Barking, Havering and Redbridge University Hospitals NHS Trust

THE TANQ—Trauma Aggregated News, Queens

V2 I3 07/03/2016

The TANQ

Trauma Aggregated News, Queens

Points of Interest:

- TARN
- Governance
- TQuINS
- Training

Inside this issue:

This month's focus has been Neurosurgery and as the presentation highlights, we are still struggling with rehabilitation of our patients. This issue by no means is isolated to our Trust, but is prevalent across the whole network. The good news is that it is now at the forefront of concerns, and plans are being implemented to resolve this.

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 66% 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.

The Trust was well represented at the National ATLS day for 2016, and a number of trauma milestones were unveiled. The 10th edition of the ATLS is planned for early next year, and there is a clear focus of adopting the latest technology as it is going mobile.

More importantly, NICE has just released their guidelines for Major Trauma, and we will be going through this with a fine toothcomb in our first Tri-annual Major Trauma MDT to be held in April. On that note, make sure you attend as everyone is invited!

Also in focus is the Junior Doctors' strike which continues with the imposition of the new contract. As always, our Junior Doctors have ensured that all emergency services run smoothly, without any hindrance, and so there is no change to the Trauma pathway yet again.

The first few months have seen a surge in attendance in the new year, with record daily attendances. After the final quarter of the financial year ends, we will analyse whether this has impacted us in any way, and if so, what the thoughts are on proceeding forward.

So far, it's turning out to be a very busy 2016!

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Trauma Calls

Monthly Breakdown 2016							
Month	Total	Home	Admit	To Theatres	Admit Other	DID	Did Not Wait
Feb	32 / 130	15 / 96	13 / 15	1 / 1	3 / 7	0 / 0	0 / 14
TOTALS	**58**	**30**	**22**	**3**	**4**	**0**	**2**

TARN PATIENT BREAKDOWN 2015

	Total upload to TARN	Approved / Accepted	Rejected
January	74	56	11
February	51	33	15
March	57	40	14
April	58	48	9
May	53	38	10
June	53	37	14
July	65	42	18
August	52	37	10
September	46	40	4
October	37	23	2
November	13	13	0
December	18	5	0
Total	577	412	107

Site	Total Submissions	Expected Submissions	Data Completeness (%)	Data Accreditation (%)
Queen's Hospital Essex	412	605	68.09	84.32

BHR
Queen's Trauma Service
Barking, Havering and Redbridge University Hospitals NHS Trust

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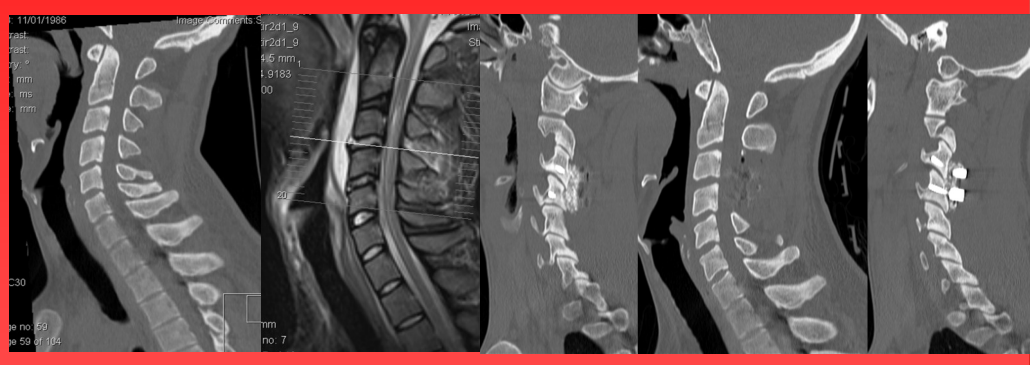
Where is the rehab unit??

