Intensive & Critical Care Nursing 54 (2019) 1–6

Contents lists available at ScienceDirect

Intensive & Critical Care Nursing

journal homepage: www.elsevier.com/iccn

Research Article

Experiences of suffering multiple trauma: A qualitative study

Linda Sandström*, Åsa Engström, Carina Nilsson, Päivi Juuso

Division of Nursing, Department of Health Science, Luleå University of Technology, Luleå, Sweden

ARTICLE INFO

Article history:
Received 17 January 2019
Revised 11 June 2019
Accepted 16 July 2019

Keywords:
Life change events
Multiple trauma
Patient care planning
Qualitative research
Recovery
Wounds and Injuries

ABSTRACT

Objectives: In an effort to strengthen health care professionals' ability to anticipate and address multiple trauma patients' needs, this study aims to explore the experience of suffering from multiple trauma.
Design: This is a qualitative descriptive study. Nine interviews were analysed using content analysis.
Setting: The study included patients who had been registered in the Swedish Intensive Care registry [SIR] due to suffering multiple trauma.
Findings: The analysis revealed one theme, A detour in life, based on three sub-themes: (a) Feeling lost and not knowing what to expect, (b) Striving to get life back on track and (c) Dealing with 'dead ends' during rehabilitation. The theme showed that those who suffered multiple trauma did not know what to expect of their recovery and they expressed experiencing a lack of understanding and guidance from healthcare professionals. As it was important to focus on the present and find ways to move on in life, they sought for other ways to find direction in matters of rehabilitation and care.
Conclusions: A shared understanding is essential in order to define a person's needs. By setting short-term goals and improving documentation, healthcare professionals across the trauma recovery continuum could more easily gain insight of their patients' needs and address them with supportive guidance.

Implications for Clinical Practice

- A shared understanding between the injured person and healthcare professionals is essential in identifying and addressing the patient's needs/problems.
- By setting short-term goals and improving documentation, healthcare professionals across the trauma continuum could more easily gain a shared understanding and be able to reassure and give guidance to patients through their recovery.
- Relatives can be a resource for the patient, and it is important to find ways to incorporate them.

Introduction

When one's life circumstances change rapidly, as due to physical trauma, it can have a drastic effect on everyday life. In addition to the potential physical limitations following a traumatic injury, studies show that the injured may also suffer from mental health problems, such as psychological distress (Aitken et al., 2014; Skogstad et al., 2014), anxiety, depression and post-traumatic stress disorder (Wiseman et al., 2013, 2015). Therefore, the focus during recovery from a physically traumatic injury needs to be on more than simply regaining one's physical abilities. Griffiths and Jordan (1998) suggest that a prerequisite for a successful recovery are feelings of being in control and content with one's life, regardless of potential physical impairments. Becoming injured has been described as the beginning of a clinical care continuum (Richmond and Aitken, 2011) and the start of a journey toward recovery for the survivor (Richmond et al., 2000). The starting phase of the journey, when the accident takes place, has been described as a time of chaos, where the injured is overwhelmed both physically and cognitively (Ogilvie et al., 2012) and struggles to make sense of the event (Gustafsson et al., 2001). This initial phase is followed by a phase where one gains awareness of the injuries and the effect they will have on one's life. They grieve

---

* Corresponding author at: Department of Health Science, Luleå University of Technology, SE 971 87 Luleå, Sweden.

E-mail address: linda.1.sandstrom@ltu.se (L. Sandström).

https://doi.org/10.1016/j.iccn.2019.07.006

the loss of their physical well-being and struggle with making comparisons to their former functioning (Ogilvie et al., 2012). At the same time they strive to overcome inactivity and feelings of being inferior due to disability (Gustafsson et al., 2001) as they try to create new daily routines (Franzén et al., 2006). The final phase of the journey toward recovery after becoming injured entails reconciling themselves with the injuries (Ogilvie et al., 2012). It starts when the physical injuries have evolved to a stage of stability and where the outcome of the injuries is relatively known. In this phase, the injured can find a way of living, a future, and ways to adapt to new conditions caused by the physical trauma (Tutton et al., 2012).

