

## MTC Clinical Governance Group - First 18 Months Report (Oct 2018-Mar 2020)

### Description:

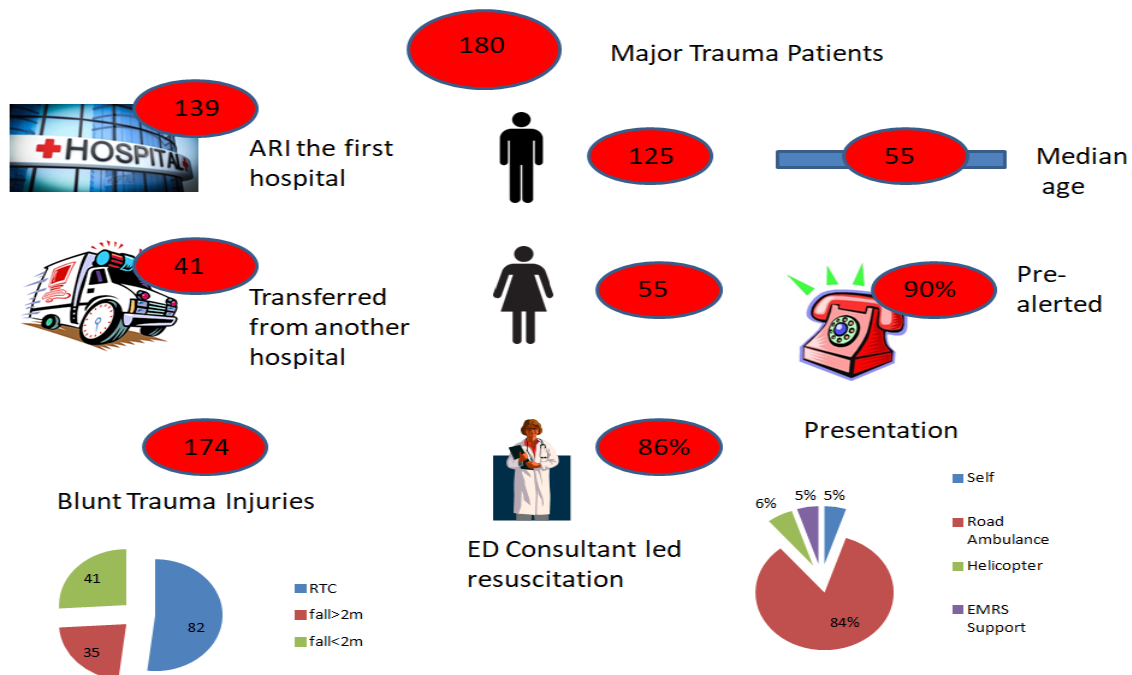
A multi-disciplinary, multi-professional group with representation from across the whole trauma patient journey (EMRS, SAS, ED, Radiology, Anaesthetics, Critical Care, PTU/Orthopaedics, Trauma and rehabilitation co-ordinators, AHP and rehabilitation teams, STAG, MTC and Network management). The group meets once a month to:

- Conduct 'short case' review of all major trauma patients managed within the MTC at any part of their patient journey, any patient that has died following any trauma (whether major or not) and any other patient highlighted by STAG, Datix or members of the group.
- Conduct more detailed 'long case' review of patients highlighted by above process as a potential opportunity for MTC/Network learning. Specialist teams, as appropriate, are invited for these.
- Understand the trauma patient pathway and identify good practice.
- Review performance against Network KPIs.
- Agree learning and feedback for MTC and, as appropriate, Trauma Network and/or other services.

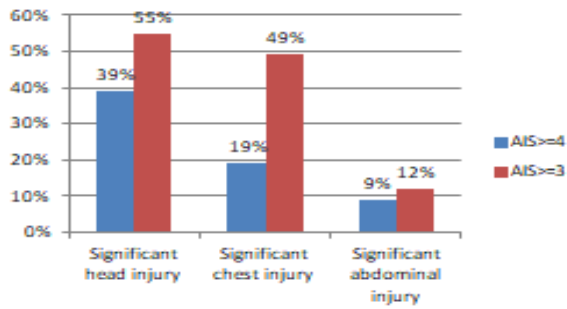
### Major Trauma:

Whether a patient has sustained major trauma is (retrospectively) defined by the injuries that they have sustained. This may be a combination of very significant and less significant injuries across several body regions or one very significant injury in one body region (the latter most commonly an isolated head injury). For many patients it will be obvious, from the point of injury, that they have sustained major trauma. However, this may not be so obvious in others patients particularly in those who are elderly and injure themselves in a 'simple' fall.