Presented by Mr Babak Arvin, Consultant Neurosurgery, Queens

Case 1

25 year old male semi-professional football player, 0200 28/10/11; assault, slipped on floor with neck twisted found face down. Flaccid paralysis. Arrived ED 03:45; Trauma call led by ED MG. Laceration to head and chin, no other injuries. O/e 4 limbs 0/5 power, spont respiration. CT 04:08: No fracture or dislocation. MRI@09:00. Case discussed with Stanmore co-ordinator and consultant on call@10:30. on line form filled. Asia 31/10/11 Motor 3 + Sensory 48, Asia 18/11/11 Motor 12 +



Sensory 87, Upper limb right elbow flexion 3/5, >Right elbow flexion 3/5; elbow extension 1/5 >Left elbow flexion 2/5 ; elbow extension 0/5 >Hip flexion 1/5; Knee extension 1/5; ADF 1/5

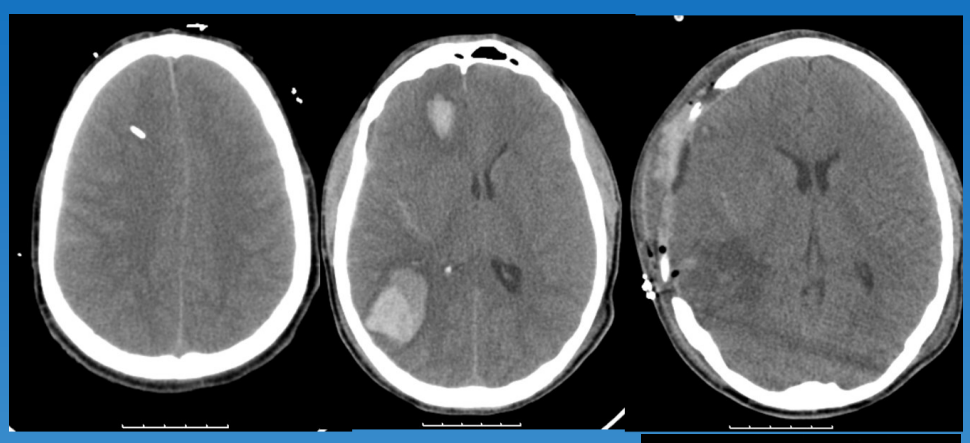
Rehab as in-patient

Transferred to Stoke-Mandeville **51 days after** referral

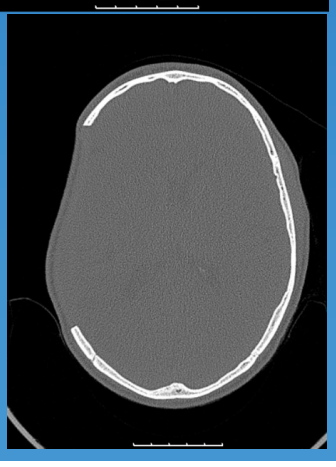
- Rehabilitation?

Case 2

22 year old Assault, GCS on arrival 3/15 un-reactive pupils, ICP inserted initial conservative treatment. Failed medical treatment of raised ICP



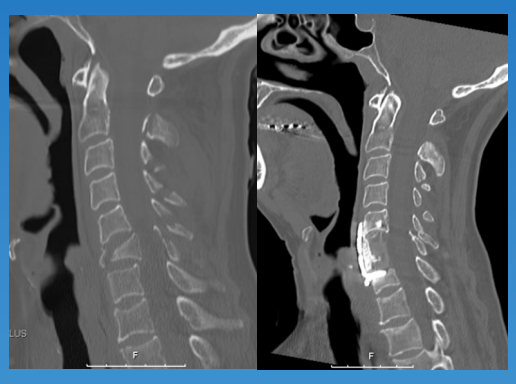
24 days in-patient, Transfer back and slow rehab, St Margaret Rehabilitation unit 3 for month, "almost" back to normal, Now driving but not yet at work. Crainoplasty done July 2011.



- Quicker access to Rehabilitation?

Case 3

57 year old female alcoholic COPD osteoporosis. Fall down stairs while drunk. Transferred from Basildon. Multiple injuries, bilateral upper limb weakness, C6#, SP C3C4C5C6# 5-11 rib# L2-L4#, Aspiration Pneumonia, intubated, Corpectomy, Multiple organ failure, tracheostomy



Transfer back to Basildon 41 days after admission with trachy. Moving all 4 limbs. Transferred to Billiricay rehab unit, Walked in to clinic Dec 2011 unaided, Stopped drinking and smoking (so far!!)

