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PRE-HOSPITAL DOCUMENTATION IS IT REALLY NECESSARY?

*by
Mike Smith NREMT-P*

TraumaVue

**“NO JOB IS
COMPLETE
UNTIL THE
PAPERWORK
IS DONE”.**

“NO JOB IS COMPLETE UNTIL THE PAPERWORK IS DONE”. How many times have we, as pre-hospital care providers, heard supervisors, administrators, and other people make this statement? How true this statement is in the pre-hospital environment. Is documentation of what we do as providers of emergency care in the field really necessary? Yes it is.

Why do we have to complete an ACR (Ambulance Call Report), PCR (Patient Care Report), EMS Call Report, or whatever we providers call the documentation of a patient encounter? Does anybody really pay attention to what we have to say about that patient we bring into the emergency department? Yes, more than you may think. Not one of us really likes to sit down for an extended period of time to document what transpired during the patient encounter, but it is necessary. Let's look at some reasons why pre-hospital documentation is important.

We all know that patient care is our responsibility, when we are called to assist a victim of sudden accident or illness. The information we provide in our documentation is essential to the continuum of care for that patient. Our documentation reflects how that patient was found, a history of the present accident or illness, a detailed physical examination of the patient, mental status, injuries, complaints, allergies, past medical history, medications, treatment and other pertinent information which may be important to the continued care of that patient. Not only does it paint a picture for the physician in the emergency department, but it also helps paint a picture for the patient's attending physician, as they become involved in the patient's care.

The EMS Call Report is also a legal document. It becomes part of the patient's medical record in the hospital. As a legal document, it can be called into court. It can protect the patient, you, the hospital/emergency department. Just a few years ago, EMS did not have to worry too much about being called into court to testify, or the EMS records being subpoenaed. Now district attorneys, private attorneys, corporate attorneys, insurance companies, and even the patients and their families are requesting copies of the EMS Call Reports. Each of these has realized EMS is an important source of information and is utilizing this information in many ways.

If documentation is not completed, there will be no way to audit patient care, and thereby, no way to improve or prove what we do. We, as EMS providers must write legibly so that our notes may be easily read. We want to use only approved abbreviations and above all, spell correctly. There is nothing more humiliating than to be called into court and face some attorney, who decides he/she would like to discredit you as a witness, because of a poorly written report. It is our responsibility to assure our documentation is appropriate.

*Duke Trauma Center
Life Flight/Life Care*

*Duke University Hospital
Durham, North Carolina*

Duke Trauma Center

Our third meeting of the Duke Regional Advisory Committee (RAC) was held on April 30th. It was well-attended by our membership, which includes twenty hospitals, representing eighteen counties, in central North Carolina. Our primary focus for the first few meetings has been organizational structure and rules governing the Duke RAC. With the membership set, we proceeded with committee assignments for our initial four standing committees: Process Improvement, Care Management, Education, and Legislation. The committee (and sub-committee) work will constitute the real nuts and bolts operation of the Duke RAC, so we are all excited about the interest and enthusiasm generated at the meeting.



Donald Hartwell

After a several month search, we are pleased to announce the hiring of Donald Hartwell as our new Trauma Registrar. Don's background as an EMT and as a computer guru matches well with the registry position. Don moved to Durham from Princeton, West Virginia in 1984. He is married to Brenda, who is a MICU nurse at Duke. He was most recently self-employed as a computer contractor, and he has extensive programming experience. We welcome Don and look forward to working with him!

Steven N. Vaslef, MD, PhD
Director, Duke Trauma Center

PRE-HOSPITAL DOCUMENTATION IS IT REALLY NECESSARY?

If a patient, family member or bystander makes a statement, which you feel is important, write what that individual says and set it off in quotation marks. ("_____"). Something, which may seem very minor to others at the time, may be extremely important to that patient's care later on. You want to make sure you reflect any physician's orders in your documentation.

Be specific when describing the patient's complaint(s). Be sure to document if your patient refuses any treatment, medication, or transport and state his/her reason for refusing. This may be very important later on.

You also want to be specific about what you see, feel, hear and smell. These senses are very important in your field assessment, and to your patient's care.

Be specific about documenting specific sites of pain and/or injury. Be accurate and complete. Fill in all areas of your patient care report. Take complete vital signs, and repeat those vital signs more than once. One set of vital signs only provides a baseline.