Previous research shows that people who become injured and are in need of care will encounter a variety of healthcare professionals, who, with their presence and actions, can support feelings of hope, thus facilitating an emotional and physical progression through recovery (Tutton et al., 2012; Warwick, 2012). Sandström et al. (2016) explored nurses' experiences of caring for trauma patients in an in-hospital setting. They found that trauma patients need time invested in them by healthcare professionals, as both they and their relatives initially are in a state of shock. Furthermore, Ringdal et al., 2008 hypothesise that healthcare professionals can influence the patients' memories of suffering a trauma as being either good or bad, which affects the patients' overall experience. According to Tutton et al. (2012) healthcare professionals' skills must encompass a holistic practice, which includes knowing the patient, their families, the nature of the injury and the process of recovery. Only then can they imbue the injured with realistic hopefulness that will enable them to manage their oscillation between feelings of hope and despair during the time that they are unsure of what the future holds for them. In addition, Richmond and Aitken (2011) stress the importance of integrated care across the whole of the trauma continuum, from the start of the care continuum to the post-discharge care, in order to enhance optimal long-term outcomes. Based on these insights, we understand that the encounter between trauma patients and healthcare professionals is of great importance for their recovery. Despite knowing this, research shows that there are patients who consider hospital care to be depersonalising and have an unfulfilled need for information regarding treatment and aftercare following injury (Sleney et al., 2014). Other studies show similar findings, that people injured in accidents feels abandoned by their caregivers when they return home (Ringdal et al., 2008) and that up to 42% of trauma patients do not know how or where to seek help to cope with negative emotions after their injury (Fakhry et al., 2017).

In summary, research demonstrates that recovery after trauma is complex and that it is important to minimise the risk for psychological and emotional distress and to ensure an optimal trauma care continuum for those who have suffered an accident. Several previous studies focus on the initial trauma treatment and nursing care (Granstrom et al., 2018; Morse and Proctor, 1998; Sandström et al., 2017). Increased knowledge of the way patients handle their recovery process is important in order to strengthen nurses' and other healthcare professional's ability to anticipate and address patients' needs and resources.

Methods

Objectives

The aim of this study was to explore experiences of suffering multiple trauma. With a qualitative approach, data were gathered by individual interviews and analysed using qualitative content analysis. The implementation of the study complied with the Standards for Reporting Qualitative Research: A Synthesis for Recommendations (O'Brien et al., 2014).

Settings

Participants were gathered by searching among patients registered in the Swedish intensive care registry [SIR] between November 2013 and February 2016 at a midsize hospital in northern Sweden.

Ethical approval

Before conducting the study, approval was obtained from the Ethical Review Board in Umeå, Sweden [Dnr 1828-13]. All participants gave their written consent, the majority by signing and returning an attached consent form and the rest by signing their consent in conjunction with the data collection (e.g., some wanted to be phoned and given further information before signing). At time of the data collection they were reminded of the voluntary nature of their participation and their right to withdraw at any time without further explanation, and that data were to be treated confidentially, meaning that no one other than the researchers would have knowledge of their identity.

Data collection

Inclusion criteria were: patients over the age of 18 and diagnosed with multiple trauma, which is, with two or more lesions in at least two different parts of the body caused by accidents where the injuries may affect one or more body systems and pose a risk individually or together constitute a life-threatening condition. All injuries were included, e.g. neurological, skeletal etc. A request letter was sent out to those who matched the criteria (n = 40). Nine agreed to participate in the study (three women and six men, aged 21–81) and were contacted by the first author (LS) in order to agree upon a time and place for an individual interview. The time from the accident in which the participants suffered multiple trauma and their interview ranged between 4 months and 2 years 11 months (see Table 1).

The first author (LS) gathered data by doing individual, semi-structured interviews in order to obtain rich interviews (Polit and Beck, 2008). An interview guide was used to ensure coverage of different aspects (see Table 2). During the interviews, participants were encouraged to reflect on their experiences of suffering a trauma. Probing questions were used to clarify experiences, thoughts and feelings concerning the accident, changes in daily life, perception of the care they received when hospitalised/care after discharge and views of their own needs and support in relation to the multiple trauma. The interviews lasted between 30–105 minutes.

