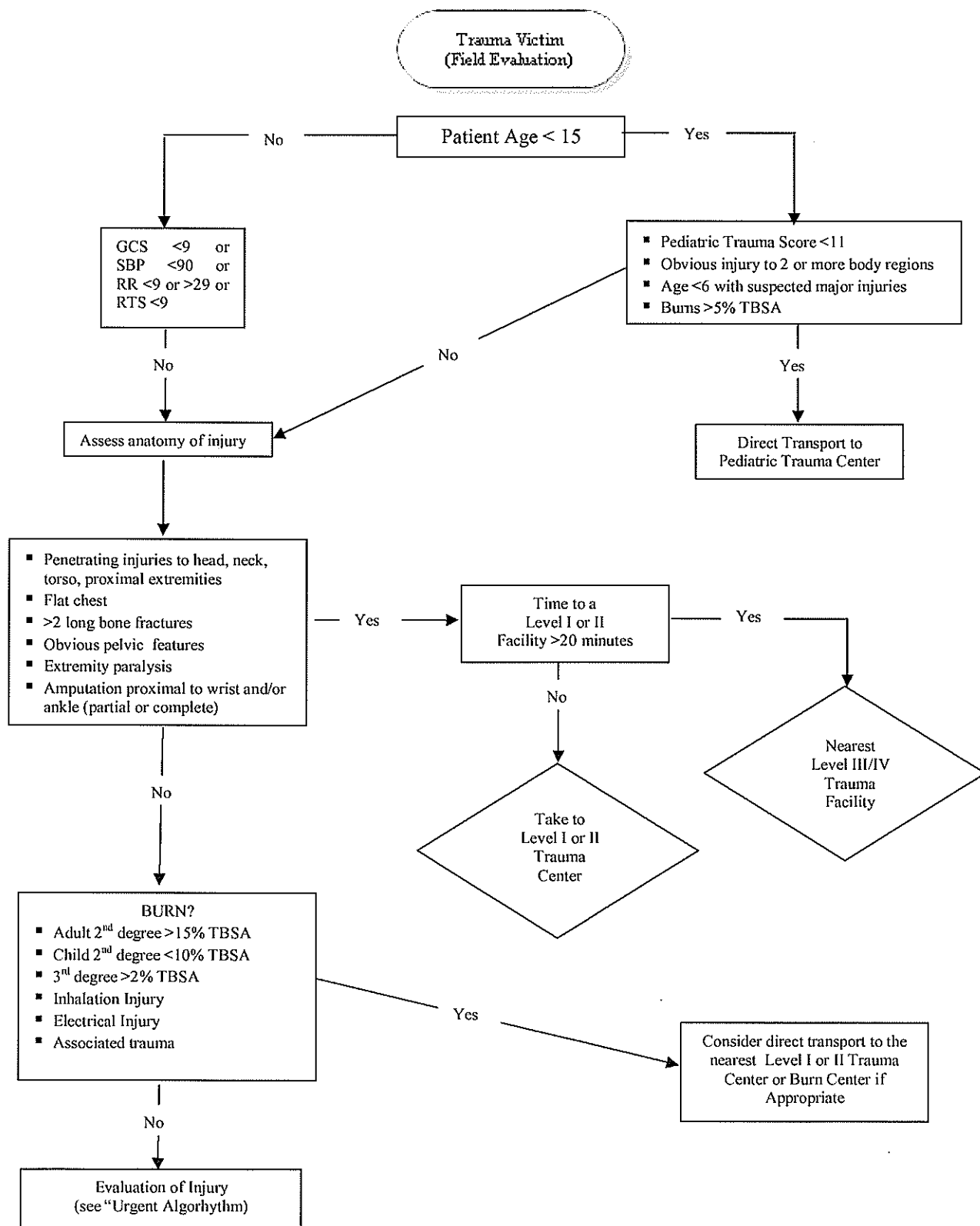
