



BRITISH ORTHOPAEDIC ASSOCIATION AUDIT STANDARD for TRAUMA (BOAST)

August 2016

BOAST 13: REHABILITATION AND COMMUNICATION WITH TRAUMA PATIENTS

Background and Justification:

Rehabilitation is the process of restoration of a patient to their pre-injury state. A rehabilitation Prescription starts by identifying the components of the injury and the interventions required. These interventions may include acute management, surgery and therapies. Trauma can be a sudden and life changing event that may have a devastating effect on patients, their families and friends. Since the advent of trauma networks, the most appropriate care may require transfer and treatment away from the nearest hospital. It is recognised that recovery from injury requires multidisciplinary coordinated care including good communication and rehabilitation from the time of injury.

Included Patients: All patients admitted to hospital after trauma.

Standards for practice audit:

1. A rehabilitation prescription should be initiated within 24 hours of admission and would be anticipated to evolve.
2. A rehabilitation prescription should be standardised to include information such as diagnosis, treatment, management plan, transfer/discharge plan, medication, thromboprophylaxis, expected goals, therapy requirements, out-patient visits, wound care and referral for further care (including psychological support).
3. The rehabilitation prescription should accompany the patient on transfer or discharge. In addition when inter-hospital transfer occurs, there must be documented liaison between trauma coordinators and treating specialty teams.
4. The patient's management plan, and any changes to this, should be communicated to the patient and relatives/carers in a timely fashion.
5. Each unit should have a designated coordinator, who is responsible for communication and liaison. This person should be identified to the patient and or relatives/carers, within 12 hours of admission.
6. Within 24 hours of admission there should be a written summary which gives the diagnosis, management plan and expected outcome, aimed at the GP but written in plain English, understandable by patients and carers, and available in the patients records.
7. Issues with regard to safeguarding, comorbidities, falls risk and future bone health should be addressed.
8. After major trauma, all patients and carers should have at least one face-to-face meeting with the Major Trauma Coordinator.
9. Written information should be provided about ward and hospital services, including visiting hours, parking, where to eat, rest areas, in-house and local hotel services and religious support. If requested, additional information on travel expenses from social services must be available.
10. Patients should be given advice on when they would be expecting to return to previous function, including employment, driving and recreational activities.
11. There should be a contact number made available if there are further queries.
12. All healthcare practitioners must have access to all records to ensure consistent information is provided, respecting patient confidentiality at all times.
13. A system should be in place to identify and contact patients with complex needs, 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.

Evidence base:

Consensus statement based upon the views of patients, families and carers plus professional guidelines for doctors and nurses.

www.nice.org.uk/guidance/ng40