Barking, Havering and Redbridge University Hospitals NHS Trust

The TANQ

Trauma Aggregated News, Queen's

Queen's Trauma Service

BHR

Points of Interest:

- TARN
- TQuINS
- Governance
- Supplement
  - Poster 1
  - Poster 2
  - Poster 3

Inside this issue:

The month of April has seen us host our first Tri-annual Major Trauma MDT. These three MDT's allow us to analyse our status as a Major Trauma Centre more intensely. It is open to all members of the Trust and Network, where as the remaining MDT's focus on the core trauma specialities. Our regional network governance director was also present.

We've had great feedback from TARN and the NELETN for the efforts put in to data upload. In the last three quarters, we have improved ten folds, increasing data upload from a mere 6% to 74% and counting. Our data accuracy well above 85%.

This is important, as we will soon be having our Trauma Peer Review, so every effort has to be made to maintain ourselves at this level. Local criteria for Trauma Unit Performance have been set up in anticipation of the upcoming TQuINS, and these were discussed in the meeting. This will lead on to development of a number of trauma protocols and policies. In addition to this, the Major Trauma Policy for the Trust has been updated, and the revised version will soon be available on the intranet.

The case studies discussed both had one issue in common, and that was the management of cardiorespiratory arrest in patients with trauma. As a result of the interesting dialogue that ensued, the decision has been made to create a Trust protocol for traumatic cardiac arrests.

Two complaints were discussed which highlighted concerns with the immediate transfer of trauma patients pathway and also the radiology reporting online system.

The final news headline for this month are the junior doctor strikes again. There are two sets of strikes, the first set in early April were similar to the previous strikes and did not affect the emergency pathway. However, the strikes on 26 and 27, will be a full walkout by junior doctors between the hours of 8 am and 5 pm. Needless to say, preparations have been made to ensure the Trauma Pathways runs smoothly.

At present, the plan is for all Trauma dect phones will be held by consultants of the relevant specialties, and the Trauma Team will function as normal. Similar setups exist for all other emergency pathways.

PRIDE

TARN
THE TRAUMA AUDIT & RESEARCH NETWORK

Trauma at Queens

It can get confusing trying to understand the difference between the trauma patients brought in as a trauma call and the trauma patients identified by TARN. Not all Trauma calls will be TARN patients and not all TARN patients will come in as a Trauma call!

TARN patients may enter the hospital via any route and in most cases require admission for at least three days with trauma related injuries. Being a trauma unit, most of our trauma calls end up being discharged home, and thus do not end up being put on TARN.

The column to the right shows our project TARN patients for the current year.

