

TRAUMA PROTOCOL

ATAB 1

Patient Identification:

Patients are to be entered into the Trauma System in ATAB 1 (Multnomah, Washington, Clackamas, Columbia, Clatsop, Tillamook and Yamhill Counties) when they meet **any** one of the following criteria **and** have been involved in a trauma incident.

The EMT is required to report the exact reason for patient entry to the Trauma Communications Center (TCC) and document the incident fully, including the reason for Trauma System entry.

Mandatory Criteria:

A. Physiological criteria:

1. A systolic blood pressure of less than 90 mm/Hg.
2. Respiratory distress as evidenced by a respiratory rate of less than 10 or greater than 29 or invasive airway management is required.
3. Altered mental status as evidenced by a Glasgow Coma Scale score of 12 or less.

B. Anatomical Criteria:

1. The patient has a flail chest.
2. Two or more obvious proximal long bone fractures (humerus, femur).
3. A penetrating injury of the head, neck, torso, or groin associated with transfer of energy.
4. An amputation proximal to the wrist or ankle.
5. Numbness or paralysis in one or more limbs which is associated with a suspected spinal cord injury.

C. Mechanism of injury:

1. Extrication from a motor vehicle that takes greater than 20 minutes and requires the use of heavy extrication tools.
2. Death of an occupant in the same vehicle as the patient.
3. Ejection of the patient from an enclosed vehicle.

EMT Discretion:

A. High energy transfer, such as:

1. Falls >20 feet.
2. Pedestrian versus auto collisions.
3. Rollover motor vehicle crash.

4. Motorcycle, ATV, or bicycle accident.
 5. Significant impact or significant intrusion into the occupant space of the vehicle.
- B. Co-morbid factors (if combined with high-energy transfer, trauma system entry is **strongly recommended**):**
1. Age less than 12 or greater than 65.
 2. Pregnancy (especially third trimester).
 3. Patient is morbidly obese.
 4. Presence of intoxicants.
 5. Extremes of environment (hot or cold).
 6. Complicated medical history (i.e., anticoagulant therapy).

Medical Direction

- A.** Off-line medical direction for trauma patients is controlled by the BLS or ALS protocols as adopted by ATAB 1, the EMS agencies, and the Physician Supervisors.
- B.** On-Line Medical Control (OLMC), within radio range of the TCC, is controlled by the TCC and its protocols.
- C.** On-Line Medical Control, in areas where radio communication with the TCC is impossible, is the responsibility of the Level-3 or Level-4 Trauma Centers in their service areas ¹.
- D.** On-Line Medical Control may override off-line medical direction. Any instances where this occurs will be reported to the System Audit Group (SAG) of ATAB 1.

¹These service areas are: Tillamook Hospital for Tillamook County; Columbia Memorial Medical Center for Clatsop County; and Newberg Hospital for Yamhill County. It is anticipated that St. Johns Medical Center in Longview, Washington will provide medical direction for some areas of Columbia County.)

Communications

- A. Communications from the EMT at the scene to the TCC:
1. It is essential that early communications be established with the TCC concerning trauma patient(s).
 2. After assessing a trauma situation and making the determination that the patient should enter the Trauma System, the EMT who is designated (in an MPS - Medical Branch Director) will contact the TCC by 800 MHz (on the TRAUMA talkgroup); the HEAR System; or cellular phone at the earliest practical time.
 3. The EMT shall provide the TCC with the following information:
 - a. Unit number, identity, and certification level of person making contact
 - b. Location of the incident, street address if appropriate
 - c. Number of patients. Follow ***Multiple Patient Scene or Multiple Casualty Incident*** protocol, if applicable.
 - d. Age and sex of the patient(s).
 - e. Trauma System entry criteria (be as specific as possible).
 - f. Trauma Band number(s).
 - g. Patient(s) vital signs, specify if **not taken** or **not present**.
 - h. Approximate ETA of patient(s) to Trauma Center; include loading time if appropriate.
 - i. Unit number and mode and priority of transport.
 - j. Patient destination based on incident location or request.
- B. Communications from the TCC or from On-Line Medical Control (Level-III or Level-IV Trauma Centers) to EMTs in the field:
1. The TCC will inform the EMT if more information is needed by the receiving trauma center.
 2. The TCC will inform the EMT if the destination trauma center is unable to receive the patient and will assist in designating an alternate destination.
 3. In the event there are between 3 and 9 Trauma System entry patients at the same scene, the TCC will assist the EMT at the scene in determining the destination of all patients, and will utilize the ATAB approved ***Multiple Patient Scene*** protocol. (If more than 10 patients exist at any one scene, the TCC will direct the EMT to use the ***Mass Casualty Incident*** protocol).

