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International Emergency Nursing

Patients' experience of trauma care in the emergency department of a major trauma centre in the UK

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INTRODUCTION

Trauma is the fourth leading cause of death in western countries and the leading cause of death in people under 40 years old (National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) 2007). There has been focus on developing trauma care in the last few years with the National Health Service (NHS) Outcomes Framework (Department of Health (DoH) 2013) Domain 3 being focused on survival for major trauma. Major trauma describes serious and often multiple injuries where there is a strong possibility of death or disability (National Audit Office 2010).

Trauma affects people from all age groups, geographic areas and socioeconomic classes. Trauma patients require specialist care from a multidisciplinary group of professionals. The initial assessment of major trauma patients' is challenging with minutes making the difference between life and death. Trauma can impact physically, emotionally and financially on the patient as well as their family and friends, both by the immediacy of the traumatic event and the long-term effects.

The trauma team consists of clinicians who carry out pre-assigned roles simultaneously so that interventions occur rapidly (Cole and Crichton 2006). Good trauma care involves getting the patient to the right place at the right time for the right care (NHS.UK 2014), and major trauma centres (MTC) are set up to provide this specialised care. This involves rapidly identifying injuries, completing investigations and accessing specialist care as soon as possible after arriving at hospital.

34 Despite on-going improvements in trauma care and trauma systems, there is
35 little literature looking at the patients' experience of trauma care in the
36 emergency department (ED). In a review of the literature, seven studies were
37 identified which examined the trauma care from the patient perspective, one
38 of which was UK based. When O'Brien and Fothergill-Bourbonnais (2004)
39 interviewed seven trauma patients about their perspectives on trauma
40 resuscitation in the Emergency Department (ED), they found patient's initial
41 perceptions of vulnerability subsided as a sense of feeling safe became
42 prominent and that caring behaviours, such as touch and tone of voice
43 contributed to a positive experience. The combination of efficiency and caring
44 by the trauma team helped to create an environment where patients' felt safe.
45 An earlier study by Jay (1996) explored and described issues in relation to
46 nursing care that are important to trauma patients in the ED in England. In
47 their findings based on seven interviews with trauma patients, they concluded
48 that touch, company and information were important in coping and regaining
49 control, as well as the need to trust the healthcare professionals.
50
51 Patients in an MTC are likely to be severely injured and Franzen et al (2008)
52 found that severely injured patients tended to rate the quality of care more
53 highly. Franzen et al (2008) and Wiman et al (2006) found that the less
54 severely injured patients felt that communication was lacking affecting their
55 perception of quality of care. Wiman et al (2006) focused on the trauma
56 patients' conceptions of encounters with the trauma team. Their findings
57 focused on communication between the patient and the healthcare
58 professionals and found that participants were more confident, satisfied and
59 gained comfort from professionals who treated them with both good physical
60 care as well as providing psycho-social care.
61
62 Increasing knowledge about the patient experience of care in the ED is
63 important to understand their situation and their needs following a traumatic
64 event.
65
66
67

METHODS

A qualitative research design was used and data collected by semi-structured interviews. The interviews were transcribed verbatim and analysed thematically.

The study aim was to describe the patient perspective of trauma care in the ED. The study objectives were to: describe the ED environment from the perspective of the trauma patient; explore the trauma patient's experience of engagement with healthcare professionals in the ED; illuminate the trauma patient's emotional trajectory and their reflections on care in the ED.

Study context and participants

The participants for this study were recruited using a pragmatic convenience sample from adult patients admitted to the trauma ward of an MTC in London, having suffered a traumatic injury. The use of convenience sampling for the patient group allowed for recruitment of a diverse group of participants as described in Table 2.

