PTC PROGRAMME REPORT

SOROTI - MAY 2013

Tim Beacon

June 2013

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C O N T E N T S

R E P O R T

1. INTRODUCTION

This report details a UK team visit to Soroti in Northern Uganda to run a Primary Trauma Course Foundation Programme (PTCF) in May 2013. This was the second of a new wave of THET funded PTC courses in Uganda as part of the COOL project via Oxford and COSECSA.

With the high incidence of trauma and its poor management well documented throughout Africa, the need for improved trauma management is of paramount importance in order to save life and promote both a rapid and quality recovery. The PTCF aims to address this issue through a properly structured and consistent programme that takes into account the often poor resource environments the medical teams work in.

This report summarises each stage of the two courses together and concludes with discussion points and issues raised.

Tim Beacon
Course Director
June 2013

2. KEY STAFF INVOLVED IN PLANNING AND CO-ORDINATION

Alex Bangirana (AB)	PTC Coordinator Uganda
Tim Beacon (TB)	UK Course Director
Annette Clack (AC)	PTCF Administrator
Joseph Epodoi (JE)	Consultant Surgeon Soroti Hospital
Emmanuel Moro (EM)	PTC Representative for Uganda COSECSA
Nigel Rossiter (NR)	UK Country Coordinator for Uganda

3. UK PTC INSTRUCTORS

Tim Beacon.	Managing Director, Medical Aid International (MAI)
Dr Tamsin Gregory	Consultant Anaesthetist, Addenbrooks Hospitals NHS Trust
Mr Andy Kent	Consultant Trauma and Orthopaedic Surgeon, Raigmore Hospital, NHS Scotland.

4. PURPOSE OF VISIT

The purpose of the visit was to run a PTC Programme in the Soroti district of northern Uganda at the main hospital in the town of Soroti. This follows on from NR's very successful course in February 2013 and the one TB participated in with NR in November 2010.

The course was instigated by NR, the Country Director for PTC who asked me to act as Programme Director. The aim was to run an initial instructors' course followed by one for the larger team led by the recently trained instructors.

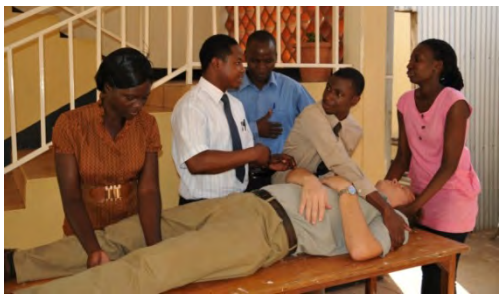
5. EXECUTIVE SUMMARY

1. Nineteen people trained including four instructors.
2. UK organisation through NR and AC was superb.
3. All Ugandan organisers did very well to put together a venue and delegates group at such short notice given the late change of programme location.
4. A visit pre-course to a Ugandan health facility, preferably the local base hospital, should be carried out whenever possible.
5. The entire programme was only four days due to short notice as a result of the venue change, although with only four on the instructors' course this was manageable.
6. The first course was UK led; the second was led by the Ugandan instructors trained on days one and two with UK mentoring.
7. The immediate educational outcomes where very good in terms of awareness of the ABCDE treatment protocol and technical skill enhancement. Encouragement and support needs to be on going to encourage the implementation of the training and its roll out long term.

8. If it is to be rolled out to community clinics, ambulance personnel and the police then many of the teaching slides are not necessary. This area needs to be explored.
9. The hotel meeting room was first class. The teaching equipment was superb. The ability of the data projector to run with a memory stick is very useful.
10. The use of training equipment as a national resource needs to be encouraged.
11. An upfront payment into a Ugandan bank account to enable instant access to money for hotel and other payments would make in-country organisation much easier for the Ugandan team.

6. PROFESSIONAL ASPECTS OF VISIT

Prior to the course NR gave very detailed briefings with regard to logistics and teaching and selected the excellent faculty. AC working with AB managed the in-country logistics very professionally prior to our departure.



TG visited the MAI office for half a day prior to departure to go through the programme and plan teaching and AK arrived at our office on the day before we left in order for us to go through the programme prior to leaving the next day. Given the above and the amount of e mail correspondence and NR's input this meant we were well prepared.

