Utilizing Protocols to Improve Trauma Transfer Time
Earvin L. Baker, Jr., RN, MBA, Harris County Hospital District, LBJ
Dr. Emily Robinson, Martha Stancil, Marilyn Houston, Janet Anders, Gloria Bagshaw

Problem:
Review of the Trauma Registry in a Level 3 Trauma Center for a one-year time period revealed that time for transfer to a higher level of service, such as transfer of patients with head trauma requiring neurosurgery to a Level 1 Center, was taking approximately 14 hours.

Evidence:
Best-practice guidelines established by the State of Texas identify that transfer of patients requiring a higher level of care should occur within a 2-hour timeframe.

Strategy:
The organization’s Trauma Program Committee was charged with evaluation of the Emergency Room (ER) transfer process to determine and implement interventions to decrease the length of emergent transfer time to 2 hours.

Practice Change:
Stable and Unstable Head Trauma Protocols were developed and implemented in the Trauma Center. Timeframes were established for each step of the transfer process. Transfer time data were collected and evaluated.

Evaluation:
Timeframes for five key steps in the transfer process were evaluated: (1) Time from triage to CT scan. (2) Time from CT to decision to transfer. (3) Time for development of Memorandum of Transfer and contacting Level 1 facility. (4) Time to obtaining acceptance for transfer. (5) Documentation of time from request to arrival of transportation for transfer.

Results:
Over the first 12-month period, emergent trauma transfer times decreased from an average of 14.8 hours to 7 hours (52.7% decrease) and are currently at 3.5 hours (76% decrease). The team continues to work to decrease transfer time to less than 2 hours.

Recommendations:
Trauma systems should continue the development and use of protocol driven care for the assurance of getting the right patient to the right facility at the right time.

Lessons Learned:
Collaboration of administrators, physicians, nursing staff, transportation services and referring facilities were key to success with development and implementation of the protocols. Protocols can be developed for other trauma injuries to facilitate prompt transfer whenever higher levels of trauma care are determined necessary.

Bibliography:
Committee on Trauma, American College of Surgeons. Resources for Optimal Care of the Injured Patient 2006, 2006; 27-29.
Texas Administrative Code, 25.157.125