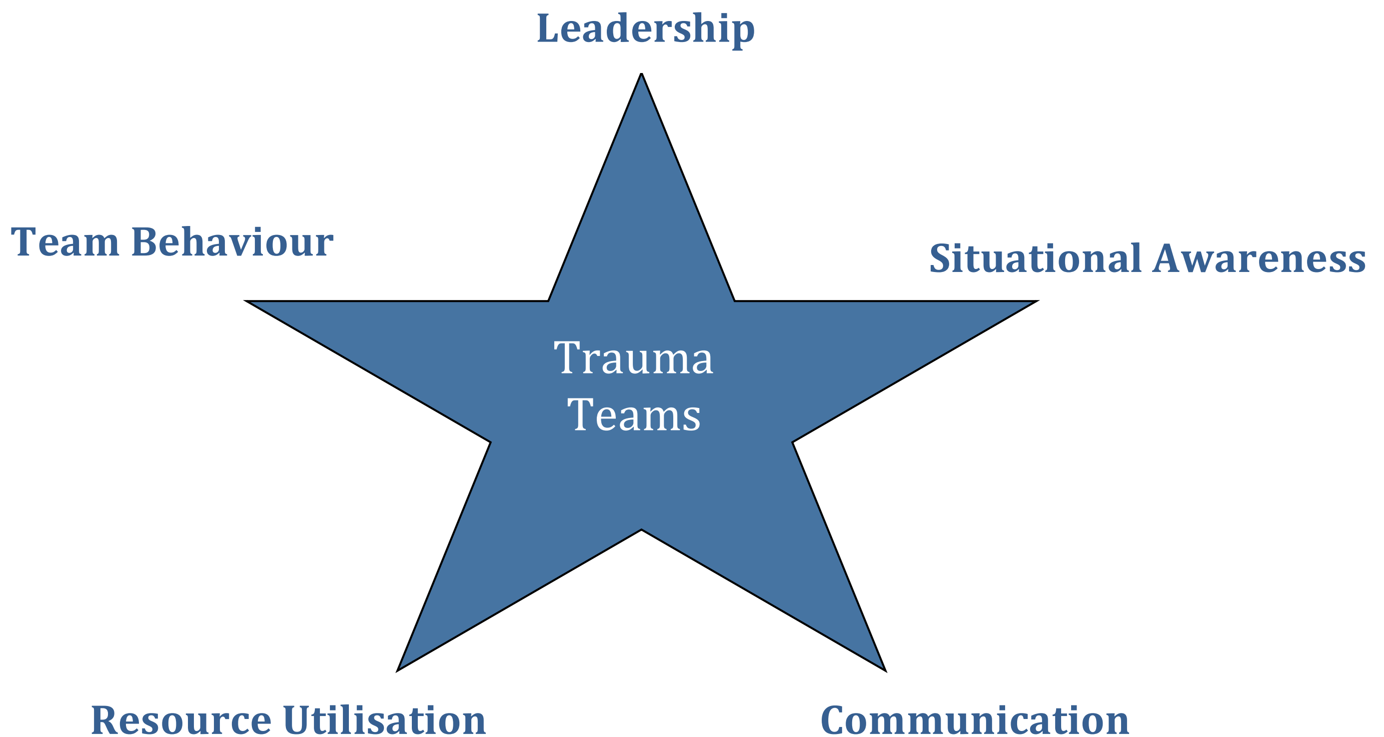
'Trauma Teams save time and lives'



RIE Trauma Teams Version 4 November 2017

Author: Dean Kerslake

Contributions: Callum Johnston (SAS), Nicola McCullough (ED Trauma lead), Sara Robinson (ED), Chris Connolly (ED CNM), Ray Middlemiss (ED charge nurse) Christopher Hay (Radiology), Laura Fitton (Anaesthesia), Bernhard Heidemann (anaesthesia), Phil Docherty(anaesthesia), Neil Emslie (ODP), Stuart McKechnie (General Surgery), Peter Lamb (General Surgery), Laura Wilson (Radiography), Tim White (Orthopaedics), Gregor McNeill (critical care) Kallirroi Kefala (critical care), Jackie Brady, Jackie Drummond, Nyree Brown

TRAUMA TEAM ROLES & RESPONSIBLITIES

1.1 Background

- To provide all major trauma patients with a consultant led team immediately upon their arrival.
- To ensure patients are diagnosed and treated quickly and appropriately using a multidisciplinary approach.
- To ensure that >95% of Major Trauma patients have an enhanced trauma team activated.
- To ensure that no more than 40% of enhanced trauma team activations occur in patients with minor injuries.
- To accurately and clearly document the attendances and actions of the trauma team.
- To improve patient outcomes and experience of trauma.

1.2 Ambulance pre-alert

- The ambulance service will provide a structured pre-alert report aiming to provide at least 10 minutes notice where possible (see Fig.1).
- This Pre-Alert form should be completed in full and kept with the patients notes at all times.
- The Nurse in charge, resus coordinator or consultant will be notified immediately and determine the appropriate team to activate.

