Diversion Criteria

POLICY

THE RULE

1. Critical care diversion declared: penetrating head/neck/chest/abdomen/pelvis injury, amputation proximal to wrist or ankle, GCS < 13, SBP < 90 adult (< 60 pediatric), focal neuro deficit within 3 hours, STEMI, patients needing intubation, and post-ROSC go to the next closest appropriate facility
2. Trauma diversion declared: the trauma list above (minus STEMI and post-ROSC) goes to the next closest appropriate facility
3. ED diversion / closed to EMS: every patient bound for that facility diverts to the next closest appropriate facility
4. Once you have given report and been accepted by a facility, you continue there — later status changes do not divert you
5. Burn divert (Mercy): ground units continue to Mercy — Springfield for burn surgeon evaluation; outlying services consider direct air transport to a designated burn facility

WHY IT EXISTS

To reduce confusion, promote consistency, and speed patients to definitive care (Policy 2-10)

APPLIES WHEN

- Mercy EMS ground units transporting patients, whenever a hospital declares critical care, trauma, or ED diversion

EXCEPTIONS & EDGE CASES

- Diversion is a request, and in most cases should be honored
- If the patient refuses the alternate destination after being told the reason and what each hospital can and cannot provide, continue transport and report to the hospital
- Concerns: consult Medical Control, EMS leadership, or the EMS Medical Director

DOCUMENT IT

- Document the declared diversion, the facility you contacted, and acceptance
- If the patient refuses diversion, document that they were informed and chose to continue

Take Home Message:

Know which list your patient is on before you arrive: diversion category decides destination — and an accepted report locks it in.