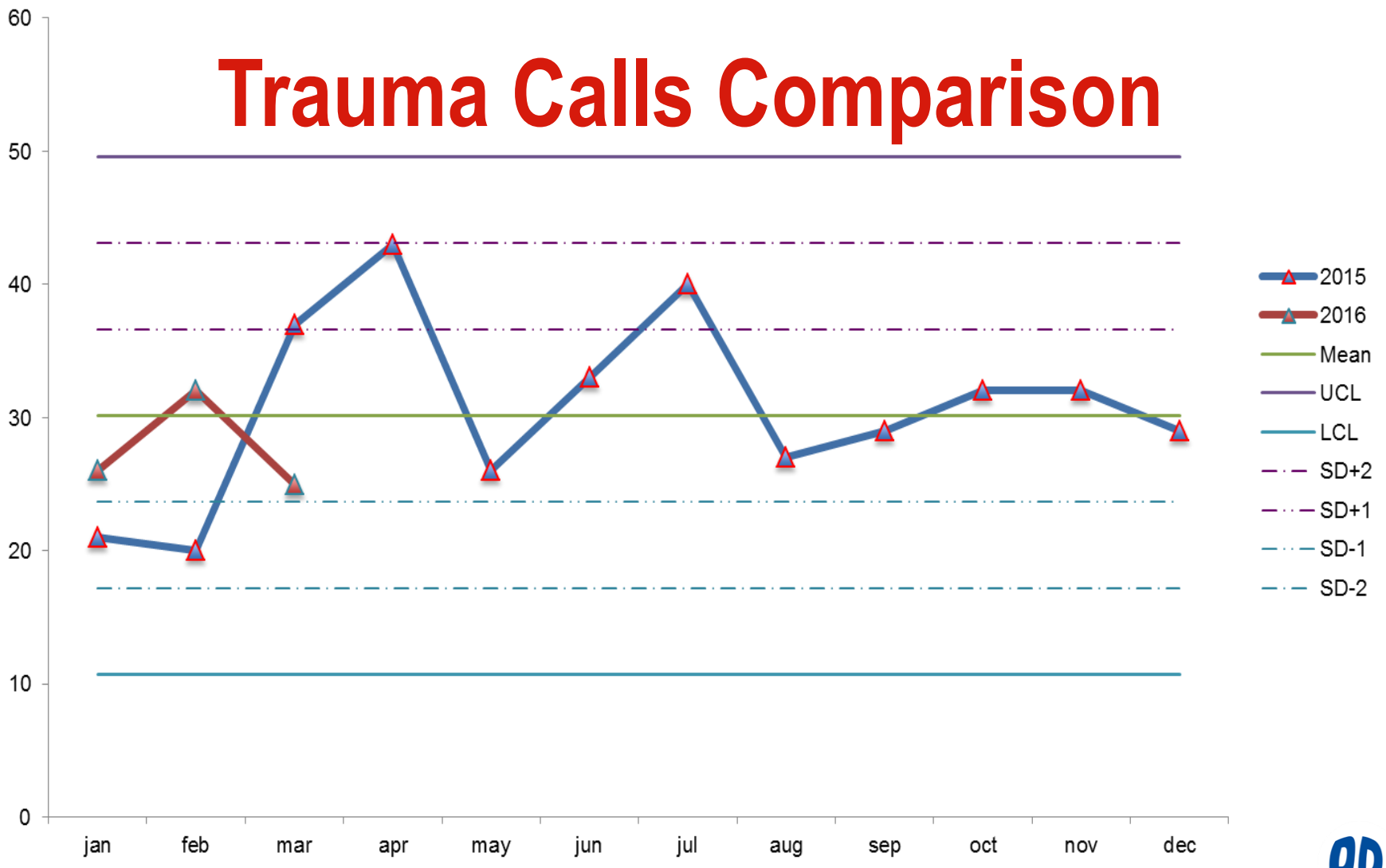
The graph below is a comparison of our Trauma calls of 2015 and 2016 to date. It is plotted as a control chart, with the mean in the centre and upper and lower control limits of three standard deviations.

Applying the Nelson rules, the pattern is completely random, as would be expected, and there are no areas of concern at the moment of the Trauma Call pathway.

EXPECTED TARN PATIENT 2016

Month	Expected Submissions
January	42
February	41
March	45
April	53
May	58
June	41
July	60
August	60
September	47
October	67
November	52
December	49

Trauma Calls Comparison



"Pan London major trauma system local criteria for trauma unit performance reviews 2016"

Evidence of institutional commitment

- Named senior lead to attend Network Board (75% attendance)
- Named lead to lead both locally and at network group (1PA, 75%)
- Named clinical lead for elderly trauma to lead locally
- Named rehab lead to attend network rehab group (75%)
- Named TBI and spinal champions to lead locally (75%)
- EPLO representation at network EPLO group (75%)
- Nursing rep at network nursing group (75%)
- Named clinical lead for other network subgroups
- Named management support for clinical lead
- Evidence of local trauma delivery group meetings with MDT attendance (minimum quarterly)
- Evidence of dedicated resources that support TARN data entry

Evidence of tarn data completeness

- RED: Below 60%. CEO and CCG informed. Trust level action plan needed with review in 6 month times
- AMBER: 60 – 79%. CEO and CCG informed. Trust level action plan needed with updates via network forums
- GREEN: 80% and above. No action required