4. If the EMT contacting the TCC needs OLMC regarding care of the trauma patient, a physician at the TCC will offer direction using the ATAB-1 approved **Trauma** protocol as a guide.
- C. Level-I trauma centers will be notified immediately by the TCC when a trauma patient has been identified and is bound for their facility.
1. Level-I trauma centers are encouraged to monitor the (Portland) 800 MHz **Trauma** talkgroup to ensure early notification when ambulances have short transport times.
 2. **At No Time** will the Level-I facility transmit on the **Trauma** talkgroup.
 3. If more information is needed, communications shall be directed through the TCC.
- D. Level-I trauma centers are responsible for notifying the TCC if they are unable to accept a trauma patient directed to their facility because of unexpected or expected patient arrivals or multiple patient scenes. [Level-1 trauma centers should be prepared to make this notification immediately in order to facilitate the re-direct of ground or air ambulances]
- E. Communications from the TCC, or from On-Line Medical Control (Level-III or Level-IV Trauma Centers), to the receiving trauma center:
1. Estimated time of arrival at the trauma center.
 2. Location of the incident.
 3. Number of patients en route to the trauma center.
 4. Age and sex.
 5. Trauma System entry criteria (also a brief description of each patient(s) condition).
 6. Trauma Band number(s).
 7. Patient vitals signs, specify if **not taken** or **not present**.
 8. Unit number and mode of transport for each patient.
 9. Any other pertinent information received from the scene.

Transport Protocol

- A. All Trauma System entry patients should be transported to a Level-I Trauma Center unless advised by OLMC or under the following circumstances:
 - 1. If unable to establish and maintain an airway, the nearest hospital is appropriate to obtain definitive airway control.
 - a. In this event, the TCC shall be contacted by the EMT's.
 - b. The TCC will contact the receiving facility with patient information and ETA.
 - 2. A Level-III hospital is appropriate if the expected scene and transport time to a Level-I facility is greater than 30 minutes and the Level-III hospital is closer.
 - 3. A Level-IV hospital is appropriate for immediate evaluation and stabilization if the expected scene and transport time to a Level-I, -II or -III is greater than 30 minutes and the Level-IV hospital is closer.
- B. The designated trauma center destination from the scene, if by ground ambulance, is to be determined based on the following criteria:

Emanuel Hospital Service Area: Patient origin **on or north** of Tualatin Valley Highway beginning at the west city limits of Hillsboro, to Canyon Rd., Canyon Rd. to Highway 26, to I-405, to NW Lovejoy St., across the Broadway Bridge to the east bank of the Willamette River to E. Burnside St. From this point, all patients **north of but not on** the following line are to be transported to Emanuel: East on E. Burnside St. to NE Sandy Bv.; Sandy Bv. to its intersection with Glisan St. at 21st Av.; then east on Glisan St. to 242nd Av. in Gresham (see map).

University Hospital Service Area: Patient origin **on or south** of Glisan St. beginning at 242nd Av. in Gresham, west on Glisan St. to Sandy Bv. to its intersection with 21st Av.; Sandy Bv. to E Burnside St.; then west on E. Burnside St. to the east bank of the Willamette River, north along the river bank to the Broadway Bridge, then **south of but not including** the Broadway Bridge, west to Lovejoy St., to I-405, and then **south of, but not on Highway 26**, to Canyon Rd, to Tualatin Valley Highway, to the west city limits of Hillsboro (see map).