Both courses were run at the Landmark Hotel in Soroti. The venue was superb; the staff could not do enough to help us. The meeting room was a good size and the food and refreshments provided where excellent.

Prior to the course, at the beginning of April, there was a change of venue due to an issue with examinations at Mbale. AB did very good work alongside EM and JE to organise the alternative Soroti venue. It meant we had fewer members on the first instructors' course (four) although the subsequent course had 15 delegates.

There where challenges in communication between the UK and Soroti in the lead up to the course due to very poor phone lines and intermittent e mail which meant TB only had one very brief conversation with JE prior to our visit. This did, however, lead TB to suspect they had only allocated four days for the entire programme (see below). This proved correct.

Of note was the issue of expenses for the Ugandan faculty which meant AB could not attend the programme. This was anticipated and we had made plans accordingly.

AC's role in co-ordination prior to the programme was much appreciated. The journey to Soroti took most of the day, but on arrival we went straight to the hospital to meet JE and to get an insight into the local conditions and resources as well as meet some of the hospital staff. It was a very helpful visit that gave the UK team great insight, especially the fact that there was no resuscitation room as such and that the accident and emergency department, in common with many hospital in Africa, was more of an out patients department.

We were very grateful too that EM was able to travel with us and attend the course for the first three days. His presence, given his senior position, was much appreciated by all, especially as he had to change his busy schedule.

7. INSTRUCTORS' COURSE

Course Participants

See Appendix 1 for a list of the four attendees.

It transpired that we only had two days with the instructors and not three. However, we had anticipated this and following discussion with EM and JE we agreed we would:

1. Incorporate and mention briefly, as appropriate, different teaching techniques and styles on the clinical aspect of the course as the course progressed.

2. Plan to finish the course mid-afternoon on day two. We would then take the delegates through the instructors' slides and reinforce learning from the course.

8. INSTRUCTORS' PTC COURSE

The pre and post course test paper results are below:

	CORRECT	1		2		3		4		No Incorrect	
Question No		**Pre**	Post	**Pre**	Post	**Pre**	Post	**Pre**	Post	Pre	Post
1	B	**E**	B	**D**	B	**E**	B	**D**	B	4	0
2	D	**D**	D	**D**	D	**E**	D	**D**	D	1	0
3	A	**A**	A	**A**	A	**A**	A	**A**	A	0	0
4	C	**C**	C	**C**	C	**C**	C	**C**	C	0	0
5	D	**C**	D	**C**	D	**D**	D	**C**	C	3	1
6	B	**B**	B	**B**	B	**B**	B	**B**	B	0	0
7	A	**A**	A	**A**	A	**A**	A	**A**	A	0	0
8	A	**A**	A	**D**	A	**A**	A	**D**	A	2	0
9	D	**D**	D	**E**	E	**D**	D	**C**	C	2	2
10	A	**D**	A	**D**	D	**A**	A	**A**	A	2	1

11	D	**D**	D	**A**	D	**D**	D	**D**	D	1	0
12	A	**A**	A	**A**	A	**A**	A	**A**	A	0	0
13	E	**D**	E	**C**	E	**E**	E	**E**	E	2	0
14	D	**E**	D	**E**	B	**D**	D	**D**	D	2	1
15	B	**B**	B	**D**	B	**B**	B	**B**	B	1	0
16	C	**E**	C	**D**	D	**C**	C	**C**	C	2	1
17	A	**A**	A	**A**	A	**A**	A	**A**	A	0	0
18	A	**A**	A	**D**	D	**A**	C	**A**	A	1	2
19	A	**A**	A	**E**	E	**A**	A	**E**	E	2	2
20	D	**D**	D	**D**	D	**D**	D	**D**	D	0	0
21	B	**B**	B	**D**	B	**B**	B	**A**	B	2	0
22	C	**C**	E	**C**	B	**E**	C	**D**	E	2	3
23	B	**A**	A	**C**	D	**A**	A	**D**	A	4	4
24	B	**B**	B	**B**	B	**B**	B	**B**	B	0	0
25	B	**B**	B	**A**	B	**B**	B	**A**	A	2	1
26	C	**D**	C	**B**	C	**C**	C	**C**	C	2	0
27	C	**D**	C	**C**	C	**C**	C	**B**	B	2	1
28	C	**C**	C	**B**	A	**E**	C	**C**	C	2	1
29	B	**B**	A	**A**	B	**B**	B	**B**	B	1	1
30	B	**B**	B	**B**	B	**B**	B	**B**	A	0	1
X/30		**21**	27	**12**	22	**25**	28	**19**	22	42	22
%		**70**	90	**40**	73	**83**	93	**63**	73		

These show a significant improvement in the delegates' knowledge. This was also demonstrated in the discussion and role plays that took place and also by the evaluation forms.

