Attachment O

The Trauma Education program for June 2020 to May 2021 has consisted of quarterly trauma scenario's held in either the simulation lab or in the Emergency Department. The scenarios are run by the Nurse Manager of Education and the TPM. All ICU and ED nurses are required to attend one scenario annually but are able to come to as many as they can or desire. The ED Physicians and General Surgeons are also invited to attend the scenarios.

Education and updates based on feedback from chart reviews are done through either the Weekly Update by the TPM or through individual follow-up via email or in person education.

Starting in May of 2021 we have a monthly ED Newsletter that includes the Trauma Talk which includes education on care of the trauma patient with a focus on specialty populations. This education is also distributed to the Urgent Care Provider and Nursing staff as well as the ICU Nursing Staff.

Moving into FY 22 the education program will consist of monthly trauma scenarios, tabletops or in department scavenger hunts based on feedback from staff in May of 2021.

In addition LRH holds the annual Northern NH EMS conference which includes participation from EMS services throughout the state. The TPM attends the State Trauma Meetings.

MED/SURG SPECIFIC UPDATES

UPCOMING STAFF MEETINGS—all at 0730 unless otherwise noted

July 28, 2021

September 29, 2021

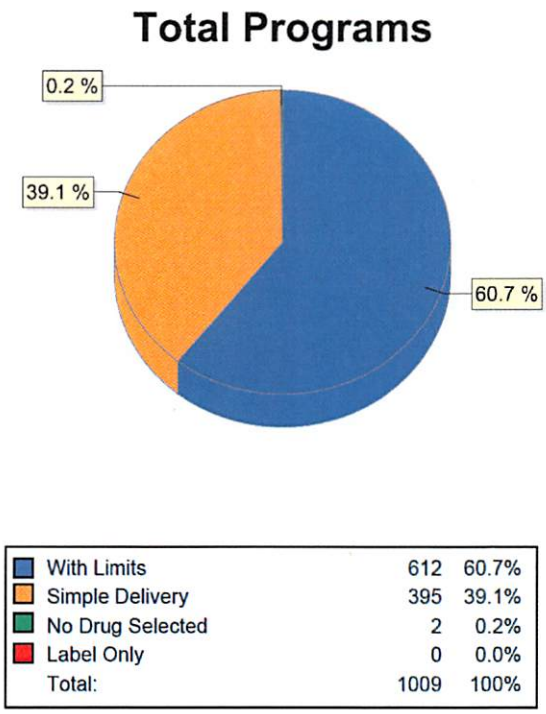
November 17, 2021

CPMs: Over the next two weeks we will be weaning out CPM machines. Only patients who already have a CPM at home will use one in the hospital next week.

Pay adjustments: If I have not already caught you—your pay adjustment paper is in your mailbox. Please sign and return to me ASAP.

Smart Pump Usage: Please make every effort to be programming your IV pumps each and every time that you are using them. This is the report for April for MedSurg (translation: pumps are being programmed about 61% of the time):

CA: Med/Surg



With Limits	612	60.7%
Simple Delivery	395	39.1%
No Drug Selected	2	0.2%
Label Only	0	0.0%
Total:	1009	100%

ED Staff meetings–

April 8 ED Staff Meeting Uploaded to the Intranet 04.16.2021

May 5, 2021

Staff meetings are 0800-0900, unless otherwise noted

Medical Records: Please be sure that you are stickering all items that you are sending down to medical records. If it is not stickered them Medical Records cannot identify who the paperwork belongs to and it does not end up in the patients chart. When you are discharging a patient please make sure that you are putting all paper documentation together and paper clipping. We have had an increased amount of lose papers that become caught up in another patients chart. This increases the work for Medical Records and cause errors in scanning resulting in incorrect patient information in the patients chart. Additionally, MARs

from other facilities, lab and radiology print outs that have no further documentation written on them do not need to be included in what goes to Medical Records. Labs and radiology reports are already in the medical record unless you have written call back information on them and the patients profile should be update with the list of current medications.