Original must be kept with patients notes

Pre-Alert minimum 10 mins for trauma

Trauma Medical

Call sign:

AGE: M □ F □

TIME OF INCIDENT/ONSET:

MECHANISM OF INJURY/ MEDICAL COMPLAINT:

INJURIES/ INFORMATION RELATED TO COMPLAINT:

SIGNS/ SYMPTOMS	RR:	GCS (Trauma):		
	SpO2	E:	V:	M:
	Pulse:	AVPU (Medical):		
	BP:	Temp:		
		NEWS:		

TREATMENT GIVEN:

Cardiac Arrest: Autopulse Yes No

REQUIREMENTS (blood, specialists, intubation, access etc.):

ETA:

DATE: TIME: NAME:

NAME OF CON/REG INFORMED (phone 23687 or 23511):

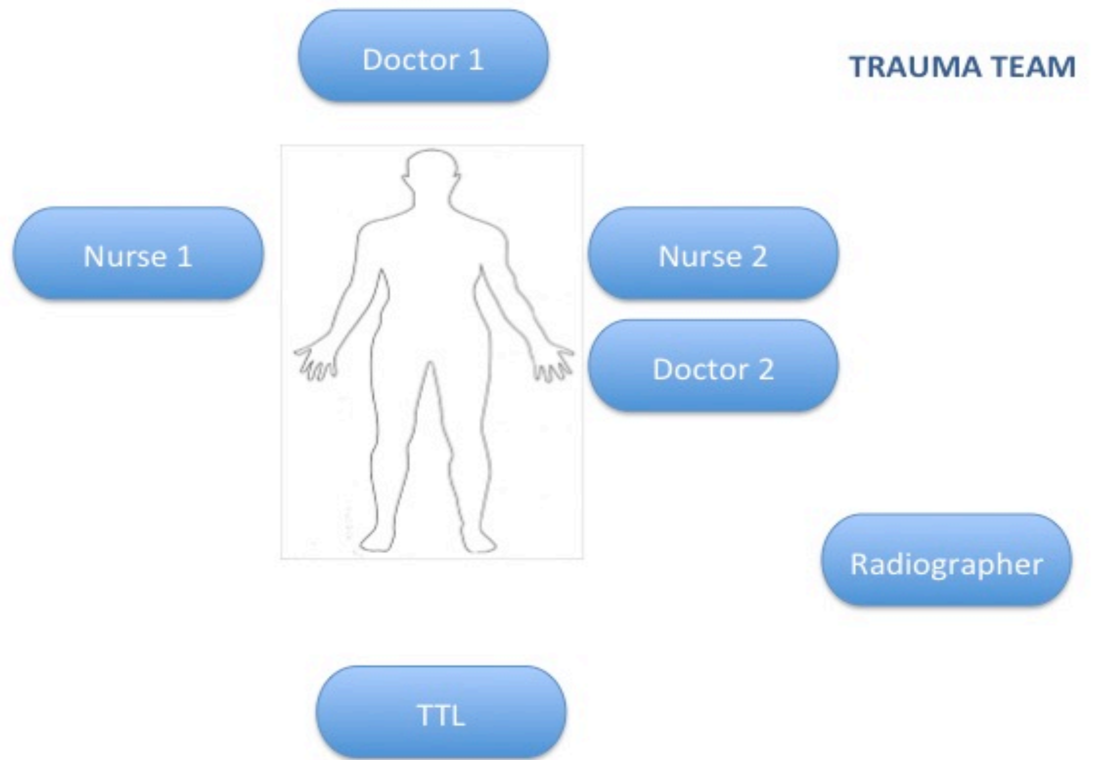
L Moncur, D Kerslake v 1.0 Nov 2017 Feedback: lmoncur@nhs.net

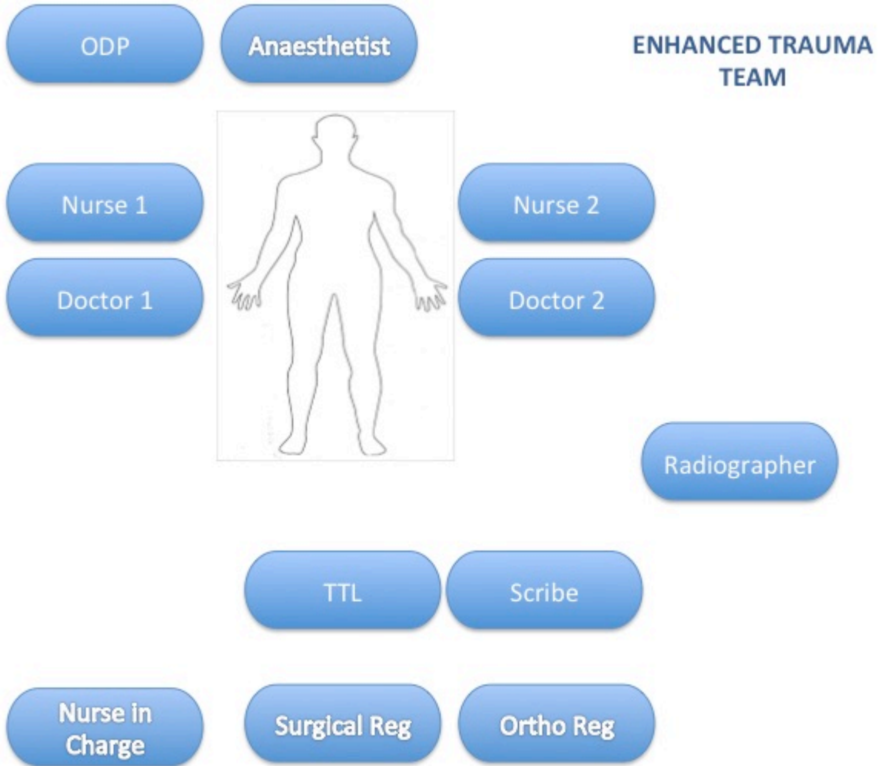
Fig.1 – Mandatory standardised criteria passed during the ambulance pre-alert

