Trauma Teams save time and lives

RIE Trauma Teams Version 5 **May 2025**

Author: Dean Kerslake

Contributions: Callum Johnston (SAS), Nicola McCullough (ED Trauma lead), Sara Robinson (ED), Chris Connolly (ED CNM), Ray Middlemiss (ED charge nurse) Christopher Hay (Radiology), Laura Fitton (Anaesthesia), Bernhard Heidemann (Anaesthesia), Phil Docherty (Anaesthesia), Neil Emslie (ODP), Stuart McKechnie (General Surgery), Peter Lamb (General Surgery), Laura Wilson (Radiography), Tim White (Orthopaedics), Gregor McNeill (Critical Care) Kallirroi Kefala (Critical Care), Jackie Brady, Jackie Drummond, Nyree Brown, Lyle Moncur (ED), Craig Walker (ED)

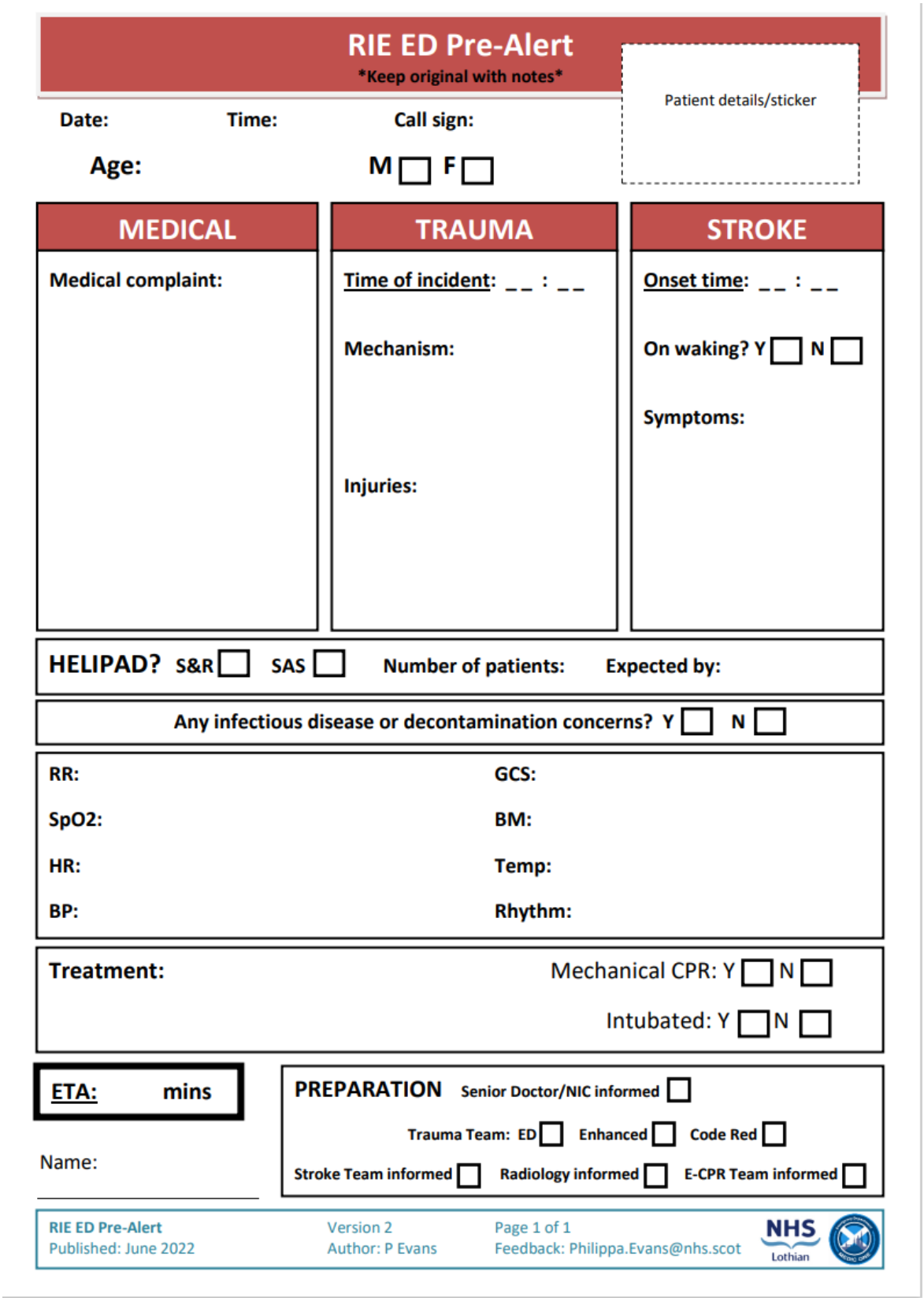
TRAUMA TEAM ROLES & RESPONSIBLITIES

1. Background

- To ensure all major trauma patients receive immediate, consultant-led care on arrival.
- To support timely and appropriate diagnosis and management using a multi-disciplinary team (MDT) approach.
- To aim for >95% of Major Trauma patients receiving an Enhanced Trauma Team response.
- To limit Enhanced Trauma Team activation for patients with minor injuries to <40%.
- To ensure clear documentation of all trauma team attendances and interventions.
- To improve outcomes and patient experience in trauma care.

1.2 Ambulance pre-alert

A structured pre-alert should be provided with a minimum of 10 minutes notice, where possible. The pre-alert form should be completed in full and accompany the patient's notes. The nurse in charge (NIC), resus coordinator, or ED consultant will be notified and will decide which trauma team tier to activate.