Given the small number of delegates, there was a lot of interaction between them and the faculty, frequently leading to highly effective discussions on each topic. We supplemented the slides with some pictures taken on our arrival in the hospital and a small number of case histories from hospitals throughout Uganda.

9. TRAIN THE TRAINER

This was short – two hours, but effective, with obvious engagement from the delegates. This was demonstrated when they ran their own programme the next day, see below. All course slides where shown.

10. HOSPITAL PTC COURSE

This was run by the team we had taught on days one and two. The UK faculty had emphasised that courses should start on time and that the teaching team need to be prepared. We had demonstrated this in our own teaching.

The faculty team where ready in time and the delegates where all prompt to arrive. It must be noted that the number of delegates was to be commended given the short notice. Attendance on both days was 100%.

The UK team took an advisory role largely guiding on timings and making suggestions as to how to run rotating discussion groups and scenarios effectively. We would take part in the first of these sessions and then withdraw and watch and advise from a distance.

The Ugandan faculty team had a wide range of experience including a senior surgeon and anaesthetist.

There were 15 delegates with a range of experiences. The two senior nursing officers had worked with Aid Agencies and had seen some significant trauma due to the terror campaigns led by the Lord's Resistance Army. The course was a success based on the evaluation data and written feedback

11. POST COURSE EVALUATIONS

Clinical

How confident do you feel in managing:

		AVERAGE
A	5 yr old child with # pelvis	4.7
B	30 yr old pregnant female with # femur	4.7
C	25 yr male with knife in abdo	3.9
D	60 y female with 40% burns	4.5
E	50 yr old male unconscious with fixed dilated pupil	4.2
F	20 yr male conscious but cannot move legs	4.7
G	2 year old child with major haemorrhage due to traumatic amp of leg	4.5
H	50 yr old male cyanosed with tension pneumothorax	4.4

Course Feedback Questionnaire

DAY 1	AVERAGE
Local trauma perspective	4.5
The ABCDE of trauma and Primary Survey	4.8

Airway and breathing	4.7
Circulation and shock	4.7
Skill stations	4.5
Secondary Survey	4.7
Demonstration scenario by instructors	5.0
Scenarios Practice	4.5
Chest trauma	4.5
AVERAGE	**4.6**
DAY 2	**AVERAGE**
Head trauma	4.7
Spinal trauma	4.5
Abdominal trauma	4.8
Limb trauma	4.8
Trauma in children	4.5
Trauma in pregnancy	4.2
Burns	4.4
Workshops	4.5
Disaster management	4.4
Scenarios practice day 2	4.7
Multiple Choice Questionnaire	3.8
AVERAGE	**4.5**

It was very encouraging to see the quality of the teaching and how the Ugandan team had distributed lectures to play to their strengths. Likewise they made exceptionally good use of alternative resources such as the flip chart and encouraged discussion extremely well and effectively.

There was genuine and lively interaction and debate between the delegates and the Ugandan faculty with a real desire to improve the service they give. The UK faculty contributed as required – specifically AK in terms of limb trauma management and major disasters, TG in terms of managing raised ICP and head injuries and TB in facilitating discussions on how to improve the facilities in the hospital with regard to trauma care.

We discussed training other people in the hospital and in other areas including the community. This was a positive, practical and realistic final session.

12. DISCUSSION

The course trained all attendees on both courses very effectively. This is borne out by the pre and post course MCQ data and the evaluations. It was also evident in terms of watching and listening to the delegates. In that sense the course was of great benefit to all and the UK faculty team where very pleased and proud to have been a part of this.

The visit to the hospital on arrival was of great benefit, it showed we were very keen to understand their world and challenges and should be regarded as a standard part of these courses wherever possible.