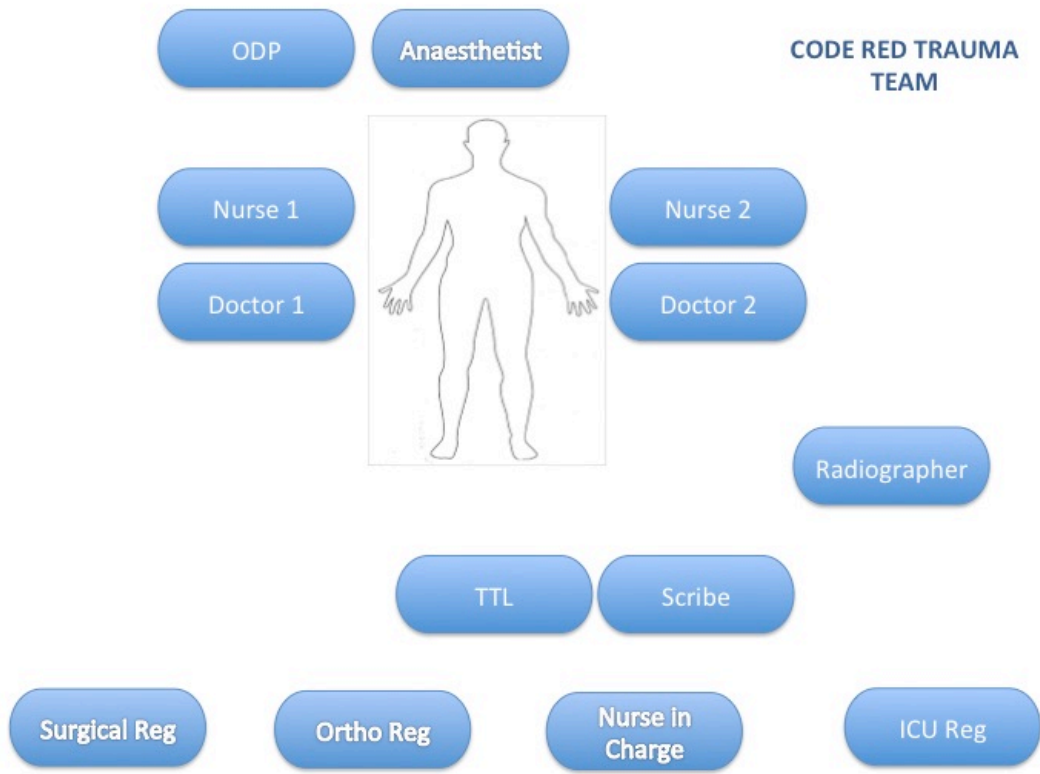
1.3 The Three Tiered Trauma teams

The RIE operates a three tiered trauma system to maximise the correct response for Major Trauma patients whilst minimising the impact on the hospital.

SPECIALTY	**TRAUMA TEAM**	**ENHANCED TRAUMA TEAM**	**CODE RED TRAUMA TEAM**
Emergency Medicine	TTL (CONSULTANT/ST4+) DOCTOR DOCTOR NURSE 1 NURSE 2	TTL (CONSULTANT) ST4+ DOCTOR NURSE 1 NURSE 2 NURSE TEAM LEAD (scribe) RECEPTIONIST	TTL (CONSULTANT) ST4+ DOCTOR NURSE IN CHARGE NURSE 1 NURSE 2 NURSE TEAM LEAD (scribe) RECEPTIONIST
Orthopaedics		REGISTRAR	REGISTRAR
General Surgery		REGISTRAR	CONSULTANT/REGISTRAR
Radiography	RADIOGRAPHER	RADIOGRAPHER	RADIOGRAPHER
Anaesthesia		REGISTRAR/CONSULTANT ODP	CONSULTANT/REGISTRAR ODP (Theatre coordinator paged)
Critical Care			CONSULTANT/REGISTRAR
Radiology		(notified when patient on CT table)	(notified when patient on CT table)