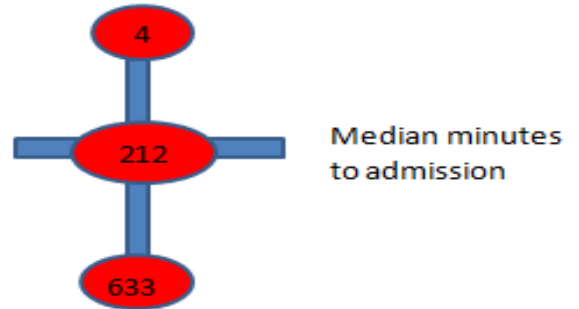
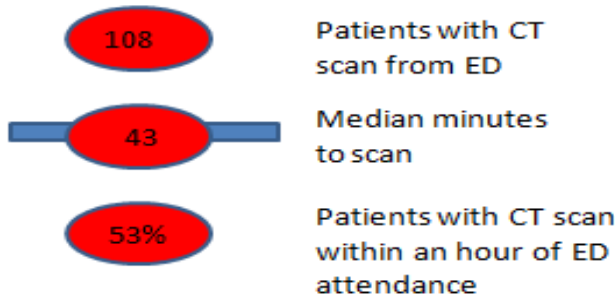
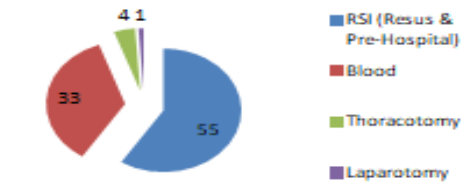
### The first 18 months of MTC (Oct 2018 – Mar 2020 inclusive):



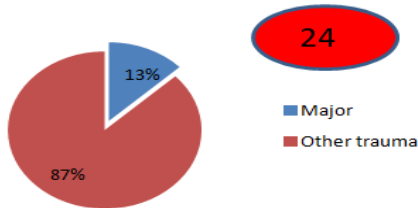
**Type of major trauma**



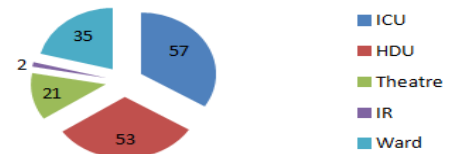
**Interventions**



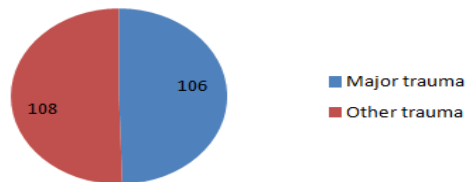
**Death from Trauma**



**Destination from ED**



**214 Rehabilitation Plans written**



**Major Trauma - Median age 54**

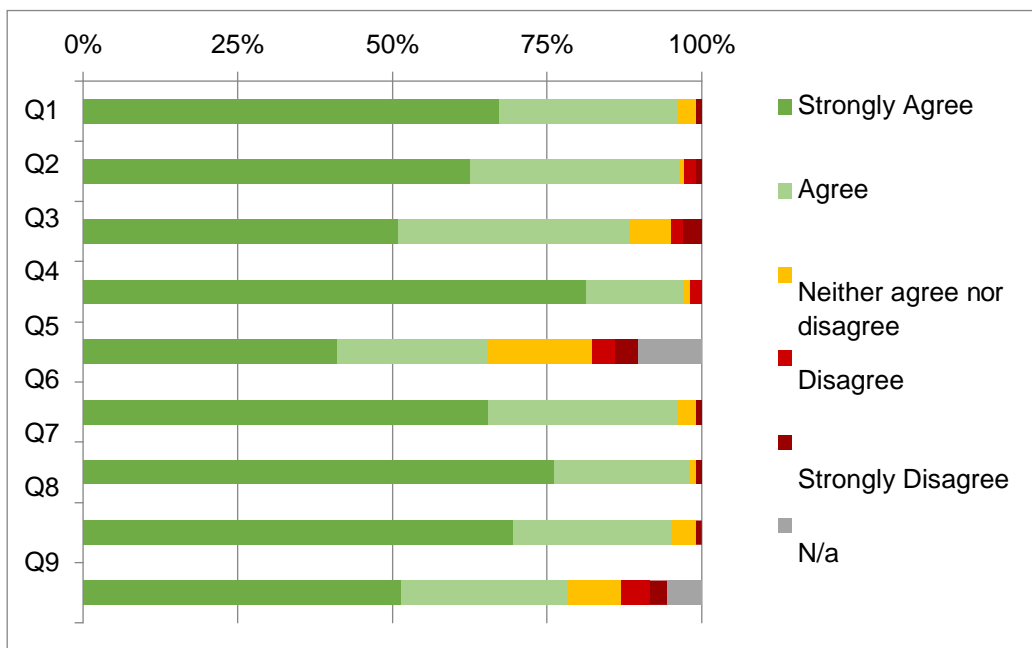
	Younger 50%	Older 50%
Median ISS (Range)	22 (16-57)	22 (16-42)
Standby call	98%	77%
Transport	58%	37%
Fall > 2m	28%	19%
Fall < 2m	2%	37%
Clinical area	93% in 'resus'	68% in 'resus' 28% in 'majors' 4% in 'minors'

