PRACTICE GUIDELINE

Effective Date: **1-23-04** Manual Reference: **Deaconess Trauma Services**

TITLE: RESUSCITATION ROLE ASSIGNMENTS

PURPOSE:

- To clearly define the roles, responsibilities and performance improvement activities of the members of the Trauma Team.
- To provide optimal patient care by defining specific responsibilities for each member of the trauma team.
- To define educational requirements for each unit caring for trauma patients and outline monitoring/reporting requirements.

GUIDELINES:

A. For a resuscitation to be sufficient, every member of the team should understand his/her particular responsibilities. These should be organized into tasks to be completed before the patient arrives and during the initial assessment and evaluation of the trauma patient.

B. The assignments of roles as outlined below are provided to prevent confusion while caring for patients with multi-trauma. The Trauma Performance Improvement Nurse or designee will respond to Category I trauma activations when available to help with this process.

C. Personnel on the trauma team for each level of activation is listed below:

Category I:

- Trauma Surgeon
- Emergency Physician
- Trauma Advanced Practice Clinician (APC) (when available)
- Anesthesiologist (based on airway needs)
- Trauma Nurse(s): Primary(Recorder) & Secondary
- Emergency Department Technician/Patient care tech
- Lab & Blood Bank Personnel
- Respiratory Therapist
- Radiology Technologist / CT Technologist
- Chaplain
- OR Charge Nurse
- Trauma Intensive Care Charge Nurse
- Assistant Director of Campus Operations (ADCO)

Category II:

- Emergency Physician
- Trauma Surgeon (at the discretion of ED physician)
- Trauma Nurse(s): Primary (Recorder) & Secondary (based upon patient acuity)
- Emergency Department Technician/Patient care tech

D. ROLES / RESPONSIBILITIES & PROCEDURES:

TRAUMA SURGEON:

- Captain of the team, leads resuscitation
- Trauma surgeon will respond to all Category I activations within 15 minutes of notification. The trauma surgeon often arrives prior to the patient and thus acts as the primary provider.
- Trauma surgeon will respond within 6 hours for Category II activations. ED physicians will routinely evaluate the trauma patient prior to activation and trauma surgeon consultation.
- If trauma surgeon arrives after patient arrival, he/she will communicate with the ED physician to establish patient report and begin primary and secondary trauma patient assessment. Thereafter, the trauma surgeon will work collaboratively with the ED physician as needed.
- If trauma surgeon arrives prior to patient arrival, he/she will begin primary and secondary trauma patient assessment and ask for ED physician assistance as needed, especially with resuscitation needs.
- If at any time the trauma surgeon is not present in the ED with the Category I or Category II trauma patient, the ED physician is responsible for oversight of care.
- Removes backboard after completing secondary assessment upon rolling patient to assess the back. The order for spine clearance should be entered by admitting physician to ensure appropriate spine care provided on admission.
- Splints and dressings should be removed and injuries assessed with secondary assessment. All open fracture wounds should be reported immediately to the on call Orthopedic surgeon for further assessment.
- Trauma surgeon notifies ED recorder of arrival time (this function is completed by the Unit Secretary and/or the ED RN).
- Trauma surgeon is responsible to assist phlebotomy, respiratory therapy and/or ED staff to obtain blood specimen timely by performing a femoral stick if blood draw of a trauma panel and baseline ABG if unsuccessful after first attempt by any staff; especially on Category I patients.
- Once stabilized via ATLS protocols, trauma panel and portable chest x-ray completed, triage of patient begins – either to CT scan, OR, or to Trauma ICU/floor. Goal is to have all Category I patients out of the ED within 2 hours and Category II patients within 4 hours.
- If patient is unstable needing emergent surgery to stabilize, trauma surgeon is responsible to notify surgery immediately of the need for surgery suite and resuscitation resources. Trauma surgeon should not triage patient to the Intensive care unit prior to OR for resuscitation needs. This should be completed in the OR.
- Trauma surgeon will follow patient to OR for emergent surgery/resuscitation; to CT scan for timely diagnostic studies/results; to STICU to report to primary RN and complete trauma admission orders.
- Trauma surgeon will make contact with patient's family prior to leaving the patient's bedside.
- Trauma surgeon must accompany unstable patients and manage resuscitation in cath lab, radiology, or other specialty area, unless anesthesiologist is available to manage resuscitative efforts.

EMERGENCY DEPARTMENT PHYSICIAN:

- Co-captain of a trauma resuscitation, leads resuscitation if trauma surgeon is not available or present.