Doctor 1
TRAUMA TEAM
Nurse 1
Nurse 2
Doctor 2
Radiographer
TTL


ODP
Anaesthetist
ENHANCED TRAUMA TEAM
Nurse 1
Nurse 2
Doctor 1
Doctor 2
Radiographer
TTL
Scribe
Nurse in Charge
Surgical Reg
Ortho Reg


ODP
Anaesthetist
CODE RED TRAUMA TEAM
Nurse 1
Nurse 2
Doctor 1
Doctor 2
Radiographer
TTL
Scribe
Surgical Reg
Ortho Reg
Nurse in Charge
ICU Reg

1.4.1 ‘Code Red Trauma Team’ Activation criteria

‘Code Red Trauma Team’ is declared if *all* of the following criteria are met:

- Suspected or confirmed active haemorrhage
- SBP<90
- Unresponsive to volume resuscitation (avoid clear fluids in bleeding patients)

This will usually be requested by MEDIC 1/EMRS
The TTL can declare a code red trauma team based upon the pre-alert information.
This may be declared on patients already in the ED

Code red patients should have early consultant involvement where possible. All the information may not be available but consultants should be expected to attend a request within 30 minutes.

Consider alerting INTERVENTIONAL RADIOLOGY, CARDIOTHORACICS, VASCULAR, 2nd ED CONSULTANT, NEUROSURGERY etc.

1.4.2 ‘Enhanced Trauma Team’ activation criteria

***Any of* the following** conditions mandate an ‘Enhanced Trauma Team’ activation.

1. PHYSIOLOGY

    a. GCS <14
    b. RR<10 or >29
    c. SBP <90 or sustained loss of radial pulse

2. ANATOMY

    a. Penetrating injury proximal to shoulders and knees
    b. Chest wall instability or deformity
    c. Two or more proximal limb fractures
    d. Crushed, de-gloved, mangled or pulseless extremity
    e. Amputation proximal to wrist or ankle
    f. Suspected pelvic fracture
    g. Open or depressed skull fracture
    h. Paralysis

3. IMMEDIATE TRANSFERS FROM TRAUMA UNITS/LOCAL EMERGENCY HOSPITALS

4. IF THERE IS ANY CONCERN FROM TTL/CHARGE NURSE

5. AT THE REQUEST/INFO GIVEN FROM MEDIC ONE/EMRS/SCAA etc.

1.4.3 'Trauma Team' Activation criteria

The 'trauma team' is activated for all the following patients that do not reach criteria to activate an enhanced or code red trauma team

1. MECHANISM

    a. Falls >20 feet
    b. Ejection from vehicle
    c. Death in the same vehicle
    d. Vehicle vs. pedestrian/cyclist >20mph
    e. Motorcyclist >20mph

2. SPECIAL CONSIDERATIONS

    a. Age >55
    b. Bleeding disorders (including anticoagulation)
    c. Morbid Obesity
    d. Pregnancy >20 weeks (Consider Fast Page Obstetrician +/- Enhanced trauma team response)

1.5 How to activate Trauma Teams

- There are two situations when trauma teams will be activated:

    1. Based upon the Ambulance Pre-Alert *or*
    2. On arrival of the patient in the ED

- **STAY ON THE PHONE AFTER ACTIVATING THE CODE RED TRAUMA TEAM AS SWITCHBOARD WILL TRANSFER YOU TO BLOOD TRANSFUSION TO CONTINUE THE CODE RED TRANSFUSION PROTOCOL**
- Enhanced Trauma teams should ideally be activated 10 minutes before the ETA.
- Code Red teams should ideally be activated 15 minutes before the ETA.
- Multiple patients should activate further calls stating e.g. '2nd enhanced trauma team to resus' etc.
- Fast Bleep specialties using '2222' to contact specialists that may not be alerted via the usual trauma team e.g. Neurosurgeons, vascular

TIERED TRAUMA TEAM ACTIVATION

CODE RED TRAUMA TEAM CALL (SEE NOTE BELOW)

- Suspected or confirmed active haemorrhage ☐
- SBP ≤ 90mmHg ☐
- Unresponsive to volume resuscitation ☐

ENHANCED TRAUMA TEAM CALL (TANNOY & 2222)

- GCS <14 ☐
- RR<10 or >29 ☐
- SBP ≤ 90mmHg or sustained loss of radial pulse ☐
- Penetrating injury proximal to shoulders or knees ☐
- Chest wall instability or deformity ☐
- Two or more proximal limb fractures ☐
- Paralysis ☐
- Crushed, de-gloved, mangled or pulseless extremity ☐
- Amputation proximal to wrist or ankle ☐
- Suspected pelvic fracture ☐
- Transfers from other Emergency Departments ☐
- At the request of Pre-hospital team/Team leader/Senior Nurse ☐

TRAUMA TEAM (ED TANNOY ONLY)

- Falls >20 feet ☐
- Ejection from vehicle ☐
- Death in the same vehicle ☐
- Vehicle vs Pedestrian ☐
- Vehicle vs Cyclist ☐
- Motorcyclist >20mph ☐
- Age >55 ☐
- Bleeding disorder (including anticoagulation) ☐
- Morbid obesity ☐
- Pregnancy >20 weeks ☐

1. **Place tannoy call stating which team is activated**
2. **Dial 2222 to** activate either enhanced or code red trauma teams
3. **For CODE RED TRAUMA CALLS – The Nurse in charge or Trauma Team Leader will nominate who dials 2222.** Switchboard will immediately transfer the call to BTS so they must be familiar with ordering blood products according to the code red transfusion protocol and be part of the code red trauma team.