RIE ED Pre-Alert

Keep original with notes

Patient details/sticker

Date: Time: Call sign:

Age: M ☐ F ☐

MEDICAL	TRAUMA	STROKE
Medical complaint:	Time of incident: _ _ : _ _	Onset time: _ _ : _ _
	Mechanism:	On waking? Y ☐ N ☐
		Symptoms:
	Injuries:	

HELIPAD? S&R ☐ SAS ☐ Number of patients: Expected by:

Any infectious disease or decontamination concerns? Y ☐ N ☐

RR:	GCS:
SpO2:	BM:
HR:	Temp:
BP:	Rhythm:

Treatment: Mechanical CPR: Y ☐ N ☐

Intubated: Y ☐ N ☐

ETA: mins

Name:

PREPARATION Senior Doctor/NIC informed ☐

Trauma Team: ED ☐ Enhanced ☐ Code Red ☐

Stroke Team informed ☐ Radiology informed ☐ E-CPR Team informed ☐

RIE ED Pre-Alert Version 2 Page 1 of 1

Published: June 2022 Author: P Evans Feedback: Philippa.Evans@nhs.scot

NHS Lothian

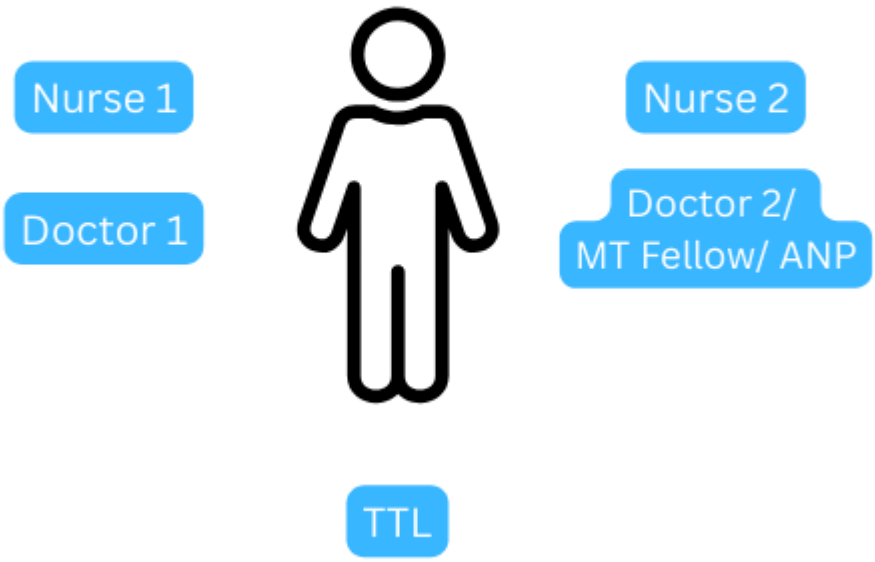
Fig.1 – Mandatory standardised criteria passed during the ambulance pre-alert

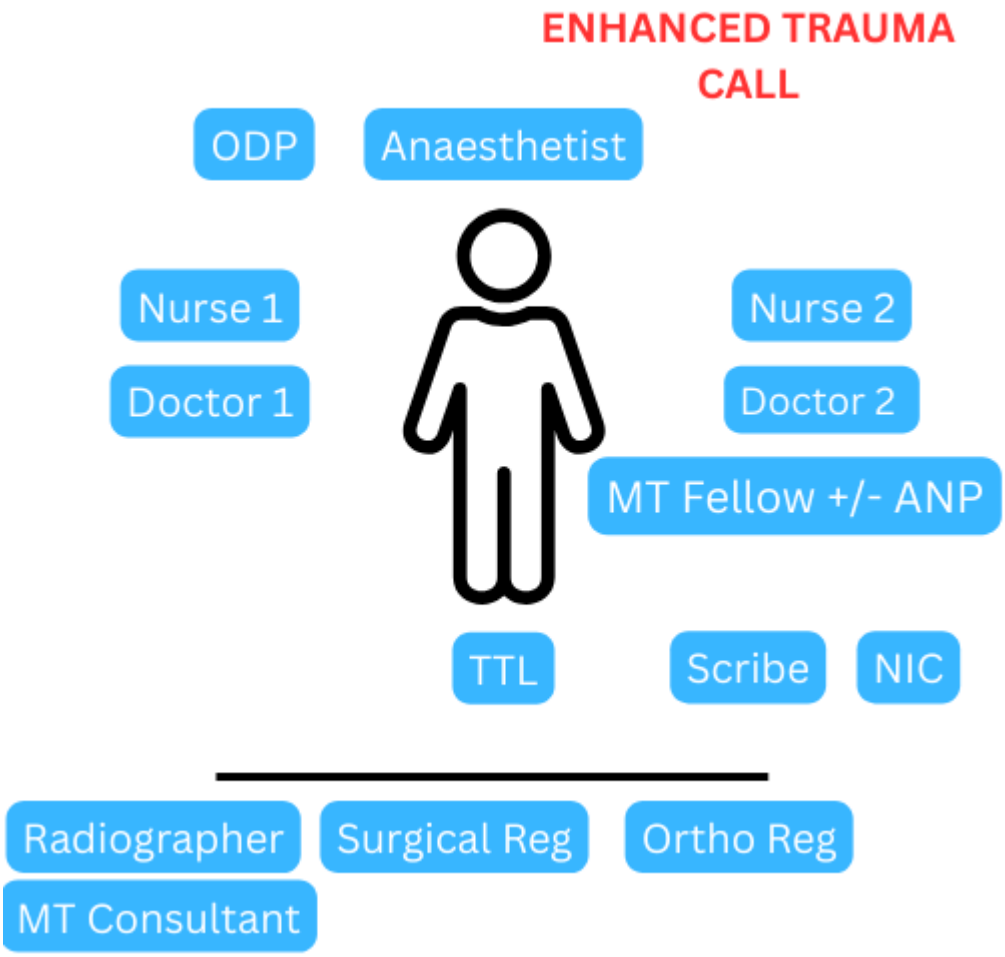
1.3 The Three Tiered Trauma teams

The RIE operates a three-tiered trauma response system to ensure an appropriate, scalable response to major trauma while minimising service disruption.