Data analysis

Qualitative content analysis according to Graneheim and Lundman (2004) was used to analyse the transcribed interviews. Meaning units consisting of sentences or paragraphs that responded to the aim were extracted and then condensed, while preserving the core meaning. The condensed meaning units were sorted into sub-themes depending on their similarities or differences. A theme was then subsumed that represented the underlying meaning of the sub-themes. During the gathering of data and the analysis process, the first author (LS) had ongoing dialogues with the other authors to ensure focus on the aim of the study and a consistent judgment of data (cf. dependability). The findings are presented below with quotes that contextualise and illustrate the experiences of suffering multiple trauma.

Table 1
Participant demographics.

Length of hospital stay in conjunction with the multiple trauma	Type of injury	Surgery	Number of hospitals enrolled at in connection with trauma	Living situation at time of the interview	Occupation at time of the interview
17 days to 5.5 months	vehicle accidents (4)	67% (5) received surgery during initial care	One hospital (3)	Living alone (4)	Retired before the accident (2)
	falls (2)		Two hospitals (3)	Living with partner/ children (4)	100% sick leave (2)
	work-related (2)		Three hospitals (3)		≤50% sick leave (3)
	horse-riding accident (1)	44% (4) received surgery following discharge		Living with parents (1)	Working full time (2)

(The number of participants is stated in parentheses.)

Table 2
Interview guide.

Opening question
Can you please tell me about the accident?
Questions
How has it affected you?
What were your thoughts about the care you received?
(Pre-hospital, in-hospital, post-discharge)
What does participation mean to you? How was your participation made possible?
Probing questions
Can you tell me more?
What happened then?
How did it make you feel?

Findings

The theme, "A detour in life", describes experiences of suffering multiple trauma. After the injury, participants felt lost as they did not know what to expect of their recovery process. They expressed a lack of understanding and guidance from healthcare professionals. When becoming injured they were worried about the potential outcomes related to their accident and injury. At the same time, they felt they needed to put these worries aside and focus on living in the present and to move on in life. Suffering multiple trauma could entail a long period of recovery; a period that could be challenging, especially as they felt that their expectations of healthcare services were not being met. When this occurred, they sought other ways to find advice regarding rehabilitation and how to handle everyday life with their injuries.

The following three sub-themes constructed the overall theme (see Table 3):

Feeling lost and not knowing what to expect

After their accidents, the participants felt gratitude for the support of the healthcare system and the emergency care they received, as it was a matter of survival. They described meeting devoted practitioners. However, they also experienced flaws in the system. For example, sometimes they were placed in a ward 'because they had room'. This resulted in feelings of unfairness and distress, because, although the staff they met did their best, some experienced the care as insufficient and failing to meet their needs. Some expressed how their needs were not taken under proper consideration or addressed with actions, and they questioned the lack of shared understanding between themselves and the healthcare professionals who cared for them.

> *"They [healthcare professionals] weren't unpleasant or anything, perhaps they did the best they could, but…//… they sat down with me when I cried of pain and said "I'm sorry I can't help you", but of course they can…//… I had to demand an assessment from a specialist – should it be up to me?" (9).*

> *"They [healthcare professionals] said it would take time for me to come back to my previous state and that I needed a long hospital stay. Then suddenly without any dialogue whatsoever, they had planned [to send] me home. To a home undergoing renovations. I told them it wouldn't be possible to manage there, without toilet or anything" (2).*

The long-term outcome after suffering multiple trauma was unclear for most of them and they could merely hope for the best. Regarding conversations with caregivers about potential outcomes, the participants stressed the importance of achieving a shared understanding as they had experienced misinformation that had led them to have unrealistic expectations regarding their recovery. When they realised later that an outcome they were waiting for was never achievable, they felt foolish and naïve, and believed that if they had a better understanding they would also have been better prepared to cope with the consequences.

