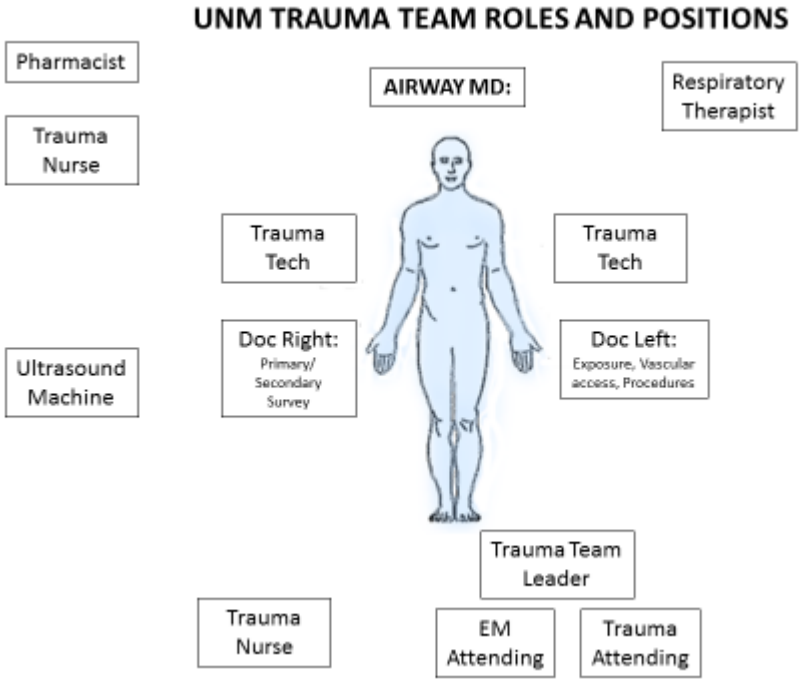
UNM Trauma & EM Operational Policies

Subject: Trauma Team Roles and Responsibilities for TRAUMA ACTIVATION patients

Purpose: To define the roles and responsibilities of personnel responding to trauma activations, emphasizing clear, organized communication and team function.



1) General Principles

a) Leadership: Good communication and leadership are keys to a well organized and efficient trauma resuscitation.

b) All PRIMARY trauma team members must report to the documenting nurse so that he/ she can document the team member's time of arrival to the trauma.

c) Noise Control: Individual conversations ARE NOT permitted in the trauma resuscitation area. One voice should be heard by the entire trauma team. NO ONE should be talking while EMS is giving report.

d) Pre- Brief: Prior to patient arrival, a pre- brief should be initiated by the trauma team leader or the recording nurse. The pre-brief consists of the introduction of the team members (name, role & discipline) & concludes with a summary of available patient info and plan of care (ie. From the sound of the report this patient may require a surgical airway, or thoracostomy tube…)

Personal protective equipment: For individuals working inside the patient care zone/ anyone who will contact the patient including

(Attendings, airway doc, docs Rt & left, nurses, techs & RT). Standard safety precautions for health care providers includes consistent use of: gown, gloves, head cover, mask/eye shield, shoe covers. As it will be required for the at least 2 doctors to remain in the room during X-ray, it is recommended that at least 2 of those 4 (TTL, airway doc, docs Right & Left) wear lead protection.

2) Trauma Resuscitation Team/Personnel Responsibilities

a) Trauma Team Leader (TTL)–

i) Stands at the foot of the bed
ii) Directs overall resuscitation (e.g. fluid resuscitation, blood products, interventions, disposition)
iii) Responsible for majority of communication during resuscitation
iv) Responsible for determining need for major invasive procedures performed (e.g. central lines, chest tubes, thoracotomy)
v) Accountable for determining whether the patient is safe for transport to CT scanner vs the need for immediate operative therapy for suspected injuries
vi) TTL will not perform procedures in order to focus on directing the resuscitation
vii) TTL may delegate additional tasks to others not explicitly mentioned here (ie. FAST exam, dressing wounds etc)

