Monroe Livingston Region Program Agency

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To: All EMS Providers

From: Jeremy T. Cushman, MD, MS, EMT-P
Regional Medical Director

Date: November 22, 2013

Re: Advisory 13-11: Trauma Triage and Hospital Notifications

Providers are reminded that the decision to transport a patient to a trauma center is guided by the CDC Trauma Triage Guidelines (attached) which are part of the MLREMS Protocols. All providers in the system are expected to be familiar with these guidelines and no other guidance documents should be used. For free CME on the use of the Trauma Triage Guidelines, click to www.cdc.gov/fieldtriage/.

Hospital notification is important in any patient meeting trauma center referral criteria, and any unstable or potentially unstable medical or trauma patient. This allows our area emergency departments to be adequately prepared to receive your patient.

Medical Control is provided by four area hospitals: Rochester General, Unity, URMC Highland, and URMC Strong. Pediatric Medical Control is to be contacted for patients 18 years of age or younger whose destination is URMC – Strong, and for patients 21 years of age or younger whose destination is Rochester General. The following are the area's Medical Control numbers:

Rochester General Hospital Adult Medical Control	585-338-3367
Rochester General Hospital Pediatric Medical Control	585-338-1014
Unity Medical Center/Park Ridge Medical Control	585-368-4068
URMC – Highland Medical Control	585-341-6444
URMC – Strong Adult Medical Control	585-271-2769
URMC – Strong Pediatric Medical Control	585-756-3430

The EMS provider in charge is encouraged to contact the appropriate Medical Control and provide information directly to the physician or communications nurse, particularly when requesting orders or notifying the ED of a critically ill patient. Physician orders may only be obtained by direct provider to physician communication.

Highland and Unity Hospitals request notification via radio 155.3400 to assist in placement and bedding of stable, inbound EMS patients. Unity Hospital has also established a notification-only phone number of 585-723-7525 to report stable, inbound patients. Please note that ***no medical control will be provided via this number.***

Should the provider be unable to establish direct communication with the Medical Control Physician due to patient care responsibilities, they may have their dispatch center relate relevant patient information for critical patients by calling the respective Medical Control Phone. ***No EMS communication is to be routed by calling the charge nurse, communications nurse, triage nurse, or other emergency department phone number.*** Key information that should be related through the Medical Control phone includes the following:

1. Agency Name
2. Estimated Time of Arrival
3. Patient Age and Gender
4. Chief Complaint or Mechanism of Injury
5. Location of Injuries (If applicable)
6. Heart Rate and Blood Pressure
7. Whether the patient is intubated or on CPAP
8. Estimated weight

This information is vital to ensure appropriate resources are mobilized prior to the arrival of a critical patient and your assistance is greatly appreciated.

2011 Guidelines for Field Triage of Injured Patients

1

Measure vital signs and level of consciousness

Glasgow Coma Scale	≤13
Systolic Blood Pressure (mmHg)	<90 mmHg
Respiratory Rate	<10 or >29 breaths per minute, or need for ventilatory support (<20 in infant aged <1 year)

YES → **Transport to a trauma center.** Steps 1 and 2 attempt to identify the most seriously injured patients. These patients should be transported preferentially to the highest level of care within the defined trauma system.

NO

Assess anatomy of injury

2

- All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
- Chest wall instability or deformity (e.g. flail chest)
- Two or more proximal long-bone fractures
- Crushed, degloved, mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Pelvic fractures
- Open or depressed skull fracture
- Paralysis

YES → **Transport to a trauma center.** Steps 1 and 2 attempt to identify the most seriously injured patients. These patients should be transported preferentially to the highest level of care within the defined trauma system.

NO

Assess mechanism of injury and evidence of high-energy impact

3

- **Falls**
  - — Adults: >20 feet (one story is equal to 10 feet)
  - — Children: >10 feet or two or three times the height of the child
- **High-risk auto crash**
  - — Intrusion, including roof: >12 inches occupant site; >18 inches any site
  - — Ejection (partial or complete) from automobile
  - — Death in same passenger compartment
  - — Vehicle telemetry data consistent with a high risk of injury
- **Auto vs. pedestrian/bicyclist thrown, run over, or with significant (>20 mph) impact**
- **Motorcycle crash >20 mph**

YES → **Transport to a trauma center,** which, depending upon the defined trauma system, need not be the highest level trauma center.

NO

Assess special patient or system considerations

4

- **Older Adults**
  - — Risk of injury/death increases after age 55 years
  - — SBP <110 may represent shock after age 65
  - — Low impact mechanisms (e.g. ground level falls) may result in severe injury
- **Children**
  - — Should be triaged preferentially to pediatric capable trauma centers
- **Anticoagulants 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 → **Transport to a trauma center** or hospital capable of timely and thorough evaluation and initial management of potentially serious injuries. Consider consultation with medical control.

NO

Transport according to protocol

When in doubt, transport to a trauma center.

Find the plan to save lives, at www.cdc.gov/Fieldtriage

National Center for Injury Prevention and Control
Division of Injury Response