> *"I went around telling my friends that I would probably gain my sight back, as they [healthcare professionals] had told me that, but then I talked to a specialist a year later, who said; "Yeah, we knew this would happen"… It was pretty hard 'cause I had my hopes up" (1).*

Table 3
Sub-themes and theme.

Sub-themes	Theme
Feeling lost and not knowing what to expect *Striving to get life back on track* *Dealing with dead ends during rehabilitation*	A detour in life

Striving to get life back on track

After suffering multiple trauma, the participants recurrently had thoughts of 'what if' scenarios: "What if I had died? What if I had done something different? This might not have happened". Recognising that these agonising thoughts only consumed energy was a way to set them aside. At the same time, it could be hard not to think about the future and feel concerned or fretful over yet-unknown consequences of their injuries: whether they would regain their abilities to be able to continue working or engage in family and social activities as before the accident. Suffering multiple trauma made them more aware of their physical abilities, which post-injury often were more limited and weak. One person described how she felt like a 'porcelain doll', afraid of breaking even when doing ordinary things like walking outdoors as there was always a chance she might trip and fall. The participants acknowledged that their fear of suffering another accident or having injuries that deteriorated over time had to be overcome in order for them to resume a normal life.

> *"You still have to function normally… that's the most important for me… they don't count on that in the hospital. They just say, "Take it easy". But when you've been through an accident you need to do things that make you feel alive, not just live like "I barely survived"…" (1).*

The participants expressed how different setbacks (e.g., pain relapse, failing to reach rehabilitation goals) caused feelings of helplessness and resignation, which made them question if life would forever be limited due to factors such as pain, physical impairment or brain fatigue.

Despite these uncertainties of not knowing what the future would hold and having the path to recovery being full of setbacks, they still found the capacity to "go on". Bullheadedness was a trait they leaned on. It was indispensable to them when striving to reach rehabilitation goals and resuming their everyday life as these were time-consuming and long-term processes.

> *"I have to continue rehabilitation for another six months… before I can [know the outcome] – I'm not a person who wants to be home and I've been home for so damn long… so, I just hope I can be – train myself well enough so I can start working again, eventually… But everything is affected you know, even my sex life, you know, due to nerve problems in my legs…" (8)*

Dealing with 'dead ends' during rehabilitation

When returning home after suffering a multiple trauma some required home-care services, which for some was satisfying, while others felt it was insufficient. After hospital discharge, they could feel both confused and distressed, as they did not know whom to turn to with their questions regarding their rehabilitation and recovery. Seeking answers to these questions was challenging, as their efforts to come in contact with different caregivers could be time consuming and at times unachievable, which in turn made them feel both powerless and desperate.

> *"…nobody really cares about my hand, so to speak. I may have wished that they did. Because it was like [a problem]… it still kind of is…I can't write unhindered as I used to… and above all, I can't play guitar like I did." (3).*

When meeting new caregivers within primary health care or within secondary care follow-up, they faced a recurrent issue with inaccessible medical records. Because of that, they repeatedly needed to explain and emphasise their rehabilitation needs. Having to retell their story so frequently was experienced as emotionally exhausting.

> *"Thanks to being bull headed…and managing to endure calling again and again and again and again…then something happens [referral to another hospital for secondary surgery]. Otherwise nothing…It is frightening…" (7).*

They turned to friends and relatives who helped them in their correspondence with caregivers as some of them had professional experience in the healthcare system. They could help them explain or express their needs when trying to access different health care (e.g., second opinion, specialist care, rehabilitation measurements etc.). Some of those who suffered multiple trauma expressed how they needed to fight for care and that they felt they had to question care in order to be sure they received what was best for them. They were afraid that if they themselves did not push forward and demand care, the care they received would eventually decrease and become minimal support. One man expressed his frustration in the following way after unwillingly being moved to a primary care centre that lacked the right equipment for his physical rehabilitation, thus postponing his needed exercise:

> *"I feel like a disgrace to health care, being refereed to primary care …//…they don't understand what I need nor what I want…. //… I won't be better off sitting and waiting…" (6).*

Having a supporting family was important but could also lead to feelings of being a burden. When suffering multiple trauma, they became more aware and more in need of their relationships with family and friends. The support they received helped them continue with their lives, for which they felt a great gratitude.

