TRAUMA COMMITTEE
Chair: Dr. Michelle McNutt

The committee met virtually on 11.05.2020 with roughly 40 attendees. Vice-Chair elections were held electing Christine Campbell, HCA Gulf Coast Division, to the Vice Chair Hospital Representative position. Revisions to the SETRAC Regional Trauma Plan were reviewed and approved by the committee with pending updates to the Pediatric Transport Guidelines (see page 2). The trauma plan is attached as the committee is seeking approval from the Board. Members of the Pediatric Committee and EMS Committee are collaborating to standardize and combine the adult and pediatric transport guideline into one document.

The committee is currently focusing on best practice dosage guidelines for pre-hospital Ketamine usage. Guidelines are being researched for bet practice. EMS partners within the committee are also working with Gulf Coast Blood Center for better utilization path for whole blood. Progress for this project has been delayed due to COVID-91 as well as the national blood bank industry's efforts to standardize on the blood bank level. This committee operates with a subcommittee and several workgroups currently focused on regional data collection, trauma related research projects, and education.

The Trauma Data subcommittee reviewed the regional complications dashboard, discussed changes to the National Trauma Data Bank (NTDB) data dictionary, and Q2 2020 (see pages 3-6). The subcommittee requested approval from the Trauma Committee to remove isolated burns from the quarterly review as isolated burns will be removed from the trauma registry beginning Q1 2021. Approval received and seconded. Burn data will be available for review upon request.

The clinical complications dashboard is utilized to determine education needs. Virtual registrar education workshops are being developed to ensure complications are captured accurately. This education will be combined with AIS coding education aide in correcting errors in ISS documentation. Education planned for late Q1 2021. Trauma data slides were presented at the last EMS Committee meeting.

The Trauma Research workgroup reviewed the data from 2013 – 2019 highlighting the impact that level II trauma centers have had on TSA-Q. Data is being re-validated to ensure accuracy prior to moving forward with potential publishing. Noted volume in level I centers have been relatively stable, even after the addition of level II centers and have not negatively affected level I trauma centers in our region. This workgroup is continuing to work on a poster presentation for the 2021 TQIP Annual Scientific Meeting and Training conference highlighting the increase in tourniquet usage from 2018 to 2019 (see pages 7-8). The workgroup's goal is to showcase the creative and positive strides that SETRAC has made. Tourniquet data will be collected continuously.

Pre-hospital Adult & Pediatric Transport Guidelines

- No changes to the adult protocol
- Propose a simplified pediatric protocol and forward to the Pediatric and EMS committees for approval

Note: Add in Open long-bone fractue Prehospital protocol and Spinal Movement restriction as addendums.

SETRAC Pre-Hospital Adult Trauma Transport Guidelines

This is a guide to assist in appropriate trauma transport. Like all protocols, it cannot cover all situations. Good clinical assessment in conjunction with patient stability, MOI, and special patient consideration should guide you to the correct trauma facility. All times indicated are considered from EMS Contact time.

EMS Witnessed Blunt Traumatic Arrest or unable to manage airway (Cannot intubate or ventilate patient) — YES → Transport by ground to the nearest facility capable of managing the patient

NO ↓

EMS Witnessed Penetrating Traumatic Arrest — YES → Transport time within 20 minutes via fastest means? — YES → Level I/II Trauma Center; NO → Transport patient to the closest and highest level trauma center possible via fastest means / consider air transport

NO ↓

Level I/II trauma center acuity
1. GCS ≤ 12 or AVPU = P or U
2. Respiratory Rate < 10 or > 30
3. Systolic BP ≤ 90 mmHg
4. Tourniquet used

YES → Transport time within 45 min via fastest means? — YES → Level I/II Trauma Center; NO → Transport patient to the nearest Level III trauma center / consider air transport

NO ↓

Level III trauma center acuity
1. GCS ≥ 13
2. Respiratory Rate > 10 or < 30
3. Systolic BP > 90 mmHg

YES → Transport time within 45 min via fastest means? — YES → Level III Trauma Center; NO → Transport patient to the nearest Level IV trauma center

