The Trauma Aggregated News,

Volume 1, 09 November

Special Points of Interest:

- TARN
- TQuINS
- Governance

Inside this issue:

5th Issue of the TANQ and new structures, new colleagues and looking forward to new positive way of working, "onwards and upwards" as they say.

The focus over the last few months have been over TARN data and getting our submissions in order. Due to the lack of a formal TARN coordinator, our figures for submissions last few years were less than 10%. However, by means of a concerted drive and appointing a New Trauma Administrator Manager, we have already input 60% of the data required and continue to, and have a trajectory of reaching 80%.

This was crucial, as the future of BHRUT is in the balance, TARN data submission may have lead us to being downgraded from a Trauma Unit to a Local Emergency Hospital on a network level, and as they say in Star Wars "may the force be with you" we used that to drive forward.

We are still in the process of appointing a Band 3 Data Coordinator. The Job is due out soon, so watch this space

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Trauma Calls

Monthly Breakdown

Month	Total	Home	Admit	To Theatres	Admit Other	DID	Did Not Wait
Jan	21	6	11	2	1	1	0
Feb	20	12	5	1	2	0	0
March	37	21	11	0	3	0	2
April	43	17	22	0	3	0	1
May	26	15	10	1	0	0	0
June	33	19	11	1	1	0	1
July	40	21	14	1	1	0	1
August	29	14	11	0	2	0	2
September	30	12	16	1	1	0	0
October	32	17	15	0	0	0	0
November							
December							
TOTALS	311	157	126	7	14	1	4

VS

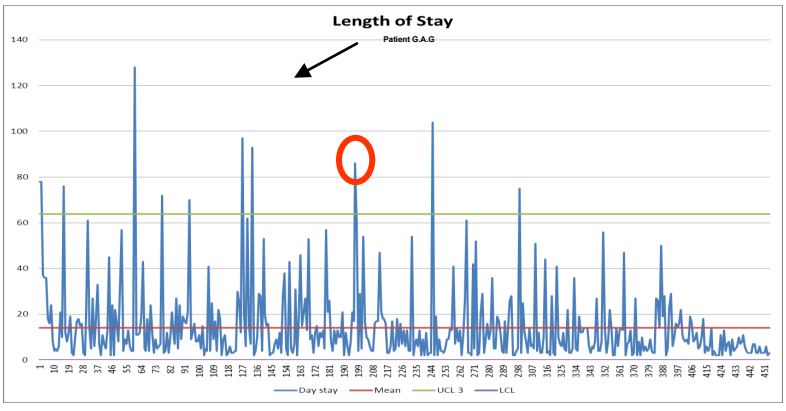
TARN Patients

Monthly Breakdown 2015

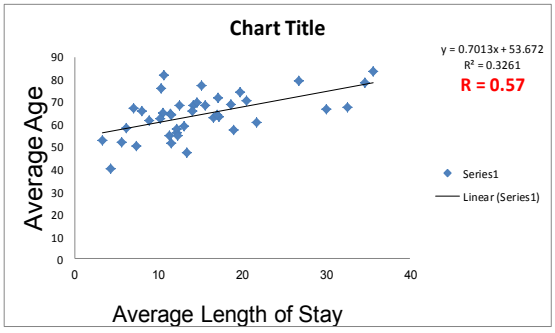
Month	Total
Jan	37
Feb	26
March	25
April	39
May	31
June	35
July	45
August	61
September	35
October	62
TOTALS	370

To Trauma Call or not to Trauma Call? But the question would be for a Trauma Center or Unit. We managed to conduct an audit between the number of Trauma calls vs TARN patients, (the number of patients being uploaded to TARN). But its no means a conclusive result.