> *"I would never have come this far [in my recovery] if I hadn't had my wife…//… the worst was when no one wanted to sign my sick leave. They said that "It's not on my table"… my wife called and cried to them, and it finally got a result…" (7).*

Discussion

The aim of the present study was to explore experiences of suffering multiple trauma and is illustrated by the theme "A detour in life". It shows that the participants had difficulties knowing what to expect from their recovery, but they hoped for the best and sought ways to continue with their lives. Participants felt they needed to question the care they received, or the lack of care, and were worried that if they did not do this the care would decrease and they would be left without support during their recovery.

The results in our study show that the time after injury was uncertain for the participants and led to feelings of being lost. There was an ambivalence between satisfaction with the received care and dissatisfaction related to not being taken seriously. Kellezi et al. (2015) highlight that, when suffering an injury, one's need for information changes over time. Aitken et al. (2016) describe that injured persons show an increasing recognition of the overall impact of the injury, both in general and in daily living, when comparing time prior to discharge and three months post-discharge. For example, they would re-evaluate which activities they found important and could have a more complex reasoning as to why they were important. This would imply that to increase healthcare professionals' ability to anticipate their patients' needs, they must acknowledge their life circumstances and their changing needs throughout the recovery process.

In our study, the findings illustrate how the participants strived to get life back on track, which we interpret as a search for normality, a way back to normal life from their injuries. Claydon, Robinson and Aldridge (2017) write that regaining a sense of normality after a major orthopaedic trauma entails measuring progress, restoring independence (achieving and performing tasks) and redefining oneself. They describe that redefining oneself, and to actually recover, was achieved when they were able to achieve and perform tasks with confidence and enjoyment. They further suggest that healthcare professionals can help those who have suffered an injury by reassuring them of their recovery by measuring progress of their ability over time. This would imply that, in the absence of knowing a definite outcome, it is important that healthcare professionals define goals for recovery from a more short-term perspective. Furthermore, both primary and secondary care should be designed to allow care to be continuously re-evaluated, as those who suffer multiple trauma need time to evaluate and comprehend the impact of their injuries so that healthcare professionals during this time can help reassure them of their abilities during their recovery process.

Our study results show that participants questioned whether there was a shared understanding between them and those who provided care for them, as they experienced that their needs were not taken under proper consideration. Butler, Derrett and Colhoun (2011) show that a vague diagnosis, or no diagnosis, following a serious injury potentially reduces legitimate access to both rehabilitation and the sick role, which may be one way of understanding our findings and that those who suffer multiple trauma may experience symptoms that initially are undiagnosed. Arman and Rehnsfeldt (2007) describe that "good care", and an alleviation of suffering, was experienced when the patient felt they had "been seen", meaning the patients were met in their understanding of life. They further mention that although caregivers aim to "see" the patient, the patient might not experience it, and that it may require "the little extra", an act of caring, which for example can be engaging in a matter that is of concern to the patient. We interpret that the doubt our participants had regarding a shared understanding is an expression of not "being seen", and that it can also be understood as a suffering caused by neglect. In order to "see", and to show an act of caring, we believe a fundamental prerequisite is that the healthcare professionals become familiar with the ways the patients experience their injuries and what impact they view it to have on their lives. Flink et al. (2015) explored patient handovers between primary and secondary care by assessing medical records. They describe that aspects of shared understanding entail the following: problem definition, goals of treatment/management, agreement on patient roles, and healthcare professionals' roles. In 98% of the records, they judged shared understanding to be poorly documented. Moreover, Larsson, Sahlsten, Segesten and Plos (2011) highlight insufficient documentation as a structural barrier that prohibits patient participation, while another structural barrier is constantly meeting new people. Care under such circumstances undermines the patients' opportunities to exert control and the possibility to influence their own care. In addition to this, the participants from our study felt that the process of repeatedly meeting new healthcare professionals to whom they needed to explain themselves yet again was exhausting. We therefore suggest that documentation regarding the patient's recovery process could benefit if aspects of shared understanding were included. The patients would possibly have greater influence on their own care, and healthcare professionals being better informed about the patients would more easily be able to measure the patients' progress over time and create conditions for meeting the patients in their understanding of life.