- Aids in assisting ED staff with determining if trauma activation is needed and at what level. The appropriate level of activation is determined from criteria communicated by EMS, referring facility staff, or patient report. Trauma Services tracks all under/over activations monthly and reports to Trauma Operational meeting.
- ED physician (or ED RN) is required to activate the trauma system within 10 minutes of patient arrival to the ED for Category I patients. Therefore, primary and secondary assessment is critical to be timely.
- In the event that the trauma surgeon is not immediately present during a Category I activation, the ED physician is responsible for the initial assessment and ongoing resuscitation and care until the arrival of the Trauma Surgeon in the ED. Category I patients should remain in the ED for evaluation by the Trauma Surgeon. In the event that it is deemed necessary for these patients to undergo emergent imaging prior to assessment by the Trauma Surgeon, the patients should be properly monitored and accompanied by the trauma response team.
- Category II patients are initially cared for by the ED physician. The trauma surgeon is either consulted to see patient on the floor or the patient is upgraded to a Category I and the trauma surgeon immediately responds to the ED.
- Category II patients are "worked up" by the ED physician and triaged appropriately. The ED physician is responsible for contacting the trauma surgeon for patient report prior to the patient leaving the ED. The ED physician is responsible for writing trauma admission orders, including spine clearance, pain medication, activity and diet orders.
- Removes backboard after completing secondary assessment upon rolling patient to assess the back. May elect to "clinically clear" cervical spine and remove c-collar. The Primary ED RN should record this time.
- Splints and dressings should be removed and injuries assessed with secondary assessment. All open fracture wounds should be reported immediately to the on call Orthopaedic surgeon for further assessment.
- ED physician is responsible for admitting the trauma patient to the appropriate service. All non-surgical admissions and inappropriate transfers are monitored and tracked as PI by Trauma Services. The ED physician is held responsible for inappropriate admissions and transfers.
- Emergency Department will be staffed by a board certified emergency department physician (ABEM or AOBEM) 24 hours a day, ED physicians not meeting this requirement may work in the ED as a second or third physician, but may not staff the ED independently. According to Illinois regulations, physicians not boarded in emergency medicine should not manage trauma patients.

TRAUMA ADVANCED PRACTICE CLINICIAN

- 3rd in command, will assist the resuscitation with the Trauma Surgeon and/or the ED physician

ANESTHESIOLOGIST:

- Refer to Anesthesia Trauma Call Panel Process guideline for Anesthesiologist role.

TEAM LEADER/ED CHARGE NURSE:

- Notifies the ED triage nurse of a pending trauma patient arrival; EMS report; the level of activation required; and the patient's room number.

- Facilitates the arrival of the trauma activation packet to the triage nurse; the notification/documentation sheet to the secretary; and the documentation process of patient information on the trauma activation log.
- Nursing staff assigned to trauma rooms will give other patient care responsibilities to other nursing staff.
- Assesses the number of personnel who respond to the trauma room, and assist with limiting numbers to those directly involved in care.
- Assists the trauma nurses, as requested, with communication of information to OR, Lab, Blood Bank, Radiology, and Chaplain.
- Coordinates the assignment of the critical care bed with patient placement.
- Participates in the arrangements for transfer & reviews all EMTALA forms for accuracy and completion of documentation.
- Communicates all pertinent information to the trauma team.
- Category I patients should be taken from ED or CT scan to OR or ICU. Patients should not return to the ED after CT scan. Category I patients must be accompanied by the ED RN to radiology department.
- At least one licensed Trauma Nurse Specialist (TNS) will staff each shift in the ED. (See Educational Requirements guideline for further detail).

PRIMARY ED NURSE - RECORDER:

- Remain at patient's bedside and direct/supervise all non-physician personnel.
- Monitors effects of medications/treatments and will communicate patient response to the ED physician.
- Prioritizes team member's actions in the trauma room; collaborate plan of care and orders with ED charge nurse/team leader.
- Remains with patient until transferred to another unit and gives report to the staff assuming care.
- Responsible for the completion of the trauma flowsheet and other required paper work. The Trauma Flowsheet must be completed on all Category I activations.
- Assures that the trauma patient is admitted to a trauma surgeon and is placed in the Trauma Intensive Care unit when appropriate.
- Receives the trauma activation packet from the charge nurse; will place the trauma activation number on the patient's door; and will ensure the trauma patient has been properly identified and banded with the trauma activation number.
- Documents assessments, tests, and interventions on the trauma flowsheet from the time of patient arrival to discharge from the ED.
- Allows an uninterrupted 60-second time period for EMS to give patient report to the trauma team and will then brief team members on pertinent history and mechanism of injury.
- Assures chain of custody for specimens collected for forensic purposes.
- Serves as the communication center: communicates patient status to ED Team Leader/Charge nurse, OR Charge Nurse, and Chaplain and will receive calls from the Trauma Surgeon and OR charge nurse.
- Responsible for releasing members of the trauma team when he/she feels it is appropriate.
- RN will ensure the trauma surgeon records orders for labs, radiology exams, medications, etc. on the pink order sheet for Category I patients in the ED. Pink order sheet will be taken with the patient to CT scan and should be left there for scanning.
- Communicates current patient status to team members including all physicians; will assure signing of all necessary consents (special procedures, surgical consents, EMTALA paperwork, trauma flowsheet, blood consents, etc.) and will

