## Trauma Nursing Process (TNP)

### Preparation and Triage
- Activate trauma team
- Prepare the room and any special equipment
- Don PPE and consider need for decontamination

### Across the Room Observation
- Uncontrolled bleeding? Reprioritize to <C> ABC

### Primary Survey [ABCDEFG] “When you mess, reassess”

**A** - Alertness (A₁) and Airway (A₂)
- Maintain cervical spinal stabilization
- AVPU (Alert, Verbal, Pain, Unresponsive)
- Assess airway patency (at least FOUR)

**B** - Breathing and Ventilation
- Assess breathing effectiveness (at least FOUR)

**C** - Circulation and Control of Hemorrhage
- Assess for uncontrolled hemorrhage, central pulse, skin color/temperature/moisture (ALL THREE)

**D** - Disability (Neurologic Status)
- Glasgow Coma Scale
- Pupils
- *Consider head CT for any abnormalities

**E** - Exposure (E₁) and Environmental Control (E₂)
- Remove clothing, provide warmth

**Double starred items must be completed IN ORDER prior to moving to the next step**

### Full Set of Vital Signs (F₁) and Family Presence (F₂)
- **L** – Labs: blood typing, blood gases, and lactate
- **M** – Monitor
- **N** – Naso- or orogastric tube
- **O** – Wean Oxygen based on Oximetry and assess capnography (required if sedated or intubated)
- **P** – Pain assessment AND management

### Reevaluation for Transfer to Trauma Center or Preparation for Definitive Treatment

### Secondary Survey [HI]

**H** - History (H₁) and Head-2-Toe (H₂) Exam
- History (H₁) – Prehospital report, patient- or family-generated, from electronic health record
- Head-2-Toe Assessment (H₂)

**I** - Inspect Posterior Surfaces
- Unless contraindicated by suspected spine or pelvic injury – turn, inspect & palpate, remove backboard

### Anticipated Interventions or Diagnostics
- At least THREE

### Just Keep Reevaluating
- Vital signs
- Identified injuries and effectiveness of interventions
- Primary assessment
- Pain

### Definitive Care or Transport

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