Our study showed that the participants found it difficult to know whom to turn to with their questions regarding recovery and treatment, especially post-discharge. Several studies (Gabbe et al., 2013; Kellezi et al., 2015; Braaf et al., 2018) highlight particular difficulties regarding meeting the patients' need for information during transfer from primary to secondary care, and Allum, Connolly, & McKeown (2017) emphasise that patients returning home are at risk of alienation. To address this issue, it has been suggested that discharged patients should be provided with a contact person or a support line that proactively follows-up with patients post-discharge (Kellezi et al., 2015; Gabbe et al., 2013). An intervention study directed to trauma patients included a follow-up call within 72 h post-discharge from a trauma transitional-care coordinator who can identify barriers and then help complete medical reconciliation and coordinate medical appointments and home visits (Hall et al., 2018). As part of the intervention, the coordinator continued assisting the patient with coordination of medical care/appointments and personalised problem-solving over a period of 30 days. The focus of the intervention study was primarily to reduce hospital readmission which was found to be significantly lowered (6.6% after the intervention vs. 11.3% prior to the intervention). Moreover, all who completed the intervention answered a questionnaire in which they agreed that "the intervention made them feel more prepared and in control of their new healthcare needs", and that "they were able to take care of themselves and their new normal", which supports the idea of the great benefits of ensuring a proactive follow-up.

After suffering multiple trauma, some participants in our study experienced a need to fight for care, fearing that their care otherwise risked becoming neglected. They expressed the feeling that having helpful family members or friends who could assist in coordinating information or care on their behalf was valuable, which has also been shown in a study by Braaf et al. (2018). Mitchell et al. (2019) argue that it is important to also understand and meet the needs of the families within trauma care and that an extended effect of giving them guidance and establishing a partnership is likely to be positive for the injured patients. Engström and Söderberg (2007) exemplify this in their study, where they found that close relatives served as tools for the person who was ill, facilitating better communication and an increased ability to do various things. As this study indicates, the persons who became injured were the ones who incorporated family members or friends into their care, and that they did this when they experienced that their needs were not met by health care professionals. Our interpretation is that healthcare professionals who care for multiple trauma patients may underuse their patients' resources, here being their families, and that they would benefit from incorporating them better.

Limitations

The study's credibility is strengthened by having participants of various ages who suffered a multiple trauma event under various circumstances. The different perspectives contribute to a richer variation of data and the phenomenon of suffering multiple trauma. However, we acknowledge that the criteria for multiple trauma is nonetheless wide-ranging, and due to the variation of data gathered after the first search for participants ($n = 4$), we deemed it necessary to do a second search for participants ($n = 5$) to ensure sufficient data. The second search extended back in time, a fact we considered to be troublesome as time between the accident and the gathering of data would be extended. Despite more time having passed, the participants still had vivid memories of the accident and were in different ways still in need of care. The findings show that those who suffer multiple trauma are cared for in many parts of Swedish Health Care Services, within Primary Health Care as well as within Secondary Care and have various needs of care post-discharge. In summary, we judge the transferability of our findings to other contexts to be extensive. This study indicates that those who suffer multiple trauma are in need of support and guidance after emergency care and our findings are therefore relevant to many health care settings in countries with similar healthcare systems. We suggest that it may be beneficial for future research to evaluate different interventions aimed to improve documentation and discharge planning and to develop forms for a proactive follow-up. It might also be beneficial to map the extent of the current care of patients who suffer multiple trauma with additional methods, in order to review where and when healthcare resources are used and how they can be optimised to better respond to patients' needs.

Conclusion

In order to anticipate and address patients' needs during their process toward recovery, healthcare professionals must take into consideration each individual patient's life circumstances and be responsive to the changes in their needs over time. This study shows the importance of setting short-term goals as a way of reassuring patients of their recovery, and to give them hope by doing so. It suggests that by providing improved documentation, including a clearer description of the needs/problems experienced by the patient, the goals of treatment and agreements between the patient and those who give health care would enable a shared understanding. To ensure continuity in their recovery, patients may benefit from more proactive follow-up contact from health care organisations. This study also raises awareness of the importance of engaging the patients' relatives.