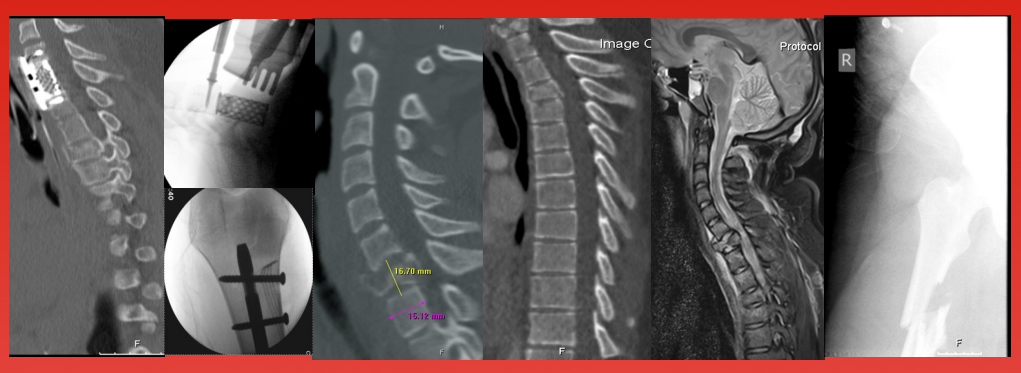
- Quicker access to Rehabilitation?

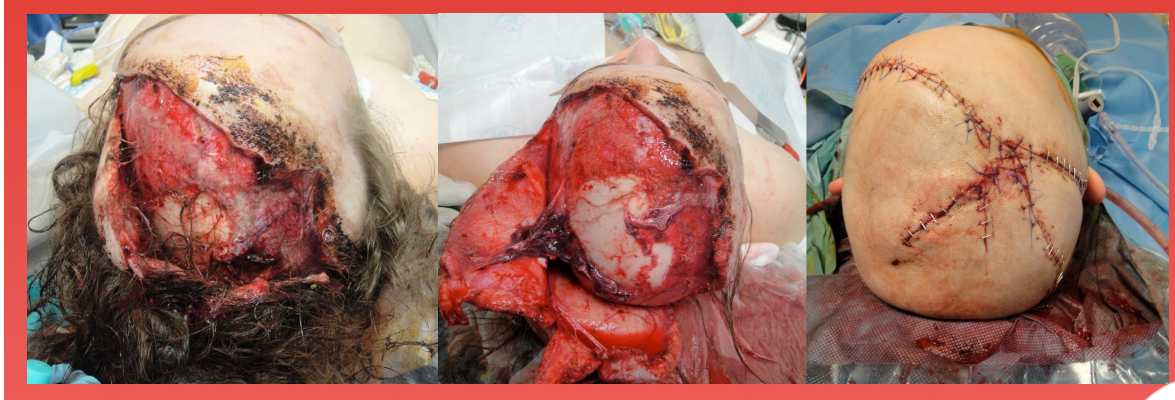
Case 4

17 year old female, joy rider back seat passenger, boys in the front strapped in. Transferred from referring hospital: Multiple injuries, upper limb weakness 3/5, lower limb 0/5 sensory level T1 ASIA A, C7#, SP # Femur Fracture, Was told small laceration to head which was dressed, On Arrival BP 60/- P 160 per-arrest Hb 5.2

Upper limb weakness resolved completely, Lower limb weakness persisted ASIA A, Rehabilitation after 32 days hospital stay.

- Quicker access ?





HISTORY

The ATLS course was established after a tragic plane crash in 1976, which devastated an entire family. The pilot, an orthopaedic surgeon named James Styner, was seriously injured while his wife was killed and three of his children sustained critical injuries. He was horrified at the treatment his family received at a local hospital in rural Nebraska and decided that the established system for managing the severely injured was wrong. A group of local surgeons and physicians, the Lincoln Medical Education Foundation, together with the University of Nebraska founded local courses aiming at teaching advanced trauma life support skills. These courses served as a framework for the national ATLS courses adopted by the American College of Surgeons' Committee on Trauma.