Utilize the Special Patient Consideration Factors by MOI and consider Level I transport	
Special Patient Consideration Factors 1. Age > 55 have increased risk of death due to injury < 18 utilize Pediatric Guidelines 2. Anticoagulation and bleeding disorders 3. Burns with no trauma to burn-specific center 4. Time sensitive extremity injuries 5. Pregnancy > 20 weeks	**MOI Factors with injury** 1. Falls > 20 feet (1 story is 10 feet) 2. High-risk MVI -Ejection, partial or complete -Death in same passenger compartment -Extended extrication time due to vehicle damage 3. Auto vs. Pedestrian or bike 4. Motorcycle crash > 20 mph

SETRAC Pre-Hospital Pediatric Transport Guidelines

(A pediatric patient is defined as less than 16 years old)

This is a guide to assist in appropriate trauma transport. Like all protocols it cannot cover all situations. Good clinical assessment in conjunction with patient stability. MOI and special patient considerations should guide you to the correct trauma facility. Times are based on EMS patients contact time.

EMS witnessed traumatic arrest OR Unable to manage airway (cannot intubate or ventilate patient) — YES → Transport by fastest means to the nearest facility with a full service Emergency Department

No ↓

Level 1 Trauma Center Acuity
1. Pedi trauma score ≤8
2. 1 red box (see back)
3. 2 blue boxes (see back)
4. Tourniquet use

YES → Transport time within 45 min via fastest means? — YES → Transport to the nearest Level 1 Pediatric Trauma Center Consider air transport; No → Transport to the nearest Level 1/2 Adult Trauma Center

No ↓

Level 3 Trauma Center Acuity
1. Pedi Trauma Scoe >8
2. 1 blue box (see back)

Transport time within 45 min via fastest means? — YES → Transport to the nearest Level 1/2 Adult Trauma Center; No → Transport to the nearest designated Trauma Center

Utilize the special patient consideration factors followed by MOI and consider Level 1 Pediatric Trauma Center

Special Patient Consideration Factors
1. Bleeding disorders or hemophilia
2. Burns without trauma to Burn Specific Center
3. Submersion injury
4. Special needs patient with suspected injury
5. Unexplained/inconsistent injury

