ADMISSION POLICY FOR MAJOR TRAUMA WARD

The Major Trauma ward has 4 x Level 1 beds and 8 x Level 0 beds.

Level 1 beds are for patients at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice and support from the critical care team.

The following patients should be admitted to the Major Trauma Ward rather than a single specialty ward:

1. Injuries to more than one body region
2. Requiring the input of 2 or more specialties
3. Significant injury to a single body region e.g.
    - High energy pelvic fractures
    - Chest wall injuries
    - High energy open long bone fractures
    - Grade III or above solid organ injuries
4. Stepping down from critical care
5. Who require a Level 1 bed

REFERRAL & ADMISSION PROCESS

- All patients will initially be accepted by a Specialty Registrar or Consultant, usually an ST4+ from one of the following surgical specialties.
    - Orthopaedic surgery
    - Cardiothoracic surgery
    - Neurosurgery
    - General Surgery
- Referrals for admission to the major trauma ward should then be made to the holder of pager 2202. This is usually the Major Trauma Fellow (2202) or Advanced Nurse Practitioner (2207). They will arrange a Major Trauma Ward bed following discussion with the Nurse in Charge.
- All patients for admission to the major trauma ward must be discussed or seen by an ST4 or above from the admitting specialty
- All patients with multiple injuries should continue to be referred to Critical Care as per current pathways. The Critical Care team may deem the patient suitable for Level One care on the MTW and the patient can be admitted under the appropriate specialty parent team.

In all patients, **a single lead Consultant will be responsible for the provision and co-ordination of care will take responsibility for the patient. This will be the named consultant on TRAK.** This Consultant will be based on the dominant injury and priorities for treatment. The Trauma Team leader (TTL) will usually refer to the most appropriate team. In the event any dispute cannot be resolved and/or is leading to any delay this should be escalated by the TTL to the relevant specialty consultants to agree a named consultant.

Where care might be considered shared between consultants, **a single lead Consultant must always be allocated and documented**.. The Major Trauma Service will ensure that the lead in-patient specialty Consultant is always explicit on TRAK and will support any necessary transitions of care as the patient's dominant care needs evolve over time.

SPECIALTY INPUT INTO MAJOR WARD PATIENTS

- All patients will be seen daily by their parent team at ST2 level or above before midday.
- They must be joined by Medical and Nursing staff from the Major Trauma service.
- The following patients must be reviewed/discussed by the parent team Consultant:
    - All **new** admissions within 14 hours
    - All patients on Level 1 area
    - Significant Family concerns
    - At Senior Nurse or Major Trauma Consultant request
    - Patients where end of life care decisions are required.

- At the weekend there is no major trauma consultant. All patients should be reviewed or discussed with the parent consultant on a daily basis over the weekend.
- All decisions are documented on a structured ward round note on TRAK either during or immediately after the ward round.
- ***It is expected that representatives from the following specialties should have contact with the Major Trauma Consultant/Ward every weekday*** to maintain close links and ensure patients with multisystem injuries are receiving early input and decision making, in particular for new patients:
    - Orthopaedic surgery
    - Neurosurgery
    - General Surgery

There should also be regular contact between the Major Trauma service, Radiology and Critical Care.

ROUTINE WARD CARE & ESCALATION

The Major Trauma Fellow/ANP will provide routine care. The parent surgical team must leave clear instructions on TRAK regarding any ongoing treatment if required, including any treatment escalation plans.

The IDL will be prepared as early as possible by the parent ward team and sent to Pharmacy with an estimated discharge date. The parent specialty consultant will usually determine patients suitable for discharge. At discharge the Major Trauma team will normally complete the IDL. Where this is not possible it is the parent team's responsibility.

A NEWS score of 3 will result in the Ward Nurses escalating to the Major Trauma Fellow/Nurse Practitioner

A News score of 5-6 will be assessed immediately by the Major Trauma Fellow/ANP who will escalate initially to:

Monday - Friday 0800-1800 - Major Trauma Consultant
Outwith these hours - the Specialty Registrar on call for the parent specialty

Patients recently discharged or recently reviewed by critical care, which are deemed suitable for escalation and who deteriorate should be discussed with Critical Care.