Where to manage trauma patients

Patients who trigger the Major Trauma triage tool should be managed in the resuscitation room.

Why this may not occur

Some patient may be bought directly to the ambulance assessment area by YAS because they have been under triaged. The ED assessment team may subsequently anchor onto the pre-hospital assessment and not recognise the relationship between mechanism of injury and injury pattern. This presents an area of risk as it leads to delay in investigations, diagnosis and management of potentially serious injuries which this cohort of patients are often found to have.

The following Mechanisms of Injury should all prompt Escalation from the Initial Assessment

- Pedestrian v Car Incidents
- All falls from greater than 1m or 5 stairs (Including found at Bottom of Stairs)
- High speed road traffic accidents (>60mph)
- Ejections from vehicle
- All vehicle roll-overs
- Death in same vehicle
- All RTA involving Cyclists or Motorcyclists
- All incidents involving horses
- All penetrating injuries to chest/abdomen or potential major vessel involvement
- All Head injuries with Altered GCS
- Multiple areas of Injuries with concerns that patient has Poly Trauma Injuries
- Deteriorating clinical condition regardless of the apparent mechanism of injury

Who should you escalate to?

The **Assessing Nurse** should discuss the presentation with the Consultant in Charge or Nurse in Charge and together decide if any of the following actions should be undertaken;

- Move the patient to resus.
- Put out a trauma call
- See the patient themselves and decide if an urgent scan is indicated
- Contact the trauma coordinator.

ANY patient that is haemodynamically compromised, has an oxygen requirement or has a reduced conscious state should be moved to resus **immediately** and a **Trauma Call** put out.

Shahzadi Zeb, Consultant in Emergency Medicine LTHT, MTC Clinical Governance Lead, ED Trauma Lead.
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