

OPERATIONAL GUIDELNES: RESUSCITATION ROLE ASSIGNMENTS

GUIDELINES:

For a resuscitation to be efficient, every member of the team should understand their particular responsibilities. The dots on the floor represent different members of the trauma team who should be at the bedside. Everyone should remain outside “the box”. The trauma team members need to tell the Scribe that they are present, as well as swipe in when they walk into the trauma bay. Universal precautions must be worn. There are no exceptions. Flexibility of roles is expected under exceptional circumstances and appropriate communication should be maintained (see Figure 1).

RESUSCITATION ROLE ASSIGNMENTS

Designate Trauma Roles

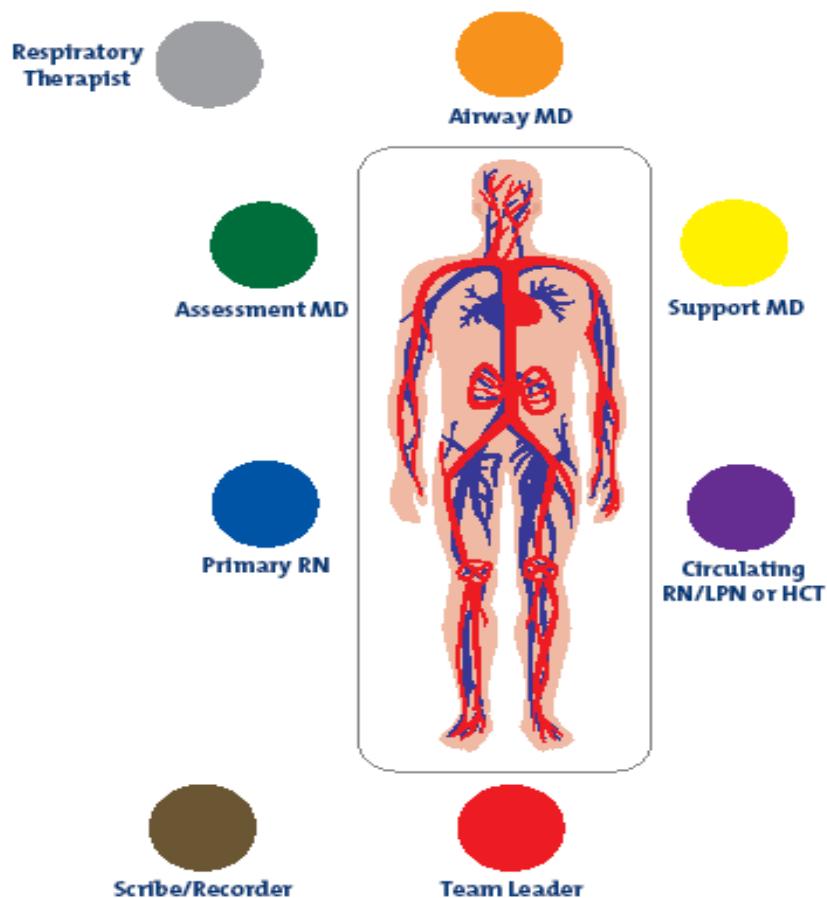


Figure 1

Trauma Team Roles in Resuscitation

- 1) If no obvious life threats, there will be a 30 second time out, EMS will give verbal report.
- 2) During this report cardiac monitor, automatic NIBP, SpO2 monitor will be placed – manual blood pressure will be checked against automatic BP after secondary survey if there are concerns, and also if abnormally high or low reading on monitor and/or there is a discrepancy between reading on monitor and clinical presentation
- 3) When time out complete primary and secondary survey will begin and carried out by the following roles:

Team Leader

The senior trauma* or ED resident stays at the foot of the bed and supervises resuscitation; intervenes in procedures when necessary and maintains a quiet controlled environment

Airway Physician

Secure the airway, head and neck exam during the primary and secondary survey; reassure the patient and inform the patient of what is happening

Right Side Resident

Primary and secondary survey, will state assessment for scribe to document; right sided procedures such as chest tube, trauma line, FAST exam

Left Side Resident

Left sided procedures, responsible for supervising C-Spine protection during secondary survey and surgical airway

Primary RN

Places peripheral IV, draws labs, give medications, and talk to the patient

Circulating Staff (RN in Level I, LPN or HCT in Level II activation)

Manages without equipment, places monitor, 2nd IV and assists with procedures (CT, trauma line etc)

HCT

Place patient on monitor, obtain vital signs, help expose patient, assist with log-roll of patient, and obtain equipment/supplies as needed, assist with transport of patient

Scribe

Documentation, records verbal orders such as MTP and helps act as a timekeeper

ED Attending

Manage/co-manage as per handoff details

Trauma Attending

Manage/co-manage as per handoff details

*The senior resident can, at any time, determine it is appropriate to take a patient to the OR and can begin a case prior to the arrival of the trauma attending if the resident believes it is in the best interest of the patient to proceed

Handoff

1.) The EM attending is the primary attending of record from the time of patient arrival until a hand-off to another service (surgery, trauma, and neurology) is done. The patient record (i.e. EPIC) record should reflect this.

- 2.) Once the trauma attending arrives, s/he will co-manage the patient with the EM attending during the initial resuscitation sequence.
- 3.) Once it is clear that the patient will require admission to the trauma service, or need to be transferred to the OR, the EM attending should hand-off care to the trauma attending. The trauma attending can decide to admit or take the patient to the OR at any moment (after or before arrival), and has the authority to assume responsibility of the patient once arrived. This also requires a hand-off to be performed.
- 4.) Hand-off may be simple, but should be formal, and should consist of the acknowledgement of care transfer.
- 5.) If the patient arrives and it is clear that the patient will **not** require admission to the trauma service, or require transfer to the OR, the EM attending should retain responsibility of the patient with close consultation of the trauma attending.
- 6.) If the patient arrives, and a disposition seems unclear until diagnostic workup is complete, the EM attending should retain responsibility of the patient until
 - a.) disposition of admission is clear, at which point hand-off is performed
 - or
 - b.) the trauma attending may assume responsibility for the patient under an "observation" status until the diagnostic workup is completed.
- 7.) If hand-off is done during or immediately after resuscitation, then the hand-off should be attending to attending. If it is done well after resuscitation (i.e. after a workup), then resident to resident is acceptable.
- 8.) If a patient is handed off to trauma service, and an appropriate hospital bed is available, there should be movement of the patient towards that bed.