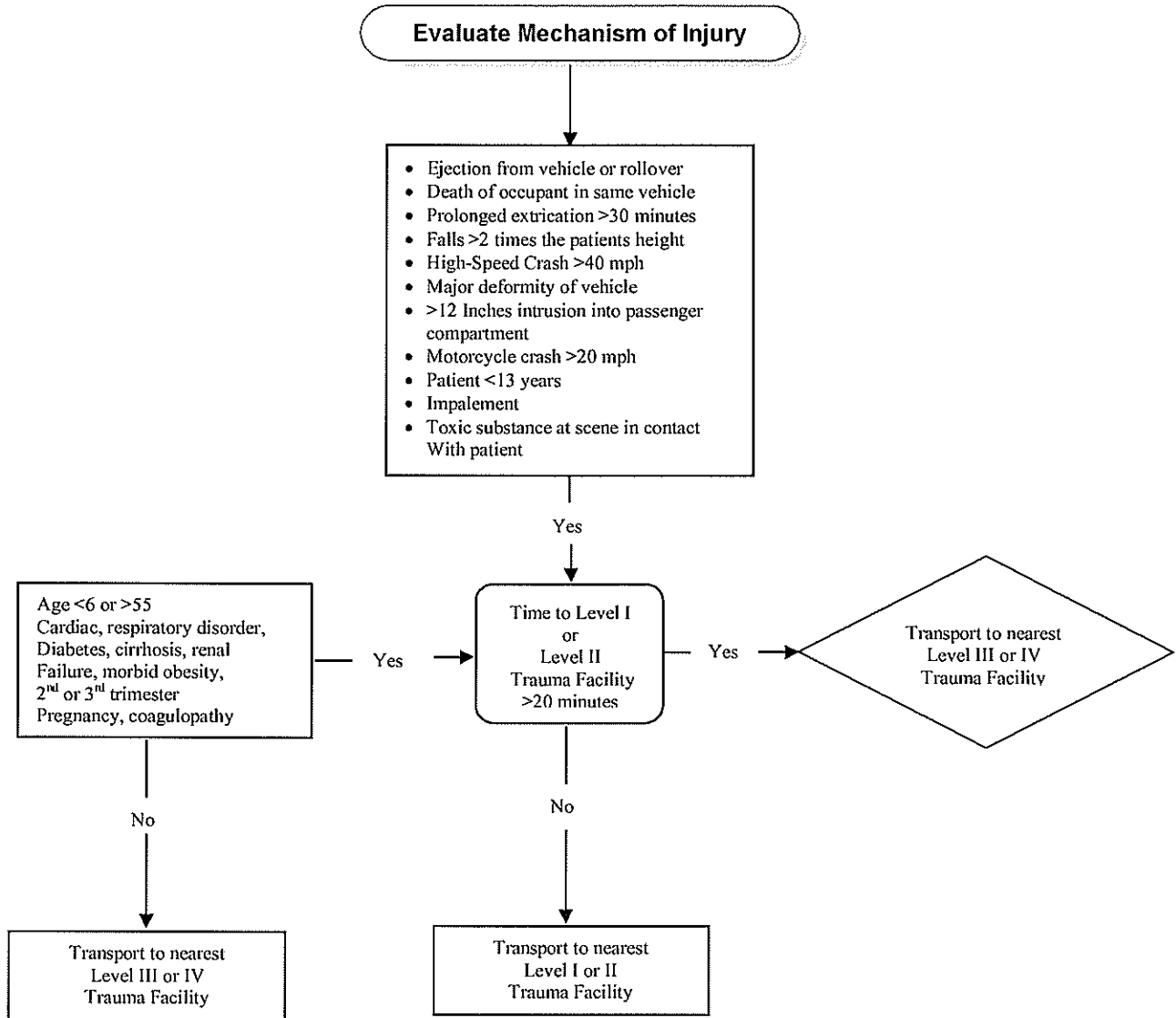