b) Trauma Surgery Attending

i) Must be present within 15 minutes of patient arrival for a TAP
ii) Assumes overall responsibility for the resuscitation and for supervising the Trauma Team Leader
iii) Collaborates with EM Attending

c) Emergency Medicine Attending

i) Responsible for supervising the Emergency Medicine Resident during Primary Assessment of the airway
ii) Supervises or assumes management of the airways (including induction plan & techniques)
iii) Assumes the role of supervising TTL when the Trauma Attending is not available or during multiple traumas
iv) Supervises doctor delegated to perform FAST exam
v) Collaborates with Trauma Attending in supervising TTL once airway is secured (EM Attending moves to foot of bead)

d) Airway Doc:

i) Stands at head of the bed
ii) Is responsible for primary assessment of the airway (and calling it out to the trauma leader & team
iii) Accountable for ensuring that the airway checklist is performed and that necessary materials needed for safe emergent intubation are available
iv) Evaluates "B: breathing", lung auscultation & tactile exam for subcutaneous emphysema, calling it out to TTL
v) Provides/ Discusses mechanical ventilator settings with RT
vi) Performs the Neurologic/ Disability ("D")component of the Secondary Assessment (after eval of C: circulation)
vii) Communicator to the patient. Relays key information to patient and obtains patient feedback.
viii) Other duties as assigned by TTL
ix) Cervical spine stabilization during patient turning
x) Once primary and secondary assessments are complete, may either perform or supervise the performance of the FAST exam as designated by TTL

e) Doc Left

i) Stands on the left side of the patient
ii) Responsible for exposing the patient by cutting/removing clothing
iii) Performs procedures as delegated by TTL (IO, CVC, peripheral IV, thoracostomy tubes)
iv) additional responsibilities as delegated by Trauma Team Leader
v) "Travels" with the patient to CT or the operating room
vi) Responsible for keeping the Trauma & EM attending, and Trauma Chief resident informed of patient's condition and any diagnostic findings
vii) May perform other tasks as delegated by TTL

f) Doc Right

i) Completes "C" (circulation) of the primary assessment (assessment of BP, central & peripheral pulses, current IV access) and announces it to the trauma team leader.
ii) Performs the secondary assessment from head to toe and reports all positive and negative findings
iii) Obtains "AMPLE" history at the completion of the secondary assessment of the patient
iv) May perform other tasks as delegated by TTL

g) Trauma Techs (2)

i) One stands to the mid right of the patient
ii) Second stands to the upper left of the patient
iii) Responsible for ensuring IV fluid bags/tubing and arterial pressure transducer equipment is setup prior to patient arrival
iv) Responsible for obtaining either automated or manual blood pressure
v) Places the patient on telemetry monitoring
vi) Obtains peripheral IV's if not established by prehospital providers
vii) Assists in obtaining labs including type and screen
viii) Connects patient to defibrillator as indicated
ix) Places gastric tubes and/or urinary catheters as delegated

h) Respiratory Therapist

i) Ensures airway equipment, & mechanical ventilator are ready for use
ii) Assists with airway management as requested
iii) Reviews ventilator strategy with Airway doc & TTL
iv) "Travels" with the intubated patient to CT scan/OR/ICU.

i) Trauma Nurse A:

i) Responsible for keeping a written record of the resuscitation events on trauma flow sheet (if Trauma B available, Trauma A RN to record next to TTL)
ii) Assists with retrieval of equipment
iii) Assists with crowd control (if RN B is unavailable)
iv) Administers medications as ordered
v) Places patient on the telemetry monitor (shared with tech)
vi) Administers blood products and fluids as ordered

j) Trauma Nurse B (if available):

i) Places patient on the telemetry monitor
ii) Assists with crowd control
iii) Administers blood products and fluids as ordered
iv) Administers medications as ordered
v) Sets up and runs Level 1 Rapid infuser
vi) Places patient on defibrillator pads and operates defibrillator

k) Pharmacist-

i) Prepares drugs, assures appropriate doses, identifies potential interactions, provides clinical support

FAQs:

Who is TTL?