assure patient ID/name bracelet is on patient's wrist once patient's name has been verified.

- The trauma patient's disposition from ED will be monitored as part of the trauma performance improvement process.
- RN to assure a complete trauma panel is drawn by lab and urine is sent for drug screen for all Category I patients. If this is not completed in ED, this is communicated to the primary RN at patient's final destination.

SECONDARY ED NURSE:

- Prepares the trauma room with appropriate trauma resuscitation equipment including personal protective equipment (goggles, masks, gowns, gloves) and lead aprons. Assures that lead aprons are available and being utilized by the trauma team members in the trauma room while x-rays are being performed.
- Performs primary/secondary surveys and will relay findings/interventions to the recorder.
- Monitors vital signs, ongoing neuro assessments, and establish an initial B/P manually.
- Assures that two large bore peripheral IVs have been established and are patent; facilitates staff with blood draws as needed; and will use approved techniques for forensic specimens. For unstable trauma patients (i.e. Category I), vital signs should be obtained every 15 minutes while in the ED.
- Splints and dressings should be removed and injuries assessed with secondary assessment. All open fracture wounds should be reported immediately to the on call Orthopedic surgeon for further assessment.

ED TECHNICIAN/PCT:

- Documents the activation and arrival of team members on the trauma flowsheet including all physicians.
- Assures that all trauma team members sign and document the time of their arrival to ED on the trauma activation board.
- Performs a 12 lead EKG on all Category I patients with blunt trauma.
- Performs other duties as directed by the Primary RN.

CLINICAL LABORATORY:

- Responsible for acknowledging the trauma pager when activated & immediately sends a Phlebotomist to the Emergency department. Documents arrival time on the flow sheet in ED.
- Upon receipt of the trauma specimens, Chemistry, Hematology, and Microbiology will make trauma a priority by processing and analyzing these samples according to stat protocols.
- The results will be transmitted to the ED via electronic medical record or down time slips. Critical values will be resulted according to policy.
- Maintains/documents chain of custody for specimens according to established policies.

PHLEBOTOMIST:

- Personnel will document their arrival time and name on the trauma activation board in ED upon arrival.
- Responds immediately to the ED for all Category I trauma activations.
- Assures ID band is in place before labs drawn. The phlebotomist will draw a specimen for type specific/cross match and will apply the blood band at this time.

- Collects the necessary blood specimens for all Category I activations. The Trauma Lab Panel includes is required for all Category I activations. Additions or exceptions to the trauma panel may be made by verbal physician order. If blood draw is unsuccessful after first stick, notifies trauma surgeon or ED physician to obtain blood from a femoral stick for a trauma panel and baseline ABG for Category I patients.
- Specimens will be labeled with identification number, time, date, and initials of the personnel who have collected the blood specimens.
- Maintains/documents chain of custody for specimens according to established policies.
- Communicates status of lab draws to recorder.
- Stays available for additional draws until released by the recorder.

BLOOD BANK:

- Responsible for keeping the trauma pager with them at all times. Upon activation, acts immediately to provide blood for the trauma patient in the Emergency Department.
- Documents their arrival time and name on the trauma activation flow sheet in the ED upon arrival.
- Responds to all Category I activations with 4 units Type O uncrossmatched PRBCs for emergency release. This will be brought to ED in an appropriate cooler ready to be administered upon the trauma patient's arrival.
- Responsible for assisting ED, OR, or ICU staff with the initiation of the massive blood transfusion protocol as they notice significant use of blood products within a short resuscitation time period.
- Will not respond to Category II activations unless the trauma patient's condition changes requiring that the activation is upgraded to a Category I.
- Upon the receipt of the trauma specimen, personnel will make trauma a priority by performing a Type and Crossmatch for 4 units of PRBCs according to stat protocol.
- Responsible for retrieving the uncrossmatched blood from the Emergency Department trauma room if not needed or used.
- The Blood Bank will be monitoring massive transfusion protocol compliance and trauma room arrival procedures that are in place with ED registration staff to ensure there are no delays. This will be reported at Trauma Operational Committee.

