TRAUMA ADMISSION CRITERIA

Floor/Observation Admission

- Patients who do not meet admission criteria for SICU or SDU
- Age <70 not meeting ICU/SDU criteria

SDU Admission

- Grade II, III solid organ injury without blush on CT
- Multiple injuries patient
- Rib fx with FVC> 1000, FVC <1500
- Any patient on pre-injury anticoagulant therapy with an injury not requiring ICU
- Major soft tissue trauma with history of any anticoagulant therapy
- Need for q 2 hour vital signs/Neurovascular checks/cardiac monitoring
- Multiple co-morbidities
- All trauma patients >70 years old not meeting ICU criteria
- C-spine fractures
    - Exclusive of SP and TP, without neurologic injury
- History of sleep apnea who needs narcotics
- Attending discretion

ICU Admission

- Grade IV or greater solid organ injury or Grade III with a blush
- Any hemodynamic instability
- Base deficit >6
- Pelvis fracture needing blood or angiogram/embolization
- Any spine fracture with neurologic injury
- Mandible or other facial fractures with edema/hematoma and concern for airway compromise
- Traumatic brain injury and GCS <13
- Intracranial hemorrhage with use of anti-coagulants
- Intracranial hemorrhage >55 years old
- Concern for Airway compromise
- High risk rib fracture patient, FVC <1000
- Pulmonary co-morbidities
- Blunt myocardial injury with new:
    - Arrythmia
    - Hemodynamic instability
    - Cardiac Failure
- Unstable spine fracture
- Frontal contusions >2 cm
- Solid organ/pelvis with active extravasation on CT
- Attending discretion

Call 71899 to notify ICU MD of admission PRIOR to leaving the ED.

Requires ICU attending acceptance of admission

Revised 12/2023

TRAUMA ADMISSION CRITERIA

Admissions:

A. Add Patient to Trauma Rounding List & Trauma Attending List

B. Admission Navigator

a. Admit Now Orders

i. Patient Level of Classification

ii. Attending Physician Physically in ED or Attending Physician for Week

b. Patient History

i. Allergies

ii. Past Medical History

iii. Past Surgical History

iv. Social History (Alcohol/Tobacco)

v. Family History (Anesthesia Problems)

c. Problem List

i. Physical Exam Findings and Radiographic Injuries

ii. Principle Problem

1. MVC/ATV/MCC
2. Specifics of Accident and if Outside Facility
3. Check as Principle Problem
4. Mark as High Priority

iii. Consulted Service/Plan for the Injury/Other Specifics

1. Example: Right Femur Fracture
   Orthopaedic Consult: ORIF on 5/4/2011 with Dr. Hubbard. 24 hours of Abx. WBAT RLE.
2. Example: Right 5-7 Rib Fractures
   Rib Fracture Protocol.
   FVC in ED 1.1, Patient admitted to Step Down Unit.
   5/4/2011: FVC 1.3, IS 1500

iv. Additional Information: Mark as Low Priority

1. Nutritional Assessment
   a. Example: Patient NPO upon admission.
   5/4/2011: Patient advanced to and tolerating a clear liquid diet.
   5/5/2011: Patient advanced to a regular diet.
2. DVT Prophylaxis
   a. Example: SCDs upon admission. Lovenox held secondary to SDH. Scheduled to begin 5/7/2011.
3. Physical Deconditioning
   a. Example: PT/OT Evaluation: Patient safe for discharge home with Crutches.
4. Acute Pain due to Trauma
   a. Example: Patient admitted on Dilaudid PCA.
   Converted to and controlled on PO Percocet

TRAUMA ADMISSION CRITERIA

C. Admission Order Sets
   a. Trauma Floor Orders
   b. Trauma Step Down Orders
   c. Trauma ICU Orders

Important Order Sets (See Trauma Order Sets Page 15 for complete list):

1. FVC ED
2. Rib Fracture Protocol
3. Spinal Cord Injury
4. TLSO
5. 8NE Rib Fracture Protocol
6. Trauma Discharge

Important .Phrases:

1. .tesnewprog = Daily Trauma Floor Progress Note
2. .acutecare = Daily General Surgery Floor Progress Note
3. .clinicnote = Clinic Note
4. .daydc = Day of Discharge Note
5. .dissum = Discharge Summary

Patient Presentations:

Mr. Smith is a 45 year old male Post Trauma Day # 7 Status Post MVC with the following injuries:

1. Problem List with Specifics and Plan
2. Acute Issues Overnight
3. Abnormal Lab Values/New Issues
4. Criteria for Discharge
   a. Nutritional Assessment
   b. DVT Prophylaxis
   c. Pain Control Regimen
   d. Social Situation: Family Support/PT Recommendations/Placement Updates

Division of Work:

Senior/Junior: Responsible for seeing ICU patients and new admissions to ICU
Interns: Responsible for seeing Step Down and Floor patients
PAs: Responsible for seeing New Step Down and Floor patients
Responsible for seeing Discharge Ready patients: Criteria must be met to be on list

Daily Work:

- You are responsible for ALL patients, not only ones to whom you are assigned
- Orders to be entered by PA/Pharmacist/Nutritionist on rounds
- ALL residents are to go into ALL patient rooms
- Trauma List is to be run by ALL residents and the Floor PA after rounds
  - Resident on Call Reads/Runs List
  - Additional Orders Entered by Other Residents/PA

TRAUMA ADMISSION CRITERIA

    - Care Management Discussion
    - Call Consults
    - Step Down/Floor Procedures
    - Help with Discharge Summaries
- Traumas will be covered by Discharge PA during Rounds
- After rounds are completed, traumas will be covered by Resident on Call
- Afternoon Rounds: Follow up on all orders/results
    - PA on round in AM
    - Resident on Call
    - Any Other Free Residents

*** Patients coming up from the ICU must be checked out to PA/Resident on Call in PM, otherwise they will not be placed on the Intern List or seen by the Interns the following AM. Additionally their active Trauma issues must be updated in problem list and ICU orders/lines discontinued prior to transfer.

*** Problem lists must be updated daily by residents, if not the resident who has seen the patient during their hospital course will be solely responsible for the patient's discharge summary.