TRAUMA TEAM – ROLES & RESPONSIBILITIES RHSC
Background

RHSC Edinburgh has a 3 level trauma team response. This approach aims to limit both the over and under triaging of major trauma.

Level 1 – Patients where a ‘Code Red/Trauma MHP’ has been declared
Level 2 – Patients deemed to require a ‘Trauma Team response’
Level 3 – Patients initially deemed to require an ‘Emergency Department response.’

Objectives

1. To provide all major trauma patients with a consultant led team upon their arrival
2. To ensure patients are diagnosed and treated quickly and appropriately using a multidisciplinary approach
3. To ensure that >95% of Major Trauma patients have a trauma team activated
4. To ensure that no more than 50% of trauma team activations occur in patients with minor injuries
5. To accurately and clearly document the attendances and actions of the trauma team
6. To improve patient outcomes and experience of trauma in line with the Scottish trauma network initiative.
Level 1 Trauma Team Activation

Patients who meet any of the following criteria trigger Level 1 Trauma Team activation

- Suspected or confirmed active haemorrhage
- Pre-hospital Code Red activation

1. Dial 2222 and state Level 1 Trauma Team Standby in Resus
   - This will activate the level 1 trauma team
   - Consider activating ‘Code Red’ protocol prior to patient arrival

2. Clinical Co-ordinator should retrieve 2 units of o-negative blood from the blood fridge in RHSC

3. ED Lead Nurse should ensure the blood warmer is primed and ready for use.

4. Trauma Team Leader (TTL) to consider alerting Neurosurgeon/Plastic Surgeon/Cardiothoracic Surgeon depending on the call.

Level 1 Trauma Team Members:
EM consultant
Anaesthetic consultant
PICU consultant
General Surgical Consultant
Radiology Consultant
Orthopaedic Registrar
Radiographer
PICU charge nurse
Clinical Co-ordinator
Theatre Co-ordinator
Operating Department Practitioner (ODP)
Level 2 Trauma Team Activation

The following conditions mandate Level 2 Trauma Team activation.

- Obstructed Airway
- Inadequate breathing/ventilation or oxygenation
- Responding to pain only or unresponsive
- Medic One or EMRS Trauma Call if not level 1
- ED Consultant/ED Charge Nurse Discretion

IF THERE IS ANY DOUBT THE PREFERENCE IS TO ACTIVATE THE TRAUMA TEAM

1. **Dial 2222 and state Level 2 Trauma Team Standby in Resus**
   - This will activate the level 2 trauma team

2. **TTL to consider alerting neurosurgeon/ENT/Plastic Surgeon/Cardiothoracic Surgeon depending on the call.**

**Level 2 Trauma Team Members:**
EM Consultant
Anaesthetic Consultant
Operating Department Practitioner
PICU Consultant
General Surgical Registrar
Orthopaedic Registrar
Radiology Consultant
Radiographer
PICU charge nurse
Clinical Co-ordinator
Level 3 Emergency Department (ED) Response

All pre alerted trauma calls that do not fulfil the criteria for a Trauma Team response will have as a minimum

ED Doctor
Senior nurse
Nurse 2

A Trauma Team response can be called at any time but should be done early if there any clinical concerns.
TRAUMA TEAM LEADER
Will be assumed by the ED consultant upon their arrival
- Ensure appropriate level of Trauma Team has been activated
- Ensure protective equipment is worn
- Ensure personal introductions
- Clarify abilities, roles and responsibilities of the team
- Prioritises investigations & treatment
- Ensure Trauma booklet available
- Ensure team members book in with scribe

ON ARRIVAL OF PATIENT
- Digital clock started (scribe)
- All team members listen for 30 second handover whilst second paramedic books patient in with receptionist.
- Ensure all clothes are cut lengthways and removed.
- Pelvic Binder if mechanism consistent and signs of shock
- Ensure paramedic provides PRF and information to scribe after handover.
- Tranexamic acid if suspicion of bleeding and signs of shock
- Aim for CT within 30 minutes of the patient’s arrival. Ensure lines secure and life threatening conditions treated
- Do not delay CT/emergency theatre for antibiotics, arterial lines, urinary catheters and/or Tetanus.

