Approved by: P&P, Special Care,Trauma Services Committee

DEPARTMENT: Trauma	POLICY TITLE: Admission to Trauma Intensive Care Unit (STICU)
Page 1 of 2	REPLACES POLICY DATED: New
EFFECTIVE DATE: 8/2015	REFERENCE NUMBER: 653-213

PURPOSE: To establish guidelines for admission, transfer and discharge of patients to and from the TICU. This serves as a guideline and is subject to the discretion of the Trauma Surgeon on-call.

POLICY:

1. All level one trauma activations shall have a TICU bed assigned to them upon arrival to ED. The ED HUC will be responsible for coordinating bed assignment with the bed coordinator.
2. The Trauma Surgeon on call, after evaluation of a level one trauma patient shall inform the HUC to change the bed assignment as necessary.
3. All level two traumas shall have a bed assigned after evaluation by the Trauma Surgeon on call.
4. All high energy poly-trauma requiring critical care monitoring shall be admitted to the TICU
5. Penetrating torso trauma requiring critical care monitoring shall be admitted to TICU
6. All single system injuries will be admitted to TICU on a case-by-case basis. Examples include, but aren't limited to:
    a. Hemodynamic instability
    b. Severe hypoxia requiring ventilator management
    c. Patients post damage-control injuries requiring on going resuscitation
    d. Complex pelvic fractures requiring HD monitoring
    e. Isolated solid organ injury requiring HD monitoring
    f. Isolated extremity injury requiring every hour pulse checks
7. Isolated Traumatic Brain Injury requiring every hour neuro checks, ICP monitoring, or Hypertonic Therapy:
    a. Ground level fall: admit to NSICU
    b. Non-GLF: admit to TICU
8. Consider admitting medically ill patients with minimal traumatic injury to the CCU. (Example: Active MI/CVA with single extremity fracture)
9. Orders must be written at time of admission or transfer
10. Overall supervision of admissions/transfers or discharges is the responsibility of the Director of the Trauma ICU
11. Pediatric patients admitted must be 14yr or older. Exclusions requiring transfer to Pediatric Level one trauma center include:
    a. Multiple trauma requiring subspecialists not immediately available
    b. Multiple organ failure
    c. Disseminated intravascular Coagulation
    d. Acute hepatic or renal failure
    e. Ingestion
12. Patients should be transferred from the TICU when their condition is stabilized/no longer requires critical care monitoring.
13. Non-trauma patients can be admitted to TICU beds when the CCU and NSICU are full. One TICU bed shall remain empty until the code bed is the last available ICU bed. When a non-TICU bed becomes available, any non-trauma patient will be transferred to the appropriate ICU.
14. If the TICU is full and a bed is required, the Physician on-call for the TICU shall survey the patients and ascertain if any can be transferred. He/She shall transfer those patients (if trauma patient) or contact the on-call Attending for that patient. If the on-call Attending for that patient is reluctant to move his/her patient, the on-call TICU physician shall notify both the Director of the TICU and the Director of Critical Care Nursing. The Director of the TICU, or the physician-designee, shall evaluate the patient's condition and consult with the on-call provider for that patient. If the Director of the

TICU's opinion is the patient can safely be transferred and the on-call Attending for that patient again refuses, that Attending must immediately (within 30 minutes) come to the TICU, evaluate the patient, and document justification in the chart. The TICU Director may then follow the Chain of Command and refer the case to the Chief of the attending physicians department for review.

REFERENCE:

Fryman,L. et al. Maintaining an open trauma intensive care unit bed for rapid admission can be cost-effective. J Trauma Acute Care Surg. 2015;79(1):98-104.