Greater Manchester Major Trauma Network

NHS

# GM Major Trauma Network Bulletin (2 September 2019)

Further to discussion and ratification at the GM Major Trauma Network Clinical Effectiveness Committee, the (updated) Network Secondary Transfer Pathways are now available for use and dissemination to relevant colleagues:

## Network Secondary Transfer Pathways:

### a. Pit Stop Pathway

- When a patient is injured and presents with unmanageable airway, unmanageable breathing or unmanageable catastrophic haemorrhage, they will be conveyed to the nearest MTC or TU.
- When the receiving site is a TU, this should be considered an initial 'pit stop' where the patient is stabilised for onward transfer to the MTC.
- The Pit Stop pathway (attached) provides guidance in this situation. It will also apply to local emergency hospitals at which patients have self-presented.
- Management of pit stop patients should be limited to rapid investigation and interventions that will maximise stabilisation with the aim of **rapid transfer** onwards to the MTC for definitive treatment.

### b. Injured Patient Pathway (urgent secondary transfer)

- In Greater Manchester the most common occurring scenario requiring secondary transfer is when a patient has been conveyed to a TU/LEH because the pathfinder has not been triggered at the scene, or the patient has self-presented at a TU or LEH.
- The intention of the Injured Patient Pathway (attached) is to support decision making and liaison with the MTC in this situation.
- The pathway provides guidance on patients with a clinical diagnosis of major trauma, those who should be 'fast tracked' to the MTC, and those who require further investigation.
- The pathway also includes guidance on the minimum requirements of care that are required before onward transfer.

Patients in both categories should be transferred under the **Trauma Team Leader (TTL)-Trauma Team leader process**. In situations where either TTL (TU/LEH or MTC) feels that the transfer should be accelerated e.g. for patients who require time critical transfer because a specialist team is standing by to treat the patient (surgeon, vascular surgeon, interventional radiologist, neurosurgeon etc.) the Trauma Cell should be contacted to expedite this (if appropriate).

## Network Roadshow

We are also planning a Network 'roadshow' where members of the Network team will visit your site to explain, discuss and hear your views on how the new pathways are working. This will also include the recently circulated **Open Lower Limb Fracture Pathway**, and the **Frail Injured Patient Pathway**. We're hoping to meet with as many staff as possible in your hospitals, so please invite the wider Trauma team.

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# Pit Stop at Trauma Unit

**(NWAS Triage Positive for Major Trauma Pathfinder)**

***For patients who require life-saving intervention prior to ongoing transfer to MTC***

## RED STANDBY MAJOR TRAUMA 'PIT STOP' CALL TO TRAUMA UNIT

**Where possible request that crew remain with patient to complete pit stop and continue transfer to MTC**

### Unmanageable airway

- Anaesthetic review
- Manage airway
- Think TXA

**TTL to (MTC) TTL**
**Send and call**

**Timeframe for transfer as per NWAS Transfer Categories**

### Unmanageable breathing

- Consider CXR +/- eFAST
- +/- Chest Drain(s)
- Think TXA

**TTL to (MTC) TTL**
**Send and call**

**Timeframe for transfer as per NWAS Transfer Categories**

### Unmanageable catastrophic haemorrhage

- Control external haemorrhage
- Pelvic binder/tourniquet
- +/- blood products
- Think anticoagulant reversal
- Think TXA
- Consider Damage Control Surgery (rare)

**TTL to (MTC) TTL**
**Send and call**

**Timeframe for transfer as per NWAS Transfer Categories**

***If in doubt about whether to transfer, liaise with the MTC TTL (SRFT: 0161 206 2226 / MRI: 0161 276 4012)***

***If you have concerns about the timeframe for transfer, liaise with MTC TTL and Trauma Cell (0161 227 7011)***

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# The Injured Patient Pathway

**For pre-hospital pathway TRIAGE NEGATIVE or self-presenting patients**

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| 'Fast track' Criteria | |
|---|---|
| Head injured patients 70 years of age or under<br>**≤70 yrs** | Intubated **AND** abnormal scan,<br>**OR**<br>Extra-dural haematoma: >15mm thickness or >5mm midline shift, **OR**<br>**Acute** subdural haematoma: >10mm thickness or >5mm midline shift |
| Head injured patients over 70 years of age<br>**>70 yrs** | GCS > 8 **AND**<br>Living independently, **AND**<br>One of the following:<br>- Extradural haematoma >15mm thickness or >5mm midline shift<br>- **Acute** subdural haematoma > 10mm thickness or >5mm midline shift |
| Spinal Injuries | Spinal injuries with hard motor neurology |

**For catastrophic injuries (unmanageable: airway, breathing, or catastrophic haemorrhage): Go to 'PIT STOP' guidance**

**Is there a clinical diagnosis of major trauma? One or more of the following:**

- Flail chest
- Penetrating trauma to head, neck, trunk or limbs proximal to elbow/knee
- Fractures to two or more long bones (humerus / femur)
- Amputation proximal to wrist / ankle
- Ischaemic limbs – post manipulation
- Suspected spinal injury with new onset motor deficit
- Head Injury with GCS 12 or less

YES

NO

Does the patient meet 'fast track' criteria?

YES

NO

TTL to TTL
Send and call

NWAS transfer to MTC within appropriate timeframe

(See NWAS Transfer categories)

MTC

**Contact MTC TTL**

TTL-TTL discussion regarding management plan

**SRFT: 0161 206 2226 / 206 5354**
**MRI: 0161 276 4012**

Further investigation and discussion of results with a specialist may be required.

Agreed that patient requires MTC care?

YES

NO

**Diagnostics**

Positive radiological findings for **MAJOR** trauma?

YES

NO

Treat / Admit locally

If conveyed by NWAS, ambulance crew must alert triage clinician of any previous Trauma Cell discussion.

Think TXA

Think anticoagulant reversal

Frailty/futility: Discuss with MTC – will the patient benefit from transfer?

**AS A MINIMUM:**

1. Patients should be booked into receiving hospital
2. Primary set of observations recorded
3. Review by senior ED clinician