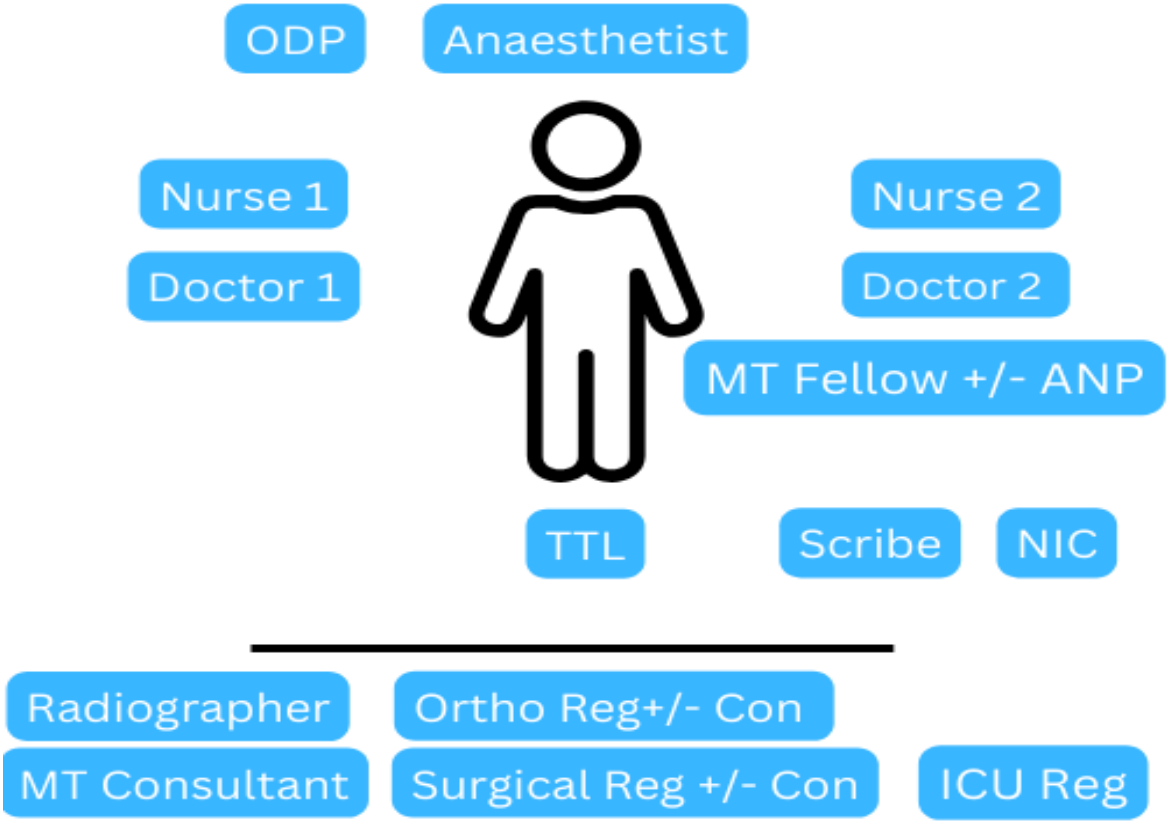
SPECIALTY	**ED TRAUMA TEAM**	**ENHANCED TRAUMA TEAM**	**CODE RED TRAUMA TEAM**
Emergency Medicine	TTL (CONSULTANT/ST4+) DOCTOR DOCTOR NURSE 1 NURSE 2	TTL (CONSULTANT) ST4+ DOCTOR NURSE 1 NURSE 2 NURSE TEAM LEAD (scribe) RECEPTIONIST	TTL (CONSULTANT) ST4+ DOCTOR NURSE IN CHARGE NURSE 1 NURSE 2 NURSE TEAM LEAD (scribe) RECEPTIONIST
Orthopaedics		REGISTRAR	REGISTRAR
General Surgery		REGISTRAR	CONSULTANT/REGISTRAR
Radiography		RADIOGRAPHER	RADIOGRAPHER
Anaesthesia		REGISTRAR/CONSULTANT ODP	CONSULTANT/REGISTRAR ODP (Theatre coordinator paged)
Critical Care			CONSULTANT/REGISTRAR
Radiology		(notified when patient on CT table)	(notified when patient on CT table)
Major Trauma	FELLOW/ANP	FELLOW/ANP CONSULTANT (in hours)	FELLOW/ANP CONSULTANT (in hours)

ED TRAUMA CALL




ENHANCED TRAUMA CALL
ODP
Anaesthetist
Nurse 1
Doctor 1
Nurse 2
Doctor 2
MT Fellow +/- ANP
TTL
Scribe
NIC
Radiographer
Surgical Reg
Ortho Reg
MT Consultant

CODE RED TRAUMA CALL



1.4.1 'Code Red Trauma Team' Activation criteria

'Code Red Trauma Team' is activated when ***all*** of the following criteria are met:

- Suspected or confirmed active haemorrhage
- SBP<90
- Unresponsive to volume resuscitation

Code Red may be activated by EMRS, advanced critical care practitioners, or the TTL based on the pre-alert.

Early consultant attendance is expected.