Evidence of government and risk management

- Evidence of trauma governance log
- Evidence of M&M meetings in which MT patients are reviewed
- Evidence of local review of patients with ISS > 15 (minimum quarterly)
- Evidence of risk register related to delivering MT care and routine reporting to Trust governance and risk board
- Evidence of a structured action plan for reviewing trauma governance and risk management (from ED to rehab) is structured within the Trust

Evidence of inpatient care and pathways

- Confirmation of lead speciality and pathway for the management of admitted trauma patients with:

Multiple injuries| Isolated head injuries|Spinal injuries|Elderly trauma patients

Evidence of transfer of care processes

- Evidence of a trust wide process for accepting patients transferred back from MTC
- Evidence of compliance with network and Pan London standards of transfer within 72 hours (includes 24 hours pre-alert) for the last 12 months
- GREEN: Average transfer time 2 days
- AMBER: Average transfer time 4 days
- RED: Average transfer time 4+ days. (CEO and CCG informed. Action plan needed with updates via network forums)

Evidence of on-going care rehabilitation practices

- Description of trauma co-ordination care service (roles and evidence of engagement)
- Evidence of agreed Referral pathways/directory of services and documentation on discharge from TU
- Evidence of training methods and logs of trained staff for spinal care and collar and brace fitting

NICE Guidelines—Major Trauma

The NICE guidelines for Major Trauma, focusing on assessment and initial management and service delivery have been published on the 17th of February 2016.

We went over the guidelines and were satisfied with the standards set overall.

There are areas of improvement for the Trust, some of these can be sorted out locally, such as performing vertex to toe scanograms prior to head-pelvis CT scans (to identify long bone fractures). Other standards, like those set for rehabilitation , will require coordination at a network level.

For a more in-depth look, access the link below:

https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0642

CLINICAL GOVERNANCE

CASE STUDIES

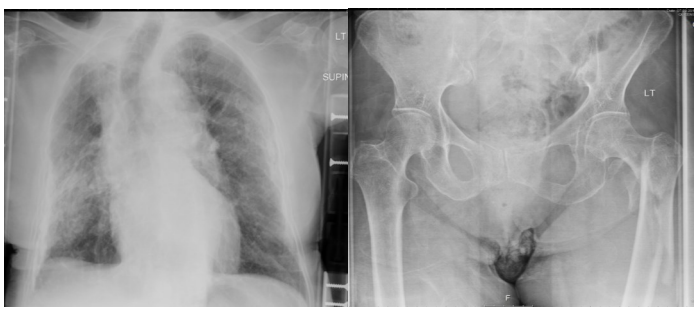
Case 1

Patient: GD Q (FA), 87yrs, Female, Presenting early March @ 0810

Pre-alert: LAS @ 0805, RTC 20 mph, Ped v Car – Head injury. Mechanism @ 0709 Concerns:- ?Head injury| laceration to limbs | ? Left femoral fracture |?BOS # | ? Chest injuries | ?abdo injuries.

ED: ED Doctor, ED Nurse, Anaesthetic SpR. Arrival @ 0810. Full team in attendance by 0830. Lead taken by Anaesthetic SpR.

Primary Survey: Monitoring: - RR 20 | Sats not recording (cold) | HR 87 | BP 110/78 mmHg | GCS: 12. Crepitus but no sub cut emphysema. Systolic drops to 96mmg Hg, bleed from left ear. Decreased movement to left lower limb. Patient vomited prior to transfer to CT, GCS drops to 5. Decision for RSI, Systolic 85 mmHg, O negative blood requested. Major haemorrhage call put out. Free fluid noted in RUQ, Multi-system injury confirmed, Decision for critical transfer to MTC.



Continued decline in BP despite O negative and TXA, PEA Arrest, Impression | Hypovlaemia | Cardiovascular injury | ± Severe head injury.

Plan: No chest compressions | Bilateral thoracostomies | Fill heart.

Traumatic Arrest / De-brief : Two failed attempts at Rt subclavian access: Likely cause – hypovolaemia Multiple rib fractures, No tension or haemothorax, echo showed cardiac standstill despite filling with 4 unit of blood.

Time of Death 0912

Case 2

Patient: DPB, 61yrs, Male, Presenting mid March @ 0725 Collapsed, hypothermic.

Primary Survey: Reveals signs of tension pneumothorax - Possible rib fractures - Subsequent cardiac arrest

Cardiac Arrest: Tension released, Chest compressions commenced, No output despite approx. 40 min CPR, Resuscitative efforts stopped

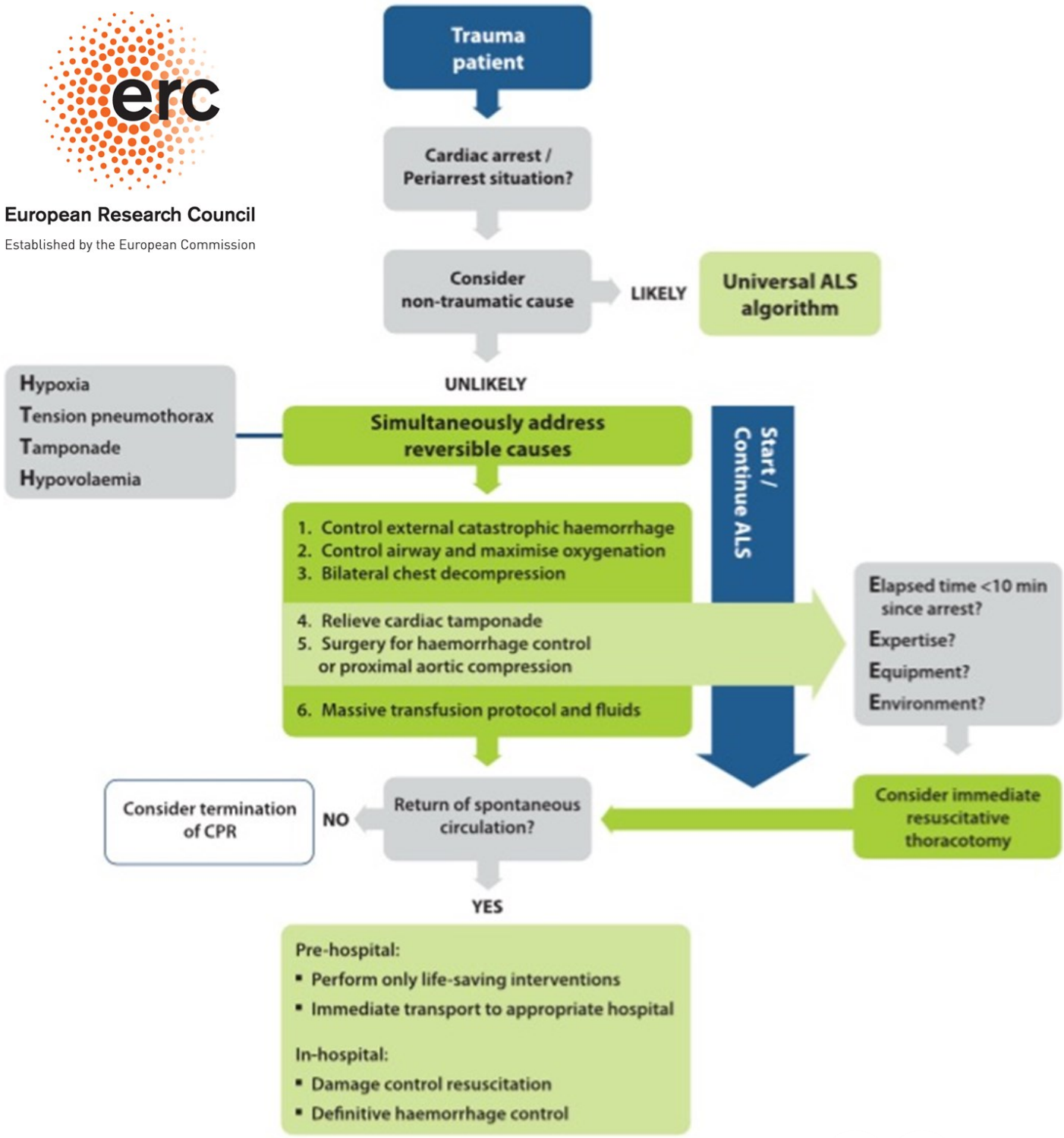
Traumatic Cardiac Arrest: Chest compressions vs. no chest compressions, Requirement to adopt protocol?

"Traumatic Cardiac Arrests"

For the average clinician, avoiding chest compressions in a cardiac arrest goes against the grain of all the years of training. However, there are times when this may actually be in the patient's interest.

Below is the European Research Council's 2015 pathway for cardiac arrests in trauma patients, and is quite comprehensive.

The bottom line is that if the arrest itself is due to a non-traumatic cause, the universal ALS algorithm applies. Otherwise, bilateral decompressions and thoracotomies may be indicated.



Education, Training & Professional Development

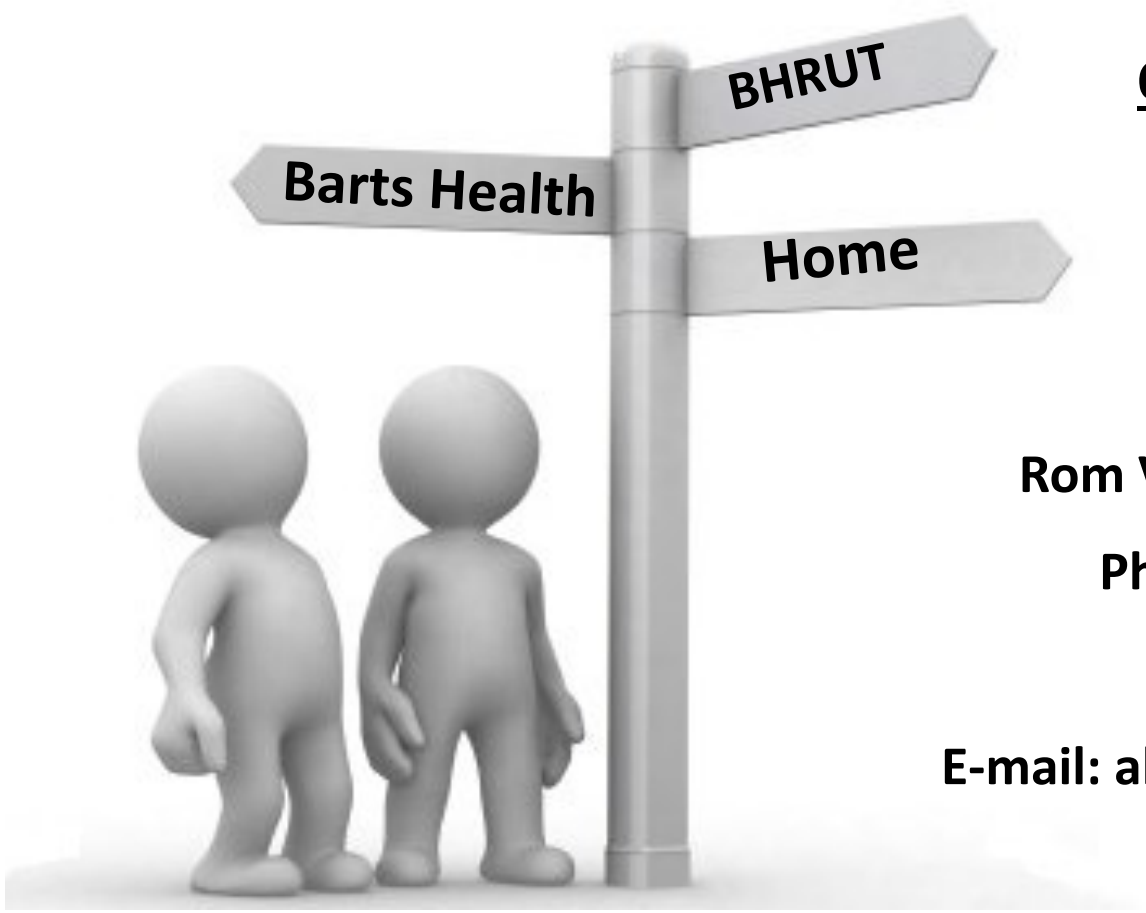
CENTRE FOR TRAUMA SCIENCES
Saving Life, Rebuilding Lives

