



ADULT RETRIEVAL VICTORIA
Retrieval Physician Guidelines

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Airflight Medicine –the basics

The Effects of Altitude on Gas Volume

Boyles Law

"When the temperature remains unchanged, the volume of a given mass of gas varies inversely to its pressure."

In flight terms, as your aircraft ascends, increasing in altitude, the barometric pressure diminishes. Any gas within an enclosed space will expand. Alternatively, as the aircraft descends and barometric pressure increases, the gas will contract.

The Effects Of Altitude On Oxygen Availability

Dalton's Law: $P_t = P_1 + P_2 + P_3 + \dots P_n$

Dalton's law states "the overall pressure of a gas mixture is the sum of the individual or partial pressures of all the gases in the mixture."

In flight terms, oxygen is "thinner" in the upper atmosphere. Why? At sea level the barometric pressure is 760 mm Hg, and the atmosphere is composed of 20.95% O₂. As altitude increases, the barometric pressure decreases, and the molecules in the atmosphere move farther apart. While oxygen still comprises 20.95% of the atmosphere, there are less oxygen particles per cubic millimeter to be utilized.

Clinically, an increase in altitude diminishes the oxygen available to the body and can result in hypoxia. For instance, at 12,000 feet the barometric pressure decreases to 483 mm Hg. The composition of the atmosphere remains the same, and so the percentage of oxygen remains at 20.95 percent. However, the partial pressure of oxygen will decrease to 101.19 mm Hg.

The Effects Of Pressure Changes On Gas Bubble Formation

Henry's Law

Henry's law states "...the quantity of gas dissolved in 1 cm³ of a liquid is proportional to the partial pressure of the gas in contact with the liquid".

In clinical terms, an example of gas solubility in a liquid is decompression sickness (a.k.a. "the bends"). As a diver ascends, the pressure is decreased on the nitrogen gas dissolved in the blood. Ascending too quickly or flying within 24 hours of a dive can result in nitrogen bubble formation in the blood, which can cause dire clinical consequences. Treatment includes 100 percent oxygen and rapid descent treatment in a hyperbaric chamber and may be necessary if the symptoms do not resolve.

Altitude restriction in air transport is a consideration in only a few rare cases. When transporting a patient with decompression sickness, altitude should be restricted to less than 1000 feet above ground level. An untreated pneumothorax is an absolute contraindication to air transport. Prior to take-off, treatment with a chest tube or temporizing one-way valve system is required. Decreased flying altitude results in increased turbulence, longer flying times, and increased fuel consumption over a decreased aircraft range, consequences which must be considered when a patient requires low altitude flight.

STRESSES OF FLIGHT

In addition to hypoxia, barometric pressure changes, and thermal variations, the stresses of flight include noise, vibration, humidity/dehydration, gravitational forces, third spacing, and fatigue.

Noise

Permanent or temporary hearing loss may occur for patient or provider. The longer the exposure, and the more intense the noise, the greater the potential damage. Consequences include headaches, fatigue, nausea, vertigo, stress, and reduction in task performance effectiveness. Noise may interfere in provider communications with the patient and other crew members, and impedes the ability to auscultate the lungs, heart or blood pressure. Hearing protection should be worn by patient and crew, and includes earplugs, headsets, and helmets.

Vibration

Vibration results from the aircraft motor/rotors and can be due to turbulent weather. Vibration may result in an increase in metabolic rate, fatigue, shortness of breath, motion sickness, and an inability to properly thermo-regulate. Low frequency vibration of the eye may cause visual decrements. Vibration in general is less well tolerated in the supine position due to x-axis vibrations. Neonates are most

susceptible to direct injury from vibration and noise. Care must be taken with fractures, as the vibration may increase discomfort at the fracture site or from an inadequately padded and secured splint. Special consideration must be given to patients with electronic monitoring as in-flight vibration may interfere with invasive and non-invasive monitoring, and may cause dysfunction of activity-sensing pacemakers. Protection from vibration is essentially limited to isolating the individual and equipment from the aircraft by use of adequate padding.

Humidity/dehydration

Patients and crew flying at high altitude for prolonged flights will be exposed to very low humidity and may develop dehydration. Patients in a hot environment or with pre-existing dehydration may have an exacerbation of their condition, and attention should be paid to oral and IV fluid intake and urine output when appropriate. Additionally, respiratory secretions may become thick, resulting in less efficient gas exchange and contributing to hypoxia. Dehydration may be prevented through humidified oxygen and adequate fluid intake.