Other specialties to consider alerting: Interventional Radiology, Cardiothoracics, Neurosurgery, Vascular.

1.4.2 Enhanced Trauma Team activation criteria

*Activated when **any of the following criteria** are met:*

1. PHYSIOLOGY

    a. GCS <14
    b. RR<10 or >29
    c. SBP <90 or sustained loss of radial pulse

2. ANATOMY

    a. Penetrating injury proximal to shoulders and knees
    b. Chest wall instability or deformity
    c. Two or more proximal limb fractures
    d. Crushed, de-gloved, mangled or pulseless extremity
    e. Amputation proximal to wrist or ankle
    f. Open or depressed skull fracture
    g. Paralysis

3. At the request of the Pre-Hospital Team, TTL or Senior Nurse

1.4.3 'ED Trauma Team' Activation criteria

For patients not meeting Enhanced or Code Red criteria but with:

1. MECHANISM

    a. Falls >20 feet

b. Ejection from vehicle
c. Death in the same vehicle
d. Vehicle vs. pedestrian/cyclist >20mph
e. Motorcyclist >20mph

2. SPECIAL CONSIDERATIONS

a. Age >55
b. Bleeding disorders (including anticoagulation)
c. Morbid Obesity
d. Pregnancy >20 weeks (Consider Fast Page Obstetrician +/- Enhanced trauma team response)
E. Suspected Pelvic fracture

1.5 How to activate Trauma Teams

Activation may occur:

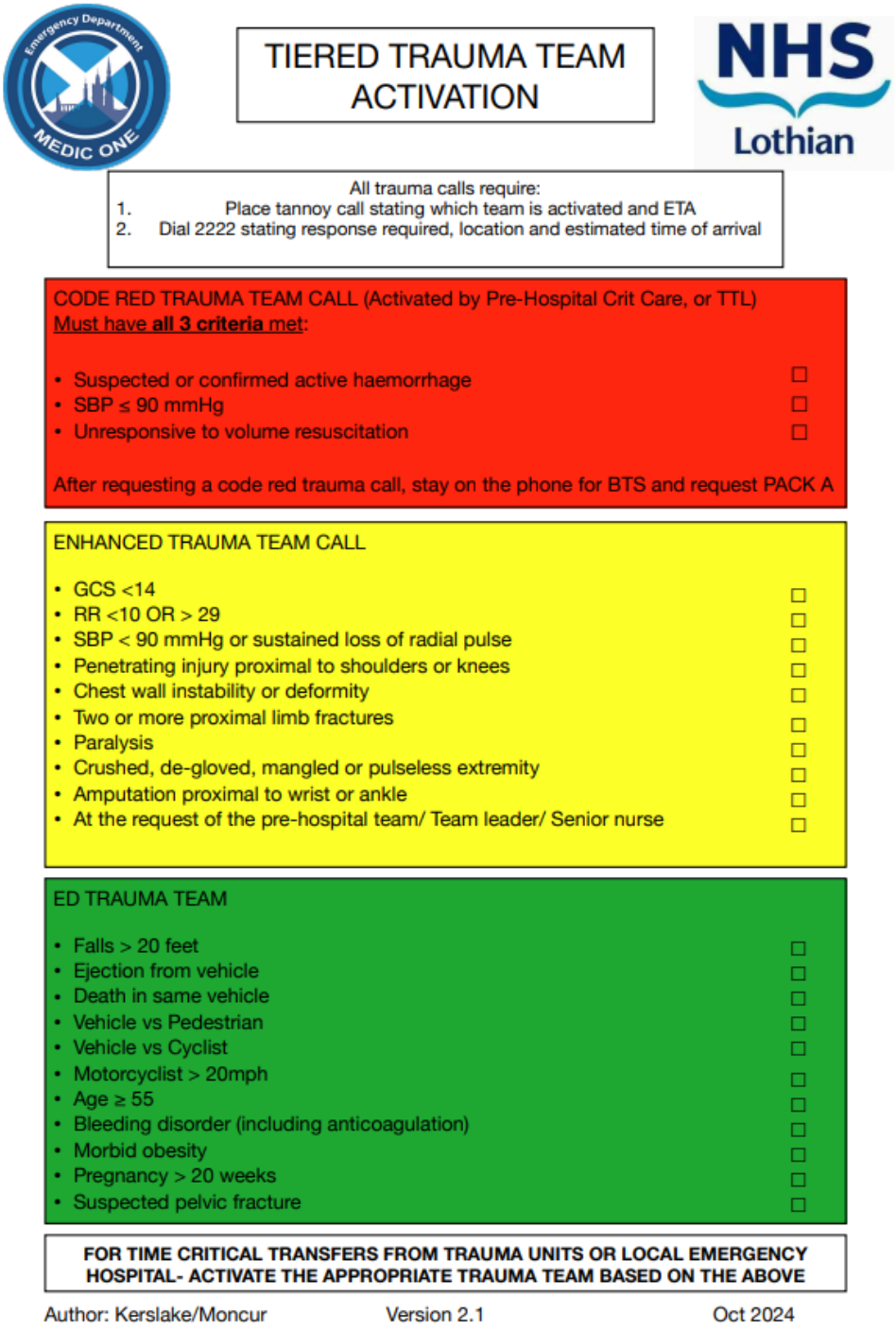
- Based on ambulance pre-alert
- On patient arrival in the ED

Timing:

- ED/Enhanced: Activate ideally ≥ 10 minutes before ETA
- Cod Red: Activate ≥ 15 minutes before ETA

Other tips:

