

All hospitals need 2 levels of activation for trauma patients. To meet this requirement, most trauma centers have a multitiered trauma team activation protocol. Even though facilities may have different nomenclature to identify various activation levels, the intent is that there will be levels commensurate with “full” and “limited” activation levels, as described in Chapter 5 Table 3. The limited activation criteria should be based on high-risk mechanisms of injury. The **Highest-Level Activation** (all hands-on deck) should always include the ACS Minimum Criteria in Chapter 5 of the ACS Orange Book:

Minimum Criteria for Full Trauma Team Activation

- Confirmed blood pressure less than 90 mm Hg at any time in adults and age-specific hypotension in children;
- Gunshot wounds to the neck, chest, or abdomen or extremities proximal to the elbow/knee;
- Glasgow Coma Scale score less than 9 with mechanism attributed to trauma;
- Transfer patients from other hospitals receiving blood to maintain vital signs;
- Intubated patients transferred from the scene, - OR -
- Patients who have respiratory compromise or are in need of an emergent airway. This includes intubated patients who are transferred from another facility with ongoing respiratory compromise (does not include patients intubated at another facility who are now stable from a respiratory standpoint)
- Emergency physician’s discretion

In hospitals with limited resources, a Full Activation may draw trauma team members from available physicians and nursing and allied health personnel. In small rural hospitals where no general surgeon or emergency physician is available, the leader may be a primary care physician, physician assistant, nurse practitioner, or nurse who coordinates stabilization and transfer to definitive care.

The **Limited Activation (select team members and resources)** criteria should be based on high-risk mechanisms of injury. The limited response criteria may include some anatomic criteria, as well as high-risk mechanisms of injury.

Limited Trauma Team Criteria

- Falls: adult >20 ft; child >10 ft or 3× height
- Fall from any height if anticoagulated older adult
- High-risk auto crash with: - Intrusion of vehicle >12” in occupant compartment; >18” in another site - Ejection (partial or complete) from automobile - Death in same passenger compartment
- Auto vs. pedestrian/cyclist thrown, run over, or with significant (>20 mph) impact
- Motorcycle crash >20 mph
- High-energy dissipation or rapid decelerating incidents, for example: - Ejection from motorcycle, ATV, an animal, and so on - Striking fixed object with momentum- Blast or explosion
- High-energy electrical injury
- Burns >10% TBSA (second or third degree) and/or inhalation injury
- Suspicion of hypothermia, drowning, hanging
- Suspected nonaccidental trauma
- EMS provider judgment
- Blunt abdominal injury with firm or distended abdomen or with seatbelt sign

In Level III and IV trauma centers, the team must be fully assembled within 30 minutes (CD 5–15).

A preplanned and coordinated approach should be defined for patients who do not arrive at the highest level of activation.

In the Level 3 hospital the emergency physicians and trauma surgeons should work closely to ensure appropriate and timely activation of the trauma team to allow surgeon arrival prior to the arrival of the severely injured patient. These patients may need consultation or admission by the trauma service or other specialty services. The emergency physician may initially evaluate the limited-tier trauma patient, but the center must have a clearly defined response expectation for the trauma surgical evaluation of those patients requiring admission (CD 5–16).

In Level 4 hospitals, who do not have surgical services available 24/7, the highest level of trauma activation must be clearly defined (using at least the six (6) required elements defined in CD 5-13) The response team must assembled within 30 minutes of activation decision and tracked through the performance improvement program. For patients who do not meet the highest-level activation, the hospital should still have criteria defined to more clearly establish risk of injury. This subset of patients could be called a Trauma Evaluation. As an example, a lower acuity trauma patient arrives in the ED, either by EMS or private vehicle that does not meet the facilities defined highest level of activation may be triaged by the nursing staff. Notification for this level could be internal to the ED staff only. This would alert the ED physician the patient is in the department and they must be seen within a determined time frame (1 hour for example). This level of activation should still be clearly defined with team members who respond, how the notification is made, and what the time requirements are for response.