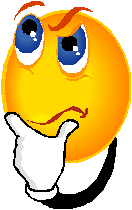
**MODET UPDATE:**



**Multiple Organ Dysfunction in Elderly Trauma: An Update for Research Teams**

**How are we doing so far?**

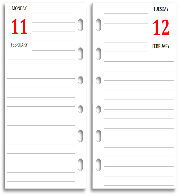
Total number of patients recruited to-date: 147

Patients aged <65 years: 104

Patients aged >65 years: 43

**Are we on-track?**

Our yearly recruitment target is 259 older patients (aged ≥65 years) and 414 younger patients (aged≤65 years). This means if each MTC is able to recruit 65 older patients and 104 younger patients in a year, we will be on track to meet our sample population. This equates to a recruitment target of 5-6 older patients and 8-9 younger patients per month for each MTC.

**A Date for your Diary…**On Wednesday 24th May from 2-3pm we will be holding the first MODET Study Steering Group Meeting at QMUL’s Blizard Institute (4, Newark Street, London, E1 2AT). This will be the first opportunity for everyone involved in MODET across London to meet and discuss the progress of the study, so it would be great to see as many of you there as possible. It will also present a valuable opportunity for networking and to meet colleagues from research teams at other Major Trauma Centres.

**TARN Report into Major Trauma in Older People Published**

The Trauma Audit & Research Network (TARN) has recently published a long-awaited report into Major Trauma in Older People which contains such important conclusions with significant implications for the way in which major trauma is managed by UK Trauma Systems. The most important finding of the report is that current systems often find it difficult to identify older patients with major trauma. The report posits that this may be due to a combination of factors including low energy transfer mechanisms of injury; co-morbidities which make the presentation of major trauma less obvious; and physiological characteristics which may result in signs of significant injury taking longer to manifest. As a result of these factors, older trauma patients are more likely to bypass a Major Trauma Centre and receive initial management by relatively junior medical staff. This lower level of early activation of the trauma care system seems to lead to delays in both investigation and management. The report highlights the urgent need for further research into the incidence of elderly trauma and associated outcomes within UK trauma systems. *In light of this, it is great that the Pan-London Major Trauma System is leading the way with pioneering collaborative projects like the Pan-London Elderly Trauma Guidelines and MODET…!*

For more info see: <https://issuu.com/tarnaudit/docs/major_trauma_in_older_people_2017/4>

***Ask Aunty Mo…***

*The only Agony Aunt you can count on for all your MODET questions and concerns…*

**Dear Aunty Mo,**

I am getting very confused about GCS SOFA scoring in patients with a tracheostomy, or who are on low-dose sedation. What GCS should I take most notice of on their ICU charts? I also feel mean when scoring patients based on their worstGCS rather than their best GCS. Any advice?

Yours sincerely, A Confused Research Nurse

***Aunty Mo says…***

*Dear Confused Research Nurse,*

*I don’t blame you for feeling confused! You’re quite right that in practice you are scoring the patient’s best GCS for treatment and prognostic reasons. However, when SOFA scoring you are assessing the worst level of organ dysfunction in a given 24-hour period, which is why we ask for their lowest GCS score. The best advice I can give is to record the lowest score for those patient in which no aspect of their care or treatment could be affecting their GCS and in all other cases (eg. patients under any sort of sedation) score based on their last known GCS without sedation or other confounding factors. It is also worth remembering that the most you can score a fully conscious and un-sedated patient with a tracheostomy is an 11/15 unless the patient has a speaking valve in-situ and you are able to assess their ability to verbalise for signs of confusion. The confounding effects of brain injury will be taken into account at MODET HQ when data is analysed for overall results.*

*Yours Lovingly, Aunty Mo xxx*

**Dear Aunty Mo,**

*I have a patient who was admitted to the ICU at17:00 hours on 03/05/17. Our ICU charts run from midnight to midnight. What should I count as their admission day, 03/05/17 or 04/05/17?*

*Best wishes, An Anonymous Research Nurse*

***Aunty Mo says…***

*Dear Anonymous Research Nurse,*

*For the purposes of SOFA scores in MODET, we need as near to a full 24-hour period for scoring. If you have more than 12 hours of data for the first day, you could consider counting this as the ‘admission day’ and scoring accordingly. However, if you have less than 12-hours of data on your first ICU chart, then include the data from that chart and the next (first full) chart in your score calculations. Essentially, it is acceptable to score data in just under or just over a 24-hour period, but any data amounting to less than 12 hours should be rounded-up and included with the next set of full-chart data. I hope this clears up the confusion!*

*Yours in good faith, Aunty Mo xxx*