There are some DON'Ts that go along with pre-hospital documentation. Some of these are:

- Don't ... Chart activities before they are completed.
- Don't ... Say "Appears to be _____". Stick to what you perceive with your own senses.
- Don't ... Erase to correct. Draw a line through the error and initial it.
- Don't ... Write "error" above a correction.
- Don't ... Leave open space. Sign your name at the end of your completed documentation.

Remember to leave a copy of your patient care report in the emergency department, once you have completed it. If you are unable to leave a copy at the time, for whatever reason, fax the patient care report to the emergency department as soon as possible. There are emergency department physicians, nurses, attending physicians and others who are paying a lot of attention to, and depend upon, the pre-hospital documentation to assist them in the continued care of the patient.

The answer to the question is "YES"; pre-hospital documentation is important and necessary.

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If you have comments or suggestions for future articles, please contact Claudia McCormick at DUMC 3402, or via e-mail at mccor019@mc.duke.edu.

Designed and produced by: Duke Publications Group

Duke Trauma Registry Form

Mike Smith has done an excellent job of explaining the importance of good documentation from the Emergency Medical Services standpoint. I would like to review the part of the trauma registry form that pertains to Emergency Medical Services.

SCENE No A-C-P-U-Com
 EMS _____ Heli _____
 Run # _____ Date _____
 Amb Dispatch _____ P _____
 Scene Time of Arrival _____ R _____
 Scene Leave Time _____ BP _____

REVISED TRAUMA SCORE

A. Respiratory Rate	10-29 <input type="checkbox"/>	4	ALS <input type="checkbox"/>	BLS <input type="checkbox"/>
	>29 <input type="checkbox"/>	3	No chart <input type="checkbox"/>	
	6-9 <input type="checkbox"/>	2	CPR scene <input type="checkbox"/>	
	1-5 <input type="checkbox"/>	1	enroute <input type="checkbox"/>	
	0 <input type="checkbox"/>	0	Airway:	
B. Systolic Blood Pressure	>89 <input type="checkbox"/>	4	Intubated <input type="checkbox"/>	Oral <input type="checkbox"/>
	76-89 <input type="checkbox"/>	3		Nasal <input type="checkbox"/>
	50-75 <input type="checkbox"/>	2	BVM <input type="checkbox"/>	
	1-49 <input type="checkbox"/>	1	EOA <input type="checkbox"/>	
	0 <input type="checkbox"/>	0	Cric <input type="checkbox"/>	
C. Glasgow Coma Scale			MAST <input type="checkbox"/>	<input type="checkbox"/> ↑ <input type="checkbox"/> ↓ <input type="checkbox"/>
1. Eye Opening			Crystalloid _____	
Spontaneous	_____	4	Blood _____	
To Voice	_____	3		
To Pain	_____	2		
None	_____	1		
2. Verbal Response				
Oriented	_____	5		
Confused	_____	4		
Inappropriate words	_____	3		
Incomprehensible words	_____	2		
None	_____	1		
3. Motor Response				
Obeys commands	_____	6		
Purposeful movement (pain)	_____	5		
Withdraw (pain)	_____	4		
Flexion (pain)	_____	3		
Extension (pain)	_____	2		
None	_____	1		
Total GCS Points (1+2+3)	_____			
	TRAUMA SCORE _____			
	(Total Points A+B+C)			

No – Of course there was a scene of the injury but if EMS was not called this is a No

A-C-P-U – (C = V or AVPU) quick assessment of neuro status

EMS – This is the EMS system sent to the scene. This field is used for Performance Improvement

RUN# – For easier identification of the team involved in the run

Amb Dispatch – Time of dispatch

Scene Time of Arrival – Time EMS arrives at scene

Scene Leave Time – Time EMS leaves scene

These times are used to look at how long from the time of injury to the time health care

Heli – Did a helicopter come to the scene

Date – Date of arrival at scene (could be different then the date you leave the scene if near midnight)

P,R,BP – Vital signs to help determine Revised Trauma Score and to provide a baseline of the patient at the scene

Revised Trauma Score – This helps determine a baseline at the scene. This includes the Glasgow Coma Scale

ALS/BLS – level of response

No chart – If we do not receive an EMS report to obtain this information for the registry

CPR scene / enroute – procedures that occurred in the field

Airway – what was required and done in the field and what level of treatment was required

Crystalloid / Blood – fluids in the field to help determine the patients total fluid requirement

Much of this data is used to determine patterns of care such as how long it takes for patients to get medical assistance, what kind of care is needed most frequently. A comparison of baseline data obtained in the field to discharge outcome data focuses on what are successful methods of treatment. We really appreciate the help we get in obtaining this data. EMS reports are frequently pieces of information we have trouble getting. If the patient is admitted at a facility other than Duke to begin with please send us a copy of the report. If the patient is coming straight to Duke please be sure and leave your reports at the Emergency Department. The information is required by the state and we would appreciate your help.

