Stealth Trauma in the North

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Older Person Trauma Lead for Northern trauma Network
TARN Older Person Trauma Report

- Massive shift in presentation of major trauma
- Typical major trauma patient – ‘nan down’
- Don’t trigger trauma bypass
- More likely to be seen in TUs by junior doctors
- Longer times to investigation and intervention
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In the North…

• Northumbria changed practice in February 2016 across various aspects of older person trauma
• Local CQUIN at Northumbria
• NTN formed Regional Older Person Trauma Group in August 2016
Regional Older Person Trauma Work Streams

- Pre-hospital triage
- ED triage
- Imaging
- Various care pathways
- Training
- Documentation
Regional Older Person Trauma Achievements

- All patients with chest pain or tenderness undergo CXR as minimum
- If abnormal observations or CXR consider for admission & discuss with senior
- Senior to decide need for CT, level of analgesia, admission, need for ABGs
- Parameters around need for anaesthetic review
- Evidence based analgesia recommendations and advice to move towards 24/7 regional block service
- Recommendations for physio review and ongoing rehab
- Links to regional guidance for rib fixation
- Recommendations regarding where to admit patient to
- Recommendations regarding use of frailty scoring and need for early CGA for those who would benefit
- Patient perspective information leaflets
- Areas for audit  https://1drv.msAgICR02MtPXrgTXdTyu4EQcxgcNn
Scenario 1

- 82 year old man with a history of IHD and mild COPD, CFS 4
- On clopidogrel, bisoprolol, inhalers
- Slips on grass – bump to occiput, abrasions and tenderness to left posterolateral chest wall
- Presents to WIC
- P59, BP177/81, RR20, SpO2 97%, GCS 15/15
Scenario 1

• Transferred to ED – CT scan shows fractures of left 6th/7th/8th ribs with basal atelectasis
• Discharged with Paracetamol and Codeine

• Re-attended 2 days later
• Delirium and pneumonia
• Prolonged admission
• Discharged CFS 6
Regional Older Person Trauma Achievements

Cervical Spine Imaging

Number of scans

Week

Total scans Mean UCL LCL

Cervical Spine Imaging

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<thead>
<tr>
<th></th>
<th>Pre campaign</th>
<th>Post campaign</th>
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<tbody>
<tr>
<td>Numbers of scans</td>
<td>269</td>
<td>596</td>
</tr>
<tr>
<td>Numbers of fractures</td>
<td>25</td>
<td>30</td>
</tr>
<tr>
<td>Numbers of incidental findings</td>
<td>42</td>
<td>75</td>
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- Number of head scans in post campaign period 1593
- 6 cases with delayed diagnosis in pre intervention period, only 2 in post intervention period and then new guidance not followed

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<thead>
<tr>
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<th>Pre campaign</th>
<th>Post campaign</th>
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<tbody>
<tr>
<td>Time to request</td>
<td>103 minutes</td>
<td>74 minutes</td>
</tr>
<tr>
<td>Time to scan</td>
<td>144 minutes</td>
<td>109 minutes</td>
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<tr>
<td>Time to report</td>
<td>211 minutes</td>
<td>176 minutes</td>
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Convincing the Region

Regional TARN data 2014/2015
31 cases of delay in diagnosis
22 of which submitted by MTCs
2 spinous process 1 transverse process

• Problem more profound in TUs
• Likely underestimation
• Impact data probably transferable
Regional agreement

- CT modality of choice for ≥65 yr olds
- All patients ≥65yr old post injury with any of the following should be suspected of cervical spine injury and considered for CT of the cervical spine:
  1. Any neck pain post injury
  2. Fallen >2m and meets criteria for head CT
  3. Who has new neurological deficit post injury
  4. Who meets criteria for head CT and who are unable to reliably rule out neck pain due to cognitive impairment
Scenario 2

- 85yr old lady with simple fall from standing. Tripped over slope in garden
- Presented to UCC seen by GP bilat muscular neck pain but no c spine tenderness
- D/C with usual advice for neck sprain
Scenario 2

• Returned following day ongoing concern from family due to primarily pain/ability to ‘cope’
• Seen initially by junior doctor plan for further analgesia and hospital to home physio assessment
• Rethought plan
The ethos of the course is to attempt to ensure that patients of advancing age receive safe and high quality trauma care. This care should focus on them as individuals and be directed towards treating the patient with injuries, not injuries on a patient.
Older person trauma patient with possible cervical spine injury

Patient able to lie flat and have blocks and tape applied?

NO

Attempt to identify reason for inability to comply *

Unable to lie flat
Apply blocks +/- tape in semi-recumbent position

Agitation/distress
Treat underlying cause
Support in position of comfort with blankets/padding

Spinal deformity
Use blankets/padding to support usual position
Place rolled blankets or blocks to either side of head

Transfer to hospital
Ensure that receiving staff aware of potential cervical spine injury**

YES

*Consider analgesia, reassurance
**Consider use of soft collar / ID TAG to identify C-Spine NOT cleared
TARN Older Person Trauma Report

- More likely to die but if survive not at greater risk of disability
- Comorbidity (Charlson Comorbidity Index) has adverse effect on outcome but likely other factors associated with age have greater effect
Identifying Frailty in Major Trauma
Identifying Frailty in Major Trauma

• Don’t have to be frail to sustain older person trauma
• Are frail more at risk from sustaining trauma and greater impact secondary to the trauma?
• Is older person trauma an independent risk factor for developing or worsening frailty?
• Should frail patients with older person trauma have different management?
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