

The patient experience of trauma care: a triangulation of perspectives

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Background

- ▶ MTS began in 2010 and introduced a regional trauma system to the midland region
- ▶ It incorporates a trauma registry that is data rich with information about processes within hospital and pre hospital
- ▶ The registry informs reviews of these processes and guides subsequent policy/guideline development
- ▶ The registry's endpoint is patient discharge from hospital
- ▶ As a result of the MTS, we've seen mortality reduction within the midland region since its commencement and thus survivors of serious injury have increased

- ▶ *MTS-midland trauma system



Background continued

- ▶ Last year 6720 admissions across Midland hospitals at an estimated cost of \$48 Million
- ▶ 2358 admissions at Waikato hospital alone
- ▶ Questions arise:
- ▶ What happened to these patients?
- ▶ How well did discharge supports set up by the DHB work?
- ▶ What aren't we aware of?
- ▶ Should our management end at patient discharge or should we be including longitudinal follow up of our trauma patients?



What we know

- ▶ Trauma is one of the highest contributors to mortality, morbidity and disability across all age ranges as per the Global Burden of Disease studies done in 1990 and 2000
- ▶ Trauma systems work by being able to prove mortality reduction and consequently patient survival post serious injury
- ▶ Patient recovery is individual-not everyone will have the same recovery trajectory

Literature overview- what we know from the literature

- ▶ The acute phase-homeostasis breaches (pain, injuries), uncertain future, communication, expectations, physical limitations, chaos (real vs not [memory]), tangible costs (property, income loss), inward reflection (blame/remorse/regret)
- ▶ The injury negotiation phase-social isolation, family impacts (child care/loss of earnings/transport), rehabilitation access, longer term physical limitations, concomitant disease (infection), psychological effects (stress/anxiety/PTSD), behavioural changes (negative coping mechanisms), carer consequences, loss of former life, school/study impacts
- ▶ The recovery/reconciliation phase-fear, financial impacts, new life adjustment, carer fatigue, secondary condition development (osteoarthritis)



What we don't know

- ▶ With mortality reduction, are patients potentially living with long term injury impacts and if so what are they? Are they different for the survivor and family member?
- ▶ What are the commonly perceived barriers to recovery after serious injury?
- ▶ What are we doing well? What else should we be doing?
- ▶ Does recovery after serious injury have similarities to chronic illness?
- ▶ Are we (DHB's, compensatory agencies, primary health care providers) working in silo's in our care delivery of patients with serious injury?
- ▶ What are the rates and patterns of recovery and how do these change over time?



Aim

- ▶ To explore the experience of trauma care from the perspectives of injured patients, their KSP and service providers to identify factors that impeded or facilitated recovery in order to improve service delivery.
- ▶ Future aim is to expand and replicate this study within all 5 DHB's of the Midland region +/- nationally



Methodology

- ▶ Use of MTS trauma registry (population based registry) to generate suitable patient candidates based on an eligibility criteria (≥ 16 yrs age, iss ≥ 8 , no tbi [AIS body region 1], blunt trauma only, Waikato DHB care provider, Waikato domicile patient).
- ▶ Sampling will be purposive to ensure maximum variation of the seriously injured patient within age ranges, ethnicities, gender, rural/urban demographic. 4 time periods post discharge (within 1 month, 6 months, 12 months, 24 months).
- ▶ The patient's will nominate a KSP and service provider at initial contact to be interviewed also (same question set).
- ▶ Patient experience data will be captured through phone or face to face interviews.
- ▶ The patients, KSP, service provider will be encouraged to speak freely about their experiences and perceptions through the use of individual interviews rather than focus groups.



Methodology continued

- ▶ Interviews will be recorded (with participants' permission)
- ▶ Transcription is done by external source (confidentiality agreement)
- ▶ Once transcription is complete, all identifiable data is removed and replaced with a code number
- ▶ Transcriptions will be uploaded to NVIVO where inductive thematic analysis will be implemented by the researcher
- ▶ Key themes will be identified and grouped as appropriate
- ▶ There is a distressed patient protocol

Timeframe

- ▶ Project to run September-December 2017
- ▶ September-literature search, identification of possible codes for transcription analysis, HDEC approval, patient identification through the MTS registry, purposive sampling, patient engagement, interview commencement, article writing commencement
- ▶ October-interviews continue, interview transcription, codes/themes identified with NVIVO, literature search, article writing continues
- ▶ November-ongoing thematic analysis, codes/themes checked by 2nd researcher for rigour, article writing continues, report for stakeholders
- ▶ December-final project completion, article ready for journal submission



Project end

- ▶ Improved understanding of the quality of survival of patients with serious injury up to 2 years post event
- ▶ Be able to identify recovery patterns and timeframes to inform healthcare, social, and disability service provision.
- ▶ Be able to identify the impact upon the patient's key support people
- ▶ Ascertain if this study can be feasibly replicated across the Midland region
- ▶ Will take back key learnings to my own practice as a Trauma CNS
- ▶ Will share learnings within clinical teams in the Midland regions' Trauma Services

