Trigger Team Activation for Acute Patients. A Cohort Study at a Level 1 University Hospital in Denmark

Stefan Posth (✉ stefan.posth@rsyd.dk)
University of Southern Denmark  https://orcid.org/0000-0002-4325-038X

Lonnie Froberg
Odense University Hospital: Odense Universitetshospital

Søren Bak
Odense University Hospital: Odense Universitetshospital

Lisette Okkels Jensen
Odense University Hospital: Odense Universitetshospital

Mikkel Brabrand
Odense University Hospital: Odense Universitetshospital

Annmarie Lassen
Odense University Hospital: Odense Universitetshospital

Research article

Keywords: trigger team, medical emergency patient, trauma, stroke, STEMI

Posted Date: November 19th, 2020

DOI: https://doi.org/10.21203/rs.3.rs-108214/v1

License: This work is licensed under a Creative Commons Attribution 4.0 International License. Read Full License
Trigger team activation for acute patients. A cohort study at a level 1 university hospital in Denmark

Stefan Posth¹, Lonnie Froberg², Søren Bak³, Lisette Okkels Jensen⁴, Mikkel Brabrand⁵, Annmarie Lassen¹

¹ Clinical Institute, University of Southern Denmark and Department of Emergency Medicine, Odense University Hospital, Denmark; Corresponding author

² Department of Orthopaedic Surgery, Odense University Hospital, Denmark

³ Department of Neurology, Odense University Hospital, Denmark

⁴ Department of Cardiology, Odense University Hospital, Denmark

⁵ Institute of Regional Health Research, University of Southern Denmark; Department of Emergency Medicine, Hospital of South West Jutland, Denmark; Department of Emergency Medicine, Odense University Hospital, Denmark

Abstract:

Background: While patients with major trauma, suspected ST-elevation myocardial infarction (STEMI) or stroke have implemented pathways for quick access to specialized trigger teams, other patients with time dependent diseases present with less obvious aetiology and have less documented pathways at arrival to the hospital.
Aim: To describe the number, diagnosis and prognosis of patients arriving to the trigger teams for trauma, suspected STEMI, suspected stroke, and Medical emergency patients (MEP).

Method: Retrospective cohort study of all patients who between November 2012 and September 2015 had either a trauma, STEMI, stroke or MEP trigger team activation at arrival to Odense University Hospital – a level 1 trauma centre, a direct referral centre for patients with suspected STEMI to the catheterization laboratory or stroke, and with a trigger team at emergency department arrival of MEP patients from the local area.

Results: There were 8,075 activations of a trigger team at hospital arrival, median 7.6 calls per day (range 1-18); 16.7% trauma, 28.3% STEMI, 19.7% stroke and 35.3% MEP calls. This corresponds to 161/100,000 person years (py) with trauma calls, 64/100,000 py STEMI calls, 72/100,000 py stroke calls and 340/100,000 py MEP calls.

Patients from the different calls had a 30-day mortality of 12% (trauma), 8% (STEMI), 5% (stroke), and 25% (MEP).

Whereas patients from trauma, STEMI and stroke calls were mainly discharged within a few ICD10 (International classification of diseases, version 10) main coding areas, patients from MEP calls had discharge diagnosis within many different ICD10 main coding areas.

Conclusion: Trauma, STEMI and stroke trigger teams are used at a daily base, treat a prehospitaly well-defined patient population and have a relatively low 7-day mortality. Patients with MEP calls are more frequent, have a diverse aetiology and a higher mortality than patients in the other trigger teams.

Keywords: trigger team, medical emergency patient, trauma, stroke, STEMI.
Background:

People outside the hospital in medical distress activate the Emergency Medical System. In Denmark, an ambulance is dispatched, and if the situation is deemed severe enough, a physician-manned unit (Mobile Emergency Care Unit) is deployed as well. However, when the patients arrive at the Emergency Hospital, their paths split.

A dedicated trauma team, headed by an orthopaedic surgeon or an anaesthesiologist, receives trauma patients. Patients with ST-elevation myocardial infarction (STEMI) are sent to the cardiac catheterization laboratory, and a neurologist promptly evaluates stroke patients for potential thrombolysis.

