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Deaconess REGIONAL TRAUMA CENTER

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 education requirements for each unit caring for trauma patients and to outline monitoring/reporting requirements.

Guidelines:

A. For a resuscitation to be sufficient, every member of the team should understand his/her particular responsibilities.
   a. 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. Personnel on the Trauma Team
   a. Category I Activations
      i. Trauma Surgeon
      ii. Emergency Physician
      iii. Trauma Advanced Practice Provider (APP) (when available)
      iv. Anesthesiologist
         1. Based on airway needs
      v. Trauma Nurse(s)
         1. Primary as Recorder
         2. Secondary
      vi. Lab and Blood Bank Personnel
      vii. Radiology Technologist / CT Technologist
      viii. Assistant Director of Campus Operations (ADCO)
      ix. Chaplain
         1. If not in house, Chaplain will call ADCO who will advise if immediate response is required
      x. OR Charge Nurse
      xi. Trauma Intensive Care Nurse
   b. Category II Activations
      i. Emergency Physician
      ii. Trauma Surgeon
      iii. Trauma APC when available

iv. Trauma Nurse(s)
    1. Primary as Recorder
    2. Secondary based upon patient acuity
v. Emergency Department Patient Care Technician (PCT)

C. Roles, Responsibilities and Procedures
  a. Trauma Surgeon
    i. Captain of the Team
      1. Leads resuscitation
    ii. Should respond to all Category I activations within 15 minutes of notification
      1. Trauma Surgeon often arrives prior to the patient and thus acts as the primary provider
        a. Upon patient arrival, Trauma Surgeon will begin primary and secondary trauma assessment
        b. ED Physician should be available for assistance as needed, especially with resuscitation needs
      2. If Trauma Surgeon arrives after patient arrival, (s)he will communicate with the ED Physician to establish patient report and begin primary and secondary trauma assessment
      3. Thereafter, Trauma Surgeon will work collaboratively with ED Physician as needed
    iii. Should respond within 6 hours for Category II activations
      1. ED Physicians should routinely evaluate the trauma patient prior to activation and Trauma Surgeon consultation
    iv. If at any time Trauma Surgeon is not present in the ED for an activated trauma patient, ED Physician is responsible for oversight of care
    v. Splints and dressings should be removed and injuries assessed with secondary assessment
    vi. Should 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 by any staff, especially on Category I patients
    vii. Once the patient has been stabilized via ATLS protocols, trauma panel and portable chest x-ray completed, triage of the patient begins
      1. To CT scan, OR, Trauma ICU or Trauma Floor
      2. Goal
        a. Category I patients out of the ED within 2 hours
        b. Category II patients out of the ED within 4 hours
    viii. If the patient is unstable needing emergent surgery to stabilize, Trauma Surgeon is responsible to notify OR immediately of the need for surgery suite and resuscitation resources
      1. Trauma Surgeon should accompany unstable patients and manage resuscitation in cath lab, radiology or other specialty area unless Anesthesiologist is available to manage resuscitative efforts

ix. Trauma Surgeon will follow the patient to
    1. OR for emergent surgery or resuscitation
    2. CT scan for timely diagnostic studies/results
    3. Trauma ICU to report to primary RN and complete trauma admission orders

