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