Gravitational Forces

Gravitational forces are most evident on ascent and descent, or when the aircraft changes speed or direction. Patient positioning during maneuvers may affect blood pooling and intracranial pressure. For example, in a cardiac patient it may be advantageous to position them with their head toward the rear of the aircraft during ascent, so that the G-forces help to pool blood in the upper part of the body. Conversely, in patients with intracranial injury or volume overload, a position with the feet toward the rear of the aircraft during ascent may pool fluids in the lower extremities and avoid a transient and potentially detrimental increase in intracranial pressure.

Third Spacing

Third Spacing is the loss of fluid from the intravascular space to the extravascular space in the tissues. This phenomenon is due to the effect of pressure changes and cellular increases in permeability resulting in fluid transitions. The effects of third spacing include edema, dehydration, tachycardia and hypotension. These effects may be complicated by other stresses of flight, including thermal variations, vibration, and gravitational force effects.

Fatigue

Fatigue is generally felt to be a culmination of all of the stresses of flight. Tactics should be taken by the aircrew to minimize the effects of flight and personal stresses to maximize effective performance, alertness and safety.

PRESSURIZED ENVIRONMENTS

In order to minimize the effects of barometric pressure changes and subsequent hypoxia, a controlled flow of compressed air can maintain a constant pressure in a fixed-wing aircraft. Typically the cabin pressure can simulate an 8,000–10,000 foot altitude while flying at an actual altitude of greater than 40,000 feet. Malfunction of the aircraft's pressurization system or structural damage sustained by the aircraft may result in rapid decompression. The crew must understand this emergency, and be ready to respond. A loss of pressure through a large defect results in a rush of air towards the defect. Any person or equipment not adequately restrained may be blown about the cabin or through the defect due to the development of cyclonic winds. Decompression sickness, hypothermia, hypoxia and expansion of GI tract gases resulting in decreased respiratory movements and vaso-vagal syncope can result from this loss in cabin pressure. Hypoxia is the most important immediate consequence of rapid decompression. Supplemental oxygen must first be supplied to the pilot, the crew, and then the patient or passengers. Recall that gas in medical systems will rapidly expand, and any catheters, chest tubes, NG tubes, or drains should be unclamped. Losing cabin pressure may also result in decompression sickness. This, however, is rarely a problem under 25,000 feet unless the patient has been exposed to compressed gas (i.e. scuba diving) within 24 hours of the event. The nitrogen gas bubbles can result in a decrease or blockage of blood flow to any organ system, and causes a wide variety of symptoms depending on the system affected. Treatment includes application of 100 percent oxygen and rapid descent in altitude. Unresolved symptoms will require treatment in a hyperbaric chamber.

CONFINED SPACES

A final mention should be made of the challenges of the confined space in which the crew must work. The tight quarters necessitates efficient use of space, compact equipment and conservative storage of supplies. Equipment inventory should be replaced after each transport. Advanced planning regarding patient access is also required.

Aviation resources

- The allocation of aviation resources is the responsibility of the AAV Flight Coordinator. Aviation resources may not be available due to: weather conditions, pilot duty restrictions, aircraft maintenance or performance issues, or other tasking.

Case review & Audit

- The Clinical Advisor or Director performs a document-based review of all ARV cases. Data will be extracted from the records at this point to contribute to the ARV patient record database quality indicators.
- The record is reviewed from the perspectives of compliance with documentary standards, and clinical practice standards, and screened for the documentation of adverse events or incidents that may have resulted in risk or harm.
- All cases are also screened from the perspective of logistics – assessing the smoothness of a mission, its planning and execution, and the avoidance of unnecessary delays. Cases include both patient-transfer cases, clinical-advice-only cases.

Clinical Practice Guidelines

- The Clinical Practice Guidelines developed by AV for use in the field by MICA and Flight MICA paramedics are appropriate in general scope to the range of practice of medical Retrieval Physicians. These CPG's are overseen by the Medical Standards Committee and will be the initial reference point for ARV clinical practice.
- The CPG's are guidelines and do not strictly limit the scope of clinical practice of practitioners, who in certain circumstances may reasonably work beyond or outside of the guideline. The application of guidelines will be reviewed through the case review and audit system, and appropriate feedback will be available.
- Additions to, or alterations to guidelines will occur through the processes of the Medical Standards Committee (MSC)

Command & Control

- During air missions, the pilot is responsible for the overall safety and management of logistics. In flight the pilot is in control of all resources, and is responsible for all decisions in relation to the aircraft, flight path, safe altitude etc.
- The ARV coordinator is responsible for defining time criticality of a retrieval case.
- The coordinator will determine the crew-mix that has the most appropriate skill set for a specific clinical scenario. Principle factors involved in this decision will be clinical complexity and patient instability (actual and potential).