NORTH EAST LONDON & ESSEX TRAUMA NETWORK

- Trauma Team Leaders Course (TTL) 11 April 2016
- Trauma Talks Royal London Hospital ED Seminar Room Thursday 14 April 2016
- TARN Reporting session 25 April (London)
- TARN Data Collection Sessions 26 May 2016 (London)
- Trauma Immediate Life Support (TILS) May 2016
- TILS @ Queen's to be announced
- Advance Trauma Life Support (ATLS) 14—16 September 2016

Useful websites for trauma:

www.bhrhospitals.nhs.uk | www.tarn.ac.uk | www.c4ts.qmul.ac.uk | www.nice.org.uk | www.trauma.org | www.aftertrauma.org | www.tquins.nhs.uk | www.rcseng.ac.uk | erc.europa.eu



Queen's Trauma Service

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Supplement 1

Neurosurgical team poster

ACUTE SPINAL PATHWAY

Queen's Trauma Service

Over 75's with # & back pain, Direct medical referral whom will admit then D/W N/S.
65-75 YO Assess for Co-morbidity & General medical condition first.

Patient → ED

ED ↕ Rapid Spinal Assessment Service (RSAS)

ED to assess and organise Imaging (no need to ask N/S first. If Clinically well d/c with O/P MRI & virtual ward F/U

