Standards of Care:
Trauma Patient

Objectives:
1. Provide physiological support of the patient during the acute phase in order to enhance recovery.
2. Prevent and or minimize complications.
   a. Hypermetabolism
   b. Pulmonary embolism
   c. Fat embolism
   d. Infection
   e. Sepsis
   f. Respiratory Failure
   g. Pain
   h. Hemorrhage
   i. Acute cholecystitis
   j. Renal failure
   k. Myoglobinuria
   l. Compartment syndrome
   m. Venous thrombosis
3. Provide emotional support as well as ongoing education to family and patients in order to enhance adaptive coping mechanisms.
4. Prevent tissue hypoxia.
5. Achieve comfort and appropriate sedation when needed.
6. Provide education to patient and or family regarding disease process, plan of care and procedures.

Process Standards:
1. Patient airway and adequate ventilation will be established and maintained.
2. A total patient assessment will be performed and documented upon admission and every 4 hours.
3. Vital signs should be monitored at least every 15 minutes if condition is unstable and every 1 hour if patient is stable. Vital signs to include: HR, respirations, BP, and invasive hemodynamic pressure monitoring and/or intracranial monitoring.
4. Neurological assessment utilizing the Glasgow Coma Scale should be done and documented every 1 hour x 24 hours when ordered, then q 1-4 hours until neurologic status is stable.
5. The nurse should be familiar with the Standard of Care for the Acute Closed Head Injury Patient.
6. Any change in neurological or sensory exam should be reported to a physician immediately after the change is noted. The physician’s response should be documented in the nurse’s notes.
7. If a patient has received and injury to extremity, Doppler pulses and a sensory exam should be performed and documented every hour until stable then every 4 hours. The temperature and color of the extremities distal to the injury should be documented every 4 hours after stable.
8. Any bleeding or swelling at the site of the injury should be documented. If there is any increase, a physician should be notified immediately. The physician’s response should be noted in the nurse’s notes.
9. If the patient has a spinal injury, the Standard of Care for the Patient with a Spinal Cord Injury should be followed.
10. If the patient has a chest tube, the nurse should document the presence or absence of an air leak, the presence or absence of suction to the Thoraseal, the amount and color of the drainage.
11. The physician shall be notified for all ordered parameters.
12. The patient will be turned every 2 hours. The side turned to will be documented every 2 hours. If the patient’s spine has not been cleared, the physician must have written orders for turning patient. If there is a question as to whether or not to turn, the physician will be called and orders written.
13. Tissue oxygenation should be assessed as ordered by the physician.
14. Patient/Family teaching should be done every shift and documented. If no teaching could be done then a notation should be made in the record as to why.
15. Patient will be assessed for pain every 4 hours with pain medication given as ordered.
16. Patients that need sedation will be monitored using the RASS and will document sedation levels every 4 hours.
17. If patient has a neck immobilizer on upon admit, Miami-J will be ordered as physician directed.
18. Nutritional support should be initiated as soon as possible to meet the patient’s need and as ordered by the physician.

Outcome Standards:
1. No complications are present relating to the immobility and/or prolonged bed rest.
2. Optimal recovery from the trauma.
3. Patient verbalizes adequate pain control using the scale of 0-10 to describe pain and effectiveness of interventions.
4. The patient and or family verbalizes understanding of disease process, plan of care, and procedures.

Reference: