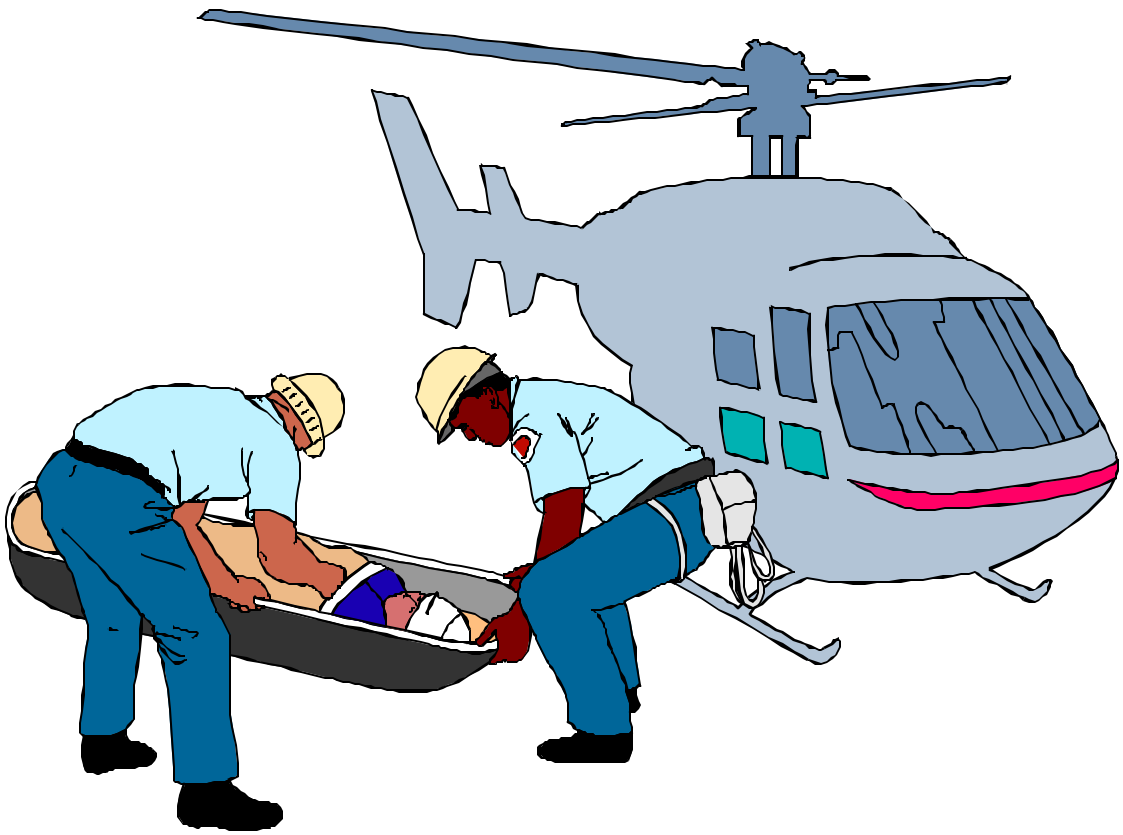
Interfacility Transfer of Injured Patients: Guidelines for Rural Communities

American College of Surgeons
Committee on Trauma
2002



Interfacility Transfer of Injured Patients: Guidelines for Rural Communities

By Scott R. Petersen, MD, FACS, and the Ad Hoc Committee on Rural Trauma, ACS Committee on Trauma

General Principles

1. The vast majority of injured patients receive their total care in the rural hospital, and transfer to a higher level of care is not necessary.

2. Physicians should assess their own capabilities and those of their institution. This assessment allows for early recognition of patients who may be safely cared for in the local hospital and those who require transfer to an institution that can provide optimal care.

3. Once the need for transfer is recognized, arrangements should be expedited and not delayed for diagnostic procedures that do not change the immediate plan of care.

4. When possible, life-threatening injuries may be stabilized at the rural facility prior to transport. This treatment may require operative intervention to ensure that the patient is in the best possible condition for transfer. Intervention prior to transfer is a surgical decision.

DO NOT DELAY

Transfer Protocols

Referring Physician	**The physician initiating transfer should speak directly to the physician accepting the patient at the receiving hospital.**
Information to Transporting Personnel	**Information concerning the patient's condition and needs during transport should be communicated to transporting personnel.**
Documentation	**Send a written record of the problem, treatment given, and patient status at the time of transfer, as well as certain physical items (such as lab findings, lavage specimens, X rays), with the patient.**
Prior to Transfer	**The patient should be resuscitated and attempts made to stabilize his or her condition with respect to ABCDEs.**
Management during Transport	**During transport, continued management of vital functions and continuous reevaluation are essential.**

Interhospital Triage Criteria

Patients with certain specific injuries or combinations of injuries (particularly those involving the brain) or patients who have historical findings indicating high-energy transfer may be at risk for death and are candidates for early transfer.

The following criteria suggest the necessity for early transfer; however, these criteria may vary with individual hospitals.

Central Nervous System

Head injury
- Penetrating injury or depressed skull fracture
- Open injury with or without CSF leak
- GCS score < 14 or GCS deterioration
- Lateralizing signs

Spinal cord injury

Chest

Widened mediastinum or other signs suggesting great vessel injury
Major chest wall injury or pulmonary contusion
Cardiac injury (blunt or penetrating)
Patients who may require prolonged ventilation

Pelvis/Abdomen

Unstable pelvic ring disruption
Pelvic fracture with shock or other evidence of continuing hemorrhage
Open pelvic injury
Solid organ injury

Major Extremity Injuries

Fracture/dislocation with loss of distal pulses
Open long bone fractures
Crush injuries or prolonged extremity ischemia

Multiple System Injury

Head injury combined with face, chest, abdominal, or pelvic injury
Major burns or burns with associated injuries
Multiple long bone fractures
Injury to two or more body regions

Comorbid Factors

Age < 5 years or > 55 years
Known cardiorespiratory or metabolic diseases (diabetes, obesity)
Pregnancy
Immunosuppression

Secondary Deterioration (Late Sequelae)

Prolonged mechanical ventilation required
Sepsis
Single or multiple organ system failure (deterioration in CNS, cardiac, pulmonary, hepatic, renal, or coagulation systems)
Major tissue necrosis

Adapted from ACS Committee on Trauma: *Resources for Optimal Care of the Injured Patient, 1999*.

American College of Surgeons
633 N. Saint Clair St.
Chicago, IL 60611