60.040 Transport Protocol

1. Patient or Guardian request: If the alert, unimpaired patient, or his/her unimpaired guardian, demands transport to a specific hospital the EMT must honor that request and notify the TCC immediately. Any deviation from this transport protocol must be fully documented.
 2. Outside of Catchment Area: If the trauma system patient is being transported from a scene outside of the service areas described above, the patient destination is to be the Level-I Trauma Center in whose service area the main thoroughfare used by the ambulance to enter Portland is located.
 3. Multiple Patients: In the event that multiple patients are to be transported from the same scene, all patient destinations are to be assigned to the above service areas, with the following exceptions:
 - a. The designated trauma center advised the TCC that the facility cannot accept and care for additional patient. The TCC will utilize the ***Multiple Patient Scene*** protocol and assist the EMT's in determining patient destinations.
 - b. If there are more than two unstable trauma patients ready to be transported from the same scene, the first two will go to the Level-I facility designated by the above service area, and TCC will direct the next two patient to the other Level-I hospital.
- C. If the patient is transported from the scene by helicopter ambulance, the destination will be determined by the flight crew using the following criteria:
1. Regardless of patient origin, the patient destination is, generally, to be alternated between the designated Level-I Trauma Centers.
 2. If two patients are transported in the same flight, they will both be brought to the same Level-I Trauma Center (based on rotation).
 3. In the event that the designated Level-I Trauma Center, which is to be the patient destination, is unable to accept the patient(s), the TCC will assist the flight crew in determining patient destination.

Mode of Transport

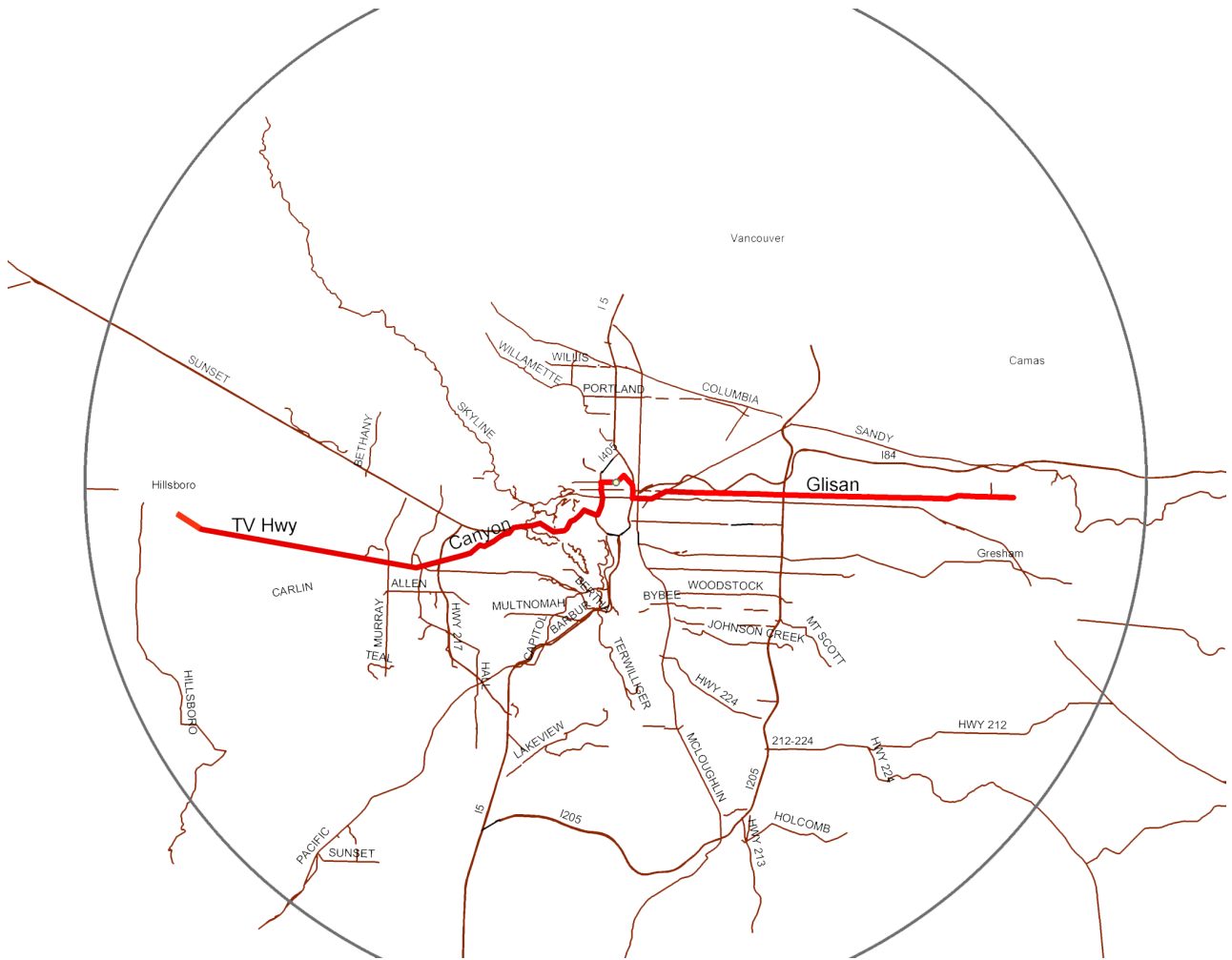
Helicopter ambulance services should be used if it has the potential to save 10 minutes in the patient's prehospital time. See "Recommended Air Ambulance Response Zones" map for information regarding area where use of the air ambulance may save time. This information is not intended to define an area in which a helicopter may not be used since there are exceptions based on major arterial routes, time of day, weather, and other factors especially close to the lines. Judgement should be used, based on specific scene circumstances.

