PRACTICE GUIDELINE

Effective Date: 9-15-06 **Manual Reference:** Deaconess Trauma Services

TITLE: TRANSFER OF THE TRAUMA PATIENT FROM DEACONESS

PURPOSE: To insure rapid transfer out of the injured patients to a higher level trauma system.

DEFINITION: Transfers from Deaconess Hospital shall be in accordance with the Deaconess Hospital transfer policy. The following guidelines are recommended for patients who are transferred OUT OF Deaconess Hospital that have sustained a traumatic injury.

CONSIDERATIONS: Higher level of care required or unavailable resources at Deaconess Health System.

GUIDELINES:

1. Types of patients to transfer:
    i. A trauma patient with an injury that requires care unable to be performed at Deaconess.
    ii. Any patient with an injury and a mechanism must be transferred to a facility of equal or higher level of care.
        a) A patient with an injury and a mechanism cannot be transferred to Deaconess Gateway Hospital.
            i) The only exceptions for transfers to Deaconess Gateway Hospital would be stable trauma patients no longer requiring trauma admission requiring:
                1) Intracerebral coiling capability
                2) Isolated orthopedic patients requiring specialized, complex joint revisions
    iii. Consider transfer of the following patients: Burns; replantation; complex hand injuries if the hand surgeon is unavailable or case is deemed too complex; plastics, oculoplastics, and complex otolaryngology if case is deemed too complex by subspecialists; acetabulums if the traumatologist is unavailable or complex ortho if traumatologist or orthopedic surgeon requests transfer due to complexity; and severely injured pediatric patients.

2. Transferring physician responsibilities:
    i. Identify patients needing transfer.
    ii. Initiate the transfer process by direct contact with the receiving trauma surgeon.
    iii. Indicate resuscitation measures within the capabilities of the facility.
    iv. Stabilize patient before transfer and address life threats within the capability of the center.
    v. Determine appropriate mode of transportation in consultation with the receiving surgeon.
    vi. Transfer all records, test results, and radiologic evaluations to the receiving facility.

3. Receiving physician responsibilities:
    i. Ensure that resources are available at the receiving facility.
    ii. Provide consultation regarding specifics of the transfer, additional evaluation, or resuscitation before transport.
    iii. Once transfer of the patient is established, clarify medical control.
    iv. Identify a performance improvement and patient safety process for transportation, allowing feedback from the receiving trauma surgeon to the transport team directly or at least to the medical direction for the transport team.

4. Management during transport:
    i. Qualified personnel and equipment should be available during transport to meet anticipated contingencies.
    ii. Sufficient supplies should accompany the patient during transport, such as intravenous fluids, blood, and medication, as appropriate.
    iii. Vital signs should be monitored frequently.
    iv. Vital function should be supported, for example, ventilation, hemodynamics, central nervous system, and spinal protection.
    v. Records should be kept during transport.
    vi. Communication should be maintained with online medical direction during transport.

5. Trauma systems responsibilities:
    i. Ensure prompt transport once a transfer decision is made.
    ii. Review all transfers for performance improvement and patient safety.
    iii. Ensure transportation commensurate with the patient's severity of injury.

6. Information to accompany the patient:
    i. Available patient demographic information and the name of the next of kin should accompany the patient. Information about the nature of the injury event, time of occurrence, and pre-hospital care (run report) constitute important facts that can influence subsequent treatment. A summary of evaluation and care provided at the transferring facility should include the results of laboratory tests and radiologic evaluations, the injuries identified the patient's response to treatment, the amount of fluids and blood infused, and a chronologic record of the patient's vital signs. Additional information that is helpful includes the medical history, current medication, medication and immunizations administered, and allergies. The names, address, and phone number of the referring physician is important. The name of the surgeon who accepted the patient at the receiving hospital also should be indicated.

7. Deaconess Emergency Department physician must contact the trauma surgeon prior to transfer if patient meets any level of trauma activation criteria.

8. The Trauma Medical Director (TMD) and the Trauma Ortho Medical Director will collaborate and discuss isolated ortho transfers before transferring to Deaconess Gateway Hospital. The TMD must be contacted for any isolated ortho or isolated neuro trauma patient requiring transfer to Deaconess Gateway Hospital before the transfer occurs. It is the responsibility of the

physician requesting transfer to contact the TMD before transfer. A bed will not be assigned by Patient Placement RN until they receive the approval from the TMD/TPM.

9. If a patient is in need of a higher level of care that cannot be provided at Deaconess Regional Trauma Center, the sub specialist must physically examine patient and arrange for transfer, unless the ED MD or trauma surgeon is comfortable with the sub specialist providing consultation and direction via phone. In these cases the sub specialist does not have to physically examine the patient. Subsequently, the ED MD and/or trauma surgeon will arrange for transfer.

10. Contingency plan for patients requiring transfer:
    i. If patient requires stabilization or resuscitation meeting CAT I or CAT II criteria: The trauma surgeon will provide initial evaluation and stabilization of the patient.
    ii. Transfer agreements are established with similar and higher-level verified trauma centers.
    iii. Direct contact is required by the sending physician, with the accepting facility to arrange for expeditious transfer or ongoing monitoring support.
    iv. All transfers will be monitored by the PIPS program.

REFERENCES:

- RESOURCES FOR OPTIMAL CARE OF THE INJURED PATIENT: 2014; Committee on Trauma American College of Surgeons.

REVIEWED DATE	REVISED DATE
JAN 2007	Nov 2006
JAN 2008	Nov 2009
JUN 2011	Feb 2014
AUG 2014	Aug 2016
JUL 2018	July 2017
JAN 2019	Feb 2019
AUG 2020	