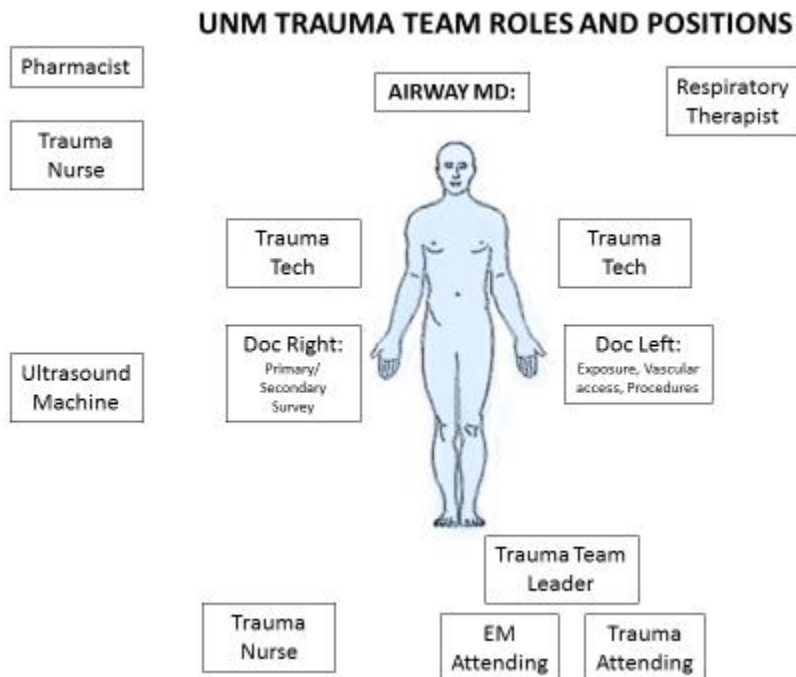


## UNM Trauma & EM Operational Policies

### ***Subject: Trauma Team Roles and Responsibilities for PEDIATRIC TRAUMA ACTIVATION patients***

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



### **1) General Principles**

- a) Children have distinct injury patterns, physiologic responses, and developmental needs in response to injury. Pediatric Trauma Resuscitations will be run with these in consideration. Pediatric Trauma Resuscitations will be run collaboratively between PED and Trauma surgery teams.
- b) Good communication and leadership are keys to a well organized and efficient trauma resuscitation.
- c) 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.
- d) 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.
- e) 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.

- f) Addressing Pediatric Pain and Anxiety: The number of persons responsible for directly comforting the child will be the bedside nurse and the airway physician; the primary purpose of fewer comforting voices is to avoid overwhelming and scaring the child. This strategy will also limit resuscitation room noise. A sufficient time frame will be given prior to re-dosing analgesia.

## **2) Pediatric 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) The TTL will use the Broselow tape to guide drug dosage and equipment choices.
- iv) Responsible for majority of communication during resuscitation
- v) Responsible for determining need for major invasive procedures performed (e.g. central lines, chest tubes, thoracotomy)
- vi) Accountable for determining whether the patient is safe for transport to CT scanner vs the need for immediate operative therapy for suspected injuries
- vii) TTL will not perform procedures in order to focus on directing the resuscitation
- viii) 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 Pediatric TAP
- ii) Assumes overall responsibility for the resuscitation and for supervising the Trauma Team Leader
- iii) Supervises the TTL in choice of equipment sizes, and drug doses based on Broselow measurement.

iv) Collaborates with PEM Attending

**c) Pediatric Emergency Medicine Attending**

- i) Responsible for supervising the Pediatric Emergency Medicine Fellow or Emergency Medicine Resident during Primary Assessment of the airway
- ii) Supervises or assumes management of the airways (including induction plan & techniques)
- iii) Supervises the TTL in choice of equipment sizes, and drug doses based on Broselow measurement.
- iv) Assumes the role of supervising the TTL when the Trauma Attending is not available or during multiple traumas
- v) Supervises doctor delegated to perform FAST exam
- vi) After initial airway assessment and management, the PED attending will transition to supervise the TTL in collaboration with the Trauma Attending.

**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. This includes correctly sized equipment according to Broselow tape measurements.
- 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, 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 placing Broselow tape on patient's right side
- iv) Responsible for ensuring IV fluid bags/tubing and arterial pressure transducer equipment is setup prior to patient arrival
- v) Responsible for obtaining either automated or manual blood pressure
- vi) Places the patient on telemetry monitoring
- vii) Obtains peripheral IV's if not established by prehospital providers (role shared with RN)
- viii) Assists in obtaining labs including type and screen
- ix) Connects patient to defibrillator as indicated
- x) Places gastric tubes and/or urinary catheters as delegated (role shared with RN)

**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) In general the PED Team will provide two nurses per trauma. A second nurse from the Main ED will provide additional support.
- ii) 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)
- iii) Assists with retrieval of equipment
- iv) Assists with crowd control (if RN B is unavailable)
- v) Administers medications as ordered
- vi) Places patient on the telemetry monitor (shared with tech)

- vii) Obtains peripheral IV's if not established by prehospital providers (role shared with tech)
- viii) Places gastric tubes and/or urinary catheters as delegated (role shared with tech)
- ix) 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?**

3 AM to 3 PM it is uniformly the trauma Chief Resident (PGY 4-5). Additionally, the trauma Chief Resident (PGY 4-5) will be the TTL from 1am on Wednesday am through 5pm on Wednesday.

From 3PM to 3AM it is the Pediatric Emergency Medicine Fellow PGY-5-6 or EM PGY 3 ***if scheduled on shift in the PED.*** If there is no Pediatric Emergency Medicine Fellow (PGY-5-6) or EM PGY 3 scheduled on a PED shift during 3PM-3AM, the trauma Chief Resident will function as the TTL during this time.

### **Who is Airway Doc at the head of bed?**

This is the Pediatric Emergency Medicine Fellow PGY 4-5 or EM PGY 2-3. As the Pediatric ED has a more variable staffing pattern, greater flexibility will be required for AIRWAY ROLES. If no PEM fellow or EM PGY 2-3 are present in the PED, the PEM attending will function as the Airway Doc.

## **If a PEM Fellow PGY and an EM Resident PGY 2-3 are both present, how will roles be assigned?**

Decisions for Airway and TTL role assignment will be made collaboratively with the PEM attending, PEM fellow, and EM Resident. Roles will be negotiated with the goal to optimize both airway and TTL experience for both the PEM fellows and EM PGY 2-3's. As EM PGY 3's are given priority in choice of role for Adult TAP traumas, PEM fellows will be given first priority for airway and TTL roles during the hours when a PEM fellow or EM PGY 3 may perform the TTL role.

## **Who is Doc Left?**

Doc left is the surgery PGY-2 or PGY-3 during all times.

## **What is the trauma chief's role when the Pediatric Emergency Medicine Fellow (PGY 4-5) or EM PGY-3 is TTL ()?**

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 PEM 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 PEM & 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 PEM 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 thoracotomy? 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 PEM 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.***