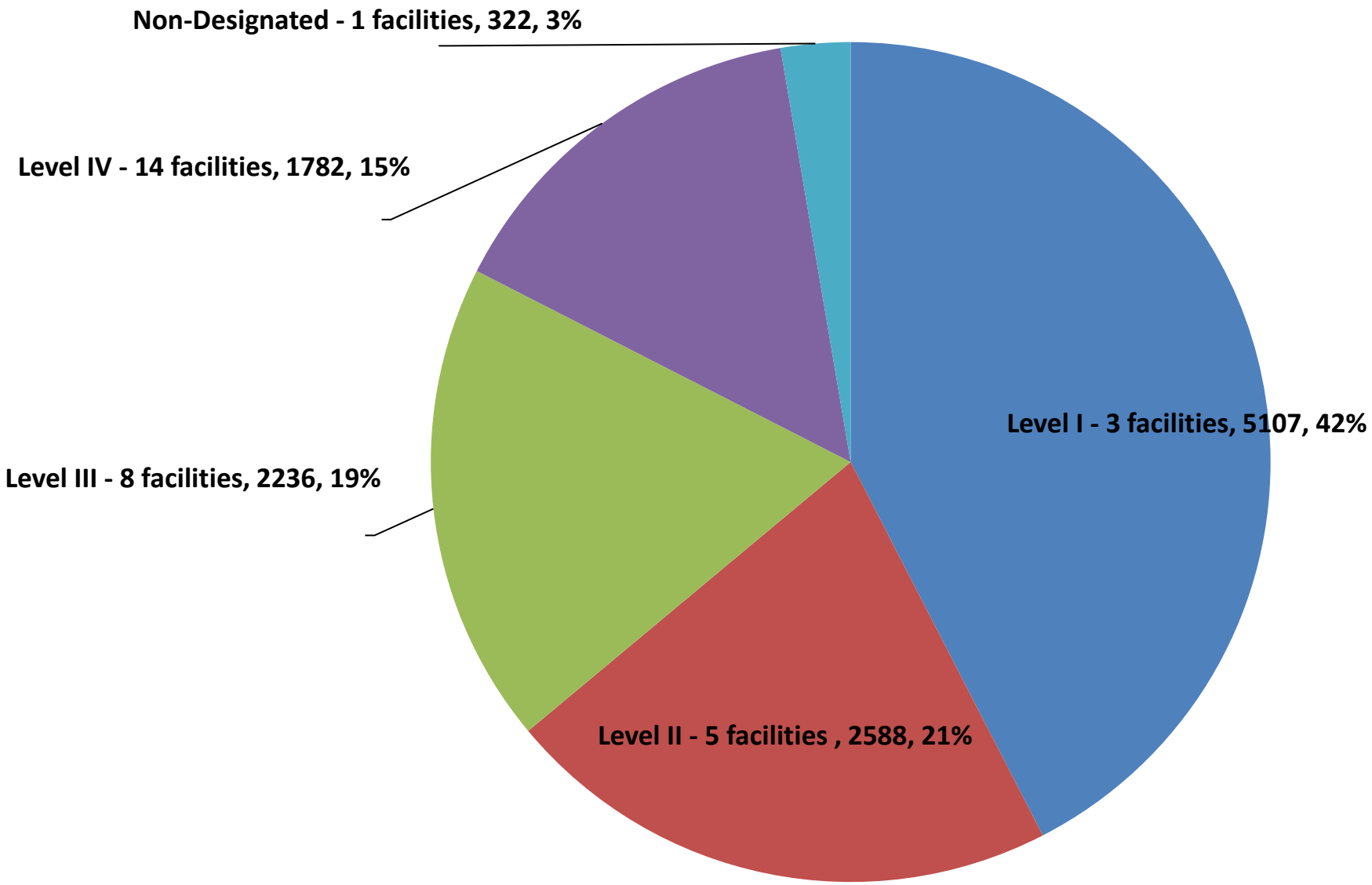
MOI Factors with Injury
1. Fall ≥3x patient height
2. High risk MVC
-Ejection, partial or complete, including child safety seat
-Death in same passenger compartment
-Extended extricaitontime due to vehicle damage with injury
-Front seat air bag deployment
3. Auto vs. pedestrian or bike
4. Motorcycle crash > 20 mph