Communication & Public relations

- The coordinator and retrieval physician must remain mindful of the need for optimal communication styles, and of communication strategies that may be applied to ensure complete and clear communication of relevant clinical and risk related matters with the referrer.
 - Always allow the referrer to complete statements – do not complete for them / put words in their mouths
 - Reflective checking is valuable: “Thank you Dr X, I understand from your statement that the patient is – is that correct?”

- Ask direct risk related questions: “Dr, Do you perceive any major risks or hazards in the transfer of this patient?”
- Leave the door open for further communication: “If you think of anything else that may be important or that arises after this call, please phone me back”
- The retrieval physician must be aware of the high visibility nature of their work, and the fact that they are often interacting with systems and individuals under pressure.
- A proportion of the work of ARV is considered ‘newsworthy’, and the involvement in cases that may be considered such should be raised with the ARV office in the first instance. The office may then liaise with press agencies via the corporate communications area of AV.
- Individual staff members must be aware of and compliant with standard AV and public service policies in regard to confidentiality and release of material to the media.

Contact and Availability

- The Retrieval Physician will be contacted by the ARV Call Taker, by phone.
- The Retrieval Physician will be available to discuss the case with the ARV Coordinator within 5 minutes.
- All phone contact will occur via **1300 368 661** to enable voice logging for quality assurance processes.
- Calls to the referring hospital should be minimised. Requests by the retrieval physician for additional information, insertion of lines or preparation of drug infusions should be made through the ARV Coordinator, or by teleconferencing all involved parties. If the ARV Coordinator is coordinating multiple concurrent tasks he/she may ask the retrieval physician to communicate directly with the referrer.
- The Retrieval Physician will at all times communicate in a professional manner, respectful of the circumstance of the referrer, the stressful nature of critical incidents, and the role of ARV and MAS in the State Health System.
- The Retrieval Physician, in conjunction with the RASO and ARV Coordinator should ensure that both the referring and receiving hospitals are informed of the estimated time of arrival (ETA) of the retrieval team. The retrieval physician should inform the RASO of ETAs on departing and arriving back at Essendon. (Or on departing the referring hospital for road missions.)

Credentialing

- Credentialing of retrieval staff occurs on an annual basis as a component of the performance management interview.
- Credentialing will be performed by the Clinical Advisor or Director and recorded in the staff HR file.

Death of Patient

- All patient deaths during the care of an ARV physician must be notified to the Coordinator at the earliest possible opportunity.
- Deaths occurring in a metropolitan based vehicle (including Air, HATS and CPAV) must be notified to the Duty Team Manager at Tally Ho. (RASO will arrange). Deaths occurring in a regionally based vehicle must be notified to the appropriate control room. This will facilitate an appropriate destination for the body.
- The coroner should be notified in appropriate circumstances.
- Peer support is available to all staff involved in the care of a patient who dies during transfer.
- The deceased’s family will need to be notified of the death.

Debriefing

- Retrieval physicians should take the opportunity to formally or informally discuss and debrief each mission with other team members after each case. This presents a mechanism to acknowledge good practice, highlight communication and to look for improvement opportunities.

Documentation

- All cases will be documented on the Ambulance Service Patient Care Record. The red sheet will remain with the patient. The other 2 copies will be forwarded to ARV (using prepaid envelopes) within 24 hours.
- Guidelines for completion of the form have been distributed.

Equipment

- Daily checking of drugs and equipment (responsibility of the 0800-1800 retrieval consultant)

