Status Active PolicyStat ID 18438533

Origination	04/2021
Last Approved	08/2025
Effective	08/2025
Last Revised	08/2025
Next Review	08/2028

Contact	Stephanie Spain: Trauma Prgm Mgr Adult
Area	Trauma Surgical Critical Care
Applicability	Erlanger Health - Baroness

Direction of Internal Vital Emergency Resources for Trauma

1. Policy statement:

As the region's only Level 1 Trauma Center, real time maintenance of essential resources for trauma resuscitation is imperative for quality care of acutely injured patients. High inpatient numbers and overcrowding in the Emergency Department (ED) have the potential to affect the readiness of the trauma resuscitation area.

2. Who Should Read This Policy?

ED Staff, Trauma Services Staff, and all Hospital and Medical Staff

3. Purpose

4. Definitions:

Vital Emergency Resources for Trauma ("trauma bay"): Space and equipment necessary for the care of the trauma patient, including:

1. A trauma resuscitation bay
2. Specialized equipment unique to trauma resuscitation ie fluid warmer, ventilator, warming equipment, surgical trays, central line kits, Belmont rapid infuser, etc.

5. The Policy

A primary trauma resuscitation bay will be set up and available at all times.

1. Baroness ED Bed 8 is the primary location for resuscitation of level 1 or 2 trauma patients.
2. If Bed 8 is unavailable, Bed 7 will be designated as an alternative trauma bay.
3. If bed 7 and 8 are unavailable beds 3-6 will be set up and made available.

4. Trauma patients undergoing ongoing emergent evaluation and treatment in the ED will be cohorted in Beds 3-8.

An assessment of vital emergency resources for trauma can be initiated by the ED and concerns brought to the attention of the on-call trauma attending. If the Emergency Department is reaching total capacity and no trauma bay beds will be available accounting for incoming transfers, anticipated EMS traffic, and nurse staffing ratios, then impromptu multidisciplinary rounds can be undertaken. If no immediate resolution can be identified by the ED charge nurse, then he/she should first notify and collaborate with the ED clinical manager (or designee) regarding concerns for potential lack of vital resources. The ED clinical manager (or designee) should then contact the Senior Director Of Emergency Services (or designee) who will notify the House Supervisor (HS) as well as immediately begin collaborating with all three of the in-patient Nurse Directors (ND) to further assess and discuss efforts to restore bed capacity for incoming acutely ill and injured patients. The ND for Trauma/Surgical Critical Care will notify the Trauma Program Manager (TPM) and the Trauma Medical Director (TMD) during this stage of attempting to restore bed capacity. The on-duty Emergency Medicine and Trauma Surgeon physicians should be made aware and included in these discussions at this juncture (if not already aware) to assist with facilitation of capacity restoration efforts. These efforts will focus attention to unoccupied beds in inpatient areas and attempts will be made to move patients out of the ED and restoring bed capacity. These efforts include but are not limited to the following:

- Nurses flexing up for short periods in in-patient areas
- Additional staff reporting for duty
- The on call manager(s) reporting for duty
- The on call manager(s) designate another manager to report for duty

In the event the above interventions do not identify additional capacity and vital emergency resources for trauma are unavailable, the Trauma/Surgical Critical Care VP will communicate the need for trauma divert to the TMD (or on-duty Trauma Surgeon as designated by the TMD). At this point the on-duty Trauma Surgeon (or designee) will notify the Erlanger Regional Operations Center (EROC) and the Chief Operating Officer (COO) of the need for trauma divert. Trauma Surgeon notification to EROC and the COO should result in:

1. Patients with non-trauma conditions be redirected to alternative hospitals that can provide necessary care after provider-to-provider discussion through EROC. Patients requiring services unique to Erlanger, such as patients requiring Acute Stroke/Large Vessel Occlusions in need of intervention and Maternal-Fetal-Medicine services may still be accepted.
2. Deferred or delayed transfers from outside facilities, (this will be continually re-evaluated with the goal of returning to normal operations as quickly as possible).
3. Trauma patients in the field that have a shorter transport time to another Level 1 trauma center should be transported to the alternative center.
4. Trauma/Surg Critical Care VP should notify the Chief Nursing Exectuive (CNE) of a facility status change if they are not already involved.