Claudia M. McCormick, RN, MSN

Heads You Win

Several years ago my son had a “typical” accident on his bicycle while riding through our “quiet and safe” neighborhood. Michael was coming to an intersection when he noticed a car approaching and tried to beat the car through the turn. He did, but failed to see the parked car, which he hit, knocking out a tail light and causing over \$500 damage. The owner of the car witnessed Michael hitting the car and came outside to make sure he was okay. Michael didn’t get up right away. The owner helped him up and made sure Michael wasn’t seriously hurt. Michael was shaken up but able to ride his bike home.

Now let me share some facts with you why this was a typical accident.

- more bicycle accidents occur in June, July and August
- more accidents occur from 6pm – 9pm, followed by 3pm – 6pm
- **10 – 14 year olds** have the highest death rate **of all ages**
- males are seven times more likely to be involved in a bicycle accident than females
- use of a helmet **reduces the risk of Head Injury by 85%**

I examined Michael’s helmet after the accident and found a large crack in the foam lining. The helmet had done its job perfectly. We returned the helmet to the manufacturer along with a letter explaining how the helmet was damaged. In our case, Troxel was nice enough to send a free replacement. The damaged helmet will be used for further research and development into making better helmets.

When should I replace a helmet?

- if it has been crashed
- if it is greater than five years old
- if it was made before 1984
- when you want one that looks “cooler” - fashion is a good excuse too

How do helmets protect your head? The helmet is made up of basically three parts: the chin strap, the protective foam inside and the outer shell. Let’s begin with the outer shell. The shell is a thin, smooth plastic which covers the foam. The plastic should be smooth so that when the helmet strikes the surface it will slide and in doing so prevents the head from snapping back. The plastic shell also disperses the energy to a wider area into the foam. The main body of the helmet, the foam, is made of EPS (expanded polystyrene) or EPU (expanded polyurethane). This material accepts the energy from your fall and is “crushed”. The foam will recover most of its original shape, but does so slowly enough that the head receives very little of the energy from the impact. Finally, the chin strap should be worn (buckled!) as snugly under the chin as comfortable. Consider the scenario where the rider is hit by a car and thrown onto the car or road. The buckle keeps the helmet in place to protect not only your brain, but can protect the forehead and face to a degree.

Which leads us directly to fit. The helmet should be worn level and rest just above the eyebrows, not cocked back exposing the forehead. When properly worn, the helmet should not be able to

be moved but an inch or so when one tries to pull it over the head or side to side.

Parents: **DO NOT** buy a helmet your child will grow into. Buy one that fits. Most helmets for kids come with pads to customize the fit.

Comfort: Helmets come in many different sizes to accommodate most heads, including bald ones. Take time in the store to try on several sizes to find the one best for you or your child. Once purchased, the chin strap and pads (if used) take from 15 minutes to half an hour to get a fit which does not cause pain, pressure or headaches. Patience will be rewarded.

How do I know I’m getting a safe, quality helmet?

Look for the ANSI (American National Standards Institute), ASTM (American Society for Testing Materials), CPSC (Consumer Product Safety Commission) or Snell Standard sticker (Snell Memorial Foundation) on the inside.

For adult riders, more statistics:

- 96% of bicyclist killed in 1996 & 1997 were not wearing a helmet
- bicyclists hospitalized with head injuries are **20 times** more likely to die compared to those admitted without head injuries
- lifetime cost for a serious head injury is estimated at \$4.5 million — consider this versus the price of a \$30 helmet
- risk of injury is four times greater in non-daylight hours, i.e., dawn, dusk and night time (consider using reflector tape or reflective safety jackets or lights) For parents of kids on bicycles:
- less than 15% of kids age 14 and under wear a helmet when riding a bike
- many serious bicycle related head injuries occur near home when no other vehicle is involved
- 60% of bicycle related deaths occur on minor roads, usually within one mile of home

As parents, my wife and I insist our children wear helmets when biking or roller blading. Michael and his sister Madison have both had accidents on their bicycles, but the helmets have prevented any serious injuries. As a parent I challenge you to do the same. Don’t let your kid out of the driveway without a helmet. No helmet, No Bike. Children will wear a helmet if you set the exam-



Michael



Madison



ple. Buy your kids a helmet they like. Helmets come in any color you can think of and a variety of styles. If it's their choice, chances are they'll wear it more often.