EQUIPMENT AND DRUG CHECKING

OCCURS DAILY AT 0800HRS & AFTER THE COMPLETION OF EACH RETRIEVAL

RETRIEVAL KITS

- There are 4 kits in total to check
- The day shift Retrieval Physician– will check **ALL** Biomedical equipment and the RED and BLUE bags and the YELLOW drug bag.
 - An **equipment checklist** must be completed for each kit and anything found missing can be sourced from the medical / equipment storeroom. The completed checklist should be left with the kit. Anything used during retrieval should be annotated on the list to facilitate restocking.
 - **Restocking** - when restocking items, if there is found to be 2 or less of a particular stock item remaining in the storeroom, you must flag that item for ordering.
 - **IN HOURS** - contact the ARV Business Manager. The BM will attempt to source the required item – however if it is 'out of stock', there will be a time lag between ordering and delivery. If the BM is not available, a message left with the ARV Admin Assistant will be passed on.
 - **AFTER HOURS** – write the item description on the whiteboard in the storeroom and it will be ordered on the next business day.
- Drug Bag
 - All expiry dates for drugs in the packs must be checked on the first of every month.
 - For drugs which are normally refrigerated, **the date when they should be discarded should be recorded on the ampoule.**
 - This would normally be 1 month for suxamethonium, 3 months for rocuronium and pancuronium.
 - Replacement Drugs can be obtained from the drug cupboard. Restricted items are held in the drug safe – and must be checked in & out by two people. This can be done by a FP &/or a MFP, and / or the FC.

BIOMED EQUIPMENT

- **Ventilators** should be checked using a circuit & test lung with O2 cylinder located in storeroom.
- **Monitors** should be turned on and attachments checked.
- **Syringe** driver battery level must be checked.
- **ZOLL monitor with external pacing** should be tested.

- **iSTAT analysers** – calibrated weekly

FAULTY BIOMED EQUIPMENT

- All ventilators, monitors and syringe drivers must be on charge while in the storeroom.
- Any equipment malfunction must be recorded **in the Maintenance Request/Defect Report book** located in the storeroom. The faulty equipment and the completed paperwork is to be given to the ARV Business Manager (BM) in hours, and after hours the equipment and paperwork should be placed in the ARV main office and an email sent to the BM. This will be followed up on the next business day.
- Under no circumstances should faulty equipment be left in the packs or put back on the shelf.

ON RETURN FROM A RETRIEVAL

- On completion of a mission the kit must be returned to base and restocked by the retrieval physician so that it is **immediately task ready**.

Handover

- A clinical handover includes the presentation of relevant history, examination and investigations. It should also include current clinical progress, including patient response to any interventions performed.
- The number of handovers should be minimised to reduce the risk of important information being 'lost'.
- All members of the 'receiving' team should have access to the handover. At the referring hospital, this includes the retrieval physician and the paramedic. At the destination hospital this includes medical and nursing staff. The 'destination' handover should be documented on the patient care record.
- The handover should occur in a manner that is safest for the patient and most efficient for staff. In general, this is whilst the patient is on a hospital bed, as opposed to an ambulance stretcher. The patient is attached to a ventilator with by piped oxygen; syringe pumps and monitors can be connected to mains power. In an unstable patient, sufficient information to facilitate resuscitation may be given initially, followed by a more complete handover as the situation evolves.
- At these handover interactions, retrieval physicians are the visible face of Ambulance Victoria and Adult Retrieval Victoria. Professional behaviours are expected.

Incident reporting

- The purpose of the ARV Incident Report is to record any issues, unusual situations or variations to normal practice relating to adult retrieval activities across the state.
- A multidisciplinary group will review the information captured on this form. This will ensure that circumstances around an identified case are explored, any suggested actions are considered and improvements to the system are introduced if required.
- Feedback regarding outcome of a report will be provided to the reporter in all cases.

Issues and Problems

- **Issues or problems** which may arise must be handled in a collegiate and professional manner, with the patient well-being and clinical outcome the over-riding consideration. Issues that cannot be simply resolved must be **escalated** to the Coordinator in the first place, and if necessary to the Director ARV or the Clinical Advisor ARV.
- Any issue or event which exposes the service or a patient to risk or which results in harm to staff, public or patient must be reported via the **ARV Incident Reporting** framework

Leave

- Applications for leave should be submitted in advance to the Admin Officer ARV. Please note that ARV will aim to accommodate all leave requests in line with other (external) employment arrangements that RP's may have, however this is not able to be guaranteed, and there may be times when restrictions are placed on the availability of leave.
- Provision of 6-8 weeks notice for leave requests is required.

Morbid Obesity

- Patients with morbid obesity (arbitrarily defined as: weight over 140kg, or BMI over 45) who require mechanical ventilation for management of pulmonary pathology, or who require mechanical ventilation and have other significant co morbidity, should routinely be crewed by ARV doctor and Paramedic MICA if available. These patients must be considered clinically very complex and at significant risk for transfer.
- It is not possible to lift **patients over 120kg** into the current fixed wing aircraft due to loading equipment limitations. This does not relate to rotary wing aircraft where patients over 120kg may be considered for transport on a case by case basis.