ONGOING CARE
- The TTL position may be handed over to the Anaesthetic Consultant on transfer to CT if the department activity is such that it would be detrimental for the ED Consultant to leave.
- Stand down staff not needed as soon as possible
- Check Trauma booklet for completeness
- Clearly handover patient to anaesthetist or admitting team
- Inform Blood bank immediately if patient moves
- Speak to relatives
- Ensure TRAK has all movements kept up to date and all specialties involved.
- Debrief team
ANAESTHETIST & ODP

- Check in with the scribe
- Communicate airway patency to TTL/Scribe
- Manage airway, oxygenation and ventilation
- Ensure appropriate C spine protection
- Control patient movements in discussion with TTL
- Prepare airway management/intubation equipment supported by ODP
- Prepare emergency anaesthesia drugs supported by ED nurse
- Perform emergency anaesthesia as indicated in discussion with TTL
- NG/OG tube when intubated
- Arterial lines should not delay transfer to CT or theatre
- Communicate with theatre co-ordinator in conjunction with surgeon
- The anaesthetist may take the lead role for transfusion in code red/MHP patients in discussion with TTL
- Assume leadership role of patient on transfer to CT/Theatre/PICU

ODP:

- Assist anaesthetist with airway management
- May assist with removing clothes
- May assist with Rapid infuser/blood warmer
- In conjunction with anaesthetist ensure emergency airway equipment and drugs taken to CT
RADIOGRAPHER

Pre – arrival

- Liaise with TTL or nurse if members are not wearing lead.
- Book in with scribe

On arrival

- Ensure Doctor 2 requests the X-rays on TRAK as soon as patient is booked in.
- Liaise with TTL if team members are obstructing your chance to take X-rays.
- The radiographer should aim to have X-rays taken within 5 minutes of the patient’s arrival.
- Inform TTL if there are delays in TRAK request.
SCRIBE

This role is invaluable to the team. You must ensure you get the information you need and inform the TTL if you are not.

- All team members should check in with you upon arriving in the resuscitation room – Please remind them if this does not happen.
- Document team members including specialty, grade and time of arrival.
- Ensure clock is started on patient arrival.
- Ensure you gather both the PRF and all other pre-hospital information before the paramedics leave.
- Document vital signs every 15 minutes (5 minutes if code red/MHP) – inform TTL if they have not been performed
- Record timings of all events and interventions.
- Place a wrist band on the patient as soon as possible
- Inform the team leader for every 15 minutes that pass
- Ensure the transfusion nurse keeps a running total of blood and blood products transfused in a major haemorrhage.
DOCTOR 1

Usually the ED Doctor on shift

- Check in with the scribe
- Confirms skill level to TTL
- Reassures patient on arrival and explain what’s happening if appropriate
- Undertakes primary survey clearly stating findings to TTL and scribe.
- <C>
- A
- B
- C
- Takes an AMPLE history from parents
- Inform TTL and scribe of outcomes.
- Performs procedures as required and competent.
- Undertakes Secondary survey including tympanic membranes. Examine neurology prior to muscle relaxants being administered.
- The Secondary survey may be omitted in the interest of time to CT/Theatre – this information must be documented in the trauma booklet.

The pelvis/limbs/abdomen and genitals are examined by the Orthopaedic and General surgical team respectively.
DOCTOR 2

May be ED/Surgical/Orthopaedic

- Confirms procedural skills with TTL
- Check in with the scribe
- Activated MHP if required
- Order FBC, U&E, LFT, Coagulation screen, Calcium, VBG and imaging as soon as patient is booked in immediately after handover.
- Inserts two large peripheral lines taking the following tubes:
  X2 BTS tube
  Coagulation tube
  Haematology tube
  Biochemistry tube
  VBG
- Ensure bloods sent
- Inform TTL if unable to secure IVA after two attempts. May be required to perform IO access.
- Administer drugs and helps with procedures under direction of TTL
- Keep patient warm
RADIOLOGIST

In line with other MTCs we should aim to complete the CT and have a hot report within 30 minutes of arrival in the ED.