Since 1978, the Advanced Trauma Life Support (ATLS) course has instructed many doctors from all over the world. In the late 1980s, a retrospective analysis of deaths attributable to injury reported that significant numbers could have been prevented. A subsequent Working Party Report from the Royal College of Surgeons, England noted the improvement in standards of care of the injured patient in the United States after the development of ATLS. ATLS was brought to the United Kingdom with the first course taught at the Royal College of Surgeons in 1988. By 1995, it had been taught in over 25 countries and has been shown to be an effective teaching course in both developing and developed countries. Today ATLS is the internationally recognised standard for the initial assessment and management of serious injury.

ATLS World MAP

CURRENT

The initial role of the course was to teach doctors working in rural situations such as general practitioners at community and small district general hospitals. Within the UK, junior doctors are encouraged to complete the course early in their career and the Royal College of Surgeons and the Faculty of Accident and Emergency Medicine both require it for college membership examinations. It has been suggested that it should be mandatory for all doctors in training.

Trainees themselves have been reported to be very favourable towards ATLS. By 1996, 97% of respondents to a questionnaire survey of senior house officers regarded ATLS as useful for preparation for the FRCS examination. In a separate study 83% trainees considered it essential for practising their proposed specialty. Most considered it an important advantage for their curriculum vitae and 94% thought that ATLS saved lives.

By 1995, 220 000 doctors had been trained on 1100 courses and currently demand for courses exceeds availability. After introduction to the UK, places on ATLS courses were preferentially offered to senior medical staff. Early providers and instructors were quick to design local courses teaching ATLS principles to jun-

AIM

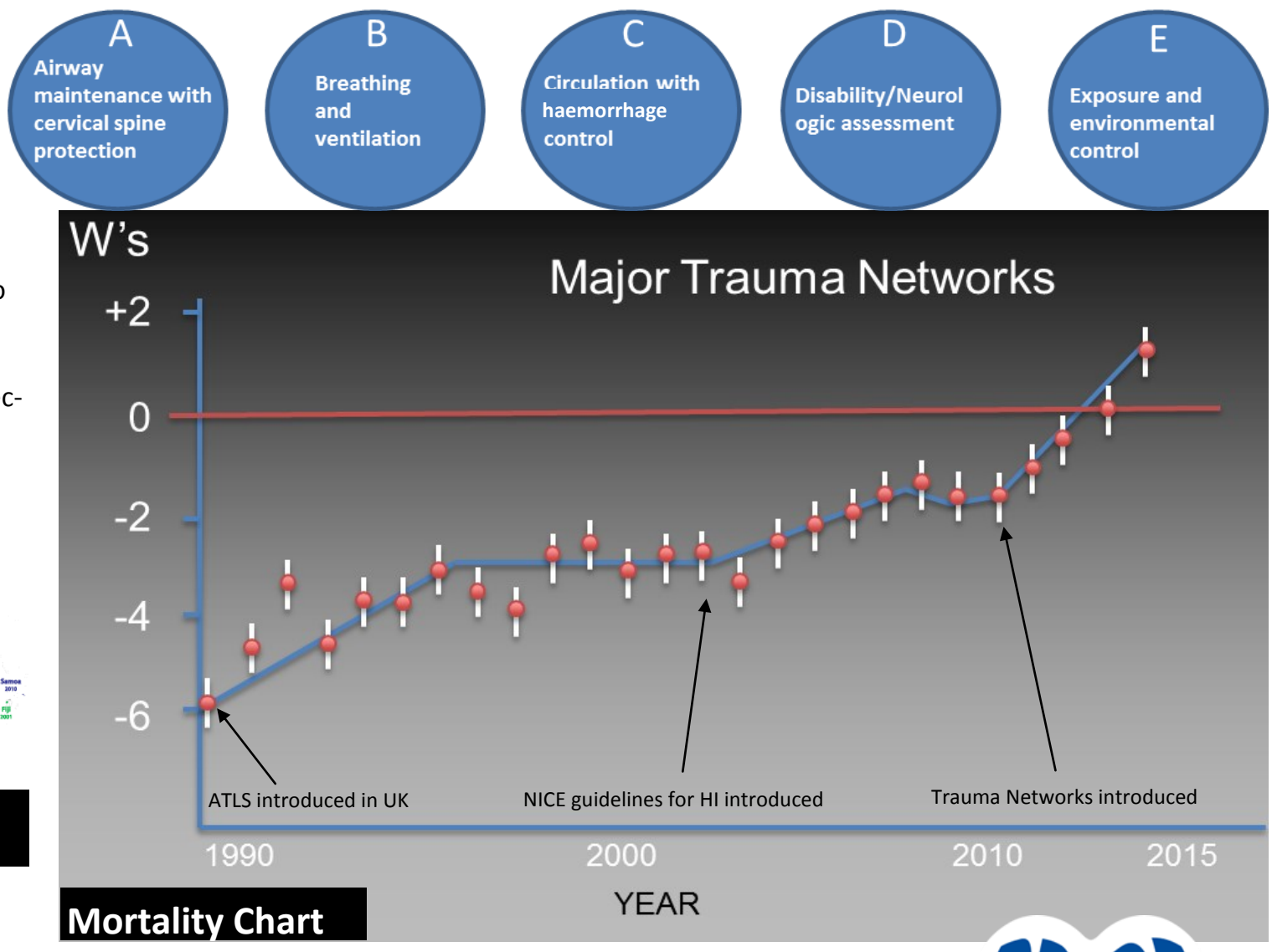
The near future:

NICE Guidelines for Major Trauma Published 17/02/2016: and it is almost in total agreement between NICE and 9th edition; principles and priorities are the same. NICE guidelines are more detailed than ATLS, some variation exists. **ATLS UK must be compliant with NICE.**

More information on the new NICE guidelines can be found on there website link below:
www.nice.org.uk/guidance/ng40

ATLS 10th Edition Changes:
-Trauma team approach
-Morbid Obesity
-Shock classification
-TXA
-Fluid management
-Reversal of anticoagulation
-Pelvic Injury examination
-Course structure: Mobile learning (mATLS)

New Date for the ATLS course can be found on the new and improved Royal College of Surgeons website listed below:
https://www.rcseng.ac.uk/



Mortality Chart

Case in Focus: Trauma v ACS

Status: Discussed in MDT; to be put forward for IR1

Profile: 73 year old Male, white; Arrival 26/02/2016 @ 1426; Trauma call, HI, confused

History: Found by wife following hearing a thud, ?collapse ?environmental fall. No LOC but acute confusion

Management: Primary survey; vomited, intubation to protect airway and facilitated CT.

CT: Clinician notes small IC bleed (see fig 1), discusses with Neurosurgeons. Not for acute intervention, extubate, observe. Stop clopidogrel.

CT report: No bleed reported

ECG: Evidence of ischaemia noted.

Bloods: Trop elevated but also concurrent AKI.

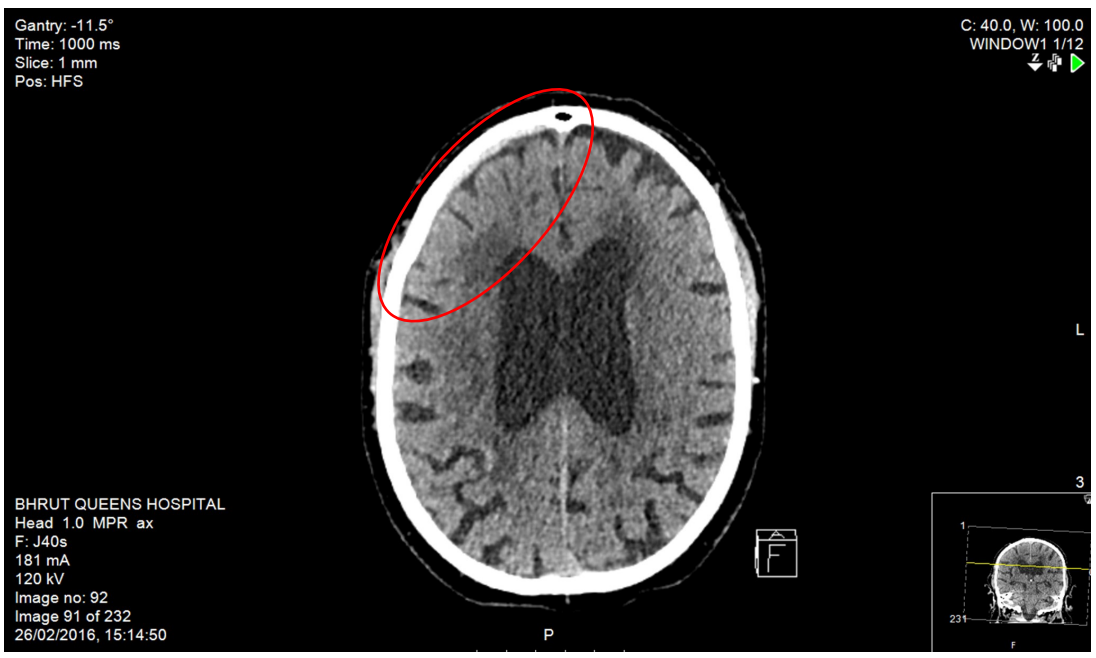
Plan: Decision not to commence on ACS treatment in sight of bleed.

