TITLE: TRAUMA FLOW SHEET

PURPOSE:

To facilitate accurate and complete documentation of occurrences and actions taken during a trauma activation

Provides a record for review and evaluation of surgical/trauma interventions.

STATEMENT:

The Trauma Flow Sheet (TFS) has been replaced by the Trauma Narrator (TN) in the electronic medical record, EPIC. The Trauma Narrator shall be initiated by a professional nurse for every trauma patient. The Physician should review the Trauma Narrator as part of the patient’s review.

PROCESS:

1. TRAUMA NARRATOR
   A. RN initiates the use of the TN and records
      1. Date/time of trauma activation
      2. Activation level
      3. Mechanism of Injury/history
      4. Primary survey
         a. Airway
         b. Breathing
         c. Circulation
         d. Disability/Glasgow Coma Scale (GCS)
         e. Environment
         f. Clothing
   B. Glasgow Coma Scale (GCS) score on admission, at least hourly and at discharge from the Shock Room.
C. Revised Trauma Score on admission and discharge from Shockroom.

D. Trauma medical team members called/responded/arrival times:
   1. Surgery Attending
   2. EC Attending
   3. Surgery junior or senior resident
   4. Radiology technician
   5. Other consulting surgical services

E. Vital signs on admission and every 15 minutes until stable and then at least hourly until admission, transfer or discharge from the Shock Room (an order for this disposition will suffice to change vital sign frequency):
   1. Pulse
   2. Blood Pressure
   3. Respiratory Rate
   4. Temperature (Normal temp can be documented q4 hours)
   5. Oxygen Saturation
   6. GCS

F. Vital signs for trauma patients in other EC care areas shall be done every 4 hours unless there is a change in patient status.

G. Secondary Survey
   1. History
   2. Patient Complaint
   3. Vital Signs
   4. Head to Toe Assessment

H. IV and drug therapy.

I. Procedures (i.e., Foley, NGT, Central Line, Thoracotomy, etc)

J. Intake and Output, at least hourly, totaled upon discharge from the EC

K. Disposition of patient from the Shockroom.

L. Condition at time of disposition from the Shockroom.
Guidelines and Protocols

M. Pertinent nursing/medical assessments, interventions and evaluations

N. Disposition from Emergency Center requires these items to be completed within one hour of discharge/transfer/admission:
   1. Pulse
   2. Blood Pressure
   3. Respiratory Rate
   4. Temperature
   5. Oxygen Saturation
   6. GCS

REFERENCE / BIBLIOGRAPHY:

OFFICE OF PRIMARY RESPONSIBILITY:

LYNDON B. JOHNSON HOSPITAL TRAUMA SERVICES

REVIEW / REVISION HISTORY

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