**Major Trauma - Median age 54**

Admitted to (incl those via Theatre)	Younger 50%	Older 50%
Ward	14%	23%
ITU	47%	26%
HDU	40%	51%
Of these, theatre direct from ED	16%	5%

Older patients are more likely to sustain major trauma with mechanisms of injury that are perceived as less significant and may not trigger a trauma call. They are therefore less likely to be pre-alerted, get a trauma call and be managed in the resuscitation room. Head, neck and/or chest injuries are common in these patients.

The Patient experience: (October 2018 – February 2020; Claire Douglas, Clinical Neuropsychology)



Q1 Staff take into account of the things that matter to me.

Q2 Staff discuss my treatment and care in a way I can understand.

Q3 I am given choices about my care and treatment.

Q4 I am treated with kindness and compassion by the staff looking after me

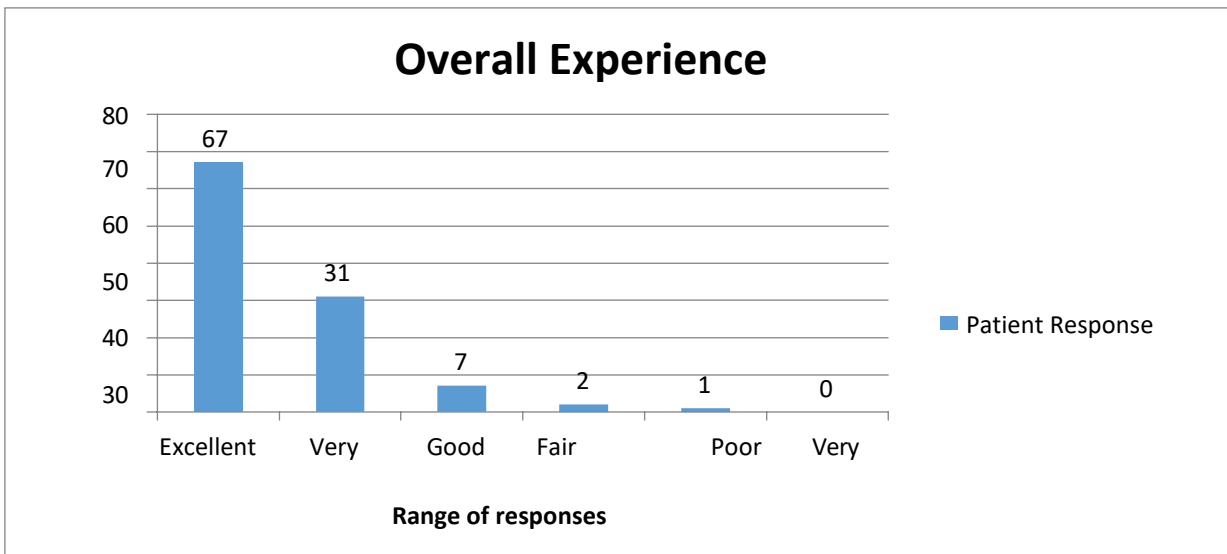
Q5 I am involved, as much as I want to be, in planning for transfer between wards and hospitals

Q6 Staff have time for me

Q7 I am confident that the staff looking after my care and treatment have the knowledge and skills to do so

Q8 The people that matter to me (such as family or carers) are involved with my care as much as I want them to be

Q9 I am involved, as much as I want to be, in plans for discharge from hospital.



**Quotes:**

“Whole team of different expertise.”