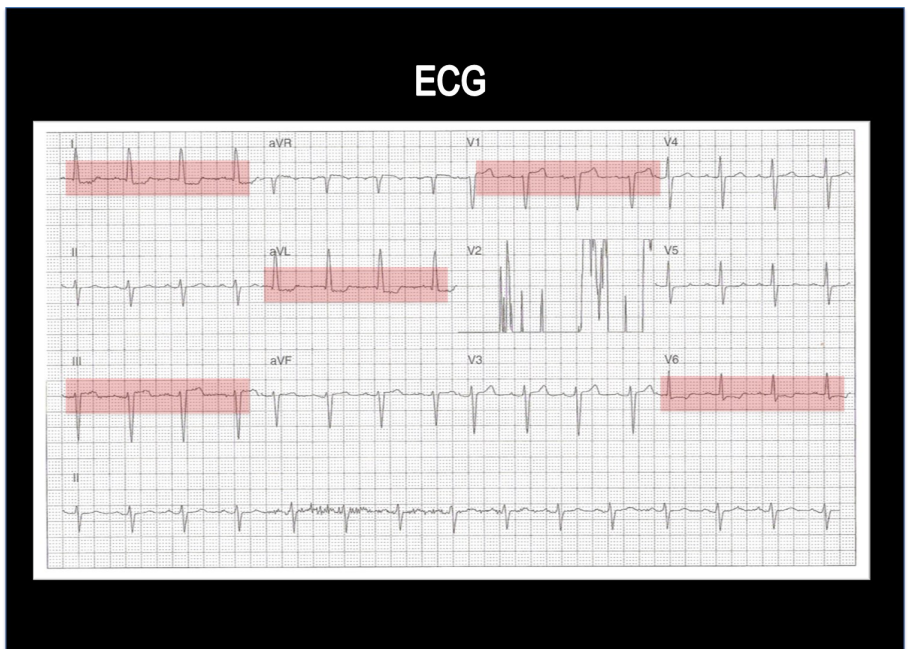
Review by Medical team: As report shows no bleed, commence ACS treatment

Review by Cardiology (day 3): Post extubation not complaining of chest pain. No change to ECG, Trop raise may be a result of renal failure. Unlikely ACS. Stop treatment.

Outcome: Patient discharged home, back to baseline. No negative outcome.

Discussion: Potential adverse outcome due to sub-optimal report. Process required to be put in place to question reports.





Education, Training and Professional Development

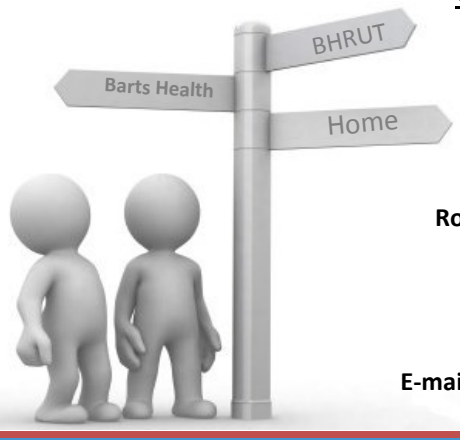
Trauma Immediate Life Support (TILS) 23rd/24th March

Trauma Team Leaders Course 11th April

Major Trauma MDT 4th April Seminar room 5

Proposed Joint ED and Neurosurgery Audit:

Primary and Secondary Survey in MTC transfers-in versus direct transfer to specialty



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