Trauma patients in Interventional Radiology (IR)

Principles

1. The role of IR for a particular patient must be the subject of surgical consultant to IR consultant discussion[1]. If a patient is going to need theatre **or** IR the consultant covering anaesthetic acutes **must** be informed as soon as a need for any form of intervention becomes apparent.
2. A patient should only be moved to IR when it is safe to do so. This requires a suitably experienced doctor and nurse / ODP who can provide necessary care for the patient during the IR procedure.
3. Patients should ideally go directly from CT to IR but if it is not safe to do so they should return to Resus while safe transfer is organised.
4. If there will be a delay in accessing IR alternative definitive care (i.e. surgery) should proceed if available.
5. A lead specialty (eg orthopaedic for pelvic trauma, gen surg for liver) must be identified.

Staff

Patients requiring IR should ideally be cared for peri-procedure by an anaesthetist / critical care doctor and an ODP regardless of whether or not they are intubated. The acute anaesthetic consultant is responsible for identifying appropriate personnel in liaison with the ED consultant. A doctor from the lead specialty must accompany the patient to IR.

To facilitate timely treatment it may be necessary for a non-anaesthetic team to transfer the patient to IR if it is, **in the decision of the relevant consultants**, safe to do so. Note that determination of safety includes the safety of the entire ED, not just the individual patient.

An ED nurse must accompany the patient to IR and hand-over to the IR nursing team.

[1] Contact IR on x23311 in hours, via switchboard out of hours

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Blood

All patients going for IR procedures post trauma are actively bleeding. If appropriate the Massive Transfusion in Trauma protocol should be activated (From Oct 2010). There is no blood fridge available in IR. Products already in the ED fridge should be transferred in a cool box with the patient[2]. Further products should be requested directly from blood bank to IR.

Post procedural care

At the end of the procedure the interventional radiologist and lead specialty must formulate and document a clear plan for what to do if ongoing bleeding is suspected (eg repeat imaging or operative intervention). This should include specific reference to what amount of ongoing blood product requirement would trigger further investigation / intervention.

The lead specialty will be responsible for organising an appropriate bed for post-procedural care eg if the patient's main injuries are orthopaedic the orthopaedic team must arrange an appropriate bed. This should be a level 2 (HDU) or above bed[3].

A patient may return to the ED from IR if further ED care is required but only after discussion with the ED consultant in charge and if no suitable alternatives are available.

[2] Note that platelets must be kept at room temperature
[3] Contact the critical care bed co-ordinator on 80-xxxx

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