

**Sabetha Community Hospital  
Trauma Transfer Protocol**

**Purpose:**

Trauma patients who will be transferred out of this facility to a definitive care facility emergently must be identified early, assessed and treated quickly and transferred efficiently in order to provide them the best possible outcome.

**Policy:**

Patients to be transferred can often be identified before they arrive in the emergency department. Arrangements for emergent transfer can often begin the moment the emergency department staff is notified by EMS that they are enroute with a major trauma patient. Other patients may require evaluation by the emergency department physician before the decision to transfer is made.

Once the decision to transfer has been made, it should not be delayed to obtain X rays, CT scans or laboratory results that do not immediately impact the resuscitation. At this point, the focus of the emergency department staff is on resuscitation and stabilization with the goal of minimizing the patient's length of stay in the emergency department.

Consideration should be given to whether the patient will be transferred via ground or air. Generally, seriously injured trauma patients should be transferred by air when possible. Consideration should be given to ground transport if the patient can be received by the definitive care facility sooner than if transported by air or if aero medical transfer is significantly delayed or unavailable for any reason.

Transport vehicles should be staffed by paramedics and/or nurses whenever possible. Trauma patients on whom invasive procedures have been performed or who have received medications must be transferred under the care of personnel who are adequately trained to manage their resulting condition. If necessary, a physician or nurse from this hospital may accompany the patient.

**The following are conditions that should immediately activate emergency transfer procedures:**

- Central Nervous System
  - Penetrating injury/open fracture with or without cerebrospinal fluid leak
  - Depressed skull fracture
  - GCS <11 or deteriorating mental status or lateralizing neurological signs
  - Spinal cord injury or major vertebral injury
- Chest
  - Major chest wall injury or pulmonary contusion
  - Wide mediastinum or other signs suggesting great vessel injury
  - Cardiac injury
  - Patients who may require prolonged ventilation
- Pelvis/Abdomen
  - Pelvic fracture with shock or other evidences of continuing hemorrhage
  - Open pelvic injury
  - Unstable pelvic ring disruption
  - Major abdominal vascular injury
- Major Extremity Injuries
  - Fracture/dislocation with loss of distal pulses
  - Open long-bone fractures
  - Extremity ischemia
  - Multiple long-bone fractures
- Multiple-System Injury
  - Head injury combined with face, chest, abdominal, or pelvic injury
  - Burns with associated injuries
- Secondary Deterioration (Late Sequelae)

- Single or multiple organ system failure (deterioration in central nervous, cardiac, pulmonary, hepatic, renal, or coagulation systems)
- Major tissue necrosis
- Mechanical ventilation required
- Sepsis

**The following conditions should be considered for immediate transfer:**

- Central Nervous System
  - GCS >10 and <14
- Chest
  - >2 unilateral rib fractures
- Abdomen
  - Solid organ injury
- Major Extremity Injuries
- Multiple-System Injury
  - Injury to more than two body regions
- Co-morbid Factors
  - Age >55 years
  - Children ≤ 5 years of age
  - Cardiac or respiratory disease
  - Insulin-dependent diabetes
  - Morbid obesity
  - Pregnancy
  - Immunosuppression
- Secondary Deterioration (Late Sequelae)

**Procedure:**

**Before patient arrival:**

1. After becoming aware that a trauma patient is en route who likely will require emergent transfer, the emergency department staff activates the trauma team and notifies the emergency department physician of the likelihood of transfer. Ascertain from EMS if they have already ordered aero medical transportation.
2. The physician identifies the appropriate mode of transfer (i.e., aero medical vs. ground) and qualifications of transferring personnel.
3. Staff contacts the appropriate aero medical and/or ground transportation, obtains ETA:
  - Sabetha Emergency Medical Services  
284-2158
  - Jackson County Emergency Transport  
364-2251
  - Seneca Emergency Medical Services  
336-2311
  - LifeStar  
800-666-9111 or pick up the LifeStar phone in the ER
  - LifeNet  
800-981-3062
  - Children's Mercy Critical Care Transport  
800-466-3729 or pick up the Children's Mercy phone in the ER or nursery

**After patient arrival:**

1. The physician identifies and contacts the receiving facility, and requests the receiving physician to accept the transfer. The two should discuss the current physiological status of the patient and the optimal timing of transfer. Frequently used higher level trauma centers include:
  - Stormont-Vail HealthCare  
Adult Level 2 Trauma Center  
877-354-6000

- University of Kansas Hospital  
Adult Level 1 Trauma Center  
877-738-7286
- Children's Mercy Hospital  
816-234-3430
- Bryan/LGH West Medical Center  
Adult Level 2 Trauma Center, Lincoln  
800-873-6572
- Nebraska Medical Center  
Level 1 Trauma Center, Omaha  
402-559-4020

**2. Before transfer, the physician should:**

- Ensure chest tubes are placed in the presence of pneumothorax.
- Ensure at least two IV lines are established.
- Consider securing the airway with an endotracheal tube, LMA or surgical airway if GCS<11.
- Consider sending additional blood, equipment and supplies (medications, fluids, etc.) that the patient may need en route if not available in the transporting vehicle.

**3. The staff makes copies of all available documentation to accompany the patient:**

- EMS report
- Resuscitation record
- X rays, CT scans
- Lab results