↕

Pelvic fracture
Sacral fracture
Poly Trauma
refer to Orthopaedic

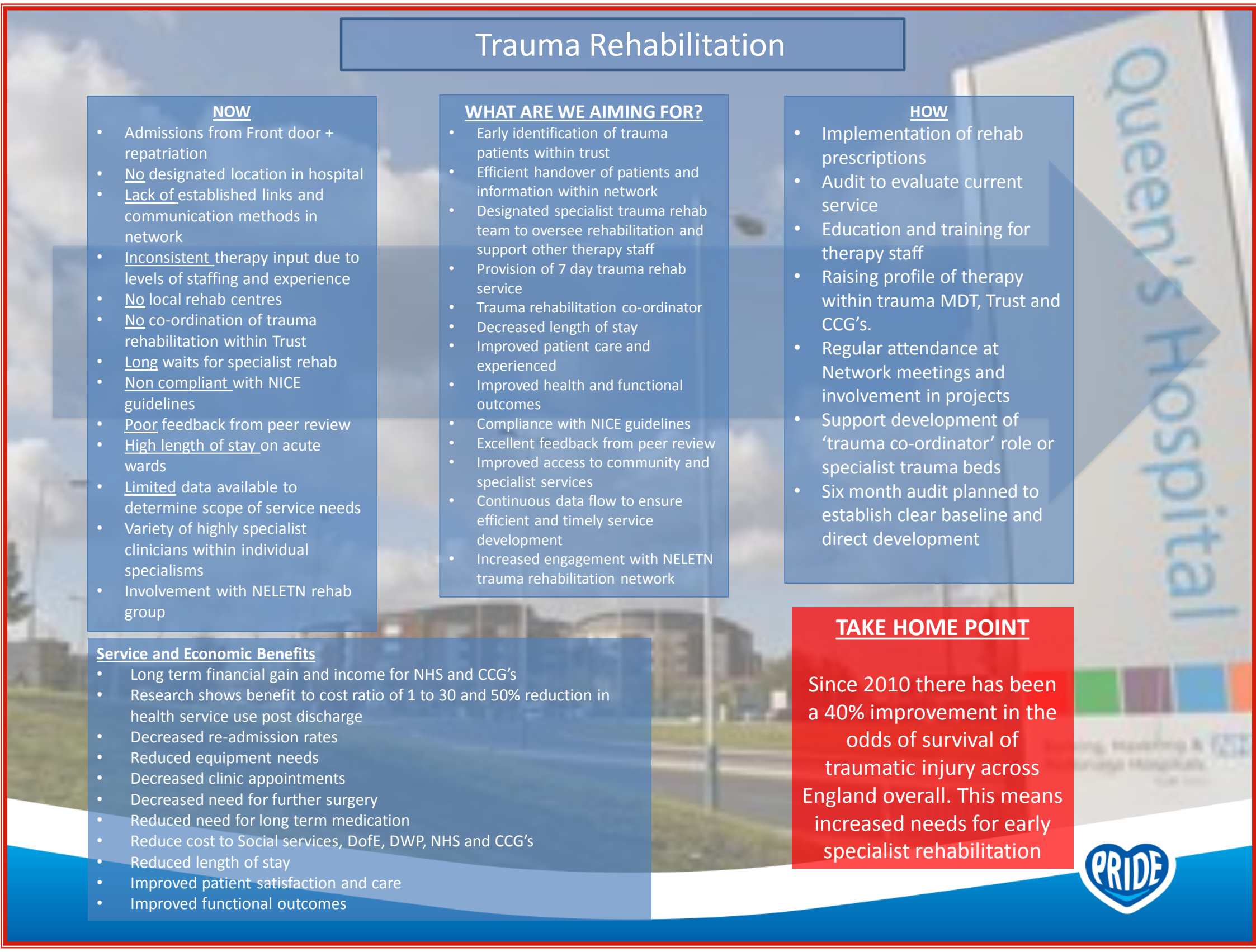
- Back pain alone no Neurology, Home GP F/U
- Trauma with + imaging and neurology, for Neurosurgeons
- Trauma with + imaging and NO neurology, refer to RSAS
- Proven disc with leg pain/arm pain long standing weakness, for Home, Neurosurgeons clinic or RSAS
- Proven disc with any Cauda Equin or Myelopathy symptoms or sighs, For Neurosurgeons
- Metastatic spine suspected for Oncology work up. If instability or compression suspected D/W Neurosurgery Reg on-call.

PRIDE

Contributed by Mr B Arvin

Supplement 2

Rehab team poster



Contributed by Ms J Smith

Supplement 3

Anaesthesiology team poster

TAKING PRIDE IN OUR CARE

Barking, Havering and Redbridge University Hospitals NHS Trust

Anaesthetics

Provision of fascia iliaca nerve block for acute pain after hip fracture

Currently:

- A programme of work to improve provision of effective analgesia to patients prior to surgery
- Nerve blocks can be given on arrival to Emergency Department
- Non-anaesthetic personnel can be trained in procedure
- Supported by large body of evidence
- Provision aids compliance with NICE Clinical guidelines for management of hip fracture.

Past Achievements:

- Details presented on multiple occasions at Clinical Governance forum
- Ongoing audit programme
- Training sessions developed for multidisciplinary tuition

Future Aspirations:

- Develop into fast-track service led by on-call anaesthetist
- Wider scope for training to ED staff

The Golden Patient Project

Currently:

- Studies of trauma theatre flow identified possibilities to improve efficiency
- Multidisciplinary discussions developed "Golden Patient" principle
- On call teams identify a patient for optimisation 12-24 hours before surgery.
- Early anaesthetic input
- Targeted for first on trauma list
- Aims to prevent delay, ensures first patient is ready for theatre and trauma list flow is enhanced

Past Achievements

- A brand new project, so it starts from here!

Future aspirations:

- Success could develop to idea of use on general surgical CEPOD list

Contributed by Dr N Borgeaud