**NMTRG Guidelines for the assessment and rehabilitation of the Major Trauma patient**

| **Discipline: Occupational Therapy** |
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| **Guideline: Management of Chest Trauma** |
| **The Occupational Therapist should have working knowledge of;**   * The Respiratory System * Anatomy of the Chest * Connective Tissues, Muscles and Innervation of the chest * Common injuries and the clinical significance, including the difference between blunt and penetrating mechanisms * Additional complexity of a patient with polytrauma and comorbidities * Medical management, surgical vs conservative approaches and common procedures. * Post operative precautions/complications eg. weight bearing status, wound care, chest drains, epidurals, PCAs, infections, delirium * Anticipated trajectory of recovery and expected return to normal function * Immediate implications for inpatient Occupational Therapy Assessment and rehab. * Longer term implications of injury, recover and impact on quality of life |
| **The Occupational Therapist should be able to recognise;**   * Impact of chest trauma upon respiratory function and functional performance * Impact of pain upon planned interventions, importance of pain assessment and regular pain relief. * Impact of chest trauma upon overall mobility and overall functional performance * Early signs of complications with chest drains, epidurals and of a deteriorating patient, checking for vital signs and escalating concerns. * Symptoms of delirium and possible causes, liaising with the medical team regarding the best management strategies. * Signs of low mood, anxiety or poor motivation that may impact on engagement with therapists and rehab. |
| **The Occupational Therapist should be able to offer the following interventions:**   * Comprehensive initial assessment of:   - Social circumstances e.g. home set up, any previous aids/ adaptations, family/ support network.  - Usual level of independence with daily activities e.g. mobility & transfers, self-care & domestic tasks, hobbies, employment, driving.  - Emotional wellbeing in the aftermath of traumatic injury.  - Significant past medical history including any previous issues with cognition, perception, mental health etc.  ● Functional assessment e.g. mobility, transfers, washing and dressing. Advise safe techniques for movement following any post-op precautions or weight bearing status.  ● Use of most beneficial approaches to each patient e.g. compensatory vs rehabilitative.  ● Include patient in discussions of therapy interventions, gaining consent and assessing mental capacity in relation to Occupational Therapy intervention.  ● Design and facilitate a goal orientated rehabilitative program targeting identified functional impairments to promote independence and enable timely discharge from hospital.  ● Assess for and provide adaptive equipment to promote independence at home and reduce risk of further injury or health deterioration.  ● Provide recommendations for support needs at home.  ● Provide education and training for patient and caregivers, for example:  - Fatigue and energy conservation strategies.  - Returning to extended activities of daily living including employment, driving, leisure activities and carer responsibilities.  ● Monitor emotional wellbeing throughout recovery and provide anxiety management education and advice.  ● Promote self-confidence and monitor adjustment to life changing injury e.g. body image, scar management  ● Liaising and joint working with MDT colleagues e.g. other therapists, specialist nurses, surgeons.  ● Onward referral to reablement/ community services with view to return to baseline level of function.  ● A rehabilitation prescription must be started within 72hrs of admission and issued to the patient at the point of discharge from acute therapy services. The rehab prescription must also be provided to all next care providers including the GP. |
| **The Occupational Therapist is expected to complete this assessment and intervention:**  ● A comprehensive Occupational Therapy assessment should take place for any patient who presents with an identified functional impairment that impacts on rehab, recovery and timely discharge from hospital.  ● Referrals can be made by any member of the MDT to Occupational Therapy, all referrals should be considered on a case by case basis.  ● Occupational Therapy intervention should begin early e.g. in the critical care setting.  ● The patient should be reviewed by the Occupational Therapy team on a daily basis, as determined by patient need.  ● Occupational Therapy should be available 7 days per week in the acute setting.  ● Discharge planning should commence from day of initial assessment.  ● Occupational Therapist should advocate for MDT Trauma Clinic review of patient at 4 weeks post discharge if not at their functional baseline at point of discharge. This review can take place remotely via telephone clinic |
| **The Occupational Therapist should have knowledge of additional services including;**  ● Inpatient MDT e.g. specialist Occupational Therapy, Physiotherapy, SLT, discharge coordinators, specialist nurses, pain team, medical team.  ● Outpatient services e.g. MDT Trauma Clinic, fracture clinic, psychology & psychiatric services, wheelchair services.  ● Charitable organisations e.g. peer support, violence reduction, victim support, youth violence support, ex-service personnel support, Age Concern.  ● Legal advice e.g. personal or criminal injury claims. |
| **The Occupational Therapist understands how to access the following pathways;**  ● Community MDT therapy services e.g. Occupational Therapy, Physiotherapy, falls teams.  ● Social services and local authority teams e.g. reablement services.  ● Outpatient services e.g. MDT Trauma Clinic, wheelchair services, hand therapy. |
| **If required the patient has access to:**   * Community Rehab * Vocational Rehab * MSK Outpatient Services within two weeks of discharge * Psychological support/ Mental Health |

| **Consideration for long term term rehabilitation:**   * Vocational Rehab * Support groups * Research groups |
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