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|  | Disposition Of The Spinal Trauma Patient Admission and Transfer Policy | |
| Scope | <ul style="list-style-type: none"> • Inpatient Acute | <ul style="list-style-type: none"> • Nursing staff • Medical staff |
| Responsible Department and Position | Emergency Department : Director or Emergency | |
| Approved By | Trauma Committee | 20/4/16 |
| Authorised By | Group Clinical Standards Committee | 16/06/2016 |

Purpose

The purpose of the policy is to provide clear expectations to all clinical staff regarding their responsibilities in managing patients with confirmed or suspected spinal injuries.

DEFINITIONS

- **ARV** – refers to Adult Retrieval Victoria
- **ED** – refers to Emergency Department
- **ICU** – refers to Intensive Care Unit
- **MTS** – refers to Major Trauma Service
- **PIPER** – refers to Paediatric Infant Perinatal Emergency Retrieval
- **SCI** – refers to spinal cord injury
- **Spinal injury** – refers to any injury of the spine (e.g. SCI, vertebral fracture, or ligamentous injury)

POLICY

- The Emergency Department Duty Consultant has the responsibility for all decisions on the management and disposition of Emergency Department patients. Where appropriate, these decisions should be made in consultation with other specialties involved in the care of trauma patients at Bendigo Hospital.
- All trauma patients must be assessed for their suitability for either transfer to a Major Trauma Service (MTS) or spinal service or for admission to Bendigo Health.
- All trauma patients with confirmed or suspected spinal injury must be discussed with, and their clinical imaging reviewed by, a registrar or consultant from a MTS or spinal service.
- There are four potential disposition trajectories for the ED patient with confirmed or suspected spinal injury:
 - 1) Direct transfer from ED to a MTS or spinal service for ongoing subspecialty care.
 - 2) Admission to Bendigo Health for initiation of definitive care with planned delayed transfer to a MTS or spinal service for ongoing subspecialty care.
 - 3) Admission to Bendigo Health for the entirety of definitive care.
 - 4) Discharge home or transfer to a peripheral hospital directly from the emergency department.

- The Emergency Department is responsible for arranging all urgent transfers of ED patients with spinal injuries (trajectory 1 and 2 above). Urgent transfers are to be organised through early contact with ARV or PIPER. Once the patient has been admitted to Bendigo Health, transfers are the responsibility of the treating team.
- All trauma admissions to Bendigo Health will be under the surgical bed card. This includes paediatric patients. Refer to BH [Trauma Admission & Transfer](#)
- All trauma admissions to Bendigo Health with confirmed or suspected spinal injury (trajectories 2 and 3 above), including paediatric patients, must also:
 - a) Have a formal written or verbal report of their clinical imaging made by the duty Radiologist.
 - b) Be assessed by the duty Orthopaedic Registrar.
 - This includes patients who require transfer to a MTS or spinal service where the transfer is delayed, except where the transfer would be further delayed by waiting for orthopaedic review.
 - The patient's insurance status is irrelevant to the referral process. Referrals still go to the duty Orthopaedic Registrar.
 - The duty Orthopaedic Registrar must discuss with the Consultant Orthopaedic Surgeon.
 - c) Have a spinal management plan in place. This is the responsibility of the duty Orthopaedic registrar. Interim spinal management plans may be formulated by the Emergency Department duty consultant after discussion with a MTS or spinal service.
 - d) Be considered for Acute Pain referral via the on call anaesthetic registrar.
- All decisions relating to the spinal management of the admitted patient with confirmed or suspected spinal injury are the responsibility of the orthopaedic team, in consultation with the surgical team (and Intensive Care for ICU patients).
- Intensive Care referral is mandatory for patients with confirmed or suspected spinal injury being admitted to Bendigo Health with:
 - confirmed SCI
 - neurological deficit attributable to the trauma
 - neurogenic shock
 - unstable spinal fractures
 - stable spinal fractures with other concurrent injuries
 - high-risk trauma patients (e.g. aspiration risk, bariatric, extremes of age)
- Non-ICU patients are to be admitted to wards equipped with monitoring capabilities and staff with up to date training in the management of patients in spinal precautions.
- Patients admitted to acute wards will be managed according to the spinal management plan. Staff are to refer to the BH Refer to [C-Spine Collar Sizing, Fitting and Patient Care](#) protocol for additional information on collar management.
- Interim admission orders may be used for non-ICU patients where the ED duty consultant has also put an interim spinal management plan in place.
- Patients with delayed presentations of stable spinal injury who complain of a slow progression of increasing pain and incapacity admixed with multiple medical co-morbidities are better suited to a direct medical or rehab admission with orthopaedic consultation.

Spinal Management Plan

- The Spinal Management Plan is the mandatory minimum documentation required for the admission of a patient with confirmed or suspected spinal injury to Bendigo Health. The Orthopaedic registrar must complete the spinal management plan on admission.
- The Spinal Management Plan must detail the following:
 - 1) Which spinal structure is confirmed or suspected to be injured, with an assessment of stability of the injury and any attributable neurology, e.g. *“Type 3 dens fracture, unstable, no focal neurology”*
 - 2) The clearance status of both the cervical and thoracolumbar sections of the spine, e.g. *“The cervical spine has a confirmed injury, the thoracolumbar spine is clinically and radiologically cleared”* or *“Cervical and thoracolumbar spine are not cleared due to intoxication”*.
 - 3) Directions for the nursing care of the patient’s spine. e.g. *“continue Philadelphia collar, nurse in supine position with head-up tilt of bed, log roll transfers”* or *“continue Aspen collar, nurse supine or sitting up to 45 degrees, may mobilise with assistance”*.
 - 4) The location of the MTS or spinal service (if contacted) providing clinical advice, the name of the specialist/ registrar providing the advice, the details of the advice, and the times of contact.
 - 5) Specific details of observations required, e.g. *“hourly neurological observations overnight”*.
 - 6) Fasting status.
 - 7) Suitable spinal trauma bed allocation

REFERENCES and ASSOCIATED DOCUMENTS

Bendigo Health Policies and Protocols

- [C-Spine Collar Sizing, Fitting and Patient Care](#)
- [Trauma Admission & Transfer](#)
- [Emergency Department Admissions to Inpatient Units](#)
- [Patient Transport Booking Protocol \(Excluding Psychiatric Services\)](#)
- [Spinal Trauma- CPG's](#)
- [Spinal Trauma Assessment and Management](#)

State and Commonwealth Legislation

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Standards / Codes of Practice / Industry Guidelines

- Victorian State Trauma System Guidelines. Spinal Trauma [internet]. Accessed 27/02/2016.
- Hadley MN, Walters BC. The Eastern Association of Surgical Trauma - Introduction to the Guidelines for the Management of Acute Cervical Spine and Spinal Cord Injuries. Neurosurgery 2013;72(3):s4-15.
- Consortium for Spinal Cord Medicine. Early Acute Management in Adults with Spinal Cord Injury: A Clinical Practice Guideline for Health-Care Professionals. Washington, DC: Paralyzed Veterans of America, 2008. (Scientific evidence – Guideline)

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MANDATORY INCLUSION

Personal information and health information as defined in the relevant Victorian law, which is required to be collected, used, disclosed and stored by BHCG in order to achieve the Purpose of this policy, will be handled by the Group and its employees in accordance with their legal obligations.

When developing this policy, BHCG has taken all reasonable steps to make its content consistent with the proper discharge of its obligations under the Charter of Human Rights and Responsibilities Act 2006.