Last revised: 4/2015

PEDIATRIC TRAUMA SCORE

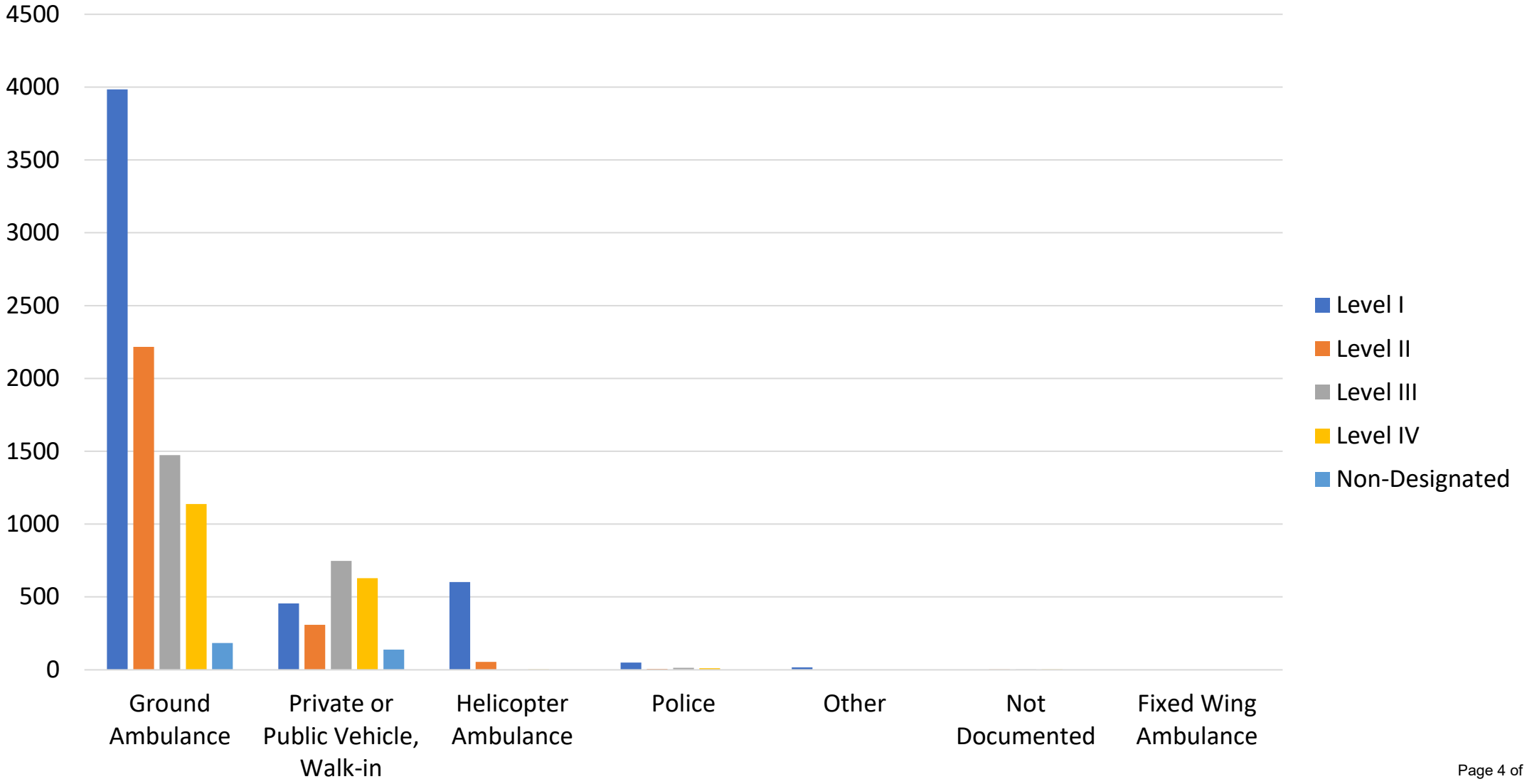
Severity	+2	+1	-1
Size	>20kg	11-20kg	<11kg or <33 inches on pedi tape
Airway	Normal	Supplemental Oxygen	Assisted or intubated
Consciousness	Awake	Amnesia or + LOC	Altered mental status coma, presence of paralysis, or suspicion of spinal cord injury, or loss of sensation
Circulation	Good peripheral pulses SBP > 90	Carotid or femoral pulses palpable, BUT radial or pedal pulses not palpable, or SBP < 90	Faint or non-palpable carotid or femoral pulses, or SBP <50
Fracture	None seen or suspected	Single closed long bone fracture	Open long bone fracture, or multiple fracture sites, or multiple dislocations
Cutaneous	No visible injury	Contusion or abrasion	Major soft tissue disruption, or major flap avulsion, or 2nd or 3rd degree burns to > 10% TBSA, or amputation, or any penetrating injury to the head, neck or torso