b. Emergency Department Physician
    i. Co-captain of a trauma resuscitation
        1. Leads resuscitation if Trauma Surgeon is not available or present
    ii. Aids in assisting ED staff with determining if trauma activation is needed and at what level
        1. The appropriate level of activation is determined from criteria communicated by EMS, referring facility staff, or patient report
        2. Trauma Services tracks all under/over triage and reports at Trauma Operational meetings
    iii. ED Physician (or ED RN) should activate the trauma system within 10 minutes of patient arrival to the ED for Category I patients
        1. Primary and secondary assessment is critical in order to be timely with activation process
    iv. In the event that the Trauma Surgeon is not immediately present during a Category I activation, ED Physician is responsible for the initial assessment and ongoing resuscitation and care until the arrival of Trauma Surgeon in the ED
        1. Category I patients should remain in the ED for evaluation by the Trauma Surgeon
        2. In the event that it is deemed necessary for these patients to undergo emergent imaging prior to Trauma Surgeon, the patient should be properly monitored and accompanied by the trauma response team
    v. Category II patients are initially cared for by ED Physician
        1. Trauma Surgeon consulted to see patient in the ED or on the floor
        2. ED Physician is responsible for contacting Trauma Surgeon for patient report prior to the patient leaving the ED
    vi. If at any time the patient's condition deteriorates, patient can be upgraded to a Category I
        1. At no time can a patient be downgraded
    vii. Splints and dressings should be removed and injuries assessed with secondary assessment
    viii. ED Physician is responsible for admitting the trauma patient to the appropriate service
        1. All non-surgical admission and transfers to a different facility are monitored by Trauma Services
        2. ED Physician is held responsible for inappropriate admissions and/or inappropriate transfers

ix. Emergency Department shall be staffed at all times by a board certified emergency department physician as attested to by ABEM or AOBEM
    1. ED Physicians not meeting this requirement may work in the ED as a second or third physician but may not staff the ED independently
    2. Per regulations from the State of Illinois, physicians not boarded in emergency medicine should not manage trauma patients
x. ED is responsible for notifying patient's emergency contact that patient is being treated in the ED
    1. If the ED is unable to speak with the patient's emergency contact, this must be reported to the person/department to which the patient is transferred,

c. Trauma Advanced Practice Provider (APP)
    i. Third in command
    ii. Will assist the resuscitation with Trauma Surgeon and/or ED Physician
d. Anesthesiologist
    i. Refer to Anesthesia Trauma Call Panel Process guideline
e. Team Leader / ED Charge Nurse
    i. Notifies the ED triage nurse of pending trauma patient arrival
        1. Includes EMS report, level of activation required, and patient's room number
    ii. Facilitates documentation
        1. Trauma activation packed (for Cat I patients) to triage nurse
        2. Notification/documentation sheet to Unit Secretary
        3. Patient information for the ED trauma activation log
    iii. Nursing staff assigned to trauma rooms will give other patient care responsibilities to other ED nursing staff
    iv. Assists the trauma nurses, as requested, with communication of information to OR, Lab, Blood Bank, Radiology, and Chaplain
    v. Participates in the arrangements for transfer and reviews all EMTALA forms for accuracy and completion of documentation
    vi. Category I patients should be taken from ED or CT scan to OR or ICU
        1. Patients should not return to the ED after CT scan
        2. Category I patients must be accompanied by the ED RN to the radiology department
f. Primary ED Nurse – Recorder
    i. Remain at patient's bedside and direct/supervise all non-physician personnel
    ii. Monitors effects of medications/treatments and will communicate patient response to the Physician
    iii. Prioritizes team member's actions in the trauma room; collaborate plan of care and orders with ED charge nurse/team leader
    iv. Remains with patient until transferred to another unit and gives report to the staff member assuming care

v. Responsible for the completion of the Trauma Flowsheet and other required paper work
    1. The Trauma Flowsheet must be completed on all Category I activations
vi. Receives the trauma activation packet from the Charge Nurse
    1. Will place the trauma activation number on the patient's door
    2. Will ensure the trauma patient has been properly identified and banded with the trauma activation number
vii. Documents assessments, tests, and interventions on the Trauma Flowsheet from the time of patient arrival until discharge from the ED
viii. Allows an uninterrupted 60-second time period for EMS to give patient report to the trauma team
    1. Will then brief team members on pertinent history and mechanism of injury
ix. Assures chain of custody for specimens collected for forensic purposes
x. Serves as the communication center by communicating patient status to ED Team Leader/Charge Nurse, OR Charge Nurse, and Chaplain
    1. Will receive calls from the Trauma Surgeon and OR Charge Nurse
xi. 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
    1. Pink order sheet will be taken with the patient to CT scan and should be left there for scanning
xii. 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
xiii. The trauma patient's disposition from ED will be monitored as part of the trauma performance improvement process
xiv. RN to assure a complete trauma panel is drawn by Lab and urine is sent for drug screen for all Category I patients
    1. If this is not completed in the ED, this should be communicated to the primary RN at patient's final destination

