Acknowedgement

It was not a matter of scientific curiosity. It was a need to deepen our understanding of human suffer. We wanted to know more about life after a severe road traffic injury. We urged to know more about the human needs and the challenges. We monitored people for one year upon their consent and generated up-to-date evidence on the long term burden resulting from their injury. We recorded the post-traumatic difficulties in daily life due to physical disability, psychological distress and economical burden. We translated this evidence into suggestions for action and policy recommendations. We hope that they will be respected by policy makers in Europe. We ought this endeavor to road traffic victims and we are very grateful to each one of them for sharing their experiences and concerns. We hope that this effort will be the beginning of action and improvement in peoples' lives.

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REHABIL-AID

Recommendations for Policy and Action

Based on face-to-face interviews with people sustaining severe injuries in road traffic crashes in three European countries

RECOMMENDATIONS

Trauma care systems at regional level

–> It is necessary to set up trauma care systems at regional level encompassing all phases of care, from pre-hospital care to acute care and rehabilitation. Successful trauma care systems need good coordination between all components of trauma care, dissemination at the grass-roots level, enactment of the guidelines in national policies, and constant monitoring and evaluation.

Trauma registry / injury surveillance

–> It is essential to develop a common electronically operated data collection form/tool, administered by health, social and mental health professionals, for the systematic collection of a set of data relevant to the physical and mental health condition of the victims of road traffic crashes as well as the various types of care offered to them from the moment of the injury until their return home as follows: a) pre-hospital care - the initial care at the scene of the accident, b) Acute care - the health, social and mental health care offered at the hospital, and, c) the rehabilitation. This tool will incorporate information collected by the police, the ambulatory staff, the medical doctors, nurses and social workers in charge of the patients in the various hospital departments and clinics, the health care practitioners offering help at the rehabilitation centre upon the patients discharge, the medical doctor and the nurse prescribing medicine and monitoring patients' health at the primary health care centre and the social worker and the nurse in charge of patients' monitoring and assistance at home. This tool will be useful in monitoring patients' health of time as well as the quantity, the quality, the effectiveness and the cost of care offered to the victims of road traffic crashes. This information will be used for health care planning at regional and national level and will be further available to the patient for personal use. This tool will facilitate easy and safe exchange of information among practitioners at various stages of care (primary, secondary, tertiary care) with a safer journey of the patients through the health and social care system and improved health outcomes.

Trauma teams in hospitals

–> Severely injured patients usually need a variety of health professionals thus a well-planned and organized response is fundamental to optimal management. This makes it necessary to set up trauma teams in hospitals to address the multiple needs of the such patients and achieve coordination among personnel. The exact composition of the trauma team may vary with local rules, conditions and staffing. However, pre-assigned roles for the members of the trauma team and collaborative practice protocols are necessary to assure efficient operation of the trauma team.

Common classification of injury

–> Description of injury is recorded in medical records unconditionally and this makes it difficult to identify injury patterns. Medical doctors should be trained to record injuries using common classification schemes of injury severity (e.g. AIS, ISS) to facilitate uniform data collection on injury and enable comparisons. This will further assist in identifying high risk patients based on their injury profile.

Screening and treatment of psychological distress in hospital

–> Given the psychological distress of severe injury and the high incidence of post-injury psychological problems, psychological counseling is essential at all hospital levels. This includes early detection of psychological distress through screening of patients sustaining severe injuries in road traffic crashes and providing appropriate treatment. It also includes assisting patients in psychological adjustment to their disabilities.

Undergraduate and continuing education on trauma care

–> There is a need to optimize the training of doctors and nurses and other key personnel in trauma care, especially in a core set of trauma-related skills that are needed and ideally in an interdisciplinary way. In rural areas training general practitioners and the primary care team on trauma care is important to manage primary health care preparedness. Continuing education for all practitioners involved in trauma care must be promoted to ensure updates to all practitioners, no matter what volume of trauma care they are handling.

Rehabilitation planning and evaluation

–> It is necessary to establish rehabilitation teams of health, social and mental care professionals (including physiatrists, physiotherapists, occupational therapists, social workers, health visitors, psychologists), operating at regional level with the mission to assess the rehabilitation needs of trauma patients, develop personalized rehabilitation plans and regularly evaluate the recovery process of trauma patients starting before their discharge from the hospital.

Resources for victims and their families

–> Given the high and long term physical and psychological burden of the victims, it is necessary to develop guidance for trauma patients and their families aiming at: a) informing them on common health and psychological outcomes of severe road traffic injuries, b) providing them with practical advice on how to early detect symptoms of low functionality and distress and how to cope with them, c) direct and guide them into a network of health, mental health and social care services. This material should be available to all citizens through the web (e.g. the website of the Ministry of Health) as well as in paper copies at the social services department of every public hospital and in other health care services.

Coordinated community response

–> Severely injured patients usually need a variety of services and most of the times it demands enormous effort to identify the appropriate services and navigate into beaureocratic procedures. Therefore, it is necessary to create a network of community services (e.g. health care centre, mental health services, social services, help at home units) for the victims of road traffic crashes, offering health and psychosocial support both to the victims and their families in the community as well as at home. This network of services should be coordinated by an agency acting as Focal Point, which will be appointed at community level to receive all newly discharged patients and direct them into the network. This network could be organized in every primary care area and could be administratively linked to the nearest hospital.

Counseling programs for the victims and their families

–> It is essential to develop community programs for the victims and their families to meet their needs in psychological, legal and social support. Such programs could be offered by mental health centers or social services operating in the community. Their main mission would be to empower them, teach them skills to manage psychological distress and early detect relapses, inform them about social benefits, legal rights and procedures.