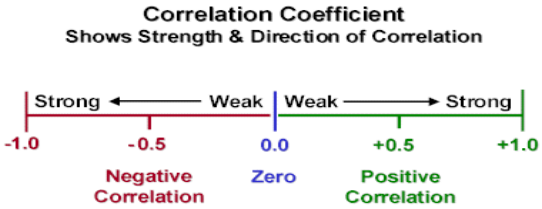
Focus on length of stay:



Correlation between



The SPC chart shows the length of stay of TARN patients since January so far. We took one special causes case at random and reviewed it.
We also noted a direct correlation between LOS and age.



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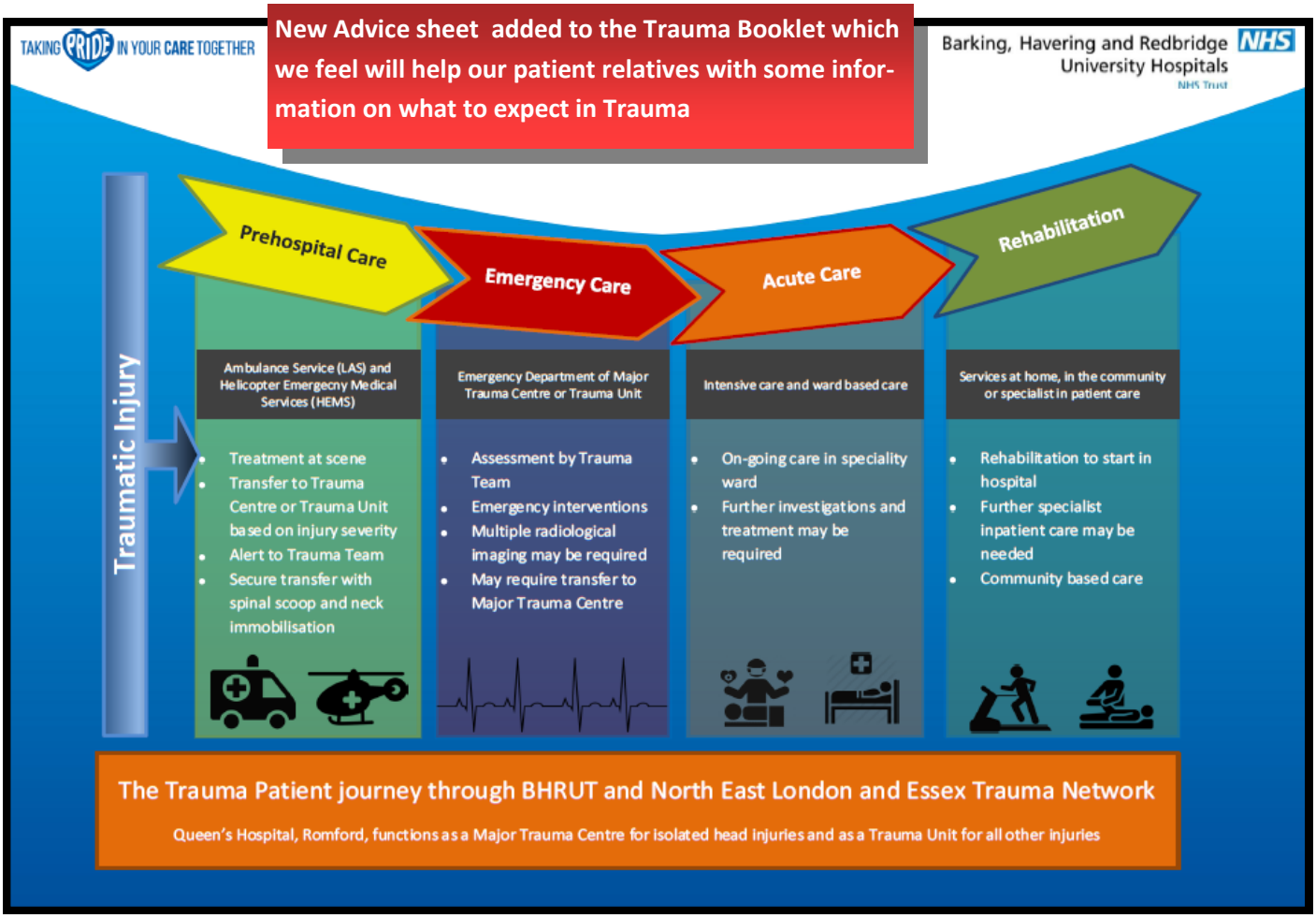
New Advice sheet added to the Trauma Booklet which we feel will help our patient relatives with some information on what to expect in Trauma



