Trauma Documentation

I. History & Physical

a. History of present illness
    i. Include at least 4 HPI components (location, quality, severity, duration, timing, context, modifying factors, associated s/s)
    ii. Complete each section as prompted
    iii. Much of this information is important for our trauma registry so please try to avoid blanks or writing unknown
    iv. Time of injury – please give accurate time or at least a good estimate. Do NOT write "prior to arrival". If you don't know the time, explain why you can't get that information (such as they transferred from another facility, records are not available, and unable to communicate)
    v. Details of incident – describe what happened prior to arrival
    vi. First BP on scene – please try to get this from EMS
    vii. Transferred from: please write either scene, personal vehicle, or the name of the facility from which they transferred. Do NOT write OSH or outside hospital
b. If you are unable to obtain histories, there is a line that says "unable to obtain…from any other source. If this is not true, please hit the "X" and remove this statement
c. Fast Exam: if done, please describe findings under the correct view
d. Consults: include the person, service, ad time of notification
e. Brief summary of events since arrival: include only pertinent information that happened in this hospital. No need to re-describe the details of the accident

II. **Tertiary Survey**

a. Complete within 48 – 72 hours on ALL trauma patients admitted to the hospital
b. Select the Tertiary Survey/Trauma Progress Note Template
    i. Edit the included normal physical exam
    ii. Include a detailed MSK/skin exam
c. Update the Problem List*
d. Complete the POA form that is located in the admission & discharge patient workflow
    i. All problems that are directly caused by the initial trauma will be POA
    ii. Example: patient w/flail chest/pulmonary contusions is on NC 2L on arrival and does poorly w/IS requires intubation on hospital day 2 as a result of the flail chest. Acute Respiratory Failure is POA because it is an expected sequela of the initial injury.
e. Ensure that home medications are accurate, reviewed, and restarted as appropriate
f. If the patient is being discharged within 48 hours, the tertiary survey may be included in the discharge summary if it is clearly documented as a tertiary exam.

III. Progress Notes

a. Use the INPT TRAUMA Manage Workflow
b. Update the Shared History of Present Illness
    i. Do NOT copy from H&P
    ii. Include the following:

1. Mechanism
2. Injuries
3. Consults
4. Skip a line then add PMH/PSH:
5. Incidental findings (briefly, not a long sentence copied from the imaging report)

iii. Do NOT include details from PTA or ED unless they are pertinent to that day's documentation.

c. Update the Shared Hospital Course daily
   i. You do not have to put every detail of the care in this section
   ii. Include all pertinent information about the hospital course
d. Shared Physical Exam
   i. Do NOT copy from the H&P
   ii. Update daily to ensure accuracy
e. Shared Plan
   i. Include a Problem-based plan
   ii. You may list related diagnoses together
   iii. Make sure to specify PTA when applicable
   iv. Include the Trauma plan of care by using the .phrase: .Traumaplanofcare, update this section daily
   v. Include a 24 hours summary at the bottom that describes how the patient is progressing and acute issues
f. Once everything is complete in the Inpatient workflow, create the note by scrolling down and selecting Trauma Progress Note. Your shared sections will pull into the note automatically
g. Add the date in the date of service section at the top by typing .date
h. Remove the duplicate trauma plan of care section by slicking on the "X" if you added this section correctly into your shared plan. If you did not, complete this section.

IV. Discharge Summary:

a. Ensure all significant diagnoses have been entered in the problem list
b. Make sure appropriate follow-up is included (review incidental findings)
c. Review need for spleen vaccines
d. Include a plan for all active issues
e. Include prescriptions provided/pain management plan
f. Complete the transfers orders section at the bottom of the note for patients discharging to a facility
g. Patient instructions can be added in the discharge workflow at any time during the hospital course. This will help to address important issues and save time at discharge.

V. Acute Events:

a. Include any changes in condition and the interventions you provided
b. Free text note or addendum to progress note explaining acute events/changes

VI. Cervical spine clearance:

a. Documentation of c-spine clearance is needed for all patients in a c-collar
b. Add to daily note or free text note
c. Be sure to change the order in Cerner to reflect that the collar is no longer needed

VII. **Incidental Findings:**

a. Document all incidental findings in the EMR and provide copies of appropriate documentation to patients/families prior to discharge
b. Inpatient consults to the appropriate service for incidental findings to arrange further tests/follow-up as appropriate

*Problem List:

- Review the: "Diagnoses to Include" CPG in the documentation section for more information
- Include all traumatic injuries
- Include major diagnoses associated with trauma including but not limited to the following:
    - Acid/base disturbances (respiratory & metabolic)
    - Acute blood loss anemia
    - Acute Resp Failure/atelectasis/acute pulmonary edema
    - Acute kidney injury/ATN
    - Electrolyte derangements (especially hyper/hyponatremia & hyper/hypokalemia)
    - Cerebral edema/brainstem compression/intracranial hypertension
    - Quadriplegia/hemiplegia/paraplegia/paresis (say paresis, not weakness)
    - Shock (include type)
    - Peritonitis
    - Morbid obesity – include BMI
    - Past medical problems – such as uncontrolled diabetes or systolic heart failure
    - Severe protein-calorie malnutrition (requires a dietician malnutrition evaluation PRIOR to including in the problem list, order the evaluation as a nutrition consult and include as the indication)
- Always include the words "acute" or "open" when applicable
- Avoid saying "possible" or "likely" in notes b/c this doesn't count