- A.** Inner "Limited Use" Zone: [up to 15 nautical miles]
Possible exceptions which might warrant use of the helicopter:
 - 1. Multiple patient incident, MPS or MCI.
 - 2. Extended extrication, resulting in extended scene times.
 - 3. Traffic impediments, such as snowy or icy roads, commuter traffic congestion, and obstructed scene.
 - 4. High system demands.
 - 5. Difficulty for ground ambulance access to the scene.
- B.** Outer Zone: [over 15 nautical miles]
Special considerations:
 - 1. Inclement weather that may prevent flight, (snow, ice, fog, etc.).
 - 2. Helicopter may be unavailable.
 - 3. Consider Landing Zone proximity to the scene and consideration of an intermediate rendezvous point between the scene and hospital.
 - 4. On main arterial roads, consider possibility that the helicopter may not be able to save time.
 - 5. It may be appropriate to activate the helicopter and to cancel if the patient is packaged, the ambulance is ready to transport, and the helicopter is not on scene.
 - 6. The helicopter may have multiple, simultaneous calls for service and may need to triage use.

Dispatch Procedure:

- A.** Standby or activation of helicopter ambulance services will be requested through "Dispatch." (BOEC in Multnomah County).
- B.** Any person who has had first aid or medical training may put helicopter ambulance services on standby.
- C.** Only emergency responders may activate helicopter ambulance services, requesting the helicopter through EMS Dispatch.
- D.** Units may cancel helicopter ambulance services if it is determined that they are not needed on scene.

Recommended Air Ambulance Response Zones



Patient Evaluation Protocol

Treatment priority should be approached in this order:

- A.** Airway maintenance (Including control of the cervical spine) - If unable to establish and maintain an adequate airway, the patient should be transported to the nearest acute care facility to obtain definitive airway control.
- B.** Breathing
- C.** Control of circulation
- D.** Control of hemorrhage
- E.** Treatment of shock
- F.** Splinting of fractures
- G.** Neurological examinations
- H.** Detailed patient assessment

