Sample Pediatric Trauma Activation Criteria # 4

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Clinical Guideline

Subject: **Pediatric Trauma Activation Criteria**

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Purpose: Define criteria and processes for pediatric trauma activation; applies to any pediatric trauma patient under the age of 18 years.

Responsibility: Physicians, physician assistants, nurse practitioners, registered nurses, unit secretaries

Guideline Content

Level 1 trauma team activation "Trauma Code" criteria:

Intubated, assisted ventilation, or respiratory distress
Confirmed hypotension
Transfer patients requiring blood or with persistent hypotension/tachycardia
Glasgow Coma Score ≤12
Presence of paralysis or loss of sensation
Penetrating injury to the head, neck, torso and/or abdomen
Partial or complete amputation proximal to wrist or ankles and/or loss of distal pulse
Discretion of ED physician or designee

Level 2 trauma team activation criteria:

Does not meet any Level 1 criteria, plus any of the below:
Two or more long bone fractures
Pregnancy greater than 20 weeks (notify Maternal-Fetal Medicine staff (XXXX) prior to arrival)
Ejection from vehicle
Death of occupant in same vehicle
Auto versus pedestrian or bike/motorcycle
Falls > 10 feet (or twice patient's height)
Discretion of ED physician or designee

Resp distress:
0-5 months: RR<20
≥ 6 months – 12 yrs: RR<16
≥13 yrs: RR<12

Hypotension:
0-5 months: SBP<60
≥6 months – 5 yrs: SBP< 70
≥6 vrs: SBP< 80

Level 3 trauma team "Evaluation" criteria:

Does not meet any Level 1 or Level 2 criteria
Consult the pediatric trauma service for any patient with multisystem trauma injuries requiring trauma evaluation, including suspected non-accidental trauma, non-isolated severe traumatic brain injury, and injured patients requiring admission to non-surgical services. Any patient with a trauma mechanism transferring from the scene or an emergency department should be seen first in the Emergency Department.

Activation Process:

Upon receiving notification of a patient meeting criteria for pediatric trauma activation, a trauma team activation process will be implemented. The pediatric group paging system will be used. The emergency department unit secretary will send the activation page at the direction of the emergency department

physician or charge nurse. The group page message will identify “PEDIATRIC TRAUMA GROUP” and include a numeric code for trauma activation level, destination, and estimated arrival time.

Example: **1*1680*2130 → Level 1 Trauma Code at Trauma Bay arriving at 2130**
2*71090*0100 → Level 2 activation at ED arriving at 0100

Level 1 trauma team activation “Trauma Codes” with advance notice will be directed to and initially managed in the XXXX Trauma Bay. The adult trauma surgeon and trauma team will respond to all Level 1 Trauma Codes to the department indicated by the pager and will manage patient care. The adult trauma surgeon will be relieved after giving report to the pediatric trauma surgeon. When the pediatric trauma surgeon is physically present, the location of the trauma code may be at their discretion, in consultation with the ED physician. A patient may be upgraded at any time using the above process.

Response Times:

Level 1 trauma team activation “Trauma Code:”

Pediatric trauma surgeon and trauma team must report to the bedside immediately. If unable to immediately attend the activation, the pediatric trauma surgeon must call the adult trauma surgeon (XXX-XXXX) to communicate his or her arrival time.

Level 2 trauma team activation “Immediate Trauma Consult:”

Trauma team must report to the bedside immediately. Discussion of the patient will then occur within 15 minutes of notification, directly between the trauma surgeon, the emergency attending, and the trauma resident. The emergency department physician will manage patient care until relieved by the pediatric trauma surgeon or another admitting physician. *Patient may only be downgraded to an evaluation or consult by the attending present at the bedside of the patient.* Documentation of the notification and response from the trauma surgeon will be documented in the EMR by the emergency department team for performance tracking.

Level 3 Evaluation “Trauma Consult:”

Response to trauma evaluation will be per Medical Staff Rules and Regulations for consults.

Triage:

Triage decisions should be documented by attending physician making the decision. Over-triage, under-triage, response times, and other performance improvement measures will be reviewed according to the American College of Surgeons recommendations and the pediatric trauma program performance improvement plan.

References:

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2. US Department of Health and Human Services, Center for Disease Control and Prevention. Guidelines for the Field Triage of Injured Patients. Recommendations of the National Expert Panel on Field Triage, 2011. MMWR January 13, 2012: 61 (1).
3. Nwomeh BC, Georges AJ, Groner JI, et al. A leap in faith: The impact of removing the surgeon from the level II response. J Pediatric Surgery 2006; 41: 693-9.
4. Mukherjee K, Rimer M, McConnell MD, et al. Physiologically focused triage criteria improve utilization of pediatric surgeon-directed trauma teams and reduce costs. J Pediatric Surgery 2010; 45: 1315-23.
5. Falcone RA, Haas L, King E, et al. A multicenter prospective analysis of pediatric trauma activation criteria routinely used in addition to the six criteria of the American College of Surgeons.J Trauma Acute Care Surg 2012; 73: 377-84.

6. Krieger AR, Wills HE, Green MC, et al. Efficacy of anatomic and physiologic indicators versus mechanism of injury criteria for trauma activation in pediatric emergencies. J Trauma Acute Care Surg 2012; 73: 1471-7.