USE OF TRAUMA FLOW SHEETS & ELECTRONIC DOCUMENTATION OF TRAUMA PATIENTS FOR LEVEL IIb & III

1. Goal: Obtain complete trauma documentation on all trauma patients from Level IIb & Level III, to include evacuation documentation, within the CENTCOM AOR in a timely fashion.

2. Background: The role of trauma documentation within the Joint Theater Trauma System for trauma performance improvement has continuously increased since the Joint Theater Trauma Registry (JTTR) was initiated in 2004. This progression is not unlike the first civilian trauma registries and standardized trauma flow sheets that were developed in the late 1980s. JTTR data acquisition and processing has improved greatly, partly because of the continuing advances (i.e. development of a standardized trauma flow sheet, initiation of Oracle based registry database, and Level II MS Access trauma database) that offer new approaches and maximize computer technologies and the deployment of trauma coordinators to most Level III sites. Data collection that allows theater wide comparison is important for the continuous learning process and to improve outcomes, standard of care development, analysis of differences in the mechanisms of injury, rescue systems and approved treatment guidelines.

Although trauma flow sheet documentation can incorporate information from numerous sources (nursing flow sheets, monitors, medevac run-sheets, I-stat print outs, etc.), if the history taking, physical examination, or decision making is not documented by the trauma team leader, it didn't occur. Therefore, good documentation on the trauma flow sheets is most important for care of the individual patient and the system-wide delivery of trauma/critical care to all injured patients within the CENTCOM AOR. It is easy to forget or only capture limited data on trauma flow sheets when trauma patients spend very little time in the ED prior to heading to the OR. However, it is imperative to document the thought process and to take the time to complete the trauma flow sheet when time permits, even if completed the next day.

Although trauma documentation requirements are well known, it is noted that this is an area in need of improvement. Although not exhaustive, the following are documentation performance improvement areas that repeatedly surface which need careful attention:

a. Complete set of initial vital signs, including temperature and respiration rate
b. GCS total score and individual Motor, Verbal & Eye opening scores
c. Total IV volume (blood, colloid and crystalloid) infused in the ED, even if fluid administration continues after transport
d. Disposition: Place and time
e. Arrival time
f. Mechanism of Injury
g. Labs transferred to trauma flow sheet (especially HCT, INR, and BE)
h. Lethal Triad Indicators (Hypothermia, Acidosis, Coagulopathy)

3. Indications For Initiation and Completion of Trauma Flow Sheets: A trauma flow sheet should be initiated on ***ALL*** patients (battle/non-battle injury coalition forces, ANA, ANP, IP, IA, LN, contractors, etc.) triaged as Immediate. In addition, trauma flow sheets should be completed on all patients seen within the first 72 hours of the following mechanisms of injury and all unstable patients regardless of injury time:

a. GSW
b. Blast (IED, bomb, grenade, mortar, landmine, RPG, etc)
c. Burns (fire, liquid, chemical, electrical)
d. Head Injury (open and closed)
e. Blunt Trauma
f. Crush Injury
g. Assault/Fight
h. Motor Vehicle or Air Frame Crash
i. Penetrating wounds (stabbing, shrapnel, penetrating eye)
j. Falls
k. Drowning
l. NBC related
m. Inhalation injury
o. All trauma admissions to any/all Level III facilities in the continuum

It is the intent of this guideline that the broadest definition of trauma be used. This should include the majority of patients with single or multi-system injury seen in the emergency department or admitted directly to the ICU and is to be used as the primary method of initial documentation.

4. Responsibilities: It is the trauma team leader's responsibility to ensure the physician's trauma flow sheet is complete at Level III and the Combined Trauma Flow Sheet is completed at Level II. It is the responsibility of the nurse assigned to the trauma bay/patient to ensure the Nursing Trauma Flow Sheet is completed at Level III and that the nursing portion of the Combined Trauma Flow Sheet is completed.

A member of the trauma team that is receiving report (CCATT, medevac, ground ambulance) should request a copy of the transport run-sheet and ensure it is included in the patient's record. All times on the trauma flow sheet should be Zulu, not local.

5. Electronic Documentation: Where MC4 is available and operational and when clinical and operational tempo permits, at a minimum, the following information should be entered into the injured patient's electronic medical record using either the TC2 or ALHTA-T module:

a. Detailed admission note by the admitting provider
b. Operative note(s) by the operating surgeon(s)

c. All radiologic dictations
d. Detailed discharge summary

Additional electronic documentation of nursing notes, ICU notes, lab results, etc are welcomed. All information entered electronically into MC4 is visible throughout the continuum of care in the Theater Medical Data Store (TMDS)/Joint Patient Tracking Application (JPTA), which is accessible from any .mil computer at the following link. https://207.87.24.38/jpta/external/login.jsp?origURL=https%3A%2F%2F207.87.24.38%2Fjpta%2Fhome.do

Where available and operational, TC2 is the ***preferred*** module to enter all inpatient documentation and for entering all ancillary services and order entry. AHLTA-T is the ***preferred*** module to enter all outpatient documentation; TMDS/JPTA is the ***preferred*** module for Level IV & V facilities to enter follow-up notes (directly or by cut and paste method) on trauma patients originating from the CENTCOM AOR.. If the preferred module is not available or operational, use one of the other remaining two modules to enter electronic documentation if available (ex. If TC2 is not available to document an inpatient encounter, use AHLTA-T or TMDS/JPTA to enter the data).

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GEORGE P. COSTANZO
COL, USAF, MC, SFS
CENTCOM JTTS Director

BRIAN EASTRIDGE
COL, USA, MC
JTTS Program Director

W. BRYAN GAMBLE
COL, USA, MC, FS
Command Surgeon
USCENTCOM