# Proposed Draft Field Triage Protocol

**Missouri Department of Health and Senior Services, Working Document**

**Trauma Task Force 2/25/09**

## Step One: Assess Vital Signs and Level of Consciousness

<table>
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<th>Criteria</th>
<th>Action</th>
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| Systolic BP < 90 or GCS < 14 or Respiratory Rate < 10 or >29 (< 20 in infant < one year) HR > 120 | Meet “Severely Injured” Criteria

- **YES**
  - Serious Airway or Respiratory Compromise that cannot be managed or immediate life threatening condition (ie, arrest)
  - Transport to closest facility capable of managing airway/respiratory compromise, immediate compromising condition
    - (within 30 minutes transport time via air or ground)
- **NO**
  - Transport to appropriate facility/trauma center

## Step Two: Assess Anatomy of Injury

- All penetrating injuries to head, neck, torso, and extremities proximal to elbow and knee
- Flail chest
- Two or more proximal long-bone fractures
- Crush, degloved or mangled extremity
- Amputation proximal to wrist and ankle
- Pelvic fractures
- Open or depressed skull fractures
- Paralysis or signs of spinal cord injury/focal neurologic deficit
- Airway compromise or obstruction, hemo- or pneumothorax, patients intubated on scene
- Active or uncontrolled hemorrhage
- Extremity trauma with loss of distal pulses
- Major burns > 20% BSA or any signs of inhalation injury
- Penetrating traumatic cardiopulmonary arrest with < or = 15 minutes pre-hospital CPR

## Color Scheme

- **Black**: Expert panel convened by CDCP & NHTSA; based on decision scheme originally developed by ACS COT; close to verbatim
- **Blue**: Washington State pre-hospital triage protocol; close to verbatim
- **Green**: North Central Texas Pre-hospital triage algorithm; close to verbatim
- **Red**: MO; combination of Central (MU), KS, and East Central Region protocols
● Any trauma patient receiving blood or blood products to maintain adequate perfusion
● All open fractures
● > or = two extremity fractures
● Penetrating injuries to distal extremity (distal to elbow to knee)
● Penetrating trauma to head or proximal extremity (proximal elbow or knee, that do not meet Class I criteria)
● Amputation distal to wrist or ankle of two or more digits
● Emergency medicine attending/paramedic discretion

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YES  ➔ Take to trauma center, preferentially to highest level of care within the trauma system (within 30 minutes transport time via air or ground)
NO ➔ Assess mechanism of injury and evidence of high-energy impact

Step Three: Assess Biomechanics of Injury

- Falls
  o Adults: > 20 ft (one story = 10 ft.)
  o Children: > 10 ft. or 2-3 times height of the child
- High-risk auto crash
  o Intrusion: > 12 in occupant site; > 18 inches in any site
  o Ejection (partial or complete) from automobile
  o Death in same passenger compartment
  o Vehicle telemetry data consistent with high risk of injury
- Auto v. Pedestrian/bicyclist thrown, run over, or with significant (> 20 mph) impact
- Motorcycle crash > 20 mph

↓
NO ➔ YES  ➔ Transport to closest appropriate trauma center; depending on the trauma system, need not be the highest level trauma center

Step Four: Assess other risk factors/ special patient or system considerations

- Age
  o Older adults: Risk of injury/death increases > age 55
  o Children: Should triage preferentially to pediatric trauma center < 5 years of age with potential for admission
- Anticoagulation and bleeding disorder
- Burns
  o Without other trauma mechanism: Triage to burn facility
  o With trauma mechanism: Triage to trauma center
- Time sensitive extremity injury
  ● End-stage renal disease requiring dialysis
- Pregnancy > 20 weeks
- EMS provider judgment
- MVC < 40 MPH or UNK speed
- Any trauma patient evaluated by the Emergency Medicine Attending requiring admission for observation/treatment for one or more injuries (does not include isolated, single-system injuries who can appropriately be cared for on other surgical specialty services)

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NO ➔ YES  ➔ Contact medical control; consider transport to trauma center or a specific resource hospital

↓ ➔ Transport according to protocol

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