Adult Volume by Trauma Designation
Q1-Q2 2020

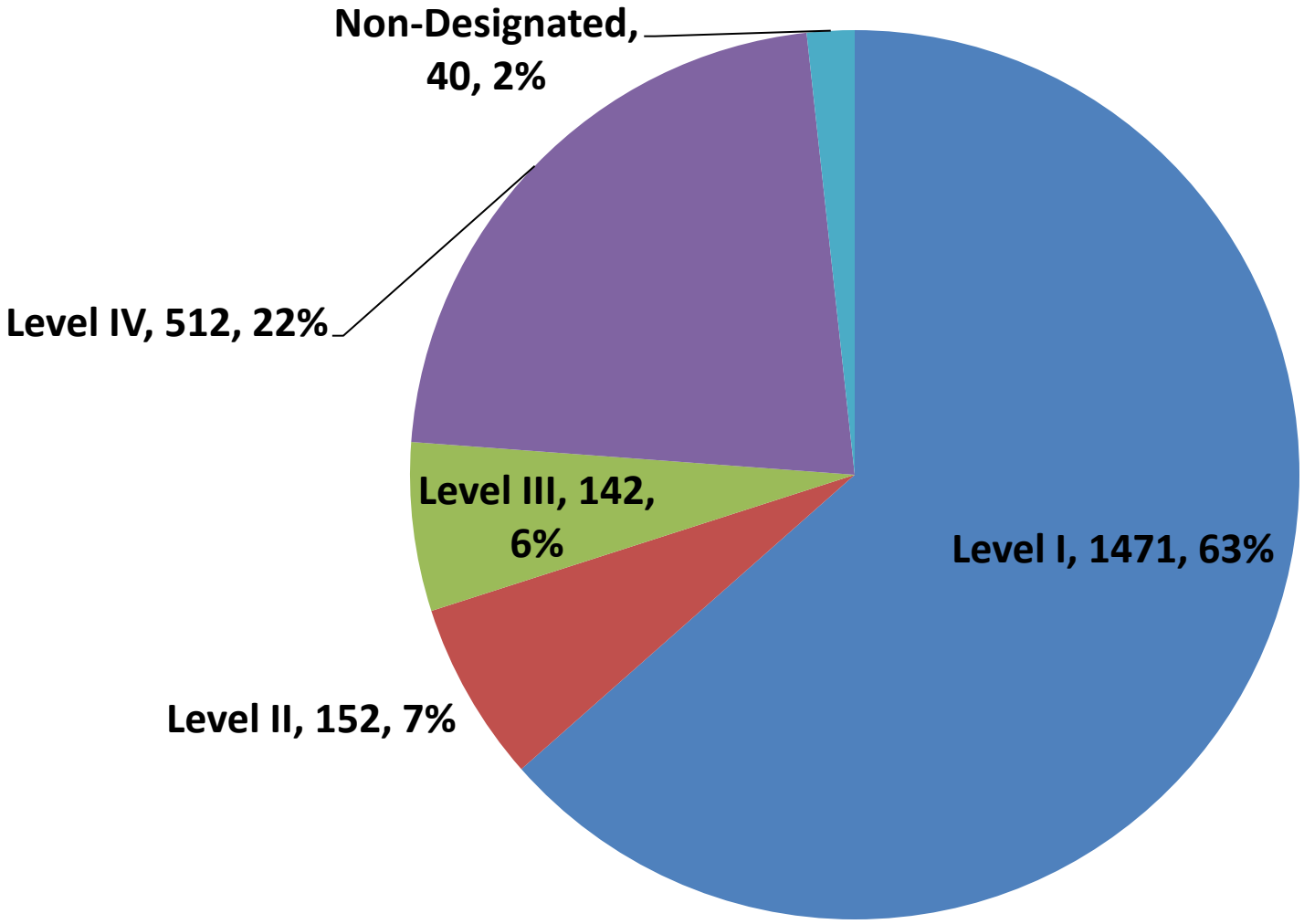


Hospital Arrival Method

Q1-Q2 2020 Transports by Trauma Designation (Adult)