Author: Dr D Kerslake   Version 1   December 2016

1.6 Trauma Team Principles

- Overall responsibility for the patient lies with the Trauma Team Leader (TTL)
- The trauma team response should be consistent for every patient and each member of the team should be familiar with his or her roles and responsibilities.
- Trauma Team Members (TTM) will attend all trauma activations and must attend immediately and certainly within 10 minutes. They must arrange cover if they are unable to attend e.g. scrubbed.
- On rare occasions where cover cannot be arranged they should phone the TTL on **21312** who can decide upon appropriate escalation.
- TTMs should be present before the patient arrives.
- TTMs must not leave the trauma team without permission from the TTL.
- The TTL should stand down TTMs as early as clinically appropriate.
- All non-attendance or late attendance must be recorded in the Trauma Booklet. This will be audited and fed back through the Major Trauma Governance group.
- On arrival each member will:
    - Introduce themselves by name and role
    - Wear a sticker with name and role
    - Sign in with the Scribe
    - Wear Aprons, gloves, lead and glasses as appropriate
    - Know and prepare for their role
    - Stand in the appropriate position
- If TTMs arrive after the patient has arrived they may be tasked to perform a role without a full briefing initially. The TTL should brief them at the earliest suitable opportunity
- Noise should be kept to a minimum at all times.

1.7 Preparation of the Resus Room (use TTL Checklist)

- The white board should be filled out with the Pre- Alert information
- The trauma mattress, sheet and trolley should be ready to receive the patient.
- Patient gown and warm blanket should be ready
- The Trauma Booklet should be ready
- The digital clock should be ready to start
- Tuff cuts x 2 should be available
- ECG dots attached to leads, ETCO2 ready, NIBP set to cycle
- US machine is ready in position with gel and protection
- Anaesthetic drugs are drawn up and equipment is ready.
- Introductions, roles and skill set of all the team verbalised.

1.8 The first 5 minutes of a trauma call

- Trauma room preparation as above
- Patient arrives on trolley
- Patient is immediately transferred over onto bed
- Immediate life threatening interventions only are rapidly determined by the TTL and communicated clearly e.g. ' can we deal with the airway before handover'
- The whole team must not perform any actions and listen quietly for a 30 second concise handover.
- The next priority is to fully undress the patient whilst maintaining privacy and minimising movement.
- 3 Team members are allocated one side of the patient (opposite side to ambulance trolley) ready to assist with removal of the patient from the scoop stretcher.
- The patient must be removed from the Orthopaedic Scoop stretcher/Spinal Board/Vacuum mattress as per video available at 'www.edinburghemergencymedicine.com'
- All commands use "Ready, Brace, Command' e.g. lift, roll etc.
- The Nurse must attach monitoring and provide a full set of vital signs within 2 minutes.
    - SpO2 probe on side of working cannula
    - NIBP on opposite
- Achieve IV access and send bloods
- Analgesia should be administered ASAP to facilitate assessment and management.
- The Primary survey should be clearly communicated by Doctor 1 'live' to the team within 5 minutes of arrival
- The patient should be kept covered with a warm blanket (and Bair Hugger if Code Red)
- A CXR, Pelvis XR and FAST scan must be performed within 5 minutes for all Code red patients.
- The TTL should formulate a plan in conjunction with specialists and communicate to a silent room at the earliest opportunity and regularly update:
    - Main injuries
    - Concerning physiology
    - Plan & on-going plan
- The Ambulance/MEDIC ONE/EMRS PRF must be given to the scribe and kept securely in the notes.

1.9 Imaging & Investigations

- All patients should have FBC, U&Es, LFTs, Coag screen, BTS x2, VBG.
- The BTS tube must be checked by 2 people to prevent error
- Consider for all patients as clinically indicated
  - ROTEM (all code red)
  - CK (all major crush/vascular)
  - Troponin (all major chest)
  - Amylase (all abdominal)
  - HCG
- Perform an ECG in all patients over 40 or younger if clinically indicated.

1.10 Transfer of patients

- The TTL and the relevant TTMs should accompany the patient to CT
- The TTL can make exception to this at their discretion
- For all enhanced or code red trauma calls the radiologist must be made aware when the patient arrives in CT
- Ensure the duty radiologist has the most up date information, which may have changed since the request to adapt imaging protocols.
- All notes should accompany the patient
- Update TRAK immediately for all patient movements as these are matched against quality standards
  - Temporary move to CT
  - Temporary move to Theatre
  - Discharge to ward

1.11 Documentation

- The Trauma booklet must be completed in full
- A TRAK entry using the short code **\trauma** must be completed for electronic documentation and STAG data collection
- Each specialty must document on TRAK stating the:
  - The consultant on call
  - Management plan
  - Movement restrictions
  - Follow up.
  - VTE prophylaxis plan
- The Ambulance PRF must accompany the patient.