Looking through the results there is some discussion to be had as to the difference in scores between the doctors and some of the nurses. What each speciality would or would not do in terms of treatment in a trauma situation is unlikely to be the same. This can make practical teaching scenarios challenging in terms of ensuring quality long term learning outcomes and making sure the teaching is appropriate to all in a mixed group. It is a difficult balance as one wants to encourage a multi-disciplinary approach by having mixed groups and there is also the middle and vital grade of Clinical Officer to consider plus the numbers in each group needs to be balanced.

Of course, however the teaching is done it does raise awareness of trauma management and a much more informed knowledge to all of what everyone is trying to achieve in terms of improving the treatment of the trauma patient, even if not everyone is likely to be directly involved. It is recognised that it is a team effort and raised awareness is to be recommended particularly in terms of hospital buy in to change.

Teaching in this forum can never be an exact science and undoubtedly our participants came away with a much greater understanding of trauma management at both a practical and theoretical level which was the objective. It is, however, worth considering this comment from the evaluations: *“Maybe simplicity, a little more the tests for non-doctors as they never really studied in depth the anatomy, physiology and surgery so they don’t really understand a lot of medical jargon. “*

Finally, with talk of rolling out to differing less experienced specialities and the PTC protocol of not changing slides / removing slides I / we wonder how this is going to be achieved as policeman and basic pre-hospital care does not need a lot of the material that a PTC programme uses.

13. ISSUES RAISED

1. The issue of in-country faculty costs has recently been dealt with by NR. This is excellent news as having Ugandan national representatives of PTC on a given programme is very important.

2. If the training is to be given to less experienced / qualified specialities such as police and ambulance personnel then many of the slides could be removed which is against PTC protocols.

3. There seemed to be confusion as to what would happen to the training equipment. I was under the impression it was only being released for the scheduled PTC courses over the next two years. This seems to be against the spirit of rolling out the training and I think some clarification needs to be made. In exploring this with EM and AB they agreed it should be made available. I did not sense a strategy to do this and I am, for example, not sure that Soroti will be planning to roll it out beyond their hospital, largely due to manpower issues. We passed several hospitals driving back, all of whom would, I am sure, benefit.

   I feel this is an in-country PTC issue to instigate but UK encouragement would be beneficial. It was agreed in conversations with EM and AB that the teaching equipment would be made available. It is a great resource that should be used more.

4. There was an issue with payment at the hotel in Soroti due to the transferred money taking a very long time to arrive. TB paid the money, but it would be worth exploring a more effective way of doing this in the future; for instance transferring over a lump sum to a PTCF or COSECSA bank account so it is always available in-country.

5. A visit to the local hospital prior to the start of the course is very highly recommended wherever possible. This to develop relationships and to get a feel for the local working conditions and pressures.

14. ACKNOWLEDGEMENTS

Many people helped make this course happen the way it did, but I would like to specifically thank my two UK colleagues Tamsin Gregory and Andy Kent for their support, enthusiasm, insight and wisdom. They were a dream team and I could not have asked for two better people to teach and represent the PTCF.

APPENDIX 1

INSTRUCTORS' COURSE ATTENDEES

Adengo Hannington	Senior Anaesthetic officer
Epodoi Joseph	Consultant Surgeon
Opero Alfred	Medical officer
Otyaluk Patrick	Orthopaedic officer

COURSE ATTENDEES

Adakun, Moses	Intern Doctor
Mboizi, Vincent	Intern Doctor
Okello, Nelson	Intern Doctor
Kisaka, Audrey Marian	Intern Doctor
Auma, Edna	Intern Doctor
Matoyu, Paul	Intern Doctor
Ochodomine, Domson	Enrolled Nurse
Alezuyo, Dinah	Registered Nurse
Guto, Oliver	Registered Nurse
Akello, Florence Collins	Senior Nursing Officer
Asano, Rose	Registered Nurse
Elwange, James	Senior Orthopaedic Officer
Ediau, Silver	Enrolled Nurse
Apolot Eyapu, Beatrice	Registered Nurse
Akello, Peggy Grace	Nursing Officer

APPENDIX 2

EVALUATION COMMENTS

What is the most useful thing you have learned on this course?