“The way everything has been explained to me, and I more or less know what's going on. I know that nothing will happen without my say so.”

“The amazing level of skill/care. Also the attention to detail, understanding of individual requirements.”

“It's a very holistic model/approach and I felt well cared for and supported.”

“There were so many departments involved initially that it became a struggle to keep up with who's who”.

“In terms of major trauma team - sometimes the info we received was different from doctors and nurses to yourselves.”

“More contact from trauma team for families who are not always able to be at hospital.”

“I was admitted after a car accident in to the trauma ward where I learned the Trauma Team that treated me were made up of all the different departments i.e. surgical, physio, OT, etc. I received the best care ever. What a great idea. Keep up the good work.”

## Key Performance Indicators:

(STAG 2020 report [www.stag.scot.nhs.uk/Publications/annual-report.html](http://www.stag.scot.nhs.uk/Publications/annual-report.html))

Key Performance Indicator	No. of patients	Percentage	National Median
Severe head injury: CT scan within 1 hour of admission.	82	54.9%	34.6%
Severe head injury: CT report within 1 hour of CT scan.	82	47%	57.8%
Open long bone fracture: IV antibiotics within 3 hours.	16	56.3%	64.8%
Severe haemorrhage: Tranexamic acid within 3 hours	16	81.3%	78%
Patients receive functional outcome assessment (PROMS)	101	58.4%	38.1%

The MTC Clinical Governance group conducted 140 short case reviews, 12 long case reviews.

## Some examples of good practice identified:

- SAS & EMRS pre-hospital interventions.
- High percentage of major trauma patient pre-alerts.
- High percentage consultant led trauma response.
- Access to CT.
- CT primary survey ('hot') report, allowing early planning.
- Early involvement of trauma co-ordinators.
- Intensive care co-ordination of care.
- MDT planning, led by MTC team.
- Anaesthetic/operative planning.
- Early rehabilitation planning and PROMS.
- Obstetric patients with trauma; consultant obstetric presence and considered imaging.
- Conservative management of intra-abdominal haemorrhage with early recognition of subsequent need to change plan.

## Examples of learning/improvement identified: (common/important themes):

- Documentation (very often) + communication (often)
- Some longer 'on scene times' + use of pelvic binders (**SAS**)
- Pre- alert timing/structure + use of trauma call (**ED + SAS**)
- Early identification of 'silver trauma' patient (**ED + SAS**)
- Trauma team leadership in resus room - use of sedation/RSI (**ED + Anaes**)
- Appropriate and timely use of antibiotics and Tranexamic acid (**SAS + ED**)
- Resuscitative thoracotomy – variance in decision making + practice (**ED, Anaes + surgical specialities**)
- Timeous definitive CT report (**Radiology**)
- Delays in admission to ward/theatre (**All**) – reasons identified include trauma team leadership, trauma team dissipation pre CT scan, decision making re ITU v. HDU, HDU named consultant, critical care bed availability, wait for final CT before patient 'accepted'. Rapid transit to theatre occasionally required.

- Trauma team leadership beyond resus room e.g. in interventional radiology, theatre **(All)**.
- Named consultant for SHDU + PTU admission **(ALL)**
- Delays in access to rehabilitation for complex patient + demands this places on clinical area looking after these patients
- Documentation (of review) + training re (im)mobilisation/handling for clinical staff looking after patients with spinal injury on wards outwith neurosurgery/orthopaedics **(Spinal/AHP)**
- Early identification of patients for rehabilitation planning **(All)**
- Pressure areas **(All)**
- Repatriation issues – co-ordination/planning, escort, tracheostomy/infection control SOPs.

#### Work in progress:

- Early identification of ‘silver trauma’ patients – QI project: use of STAC triage tool.
- Resuscitation transfer summary for patients transferred in (documentation).
- (Im)mobilisation/handling in spinal injury (documentation).
- Standard Operating Procedures (SOPs).

#### Next steps/challenges:

- More timely case reviews.
- Progress ‘work in progress’
- Link STAG data with SPOC and Trauma call data.
- Bimonthly report to MTC Steering group, summarising good practice and learning.
- Establish links with surgical & anaesthetic clinical governance processes.
- Review 2019 STAG annual report KPI performance (published September 2020) with aim of establishing further QI projects.
- Review moderate trauma patients.
- With Network Clinical Governance group, review Network trauma patients, starting with head injured patients.

**Dr Angus Cooper**  
**MTC Clinical Governance Lead**  
**19<sup>th</sup> March 2021**