The key ethical issues addressed in relation to the conduct of this study were related to ensuring informed consent and confidentiality as well as reducing the risk of coercion and any potential distress that might result from discussing a sensitive topic. A member of the clinical care team identified potential participants from trauma admissions. They used the inclusion and exclusion criteria (table 1) when screening patients, and if the patient fitted the criteria, they invited the patient to participate in the study. During the data collection period (April – June 2015), 263 patients were screened and 37 patients were identified as potential participants from the trauma unit. A patient information sheet was given to them and if they agreed, their details were passed to the researcher. Those that agreed to see the researcher were approached; after the patient had a minimum of 24 hours to consider the study. The researcher was a fulltime student during the study and was not involved in providing trauma care in the ED.13 patients in total consented to participate in the study. Participating patients were assigned pseudonyms. Coercion was minimal as a member of the clinical care team initially approached the patients, allowing patients to fully consider if they wanted to participate prior to being approached by the researcher. All patients identified

were approached to minimise any bias in recruiting patients. The impact of discussing a sensitive topic was considered in the formulation of the topic guide and in the ethics committee meeting. Participants were reassured they could stop at anytime and could be signposted to the appropriate people.

Trauma is classified using an injury severity score (ISS), an anatomical scoring system that provides an overall score for patients with multiple injuries, ranging from 0-75 with a score of 16 or greater signifying major trauma (National Audit Office 2010). The ISS for the participants ranged from 4 to 21 (mean= 12.46, SD= 5.91).

Interviews and data collection

Participants were asked to narrate their experience from the initial injury up until transfer from the ED to the ward. Open questions were used to encourage patients to describe their engagement with the healthcare professionals; the environment in the ED; as well as their feelings and emotions, using questions like ‘Can you describe the environment you were in?’ and ‘Tell me about any feelings or emotions you experiences.” Follow up questions were used to clarify thoughts, feeling and experiences if this information did not appear in the narrated story (Mishler, 2005). The interviews were semi-structured to ensure that key questions were answered in relation to the research aim whilst allowing participants to elaborate on issues they felt important. Interviews were performed between 2 and 23 days after the injury event. Interviews were conducted as soon as the patient felt they were able to participate. Interviews lasted between 9 and 42 minutes and were transcribed verbatim.

Data analysis

The interviews were analysed using thematic analysis (Braun & Clarke 2006). Thematic analysis involves discovering, interpreting and reporting patterns and clusters of meaning within the data (Spencer et al 2014). Analysis involves constantly moving backwards and forward between the entire data set, to code the data, categorise the codes, analytical reflected and

136 construction themes (Braun & Clarke 2006). After several readings codes
137 were assigned that described the content while still keeping the core content.
138 The codes were grouped into categories and sub categories. During the
139 whole process discussions between two of the authors (IS and EM) led to a
140 refinement of the codes and categories in order to strengthen the credibility of
141 the final thematic structure. The analysis resulted in four main themes.
142
143 **FINDINGS**

144 The four themes that emerged are: initial impact of the trauma; environmental
145 factors; communication styles; and reflecting on the trauma.
146
147 *Theme 1: Initial impact of the trauma*

148 - *I was in shock*

149 Participants reported how they felt both the physiological response of feeling
150 cold, shaking, tachycardia – a racing heart - as well as the psychological
151 response of a panic or disbelief that something like this could occur to them.
152 There was also a realisation that the state of shock protected them initially
153 from the realisation of what had occurred: *"I'm not cold, its shock'. You just*
154 *suddenly realise that something has happened to you"*(P9).
155
156 - *I was scared*

157 An emotional response to the trauma was described by a sense of fear and
158 panic. These feelings of fear and panic overlapped with their arrival in the ED
159 and were exacerbated by a lack of knowledge and uncertainly to the extent of
160 their injuries. This is a feeling that would remain in the ED as well due to the
161 lack of knowledge and control about the situation and the potential extent of
162 their injuries: *"I can't explain the kind of sense of panic when you are lying at*
163 *the side of the road, you think you have a serious injury and you just think*
164 *nobody knows, (my wife) doesn't know, I don't know how bad this is, the*
165 *people, there was a doctor there, but they can't do anything. I could have died*
166 *there and then and never spoken to (my wife)"*(P13).
167
168 - *I was in pain*

