RN Protocol: Abdominal Trauma

I. POLICY

A. Function: To facilitate and guide the Registered Nurse (RN) in the assessment and treatment of patients with abdominal trauma.

B. Circumstances under which the RN may perform:
   1. Setting: Triage and treatment area.
   2. Supervision: None required.

II. PROTOCOL

A. Definition: This protocol covers the assessment and treatment of patients presenting with abdominal trauma. Abdominal trauma is defined as any penetrating injury or blunt injury to the abdomen.

B. Subjective:
   1. Chief complaint (document in the patient's own words).
   2. Precipitating event (e.g., fight, accident).
   3. Date, time, and location of injury.
   4. Mechanism of injury (e.g., weapon or blunt trauma).
   5. Pain (location, intensity, quality, and radiating characteristics).
   6. If penetrating injury present, date of last tetanus immunization.
   7. Allergies.
   8. Current medications (including anticoagulants, diuretics).
   9. Time of last meal.

C. Objective:
   1. Obtain vital signs.
   2. Assess for signs of shock or hypovolemia.
   3. Auscultate lung fields and describe breath sounds.
   4. Inspect abdomen for open wounds (describe location, size, any entrance and exit wounds), impaled objects, and eviscerating organs.
   5. Observe for abdominal distention.
   6. Inspect umbilicus and flank area and note any bruising or discoloration.
   7. Auscultate bowel sounds in all four quadrants (describe).
   8. Palpate for location, intensity, quality, and severity of pain. Evaluate for guarding rigidity and rebound tenderness. Inspect genitals.
   9. Obtain urine dipstick for blood, and observe for gross hematuria.

D. Assessment:
   - Fluid volume deficit related to/evidenced by:
   - Pain related to/evidenced by:
   - Impaired gas exchange related to/evidenced by:

E. Plan:
   1. Contact Physician STAT.
   2. Based on patient condition and physician order:
      a. Maintain airway, breathing, and circulation.
      b. Administer supplemental oxygen via nasal cannula or mask to maintain O_2 saturation above 90%.
      c. Apply pressure to any open bleeding wound.
      d. Start an intravenous line with large bore needles ((14-18 gauge) and infuse Sodium Chloride Intravenous Solution (0.9%). Titrate rate to maintain systolic blood pressure ≥ 90mm Hg.
      e. Start a second IV line if there are signs and symptoms of shock or hypovolemia.
      f. **DO NOT** attempt to remove impaled object. Instead, secure object in place.
      g. Cover eviscerated organs with gauze soaked in Sodium Chloride Irrigation Solution (0.9%).
      h. Cover injured genitals with sterile gauze soaked in Sodium Chloride Irrigation Solution (0.9%).
      i. Keep patient N.P.O.
      j. Continue to monitor vital signs every 15 minutes.
   3 Prepare to transfer patient to outside facility or admit to a facility capable of providing a higher level of care.
   4 Fax a copy of the relevant progress notes, physician orders, and emergency care flow sheet to receiving facility.

F. Patient Education:
   1. Assess patient's potential for understanding the health information to be provided.
   2. Provide patient education consistent with the assessment of the condition.
   3. Document the education provided and the patient's level of understanding on the emergency care flow sheet.
   4. Refer patient to other resources as needed. Document all referrals on the emergency care flow sheet.

G. Documentation:
   All information related to the patient's complaint shall be documented on the emergency care flow sheet. The flow sheet shall be filed in the patient's unit health record.

III. REQUIREMENTS FOR RN

A. Education/Training: The Registered Nurse shall attend an in-service on the assessment and management of abdominal trauma and achieve a minimum score of 80% on the written posttest examination.
B. Experience: None.
C. Certification: None

D. Initial Evaluation: Initial competence will be validated onsite through simulated exercises, mock scenarios, and return demonstration. The Registered Nurse must satisfactorily demonstrate all critical behaviors identified on the Competence Validation Tool to be considered competent to perform standardized procedure functions.

   A written performance appraisal shall be performed by the Supervising Registered Nurse or designee six months after initial competence has been validated. Methods to evaluate performance shall include, but not be limited to direct observation, feedback from colleagues and physicians, and chart review.

E. Ongoing Evaluation: Ongoing competence will be validated annually using case study analysis, written examination, and return demonstrations where appropriate.

IV. REGISTERED NURSES AUTHORIZED TO PERFORM THIS PROCEDURE

A current list of all Registered Nurses authorized to perform this procedure shall be maintained on file in the Office of the Director of Nursing.

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

This standardized procedure was developed and approved by authorized representatives of administration, medicine, and nursing. The procedure will be reviewed annually.

REVIEW DATE: _____ REVISION DATE: _____
_____ _____
_____ _____

THE STANDARDIZED PROCEDURE WAS APPROVED BY:

_____ DATE:_____
Chief Nurse Executive/Director of Nursing

_____ DATE:_____
Chief Medical Executive