- Stay on the phone after Code Red Activation- switchboard will connect you to BTS to activate the code red transfusion protocol
- Activate additional teams for multiple casualties (e.g. "2nd Enhanced Trauma Team to Resus 1a").
- Use 2222 to fast bleep additional specialties (e.g. neurosurgery, vascular)



TIERED TRAUMA TEAM ACTIVATION

NHS Lothian

All trauma calls require:
1. Place tannoy call stating which team is activated and ETA
2. Dial 2222 stating response required, location and estimated time of arrival

CODE RED TRAUMA TEAM CALL (Activated by Pre-Hospital Crit Care, or TTL)
Must have **all 3 criteria** met:

- Suspected or confirmed active haemorrhage ☐
- SBP ≤ 90 mmHg ☐
- Unresponsive to volume resuscitation ☐

After requesting a code red trauma call, stay on the phone for BTS and request PACK A

ENHANCED TRAUMA TEAM CALL

- GCS <14 ☐
- RR <10 OR > 29 ☐
- SBP < 90 mmHg or sustained loss of radial pulse ☐
- Penetrating injury proximal to shoulders or knees ☐
- Chest wall instability or deformity ☐
- Two or more proximal limb fractures ☐
- Paralysis ☐
- Crushed, de-gloved, mangled or pulseless extremity ☐
- Amputation proximal to wrist or ankle ☐
- At the request of the pre-hospital team/ Team leader/ Senior nurse ☐

ED TRAUMA TEAM

- Falls > 20 feet ☐
- Ejection from vehicle ☐
- Death in same vehicle ☐
- Vehicle vs Pedestrian ☐
- Vehicle vs Cyclist ☐
- Motorcyclist > 20mph ☐
- Age ≥ 55 ☐
- Bleeding disorder (including anticoagulation) ☐
- Morbid obesity ☐
- Pregnancy > 20 weeks ☐
- Suspected pelvic fracture ☐

FOR TIME CRITICAL TRANSFERS FROM TRAUMA UNITS OR LOCAL EMERGENCY HOSPITAL- ACTIVATE THE APPROPRIATE TRAUMA TEAM BASED ON THE ABOVE

Author: Kerslake/Moncur Version 2.1 Oct 2024

1.6 Trauma Team Principles

- The TTL holds overall clinical responsibility.
- Trauma team responses should be consistent and well-rehearsed.
- All team members must attend immediately (within 10 mins) or arrange cover.
- Team members:
    - Introduce themselves and wear name/role stickers.
    - Sign-in with the scribe.

    - Wear appropriate PPE (apron, gloves, +/- lead, eye protection).
    - Stand in the appropriate position
    - Remain until formally stood down by the TTL.

- Late or absent attendance should be recorded. This will be audited and fed back through the Major Trauma Governance group.
- Noise in the trauma bay should be kept to a minimum
- Major Trauma clinical fellows/ANPs now attend all trauma calls 24/7
- A Major Trauma Consultant attends Enhanced and Code Red Trauma calls (Mon-Fri 0800-1800, Sat-Sun 0800-1200)

1.7 Preparation of the Resus Room (use TTL Checklist)

- Complete whiteboard with pre-alert info
- Trauma mattress and blanket ready on trolley
- Use under-patient Bair hugger for all Enhanced and Code Red trauma calls.
- Patient gown and warm blanket should be ready
- The Trauma Booklet should be ready
- Tuff cuts, ECG leads, ETCO2, US machine in place
- Drugs prepared
- Introductions, roles and skill set of all the team verbalised.

1.8 The first 5 minutes of a trauma call

- Trauma room preparation as above.
- Patient arrives on ambulance trolley and is transferred onto ED trolley.
- Determine if any immediate concerns and action as guided by the TTL.
- If no immediate concerns, then listen to 30-second concise hands-off handover
- Begin undressing patient while minimising movement and maintaining privacy The
- 3 Team members are allocated one side of the patient (opposite side to ambulance trolley) ready to assist with removal of the patient from the scoop stretcher.
- The patient must be removed from the Orthopaedic Scoop stretcher/Spinal Board/Vacuum mattress as per video available at ‘www.edinburghemergencymedicine.com’
- Use standard lift/roll commands: “Ready, Brace, Command”
- Attach monitoring and obtain vitals within 2 minutes
    - SpO2 probe on side of working cannula
    - NIBP on opposite
- Cannulation, bloods, analgesia promptly
- The Primary survey should be clearly communicated by Doctor 1 ‘live’ to the team within 5 minutes of arrival
- CXR, Pelvis XR, and FAST for all Code Reds within 5 minutes
- Avoidance of hypothermia with under-patient Bair hugger and warm blankets
- TTL to clearly state injuries, concerns and plan early

- The pre-hospital PRF must be given to the scribe and kept securely in the notes.

1.9 Imaging & Investigations

- All patients should have FBC, U&Es, LFTs, Coag screen, BTS x2, VBG.
- Use the major trauma bloods order set for enhanced and code red trauma calls.
- The BTS tube must be checked by 2 people to prevent error
- Code Red: ROTEM mandatory
- Consider HCG as clinically indicated
- ECG for all patients >40 or as clinically indicated

1.10 Transfer of patients

- TTL and TTMs to accompany patient to CT unless directed otherwise
- The TTL can make exception to this at their discretion
- For all enhanced or code red trauma calls the radiologist must be made aware when the patient arrives in CT
- Ensure the duty radiologist has the most update information, which may have changed since the request to adapt imaging protocols.
- All notes should accompany the patient
- Update TRAK immediately for all patient movements as these are matched against quality standards
    - Temporary move to CT
    - Temporary move to Theatre
    - Discharge to ward

1.11 Documentation

- Complete trauma booklet in full
- A TRAK entry using the short code **\trauma** must be completed for electronic documentation and STAG data collection
- Each specialty must document on TRAK stating the:
    - The consultant on call
    - Management plan
    - Movement restrictions
    - Follow up.
    - VTE prophylaxis plan
- The pre-hospital PRF must accompany the patient.

