CENTRAL OHIO TRAUMA SYSTEM
CLINICAL COMMITTEE
REGIONAL LEVEL I AND II TRAUMA ALERT CRITERIA

The following are regional ***minimum*** criteria for trauma alert activation in the central Ohio region. Trauma Centers may modify these criteria, but modifications should not lessen the severity of the criteria for any given alert level. These criteria are based on ACS standards and Franklin County trauma centers' current trauma alert protocols.

CATEGORY I ALERT

Patients with traumatic injuries meeting the following criteria are those requiring the highest level (Level I) of a trauma alert in central Ohio. These patients have demonstrated in the prehospital setting clear signs of major injury. According to the American College of Surgeons, this level of alert involves ***"major resuscitation."***

- **Respiratory compromise / obstruction or intubation** required for respiratory or hemodynamic resuscitation

- **Circulatory / hemodynamic instability** as evidenced by any of the following:

  - Transferred patients receiving blood to maintain vital signs
  - Systolic blood pressure less than 90 in adults, or less than "70 plus two times the child's age in years" (remembering that hypotension is a LATE sign in pediatrics)
  - Tachycardia in children after 2 fluid boluses

- **Glasgow Coma Score < 8** with a mechanism attributable to trauma

- **Gun shot wound to the abdomen, chest, or neck**

- **Emergency Physician's discretion** with prehospital report of **life / limb threatening injuries.**

CATEGORY II ALERT

Patients with traumatic injuries meeting the following criteria are those requiring a trauma alert (Level II) in central Ohio. These patients, due to the mechanism of their injury or due to findings by the prehospital providers, are at risk for significant injury. These patients do not have to physiologic or anatomic criteria that mandate a Level I Alert.

- **Glasgow Coma Score < 14 (9-13)** with a mechanism attributable to trauma

- **Flail chest**
- **Blunt abdominal trauma with significant abdominal pain**
- **Amputation proximal to wrist or ankle**
- **Two or more proximal long bone (femur / humerus) fractures**
- **Open proximal long bone fracture**
- **Clinically apparent pelvic fracture**
- **Traumatic paralysis**

- **Penetrating injury to the head, neck, chest, or abdomen, or to the extremities proximal to the elbow or knee with neurovascular compromise**
- **Open or depressed skull fracture**

- **Major burns**
- **Combination of trauma with burns**

- **Emergency physician's discretion considering the mechanism of injury and the ACS Trauma Risk Codes**. Certain mechanisms of injury are associated with significant force and warrant a high suspicion for potential critical injuries. A trauma alert may be called based on a history of these mechanisms, at the discretion of the emergency physician.

    - Ejection from automobile
    - Death in same passenger compartment
    - Extrication time > 20 minutes
    - Falls > 20 feet
    - Rollover MVA
    - High-speed collision (initial speed > 40 mph, major auto deformity > 20 in, intrusion into passenger compartment > 12 in)
    - Pedestrian vs. motor vehicle
    - Motorcycle crash > 20 mph or with separation of rider from bike
    - Vehicle rollover

TRAUMA CONSULT

Patients who do not meet criteria for Level I or II alert may still require admission to the hospital as a result of traumatic injuries. For these patients the resource mobilization for a trauma alert may not be appropriate. On less than an emergent basis, an evaluation by a member of a Trauma Service would be provided to these patients in a timely manner.

Approved by the COTS Board of Trustees: August 29, 2001