





**NI Major Trauma Network
Referral and Reverse Referral Pathway
“Right patient, right place at the right time”**

1. Aims

- a) To ensure seriously injured patients are transferred as is appropriate throughout the network in order to maximise their chances of survival and a good recovery
- b) To ensure that once patients are ready for their ongoing care to be delivered within their home trust that they are transferred to the most appropriate provider within 48 hours
- c) To allow flow of patients throughout the whole system; to facilitate a ‘call and send’ policy at the MTC but also reverse referral to the home trust.

2. Principles

- a) Patients who require referral or reverse referral are identified and communicated through an identified contact so that a consultant to consultant decision can be made. Should there be difficulty identifying a receiving consultant or should there be clinical concerns further discussion should be facilitated by trust trauma leads and / or CD.
- b) Communication between units must ensure adequate documentation and imaging is delivered to allow safe transfer, as in keeping with GAIN guidance.
- c) Reverse Transfer of a patient to their home trust to continue rehabilitation following specialist care should occur within 48 hours of the decision to transfer. As much prior notice as possible is desirable, particularly in cases where there may be complex community / social care needs.
- d) Reverse Transfer should include a clinical plan but also include a clear pathway for timely specialty advice at the MTC should it be necessary.
- e) The concept of reverse referral has been agreed at inter trust Chief Executive level and is essential in allowing systems flow. Every effort should be made to facilitate transfer despite bed pressures. Should there be a delay in this regard then a senior management plan should facilitate transfer as soon as possible.

3. Interaction of ED's with in the network.

- a) The MTC ED will accept all referrals of severely injured patients who are in need of MTC intervention (As defined by the Major Trauma Triage Tool) within the acute period.
- b) The decision to go directly or transfer to MTC will rest with NIAS / HEMS / Local Emergency Hospital senior doctor. Where possible consultant to consultant referral should be made.

- c) On occasion certain patients with a single system injury, who are stable and/or are patients for whom immediate transfer was not clinically necessary, may be admitted directly to a specialty unit in the MTC rather than through its ED.
- d) Acute patient transfers should be made as soon as possible to the RVH ED resuscitation room
- e) There should be direct communication with the MTC ED Trauma Consultant, this should be considered for information only and not for acceptance of referral.
- f) Liaison with RVH/RBHSC specialties should be made from RVH/RBHSC ED's via the Trauma Team. Where time permits and transfer delay is avoided local hospitals should also inform specialties.
- g) Documentation and imaging should accompany the patients as per GAIN guidance.
- h) Local Trusts should have simple pathways in place to allow handover of outpatients to be reviewed locally following discharge from at the MTC. This may include fracture clinic appointments or planned in patient care.

4. Notes.

¹ Damage control surgery

- Damage control surgery, along with permissive hypotension and hemostatic resuscitation, is integral to the concept of damage control resuscitation
- Damage control surgery involves limited surgical interventions to control haemorrhage and minimize contamination until the patient has sufficient physiological reserve to undergo definitive interventions
- This strategy was derived from military experience and is now increasingly adopted into civilian trauma management
- Management of the metabolic derangement of ongoing bleeding supersedes the need for definitive surgery
- Abbreviated operations that control haemorrhage and contain spillage from the alimentary and urogenital tracts
- Rapid transfer to ICU for correction of acidosis, coagulopathy and hypothermia (ongoing haemostatic resuscitation)
- Definitive operation is deferred
- These operations tend to have a high complication rate
- Survival is given preference over morbidity