

## Network incidents 2023-24

# 8 KEY POINTS

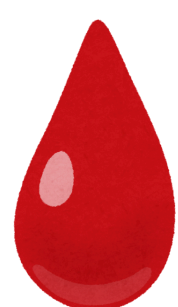
27 incidents were reported, these are the common themes:



TU - Trauma Unit

IR - Interventional Radiology

MTC - Major Trauma Centre (St George's)



1

### BLOOD

2 incidents where crystalloid rather than blood was given to hypotensive trauma patients.

**Use blood component resuscitation for hypotensive trauma patients**

2

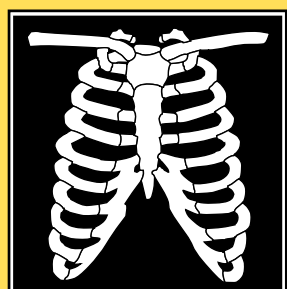
### RECEPTION

5 cases involving:

- Junior doctors managing patient.
- Trauma call not activated.
- Lack of leadership of TU trauma team

**Ensure senior leadership involvement in trauma cases**

**Use network guidelines (QR code)**

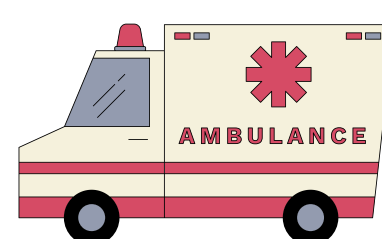


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### IMAGING

3 cases of CT scanning being incorrect or inadequate.

**Multi system injuries detected or suspected? Perform full trauma CT.**

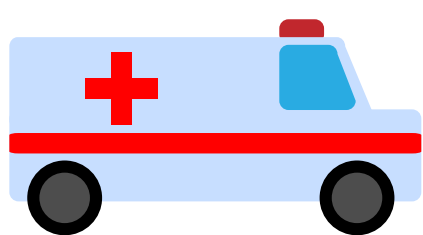


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### AMBULANCE

1 case of TU refusing patient on ambulance arrival.

**If a patient is brought to a TU they should be managed there and transferred if necessary after initial treatment.**



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### TRANSFERS 1

3 cases of inappropriate or inadequate transfer.

**No TU to TU transfers, patients should only go to the MTC. Ensure appropriate documentation, escort and handover.**



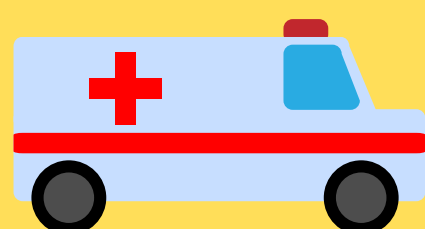
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### REFERRALS

5 cases of inappropriate onward referral or advice

**No TU to TU transfers (even for IR)**

**TUs only to liaise with MTC, not other specialist hospitals**



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### TRANSFERS 2

Delay in time critical ambulance for transfer from TU to MTC

**Contact ambulance service and ask to speak to a clinician to escalate concerns regarding time critical transfers.**



8

### OPEN FRACTURES

1 case of failure to follow the open fracture pathway and checklist. Check QR