Patients with less differentiated problems, medical emergency patients (MEP), which include many of the patients with shock, respiratory distress or depressed level of consciousness, do not fall into any of these categories. They are received in the emergency department (ED) by emergency physicians. However, they are also in an acute life-threatening situation and require immediate care. As their path through the ED is not as well defined as for patients with trauma, stroke or STEMI, many EDs have implemented each their dedicated pathway or a dedicated team to receive, assess and treat these patients. This is especially important as reliably matching patient needs with ED resources in time-dependent illness is a critical component of a coordinated emergency care system. In contrast to the implemented pathways for trauma, STEMI and stroke teams, most MEP teams are locally developed and are scarcely described and evaluated in a general setting. The aim of the study is to describe the number, diagnosis and prognosis of patients arriving to the trigger teams for trauma, suspected STEMI, suspected stroke, and MEP.
Methods:

This is a population-based cohort study. Odense University Hospital (OUH) is one of three centres in the Region of Southern Denmark performing stroke thrombolysis and the only centre receiving level 1 orthopaedic trauma, and patients with prehospitaly diagnosed STEMI. MEP can be admitted in five different hospitals in the region.

All MEP and patients with trauma, suspected stroke as well as suspected STEMI who arrived to a specialized team response at OUH between 1 November 2012 and 30 September 2015 were included in the study. Patients under the age of 18 were excluded. Data on outcome (mortality) was extracted from Danish Civil Registration System (10) and all hospital contacts from the National Patient Registry (LPR) (11). In Denmark, all inhabitants have access to universal free healthcare and use their personal identification number in relation to the contacts.

Composition of the different trigger teams is poorly defined; no international consensus exists, just suggestions for trauma teams (12).

The trauma trigger team at OUH consists of an orthopaedic surgeon, anaesthesiologist, anaesthesiology nurse, two ED nurses, radiologist, two radiology technicians, laboratory assistant, orderly and a secretary. Other specialists can be summoned to the resuscitation room as needed. Patients are received in the EDs resuscitation room. The inclusion criteria for the team call are a patient after a physical trauma with an objective or suspected life-threatening injury or an injury of more than one organ system (penetrating trauma head / torso, massive bleeding, massive blunt trauma, instable pelvis fracture, two or more major fractures, flail chest, ABCDE instable, fall >6m, trapped >30 minutes).
During the inclusion period, patients arrived from the northern part of the island of Funen, Denmark (primary trauma) and from the whole region of Southern Denmark (secondary trauma). There are 290,000 inhabitants living in the catchment area for primary trauma, and 1,220,000 for secondary trauma (figure 1).

**Figure 1:** Catchment area

STEMI: ST-elevation myocardial infarction patients

The OUH stroke trigger team consists of a thrombolysis consultant from the neurology department, ED nurse, neurology nurse, laboratory assistant and secretary. Inclusion criteria for the team call is a suspected acute ischaemic stroke, less than 4.5 hours after debut of symptoms, and a previously self-reliant patient. During the inclusion period, patients were received in the EDs computed tomography scanner and resuscitation room. They arrived from the island of Funen, including the outlying smaller islands, and the eastern part of southern Jutland, Denmark. This amounts to a catchment area of 754,000 inhabitants (figure 1).
The STEMI trigger team at OUH consists of an interventional cardiologist and three specialised nurses. The patients are received in the cardiac catheterization laboratory following prehospital visitation. The inclusion criteria for the team call are typical symptoms for myocardial infarction for less than 12 hours and electrocardiogram findings suggesting STEMI. Also, patients with cardiac arrest with a suspected cardiac reason are included in this group. The patients arrive from the whole region of Southern Denmark, with 1,220,000 inhabitants (figure 1).

The MEP trigger team at OUH consists of a medical consultant on duty in the ED, senior medical resident, two ED nurses, secretary, orderly, laboratory assistant and a radiology technician. If the patient’s airway is threatened, or if the patient is unconscious with a Glasgow Coma scale of less than 8, an anaesthesiologist and an anaesthesiology nurse are part of the MEP trigger team. Patients are received in the EDs resuscitation room. The inclusion criteria for the team call is one or more of the following: threatened airway, systolic blood pressure < 80 mmHg, pulse rate > 130/min, respiratory rate > 35/min, oxygen saturation < 80% or Glasgow Coma Scale < 8. Also, patients with cardiac arrest with a suspected non-cardiogenic reason are included in this group. The patients arrive from the northern part of the island of Funen, Denmark, resulting in a catchment area of 290,000 inhabitants (figure 1).