169 Powerful descriptors, such as horrific and excruciating, were used describe
170 the pain from the injury and procedures carried out in the ED: *"It was the pain.*
171 *It felt like my body, my whole body was exploding."*(P1). They recalled being
172 given analgesia, primarily morphine, for their injuries and recalled their pain
173 being under control. Benefits of having pre-hospital analgesia were noted,
174 making it easier to go through the initial assessments in the ED: *"My pain was*
175 *very well controlled, obviously it was bad, at the scene it was horrific"*(P13).
176 They recalled hallucinations or a feeling of detachment, resulting from the
177 analgesia: *"They gave me some morphine and stuff and from that point I just*
178 *felt a bit in the clouds really"*(P7).
179
180
181 *Theme 2: Environmental factors*
182 - *Perspectives on the physical environment*

183 Many participants arrived in the ED wearing hard collars to protect their
184 cervical spine from injury until their neck could be assessed and cleared. This
185 also involved being strapped down to a hard scoop on route to hospital and
186 then lying flat on the bed with their head between two blocks, until their spine
187 is medically cleared or waiting for CT scan results before being able to move.
188 Therefore most participants described their initial view of the environment to
189 be restricted to the ceiling and bright lights: *"But you're on your back, so your*
190 *whole world is the ceiling"*(P12). This also contributed to patients feeling a
191 loss of control and helpless to their situation: '*Claustrophobic. But I'm not a*
192 *claustrophobic person… All I could do was look up. I couldn't see the people*
193 *around me"*(P2). While lying flat, noise was a factor with the multitude of
194 machines around: *"Oh my god, all these machines beeping*"(P1).
195
196 - *Atmosphere within the ED*

197 The dynamic combination of efficiency of the staff and their caring nature created an
198 atmosphere in which these participants felt safe and cared for. Many participants
199 commented on the alertness and preparation of the staff in the ED, which created a
200 positive atmosphere: *"And then there was a kind of buzz about it… It was the*
201 *atmosphere, of well I felt they were very on, what the French would call the on the*
202 *"qui vive", they were alert and ready"*(P12). The environment also contributed to a

203 feeling of safety: *"Clean, comfortable, safe…just the ambience of the place. I don't*
204 *know whether it's because its new, but it made me feel safe"*(P4).
205
206
207 - *Witnessing the trauma team at work*

208 Positive accounts from the study participants of witnessing the trauma team at
209 work were related to the perceived harmony and efficiency of the trauma
210 team, being treated with respect and the importance of not being alone.
211 There was a strong sense of safety and reassurance associated with
212 witnessing the trauma team at work recounted by all the participants
213 interviewed. There was a combination of the perception of efficiency of the
214 trauma team with the compassion that the participants were treated with. This
215 efficiency of the trauma team is demonstrated by the following quotation: *"In*
216 *ED they were all in harmony with each other… They all had a job to do and*
217 *they did it, in sequence and sometime in parallel, they just knew what to do*
218 *and they did it"*(P4).
219
220 Participants almost unanimously reported that they felt respected by the staff
221 in the ED. This came across in the way they were spoken to and cared for.
222 This was widely related to interactions between the team as well as with the
223 participant: *"They treat you as a person, not as a lump of flesh. They do treat*
224 *you with respect"*(P9).
225
226 Participants also felt like they were not alone in the ED with most recalling there
227 always a member of staff in close proximity. They said that they were reassured that
228 they had a healthcare professional nearby to attend to their needs if required. This
229 was particularly important for those strapped down to a hospital bed, wearing a hard
230 collar waiting for results of investigations: *"The fact that it is the same person coming*
231 *back and not going away. And also making sure that I wasn't left on my own with*
232 *nobody around. I don't think that ever happened. So my memory is that at no point*
233 *was I left with nobody to say what's happening"(*P13).
234
235
236 *Theme 3: Communication styles*

237 ○ *Informal – humour*

238 Participants felt respected by the staff in the ED; this came across in the way
239 they were spoken to. There were recollections of the use of humour by nurses
240 and paramedics, particularly when clothes were being removed, which helped
241 to put them more at ease: *"I said 'look at me lying here like this, everyone is*
242 *looking at me' But we were all having a laugh about it. But you know*
243 *respectfully, because they did respect you as a person"(P9).* Humour was
244 also used during some of the procedures: *"The nurse was talking to me while*
245 *she was stitching my head and you know, just talking in general and we had a*
246 *little laugh"(*P11).