Funding source

This research received no specific grant from any funding.

Ethical approval details

Before conducting the study, approval was obtained from the Ethical Review Board in Umeå, Sweden [Dnr 1828-13].

Declaration of Competing Interest

The authors declare there is no conflict of interest.

Acknowledgement

We would like to thank the participants for taking the time and making the effort to share their experiences, thus making this study possible.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.iccn.2019.07.006.

References

Aitken, L.M., Chaboyer, W., Schuetz, M., Joyce, C., Macfarlane, B., 2014. Health status of critically ill trauma patients. J. Clin. Nurs. 23 (5–6), 704–715.

Aitken, L.M., Chaboyer, W., Jeffrey, C., Martin, B., Whitty, J.A., Schuetz, M., et al., 2016. Indicators of injury recovery identified by patients, family members and clinicians. Injury 47 (12), 2655–2663.

Allum, L., Connolly, B., McKeown, E., 2017. Meeting the needs of critical care patients after discharge home: a qualitative exploratory study of patient perspectives. Nurs. Crit. Care.

Arman, M., Rehnsfeldt, A., 2007. Thelittle extra'that alleviates suffering. Nurs. Ethics 14 (3), 372–386.

Braaf, S., Ameratunga, S., Nunn, A., Christie, N., Teague, W., Judson, R., et al., 2018. Patient-identified information and communication needs in the context of major trauma. BMC Health Serv. Res. 18 (1), 163.

Butler, M.P., Derrett, S., Colhoun, S., 2011. The lived experience of patients with uncertain medical diagnosis following a serious injury: a qualitative study. Disabil. Rehabil. 33 (22–23), 2247–2254.

Claydon, J., Robinson, L., Aldridge, S., 2017. Patients' perceptions of repair, rehabilitation and recovery after major orthopaedic trauma: a qualitative study. Physiotherapy 103 (3), 322–329.

Engström, Å., Söderberg, S., 2007. Receiving power through confirmation: the meaning of close relatives for people who have been critically ill. J. Adv. Nurs. 59 (6), 569–576.

Fakhry, S.M., Ferguson, P.L., Olsen, J.L., Haughney, J.J., Resnick, H.S., Ruggiero, K.J., 2017. Continuing trauma: the unmet needs of trauma patients in the postacute care setting. Am. Surg. 83 (11), 1308–1314.

Flink, M., Glas, S.B., Airosa, F., Öhlén, G., Barach, P., Hansagi, H., et al., 2015. Patient-centered handovers between hospital and primary health care: an assessment of medical records. Int. J. Med. Inf. 84 (5), 355–362.

Franzén, C., Björnstig, U., Jansson, L., 2006. Injured in traffic: experiences of care and rehabilitation. Accid. Emerg. Nurs. 14 (2), 104–110.

Gabbe, B.J., Sleney, J.S., Gosling, C.M., Wilson, K., Hart, M.J., Sutherland, A.M., et al., 2013. Patient perspectives of care in a regionalised trauma system: lessons from the victorian state trauma system. Med J Aust. 198 (3), 149–152 http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=23418695&site=ehost-live.

Graneheim, U.H., Lundman, B., 2004. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Educ. Today 24 (2), 105–112.

Granstrom, A., Strommer, L., Schandl, A., Ostlund, A., 2018. A criteria-directed protocol for in-hospital triage of trauma patients. Eur. J. Emerg. Med. 25 (1), 25–31.

Griffiths, H., Jordan, S., 1998. Thinking of the future and walking back to normal: an exploratory study of patients? Experiences during recovery from lower limb fracture. J. Adv. Nurs. 28 (6), 1276–1288.

Gustafsson, B.Å., Nordström, G., Ponzer, S., Lützen, K., 2001. The role of interactive affirmation in psychosocial rehabilitation after orthopaedic injuries. J. Orthop. Nurs. 5 (1), 9–14.