Information on inhabitants in the different catchment areas are retrieved from Statistics Denmark (numbers from 1 January 2018).

Data was analyzed using Stata/IC (version 15).

Results:
In the 35 observation months, there were 8,075 trigger team activations for adult patients at arrival to OUH, range 1-18, median 7.6 per day. An additional trigger team was activated in 36 cases (0.5%), for example an initial trauma trigger call was supplemented with a MEP trigger call.

Whereas 7,568 patients (94.7%) experienced one trigger call during inclusion period, 374 (4.6%) experienced two trigger calls at different points of time, and two patients experienced 13.

The demographic details of patients involved in all trigger calls are shown in table 1. 16.7% of all trigger team activations were trauma, 28.3% STEMI, 19.7% stroke and 35.3% MEP. This corresponds to 161/100,000 person years (py) with trauma calls, 64/100,000 py STEMI calls, 72/100,000 py stroke calls and 340/100,000 py MEP calls.

Patients from the different calls had a mean age of 48 for trauma calls, and a similar mean age of around 65 for the other calls. Most of the trauma and STEMI call patients were male, whereas the female / male distribution was more even for stroke and MEP calls. Seven-day mortality was lowest for stroke patients and highest for MEP. Transferral rate for patients to the intensive care unit was lowest for stroke and highest for trauma call patients.

**Table 1:** Demographic information on all included patients

<table>
<thead>
<tr>
<th>Trigger team</th>
<th>Activations</th>
<th>Activations / day (range ± SD)</th>
<th>Activation / 100,000 inhabitants / year</th>
<th>Sex (female / male [%])</th>
<th>Age (mean ± SD)</th>
<th>LOS (days mean ± SD)</th>
<th>7-day mortality (%)</th>
<th>30-day mortality (%)</th>
<th>90-day mortality (%)</th>
<th>ICU (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma</td>
<td>1,347</td>
<td>1.3 (1-6 ± 1.0)</td>
<td>161</td>
<td>29 / 71</td>
<td>48 ± 20</td>
<td>10.5 ± 18.6</td>
<td>10.4</td>
<td>12</td>
<td>13.2</td>
<td>37.1</td>
</tr>
</tbody>
</table>
We found no statistical difference regarding the day of arrival for patients in all trigger teams. Looking at time of arrival, most trigger team patients arrive during daytime, with the amount of trauma patients peaking in the early evening, STEMI patients around noon, and MEP in the morning. Hardly any patients suspected for stroke arrive in the early morning hours.

Figure 2 shows the Kaplan-Meier survival graph for patients of the different trigger calls, with the highest mortality for MEP.
The final diagnosis of patients included in the study are shown in figure 3. Whereas patients from trauma, STEMI and stroke calls were mainly discharged within a few ICD10 main coding areas, patients from MEP calls had discharge diagnosis within many different ICD10 main coding areas.

**Figure 3:** Final diagnosis (International classification of diseases, version 10)

a) Trauma patients, b) STEMI patients, c) Stroke patients, d) MEP

STEMI: ST-elevation myocardial infarction; MEP: medical emergency patients
Discussion:

Huge improvements regarding their outcome were made in recent years for patients with trauma, stroke and STEMI. There is a lack of national databases and guidelines for MEP to reach comparable successes for this patient group. MEP are complex, have a low chance of survival, and they are frequent.

There are well established databases for patients with trauma (Danish Trauma Registry, TraumaRegister DGU), STEMI (Acute Coronary Syndrome STEMI (ACS) Registry) and stroke (SITS – Safe Implementation of Treatment in Stroke), with published studies illuminating their mortality and outcomes (13–16).

Similar databases for MEP are lacking, and only few studies have been published describing this patient group (4,5,7,17–21). The survival rates and base characteristics for patients with trauma, STEMI and suspected stroke at OUH match those published in international databases (13,14,16).

In this study, we were able to compare the outcome of all patients admitted by trigger teams to a level 1 university hospital. There are only 21 emergency hospitals in Denmark. OUH is the only hospital in a perimeter of 50 km, as well as the only level 1 hospital in the whole region. All patients fulfilling the inclusion criteria for the different trigger calls were admitted here and could not be transported to an alternate hospital. This makes comparison of the different patient groups possible and is one of the strengths of the study.