CT TECHNICIANS:

- Notifies ED via telephone within 3 minutes that activation was received over trauma pager and currently triaging patients to open a CT scanner.
- When the patient arrives to CT scan, the orders written on the pink order sheet for Category I patients will be verified and entered into the electronic medical record. Pink order sheet will be kept in the CT are for pickup by ED quality analyst.
- When CT scans are completed, ensures that the films are available to the Radiologist for immediate interpretation.
- The time of the CT scan to results will be monitored as part of the trauma performance improvement process by the Radiology leadership team.

RADIOLOGY TECHNOLOGIST:

- Documents arrival time and name on the trauma activation board in ED upon arrival.

- A Trauma Radiology Panel is available to be ordered for trauma patients for easy and quick computer access. The Trauma Radiology Panel is not an automatic order.
- Responds immediately to ED for Category I trauma activations with a portable x-ray machine prepared to complete all films stat upon patient's arrival to ED.
- Assures that lead aprons are available and being utilized by the trauma team members in the trauma room while x-rays are being performed.
- Obtains films immediately as ordered. The technologist will not remove any immobilization devices from the trauma patient. If immobilization devices prohibit adequate visualization of the cervical spine by x-ray films, the immobilization devices may be removed to complete the x-ray ONLY if manual cervical stabilization is maintained by trained personnel. Manual cervical stabilization must be maintained until cervical immobilization devices are re-secured properly by trained staff. The immobilization devices may be permanently removed ONLY when the cervical spine is cleared by the ED physician or Trauma surgeon.
- Radiologic images are digital and will be placed in electronic medical record.
- Communicates status of x-ray order completion to the entire trauma team.
- Available for additional x-rays until released by recorder and no further x-rays anticipated.

RESPIRATORY THERAPIST:

- Documents their arrival time and name on the trauma activation board in ED upon arrival for all Category I activations.
- Responds immediately to ED for all Category I trauma activations with a ventilator that is capable of continuous monitoring of ETCO2. ETCO2 monitoring is required for all patients with cuffless tubes, head injury, or where there is high risk for tube dislodgement throughout hospitalization. ETCO2 monitoring should be documented on respiratory therapy care sheet hourly for TBI patients. ETCO2 should be documented and utilized with confirmation of ETT placement on initial intubation. ETCO2 should also be documented, monitored, and utilized with BVM ventilation with appropriate measuring device. RT should consider using ETCO2 when transporting a patient throughout the hospital for testing or procedures to monitor tube placement. A portable ETCO2 monitor is housed in ED for such transports.
- Assists with airway control/ventilation/intubation. Assures availability of suction, intubation equipment, and bag-valve-mask.
- Assesses airway patency and secures endotracheal tube.
- Assesses adequacy of ventilation/oxygenation via ventilator or bag-valve-mask; supplies supplemental oxygen as needed; and performs manual ventilation as needed.
- Draws arterial blood gases from a peripheral site. If unable to obtain blood after the initial stick, notifies the trauma surgeon to do femoral stick to obtain blood timely. All Category I activations automatically require arterial blood gases to be drawn since this is part of the trauma lab panel.
- If the trauma surgeon or ED physician directs the RT not to draw an ABG, the reason for this should be recorded in the electronic medical record.
- Communicates the patient's respiratory status (including ventilator settings) to the recorder.
- Coordinates ventilator set-ups for other areas the trauma patient is to be moved; prepares oxygen tank and portable ventilator for transport; and assists in transport of the intubated/ventilated trauma patient.

- Remains with the trauma patient until the patient is admitted to the appropriate unit.
- May be excused by the primary RN if the patient is not intubated and no further respiratory interventions is needed.

CHAPLAIN:

- Responds immediately for all Category I trauma activations. If during normal business hours, the Chaplain will respond in person to the ED. If Chaplain responds in person, (s)he will document arrival time on trauma flowsheet. If after hours, the Chaplain will call the Assistance Director of Campus Operations (ADCO) to see if immediate presence is required.
- For all Category II, the Chaplain will not respond to ED unless notified by pager that their assistance is requested or needed.
- If requested, will contact family members and/or clergy from the patient's home congregation.
- If requested, meets family members and provides appropriate waiting area for patient confidentiality and privacy.
- Assists with communication between primary ED RN, patient/family, and/or ICU/floor/OR staff.

