Major Trauma Bypass Protocol

This protocol should be used if major trauma is likely to have occurred based on a significant mechanism of injury. Examples may include:

- High speed road traffic collisions
- Motorcycle road traffic collisions
- Pedestrian or cyclist versus vehicle
- Death of an occupant in the same vehicle
- Ejection from a vehicle
- Fall from 2 storeys or more
- Crush injuries
- Assault with a weapon
- Prolonged entrapments
- Blast injuries

In the event of an unmanageable airway, transport to the nearest trauma-receiving ED and provide pre-alert

Contact the NEAS major trauma coordination desk for all cases where this protocol is applied

For all major trauma consider early HEMS/MERIT activation

Step 1 – Physiological assessment

Any **one** of:

- Current GCS 13 or less
- Sustained loss of radial pulse or systolic BP <90mmHg
- Respiratory rate <10 or >29

Trigger

Step 2 – Anatomical assessment

Any **one** of:

- Penetrating trauma proximal to elbow or knee
- Spinal injury with new abnormal neurology
- Traumatic amputation proximal to wrist or ankle
- Chest injury with hypoxia or suspected flail
- Significant burns* or inhalational injury
- Pelvic fracture with obvious deformity/instability

Trigger

Step 3 – Special circumstances

No trigger in step 1 or 2 but **high degree of clinical concern**

PLUS

Any **one** of:

- Age > 65 years
- Bleeding tendency
- Pregnancy >20 weeks

Trigger

No triggers

* **10% burns in a child**
15% burns in an adult
Circumferential burns
Hand or facial burns

Is Major Trauma Centre within 60 minutes?

No → Transport to nearest trauma receiving hospital. Pre-alert TU ED for all triggering cases

Yes → **BYPASS TO MAJOR TRAUMA CENTRE**
PRE-ALERT RECEIVING EMERGENCY DEPARTMENT

RVI	JCUH
0191 2820311	01642 282767

Version 3 updated May 2016