Recently, while preparing the trauma lecture for a PALS class, I realized it said nothing about prevention. I have been told the rewrite for PALS 2000 will address this.

But prevention is the key here folks. My letter to Troxel was forwarded to the "Spokane County Bicycle Helmet Coalition". Michael's story and picture were included in the pamphlet "Every Ride Every Time". In my letter I stated I am a Flight Nurse at Duke University. In nearly nine years of transport I have never transported a kid to the Trauma Center who was involved in a bicycle wreck and wearing a helmet.

*Edd Shope, RN, CCRN
Duke Life Flight/Life Care*

References:

- AACN Bicycle Helmet Safety Resource Kit
N Engl J. Med 1969; 320:1361-7
- Bicycle Safety Institute @ www.bhsi.org
- World Health Organization Helmet Initiative @ www.sph.emory.edu/helmets/HRC/PrudentialHC.html
- & www.sph.emory.edu/helmets/boardman.html

9th Educational Experience

The 9th Annual Trauma Conference was held at the Durham Marriott at the Civic Center March 8-9, 1999. Over 200 participants from the Triangle area, North Carolina, South Carolina, Georgia, Virginia, and Michigan enjoyed the two days of trauma related topics featuring keynote speakers Norman McSwain, MD and Robert Delorenzo, MD. Other speakers included physicians, nurses, and EMS professionals from Charlotte, Winston Salem, Rocky Mount, Raleigh, and the Durham area. Topics included mechanism of injury, fluid resuscitation, ballistics, biological and chemical agents, juvenile violence, spinal immobilization, delays in the ER, venomous bites and stings, blast related trauma, and disaster management, just to name a few.

Comprehensive conferences that provide education to many health care disciplines are very costly. Vendor support from Pfizer US Pharmaceuticals, Rhone Poulenc Rorer Pharmaceuticals, Aircast, Medical Treatment Systems, Microflex, Nutech, Sims-Smiths Industries, Southeastern Emergency Equipment, Zeneca Pharmaceuticals helped make this conference a success. Door prizes were donated by Appleton and Lange, Hill-Rom, Head Injury Association, and the North Carolina Division of the American Trauma Society.

The 10th Annual Trauma Conference at Duke is tentatively scheduled for March 6-7, 2000. Planning is underway and the conference brochure should be available before the turn of the century.

John Duskey, RN

Part 4: Challenges to Constructive Relations

The survival of organized trauma care and the transition to a market model to finance health care are both necessary for the long-term good of the health care system. To achieve this, compromise on the part of MCO's and redesign on the part of trauma centers is in order. The following describes areas where negotiation and conciliation will be required so that progress rather than chaos and further fragmentation can occur.

Payment for Uncompensated Care

Trauma centers cannot carry the burden of high uncompensated care costs without support from MCO's and their hospital networks. Failure to correct the financial inequities resulting from the concentration of these patients in trauma centers will inevitably lead to the collapse of organized trauma care. When this occurs, trauma patients will be distributed to the very hospitals that have previously been relieved of this population because of trauma systems. Overall, trauma system collapse will create even more wasteful and adverse financial conditions than currently exist because the patients will not be concentrated in specialized facilities where resources can be managed effectively.

Payment for Research, Medical Education, and Prevention

Although MCO's generally agree that they should pay a fair share of the costs of uncompensated care, accepting responsibility for the costs of academic medicine is another matter. The government is also increasingly unwilling to bail out academic medical centers due to their high costs. The tendency of teaching hospitals to delegate patient care to residents who have little concern and no accountability for patient care costs contributes greatly to the antipathy of MCO's for trauma care.

Excessive Trauma Care Costs

Trauma centers will have the reputation as wasteful and extravagant until they develop systems and controls over their runaway costs. The tendency to disregard costs and simply price gouge must be replaced with cost management mechanisms and resource conservation. This will allow trauma centers to define their costs on a case specific basis and ultimately be able to contract with MCO's using a global pricing structure.

Futile Care and Lack of Controls

High costs of trauma care are compounded by zealotry in providing care in the face of terminal injury. Although extraordinary efforts or heroics may arise from the competing mission of medical education, they are more likely a result of failure of faculty to supervise physicians in training. The failure of organized trauma care to develop standards for medical futility, the like which are seen in prehospital

"death in the field" criteria, is also at fault. Brain death is too rigid a determinant for cessation of care when research based on TRISS or other methodology could provide other criteria that would preclude expenditure of scarce and expensive medical resources.