The National Peer Review Trauma

The programme involves both self-assessment by Trauma teams and external reviews of teams conducted by professional peers, against nationally agreed "quality measures".

The National Peer Review Programme aims to improve care for patients involved in trauma and their families by:

- ensuring safe as possible services;
- improving the quality and effectiveness of care;
- improving the patient and carer experience;
- undertaking independent, fair reviews of services;
- providing development and learning for all involved;
- encouraging the dissemination of good practice.

The outcomes of the National Peer Review Programme are:

- confirmation of the quality of services;
- speedy identification of major shortcomings in the quality of services where they occur so that rectification can take place;
- published reports that provide accessible public information about the quality of services;
- timely information for local commissioning as well as for specialised commissioners;
- validated information which is available to other stakeholders.

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Case Study

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Status: Discussed at the MDM Length of stay: 86 days

Profile: 82 yrs; male; White British, Arrival: 05/05/2015 @ 15:55, P/C: Collapse with Head injury, BIBA to Resus, No trauma call

History: Found underneath car, ? circumstances, Found by passer-by, Previous collapse? cause 23/11/2005 (KGH)

Time Line

6/5/15 : CT angiogram to r/o aneurysm

8/5/15 : 0940 bibasal creps noted - Difficulty chasing CT angiogram report

12:00 Patient feeling better, orientated, alert

23:00 74% sats on 40% O2 , no distress

Progressively worsening hypoxaemia with raised d-Dimer

9/5/15: intubated, transferred to ITU 04:30 Still awaiting CTA report, 2210 CTPA: no PE

10/5/15: 0945 Large bilateral pleural effusions, Chest drains inserted

11/5/15: Extubated

12/5/15: Complete heart block, awaiting PPM, Physio commenced

13/5/15: Intermittent NIV, Tazocin commenced

17/5/15: Transfer to KGH Gardenia

18/5/15: PPM insertion, Agitation post insertion; settled

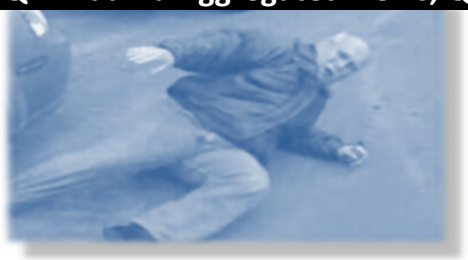
20/5/15: Increased confusion, slow cognitive processing, Social issues becoming apparent

5/6/15: Referral request for neuro-rehab (Blackheath)

10/6/15: "KC (Black Heath Hosp Administrator) reports pt's referral was not discussed during case meeting… they forgot and lead clinician was away", Pt medically fit and ready for discharge

12/6/15: Daughter wants patient home… wasting away on the ward

2/7/15: No new concerns, awaiting specialist neuro-rehab



PLAN after CT

- Not for neuro-surgical intervention
- Gen Surgery for Neuro obs
- Medics to review

Admit in neuro HDU

MEDICAL REVIEW

- Acute Kidney Injury: K 4.5; Ur 9.2; Cr 119
- +ve Trop (0.08) ?myocardial contusion ?ischaemia
- Head injury