SAS Action Card

PRIOR TO PATIENT ARRIVAL
Ideally major trauma patients should arrive undressed aiming for a 10 minute pre-alert (or longer if shocked)
Use the ATMIST mandatory criteria for the pre-alert
ON ARRIVAL OF THE PATIENT
Transfer the patient on the scoop over to the trauma mattress
State any immediate life threatening needs - If none/once addressed the team will listen for a 30 second MIST handover MECHANISM INJURIES SYMPTOMS & SIGNS TREATMENTS
Assist the team removing the patient off the scoop
Further more detailed history can be given to the TTL & scribe prior to leaving whilst the team can continue patient care

Trauma Team Leader Action Card

PRIOR TO PATIENT ARRIVAL
Completes the TTL checklist to prepare for patient arrival
AIM TO BE HANDS OFF AT THE END OF THE BED AT ALL TIMES
ON ARRIVAL OF THE PATIENT
Addresses only immediate life threatening needs before all the team listen quietly to 30 second handover - seek further information or clarification separately whilst team get to work
Ensure clothes and scoop are removed as per standardised method
Prioritises investigations and treatment
Ensures Pelvic Binder if mechanism consistent and SBP <110mmHg
Ensures administration of TXA if suspicion of bleeding and either HR >110 or SBP <110
Code RED patients require an immediate CXR, Pelvis XR and eFAST
Aim to leave for CT within 20 minutes ensuring lines are secure and working. Some patient may require theatre rather than CT
Arterial lines should only be considered prior to CT if NIBP not reading
Ensures Blood Bank aware of patient movements.
Stand down TTMs as soon as not needed
Ensure ambulance PRF, booklet and TRAK documentation completed
Clearly handover leadership when required – though TTL would usually see patient to CT
Hot Debrief for all code reds and other Major Trauma (this may mean re-paging the team at a defined time)
Ensure relatives are spoken to

Doctor 1 (usually EM ST4+) Action Card

PRIOR TO PATIENT ARRIVAL
Report name and grade to scribe
Confirm skill level to TTL
Wear lead, apron, gloves and consider eye protection
ON ARRIVAL OF THE PATIENT
Reassures patient on arrival and explain what's happening (may be shared with anaesthetist)
Undertakes a primary survey clearly stating loudly all relevant findings to team along the way - <C>ABCDE
Performs an eFAST scan if requested and competent
Ensures neurology is documented prior to muscle relaxation (may be shared with Anaesthetist)
Takes an AMPLE history (may be shared with anaesthetist)
Completes the secondary survey (may be shared with the Orthopod) (Head/face/neck/chest)
Ensures code red patients are kept warm with Blankets/Bair Huggers
Prescribes/Administers Drugs
Ensures TRAK entry accurate according to template (can be shared with Dr 2)

Doctor 2 Action Card

PRIOR TO PATIENT ARRIVAL
Report name and grade to scribe
Confirm skill level to TTL
Wear lead, apron, gloves and consider eye protection
Order imaging as requested and Major Trauma blood order set
ON ARRIVAL OF THE PATIENT
Ensure there are two large peripheral lines. Do not try more than twice without informing the TTL
Obtain the following tubes in order: 2 x Blue, VBG, 2 x Green, 1 x red, 1 x Orange
Ensure the BTS tubes and form is correctly filled out with another team member
Run a ROTEM in code red patients
Ensure the VBG and ROTEM result are handed to the team leader as soon as they are ready
Ensures the code red patient is kept warm with Blankets/Bair Hugger
Prescribes/Administers drugs
Helps with procedures
Ensures TRAK entry accurate according to template (can be shared with Dr 1)

Nurse 1 Action Card

PRIOR TO PATIENT ARRIVAL
Check in with the scribe and wear role sticker
May need to take role as airway assistant if ODP unavailable
Ensure Trauma Mattress on trolley
Monitor ready to attach: • ECG dots on telemetry • ETCO2 ready (off Standby) • NIBP set to 3min cycle
Wear lead and PPE
Ensure Tuff cuts x 2 available
Ensure Oxygen under trolley
Pelvic Binder available/on trolley as indicated
Set out chest drain/other procedure sets as required
ON ARRIVAL OF THE PATIENT
Attach monitoring in the following order SpO2 on drip arm NIBP on non drip arm ECG dots
Assist removing clothing and store securely
Check Temperature and BM. Perform ECG as requested.
Cover with warmed Blankets (if code red – Bair Hugger as well)
Administer drugs as prescribed
Assist (Dr 1) with procedures - Catheters including pregnancy test, A-Line, chest drains etc.
Prepare to leave for transfer and go with patient to CT

Nurse 2 Action Card

PRIOR TO PATIENT ARRIVAL
Check in with Scribe – if no scribe present you will act as scribe
Wear PPE
Draw up drugs prior to patient arrival as requested
Help Nurse 1 prepare
Run through blood on Belmont with extension and three way tap for all code red patients (can share with other nurse)
ON ARRIVAL OF THE PATIENT
Remove clothing
Draw up and administer drugs as required
Assists (Dr 2) with procedures
Ensure the patient is kept warm
Prepare for transfer to CT
Ensure TRAK moves are kept up to date lwhen patient leaves for CT and theatre.