Trauma Care Priorities

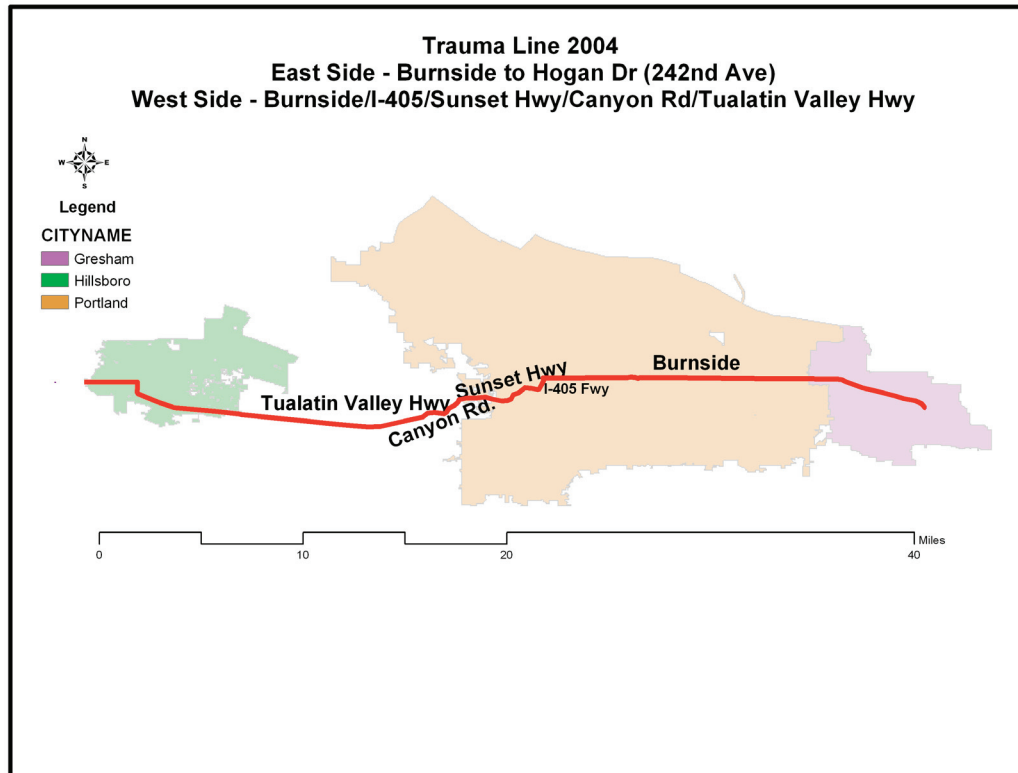
- A. Assess and Maintain Airway - Protect Cervical Spine
 1. Chin lift/jaw thrust.
 2. Clear airway of foreign bodies.
 3. Oropharyngeal or nasopharyngeal airway.
 4. Support respirations per *Airway Management* procedure.
 5. Endotracheal intubation, which may include use of paralytic agents; or needle cricothyrotomy. (Endotracheal intubation is the preferred method of maintenance of a patent/protected airway.)
- B. Breathing Control:
 1. Assessment
 - a. Expose chest and neck.
 - b. Rate and depth of respirations.
 - c. Inspect and palpate for unilateral and bilateral chest movement, subcutaneous emphysema, sucking chest wounds.
 - d. Distended neck veins or deviated trachea.
 - e. Auscultate.
 2. Management
 - a. Seal open pneumothorax.
 - b. Start O₂, follow *Airway Management* procedure.
 - c. Alleviate tension pneumothorax (needle thoracentesis).
 - d. Support ventilation.
- C. Circulatory Control
 1. Identify exsanguinating hemorrhage:
 - a. Apply direct pressure, or indirect pressure and elevation (if able) to bleeders.
 - b. Apply tourniquet if bleeding uncontrollably on extremity.
 2. Assess for pulses:
 - a. Radial pulses present — systolic pressure of 80 mm/Hg.
 - b. Femoral pulse present —systolic pressure of 70 mm/Hg.
 - c. Carotid pulse present — systolic pressure of 60 mm/Hg.

3. Evaluate perfusion:
 - a. Pulse, rate and character
 - b. Capillary refill
 - c. Skin color, (i.e., pink, pale, cyanotic, or mottled).
 4. Initiate two (2) large bore IV's with Normal Saline during transport.
 5. Obtain blood pressure. This is low priority, consider obtaining during transport.
- D.** Assess neurologic status per Glasgow Coma Scale:
1. Eye Opening
 2. Best Verbal Response
 3. Motor Response: Standardized pain stimulus is either supraorbital ridge pressure or fingernail pressure.

Scene Time

- A.** After gaining access to the patient, scene time should not exceed ten (10) minutes for any patient who is entered into the Trauma System.
- B.** Plan to start IVs and initiate other care once en route to the Trauma Center.

ATAB-1 Trauma Designated Hospitals



ATAB 1 Designated Trauma Hospitals:

- Level I** Emanuel Hospital and Health Center, Portland, OR
Oregon Health Sciences University Hospital, Portland, OR
 - Level III** Columbia Memorial Medical Center, Astoria, OR
Southwest Washington Medical Center, Vancouver, WA
St. Johns Medical Center, Longview, WA
 - Level IV** Tillamook General Hospital, Tillamook, OR
Newberg Community Hospital, Newberg, OR
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