OPERATING ROOM:

- Acknowledge the Category I trauma activation by calling the ED for time to be recorded. Staff immediately prepares for the anticipated need for an emergent OR suite.
- Identify an operating room to be prepared to receive the trauma patient within 30 minutes. The patient should be in the operating room within 30 minutes from book time for an emergent surgery. This turnaround time will be monitored as part of the trauma performance improvement process and be reported at Trauma Operational monthly; these emergent surgeries include emergent craniotomy for acute hemorrhage, emergent exploratory laparotomy for a hemodynamically unstable patient, pelvic stabilization for hemodynamically unstable patient, and penetrating wounds that require emergent exploration, or any other trauma patient needing emergent surgery. Elective operations will be postponed to hold an operating room open for an emergent case determined by the trauma surgeon.
- An operating room must be adequately staffed (RN and CST) and available within 15 minutes (not including anesthesia, see anesthesia call panel guideline). A surgery staff team is in house 24 hours a day.
- Anesthesia must arrive within 30 minutes of notification of emergent surgery (See Anesthesia Trauma Panel).
- If the first operating room is occupied, an adequately staffed additional room must be available. The surgery trauma call team (RN and CST) will be available in house within 30 minutes.
- The trauma surgeon will be responsible to notify the OR charge nurse that the OR surgical suite will be needed. He/she will also be responsible to release the OR surgical suite if it is no longer needed and was already scheduled.
- Confirm the need for the anesthesiologist; arrange operating room staffing; notify PACU; and order necessary equipment and supplies for anticipated procedure(s).
- Obtain needed information from the trauma surgeon that has assessed the trauma patient in the ED.
- If the surgical team is available, one staff member and/or anesthesiologist may report to the trauma resuscitation room in ED or CT scanner to assess the patient and surgical needs.

- The trauma surgeon, OR staff, and anesthesiologist response time to the operating room will be monitored as part of the trauma performance improvement process and be reported at Trauma Operational monthly.
- The turnaround time from the time the trauma surgeon schedules an emergent case in surgery until the patient arrives in surgery from ED will be monitored as part of the trauma performance improvement process and be reported at Trauma Operational monthly.
- PACU staff after hours must be available within 30 minutes from being called in to arrival.
- Patient may recover in ICU post-operatively if remaining on the ventilator.

TRAUMA INTENSIVE CARE NURSE:

- Acknowledges all Category I trauma activations by calling the ED charge nurse/team leader to document response time.
- Identifies the need for a trauma admission and will immediately anticipate a plan for placement in the Surgical Trauma Cardiovascular ICU (Unit 4800).
- Collaborates with the ADCO/PPRN for bed placement into the Surgical Trauma Cardiovascular ICU (Unit 4800) and/or will assist with triage of patients to open a bed for the ED trauma patient.
- Acute trauma patients that are in need of ICU care, will keep a 2:1 patient to nurse ratio at all times in the Surgical Trauma Cardiovascular ICU (Unit 4800).
- Trauma Surgeon is available within 15 minutes for emergent needs in the ICU. A backup surgeon is available as well to respond within 15 minutes.

ASSISSTANT DIRECTOR OF CAMPUS OPERATIONS (ADCO):

- Responds to all Category I activations and documents arrival time on trauma flowsheet.
- If after normal business hours, will serve as liaison for Chaplain.
- Coordinates bed placement for the Category I trauma patient by communicating with patient placement RN and, if necessary, will assist with triage of patients to facility appropriate patient placement.
- Advices the 4800 Charge RN if patient will be placed into the Surgical Trauma Cardiovascular ICU (Unit 4800).

E. The trauma patient's disposition from ED will be monitored as part of the trauma performance improvement process.

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REFERENCES:

- Emergency Department Policy and Procedure Manual: "Identifying MULTIPLE Trauma Patients in the Emergency Department".
- Trauma Guideline Manual: "TRAUMA ACTIVATION / ALERT PROCESS".
- Registration Department Policy and Procedure Manual: "Registration Procedure and Coverage for Trauma Activation".
- Resources for the Optimal Care of the Injured Patient: 2014.
- Trauma Guideline Manual: "Anesthesia Trauma Call Panel Process".

REVIEWED DATE	REVISED DATE
Removed all prior dates for space.	
JUNE 2012	4-11-16
OCT 2012	5-23-16
DEC 2012	7-31-17
JAN 2013	1-29-18
AUG 2014	10-4-19
JAN 2019	7-21-20
AUG 2020	
APR 2021	

Trauma Resuscitation Team