CORE STANDARDS

Standard	Where Used
NICE Head Injury Guidelines 2014 CT imaging of the head should be performed within 1 hour of arrival for patients meeting the NICE Dead Injury Criteria. See http://www.nice.org.uk/guidance/cg176 for details.	Time to CT Scan
BEST PRACTICE TARIFF SECTION 4.10 MAJOR TRAUMA Standard 7 If the patient is admitted directly to the MTC or transferred as an emergency, the patient must be received by a trauma team led by a consultant in the MTC. The consultant can be from any specialty, but must be present within five minutes**.** See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file /300549/Annex_4A_Additional_info_on_currencies_with_national_prices.pdf for details.	Most senior doctor attending patients within 5 minutes of arrival

THORACIC AND ABDOMINAL INJURIES REPORT (MARCH)

Standard	Where Used
RCS / BOA STANDARDS OF CARE SECTION 13.3: CARDIOTHORACIC INJURIES Standard 1 Examination of the chest is a fundamental component of the cardiopulmonary assessment of the seriously injured and should be supervised by the most experienced clinician	Most Senior in ED
RCS / BOA STANDARDS OF CARE SECTION 13.4 Standard 1 In a hospital receiving severe trauma, the input of a general surgeon into the resuscitative team is essential.	Presence and Grade of General Surgeon in ED for Abdominal Injuries
RCS / BOA STANDARDS OF CARE SECTION 13.4 Standard 5 Where visceral injury requires operative management, the start of the operation must be possible within 60 minutes of admission in all cases.	Time to Theatre for Abdominal Injuries
Systolic blood pressure below 110mmHg is associated with increased mortality in blunt major trauma patients. Resuscitation 2011 82(9):1202-7	Management of shocked* patients *Adults with SBP < 110 pre-hospital or in the ED & a blunt injury mechanism
The importance of early treatment with tranexamic acid in bleeding trauma patients: an exploratory analysis of the CRASH-2 randomised controlled trial Lancet. 2011 Mar 26;377(9771):1096-101	Patients receiving Tranexamic Acid

ORTHOPAEDIC INJURIES REPORT (JULY)

Standard	Where Used
RCS / BOA STANDARDS OF CARE SECTION 13.5: SOFT TISSUE AND SKELETAL INJURIES Open Fractures Standard 3 A full wound excision and irrigation should be performed by the consultant surgeon within six hours of injury. Reduction and stabilisation of the fracture with internal or external fixation (as appropriate) should be achieved at that primary procedure.	Time to Theatre for Open Limb Injuries Grade of Surgeon for Open Limb Injuries Grade of Anaesthetist Open Limb Injuries
BOA STANDARDS FOR TRAUMA (BOAST) BOAST 4 Early wound excision to reduce dead tissue and bacterial contamination is critical in avoiding both primary and hospital acquired infection. This should be undertaken promptly and thoroughly by a senior experienced surgeon. Concurrent reduction and stabilisation of an open fracture will reduce further ongoing damage and swelling and allow optimum and prompt soft tissue reconstruction; these are the most important measures in reducing the potential for infection. In achieving the above, there is strong evidence to support the combined early involvement of Orthopaedic and Plastic surgery.	Time to Theatre for BOAST 4 injuries (high impact open tibia/ fibula fractures). Grade of Surgeon BOAST 4 injuries (high impact open tibia/ fibula fractures) Grade of Anaesthetist BOAST 4 injuries (high impact open tibia/ fibula fractures)
RCS / BOA STANDARDS OF CARE SECTION 13.5: PELVIC AND ACETABULAR FRACTURES Standard 6 Imaging is required to determine the role of surgery and the need for transfer. This is usually AP and Judet oblique plain radiographs of the whole pelvis for acetabular fractures. CT is optional. An AP pelvis radiograph and CT scan [10mm cuts] are required for pelvic disruptions.	Patients with severe (AIS 4+) pelvic fractures: Time to Pelvic CT or AP Judet Radiograph

HEAD AND SPINAL INJURIES REPORT (NOVEMBER)

Standard	Where Used
RCS / BOA STANDARDS OF CARE SECTION 13.2: MAJOR HEAD INJURIES Standard 8 Patients with severe head injuries or focal signs should be transferred to the care of neurosurgery units, regardless of whether they need surgical intervention. Severe head injuries are defined as having an Abbreviated Injury Scale score of more than 2 in the head (with or without injuries to other body regions) with a recorded Glasgow Coma Score of less than 9 OR a recording of intubation and/or ventilation.	Transfer status of patients with AIS 3+ head injuries
NICE Head Injury Guidelines 2014 CT imaging of the head should be performed within 1 hour of arrival for patients meeting the NICE Dead Injury Criteria. See http://www.nice.org.uk/guidance/cg176 for details.	Patients with AIS 3+ head injuries, timing: CT
RCS / BOA STANDARDS OF CARE SECTION 13.2 MAJOR HEAD INJURIES Standard 9 The system of care should achieve surgical evacuation of a significant subdural / extradural haematoma within four hours.	Patients with AIS 3+ head injuries, timing

PERFORMANCE COMPARISONS (UPDATED AND PUBLISHED ON TARN WEBSITE FEBRUARY, MAY, AUGUST AND NOVEMBER)

Standard	Where Used
RCS / BOA STANDARDS OF CARE SECTION 13.2: MAJOR HEAD INJURIES Standard 8 Patients with severe head injuries or focal signs should be transferred to the care of neurosurgery units, regardless of whether they need surgical intervention. Severe head injuries are defined as having an Abbreviated Injury Scale score of more than 2 in the head (with or without injuries to other body regions) with a recorded Glasgow Coma Score of less than 9 OR a recording of intubation and/or ventilation.	Injuries to the Brain and Skull - Transfers
NICE Head Injury Guidelines 2014 CT imaging of the head should be performed within 1 hour of arrival for patients meeting the NICE Dead Injury Criteria. See http://www.nice.org.uk/guidance/cg176 for details.	Injuries to the Brain and Skull - Time to CT
RCS / BOA STANDARDS OF CARE SECTION 13.5 - Unstable Spinal Injuries Standard 3 Immediate referral must be made to the appropriate spinal injury service if there is evidence of partial or complete spinal cord or cauda equina lesion.	Injuries to the Spine - Transfers
RCS / BOA STANDARDS OF CARE SECTION 13.3: CARDIOTHORACIC INJURIES Standard 1 Examination of the chest is a fundamental component of the cardiopulmonary assessment of the seriously injured and should be supervised by the most experienced clinician	Injuries to the Chest - Most Senior Doctor in ED
BOA STANDARDS FOR TRAUMA (BOAST) BOAST 4 Early wound excision to reduce dead tissue and bacterial contamination is critical in avoiding both primary and hospital acquired infection. This should be undertaken promptly and thoroughly by a senior experienced surgeon. Concurrent reduction and stabilisation of an open fracture will reduce further ongoing damage and swelling and allow optimum and prompt soft tissue reconstruction; these are the most important measures in reducing the potential for infection. In achieving the above, there is strong evidence to support the combined early involvement of Orthopaedic and Plastic surgery.	Injuries to the Limbs and Pelvis - Grade of Surgeon