Trauma Room: As many of you may have noticed Marshall, Emily, Shelley and Dr. Klingler have done some great work in organizing room 7. This work includes reorganizing the Airway cart to be more user friendly and the Trauma Cart. Once we have finalized all the organization we will let everyone know so they can become familiar with the carts. (Think July Trauma Scenario?!!)

Trauma Scenario: We had a FANTASTIC turn out for the trauma scenario on May 13th. Heather did a great job in setting up a scenario in which we could practice our skills. Here is an overview of the scenario and some lessons learned:

This was a female patient who was the victim of a gunshot wound to the abdomen. Trauma Red was called. She had entrance and exit wounds and was intubated on arrival. Dr. Beauboeuf led the team with the ATLS/TNCC Primary and secondary survey. In which it was determined that the patient had a hemothorax requiring chest tube placement. The patient was hypotensive and received isotonic fluids as well as blood products. The patient stabilized after these interventions and it was deemed that as there was clear in and out of the bullet and that the patient had stabilized with the interventions performed that the patient would be admitted to the ICU.

We had a great turn out from ED, ICU and Clinical Supervisor staff. Our discussion focused on the roles of nursing staff in a trauma. We discussed setting the role of Primary nurse and having clear guidelines for this role as well as others.

Primary Nurse or Trauma Resuscitation Nurse: Takes report from EMS

- Ensure the room is set up for the arrival of the trauma patient
- Controls and directs nursing staff and ancillary personnel in the trauma room
- Ensures ABCs are intake in primary survey on patient arrival
- Stands at the foot of the bed or other designated area where s/he is visible to everyone in trauma room and can be heard by everyone in the trauma room
- Directs all procedures in the trauma room with closed loop communication, delegating tasks to appropriate available staff.
- Crowd and noise control
- Once immediate resuscitation/assessment are done reviews documentation and directs restocking/clean up of room.

We discussed how having clearly defined roles and including additional staff ICU and OR in the trauma scenarios would help have more staff available to help in traumas and enable us to use the role of the primary nurse who is focusing on the bigger picture and not caught in procedures or tasks.

We also discussed increasing the frequency of trauma scenarios. We will be working on a plan to move to every other month scenarios alternating table top in ED practice and Sim lab practice.

We also discussed that in the scenario the primary and secondary nurse did a good job of speaking up and asking questions. Both Dr. Beauboeuf and Dr. Hirsch where appreciative of this open communication.

LITTLETON REGIONAL HEALTHCARE

Trauma Scenario Summary

Present: Shelley MacKay, Serena Richardson, Dr. Klingler, Natalie Kennett, Cindy Fagnant, Thomas Jaglowski, Laurian Weden

Summary of Scenario:

This is a 29 week pregnant pt who was stabbed in the right upper abdomen by significant other. She has significant blood loss and rupture of membranes, 2cm dilated and no contractions.

Hypotensive and tachycardic

A. Intact
B. Clear lung sounds
C. Significant bleeding from stab wound, abd pads change and pressure applied, 2 IVs crystalloid stated, blood uncrossmatched ordered to have on hand , type and screen sent, rhogam
D. Turn to left side lying, no evidence of other stab wounds
E. Warm blankets on
    a. OB called and warmer brought

Discussion of case

Did we call actually call a trauma red? – Need to be more vocal and voice the needs out loud and have loop closure that someone is completing task

We need to review what is in the ED major and ED minor tray and if we actually need these items or if we could make these more useful

Side note rib spreader? Where is it and can we remove the old one.

Plan: We are going to review the Trauma rooms and trauma carts to two rooms that are identical and to ensure we have the right equipment in places that make sense and are easily accessible when needed.

Scene safety: in this instance we know there is an angry SO that may come to the hospital, we need to involve security and have security on high alert and present in ED waiting area. Also, if during day making sure medical office building is aware to monitor for suspicious behavior.

Is there an opportunity for an in-room Omnicell to use for traumas? -Hold this discussion for later time perhaps during ED renovation. Is there a way to have a dual sided Omnicell that could split rooms 6 and 7 and be accessible from both rooms?

Perform a morning and evening check at the beginning of each shift to ensure that we are trauma ready. – A good time to implement would be once we standardize the rooms and once everyone has been education on the changes.