Adverse Selection and Cherry-picking

If trauma centers are to continue to receive the sickest and highest cost patients, leaving mostly private and for-profit medical centers with a choice payer mix, redistribution of revenues must occur. The "skimming" of less injured patients through selective transfers also is perilous to trauma center survival. Patient repatriation patterns need to be designed to conserve the numbers of patients the trauma center needs to maintain technical excellence and financial viability.

System Overcapacity

Excess capacity within some trauma systems has contributed to waste, produced inequitable pricing and resulted in some of the managed care organization's practices that are destabilizing organized trauma care. The American College of Surgeon's considers that an average of 1 trauma case per 100,000 population occurs nationally.

This or some other population based data should be used to determine system needs and overcapacity addressed through trauma center consolidation or elimination, so that nearly continuous use of expensive resources is maintained. Maneuvers by emerging hospital networks to create trauma centers within their member hospitals that coincidentally creates overcapacity within the regional trauma system must also be addressed.

SUMMARY

Despite many similarities and nearly consistent goals, organized trauma care and managed care have obstacles to overcome in order to meet their mutual goal of providing trauma care in a cost effective manner. The energies of trauma center leadership need to be directed to re-engineering organized trauma care to meet the market's demand for high quality, low cost care at a fair and predictable price.

Ultimately, when the managed care market matures, the cost-shifting strategy that has historically funded trauma care will not work and a new approach emphasizing cost management will be required. New prospective pricing schemes that provide appropriate incentives, along with an integrated physician/hospital structure capable of managing costs, will be needed to support the structures which have taken nearly 20 years to create and to sustain them for the benefit of future trauma patients.

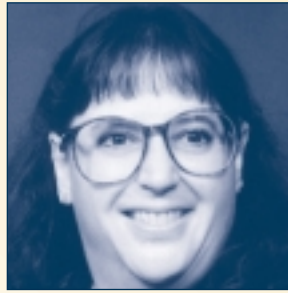
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Trauma 2000 Project,
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Outreach Corner

Hello! So who else is in the Duke RAC?



By
Claudia M. McCormick, RN, MSN

Durham Regional Hospital is located in Durham, North Carolina. We have recently completed our renovation of the Emergency Department, Surgical Services, and Outpatient areas. We also just joined with Duke University Health System as a partner and look forward to our joint relationship. Improving trauma care has consistently been one of our performance improvement indicators. The involvement with the Duke RAC will provide more opportunity to network and assure quality patient care is provided within our community and our state. Although we are not a trauma center, future planning includes working toward Level II designation. The Emergency Services Medical Director, Dr. Ted LaMay, and Nursing Director, Deane E. Schweinsburg, RN, BSN, plan to take part in RAC activities. Some of our other key people helping with the 43,000 patients (1250 admitted trauma) that come



Durham Regional Hospital ED entrance

Trudie (in her plaid jacket) and Dr. Carter with a group of ED nurses



through the Emergency Department are Larry T Suitt, COO, and Beverly J. Wright, RN, BSN, Nurse Manager. We are eager to participate in the building of the integrated North Carolina Trauma System – Deane.

Joining us from the southern part of the state is Scotland Memorial Hospital in Laurinburg, North Carolina. Greg Wood, CEO, and Ruth Glaser, VP – Operations keep the whole operation going but in the Emergency Department look for Trudie Wilburn, RN, CEN to keep you organized. Trudie, with the help of Dr. Ken Carter, ED Medical Director, sees about 23000 patients

a year come through the ED with 900 of those patients being admitted for trauma. Presently Scotland Memorial is increasing the services they offer to patients, employees, and the community. Some new prospects on the horizon include a new rehabilitation facility, a wellness program for employees, a community education mobile van, and a cardiac rehabilitation center. We wish you luck with all your projects.

Dr. John Guha is in charge of one busy Emergency Department in Smithfield, North Carolina. Thank goodness Gail Evans, RN, ED Nurse Manager at Johnston Memorial Hospital is there to help. If you remember, Johnston Memorial Hospital was featured in the fall 1998 edition of TraumaVue when they opened their new Emergency Department. At that time they tripled the number of beds and I am sure that Lee Farnell, Hospital Administrator is happy that they can provide those beds for the community.

