Daily Checklist for Care of Trauma Patients

Review each of the following daily and address as appropriate

- Nutrition
  - Initiate nutrition ASAP
  - Full-liquid diet, mechanical soft, or regular as appropriate. Clear liquid diets are rarely indicated
  - Follow enteral feeding guidelines, start TF at goal, do NOT check residuals
  - Do NOT hold enteral nutrition for OR after midnight in patients with protected airways (except for surgeries that involve airway manipulation or GI tract)
  - Do not start TPN until NPO for 7 days unless malnourished on presentation
- Analgesia
  - Follow pain management algorithm
  - Maximize adjuncts and minimize opioids
  - Discontinue IV opioids as soon as possible
  - Avoid morphine in patients >75 yo or with renal insufficiency
- Sedation
  - Avoid benzodiazepines (unless regularly taken at home)
  - Try to avoid continuous sedation
  - See delirium/agitation guidelines
- Thromboembolic prophylaxis
  - SCDs unless contraindicated
  - Start chemoprophylaxis per guideline for VTE prophylaxis & VTE prophylaxis following TBI
  - Consider angel catheter in patients unable to receive chemoprophylaxis for more than 48 hours
- HOB/mobility
  - Clear C-spine ASAP per guideline
  - Clear T/L spine once final reads are negative for acute fracture
  - Mobilize all patients as soon as possible
  - Contraindications to mobility include:
    - Significant doses of vasopressors for hemodynamic instability
    - Mechanically ventilated with FiO2 >.8 and PEEEP >12 or acutely worsening respiratory failure
    - Neuromuscular blockers
    - Acute neurologic event with worsening mental status and/or ICP >20
    - Unstable spine or extremity fractures
    - Poor prognosis with transition to comfort care
    - Open abdomen, at risk for dehiscence (relative contraindication)
    - Active bleeding
  - Order PT for patients with
    - Stable extremity fractures
    - Stable spine fractures requiring a brace
    - Spinal cord injury
    - Moderate to severe traumatic brain injury
    - Baseline disability or fall from standing
    - Poor tolerance of activity with nursing staff
  - Nursing should provide mobility to patients without indications for PT – place an order for out of bed with nursing
  - Use ICU Mobility Scale to communicate mobility goals and levels
- Stress ulcer prophylaxis
  - Order H2 blocker per guideline – oral preferred when appropriate

    - Discontinue SUP as soon as indications have resolved
    - Administer PPI to those who take them at home
- Glucose
    - Initiate ICU glycemic protocol on admission to ICU
    - Initiate insulin drip when BG >300 or >200 more than twice
    - Avoid oral diabetic medications while in ICU
    - Transition to long-acting insulin once stable, if needed
    - Change glycemic protocol to the non-critical protocol when leaving the ICU
    - Discontinue all glycemic protocols when no longer needed
- Skin
    - Document all wounds on arrival
    - Document staples/sutures on the list
    - Remove staples/sutures in an appropriate time frame
    - Ensure appropriate orders for wound care
- Labs
    - Discontinue all routine labs as soon as possible
    - Do not order serial H&Hs or CBCs for solid organ injury
    - Do not trend troponins for blunt cardiac injury
    - Check a single CK level for suspicion of rhabdomyolysis
        - If level <5,000, do not recheck
        - If level >5,000, recheck every 24 hours until down-trending
    - Only order labs or tests that will impact management
- Medications
    - Only prescribe medications if you know how they work
    - Discontinue medications as soon as possible
    - Review home medications and restart as appropriate
    - See guidelines for antibiotic use
- Pulmonary toilet/mechanical ventilation
    - Trial on a spontaneous mode of ventilation (pressure or volume support) once the patient is breathing spontaneously
    - Extubate as soon as criteria are met
    - Order IS/flutter for all post-operative patients and those with chest trauma or spinal cord injury
- Invasive lines/drains
    - Remove all Foley catheters/lines once there is no longer an indication
    - Discuss removal of drains with the team daily
    - Know where drains are located and why they were placed
- Order restraints every 24 hours, if indicated.
- Disposition
    - Early involvement of social services for patients who will need assistance after discharge
    - Communicate discharge needs ASAP
    - Do not suggest rehab/SNF without discussing with social worker or with patients who are self-pay
    - Ensure patients are applied for disability ASAP when appropriate