HDU REVIEW 5/5/15 23:10

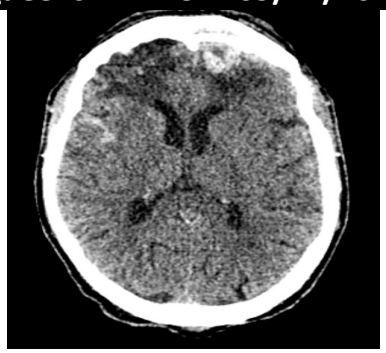
- Rising Trop 0.08 to 0.14
- Neurosurgical SpR advises against anticoag - Haemorrhagic brain contusion
- Medical SpR advises against ACS treatment - Lack of symptoms
- Patient spiked temperature
- Neuro-obs and cardiac monitoring

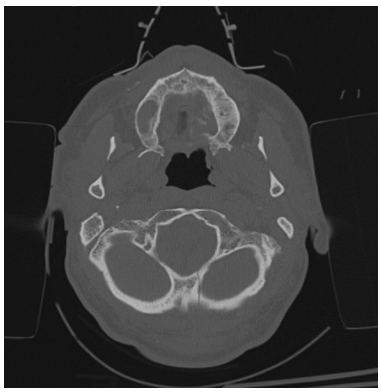
Time Line cont...

14/7/15: Patient accepted but awaiting CCG funding

22/7/15: After review, patient found not suitable for specialist neuro rehab (Blackheath), Accepted at Hothfield, Pt prefers to go home

30/7/15: Confirmation that Slow Stream Rehab at Hothfield Manor Centre has approved for 12 week rehabilitation by B&D CCG.





CT

- Marked bilateral frontobasal/ frontopolar and bilateral but mainly right-sided temporal polar haemorrhagic brain contusion.
- Left occipital parasagittal fracture.

31/7/15: Patient Finally Discharged
Day 86

The good, bad & not so ugly:

Patient assessed quickly and pathologies quickly identified.

Good input from multiple specialities.

Complications picked up quickly and dealt with appropriately.

Prolonged length of stay due to rehab needs.

Unable to provide rehab at BHRUT

Repatriation

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S t e p 1

Primary area of Injury*	BHRUT Speciality to Accept	BHRUT Clinical Contact
* decided by Trauma Team		
Chest/Abdo-pelvic/Vascular	Gen Surgery	Gen Surgical SpR DECT: 6366 Failure to contact: Surgical Consultant on-call
Spine/Head Injury	Neurosciences	Neurology SpR DECT: 6836 Neurosurgery SpR DECT: 6177 Failure to contact: Neuro Consultant on-call
Limb/Pelvis/Rib	Orthopaedic	Orthopaedic SpR DECT: 6176 Failure to contact: Ortho Consultant on-call
Elderly Care/ Medical Care	General Medicine	General Medicine SpR DECT: 6591 Failure to contact: Gen Med Consultant on-call
Paediatric	Paediatric	Paediatric SpR DECT: 6816 Failure to contact: Paediatric Consultant on-call

S t e p 2

BHRUT Clinician to inform BHRUT Bed Manager (DECT 6071) of accepted Repatriation

S t e p 3

Outside Clinician to e-mail patient details to BHRUT Cascade Team

BHRUT Repatriation communication group

(Referring Trust to e-mail entire BHRUT group [below] with every repatriation request)

Bed Manager's		
Operational Manager Bed / Site Team		
Inpatient coordinators		
A&E Matron		
Trauma Director		
Trauma Administrator Manager		

If no clear plan of acceptance within 24Hrs of request, please e-mail Dr Mir Ahmad Clinical Trauma Lead

Please note this is a proposed version and will/can be changed.

We are looking to stream line our repatriation process, please not this from along with the repatriation booklet (which we are working on) will need to actioned.

All Repat patients will need to discussed with a clinician.

All relevant information must be sent prier to the patients arrival in order for BHRUT to safely manage patient.

All Repatriation patient must be captured on TARN.

Once the patient is Discharged a copy of the Discharged must me sent to the

Any suggestions will be much appreciated.

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