Which patients with trauma should be in resus?

Review of the care of patients admitted to the LGI with significant injuries highlights that we don't pick up all of these patients as early as we should. This leads to delay in appropriate investigations (particularly CT), delay to review by a senior, and delay in providing appropriate care to the patient. This happens for a number of reasons:

1. The ambulance crew don't recognise the severity of injury and don't pre-alert us to the patients arrival.

2. The initial assessment of the patient by the ED team may not recognise the potential significance of the mechanism of injury in a patient who may appear to be 'OK'. This is particularly common in children and the elderly.

To try and prevent this happening the following mechanisms of injury should all prompt initial assessement **IN RESUS** by a team including or directly supervised by a more experienced ED doctor eg ST3 and above, but ideally a consultant. The patient can be stepped down from resus as soon as the senior clinician feels is suitable, taking into account the demands on the department as a whole.

HIGH RISK MECHANISMS OF INJURY –
ALL AMBULANCE BORNE PATIENTS TO BE ASSESSED IN RESUS

- Pedestrian hit by motorised vehicle
- All falls from greater than 1m or 5 stairs
- High speed road traffic accidents (>60mph)
- Ejections from vehicle
- All vehicle roll-overs
- Death in same vehicle
- All incidents involving cyclists (pedal or motorcycle)
- All incidents involving horses
- All penetrating torso or head injuries

This list is not intended to be **exclusive** - patients should still be assessed in resus if their clinical condition requires it, regardless of the apparent mechanism of injury!

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