



## Trauma Team Activation Criteria

### Class I Activation (one or more of the following)

- Confirmed SBP < 90 at any time in adults, age-specific hypotension in children, and/or clinical signs of shock
- HR >120 in adults, age-specific tachycardia in children, and/or clinical signs of shock
- Active or uncontrolled hemorrhage, any source
- Respiratory rate <10 or >29
- ANY intubated trauma patients
- Penetrating trauma to the neck, torso, groin
- Penetrating traumatic cardiopulmonary arrest with ≤ 15 min pre-hospital CPR
- GCS ≤ 11 with mechanism attributed to trauma
- Focal neurologic deficit
- Mangled, pulseless, or crushed extremity injury
- Amputation proximal to elbow or knee
- Any trauma patient receiving blood or blood products to maintain adequate perfusion
- Emergency Medicine Attending discretion

### Class II Activation (one or more of the following)

- GCS 12-14 with mechanism attributed to trauma
- Penetrating trauma to the head or extremity
- ≥ 2 extremity fractures
- Any open long-bone fracture
- Amputation distal to elbow or knee with controlled hemorrhage
- Burns with associated trauma
- Pregnant trauma patients ≥ 24 weeks
- Traumatic cardiopulmonary arrest- blunt or penetrating with >15 min CPR
- Emergency Medicine Attending discretion

### Potential Class II Activation

- Age >55 with significant mechanism of injury
- Fall >20 feet
- Rollover MVC
- Ejection of patient
- Extrication >20 minutes
- Motorcycle crash speed >20 MPH
- MVC crash speed >40 MPH
- Same vehicle occupant fatality
- Pedestrian struck by motor vehicle
- Intrusion into vehicle >12 inches
- Blast injury
- Multiple system trauma transfer involving ≥ 2 surgical specialties

#### Age-Specific Vital Sign Abnormalities

Clinical criteria for activations listed are applicable to pediatric patients. Level of consciousness, peripheral pulse, and skin perfusion should aid in the identification of shock.

Age	Hypotension	Tachycardia
0-1	≤ 60	≥ 160
1-3	≤ 70	≥ 150
3-5	≤ 75	≥ 140
6-12	≤ 80	≥ 120
12 and over	≤ 90	≥ 100

### Class III Activation

- Any trauma patient evaluated by the Emergency Medicine Attending requiring admission for observation/treatment of one or more injuries (Does NOT include isolated, single-system injuries who can appropriately be cared for on other surgical specialty services)
- The EC Charge RN or other EC personnel designated to take pre-hospital/referral facility report should determine final classification. If patient condition deteriorates, upgrade to the appropriate classification prior to or upon arrival. EMS should not be solely responsible for correct classification, but strive to provide as much pertinent information as possible to mobilize necessary hospital resources.
- Only the Emergency Medicine Attending, Trauma Surgery Attending, or Trauma Surgery Chief Resident can downgrade or cancel activations.
- The mortality rate for blunt traumatic arrest and penetrating traumatic arrest with ≥ 15 minutes pre-hospital CPR approaches 100%. Therefore every effort should be made to determine an accurate time from arrest to EC arrival to better determine appropriate activation level and/or use of the "Termination of Resuscitation Using Pre-Hospital Criteria" protocol. If a Class II traumatic arrest does not meet DOA criteria and is successfully resuscitated, immediate upgrade to a Class I activation is appropriate to mobilize necessary resources.
- Patients should no longer be activated on mechanistic criteria alone. Clinicians should have suspicion of serious injury or the patient may meet another Class I/II activation criteria.
- Telephone communication between the Trauma Surgery Chief Resident and Attending will occur following all trauma activations. The Trauma Attending will see any Class II or III patient requiring ICU admission within 1 hour. Floor admissions will be seen within 16 hours.