- Clear the CT scanner and communicate with the TTL when the scanner is available.
- Attend the trauma call where possible.
NURSE 1

You will be the patients named nurse
Check in with the scribe

Prepare the following
- Blood warmer run through when indicated
- Warmed iv fluids available
- Chest drains sets out if suggested
- Pelvic binder available
- Monitor ready to attach
- Scissors/shears
- Oxygen under trolley

Start clock when patient arrives (shared with ODP)

- Remove all clothing and store securely
- Check temperature
- Perform a full set of vital signs including BP and inform TTL and scribe
- Cover with Bair Hugger/blankets
- Prepare drugs and fluids
- Prepare for transfer to CT/theatre (ideally within 20 minutes of arrival)
- Go with the patient to CT
NURSE 2

Check in with the scribe
Help nurse 1 prepare

- Assist Dr 2 with IVA
- Assist nurse 1 in preparing fluids
- Administer fluids or blood as requested
- Assist nurse 1 in preparation for transfer to CT
- Dressings and splints for open wounds and fractures.
- Assist with procedures
- Ensure patient is warm
- Ensure the relatives are kept up to date
SURGICAL REGISTRAR

May take the role of Doctor 1 (especially if multiple casualties) otherwise stays behind line unless actively treating/assessing.

Identify yourself to TTL including skillset
Log in with scribe

- Wear PPE if you are doctor 1
- Inform surgical consultant early if theatre is likely.
- Stay with the patient in resus/CT until stood down by TTL
- Performs abdominal examination
- Discusses surgical plan/needs/priorities with TTL
- Liaise with theatres, anaesthetist, clinical co-ordinator and consultant early with plan for theatre or admission

Assist with
- sending/ordering tests
- liaising with specialists
- Procedures – chest drain and urinary catheter

Documents actions and findings in patient notes/TRAK
ORTHO PAEDIC REGISTRAR

May take the role of Doctor 1 (especially if multiple casualties) otherwise stays behind line unless actively treating/assessing

Identify yourself to TTL including skillset
Log in with scribe

- Wear PPE if you are doctor 1
- Inform Orthopaedic consultant early if theatre is likely
- Examine Pelvis – Usually by inspection only or note if in a binder. Consider any open wounds
- Examine limbs
- document all wounds/grazes/degloving
- All joints and long bones
- Neurovascular exam
- Peripheral pulses
- Splint fractures
- Extend CT scan early
- Order X – rays – should not delay CT
- Discuss plan with TTL
- Stay with patient in resus/CT until stood down by TTL
- Liaise with theatres, anaesthetist, clinical co-ordinator and consultant early with plan for theatre or admission

Assist with
- sending/ordering tests
- liaising with specialists
- Procedures – chest drain and urinary catheter
Documents actions and findings in patient notes/TRAK

SAS PARAMEDIC/TECHNICIAN

Ideally patients should arrive with a pre alert, fully undressed covered with blankets

- Transfer the patient on the scoop over
- State any immediate life threatening needs.
- If none/once addressed the team will listen for a 30 second hand over – MIST

MECHANISM
INJURIES
SYMPTOMS & SIGNS
TREATMENTS

- One member of crew will give the details to book the patients in whilst handover is occurring.
Clinical Co-ordinator

Identify yourself to the TTL
Log in with scribe

- Co-ordinate MHP/Code Red as per usual role
- Retrieve the 2 units of RCC from the blood fridge
- Ensure the TTL has given an up-date in destination of patient as soon as known
- Ensure theatres are prepared if required
- Liaising with management and escalate as appropriate as per usual role.