g. Secondary ED Nurse
    i. Prepares the trauma room with appropriate trauma resuscitation equipment including personal protective equipment (including goggles, masks, gowns, and gloves) and lead aprons
    ii. Performs primary/secondary surveys and relays findings/interventions to the Recorder
    iii. Monitors vital signs, ongoing neuro assessments, and establishes an initial BP
        1. For unstable trauma patients (i.e. Category I), vital signs should be obtained every 15 minutes while in the ED
        2. Intake and output should be recorded

iv. Assures that 2 large bore peripheral IVs have been established and are patent
    1. Facilitates staff with blood draws as needed
    2. Uses approved techniques for forensic specimens
v. Splints and dressings should be removed and injuries assessed during secondary assessment

h. ED Technician/PCT
    i. Documents the activation and arrival of team members, including all physicians and APPs, on the Trauma Flowsheet
    ii. Assures that all trauma team members sign and document the time of their arrival to the ED on the Trauma Activation board
    iii. Performs a 12 leak EKG on all Category I patient with blunt trauma
    iv. Performs other duties as directed by the Primary RN or ED Physician

i. Clinical Laboratory
    i. Responsible for acknowledging the trauma pager when activated and immediately sends a Phlebotomist to the ED
        1. Documents arrival time on Trauma Flowsheet
    ii. 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
    iii. The results will be transmitted to the ED via electronic medical record (EMR) or down time slips
        1. Critical values will be resulted according to policy
    iv. Maintains/documents chain of custody for specimens according to established policies

j. Phlebotomist
    i. Personnel will document their arrival time and name on the Trauma Flowsheet upon arrival in the ED
    ii. Responds immediately to the ED for all Category I activations
    iii. Assures ID band is in place before labs are drawn
        1. The Phlebotomist will draw a specimen for type specific/cross match and will apply the blood band at this time
    iv. Collects the necessary blood specimens for Category I activations
        1. The Trauma Lab Panel is required for all Category I activations
        2. Additions or exceptions to the Trauma Panel may be made by verbal physician order
        3. If blood draw is unsuccessful after first stick, notify Trauma Surgeon or ED Physician to obtain blood from a femoral stick for Trauma Panel and baseline ABG for Category I patients
    v. Specimens will be labeled with identification number, time, date, and initials of the personnel who have collected the blood specimens
    vi. Maintains/documents chain of custody for specimens according to established policies
    vii. Communicates status of lab draws to Recorder
    viii. Remains available for additional draws until released by Recorder

