

Sample Level 3 Trauma Diversion Policy

Purpose:

Occasions may arise when one or more essential hospital resources are functioning at maximum capacity or otherwise unavailable and it is in the best interests of the trauma patient to be directed to an alternative facility for care.

Policy:

The need to go on “trauma divert” is a rare situation but might occur in the following circumstances:

- The emergency department is saturated; demand for critical patient care resources exceeds availability.
- Emergency department resources are fully committed due to an external disaster/multiple-casualty event.
- Emergency department resources are unavailable due to an internal disaster or catastrophic mechanical failure.
- All available trauma surgeons are in the operating room.
- The operating room is functioning at maximum capacity; no surgical suites are expected to become available within one hour.
- General surgeons are overwhelmed with cases.
- The general surgeon is physically unable to operate.

In such rare cases the surgeon in collaboration with the emergency department physician may make the decision to divert trauma patients for a short period of time. The need to remain on divert status should be reviewed at least hourly to provide for the shortest possible time on divert.

The diversion of trauma patients only pertains to incoming ambulance patients and not to walk-in patients. A patient incoming via ambulance while on “trauma divert” will be accepted if the EMS provider and monitoring physician determine that the patient is experiencing a condition such that transport to the next closest appropriate trauma hospital could reasonably result in increased morbidity or death. “Trauma divert” status is a request to EMS personnel to transport the patient to another facility. The patient or EMS personnel may decline the request to divert provided they have been properly apprised of the potential for delayed treatment affecting the care of the patient.

Ambulance patients who have arrived on hospital property will be admitted to the emergency department and evaluated by a physician regardless of the hospital's diversion status.

Procedure:

Going on divert:

1. The surgeon on call and the emergency department physician will collaborate and decide on the need to go on "trauma divert." They will notify the emergency department charge nurse.
2. The charge nurse notifies the following of trauma divert status:
 - A. Emergency department nursing staff
 - B. ICU nursing staff
 - C. EMS dispatch center(s) (e.g. sheriff departments); request EMS personnel to call hospital early with patient information
 - D. [NEIGHBORING HOSPITAL(S)]
3. The emergency department charge nurse begins a "Trauma Divert Tracking Log."

When contacted by EMS with information regarding a seriously injured trauma patient, the emergency department staff person taking report notifies the EMS crew that the hospital is on trauma divert and immediately puts the crew in contact with the emergency department physician. The physician will determine if the patient is to be seen in the emergency department or diverted to a nearby facility. The decision whether or not to divert must be accomplished very quickly in order to minimize the amount of time the patient spends in transit.

Going off divert:

1. The surgeon and emergency physician who initiated the closure must:
 - A. Continuously evaluate the need to remain on trauma divert.
 - B. Make the decision as to when the hospital is no longer on trauma divert.
 - C. Notify the emergency department charge nurse when no longer on trauma divert.
2. The charge nurse notifies:
 - A. Emergency department nursing staff
 - B. ICU nursing staff
 - C. EMS dispatch center
 - D. [NEIGHBORING HOSPITAL(S)]

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3. The emergency department charge nurse completes the "Trauma Divert Tracking Log" and forwards it to the trauma program manager.