UNM Trauma & EM Operational Policies

Subject: Trauma Team Roles and Responsibilities for Non-TRAUMA ACTIVATION patients or when multiple traumas are occurring at once

Purpose: To define the roles and responsibilities of personnel responding to non-trauma activations or during times of multiple trauma evaluations occurring at once and with limited physician availability, 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.

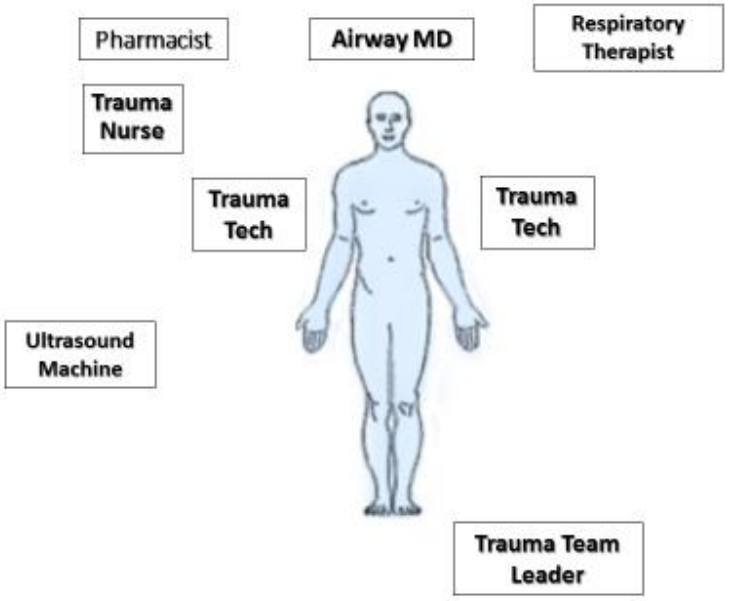
b) All PRIMARY trauma team members must report to the documenting nurse so that he/ she can document the team member's time of arrival to the trauma.

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 may be required for the a doctor to remain in the room during X-ray, it is recommended that at least one MD wear lead.

2) Trauma Resuscitation Team/Personnel Responsibilities- 2 Physician Resuscitation



a) ***General Principles-*** with limited personnel (2 physicians) available for non-tap trauma activations and multiple traumas occurring at once, one physician assumes the role of Trauma Team Leader and another as the Airway Doc with the expanded roles delineated below. Who plays the role of Airway Doc vs. Trauma Team Leader can be decided between the ER Attending Physician and the ER/Trauma Resident.

b) ***Airway Doc:***

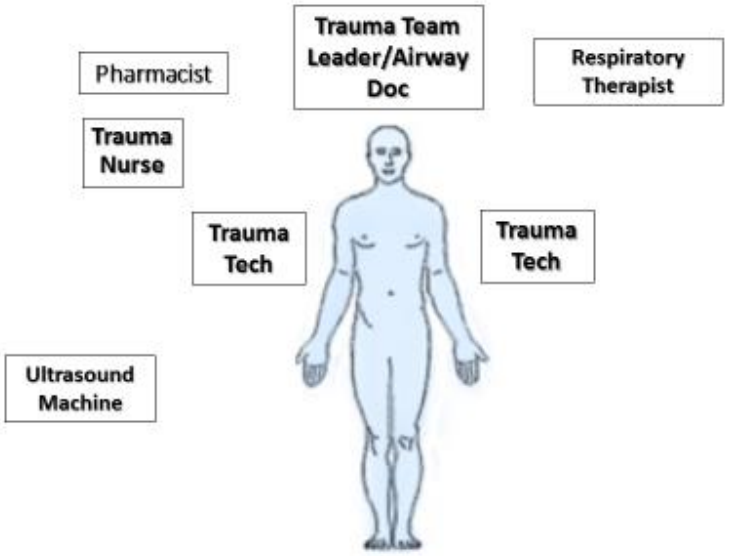
i) Stands at head of the bed
ii) Is responsible for primary assessment of the airway (and calling it out to the trauma leader & team
iii) Accountable for ensuring that the airway checklist is performed and that necessary materials needed for safe emergent intubation are available
iv) Evaluates "B: breathing", lung auscultation & tactile exam for subcutaneous emphysema, calling it out to TTL
v) Completes "C" (circulation) of the primary assessment (assessment of BP, central & peripheral pulses, current IV access) and announces it to the trauma team leader, nurse and tech.

vi) Provides/ Discusses mechanical ventilator settings with RT
vii) Performs the Neurologic/ Disability ("D")component of the Secondary Assessment
viii) Performs the secondary assessment from head to toe and reports all positive and negative findings
ix) Obtains "AMPLE" history at the completion of the secondary assessment of the patient
x) Responsible for exposing the patient by cutting/removing clothing
xi) Performs procedures as delegated by TTL (IO, CVC, peripheral IV, thoracostomy tubes)
xii) "Travels" with the patient to CT or the operating room
xiii) Responsible for keeping the Trauma Team Leader informed of patient's condition and any diagnostic findings
xiv) Communicator to the patient. Relays key information to patient and obtains patient feedback.
xv) Other duties as assigned by TTL
xvi) Cervical spine stabilization during patient turning
xvii) Once primary and secondary assessments are complete, may either perform or supervise the performance of the FAST exam as designated by TTL

e) 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) While traditionally the TTL will not perform procedures in order to focus on directing the resuscitation, given limited physician availability can at times assist with procedures if needed
vii) TTL may delegate additional tasks to others not explicitly mentioned here (ie. FAST exam, dressing wounds etc)

3) Trauma Resuscitation Team/Personnel Responsibilities- 1 Physician Resuscitation



a) ***General Principles-*** with limited personnel (1 physician) available for non-tap trauma activations and multiple traumas occurring at once, one physician assumes the role of combined Trauma Team Leader an Airway Doc with the expanded roles delineated below.

b) ***Trauma Team Leader/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. Completes “C” (circulation) of the primary assessment (assessment of BP, central & peripheral pulses, current IV access) and announces it to the trauma team leader.
vi. Provides/ Discusses mechanical ventilator settings with RT
vii. Performs the Neurologic/ Disability (“D”)component of the Secondary Assessment
viii. Performs the secondary assessment from head to toe and reports all positive and negative findings
ix. Obtains “AMPLE” history at the completion of the secondary assessment of the patient
x. Responsible for exposing the patient by cutting/removing clothing
xi. Performs procedures (IO, CVC, peripheral IV, thoracostomy tubes, airway management) as indicated
xii. “Travels” with the patient to CT or the operating room
xiii. Communicator to the patient. Relays key information to patient and obtains patient feedback.
xiv. Cervical spine stabilization during patient turning
xv. Once primary and secondary assessments are complete, may perform FAST exam
xvi. Directs overall resuscitation (e.g. fluid resuscitation, blood products, interventions, disposition)
xvii. Responsible for majority of communication during resuscitation
xviii. Responsible for determining need for major invasive procedures performed (e.g. central lines, chest tubes, thoracotomy)
xix. Accountable for determining whether the patient is safe for transport to CT scanner vs the need for immediate operative therapy for suspected injuries
xx. While traditionally the TTL will not perform procedures in order to focus on directing the resuscitation, given limited physician availability performs all procedures as indicated
xxi. TTL may delegate additional tasks to others not explicitly mentioned here (ie. FAST exam, dressing wounds etc)