Night transfers

- Transfer must never be delayed in a time critical patient. (This includes patients with significant risk of deterioration during the time delay).
- Non Time Critical aviation transfers should not occur after midnight (air crew fatigue and human factors issues).
- It is imperative that the skill set and capacity to provide ongoing care at the referral site is factored in any decision to delay a transfer.
- All cases where transfer at night is delayed will be specifically audited.

Patient preparation and packaging

- Depending on sending hospital resources and expertise, patients may require little or extensive interventions by the retrieval team before they are suitable to be transferred. Requests to the sending hospital e.g. drugs pre-prepared in 50ml syringes should be made through the coordinator.
- It is not possible to lift patients over **120kg** into the current fixed wing aircraft due to loading equipment limitations.
- Patients with **IABP or ECMO** require retrieval by a RP by road (transfer by fixed wing is possible). A private perfusion service is available to assist. Retrieval Physicians should not attempt these missions without the aid of staff familiar with the operation and troubleshooting of this specialist equipment.

Performance Management

- Retrieval physicians will participate in yearly performance reviews which will be performed in accordance with [AV](#) policy, and which are modified to ensure relevance and appropriateness to medical staff.
- The performance management system also defines the general scope of practice of the retrieval physician.
- Retrieval physicians will be expected to maintain a general level of health and physical fitness appropriate for the physical requirements of their work and the retrieval environment.

Retrieval Logistics

- Both Road and Air departure points will normally be from Essendon Airport (AAV), where all ARV equipment is stored and maintained. Equipment is not to be sent unescorted by taxi due to safety issues surrounding the transport of drugs.
- Early activation is imperative to optimise system efficiency and responsiveness. Activation may occur prior to the known availability of a destination (receiving) hospital. Retrieval physicians may be despatched before the coordinator is able to give full details of the task.
- Activation includes early communication with all resources / platforms: AAV, Regional Ambulance Control rooms, Metropolitan Ambulance Clinicians, DTM (for CPAV) and NPT (for HATS.)
- ARV departure response times of less than 30 minutes will be aimed for where possible, and all activation delays greater than 60 minutes will be audited.
- It will therefore normally be impractical for retrieval physicians to be on call from a site that is more than 15(-20)km from the metro centre or Essendon airport.
- Retrieval physicians may respond to base by private vehicle or taxi, however taxi fares will cover only responses within the general distance guidelines above.
- Recall times commence at the active commencement of a mission (leaving a site of recall), and do not include advanced warning of (planned delayed onset) missions.
- At present, metropolitan public hospitals are expected to provide a medical escort for transfers. (Exceptions are Weribee Mercy, Williamstown, Sandringham, Angliss, Casey and Private Hospitals). ARV may provide retrievalist support to other metro hospitals on consideration of the case by the Director or Clinical Advisor ARV.
- The retrieval physician is part of a retrieval team. They bring a certain skill mix, which is supplemented by the skill mix of the (MICA) paramedic.
- AV has a zero blood alcohol policy for all active staff.
- Tarmac Handovers are generally inappropriate, and patients should be retrieved from a hospital setting. This allows for controlled handover, assessment of the patient, checking of all equipment, connections, placements etc. All tarmac handovers will be considered a variation and audited. (Exceptions may exist e.g. an uncomplicated AMI being transferred urgently for PCI – in such a case the risks associated with tarmac handover are low, and the time benefit may be great)

Road resources

The current options for road transport platforms include – emergency ambulance, CPAV, HATS, non-emerg vehicle. Due to current staffing and crewing structures the standard approach to road vehicle choice is as follows:

- ⇒ HATS (with driver + Crit Care Nurse crew) is preferred option during periods of availability, and if response time is appropriate, unless
- ⇒ ARV Coordinator contacts HATS in the first instance as this is the preferred resource for ARV retrievals
- ⇒ If HATS is not available the ARV Coordinator contacts the **Clinician**
- ⇒ In consultation with the ARV Coordinator the **Clinician** will provide the most appropriate resource to accomplish the retrieval. In most cases this will be an AGP with at least one ALS qualified paramedic aboard
- ⇒ If the ARV Coordinator determines that the retrieval requires MICA skill sets to assist the retrieval physician (uncommon), the **Clinician** will organize a CSO/SRU to accompany or a MICA vehicle to do the transfer
- ⇒ The **Clinician** may consider the use of a CPAV or Netcomm vehicle if they are able to resource either unit with an ALS qualified or MICA paramedic
- ⇒ If required, the ARV Coordinator can liaise with the Clinician to determine clinical requirements prior to contacting the **Clinician** to organize the retrieval

Activation of HATS is performed via Coordinator contacting NPT (private ambulance service) on 1300 628728 (The RASO will fax a booking form to Netcom also).