Radiographer Action Card

PRIOR TO PATIENT ARRIVAL
Place detector in position under the trolley for a chest X ray
Position X-ray tube over trolley
Liaise with TTL or nurse if members are not wearing lead
ON ARRIVAL OF THE PATIENT
In code red patients the X-ray can be taken as an emergency patient with a verbal request if required (only send to PACS once merged)
Ensure Doctor 2 or scribe requests the X rays on TRAK as soon as patient ibooked in.
Liaise with TTL if team members are obstructing your chance to take X rays.
The radiographer should aim to have both X rays taken within 5 minutes of the patient's arrival. (If both the CT scanner and the patient are ready then either of these may be omitted at the discretion of the team leader.)
Inform TTL if there are delays in TRAK request.
When **you** are ready to expose, countdown: 'X-rays in 3-2-1 XRAY' – TTMs should be expected to leave or be protected and not delay this.

Nurse Team Leader (scribe) Action Card

PRIOR TO PATIENT ARRIVAL
This role is invaluable to the team. You must ensure you get the information you need and inform the team leader if you are not. You will act as the primary nurse team leader (with assistance from the NIC when present)
All team members should check in with you upon arriving in the resuscitation room – Please remind them if not.
Document team members including specialty, grade and time of arrival.
Work closely with the TTL and ensure that progress and interventions are achieved
Acts as the main link with BTS in code red patients. Activates the code red team in discussion with Nurse in charge/TTL
ON ARRIVAL OF THE PATIENT
Start the digital clock
Document vital signs at least every 15 minutes (3 minutes if code red/MHP) or as clinically appropriate– inform the team leader if they have not been performed
Record timings of all events and interventions.
Inform the team leader for every 15 minutes that pass
Place a wristband on the patient as soon as the notes arrive.
If code red ensure there is an allocated transfusion nurse and that used products are kept together in a clinical waste bag for later double checking
Ensure you gather both the PRF and all other pre-hospital information before the paramedics/MEDIC ONE/EMRS leave.
Ensures the team leader gives clear regular updates of current situation and plan
Ensures and prioritises the nursing workload and allocation of tasks in conjunction with the TTL and NIC.
Ensures liaison with relatives
Thinks, plans and prepares ahead at all times

Anaesthetist Action Card

PRIOR TO PATIENT ARRIVAL
Liaise early with theatre coordinator
Report name and grade to scribe
Always Wear lead, apron, gloves and consider eye protection
The Anaesthetist usually controls all movements using the commands 'Ready, Brace, Command e.g. lift, roll
Draw up drugs with ODP - usually Ketamine, Fentanyl & Rocuronium and prepare a propofol infusion
Prepare the airway trolley with the ODP against the RSI checklist, including equipment and monitoring preparation.
Ensure you will be ready to move the patient within minutes of arrival e.g. Transfer Bag, suction, Drugs, Oxygen on trolley
ON ARRIVAL OF THE PATIENT
Assist transferring the patient from stretcher to trolley and coordinate any further movements,
Talk and reassure the patient explaining what is happening
Communicate airway patency to TTL & Scribe (may be shared with Dr 1)
Ensures C – Spine immobilisation (unless penetrating trauma)
Communicates GCS, pupils & limb movements (may be shared with Dr 1)
Communicates an AMPLE history (may be shared with Dr 1)
Intubates and manages ventilation when appropriate in discussion with TTL
Passes an NGT/OGT when intubated
Only considers an arterial line if NIBP not measuring – rarely delay transfer
On-going assessment of GCS and pupils
Assist with IV access as indicated

ODP Action Card

PRIOR TO PATIENT ARRIVAL
Report name and grade to scribe
Always Wear lead, apron, gloves and consider eye protection
Draw up drugs with the anaesthetist - usually Ketamine, Fentanyl & Rocuronium and prepare a propofol infusion
Prepare the airway trolley against the RSI checklist, including equipment and monitoring preparation.
Ensure you will be ready to move the patient within minutes of arrival e.g. Transfer Bag, suction, Drugs, Oxygen on trolley
Helps prepare the Belmont in conjunction with allocated nursing staff as requested
ON ARRIVAL OF THE PATIENT
Assist transferring the patient from stretcher to trolley
Intubates and manages ventilation when appropriate in discussion with TTL
Assists with procedures as appropriate
Ongoing assistance with Belmont rapid infuser