Triage Decision Scheme (Critical)



Triage Decision Scheme (Urgent)



Note: Every attempt should be made to call the ED Call Center of the receiving hospital at least 15 minutes pre-arrival.

FACILITY TRIAGE PATIENT CRITERIA			
Patient Arrives At:	Critical Adult Patient:	Urgent Adult Patient:	Critical or Urgent Pediatric Patient:
Level I	Admit	Admit	Admit to Trauma Service or Transfer to Pediatric Center
Level II	Admit or Stabilize and Transfer to Level I	Admit or Transfer to Level I	Admit to Trauma Service or Transfer to Level I or Pediatric Center
Level III	Stabilize and Transfer to Level I or II	Stabilization and Admit to appropriate Service if Available, otherwise, transfer to Level I or II Trauma Center	Stabilize and Transfer to Level I, II, or Pediatric Center
Level IV	Stabilize and Transfer to Level I or II	Stabilize and Transfer to Level I, Level II, or Level III	Stabilize and Transfer to Level I, II, or Pediatric Center

CATEGORY I PATIENT: (Critical)	CATEGORY II PATIENT: (Urgent)
<p>* CENTRAL NERVOUS SYSTEM:</p> <ul style="list-style-type: none"> — Neurologic Injuries producing prolonged loss of consciousness, posturing, paralysis, or Internalizing signs — Spinal Injuries with or without neurological deficit — Open Penetrating or depressed skull fractures — CSF leak — Deterioration of GCS of 2 or more <p>* CHEST:</p> <ul style="list-style-type: none"> — Major Chest wall injury — Suspected great vessel or cardiac injury — Patients who may require prolonged mechanical ventilation — Respiratory distress with a rate >35 or <10 — Penetrating thoracic wound <p>* PELVIS:</p> <ul style="list-style-type: none"> — Pelvic ring disruption with shock requiring more than 5 units transfusion — Evidence of continued hemorrhage — Compound/open pelvic injury or pelvic visceral injury <p>* ABDOMEN:</p> <ul style="list-style-type: none"> — Blunt abdominal trauma with hypotension — Penetrating abdominal wound <p>* MULTIPLE SYSTEM INJURY:</p> <ul style="list-style-type: none"> — Severe face injury with head injury — Chest injury with head injury — Abdominal or pelvic injury with head injury — Burns with head injury <p>* SPECIALIZED PROBLEMS:</p> <ul style="list-style-type: none"> — Second or third degree burns greater than 10% TBSA or involving airway — Carbon monoxide poisoning — Barotrauma — Uncontrolled hemorrhage — Severe maxillofacial or neck injuries — Revised Trauma Score of 11 or less — Open fractures — Second/third trimester pregnancy <p>* SECONDARY DETERIORATION (LATE SEQUELAE):</p> <ul style="list-style-type: none"> — Patients requiring mechanical ventilation — Sepsis — Oxygen system(s) failure (deterioration in CNS, cardiac, pulmonary, hepatic, renal, or coagulation) — Osteomyelitis 	<p>Patients who are hemodynamically and physiologically stable whose injuries may include:</p> <p>* CENTRAL NERVOUS SYSTEM:</p> <ul style="list-style-type: none"> — Transient Loss of consciousness <p>* CHEST:</p> <ul style="list-style-type: none"> — Injuries not producing respiratory distress — Rib fractures without flail segments <p>* ABDOMEN</p> <ul style="list-style-type: none"> — Blunt trauma not producing hypotension (should also be managed by trauma services) <p>* SPECIALIZED PROBLEMS:</p> <ul style="list-style-type: none"> — Closed fractures — Soft tissue injuries with controlled hemorrhage — Second/third trimester of pregnancy
	<p>CATEGORY III PATIENT:</p> <p>Patients who are continually stable but whose injuries may include:</p> <ul style="list-style-type: none"> — Closed fracture without neurological deficit — Normotensive and/or hemodynamically stable — Soft tissue injuries of moderate degree

Facility Triage Patient Criteria

Trauma patients may be placed into one of the following categories by the attending physician upon arrival in the Emergency Department based upon the severity of their injuries. Inter-hospital transfer should then be initiated as appropriate according to the RAC-G Facility Triage Decision Scheme.

Category I Patient

Central Nervous System:

- Neurological injuries producing prolonged loss of consciousness, posturing, paralysis or lateralizing signs
- Spinal injuries with or without neurological deficit
- Open, penetrating or depressed skull fractures
- CSF leak
- Deterioration of GCS of 2 or more

Chest:

- Major chest wall injury
- Suspected great vessel or cardiac injury
- Patients who may require prolonged mechanical ventilation
- Respiratory distress with a rate >35 or <10
- Penetrating thoracic wound

Pelvis:

- Pelvic ring disruption with shock requiring more than 5 units transfusion
- Evidence of continued hemorrhage
- Compound/open pelvic injury or pelvic visceral injury

Abdomen:

- Blunt abdominal trauma with hypotension
- Penetrating abdominal wound

Multiple System Injury:

- Severe face injury with head injury
- Chest injury with head injury
- Abdominal or pelvic injury with head injury
- Burns with head injury

Specialized Problems:

- Second- or third-degree burns greater than 10% TBSA or involving airway
- Carbon monoxide poisoning
- Barotrauma
- Uncontrolled hemorrhage
- Severe maxillofacial or neck injuries
- Revised Trauma Score of 11 or less
- Open fractures
- Second/third trimester pregnancy
- Secondary Deterioration (Late Sequelae):
- Patients requiring mechanical ventilation
- Sepsis
- Organ system(s) failure (deterioration in CNS, cardiac, pulmonary, hepatic, renal or coagulation)
- Osteomyelitis

Category II Patient

Patients who are hemodynamically and physiologically stable whose injuries may include:

Central Nervous System:

- Transient loss of consciousness

Chest:

- Injuries not producing respiratory distress
- Rib fractures without flail segments

Abdomen:

- Blunt trauma not producing hypotension (should also be managed by trauma service)

Specialized Problems:

- Closed fractures
- Soft tissue injuries with controlled hemorrhage
- Second/third trimester of pregnancy
- Second degree burns to >10% TBSA

Category III Patient

Patients who are continually stable but whose injuries may include:

- Closed fracture without neurological deficit
- Normotensive and/or hemodynamically stable
- Soft tissue injuries of moderate degree

Facility Triage Action Plan

On-line consultation with Medical Control should be undertaken when confusion exists regarding appropriate facility for transfer.

Patient Arrives At:	Critical Adult Patient	Urgent Adult Patient	Critical or Urgent Pediatric Patient
Level I	Admit to Trauma Service Or consider transfer to appropriate specialty center (i.e. burn)	Admit to Trauma Service or Surgical Subspecialty Service with Trauma consultation	Admit to Trauma Service or transfer to a Pediatric Trauma Center
Level II	Admit to Trauma Service Or consider transfer to appropriate specialty center (i.e. burn)	Admit to Trauma Service or Surgical Subspecialty Service with Trauma consultation	Admit to Trauma Service or transfer to a Pediatric Trauma Center
Level III	Stabilize and transfer to a Level I or II Trauma Center Or appropriate specialty center if needed (i.e.burn)	Patient stabilization and admit to appropriate Surgical Service or transfer to Level I or II Trauma Center or appropriate specialty center	Stabilize and transfer to Pediatric Trauma Center
Level IV	Stabilize and transfer to a Level I or II Trauma Center Or appropriate specialty center (i.e. burn)	Stabilize and transfer to a Level I or II Trauma Center or appropriate specialty center	Stabilize and transfer to Level I, II or Pediatric Trauma Center

Trauma Facility Diversion Policy

PURPOSE: To develop a standardized diversion policy that identifies area specific trauma resources and assures continual access to the appropriate trauma facility for each trauma patient.

1. Each facility will develop procedures for their facility to be placed on diversion status. The RAC utilizes the EMSsystem for “real time” communication of diversion status.

Suggested reasons for facility diversion may include, but are not limited to:

- Trauma Surgeon/General Surgeon is not available
- Internal Disaster
- Facility structure compromise
- Exhaustion of facility and/or emergency resources
- Specialty Surgeon (Neuro, Ortho) is not available
- Specialty equipment (CT Scanner, MRI) is not available
- Patient ‘s needs exceed facility capabilities

2. Each facility shall designate a person responsible for decisions regarding diversion status.
3. There must be appropriate documentation of any diversion. This diversion should be reviewed in your performance improvement process and may also be reviewed in the RAC Performance Improvement Committee.
4. Each facility is required to have a local Mass Casualty Plan and know how to activate additional resources within RAC-G if needed. The use of the EMSsystem will facilitate this process.
5. Each facility must have policies and procedures in place to open critical care beds in the event there is a mass casualty situation. The use of the EMSsystem allows constant real-time communication between the hospitals and pre-hospital providers.
6. Each Level I, II, III or IV facility is required to notify all EMS dispatch centers within their service area when a facility goes on and off diversion. The EMSsystem facilitates this process.

Facility Bypass

GOAL: Trauma patients who are medically unstable, unconscious or at high risk for multiple and/or severe injuries will be quickly identified and transported to an appropriate designated trauma center.

DECISION CRITERIA:

Transport protocols must ensure that patients who meet triage criteria for activation of the RAC-G Regional Trauma System Plan will be transported directly to an appropriate trauma facility rather than to the nearest hospital, except under the following circumstances:

1. If unable to establish and/or maintain an adequate airway, or in the case of traumatic cardiac arrest, the patient should be taken to the nearest trauma facility for stabilization.
2. A Level III or IV trauma facility may be appropriate if the expected scene-to-Level I or II Trauma Center time (i.e., transport time) is excessive (>20 minutes) and there is a qualified physician available at the facility's Emergency Department.
3. Medical Control may wish to order bypass in any of the above situations as appropriate, such as when a facility is unable to meet hospital resource criteria or when there are patients in need of specialty care.
4. If expected transport time to the nearest trauma facility is excessive (>20 minutes) or if prolonged extrication time is expected, the EMS crew or Medical Control may consider activating air transportation resources available within the trauma service area.

NOTE:

If there should be any question regarding whether or not to bypass a facility, on-line Medical Control should be consulted for the final decision.