Indiana Trauma Field Triage and Transport Destination Protocol Template

The Indiana Trauma Field Triage and transportation Protocol was signed by Governor Mitch Daniels on July 10, 2012. This rule will help to determine where traumatically injured patients should be transported and guide field responders when making those selections.

Medical Directors should establish further guidelines and recommendations within this document that are consistent with the Trauma Rule. It is important to instruct field responders on how to determine transport times and to help establish what types of circumstances a patient’s life might be in danger by not going to a closer medical facility. These guidelines should be pertinent to your areas of operation and take into consideration the terrain and make-up of your geographic locations as well as any other conditions affecting transportation. Responders should also be reminded that if they are ever in doubt of where to transport a patient, they should utilize on-line medical control to help make that determination.

**Indiana Trauma Field Triage and Transport Destination Protocol**

1. The purpose of this article is to provide a regulatory plan to ensure that injured patients in the pre-hospital setting are transported to the most appropriate hospital facility within the Indiana state trauma system based on field assessment by emergency medical services personnel of the potential severity of injury, available transportation and hospital resources.

2. This article does not apply to interfacility transfers.

3. Transportation destination procedures
   a. Upon arrival at an incident, emergency medical services personnel shall assess the condition of each patient using the field triage decision scheme to determine the appropriate transport destination.
   b. Patients determined to need trauma center care by virtue of their satisfying either step one or step two of the field triage decision scheme shall be transported to a trauma center [level of trauma center not specified in Field Triage Guideline], unless transport time exceeds 45 minutes or, in the judgment of the emergency medical services certified responder, a patient’s life will be endangered if care is delayed by going directly to a trauma center, in which case the patient shall be transported to the nearest appropriate hospital as determined by the provider’s protocols.
   c. Patients determined to need trauma center care by virtue of their satisfying either step three or step four of the field triage decision scheme shall be transported to either a trauma center or the nearest appropriate hospital, as determined by the provider’s protocols.
   d. Patients who do not meet the field triage decision scheme criteria for trauma center care may nonetheless be transported to a trauma center if permitted under the provider’s protocols.

4. Advance Notification
   Emergency medical services personnel shall provide advance notification to the receiving hospital or trauma center whenever possible to allow appropriate activation of resources prior to patient arrival.

- The following website contains this rule in the form of LSA Document #10-628(F): [http://www.in.gov/legislative/iac/20120808-IR-836100628FRA.xml.pdf](http://www.in.gov/legislative/iac/20120808-IR-836100628FRA.xml.pdf)
The following is the Field Triage Decision Scheme:

1. Measure vital signs and level of consciousness
   - Glasgow Coma Scale (GCS) ≤ 13
   - Systolic Blood Pressure (SBP) < 90 mmHg
   - Respiratory Rate (RR) 10 or > 29 breaths per minute or need for ventilatory support

   - Transport to a trauma center, steps 1 and 2 attempt to identify the most seriously injured patients. These patients should be transported preferentially to the highest level of care within the defined trauma system.

2. Assess anatomy of injury
   - All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
   - Chest wall instability or deformity (e.g., flail chest)
   - Two or more proximal long-bone fractures
   - Crushed, degloved, mangled, or pulseless extremity
   - Amputation proximal to wrist or ankle
   - Pelvic fractures
   - Open or depressed skull fractures
   - Paralysis

3. Assess mechanism of injury and evidence of high-energy impact
   - Falls
     - Adults: > 20 feet (one story is equal to 10 feet)
     - Children: > 10 feet or two or three times the height of the child
   - High-risk auto crash
     - Intrusion, including roof: > 12 inches occupant seat
     - 10 inches any site
     - Ejection (partial or complete) from automobile
     - Death in same passenger compartment
     - Vehicle telemetry data consistent with a high risk of injury
   - Auto vs. pedestrian/bicyclist thrown, run over, or with significant (> 20 mph) impact
   - Motorcycle crash > 20 mph

4. Assess special patient or system considerations
   - Older adults
     - Risk of injury/death increases after age 55 years
     - SBP < 110 may represent shock after age 65
     - Low impact mechanisms (e.g., ground level falls) may result in severe injury
   - Children
     - Should be triaged preferentially to pediatric capable trauma centers
   - Anticoagulants and bleeding disorders
     - Patients with head injury are at high risk for rapid deterioration
   - Burns
     - Without other trauma mechanism: triage to burn facility
     - With trauma mechanism: triage to trauma center
   - Pregnancy > 20 weeks
   - EMS provider judgment

When in doubt, transport to a trauma center.

Find the plan to save lives, at www.cdc.gov/fieldtriage