General Surgery Action Card

PRIOR TO PATIENT ARRIVAL
Surgical consultant should be present if on site for code red patients or alerted early if off site
Ensure a theatre is immediately available for code red patents in conjunction with anaesthetist and theatre coordinator.
Report name and grade to scribe and TTL including skillset
Wear lead, apron, gloves and consider eye protection as appropriate
Be prepared to/Scrub to perform surgical intervention as guided by TTL - External Haemorrhage control - Intercostal Chest Drain Emergency Thoracotomy (if possibility from pre-alert, identify an assistant with help of the TTL)
Stays with the patient including to CT unless stood down by the TTL or after discussion with the TTL.
May take the role of DOCTOR 1 (usually only during multiple casualty scenarios)
ON ARRIVAL OF THE PATIENT
Stand behind the line until discussion with TTL
Assists with procedures, which may include sending/ordering/requesting of tests.
Perform surgical interventions above as required/competent by TTL including NGT, Urinary Catheter, ICDs, Thoracotomy
Discusses surgical plan/needs/priorities with TTL
If a patient is going to directly to theatre ensure consultant contacted en route and go directly to theatre so you are scrubbed prior to arrival of the patient.
You must go to CT with the patient to receive the hot report with the TTL from the radiologist.
Document using standard template on TRAK

Orthopaedic Action Card

PRIOR TO PATIENT ARRIVAL
Orthopaedic consultant should be present or alerted early (if off site) if confirmed pelvic fracture & Code Red
Report name, grade and skillset to scribe and TTL
Ensure a theatre is immediately available in conjunction with anaesthetist
Wear lead, apron, gloves and consider eye protection as appropriate
Be prepared to/Scrub to Assist the General Surgical team with life saving surgical interventions
May take the role of DOCTOR 1 (usually only in multiple casualty scenarios)
ON ARRIVAL OF THE PATIENT
Stand behind the line until discussion with TTL
Assists with procedures, which may include sending/ordering/requesting of tests.
Perform surgical interventions above as required by TTL which may include chest drains, urinary catheter etc.
Ensure the following early and ideally prior to CT: - The pelvic splint is appropriately placed - Basic splinting & traction of long bone fractures
Identify Limb Threatening injuries – Does CT need to include the lower limbs?
You must go to CT with the patient to receive the hot report with the TTL from the radiologist unless stood down
For patients who go to theatre – Decide in conjunction with TTL, anaesthetist and other surgical consultant the need for any damage control orthopaedics
Perform and document a secondary survey as early as possible include: All wounds/grazes/de-gloving Joints and long bones Neurovascular exam Peripheral pulses
Order further X rays and act upon the results including wound & fracture management
Document standardised TRAK entry

Receptionist Action Card

PRIOR TO PATIENT ARRIVAL
Attend Enhanced and Code red trauma calls
ON ARRIVAL OF THE PATIENT IN ED
Book in patients immediately after handover

Radiology Action Card

PRIOR TO PATIENT ARRIVAL
Ensure Radiographer is on site and CT scanner ready to receive patient
ON ARRIVAL OF THE PATIENT IN CT
For all Enhanced Trauma Teams and Code Red patients the TTL will ensure the radiologist is alerted (usually by a knock on the door). If there is further relevant clinical information which may alter the scanning protocol or interpretation this should be communicated
IR consultant and IR lab should be considered early if patient is a code red with a pelvic fracture.
Provide a hot verbal report to the TTL within 5 minutes
Provide a typed provisional report within 1 hour
Provide a typed consultant report within 24 hours

Critical Care Action Card - Code Red

PRIOR TO PATIENT ARRIVAL
ICU consultant should be present if on site.
Report name and grade to scribe
Ensure a bed is available immediately on critical care
Wear lead, apron, gloves and consider eye protection as appropriate
Be prepared to/Scrub to : Identify Subclavian Trauma Line equipment & tray
Ensure receiving critical care area have bed space/equipment prepped and ready for patient arrival
ON ARRIVAL OF THE PATIENT
Stand behind the line until discussion with the TTL
Assist with central / subclavian access and transfusion/resuscitation as requested by TTL
Maintains awareness with Anaesthetist and Surgeon re operative interventions.
Liaise with critical care regarding likely timing. of transfer and immediate needs on ICU arrival

Charge Nurse Action Card – Code Red

PRIOR TO PATIENT ARRIVAL
Check in with Scribe
Stand next to the TTL
Ensure lead jackets are worn by Anaesthetist, ODP, Nurse 1, Nurse 2, Doctor 1
Ensure the room is prepared and ready to receive the patient e.g. Chest drains, Belmont etc. as appropriate
ON ARRIVAL OF THE PATIENT
If code red - Resource extra nursing staff if required and allocate somebody sole responsibility for Transfusion when Belmont required (over and above Nurse 1, 2 and Scribe)
Ensure someone has looked after relatives

Theatre Coordinator Action Card - Code Red

PRIOR TO PATIENT ARRIVAL
Ensure that a theatre space and team are ready to immediately receive a trauma patient
ON ARRIVAL OF THE PATIENT IN ED
Liaise with the Anaesthetist/ODP/Orthopod/Surgeon which theatre is suitable and when it is ready