Regions Trauma Admissions

TL:DR Version: Every trauma patient with documented injuries should be admitted to trauma unless low mechanism and isolated extremity injury.

- **Level 1 Trauma Activation** patients **with documented injuries** being admitted for management of those injuries should be admitted to the **trauma service**. (Medicine consultation can be considered for management of multiple comorbidities.)

- **Non-Level 1 Trauma Activation** patients sustaining **high energy mechanisms** (MVC, motorcyle, ATV, snowmobile, pedestrian struck, fall ≥ 10ft) **with injuries** identified that require admission should be evaluated by and admitted to the **trauma service** with appropriate consultation of surgical subspecialties. (Medicine consultation can be considered for management of multiple comorbidities.)

- Patients with injuries requiring the involvement of **multiple (≥2) surgical subspecialties** should have a trauma evaluation in the ED and be admitted to the **trauma service**.

- Patients with **facial trauma** requiring admisison and evaluation by one of the maxillofacial teams should be admitted to the **trauma service**.

- Patients with **isolated injuries** to the distal upper extremity (below elbow) requiring plastic surgery/hand surgery can be admitted to **the plastic surgery service** without additional trauma surgery involvement.
  - If the plastic surgery team has concerns about a patient a trauma evaluation can be performed at their request. A transfer of service to the trauma service can be considered based on the evaluation.

- The trauma service should evaluate and admit all **acute (injury ≤ 7 days) neurotrauma** patients that require admission to the **trauma service.** (Occasional exceptions can be made if the burden of medical comorbidities is significant but a trauma evaluation must still occur. Medicine consultation can be considered for management of multiple comorbidities.)

- Patients with **low-energy mechanism** and **isolated orthopedic injuries** can be admitted to the **orthopedic surgery service** without additional trauma surgery involvement. Isolated hip fractures can continue to be managed by orthopedic surgery and medicine teams without trauma involvement.
  - If the orthopedic surgery service has concerns about a patient a trauma evaluation can be requested. A transfer of service to the trauma service can be considered based on the evaluation.

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- Patients initially admitted to the trauma service who have **isolated orthopedic injuries**, will be **transferred to the orthopedic surgery service after 24h** and if the following criteria met:
  a) Isolated orthopedic injury (does not have to be operative)
  b) Age <65
  c) Hemodynamically normal
  d) Not initially admitted to the ICU
  e) No significant comorbidities (i.e. uncontrolled diabetes, cirrhosis, uncontrolled hypertension, arrythmias, etc)
  f) Completion of a tertiary survey

  *These transfers do not require secondary orthopedic surgery attending approval and the transfer should be communicated between trauma surgery resident/APP and the orthopedic surgery resident/APP. **These transfers should occur during daytime hours (6a-6p) and otherwise should be deferred to the following day.**

- The trauma service should evaluate all patients who present to the ED after discharge in the acute period (≤ 14 days) due to trauma-related concerns and require admission **(trauma readmission**).

- For **combined trauma/burn mechanisms**, trauma staff and burn **staff will discuss appropriate primary service** depending on the burden of burn injury vs traumatic injuries.

- **Pediatric** trauma patients should be admitted to the **trauma service** when **non-accidental trauma** is suspected to ensure the appropriate work-up is completed and the appropriate child abuse specialist can be consulted.