In concordance with earlier studies (18,21) we can show a high mortality rate for MEP, higher than for the patients received by the other trigger teams. This is also true when comparing patients with suspected stroke and MEP, who show approximately the same base statistics (i.e. age and gender). From our data, we cannot conclude the reason for this, but it probably partially reflects the improved care
after the introduction of thrombolysis, and a therefore reduced mortality rate for stroke patients. It could also be a sign for a higher multimorbidity of MEP.

Looking at ICU admission, two groups of patients are sticking out, trauma patients and MEP. Both show a high percentage of ICU admission (37.1% and 26.8%, respectively), but more MEP die within 90 days after admission (13.2% and 31%, respectively).

Our results illustrate that we receive more MEP per 100,000 inhabitants than patients for the other trigger teams. In other studies, it was not possible to show this divergence, as there are usually multiple hospitals in the catchment areas, and there could be a distribution of the patients to different hospitals according to the suspected severity of their acute symptoms.

It is not surprising that the final discharge diagnosis for patients with trauma, suspected stroke and STEMI were limited to a narrow spectrum of the ICD10 catalogue. However, that is different for MEP. Here, we found a wide distribution of diagnoses, ranging through the entire ICD10 catalogue. The most common diagnosis groups were those describing respiratory and circulatory diseases. This shows the inhomogeneity of this patient group and illuminates the complexity of developing diagnostic and treatment guidelines for MEP that incorporate all possible aspects.

In 2014, a national register and a definition of MEP was requested in Germany (21), to better define the patient population and develop guidelines. In Germany, in 2016, a consensus document was published, with focus on patients arriving at the hospital with sepsis, amongst other diseases (23). Other MEP were not included in the study. An Australian study could show that MEP received by an ICU based trigger team had a shorter length of stay (24). Here, the setup did not include emergency physicians.

A study published in 2018 reviewed the outcome of MEP admitted in a similar set up as ours, with equally high mortality, but also a much higher ICU admission (25). This probably reflects different local
setups and lack of international guidelines. In Denmark, only one study is published focusing on MEP
(18).

MEP are heterogenic, and as there is no international agreement on their receival and treatment in the ED, their path through the ED differs from hospital to hospital. A review from 2017 concluded that it was not possible to suggest practice recommendations for MEP (22). Reason for this was the lack of sufficient data on MEP.

Our study has limitations. Some patients with cardiac arrest could have been coded as STEMI patients or MEP, thus raising the 7-day mortality. The study was composed as a single centre study and reflects the local setup for the trigger teams. We have no information on base values, Charlson comorbidity index, or lab findings to compare the different patient groups.

**Conclusion:**

In this study, the amount and outcome of patients received by specialized teams for trauma, stroke, STEMI and MEP at a level 1 hospital can be compared, as there is definiteness regarding the catchment areas. MEP have a higher mortality and ICU admission rate than patients of the other groups. Their final diagnosis ranges through the whole ICD10 catalogue.
List of abbreviations:

STEMI ST-elevation myocardial infarction

MEP Medical emergency patients

ED Emergency department

OUH Odense University Hospital

LPR National Patient Registry (Landspatientregisteret)

SD Standard deviation

LOS Length of stay

ICU Intensive care unit

ICD10 International classification of diseases, version 10

SITS Implementation of Treatments in Stroke

Declarations:

Ethics approval and consent to participate:
The study was approved by the Danish Health and Medicines Authority (File no. 3-3013-1385/1) and the Danish Data Protection Agency (File no. 2013-41-2435). In accordance with Danish law no further approval was needed. The reporting of this study conforms to the STROBE statement (26). Consent for publication not applicable.

Availability of data and materials:

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Competing interests:

The authors declare that they have no competing interests.

Funding:

Annmarie Lassen is funded by an unrestricted grant from the philanthropic fund TrygFoundation given to the University of Southern Denmark.

Authors’ contributions:
SP and AL analyzed and interpreted the patient data. SP mainly wrote the publication. AL and MB were major contributors in writing the manuscript. LF, SB and LO contributed to data collection and interpretation.

Acknowledgements:

Not applicable.

References:


Figures

Figure 1

Catchment area STEMI: ST-elevation myocardial infarction patients
Figure 2

Kaplan-Meier survival estimates
Figure 3

Final diagnosis (International classification of diseases, version 10) a) Trauma patients, b) STEMI patients, c) Stroke patients, d) MEP STEMI: ST-elevation myocardial infarction; MEP: medical emergency patients