UAMS MEDICAL CENTER

TRAUMA and CRITICAL CARE SERVICES MANUAL

SUBJECT: Transfer of Service Protocol

SUPERSEDES: New **PAGE:** 1 of 2

RECOMMENDATION(S): Melissa Kost, MD **APPROVAL:** 12/11/2020

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Purpose: To define the appropriate patient population, timing of transfer, and evaluation that will be completed for patients with isolated traumatic specialty service injuries.

Patient population: The Trauma Service will admit patients with isolated orthopedic and neurosurgical injuries at high risk for additional injuries or significant physiologic derangements. These are primarily patients with high energy blunt traumatic mechanisms, including:

- Pedestrian struck by vehicle
- Crush injury
- Fall >15 feet
- Fatality at scene
- Motor vehicle collision at high velocity
- Isolated pelvic fracture caused by high energy mechanism

This is not an exhaustive list. If there is clinical concern about an individual patient that does not meet the above criteria, an attending to attending conversation is encouraged to direct the patient to the most appropriate service.

Transfer checklist: Patients with isolated specialty service injuries admitted to Trauma Surgery on Hospital Day #1 will be transferred to the respective specialty service when the following criteria are met:

1) Imaging reads have been reviewed by an Attending Radiologist
2) Tertiary exam is complete and documented
3) No additional non-specialty service injuries are identified
4) Verbal sign out has occurred between Day Team services
5) The patient has been observed for at least 8 hours (morning after injury)

Special Considerations:

- If these criteria are not met until after definitive specialty service operative intervention, the patient will still be transferred to that service.

- If the patient has multiple sub-specialty service injuries (ex, Ortho hand and Ortho trauma), the patient will still be transferred to that specialty, with the attending of record chosen by the receiving team.

ICU admissions:

1) Patients with devastating brain injury being considered for organ donation will be admitted to the SICU with Trauma Surgery as primary.
2) Patients with devastating brain injury transitioning to comfort care will be admitted to the appropriate level of care with Trauma Surgery as primary.
3) Patients with isolated spine trauma requiring critical care management will be admitted to the SICU with the primary service determined by the guidelines as stated above.

EXCEPTION: isolated c-spine and high t-spine fracture with associated cord injury will be admitted to and remain on the Trauma service.

4) Patients with isolated brain trauma requiring critical care management will be admitted to the SICU with the primary service determined by the guidelines as stated above.

If there are any concerns or disagreements regarding patient transfer between services, this will immediately be brought to the attention of the Attending Surgeons of the respective services to discuss directly.