Communication and Liaison with Major Trauma Patients and Next of Kin

(Reviewed September 2016)

Background:

Major trauma is a sudden and life-changing injury that can have a devastating effect on patients, their families and friends. The development of major trauma networks has significantly improved care for these patients but has required patients and relatives to travel relatively long distances, sometimes to unfamiliar towns or cities, to receive care in a Major Trauma Centre. Major trauma has an impact on patient's lives, not just their physical wellbeing but also major psychological, social and financial impacts. It has become increasingly clear that recovery from severe injury requires coordinated care: early rehabilitation and good communication that addresses all of these facets is a key factor.

Included Patients:

All patients suffering major trauma and treated in a Major Trauma Centre.

Standards for practice audit:

1. The patient and their relative/carer must have a named nurse or Allied Health Professional who coordinates the care pathway and is responsible for communication and liaison. They should be identified to the patient and their relative/carer within 12 hours of admission.
2. The patient and relative/carer must be provided with written information on hospital services including visiting hours, parking, where to eat, where to take a break or go for a walk, rest areas, in-house and local hotel services and religious support. If requested, additional information on travel expenses from social services must be available.
3. There should be a dedicated telephone contact for relatives and carers that must be provided as soon as possible and no longer than 12 hours after the relatives or carers have been identified and contacted.
4. The dedicated phone number should be available 7 days per week during normal working hours, with a ward contact number and message service at other times.
5. All patients and careers should expect at least one face-to-face meeting with the Major Trauma or Rehabilitation Coordinator.
6. Changes in planned treatment must be communicated clearly to patients and relatives.
7. Throughout the hospital stay, the patient and their relative/carer must be provided with information about the patient's treatment and care pathway in a medium that they can understand and assimilate. These discussions must be recorded in the patient's records.
8. Plans for repatriation or discharge must be discussed and agreed with the patient and their relative/carer. All this must be recorded in the nursing or medical records.
9. Patients and carers should be provided with written or electronic information in preparation for discharge. Information should include medication, what to expect for the first few days, pain control, diet, bowels, dealing with stress, wound care, General Practice services and key contact numbers.

10. On discharge home or repatriation, patients should be provided with a contact number to obtain additional advice.
11. At the time of discharge or transfer from the Major Trauma Centre, the patient, relative/carer, general practitioner and any receiving hospital should be provided with a written summary of their injuries, operations, proposed rehabilitation and any outpatient follow-up appointments.
12. All patients should be contacted by telephone within 14 days of discharge to discuss their progress and on-going physical, psychological and social needs. Issues identified must be communicated with their general practitioner.