Hall, E.C., Tyrrell, R., Scalea, T.M., Stein, D.M., 2018. Trauma transitional care coordination: protecting the most vulnerable trauma patients from hospital readmission. Trauma Surgery Acute Care Open 3, (1) e000149.

Kellezi, B., Beckett, K., Earthy, S., Barnes, J., Sleney, J., Clarkson, J., et al., 2015. Understanding and meeting information needs following unintentional injury: comparing the accounts of patients, carers and service providers. Injury. 46 (4), 564–571.

Larsson, I.E., Sahlsten, M.J., Segesten, K., Plos, K.A., 2011. Patients' perceptions of barriers for participation in nursing care. Scand. J. Caring Sci. 25 (3), 575–582.

Mitchell, M., Dwan, T., Takashima, M., Beard, K., Birgan, S., Wetzig, K., et al., 2019. The needs of families of trauma intensive care patients: a mixed methods study. Intensive Crit. Care Nurs. 50, 11–20.

Morse, J.M., Proctor, A., 1998. Maintaining patient endurance: the comfort work of trauma nurses. Clin. Nurs. Res. 7 (3), 250–274.

O'Brien, B.C., Harris, I.B., Beckman, T.J., Reed, D.A., Cook, D.A., 2014. Standards for reporting qualitative research: a synthesis of recommendations. Acad. Med. 89 (9), 1245–1251.

Ogilvie, R., McCloughen, A., Curtis, K., Foster, K., 2012. The experience of surviving life-threatening injury: a qualitative synthesis. Int. Nurs. Rev. 59 (3), 312–320.

Polit, D., Beck, C., 2008. In: Nursing Research: Generating and Assessing Evidence for Nursing Practice. 10th ed., p. 2017.

Richmond, T.S., Aitken, L.M., 2011. A model to advance nursing science in trauma practice and injury outcomes research. J. Adv. Nurs. 67 (12), 2741–2753.

Richmond, T.S., Thompson, H.J., Deatrick, J.A., Kauder, D.R., 2000. Journey towards recovery following physical trauma. J. Adv. Nurs. 32 (6), 1341–1347.

Ringdal, M., Plos, K., Bergbom, I., 2008. Memories of being injured and patients' care trajectory after physical trauma. BMC Nurs. 7 (8). 6955-7-8.

Sandström, L., Nilsson, C., Juuso, P., Engström, Å., 2016. Experiences of nursing patients suffering from trauma – preparing for the unexpected: a qualitative study. Intensive Crit. Care Nurs. 10 (36), 58–65.

Sandström, L., Nilsson, C., Juuso, P., Engström, Å., 2017. The helicopter as a caring context: experiences of people suffering trauma. Int. Emerg. Nurs. 32, 34–38.

Skogstad, L., Tøien, K., Hem, E., Ranhoff, A.H., Sandvik, L., Ekeberg, Ø., 2014. Psychological distress after physical injury: a one-year follow-up study of conscious hospitalised patients. Injury 45 (1), 289–298.

Sleney, J., Christie, N., Earthy, S., Lyons, R.A., Kendrick, D., Towner, E., 2014. Improving recovery-learning from patients' experiences after injury: a qualitative study. Injury-Int. J. Care Inj. 45 (1), 312–319.

Tutton, E., Seers, K., Langstaff, D., 2012. Hope in orthopaedic trauma: a qualitative study. Int. J. Nurs. Stud. 49 (7), 872–879 http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=2011596828&site=ehost-live.

Warwick, A., 2012. Recovery following injury hinges upon expectation and hope. J. Trauma Nurs. 19 (4), 251–254.

Wiseman, T.A., Curtis, K., Lam, M., Foster, K., 2015. Incidence of depression, anxiety and stress following traumatic injury: a longitudinal study. Scand. J. Trauma, Resuscitation Emerg. Med. 23 (1), 29.

Wiseman, T., Foster, K., Curtis, K., 2013. Mental health following traumatic physical injury: an integrative literature review. Injury. 44 (11), 1383–1390.