Network(s)
Midlands Trauma Networks
Publication:
Document name: **MTC Major Trauma Patients for Continued Care Closer to Home Pathway**
Document purpose: This document contains the flowchart for Care Closer to Home Arrangements
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Target audience: Major Trauma Centres, Trauma Units, Local Emergency Hospital
Action required: Dissemination to MTC, TU, LEH personnel for action.
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Patient assessed as no longer requiring care within MTC but still requiring inpatient acute care in local TU.

Lead specialty team & rehabilitation coordinators identify most appropriate specialty within local TU & refer patient as follows:

- Consultant to consultant, or his/her deputy referral. *Clock starts regarding the 48 transfer time target following the first verbal conversation around the acceptance of the patient by the TU.*
- Followed by written referral sent by either secure email (preferably nhs.net) or secure safe-haven fax to the TU
- TU to acknowledge receipt of the referral
- Telephone call to TU coordinator
- Rehabilitation Prescription sent via secure email/fax

TU to contact MTC with details of the accepting ward.

MTC nursing team will provide:

- Verbal nursing handover
- Organise appropriate transport
- Ensure patient has copy of Rehabilitation Prescription & MTC Discharge Summary

Transfer of patient to TU within 48 hours

Failure to transfer within 48 hours:
Service Manager to be notified for escalation to
Chief Executives of MTC and TU