VANDERBILT UNIVERSITY MEDICAL CENTER

DIVISION OF ACUTE CARE SURGERY

T2 Trauma Resident/APP Service

Expectations and Workflow of T2 Resident/APP:

A. Sign-out: day shift 0600 (0530 Wed/Fri), night shift 1800
   a. Sign-out goal: time-efficient and limited to major action items and plans for patients
   b. Include:
      i. Trauma injury overview (i.e. brief HPI & injury overview: injury fixed vs waiting on surgery/braces, pending consults/therapy, etc.)
      ii. Pertinent vitals, oxygenation (O2, IS, trach/ETT-date placed, size, FiO2, vent) lab abnormalities.
         1. Discuss plan if issues only. No need to discuss if everything is WNL.
      iii. Ins and Outs
         1. Foley/in & out cath, issues with BM and plan, ostomy with output, swallow study plan, DHT/PEG, feeding plans
      iv. Accessories/LDA - ex. restraints, wounds, drains, lines, TEC, braces, trach/ETT
         1. Include location, output amount & character, when and who placed, plan
      v. Dispo issues – will discuss triage during rounds
      vi. Resident not giving sign-out will run computer, enter orders discussed and show images needing to be reviewed
      vii. If high census, give brief review of new patients that will be discussed in Trauma Morning Report
B. Trauma Morning Report 0700-0800 (0730-0830 Wed, 0615-0700 Fri)
C. Communication/responsibilities:
   a. TEAMS chat between residents and APPs created each shift by T2 resident
      i. Communicate: patient issues, dispo planning, new admissions
   b. Residents and APPs will sit near and work together to efficiently care for Trauma patients. Do not sit in office and check charts as this could be very inefficient and lead to multiple providers working on the same thing.
   c. T2 Resident will respond to levels and new consults as necessary.
   d. T2 Resident will be assigned pager responsibilities per Trauma Senior and will communicate to team.
   e. Each T2 resident/APP should be present on the unit for the majority of each shift if not assessing trauma patients in another area. Resident/APP to communicate with 10N staff and each other about location.
D. Rounds
   a. Dayshift after Trauma Conference and Nightshift after sign-out
      i. Will communicate timing of rounds based on levels or procedures after conference or sign-out
   b. Participants: Attending/2nd Year Fellow, Senior Resident, Junior Residents on T2, T2 APP, Pharmacist

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Brad Dennis, MD, Trauma Medical Director

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i. If all parties unable to participate in rounds, APP will continue seeing patients with any available MD. Will communicate with Trauma Attending & Senior when they are able.

c. Trauma Resident or APP will present patients
   i. Assess patients, discuss plan, review orders, assign responsibilities (pulling chest tubes, discharge, following up on tasks, etc during rounds)
   ii. Discuss Triage assignment for each patient
   iii. Nightshift resident to do complete physical and document progress note

E. Triage
   a. Triage Options: Dispo per ED, T1, T2 (may stay in CPOD or priority to come up), T3, T4 monitored vs non-monitored
   b. Making the triage list
      i. Triage list is made by Senior Resident(s) and APP during back hall signout (AM/PM) as patients are signed out
      ii. Triage list will be communicated by APP and/or Senior Resident to Charge after rounds. If bed needs arise, Charge will communicate to APP/Senior Resident to determine an option. Senior Resident and APP will discuss any changes to triage list after formal rounds (AM) or informal rounds (PM); if changes are required, Senior will communicate to Charge or delegate communication to APP
      iii. New admission (see new admissions section for more detail): Senior will communicate changes to Charge re: new admissions and their place on the triage list or delegate this communication to admitting junior
      iv. The triage list is dynamic, and should be reassessed and updated throughout the day as patients move off 10N and new patients are admitted; the Senior is responsible for ensuring this occurs, but all team members (Senior, Juniors, APPs, and Charge) should communicate to ensure that appropriate patients are moving off 10N and patients that need to come upstairs are doing so throughout the shift

If there are issues with appropriate flow of patients off 10N (e.g. sick patients need to come upstairs but no beds are available), the Senior, APP, and Charge may reach out to the attending to determine what other options are available

   c. Trauma patients will flow from T1 to T2/T3 to T4
      i. If new admission and appropriate for T3 or T4, resident will discuss with attending and APP and ensure traumagram is complete
      ii. If T1 patient triaging to T4:
         1. ICU to ICU/T4 primary should be discussed with each ICU attending
         2. ICU to T4 (non-ICU) should be discussed with Trauma attending and T4 APP prior to bed assignment
   d. If Trauma charge needs to open beds before rounds end, Charge will communicate the need to the APP and APP will provide appropriate patients who are able to triage off of 10 North
   e. Contraindications for direct admission to T3 or T4
      i. Unstable vital signs
      ii. Vasoactive drips, blood transfusions, map goals, spine precautions, q2h neuro checks, frequent vascular checks, serial abdominal exams, arterial line in place

iii. Any procedure performed in trauma bay as part of resuscitation (chest tube, intubation, CVL or IO placement, etc.)
iv. Any condition requiring ICU admission

f. Trauma Resident/APP will communicate who is calling T3/T4 to give sign-out
i. Do not assign patient to another service until admission criteria to the service has been met, the patient has a bed assigned and there has been communication with the T3/T4 service.

F. Review patient charts/implement plan for all Trauma Resident Patients
a. Review and order labs/imaging, consult recommendations placed if necessary
b. Orders are clear and appropriate
i. "Crack bed" orders, diet orders, wound care orders, weight bearing statuses, PT/OT/ST (do not order until patient is able to do the therapy), and d/c orders that are not applicable any longer (bedrest, central line, arterial line, tube feeds, nursing orders). If the patient needs or does not need something, the orders should reflect the plan so the nurse knows what is expected to do.
ii. Post-op reset to include appropriate labs (cbc/bmp/lactate only if necessary), diet plan (considering injury and swallow function), imaging (ie CXR if PTX, ortho/spine films, etc)
iii. Trauma Resident Handoff (trauma handoff)
1. Problems should be brief
2. Traumagram info: do not copy all words. If not finalized, do not put the word "final".
3. DVT risk: For DVT prophy PMG. Do not put what DVT prophylaxis they are on as we will have to remember to change every time there is a change. This is for Risk scale, dopplers and Anti Xa levels

G. Progress Notes
a. Resident responsible for writing all progress notes on night shift
b. If Trauma Resident patient moves to T3 or T4 before midnight, Trauma APP will write progress note

H. New admissions
a. Resident to inform Trauma Senior, staff with Attending, and inform T1&2 APPs and Charge
b. Resident to complete admission note in EStar
c. Admission orders entered and cleaned up and reflect what is necessary for each patient
d. Update handoffs with all new information.

I. Tertiary Survey
a. Any patient with a traumatic MOI not admitted to a Trauma Service needs a tertiary survey
b. Resident will ensure all imaging is read and patient has an admitting service
c. Resident/APP will start Handoff by using tertiary handoff
d. Resident will call T4 APP and give brief information and MRN

J. End of shift discussion
a. To be done at 0300 or 1500. Complete in approximately 30 minutes.
b. Resident and APP will discuss updates only and items still needed to be completed or followed up
c. Not to be a full sign-out or working rounds

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