1. ABCDE in order
2. Organized and systematic approach to trauma patients
3. Whenever I receive a trauma victim I should use ABC and very quick.
4. To be systematic and organized while dealing with trauma cases.
5. Including stabilisation of the cervical vertebra in airway management.
6. To never forget ABCDE in any trauma patient.
7. How to insert a chest drain.
8. The ABCDE basic principles.
9. The technique of managing airway obstruction.
10. Proper management using ABCDE approach.
11. Management of traumatic patient using PTC method.
12. Management of all trauma patients in a short time.
13. The most is the use of ABCDE assessment.
14. A systematic and easy-to-remember way of providing primary trauma care to a patient.

What two things do you plan to change in your trauma management as a result of this course?

1. a) I plan to be systematic b) I'll be more confident as I receive even badly injured patients.
2. a) To keep the patient breathing before doctor arrival b) Avoid further shock, resuscitate and keep reassessing.
3. a) Communication while managing trauma patients b) Follow the ABCD and the next come after.
4. a) Log roll of patients b) More equipment to the casualty unit.
5. a) Application of skills learnt b) Working in A TEAM.
6. a) Ensuring the stability of cervical spine b) Intubation during primary survey.
7. a) The approach to first contact with a client with trauma.
8. a) Always stabilise my patient's spine in case of trauma b) To always use triage in case of mass casualty.
9. a) In primary survey, cervical stabilisations should always be included in airway management b) In pelvis fractures, pelvis stabilisation can easily be done with a piece of cloth tied around it.
10. a) Be organised b) Triage and always use primary survey.
11. a) Use ABCDE b) Be very fast and systematic/organized.

12. a) Improvement in the time required to prevent death from airway breathing and circulation b) Being organised in the patients' assessment and management.
13. a) Become more organised and systematic in handling trauma patients.

Thinking about the last trauma case that worried you (described in the pre-course questionnaire at the beginning of this course) would you change anything in your management? Please explain.

1. Ensure that I take more interest in the primary survey and get other members involved when I am sure the patient is stable.
2. Yes, I have realised that life of a trauma patient can be saved by simple manoeuvres such as chin lift and jaw thrust, may not necessarily require surgical and/or sophisticated management. One only needs to be organised and systematic in the approach and management of the victim
3. Apply ABCDE principles and act very fast.
4. Yes, I would, because triage would have been a very useful aspect of management.
5. Yes I would, emphasis on a segmental approach; primary survey-ABCDE, then the secondary survey- head to toe assessment, if the patient becomes unstable, start all over from primary survey.
6. 1) Secure a better cervical spine collar if the first collar put was unstable, insert an airway (patient had mixed breathing) 2) Give oxygen 3) To do a proper secondary survey (examine from head to toe)
7. Yes, having acquired the skills of assessing patients (ABCDE) I will be in a position to avoid the possible cause of death (airway obstruction)
8. Yes because I now have the knowledge and able to do better.
9. I would triage, then systematically manage the patients from P1 to P3 patients, also there was a patient I tried to help yet I knew she was too far gone and indeed she died, next time I'll accept things as they are and not waste time on patients when I see no hope.

What was the best part of the course?

1. Everything.
2. The ABCDE of trauma and primary survey.
3. Scenarios practice.
4. ABC management.
5. ABCDE approach.
6. Skill in log rolling.
7. Scenarios practice.
8. Scenario practice.
9. Airway management.
10. Scenarios practice.
11. Scenarios.
12. The course was really interactive and hence very interesting.
13. The scenarios.

What would you change?

1. Increase on group work/discussion and presentation.
2. Nothing because even the time management was up to date.
3. Time management.

- Preach the gospel of PTC.
- Invite more people to attend especially the non-medical staff.
- The approach to the first care to the client with trauma.
- Demand for equipment to make it possible to practice.
- Nothing (x3)
- I will not wait for the doctor but I have to keep the patient alive and breathing.
- Maybe simplicity, a little more the tests for non-doctors as they never really studied in depth the anatomy, physiology and surgery so they don't really understand a lot of medical jargon.

COSECSA Oxford Orthopaedic Link (COOL)

This Primary Trauma Care course is part of a project funded through the Health Partnership Scheme, which is funded by the UK Department for International Development (DFID) for the benefit of the UK and partner country health sectors and managed by the Tropical Health Education Trust (THET). The project is called the COSECSA Oxford Orthopaedic Link (COOL). More information is available at www.ndorms.ox.ac.uk/cool.php