k. Blood Bank
    i. Responsible for keeping the trauma pager with them at all times
        1. Upon activation, acts immediately to provide blood for the trauma patient in the ED
    ii. Documents their arrival time and name on the Trauma Flowsheet upon arrival in the ED
    iii. Responds to all Category I activations with 4 units Type O uncrossmatched PRBCs for emergency release
        1. This will be brought to the ED in an appropriate cooler ready to be administered upon the trauma patient's arrival
    iv. Responsible for assisting ED, OR, or ICU staff with the initiation of the Massive Transfusion Protocol (MTP)
    v. Will not respond to Category II activations unless the patient's condition changes, requiring the activation to be upgraded to a Category I
    vi. 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
    vii. Responsible for retrieving the uncrossmatched blood from the ED trauma room if not needed or used
    viii. Will monitor MTP compliance and trauma room arrival procedures that are in place with ED registration staff to ensure there are no delays
        1. This information is reported at Trauma Operational Committee
l. CT Technicians
    i. Notifies ED via telephone within 3 minutes that activation was received over trauma pager and shall appropriately triage patients to allow the trauma patient quicker access to the CT scanner
    ii. 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 EMR
        1. Pink order sheet will be kept in the CT area for pickup by ED quality analyst
    iii. When CT scans are completed, ensures that the films are available to the Radiologist for immediate interpretation
    iv. The time of the CT scan to results will be monitored as part of the trauma performance improvement process by the Radiology leadership team
m. Radiology Technologist
    i. Documents arrival time and name on the Trauma Flowsheet upon arrival in ED
    ii. Trauma Radiology Panel is available to be ordered for trauma patients for quick and easy computer access
        1. The Trauma Radiology Panel is not an automatic order
    iii. Responds immediately to the ED for Category I trauma activations with a portable x-ray machine, prepared to complete all films stat upon patient's arrival to the ED
    iv. Assures that lead aprons are available and being utilized by the trauma team members in the trauma room while x-rays are being performed
    v. Obtains films immediately as ordered

vi. Radiologic images are digital and will be placed in the EMR
vii. Communicates status of x-ray order completion to the entire trauma team
viii. Remains available for additional x-rays until released by Recorder

n. Respiratory Therapist
    i. For Category I patients, documents their arrival time and name on the Trauma Flowsheet upon arrival in the ED
    ii. Responds immediately to ED for all Category I activations with a ventilator that is capable of continuous monitoring of EtCO2
        1. EtCO2 monitoring is required for all patients on mechanical ventilation
        2. EtCO2 monitoring should be documented on respiratory therapy care sheet hourly for patients with traumatic brain injury
        3. EtCO2 should be documented and utilized with confirmation of endotracheal tube (ETT) placement on initial intubation
        4. EtCO2 should be documented, monitored, and utilized with bag-valve mask (BVM) ventilation with appropriate measuring device
        5. Should consider using EtCO2 when transporting a patient throughout Deaconess Midtown for testing or procedures to monitor tube placement
            a. A portable EtCO2 monitor is housed in ED for such transports
    iii. Assists with airway control/ventilation/intubation
        1. Assures availability of suction, intubation equipment, and BVM
    iv. Draws arterial blood gases from a peripheral site
        1. If unable to obtain blood after the initial stick, notifies the Trauma Surgeon to do femoral stick to obtain blood timely
        2. All Category I activations automatically require arterial blood gases to be drawn since this is part of the Trauma Panel
    v. If the Trauma Surgeon or ED Physician directs RT not to draw an AGB, the reason for this should be recorded in the EMR
    vi. Communicates the patient's respiratory status, including ventilator settings if applicable, to the Recorder
    vii. Coordinates ventilator set-ups for other areas the trauma patient is to be moved, and assists in transport of the intubated/ventilated trauma patient
    viii. Remains with the Category I trauma patient until the patient is admitted to the appropriate unit
    ix. May be excused by the Primary RN if the patient is not intubated and no further respiratory intervention is needed

o. Chaplain
    i. Responds immediately for all Category I trauma activations
        1. During normal business hours, the Chaplain will respond in person to the ED
            a. Documents name and arrival time on Trauma Flowsheet

2. After normal business hours, the Chaplain will call the Assistant Director of Campus Operations (ADCO) to see if immediate physical presence is required
    a. ADCO documents Chaplain information on Trauma Flowsheet

ii. For Category II activations, the Chaplain will not respond to ED unless notified by pager that their assistance is requested or needed
iii. If requested, will contact family members and/or clergy from the patient's home congregation
iv. If requested, meets family members and provides appropriate waiting area for patient confidentiality and privacy
v. Assists with communication between Primary ED RN, patient/family, and/or ICU/Floor/OR staff