SAS Action Card

PRIOR TO PATIENT ARRIVAL
Ideally major trauma patients should arrive undressed aiming for a 10 minute pre-alert (or longer if shocked)
Use the ATMIST mandatory criteria for the pre-alert
ON ARRIVAL OF THE PATIENT
Transfer the patient on the scoop over to the trauma mattress
State any immediate life-threatening needs - If none/once addressed the team will listen for a 30 second MIST handover MECHANISM INJURIES SYMPTOMS & SIGNS TREATMENTS
Assist the team removing the patient off the scoop
Further more detailed history can be given to the TTL & scribe prior to leaving whilst the team can continue patient care

Trauma Team Leader Action Card

PRIOR TO PATIENT ARRIVAL
Completes the TTL checklist to prepare for patient arrival
AIM TO BE HANDS OFF AT THE END OF THE BED AT ALL TIMES
ON ARRIVAL OF THE PATIENT
Addresses only immediate life-threatening needs before all the team listen quietly to 30 second handover - seek further information or clarification separately whilst team get to work
Ensure clothes and scoop are removed as per standardised method
Prioritises investigations and treatment
Ensures Pelvic Binder if mechanism consistent and SBP <110mmHg
Ensures administration of TXA if suspicion of bleeding and either HR >110 or SBP <110
Code RED patients require an immediate CXR, Pelvis XR and eFAST
Aim to leave for CT within 20 minutes ensuring lines are secure and working. Some patient may require theatre rather than CT
Arterial lines should only be considered prior to CT if NIBP not reading
Ensures Blood Bank aware of patient movements.
Stand down TTMs as soon as not needed
Ensure ambulance PRF, booklet and TRAK documentation completed
Clearly handover leadership when required – though TTL would usually see patient to CT
Hot Debrief for all code reds and other Major Trauma (this may mean re-paging the team at a defined time)
Ensure relatives are spoken to

Doctor 1 (usually EM ST4+) Action Card

PRIOR TO PATIENT ARRIVAL
Report name and grade to scribe
Confirm skill level to TTL
Wear lead, apron, gloves and consider eye protection
ON ARRIVAL OF THE PATIENT
Reassures patient on arrival and explain what's happening (may be shared with anaesthetist)
Undertakes a primary survey clearly stating loudly all relevant findings to team along the way - <C>ABCDE
Performs an eFAST scan if requested and competent
Ensures neurology is documented prior to muscle relaxation (may be shared with Anaesthetist)
Takes an AMPLE history (may be shared with anaesthetist)
Completes the secondary survey (may be shared with the Orthopod) (Head/face/neck/chest)
Ensures code red patients are kept warm with Blankets/Bair Huggers
Prescribes/Administers Drugs
Ensures TRAK entry accurate according to template (can be shared with Dr 2)

Doctor 2 Action Card

PRIOR TO PATIENT ARRIVAL
Report name and grade to scribe
Confirm skill level to TTL
Wear lead, apron, gloves and consider eye protection
Order imaging as requested and Major Trauma blood order set
ON ARRIVAL OF THE PATIENT
Ensure there are two large peripheral lines. Do not try more than twice without informing the TTL
Obtain the following tubes in order: 2 x Blue, VBG, 2 x Green, 1 x red, 1 x Orange
Ensure the BTS tubes and form is correctly filled out with another team member
Run a ROTEM in code red patients
Ensure the VBG and ROTEM result are handed to the team leader as soon as they are ready
Ensures the code red patient is kept warm with Blankets/Bair Hugger
Prescribes/Administers drugs
Helps with procedures
Ensures TRAK entry accurate according to template (can be shared with Dr 1)

Major Trauma Fellow/ ANP Action Card

PRIOR TO PATIENT ARRIVAL
Check-in with TTL and scribe, confirming skill level
Wear appropriate PPE +/- lead and eye protection
Assist with trauma bay preparation and ensure situational awareness
Anticipate likely investigations and interventions based on mechanism and presentation
ON ARRIVAL OF THE PATIENT
Support the trauma team by: • Performing or assisting with primary/secondary survey • Undertaking key elements of Doctor 2's role (e.g. cannulation, blood sampling, ROTEM, drug administration) • Performing components of Doctor 1's role if required (e.g. eFAST, documentation, secondary survey)
Communicate with radiology and specialist teams (e.g. surgery, orthopaedics) to facilitate decision-making
Ensure accurate, timely documentation and assist in coordinating TRAK entries as needed
Contribute to warming measures and patient transfer to CT or theatre
Maintain awareness of bed status and update TTL on potential MTW capacity issues
Liaise with admitting specialties, ICU and the trauma ward team to plan for safe transfer/admission
Escalate any concerns early to TTL

Major Trauma Consultant Action Card

PRIOR TO PATIENT ARRIVAL
Report name and grade to scribe
Review pre-alert details and attend Enhanced or Code Red trauma calls during designated hours
Identify own base specialty and how best to support the TTL and trauma team
ON ARRIVAL OF THE PATIENT
Observe and assist as required based on clinical need and personal expertise (e.g. surgical decision making, imaging interpretation, airway support)
Support the TTL with senior decision-making and offer second opinions when appropriate
Assist with liaison to inpatient specialties or ICU if appropriate
Help coordinate admission plans or expediate transfer when delays are anticipated
Promote forward thinking: highlight risks, anticipate complications and facilitate appropriate escalation or support
Participate in hot debriefs or follow-up discussions if needed
Step back or stand down when not required to reduce crowding or role duplication

