Submission amendment guidance document

Amendments to Dispatched or Approved submissions by TARN staff, will no longer be routine practice from 1st November 2020 onwards. Trusts need to ensure their submissions are as complete as possible **prior to dispatch** to TARN.

This decision is fully supported by the TARN Executive and brings TARN into line with other National Clinical Audits who do not operate a post-dispatch amendment policy.

The only exceptions to this will be the following:

- Adding Post-operative limb splints &/or antibiotics to the BOAST screen (the system currently does not allow these to be entered prior to dispatch)
- Adding Readmission details
- Updating information regarding PM status and Cause of Death (as this information may not be known prior to dispatch).

This document highlights some common validation requests TARN to review and address prior to dispatch to TARN. The Data Entry Guides and Data Proforma available under the resources section of the website should also be used to ensure the submissions are as complete and accurate as possible prior to dispatch to TARN. TARN training sessions are also useful in understanding the TARN system and data entry.

The Data Quality report available under the audit section of the website can be used to highlight information your trust is routinely not recording. ***This can then help you to put in place systems to identify this data and record it moving forwards.***

This data should be routinely available to coordinators before submitting to TARN. Any issues with missing data should be highlighted to your Managers, Clinicians and Network Managers so that they can ensure that this is provided for future submissions.

Common request	Review Suggestion
Opening section	
Adding or amending NHS numbers	This information should be available in patient notes or online systems
Admitting Service	Use Hospital notes
Rehabilitation Prescription	Use Hospital notes for RP or rehabilitation entry/check electronic e-RP/e-discharge paperwork/check with therapists or rehabilitation coordinators
First Hospital Information e.g. GCS, pupil reactivity	Use handover notes, contact coordinator from previous hospital for information
Incident	
Date and Time of Incident	Use Pre-hospital system/handover notes-if not readily available consider a new internal process
Incident Post Code	Use Pre-hospital system/handover notes-if not readily available consider a new internal process
Pre Hospital	
PRF's	If this information is routinely unavailable discuss with manager and ambulance service to arrange better system
ED	
Time of arrival	Check hospital/ED system Check admission/HCE/local Trust paperwork
Trauma Team	Use ED system
Pre-Alert	Use Pre-hospital system/handover notes
ED observations e.g. GCS	Use patient notes/ trauma booklets
ED attendant	Use Trauma booklets, ED system; confirm grades via hospital directory; check with rota office. Only the First and most Senior Doctors from each speciality is required.
Imaging	
CT provisional report date and time	Use hospital imaging system: Helpful to have clear guidance about which dates & times to use (a local process that needs to be confirmed with imaging, depending on which imaging system is in place)
CT review date and time	Use hospital imaging system: Helpful to have clear guidance about which dates & times to use (a local process that needs to be confirmed with imaging, depending on which imaging system is in place)
Add imaging	Use hospital imaging system

Operations	
Operation procedure/details	Use hospital/operation notes/theatre system Check admission/inpatient coding for procedure details
Grade and specialisation of surgeon	Use check hospital/operation notes/theatre system
Critical Care	
Attendant details	Only the first and most senior Doctor from each speciality is required.
Critical Care observations- including GCS	Use hospital and ward notes, if patient admitted straight to Critical Care record the GCS on arrival in Critical Care.
Ward	
Attendant details	Only required for transfers in directly to the ward where the patient does not go through ED.
Ward observations- including GCS	Use hospital and ward notes, if patient admitted straight to ward use the extended data set to record the GCS on ward.
At Discharge	
Pre-Existing Conditions	Patient notes or online systems allowing access to patients Primary Care records.
Clinical Frailty Scale	Check hospital/ED system Check admission/HCE/local Trust paperwork Confirm local processes for where this information might be documented; points of contact for validating information. Some Networks have implemented TTS booklets to capture score and assessor detail.
Confirmed Injury details	Use: Hospital imaging system, hospital notes, discharge summary, gain confirmation of possible injuries from clinicians. Give Radiology Crib Sheet to your Radiologist to promote the sort of information that TARN needs in imaging reports to code accurately.