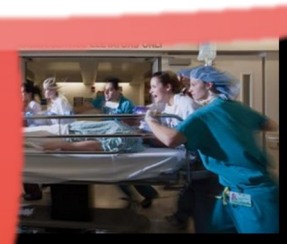
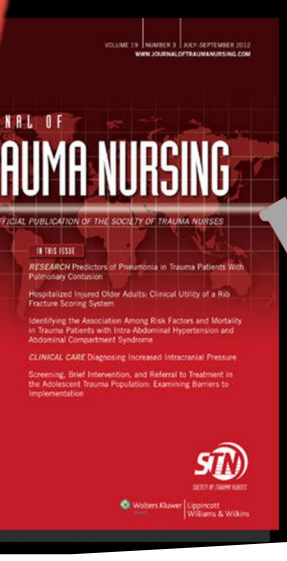
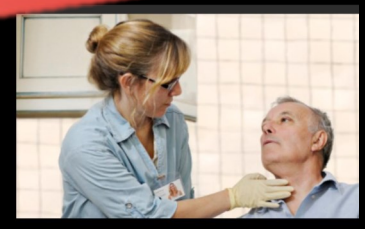
Barking, Havering and Redbridge University Hospitals NHS Trust

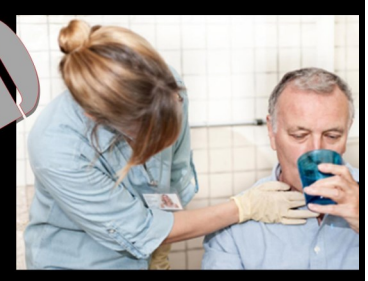
The TANQ

Trauma Aggregated News, Queen's









Queen's Trauma Service

BHR

Points of Interest:

- TARN
- TQuINS
- Clinical Governance

Inside this issue:

So, we have officially been reviewed by our Peers!

The details of it are all inside, but on the whole, the review team were very impressed by the massive improvement in the Trauma Service here at BHRUT. Key areas of good practice are our regular MDT's, all our trauma courses (including the new TILS course), the work on Rehab prescriptions and most importantly the regular publication of the TANQ. They even acknowledged the fact that we had plans and procedures in place for all the areas identified as immediate risks. All in all, things are looking very positive.

Another development that is running parallel to the trauma service is the inauguration of the Emergency Department Research Group. This group has an academic interest and one of its key focus areas is research in Trauma. It will orchestrate a structured approach in trauma related studies that is open to trainees and non-trainees alike, with the primary aim of publication. Dr Darryl Wood, ED Consultant, is the lead on this and is available by email (darryl.wood@bhrhospitals.nhs.uk). The research group will also be publishing a newsletter, so watch out for it.

With the new two-monthly MDT meetings, our calendar has changed slightly. Instead of three open-to-all MDT's a year, we will be having one annual open MDT, scheduled for December. The remaining five MDT's for the core committee will retain the focus areas, with the next one being rehabilitation for October.

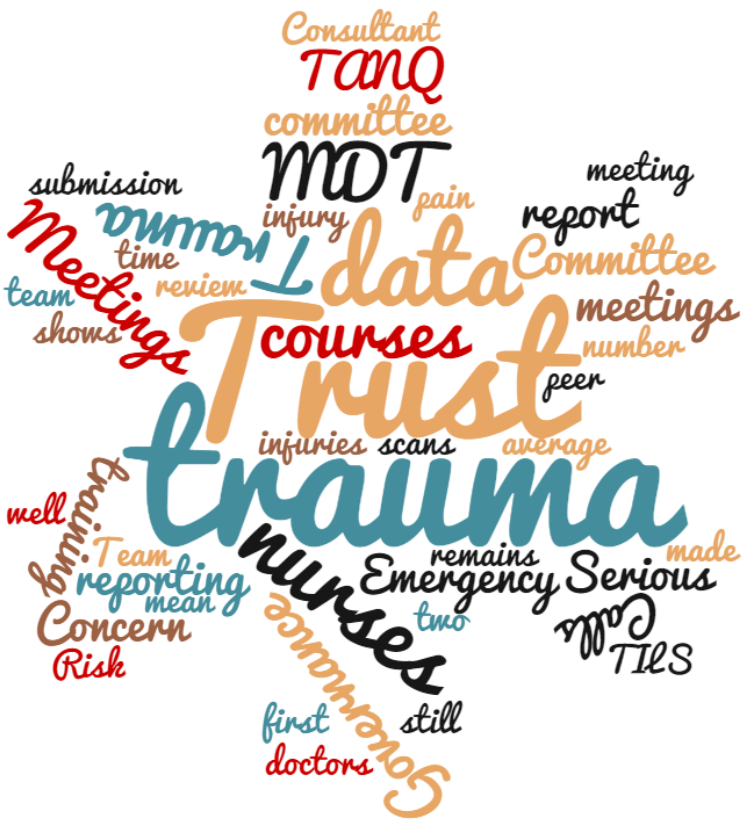
On a final note, we have stepped into the twittersphere and are trialling our individual hash tags. So far we have:

#TraumaCare

#BHRTrauma

#BHRED

All that remains is for you to find us and definitely 'like' us!



PRIDE

TARN
THE TRAUMA AUDIT & RESEARCH NETWORK

TRAUMA CALLS / Traumatic patients

Monthly Breakdown 2016

Month	Total	Home	Admit Queens	To Theatres	Admit Other	DID	Did Not Wait
2015 TOTAL	370	185	140	8	15	1	9
June	27	13	11	1	1	0	1
July	29	10	15	0	2	1	1
TOTALS	190	84	81	4	14	3	6

BREAKDOWN

Trauma call Review / June

- Trauma Call breakdown: 27
- Traumatic patients breakdown: 125
- Potential TARN patient: 42

- **Paeds 2**
- **Adult 25**
- **0800 – 2200: 15**
- **2200 – 0800: 12**

- **Neuro 5**
- **Ortho 3**
- **Surgical 0**
- **Elderly 1**
- **Paed 0**
- **Medical 0**
- **RLH Transfer 0**

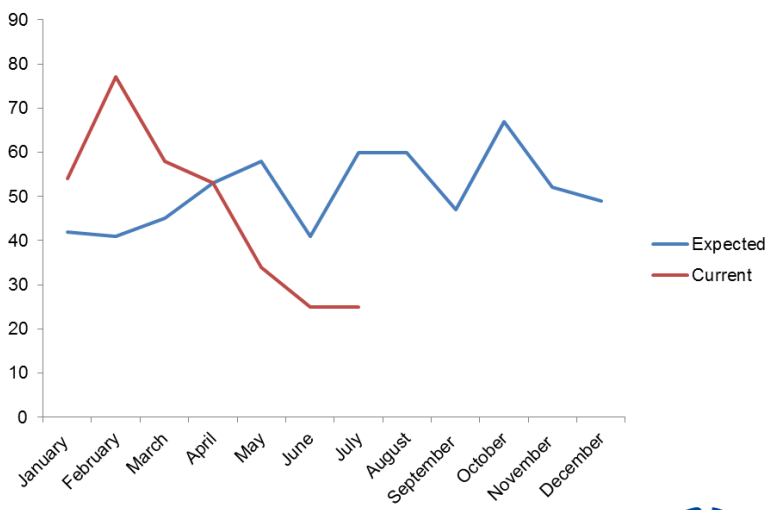
Trauma call Review / June

- Trauma Call breakdown: 29
- Traumatic patients breakdown: 114
- Potential TARN patient: 64
- **Paeds 5**
- **Adult 24**
- **0800 – 2200: 20**
- **2200 – 0800: 9**

- **Neuro 2**
- **Ortho 5**
- **Surgical 2**
- **Elderly 1**
- **Paed 3**
- **Medical 1**
- **RLH Transfer 2**

EXPECTED TARN PATIENT 2016

Month	Expected Submission	Current Submission
January	42	54
February	41	77
March	45	58
April	53	53
May	58	35
June	41	25
July	60	24
August	60	
September	47	
October	67	
November	52	
December	49	



National Peer Review Programme

TQuINS
Trauma Quality Improvement Network System

National Peer Review visit to Queen's Hospital, Barking, Havering and Redbridge University Hospitals NHS Trust 14th 2016 July

I would like to express my appreciation and thanks to you and your clinical and managerial teams for the welcome and support provided to the peer review team during their recent visit and review of the Trauma Unit at Queen's Hospital was provided at the end of the visit detailing the main findings including areas of good practice, three immediate risks and three serious concerns.

The Trust will have the opportunity to review the report for factual accuracy in the coming weeks and the final reports will be available on the TQuINS website by the end of October 2016. In the meantime I am writing to bring to your attention the immediate risks and serious concerns identified and to set out the requirement on the Trust to respond.

"IMMEDIATE RISKS"

1. There are significant delays in accessing CT reports for trauma patients. Delays in undertaking and reporting CT scans on major trauma patients may lead to significant adverse outcome for these patients
2. There is no provision for SALT cover on the weekends and the panel was not assured that nurse-led swallow assessments were routinely available. This seriously compromises patient safety and quality of care. This was raised as an immediate Risk in the NHS England Peer Review held in 2015 and while it is recognised that the SALT team has been brought in-house since then, the risk around access to dysphagia screening remains.
3. There are only 2 ANTC trained nurses with 2 more having been trained this week. Currently there is not an ANTC trained nurse on every shift in the ED This could impact on the quality of care provided to trauma patients. This was raised as a serious concern in 2015 and the panel were not provided with evidence to demonstrate that improvements had been made since this time.

"SERIOUS CONCERNS"

1. The massive haemorrhage protocol used is different from the Network protocol and was last updated in 2013. It does not reflect current practice around RBC: FFP ratio
2. There is a lack of clarity in relation to the roles and responsibilities of the Rehabilitation coordinator and the Trauma coordinator. Neither of these roles are currently filled, although there is a plan to recruit one post using the Network JD. However, this was identified as a Serious Concern in 2015 and it is noted that no progress has been made.
3. There is awareness from the Trust that there are issues around patient flow affecting the ability of Queen's Hospital to repatriate patients in a timely manner. It is currently amongst the poorest performing trauma units in the network in this measure.

An "Immediate Risk" is an issue that is likely to result in significant harm to patients or staff or have a direct serious adverse impact on clinical outcomes and therefore requires immediate action. A "Serious Concern" is an issue that, whilst not presenting an immediate risk to patients or staff safety, is likely to seriously compromise the quality of patient care, and therefore requires urgent action to resolve it.

In addition, some concerns were identified which will be detailed in the report and should be addressed within the team's Work Programme for the coming year.

As part of the national programme trusts and networks are required to respond, after receipt of this type of follow-up letter, within 10 days for an immediate risk and 20 days for a serious concern, outlining what action the trust is taking to resolve the issues. Where the resolution of the risk has not been possible in this time period then a plan with an appropriate timetable for the further action needed to solve the problem should be provided.

I would be grateful if you would formally respond to me, within the required timescale, with the Trust's plan and actions to address the issues raised I look forward to hearing from you in due course.

"AREAS OF GOOD PRACTICE"

"The Trauma Newsletter: shows transparency and dissemination of vital information across the Trust and Network"

"TILS: increasing Level 1 trauma nursing; extending to wards"

"MDT: runs effectively and regularly"

"TARN: a dramatic increase in Data input"

"Rehab Prescriptions: trial benefiting trauma patients greatly"

"Colocation of Tracheostomy patients demonstrates good practice"

CLINICAL GOVERNANCE

Case 1:50YO Male, Assault – penetrating injuries, Arrival time: 12:00 on 13/7/2016, Length of stay < 4 hours,

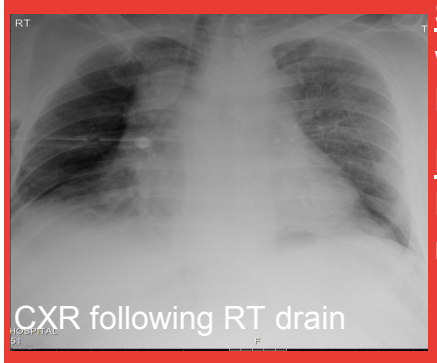
Pre-hospital information: Brought in by friend, No alert, Assaulted machette, Wheeled to resus by police, Trauma Call put out at 12:05

Trauma Team: ED consultant (Team leader) – 12:00 (T +0), ED Nurse one – 12:00 (T+0), Radiographer – 12:04 (T+4), Transfusion practitioner – 12:19 (T+19), Anaesthetist - ? Time, General Surgery - ? Time, Orthopaedics – No documentation, ODP – No documentation, Porters – No documentation

Primary Survey: A. Clear, not compromised. No triple immobilisation, B. Decreased air entry to right; bilateral chest drain; no blood; no crepitus, C. Cold to touch; CR 4 sec; rigid abdomen; stable pelvis; no free fluid seen on FAST D. PERLA 3mm; no priapism; very distressed but calmer post chest drain insertion — RR30 - O294% - HR137 - BP126/96 - Temp35.8 - GCS15/15

Time Line: Code Red activated 12:05 (T +5), Clinically shocked and SOB, CXR following RT drain, no CXR following LT

Drugs: Red Blood Cells - 1 unit 12:00(O-); 1 unit 12:05(O+); 1 unit 12:10(O+); 1 unit 12:15(O+), FFP - 1 unit 13:00; 1 unit 1305, TXA 1g IV @ 12:00, Morphine - 10mg IV 12:00; 5mg IV @ 12:30


CXR following RT drain

Secondary Survey: Chest: 2 posterior wounds; full thickness; rt pneumothorax, Lt thigh wound

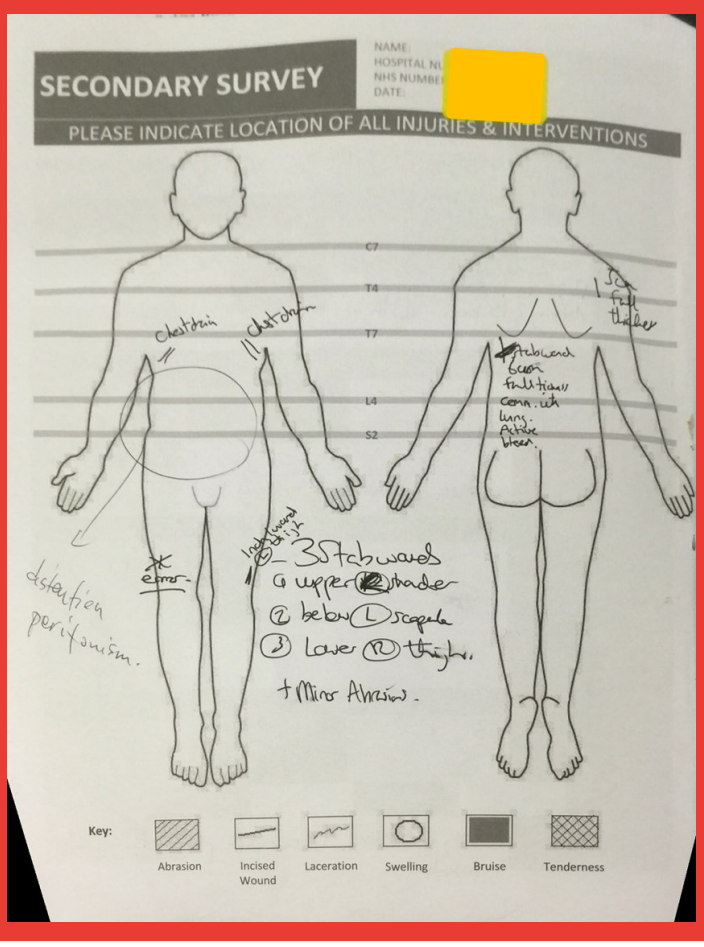
Further Management: Discussion with MTC, Hold off further blood as systolic 130 mmHg, Critical transfer to RLH, LAS K305 dispatched 13:35 arrived 13:43, Left with patient 14:12 (T +132)

Anaesthetic Notes: Anaesthetic consultant attended, Took over airway management, Anaesthetic doctor nominated for transfer

Nursing Notes: 4 Units (O-) 3 units FFP, Property handed over to Forensics, Next of Kin present - Daughter, step-father, friend

Arterial Blood Gasses: @12:32: pH 7.31, pCO2 5.24, pO2 22.33, HCO3 19.3, BE -6.4, HCT 45%, Hb 152, Lac 4.89

@13:31: pH 7.322 pCO2 6.73, pO2 24.03, HCO3- 25.6, BE, 1.2 ,HCT 45%, Hb 153, Lac 2.11



General Surgery Notes: Primary survey by ED, Reviewed by surgical team, Surgical consultant in attendance, Examined patient, Bilateral surgical emphysema to thorax Abdomen ? peritonitic; distended

Case 2: 41YO Female; Fall down stairs; Arrival time: 22:23 on 18/7/2016; Second attendance: 16:28 on 19/7/2016

Pre-Hospital Info: Fall/Intoxicated; Origin time: 21:01; On scene: 21:35; Arrival at hospital: 22:23; GCS 15/15

LAS Narrative: •On arrival – aggressive patient; Boyfriend arrived; Dangerous mechanism (fall down 14 steps); Patient lacked capacity; Needed to attend ED; Pt agitated, 'won't go in ambulance'; Boyfriend took pt to ED in his car; LAS followed with empty cab; Concerned due to swelling to rt eye and pre-tibial lac; Unable to put out trauma alert; Unable to immobilise; Seen by ED Doctor; Assessed post handover; Authorised Discharge

ED Notes: Drunk 1 bottle wine; Fell down stairs; No head injury; No soft tissue swelling;No neck or back pain; Full ROM C, T, L; No long bone injury; Chest Clear; No AP; Mobile & Alert; Home – discharge 23:19 (T +56)

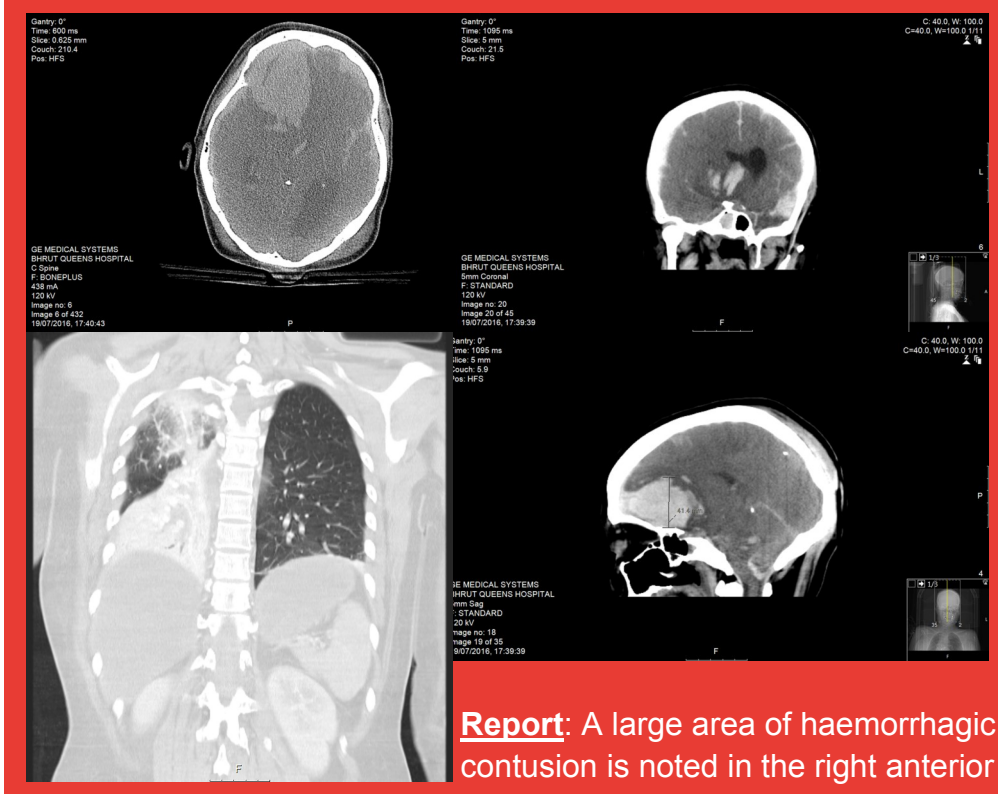
Second Attendance: LAS found pt unresponsive post fall; Hx as previously noted; Found by friend today

O/E: Tachypnoea with gurgles in chest, blood in mouth; HR 165 SVT, peripheral cyanosis; Bruises to rt eye, left knee; Torso hot to touch; temp 40°C

Resus handover: Fall last night while drinking. Unresponsive today; Pupils dilated and sluggish 6mm; GCS 3/15; Bilateral upper airway sounds; Soft abdomen; Bladder distended. ?Drug overdose ? CNS bleed; ITU

Primary Survey: A.Supported B.R basal crepitations C.P 166; BP 116/52 D.GCS 3/15, Temp 40°C E.Full exposure –Bruise and haematoma L upper tibia

Plan: Immobilise C-spine; Intubate; CT Head to pelvis; IV fluids; Ceftriaxone; Aciclovir



Report: A large area of haemorrhagic contusion is noted in the right anterior frontal region; causing midline shift of 12 mm; Descending transtentorial herniation is also seen. There is evidence of right lower lobe collapse associated with fluid density filled segmental bronchi likely representing aspiration pneumonia

ITU: Likely brain stem dead; Occasional spinal reflexes; For organ retrieval; Died on 20/07/2016

Education, Training & Professional Development

CENTRE FOR TRAUMA SCIENCES
Saving Life, Rebuilding Lives

NORTH EAST LONDON & ESSEX TRAUMA NETWORK

ATLS at Queen's Hospital, Romford: September 14-16, 2016—Education Centre

TILS at Queen's Hospital, Romford: September 22, 2016—MAU Seminar Room

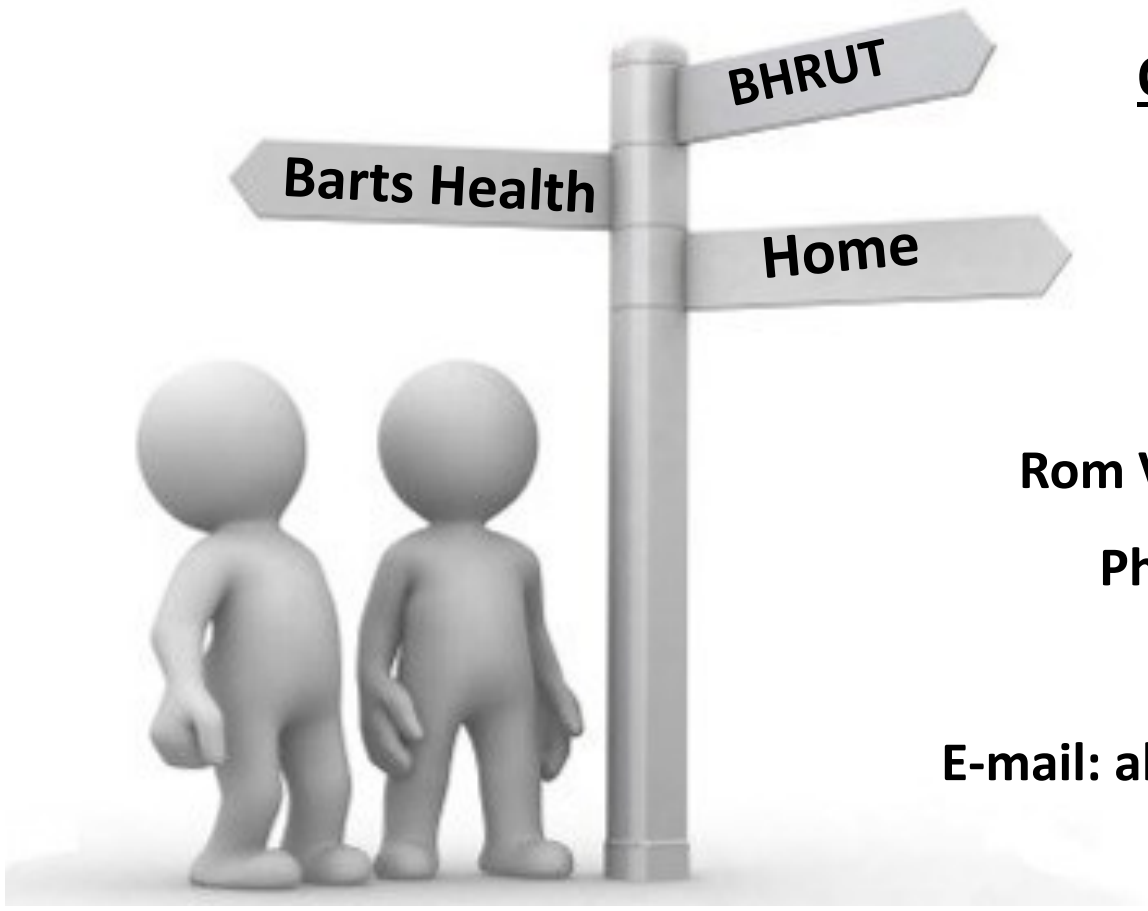
TARN Data Collection Training, London: August 11, 2016

TARN Data Reporting Training, London: August 18, 2016

2nd King's CT Imaging in Polytrauma Interpretation and Reporting Course: Jan 31 and Feb 1 2017—Royal College of Radiologists (Holborn)

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



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