Nurse 1 Action Card

PRIOR TO PATIENT ARRIVAL
Check in with the scribe and wear role sticker
May need to take role as airway assistant if ODP unavailable
Ensure Trauma Mattress on trolley
Monitor ready to attach: • ECG dots on telemetry • ETCO2 ready (off Standby) • NIBP set to 3min cycle
Wear lead and PPE
Ensure Tuff cuts x 2 available
Ensure Oxygen under trolley
Pelvic Binder available/on trolley as indicated. Under patient Bair hugger for enhanced/code red trauma calls
Set out chest drain/other procedure sets as required
ON ARRIVAL OF THE PATIENT
Attach monitoring in the following order SpO2 on drip arm NIBP on non drip arm ECG dots
Assist removing clothing and store securely
Check Temperature and BM. Perform ECG as requested.
Cover with warmed Blankets (if enhanced or code red – under-patient Bair Hugger as well)
Administer drugs as prescribed
Assist (Dr 1) with procedures - Catheters including pregnancy test, A-Line, chest drains etc.

Prepare to leave for transfer and go with patient to CT

Nurse 2 Action Card

PRIOR TO PATIENT ARRIVAL
Check in with Scribe – if no scribe present you will act as scribe
Wear PPE
Draw up drugs prior to patient arrival as requested
Help Nurse 1 prepare
Run through blood on Belmont with extension and three-way tap for all code red patients (can share with other nurse)
ON ARRIVAL OF THE PATIENT
Remove clothing
Draw up and administer drugs as required
Assists (Dr 2) with procedures
Ensure the patient is kept warm
Prepare for transfer to CT
Ensure TRAK moves are kept up to date lwhen patient leaves for CT and theatre.

Radiographer Action Card

PRIOR TO PATIENT ARRIVAL
Place detector in position under the trolley for a chest X ray
Position X-ray tube over trolley
Liaise with TTL or nurse if members are not wearing lead
ON ARRIVAL OF THE PATIENT
In code red patients the X-ray can be taken as an emergency patient with a verbal request if required (only send to PACS once merged)
Ensure Doctor 2 or scribe requests the X rays on TRAK as soon as patient booked in.
Liaise with TTL if team members are obstructing your chance to take X rays.
The radiographer should aim to have both X rays taken within 5 minutes of the patient's arrival. (If both the CT scanner and the patient are ready then either of these may be omitted at the discretion of the team leader.)
Inform TTL if there are delays in TRAK request.
When **you** are ready to expose, countdown: 'X-rays in 3-2-1 XRAY' – TTMs should be expected to leave or be protected and not delay this.

Nurse Team Leader (scribe) Action Card

PRIOR TO PATIENT ARRIVAL
This role is invaluable to the team. You must ensure you get the information you need and inform the team leader if you are not. You will act as the primary nurse team leader (with assistance from the NIC when present)
All team members should check in with you upon arriving in the resuscitation room – Please remind them if not.
Document team members including specialty, grade and time of arrival.
Work closely with the TTL and ensure that progress and interventions are achieved
Acts as the main link with BTS in code red patients. Activates the code red team in discussion with Nurse in charge/TTL
ON ARRIVAL OF THE PATIENT
Start the digital clock
Document vital signs at least every 15 minutes (3 minutes if code red/MHP) or as clinically appropriate– inform the team leader if they have not been performed
Record timings of all events and interventions.
Inform the team leader for every 15 minutes that pass
Place a wristband on the patient as soon as the notes arrive.
If Code Red, ensure there is an allocated transfusion nurse and that used products are kept together in a clinical waste bag for later double checking
Ensure you gather both the PRF and all other pre-hospital information before the paramedics/MEDIC ONE/EMRS leave.
Ensures the team leader gives clear regular updates of current situation and plan
Ensures and prioritises the nursing workload and allocation of tasks in conjunction with the TTL and NIC.

Ensures liaison with relatives
Thinks, plans and prepares ahead at all times

Anaesthetist Action Card

PRIOR TO PATIENT ARRIVAL
Liaise early with theatre coordinator
Report name and grade to scribe
Always Wear lead, apron, gloves and consider eye protection
The Anaesthetist usually controls all movements using the commands 'Ready, Brace, Command e.g. lift, roll
Draw up drugs with ODP - usually Ketamine, Fentanyl & Rocuronium and prepare a propofol infusion
Prepare the airway trolley with the ODP against the RSI checklist, including equipment and monitoring preparation.
Ensure you will be ready to move the patient within minutes of arrival e.g. Transfer Bag, suction, Drugs, Oxygen on trolley
ON ARRIVAL OF THE PATIENT
Assist transferring the patient from stretcher to trolley and coordinate any further movements,
Talk and reassure the patient explaining what is happening
Communicate airway patency to TTL & Scribe (may be shared with Dr 1)
Ensures C – Spine immobilisation (unless penetrating trauma)
Communicates GCS, pupils & limb movements (may be shared with Dr 1)
Communicates an AMPLE history (may be shared with Dr 1)
Intubates and manages ventilation when appropriate in discussion with TTL
Passes an NGT/OGT when intubated
Only considers an arterial line if NIBP not measuring – rarely delay transfer
On-going assessment of GCS and pupils
Assist with IV access as indicated