Duty Team Manager AV - 1300 551 624

Safety

- Recurrent aircraft safety training will have a positive impact on flight crew emergency preparedness. Aircraft loading and unloading competency is vital to safe operations on scene, at helipads, and at airports. Mission profile, patient acuity, and aircraft performance all impact the decision to perform hot or cold loads and unloads.
- In addition to aircraft safety, crew and patient safety must be considered. Once the patient and equipment have been secured on-board the aircraft, the air medical crew must ensure access to the patient for any interventions that may be required at altitude.
- Safety considerations and aircraft operations are essential components in the initial training and continuing education of all personnel working in and around rotary-wing and fixed-wing aircraft. The perspective and knowledge of an experienced pilot is a critical factor in the training of air medical crew members
- The flight crew members must work collaboratively with other services, including ground ambulances to assure that all actions in and around the aircraft are safely carried out.
- In general, ARV is not involved in “hot” loading or unloading .The pilot is responsible for providing security of the main and tail rotors during all load/unload operations.
- A helmet should be available for the Retrieval physician when flying in a helicopter.

Staff Welfare

- The nature of retrieval and coordination work can be stressful and difficult. Ambulance Victoria offers all staff access to peer support and counselling services. These may be accessed by individuals or via ARV management
- Peer Support: contact via Corporate Paging (for duty peer support officer) 9483 8009; Phone: 0419 002 956 Email: peer.support@mas.vic.gov.au
- Counselling Service: Ms Heather Bancroft, VACCU
Phone: 9654 4144 Email: clinical.director@vaccu.com.au

Team Performance

Successful retrieval missions are dependent upon the performance of the **team**.

Cooperation, communication, diplomacy, respect and empathy are vital.

- **Team Performance = Skills x Behaviour**

Trauma System

Adult Patients

- Ambulance services should triage adult major trauma patients and suspected adult major trauma patients directly to an adult Major Trauma Service (The Alfred and the Royal Melbourne Hospital), when the travel time is less than 30 minutes.
- If a Major Trauma Service is not within 30 minutes travel time, then the patient should be triaged to the next highest-level trauma service within 30-minute travel time, from the accident site.

Specialist Trauma Triage and Transfer

1. Hospitals with neurosurgical specialities should manage neurotrauma patients requiring critical care support.
2. Major trauma including spinal trauma should initially be triaged to a Major Trauma Service. Early consultation by each treating hospital with the Victorian Spinal Cord Unit at the Austin Hospital is essential to optimise patient outcomes.
3. Discrete spinal cord injured patients over 16yrs of age, in the absence of other indicators of major trauma, should be triaged to Austin Health’s, Victorian Spinal Cord Service by telephoning (03) 9496 5000 and asking for Spinal Unit Acute Registrar.

4. Multiple trauma, incorporating the need for microsurgery, should be referred and transferred to a Major Trauma Service. St Vincent's Hospital also have capacity as leaders to manage injuries requiring microsurgery.
5. Neurosurgical triage and transfer guidelines for major trauma still apply in rural areas, even where a neurosurgical specialist practises locally, as the management of these patients requires all the appropriate and agreed service supports of a Major Trauma Service.

Major Trauma Triage Guidelines Require:

6. Pre-hospital major trauma to be identified according to specified physiological and anatomical criteria.
7. Triage to a Major Trauma Service where a major trauma patient is less than 30 minutes transport time from a Major Trauma Service.
8. Triage to the highest designated trauma service accessible in 30 minutes where a major trauma patient is more than 30 minutes transport time from a Major Trauma Service.
9. Triage to a designated trauma service accessible in the least amount of time in isolated rural areas that are more than 30 minutes from any trauma service.
10. Where a major trauma patient appears to be in an immediately life-threatening situation during transport, the patient be diverted to the nearest designated trauma service for stabilisation, with subsequent transport to a Major Trauma Service at the earliest appropriate time.
11. Where a patient is triaged initially to a non-Major Trauma Service for stabilisation, early liaison with the Major Trauma Service should occur via the Trauma Advice and Referral telephone line 1800 700 001, which is answered by ARV calltakers. Consideration of appropriate medical retrieval or interhospital transfer to a Major Trauma Service can then occur from the initial call.