11 PM to 3 PM it is the trauma Chief Resident (PGY 4-5). From 3PM to 11 PM it is the PGY-3 EDRU resident

What is the role of the EM PGY-2 during the 3-11 (EDRU) shift?

The EM PGY-2 during this time takes the role of the Doc left; the doc responsible for clothing removal and procedures

Who is Airway Doc at the head of bed?

This is a PGY-2 or PGY-3 that rotates in from either the Manzano or Sandia pod. This occurs 24/7, regardless of who the TTL is at the time.

Who is Doc Left?

Doc left is the surgery PGY-2 or PGY-3during all times except when there is an EM PGY-2 scheduled in the EDRU, when the TTL role is assumed by the Surgery PGY-3.

What is the Surgery PGY-3 role, when the EM PGY-2 is Doc left?

In this case, the surgery PGY-3 may either take the Doc Rt position, or perform the TTL role under the supervision of the trauma chief and Attendings

What is the trauma chief 's role when the EM PGY-3 or the surgery PGY-3 is TTL (3-11)?

The trauma chief (PGY 4-5) then takes on a supervisory role, practicing to function as junior faculty. They are still backed up by Trauma and EM Attending.

It seems like the Primary Survey is divided between 2 different doctors?

That is correct. The Airway doc tasked with airway management, which is closely tied to the pulmonary exam, will perform "A & B". Doc Right who has access to the extremities to evaluate distal pulses and cap refill, fills the "C" component. Disability ("D") is then assessed by the airway doc who can easily examine the pupils, and talk with the patient to obtain a GCS score. The secondary exam then returns to Doc Right.

What is the role of Doc left if there are no procedures required?

Do not under-estimate the importance of items IV – VI. It is imperative that the Doc left is learning from & collaborating with the TTL in preparation for them to ultimately assume this role. They are also integral in CT interpretation, and "closing the loop" on the patient disposition after CT scan interpretation.

Why is there a delineated spot for the EM Attending at the head of the bed & the foot of the bed?

Because they have a dual role. At first they function as the supervisor of the airway doc. After the airway is secured, they move to a spot adjacent to the trauma Attending to collaborate on the supervision of the TTL and how the case is run.

Who is "In Charge" of the whole Process?

This is a joint collaboration between the EM & Trauma Attendings. So they are both in charge.

When something significant ultimately impacting downstream care cannot be agreed upon, the ultimate decider is the Trauma Attending who will shortly assume care of the patient.

What if one Attending cannot be present?

Both sides agree to make every effort to be there. There will be situations where the Trauma Attending is operating or the EM Attending is with another critical patient. During such situations, the Attending present takes ultimate responsibility. When the Trauma Attending is in the OR, and there is disagreement about patient disposition or other key interventions (ie. Open thoracotomoy? Etc), efforts will be made quickly to consult with the trauma Attending by phone.

How are Disagreements in management addressed?

Disagreements in management issues (ie. Airway management, sedation strategy, fluids or blood product therapies, need for and timing of procedures, patient disposition etc.) will be discussed collegially among the most Senior physicians present. We expect a give & take/ collaborative attitude to pervade these discussions. When something significant ultimately impacting downstream care cannot be agreed upon, the ultimate decider is the Trauma Attending who will shortly assume care of the patient.

What happens if Trauma or EM practitioners are not present upon patient arrival?

When this occurs, the most senior doctors available will fill these roles (regardless of the time of day) and stick to the roles and responsibilities that apply to the particular position.

******Note: This is not a comprehensive document that addresses all possible situations, and challenges or desired changes will work through the Trauma-Resuscitation Committee.***