Person Memorial Hospital, Roxboro, North Carolina has a seven bed Emergency Department. Doris Pillow, Nurse Manager has a nursing staff that consists of nine full-time nurses with over 130 years of emergency department experience. In addition, there are ten part-time nurses, five of whom are in school to further their education in the medical field. Leading the medical side of the team is Dr. Kimmie Yarborough. Together these fine people see

about 12377 emergency department admissions per year. Regis Cabonor, Hospital Administrator has something to be proud of with this group of people.

Dr. Thomas Jeffries, Medical Director and Helen Gilliam, RN, Nurse Manager have their hands full at Franklin Regional Medical Center. Franklin Regional has about 13800 patients come through each year with 20-25% of those being trauma related. Not only do they have a lot of patients coming through the ED but they have just broken ground for a NEW Emergency Department which will include two trauma/cardiac rooms in the eight bed facility. Ann

Barnhart, Hospital Administrator, has plenty to keep her busy in the beautiful community of Louisburg, North Carolina.

Durham Veterans Administration Hospital located across the street from Duke will be joining us in the Duke RAC. While military hospitals do not have to join a RAC it is wonderful that they are willing to work with the hospitals in the state to keep care for trauma patients at a standard level. Dr. Kenneth Goldberg is the Emergency Department Medical Director at the Durham VA.

Raleigh Community Hospital joins the Duke RAC from Raleigh, North Carolina. Raleigh Community has also just joined the Duke University Health System. Kate Drawdy is the Nurse Manager of the Emergency Department and Dr. John Kelsch is the Medical Director. While they

Durham Veterans Administration Hospital ED entrance



Patsy Yates, a RN from Person is in the middle of a group taking a Trauma Stabilization Course

do not see much trauma in the emergency department, they still have about 25000 patients pass through in a year. Raleigh Community Hospital is well equipped to handle any minor or major problem.

CONTINUED BACK PAGE

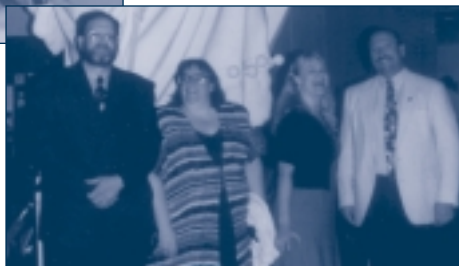
Located also in Durham is Duke University Health System. Duke has been a designated Level I Trauma Center since 1992. Ed Eroo, the Administrator over the Emergency Department and Trauma Services, will be involved in RAC activities. The Emergency Department sees about 60000 patients per year with about 1650 patients admitted for trauma. Dr. Richard Serra, Acting Medical Director, and Kathy Finch, Nurse Manager, have things in great control in the Emergency Department. This crew is very interested in injury prevention activities with involvement in such programs as Risk Watch, ENCARE, and teaching a Trauma Stabilization course. Working closely with the Emergency Department is Trauma Services. I think you know most of us from previous newsletter articles but let me review. Dr. Steven Vaslef is Medical Director of Trauma Services. Others on the team include Deborah "Hutch" Allen, RN, MSN, FNP, Nurse Practitioner and Trauma Coordinator;

John Duskey, RN, Trauma Education Coordinator; Donald Hartwell, Trauma Registrar; and yours truly Claudia McCormick, RN, MSN, Trauma Outreach Coordinator.



Duke ED

Terry Hoyle from Hickory is joining Claudia, Hutch, and John at the National ATS Convention in Washington, DC.



These, along with those featured in the last issue of Trauma Vue, are the hospitals that chose the Duke RAC as their primary RAC. Next issue we will look at those hospitals that joined as a secondary partner. Hope this article has given you some insight and some contacts. Welcome to everyone in the Duke RAC.

*Be safe and healthy,
Claudia*

Outreach Calendar

June

- 23-24 ATLS (Duke-John Duskey 919-684-2197)
- 23-July 4 Special Olympics, Triangle

July

- 8-9 ATLS (Duke-John Duskey 919-684-2197)
- 15 NC ATS, Trauma Nurse/Registrar, Trauma Registry, RAC Meetings, Raleigh
- 16 Duke RAC Meeting

September

- 16-18 American Association for the Surgery of Trauma Annual Meeting, Boston, MA
- 26-28 Emergency Medicine Today Conference
Four Seasons Holiday Inn,
Greensboro, NC
NCOEMS 919-733-2285

October

- 7-8 Trauma Conference, Frye Regional Medical Center, Hickory
Terry Hoyle 828-345-5660

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