ODP Action Card

PRIOR TO PATIENT ARRIVAL
Report name and grade to scribe
Always Wear lead, apron, gloves and consider eye protection
Draw up drugs with the anaesthetist - usually Ketamine, Fentanyl & Rocuronium and prepare a propofol infusion
Prepare the airway trolley against the RSI checklist, including equipment and monitoring preparation.
Ensure you will be ready to move the patient within minutes of arrival e.g. Transfer Bag, suction, Drugs, Oxygen on trolley
Helps prepare the Belmont in conjunction with allocated nursing staff as requested
ON ARRIVAL OF THE PATIENT
Assist transferring the patient from stretcher to trolley
Intubates and manages ventilation when appropriate in discussion with TTL
Assists with procedures as appropriate
Ongoing assistance with Belmont rapid infuser

General Surgery Action Card

PRIOR TO PATIENT ARRIVAL
Surgical consultant should be present if on site for code red patients or alerted early if off site
Ensure a theatre is immediately available for code red patents in conjunction with anaesthetist and theatre coordinator.
Report name and grade to scribe and TTL including skillset
Wear lead, apron, gloves and consider eye protection as appropriate
Be prepared to/Scrub to perform surgical intervention as guided by TTL - External Haemorrhage control - Intercostal Chest Drain Emergency Thoracotomy (if possibility from pre-alert, identify an assistant with help of the TTL)
Stays with the patient including to CT unless stood down by the TTL or after discussion with the TTL.
May take the role of DOCTOR 1 (usually only during multiple casualty scenarios)
ON ARRIVAL OF THE PATIENT
Stand behind the line until discussion with TTL
Assists with procedures, which may include sending/ordering/requesting of tests.
Perform surgical interventions above as required/competent by TTL including NGT, Urinary Catheter, ICDs, Thoracotomy
Discusses surgical plan/needs/priorities with TTL
If a patient is going to directly to theatre ensure consultant contacted en route and go directly to theatre so you are scrubbed prior to arrival of the patient.
You must go to CT with the patient to receive the hot report with the TTL from the radiologist.
Document using standard template on TRAK

Orthopaedic Action Card

PRIOR TO PATIENT ARRIVAL
Orthopaedic consultant should be present or alerted early (if off site) if confirmed pelvic fracture & Code Red
Report name, grade and skillset to scribe and TTL
Ensure a theatre is immediately available in conjunction with anaesthetist
Wear lead, apron, gloves and consider eye protection as appropriate
Be prepared to/Scrub to Assist the General Surgical team with life saving surgical interventions
May take the role of DOCTOR 1 (usually only in multiple casualty scenarios)
ON ARRIVAL OF THE PATIENT
Stand behind the line until discussion with TTL
Assists with procedures, which may include sending/ordering/requesting of tests.
Perform surgical interventions above as required by TTL which may include chest drains, urinary catheter etc.
Ensure the following early and ideally prior to CT: - The pelvic splint is appropriately placed - Basic splinting & traction of long bone fractures
Identify Limb Threatening injuries – Does CT need to include the lower limbs?
You must go to CT with the patient to receive the hot report with the TTL from the radiologist unless stood down
For patients who go to theatre – Decide in conjunction with TTL, anaesthetist and other surgical consultant the need for any damage control orthopaedics
Perform and document a secondary survey as early as possible include: All wounds/grazes/de-gloving Joints and long bones Neurovascular exam Peripheral pulses
Order further X rays and act upon the results including wound & fracture management
Document standardised TRAK entry

Receptionist Action Card

PRIOR TO PATIENT ARRIVAL
Attend Enhanced and Code red trauma calls
ON ARRIVAL OF THE PATIENT IN ED
Book in patients immediately after handover

Radiology Action Card

PRIOR TO PATIENT ARRIVAL
Ensure Radiographer is on site and CT scanner ready to receive patient
ON ARRIVAL OF THE PATIENT IN CT
For all Enhanced Trauma Teams and Code Red patients the TTL will ensure the radiologist is alerted (usually by a knock on the door). If there is further relevant clinical information which may alter the scanning protocol or interpretation this should be communicated
IR consultant and IR lab should be considered early if patient is a Code Red with a pelvic fracture.
Provide a hot verbal report to the TTL within 5 minutes
Provide a typed provisional report within 1 hour
Provide a typed consultant report within 24 hours

Critical Care Action Card - Code Red

PRIOR TO PATIENT ARRIVAL
ICU consultant should be present if on site.
Report name and grade to scribe
Ensure a bed is available immediately on critical care
Wear lead, apron, gloves and consider eye protection as appropriate
Be prepared to/Scrub to: Insert Subclavian Trauma Line if required
Ensure receiving critical care area have bed space/equipment prepped and ready for patient arrival
ON ARRIVAL OF THE PATIENT
Stand behind the line until discussion with the TTL
Assist with central / subclavian access and transfusion/resuscitation as requested by TTL
Maintains awareness with Anaesthetist and Surgeon re operative interventions.
Liaise with critical care regarding likely timing. of transfer and immediate needs on ICU arrival

Charge Nurse Action Card – Code Red

PRIOR TO PATIENT ARRIVAL
Check in with Scribe
Stand next to the TTL
Ensure lead jackets are worn by Anaesthetist, ODP, Nurse 1, Nurse 2, Doctor 1
Ensure the room is prepared and ready to receive the patient e.g. Chest drains, Belmont etc. as appropriate
ON ARRIVAL OF THE PATIENT
If code red - Resource extra nursing staff if required and allocate somebody sole responsibility for Transfusion when Belmont required (over and above Nurse 1, 2 and Scribe)
Ensure someone has looked after relatives

Theatre Coordinator Action Card - Code Red

PRIOR TO PATIENT ARRIVAL
Ensure that a theatre space and team are ready to immediately receive a trauma patient
ON ARRIVAL OF THE PATIENT IN ED
Liaise with the Anaesthetist/ODP/Orthopod/Surgeon which theatre is suitable and when it is ready