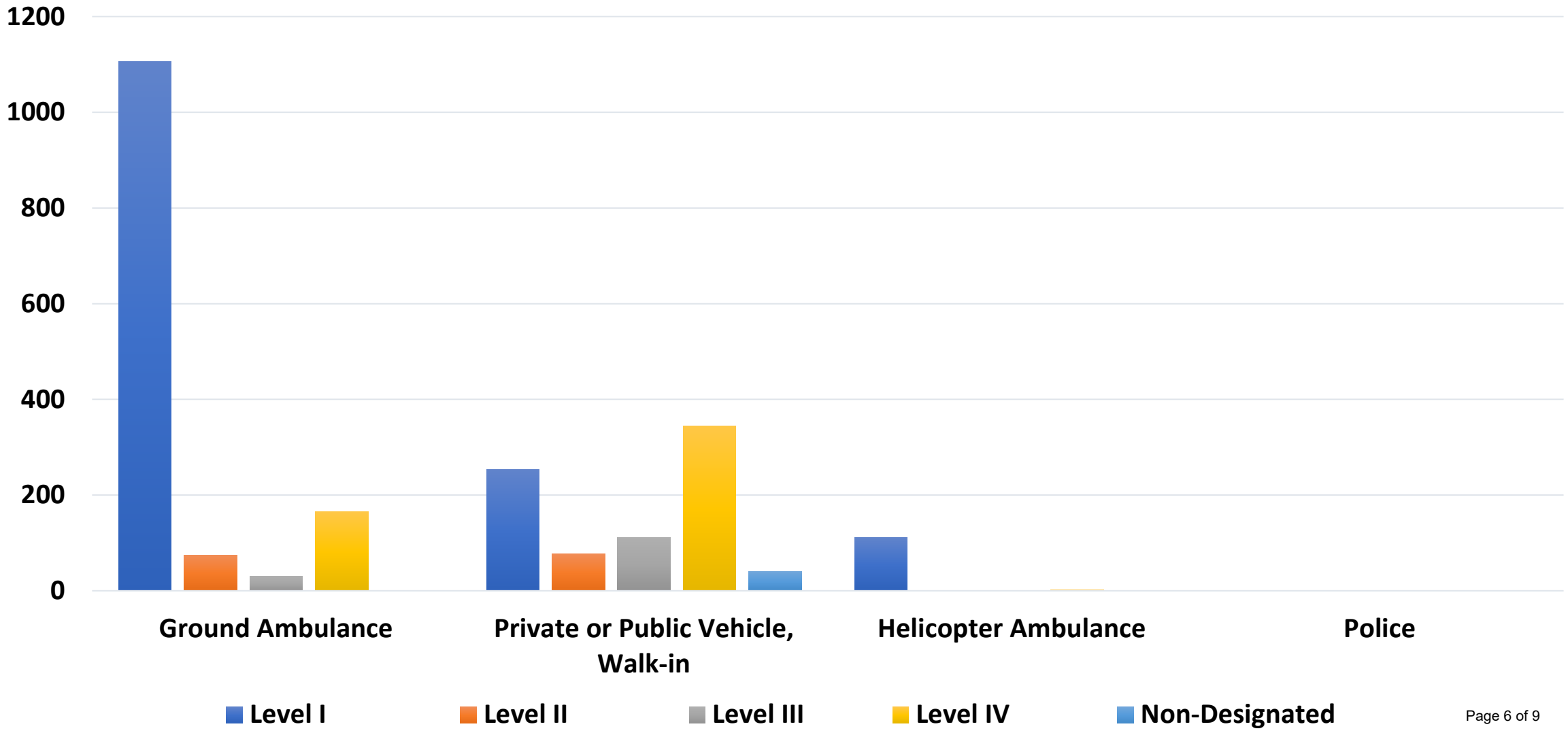


Ped Volume by Trauma Designation
Q1-Q2 2020

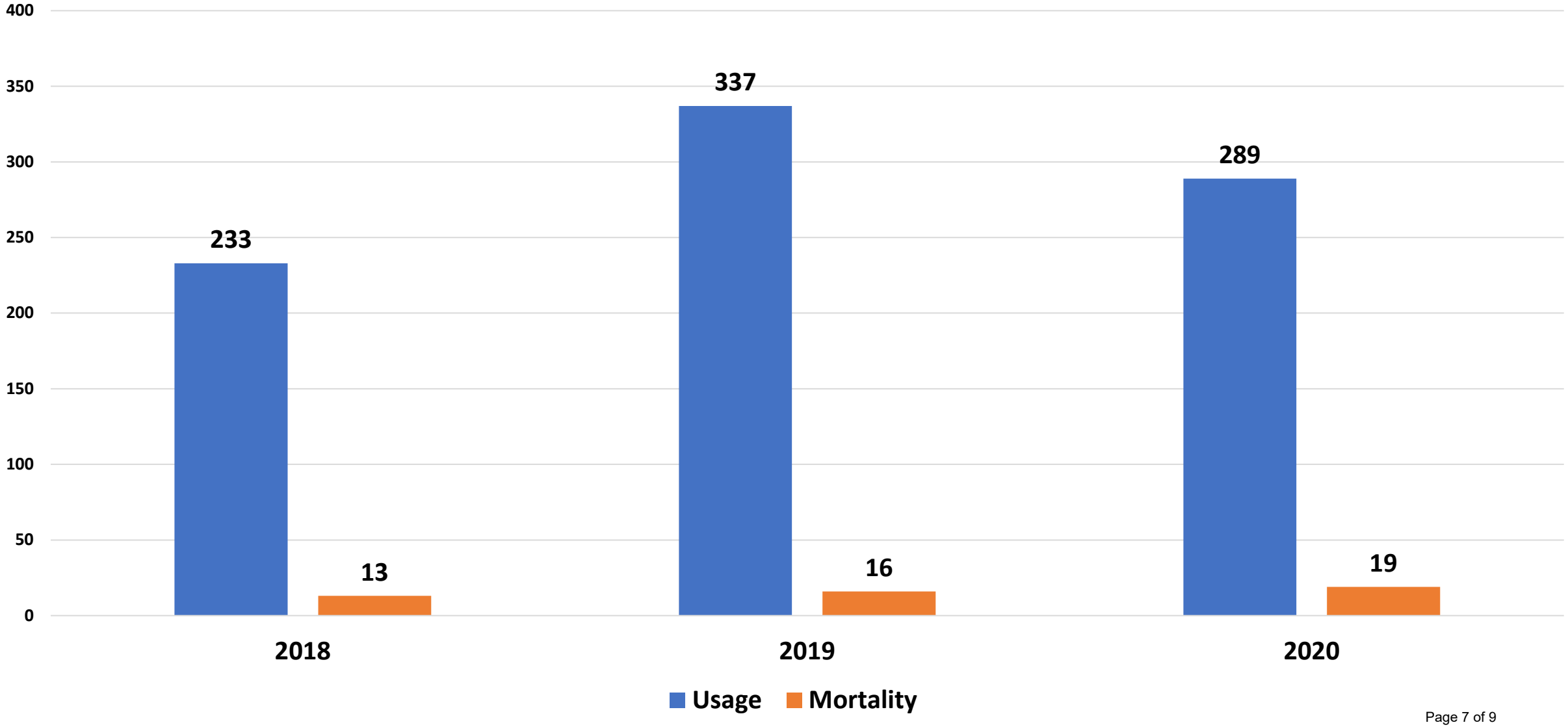


Hospital Arrival Method

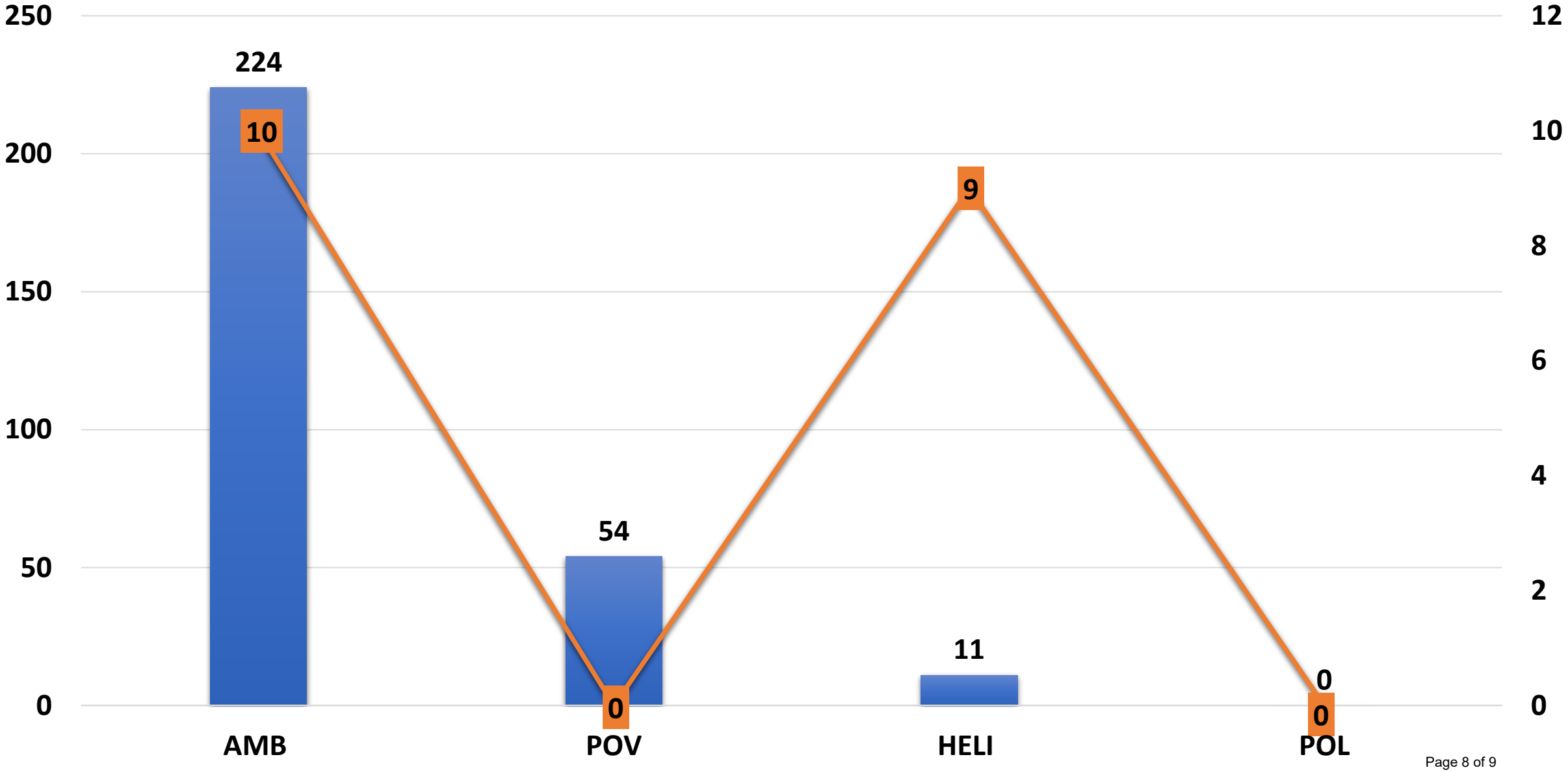
Q1-Q2 2020 Transports by Trauma Designation (Ped)



2018 vs 2019 vs Q1-Q3 2020
Total Tourniquet Usage and Mortality



Q1-Q3 2020 Arrival Mode with Mortality



INJURY PREVENTION COMMITTEE
Chair: Dr. Michelle McNutt

The committee met virtually on 10.8.2020 and 12.10.2020. Robin Garza, Vice-Chair of the Injury Prevention Committee has relinquished her position as of 9.22.2020. The announcement will be made via email and elections will commence at the meeting held in February 2021. The current focus of the committee is ensuring nursing homes provide advance directives to pre-hospital agencies at time of patient transport. A joint committee is being established between EMS, physicians, and nursing home leaders with intent to hold the inaugural meeting in January 2021. Updates to the SETRAC Injury Prevention webpage to include relevant and current links to education and resources.

The Falls Prevention workgroup held a successful virtual fall prevention program. This workgroup's leader is a certified Tai Chi instructor and has begun hosting virtual Tai Chi for Fall Prevention courses via Zoom every Tuesday and Thursday through January 2021. Identifying grants and funding for education remain a top priority. A small taskforce is being developed to begin grant applications.

The Firearm Safety workgroup analyzed the heat map data provided by the medical examiner's office and discussed injury trends noting an increase in homicides since COVID-19. Pre and post COVID-19 will be compared once data is available. Workgroup leader met with Commissioner Ellis' office for collaboration with hospital and community-based programs for 2021. Identifying grants and funding for in-hospital violence prevention education remain a top priority.

The Drowning Prevention workgroup developed water safety flyers and tip sheets for high incident apartment associations, homeowner's association, and area hospitals identified by drill down of regional submersion data. Documents have been translated to Spanish and are currently being printed for distribution.