DEPARTMENT
POLICY

TITLE: TRAUMA: TRAUMA FLOWSHEET DOCUMENTATION

Date Adopted: XX **Date Revised: XX**
Supersedes: **Date Reviewed: XX**

AFFECTED DEPARTMENTS: Emergency Department, Trauma Services

PURPOSE: To provide consistency and guidelines on the completion of the trauma flowsheet.

POLICY: All Level I trauma activation patients will have a trauma flowsheet used for documentation purposes. Patients with a traumatic diagnosis that present to the emergency department should have a trauma flowsheet used.

PROCEDURE: To properly document on the trauma flowsheet, the following steps should be followed:

1. All **bolded** areas are mandatory areas to be completed. Failure to document in these areas will create a QI follow up letter.
2. The flowsheet will be used for Level III and Level IV hospitals.
3. Page one:
    a. Arrival time - actual time patient arrives in department.
    b. Date - date patient arrives
    c. Mechanism of injury - the mechanism that created the injury, example: MVC, motorcycle, falls, gunshot wounds, stabs, and time of in jury
    d. Via: hand-write the EMS ground or Air services that brought patient in
    e. Sex: male or female
    f. Pedi Broselow color: write the corresponding Broselow colors, ie. Red, purple, yellow, white, light blue, orange, green
    g. Transferred from: the hospital/facility that patient was transferred from
    h. Allergies- patient's current medication allergies
    i. Current meds: list current medications patient is taking
    j. Past medical/surgical history: list all diseases, surgeries that patient has had
    k. Treatment PTA (prior to arrival)
        - check off all treatment given in the field or at the transferring facility prior to arrival to CHRISTUS St. Elizabeth Hospital
        - list the number of IV's prior to arrival, example IV x 2
        - intubation – size French of tube (7.0, 7.5, etc) and cm taped at

- oxygen = what type, example NRB, nasal cannula
- other – example, prehospital cryc or tracheostomy, ventilator, previous drips

l. Primary Survey is composed of C-A-B-C. Airway with C spine, breathing, and circulation. This is the assessment and interventions by the trauma surgeon in trauma bay
- Oxygen: put the number of liters the patient is placed on per each oxygen delivery device
- C spine – type is – C collar or full (c collar, backboard, head immobilizer). Document time patient was taken off backboard.
- Breathing and Circulation fill out all appropriate descriptors

m. Glasgow Coma Scale: composed of eye opening, verbal response, and motor response. Left side is adult, right side is pediatric. Total can be no lower than 3 and no greater than 15. Pupil size is not included in the GCS. The GCS should be done on ED arrival time and discharge time.

n. Revised trauma score (RTS): composed of initial spontaneous respirations (does patient have any spontaneous respirations at all, if so, what is rate? A patient that is intubated still can breathe spontaneously), systolic blood pressure, conversion of total GCS score. The RTS is a total of spontaneous respiratory rate, systolic blood pressure, and converted GCS score. RTS can be no lower than 0 and no greater than 12. An RTS should be done on ED admit time and ED discharge time.

o. Secondary survey – head to toe survey. Fill in all descriptors. Put left and right pupil size in the head section. Pupil size ranges from 1 to 9. If patient has pupillary changes, document in narrative along with interventions. If not enough room for wounds/deformities, can place on 3rd page.

4. <u>Page two</u>

a. Trauma alert called PTA per EMS/prehospital/ transferring facility report

b. Trauma alert called in ED – document what time trauma alert was called

c. Name of trauma surgeon and time of arrival must be documented

d. Document the name and time of arrival of all members of trauma team

e. Patient temperature upon arrival and discharge to be documented. Check the appropriate warming measures used. Can be more than one. Narrative documentation for any other temperature issues is encouraged.

f. VS: all vital signs are to be documented. If an initial B/P can not be detected, document radial or brachial or femoral or carotid pulse palpable. Per policy, HR, BP, RR, pulse ox should be recorded every 15 min – 1 hour as indicated for trauma alerts (level I acuity). Level 2 acuity every 1-2 hours as indicated per patient condition. Level 3 every 2-4 hours as indicated. Temperature within one hour of patient admission.
   - Respiration: spontaneous for all spontaneous breathing patients or for a patient that has spontaneous respirations while being artificially ventilated.
   - Respiration: BVM for all patients that are being artificially ventilated with a bag valve mask or on a ventilator

g. Intake – all fluids PTA and during the ED stay including blood administration will be continuously monitored for intake
   - fill in time, solution type, amount hung, location, catheter size, and rate on PTA fluids
   - fill in descriptors as new IV's are infused or started

h. Blood administration – fill in time, unit number, blood type and initials of person hanging blood.

i. Total intake = any PO fluids + above IV/blood administration

j. Output – document all urine, NG, chest tube output

k. Medications –
   - document Tetanus lot and expiration number
   - document time of medication administration, name, dosage, route of administration, pain scale prior to and after medication administration as applicable, and initials of each nurse giving medication

5. <u>Page 3</u>

a. Treatments and procedures – document all treatments and procedures done while in the ED

b. All invasive procedures should have a procedure verification and time out done per procedure

c. Fill out procedures as done

d. Major injuries – document all major injuries as described per trauma surgeon

e. Document all narrative notes including reassessment in the progress notes with corresponding time.

f. Document the time CPS/ACS is notified if applicable.

g. Document time policy agency notified, arrived, and name of police agency. Check if the patient was in custody at time of arrival in ED.

h. Document time transfer to another facility was initiated and accepted. Also document name of accepting facility.
i. Document presence of family.
j. Document patient disposition.
k. Nursing staff and trauma surgeon should sign flowsheet.

6. Page 4
   a. The fourth page is the call time and arrival time of the members of the trauma team. Place the time the members of the trauma team were called and what time they arrived.

APPROVAL:

Trauma Services: **Trauma Program Manager:** _____

Trauma Medical Director: _____

Nursing Service: **Chief Nursing Executive:** _____