

TRAUMA TEAM CHANGES AT CRMH

The people who provide field emergency medical services in southwestern Virginia are an integral part of the regional trauma system, and their skills and expertise are highly valued.

This is written in the spirit of providing better communication and an understanding about recent changes in the trauma room at CRMH when an injured patient arrives via EMS.

What's new?

- ❖ Team members are identified – verbally and with name tags on the front of protective gowns. This helps to assure that essential personnel are present.
- ❖ Team members have assigned roles and responsibilities. They have assigned positions around the patient.
- ❖ The addition of an Emergency Medicine residency has resulted in integrating their role into the Trauma Team as the physician responsible for Airway Management under supervision of the EM attending physician.
- ❖ The Physician Team Leader (PTL or Trauma Surgeon) no longer “runs the show” from the head of the bed. This is the EM physician’s position (Airway). The PTL stands at the foot of the bed and oversees team actions *without* providing any hands-on patient care.
- ❖ The Primary Survey is the joint responsibility of the EM physician and Trauma Surgeon (PTL). They will rapidly assess airway, breathing, circulation (surgery resident palpates a peripheral pulse) and disability (GCS) and call out their findings to the Team and Recorder.
- ❖ As soon as this is completed a **Time Out** is called by the Trauma Surgeon (PTL). Silence is maintained while EMS provides report. This provides an opportunity for questions or clarification.
- ❖ When EMS report is over, the Secondary Survey is begun and all appropriate interventions/procedures (IVs, chest tubes, intubation, etc) are performed.
- ❖ The Trauma Team continues to manage the patient’s course and is responsible for medications, imaging, procedures, etc. until admission or discharge.
- ❖ The Electronic Medical Record (Epic) requires entry of a patient name and date of birth in order to document patient care or physician orders. The documentation we are required to submit to the Commonwealth as an L-1 Trauma Center depends on the EMR. This is the rationale for requesting basic patient information upon arrival.
- ❖ Virginia Tech Carilion (VTC) medical students are required to complete a trauma or emergency medicine internship (or rotation). In the Trauma Bay, currently, they may only observe.
- ❖ Because space in the trauma room has been further compromised by the addition of the Pyxis machines and additional personnel on the Team, those who have completed their reports and/or tasks might be asked to step back or out of the trauma room to allow the team the space that is required to optimally perform its work.

What's the same?

- ❖ Air and ground EMS personnel contact CRMH MedCom and state that they have an injured patient who meets criteria for a Gold or Trauma Alert; they provide report.
- ❖ The Emergency Medicine (EM) physician assigned to Trauma determines the level of Trauma Team response (Gold, Trauma or Consult). Frequently they are called to MedCom to listen to the report.
- ❖ The Trauma Team assembles in the Trauma Bay after a page goes out with an ETA. The EM physician shares report with the Trauma Team in preparation for the patient's arrival; equipment and supplies are assembled.
- ❖ As a Level One Trauma Center, CRMH Trauma Services must maintain compliance with all essential criteria required by the Commonwealth of Virginia Department of Health and the American College of Surgeons.

What factors drove these changes?

- ❖ The primary purpose of the Trauma Team is to provide optimal care to the patient with multiple or serious injuries in a systematic manner.
- ❖ The ATLS criterion requires physicians to perform a rapid primary survey to address life, limb and organ injury. Team members were not consistently adhering to ATLS criteria.
- ❖ Trauma registry data revealed an increase in the volume of trauma patients and the length of time taken to assess and treat them in the Trauma Bay.