Trauma patients within our primary referral area will still be seen at BEH, including:

1. Locally transported trauma from EMS
2. Trauma patients can be accepted by the trauma attending in transfer after direct discussion with EROC and transferring physician
3. Trauma patients requiring subspecialty care can be screened by the trauma attending on-call and

they can consult with the appropriate subspecialist before diverting isolated traumatic injuries.

Return to normal operations will be communicated.

Trauma Diversion Process Review (attachment) will be immediately initiated after each diversion event and will be reviewed/discussed in the Trauma Process Improvement and Patient Safety Committee (Trauma PIPS) for the following:

- policy compliance and efficacy
- policy deviations
- opportunities to improve the policy/process

References:

A. **American College of Surgeons, Committee on Trauma. (2022). Resources for optimal care of the injured patient.**

Direction of Internal Vital Emergency Resources for Trauma

ED Charge RN identifies capacity concerns

ED Charge notifies ED Clinical Manager (or designee)

ED Clinical Manager (or designee) notifies the Senior Director of Emergency Services (or designee)

Sr. Dir. EM Services now collaborates immediately with HS and all in-patient Nurse Directors to strategize capacity restoration. The Trauma/Surg Critical Care ND will notify and update the Trauma Program Manager (TPM) and Trauma Medical Director (TMD) at any point in this phase of capacity mitigation.

Examples of strategies for ED patient movement:
- Nurses flex up for a short period (in-patient)
- Additional staff coming in
- On-call managers coming in
- Staffing office CSL assist with clinical

The on duty Emergency Medicine and Trauma Surgeon attending physicians should be made aware and included in these discussions at this juncture (if not already aware) to assist with facilitation of capacity restoration efforts.

If all the above collaborations do not result in restored capacity (open trauma bay beds 7 & 8) the Trauma/Surg Critical Care VP will update/notify the TMD (or on-duty trauma surgeon as designated by the TMD) of the definitive need for trauma divert status.

At this point the on call Trauma Surgeon (or designee) will report the facility trauma divert status to the Erlanger Regional Operations Center (EROC ext. 4195 or 1260) and the Chief Operating Officer (COO).

EROC and COO notification from the Trauma Surgeon results in the following:

1. Patients with non-trauma conditions be redirected to alternative hospitals that can provide necessary care after provider-to-provider discussion through EROC. Patients requiring services unique to Erlanger, such as patient requiring Acute Stroke/Large Vessel Occlusions in need of intervention and Maternal-Fetal-Medicine services may still be accepted.
2. Deferred or delayed transfers from outside facilities. (This will be continually re-evaluated with the goal of returning to normal operations as quickly as possible)
3. Trauma patient that have a shorter transport time to another Level 1 trauma center should be transported to the alternative center.
4. Trauma/Surgical Critical Care VP should notify the CNE of a facility status change if they are not already involved.
5. Return to normal operations will be communicated.

Trauma patients within our primary referral area will still be seen at BEH, including:

1. Locally transported trauma from EMS.
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3. Trauma patients requiring subspecialty care can be screened by the trauma attending on-call and they can consult with the appropriate subspecialist before diverting isolated traumatic injuries.

Attachments

- b64_baa4fe49-d125-4662-b31b-e3fac7052f01
- DIVERT Algorithm.pdf
- Trauma Diversion Process Review Form.docx

Approval Signatures

Step Description	Approver	Date
VP Approval	Jessica Holladay: VP & ACNO Surg & Trauma Svcs	08/2025
OC/MEC	Shana Fox: Credentialing Mgr. Med. Staff	08/2025
Trauma Services Committee Approval	Stephanie Spain: Trauma Prgm Mgr Adult	06/2025
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Applicability

Erlanger Health - Baroness