p. Operating Room
    i. Acknowledge the Category I trauma activation by calling the ED for time to be recorded
        1. Staff immediately prepares for the anticipated need for an emergent OR suite
    ii. Identify an OR to be prepared to receive the trauma patient within 30 minutes
        1. The patient should be in the OR within 30 minutes from book time for an emergent surgery
            a. This turn-around time will be monitored as part of the trauma performance improvement process and will be reported at the Trauma Operational meeting
        2. Emergent surgeries may include craniotomy for acute hemorrhage, exploratory laparotomy for a hemodynamically unstable patient, pelvic stabilization for a hemodynamically unstable patient, penetrating wounds that require emergent exploration, or any other trauma patient needing emergent surgery
        3. Elective operations will be postponed to hold an OR open for an emergent case determined by the Trauma Surgeon
    iii. An OR must be adequately staffed (RN and CST) and available within 15 minutes
        1. A surgery staff team is in-house 24 hours per day
    iv. Anesthesia should arrive within 15 minutes of notification of emergent surgery
        1. See Anesthesia Call Panel guideline
    v. If the first OR is occupied, an adequately staff additional room must be available
        1. The surgery trauma call team (RN and CST) should be available in-house within 30 minutes

vi. The Trauma Surgeon is responsible to notify the OR Charge Nurse that the OR surgical suite will be needed
    1. Trauma Surgeon is also responsible to release the OR surgical suite if it is no longer needed after being scheduled
vii. Confirm the need for the Anesthesiologist
viii. Arrange OR staffing
ix. Notify PACU
x. Order necessary equipment and supplies for anticipated procedure(s)
xi. If the surgical team is available, 1 staff member and/or anesthesiologist may report to the trauma resuscitation room in ED or CT scanner to assess the patient and surgical needs
xii. The Trauma Surgeon, OR staff, and Anesthesiologist response time to the OR will be monitored as part of the trauma performance improvement process and will be reported at the Trauma Operational meeting
xiii. The turn-around time from the time the Trauma Surgeon schedules an emergent case in surgery until the patient arrives in surgery from the ED will be monitored as part of the trauma performance improvement process and will be reported at the Trauma Operational meeting
xiv. PACU staff after hours must be available within 30 minutes from being called in to arrival
xv. Patient may recover in ICU post-operatively if remaining on the ventilator

q. Trauma Intensive Care Nurse
    i. Acknowledges all Category I trauma activations by calling the ED Charge Nurse/Team Leader to document response time
    ii. Identifies the need for a trauma admission and will immediately anticipate a plan for placement in the Surgical Trauma Cardiovascular ICU (STCVICU)
    iii. Collaborates with the ADCO/Patient Placement RN (PPRN) for bed placement into STCVICU and/or will assist with triage of patients to open a bed for the ED trauma patient
    iv. Acute trauma patients that are in need of ICU care will keep a 2:1 patient to nurse ratio at all times in STCVICU
    v. Trauma Surgeon is available within 15 minutes for emergent needs in the ICU
        1. A back-up surgeon is available if the on-call Trauma Surgeon is encumbered and should respond within 15 minutes

r. Assistant Director of Campus Operations
    i. Responds to all Category I activations and documents arrival time on Trauma Flowsheet
    ii. After normal business hours, serves as the liaison for Chaplain
        1. Will document information on Trauma Flowsheet
    iii. Coordinates bed placement for the Category I trauma patient by communicating with the PPRN and, if necessary, will assist with triage of patients to facilitate appropriate patient placement
    iv. Advices STCVICU Charge Nurse if patient will be placed into STCVICU

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

References:

- Emergency Department Policy and Procedure Manual: "Identifying Multiple Trauma Patients in the Emergency Department"
- Trauma Guideline "Activation Process for Trauma Patients"
- Registration Department Policy and Procedure Manual: "Registration Procedure and Coverage for Trauma Activation"
- Resources for the Optimal Care of the Injured Patient: 2022
- Trauma Guideline "Anesthesia Trauma Call Panel Process"