247

248 ○ *Pastoral – reassurance*

249 The feeling of reassurance that participants associated with the pastoral
250 communication was felt to be hugely important as it reduced potential panic and
251 made them more relaxed. It was also appreciated, as it helped the participants feel
252 like they were treated as with respect and kindness, as human beings. One
253 participant described the importance of good communication: *"Communication skills*
254 *in that sort of situation are so so important. Made such a difference to me…. I guess*
255 *you could equally say if I am alive here and my arm has been fixed and everything*
256 *and they were horrible to me, well does it make any difference? Well it really does…it*
257 *is probably something that could have easily been missed because obviously your*
258 *main concern is treating my injuries but the reassurance is hugely important"*(P12).

259

260 When family were contacted is was hugely reassuring for patients and
261 provided them with a sense of relief. However not all participants wanted their
262 family to be present, this appears to be due to the additional worry that their
263 family would bring, which would make the participant need to expend energy
264 on reassuring their family, as well as feeling out of control in the situation.

265

266 ○ *Formal – information giving*

267 When patients received enough information their injuries and treatment they felt safer
268 and reassured: *"They were really good, you know they kept coming through, every*
269 *step, somebody was explaining, telling me what was happening and talking me*
270 *through what they were doing…I felt very much like I knew what was going on and I*

271 *knew why things were being done and what the plan was"* (P13). However some
272 participants felt that the information given was lacking, particularly once transferred
273 out of the resuscitation area: *"I tell you the truth, coming up from ED where I was*
274 *constantly told what was happening, I've come up here and I think this is the third*
275 *ward I've been in and not been told anything…I feel like I've been put in a corner and*
276 *nobody has informed me of anything"*(P7). The following quotation described
277 concerns about the lack of communication: *"I don't think I would have rerun it any*
278 *differently except for a bit more communication when everybody faded away. I would*
279 *have liked that and a bit more talk about what was actually the matter and why they*
280 *were doing what I thought they were going to do"*(P12).
281
282 *Theme 4: Reflecting on the trauma*
283 Participants reflected on their feeling on leaving the ED and being transferred
284 to the ward. They also spoke about plans to return home and the impact on
285 their family and jobs. Participants spoke with hope about their future, although
286 the impact of the trauma still remained, with concerned about potential
287 complications and memories that remained. This theme, reflecting on the
288 trauma has been divided into subthemes: I will be okay, I appreciate the
289 health care system and looking to the future.
290
291 o *I will be okay*
292 There tended to be a sense of relief once they had been treated and
293 stabilized in the ED and were ready to be transferred to the ward. This move
294 to the ward was felt to be a move towards normalisation, a step towards a re-
295 assimilation with the outside world: *"When they said they were going to put*
296 *me on the ward, I suppose that's when I started saying, ok…suppose I am as*
297 *safe as they tell me I am. They know more than I do"*(P4). There was an
298 element of reflection on surviving the injury and knowing they were going to
299 be okay *"I now know how lucky I am to be alive*"(P8).
300
301 o *I appreciate the health care system*
302 There was a sense of appreciation throughout for the care provided as a result of the
303 traumatic injury. A couple of the participants particularly expressed appreciated for

304 the NHS as a healthcare system, who felt that the NHS is: *"At its core it is a*
305 *magnificent, unique service for people"*(P12).
306
307 With participants that had been transferred from a trauma unit into the MTC, as well
308 as the participants that were taken directly to the MTC due to the nature of their
309 injuries, there was appreciation of being taken to a centre that was a specialist in
310 dealing with traumatic injuries. Being treated by professionals who deal with trauma
311 day in day out, gave participants as sense of reassurance*: "I knew I was in safe*
312 *hands"* (P4); and P10 who said: *"I see now why they send you to certain places for*
313 *specific illnesses or conditions".*
314
315 - Looking to the future

316 After surviving the traumatic injury and undergoing the period in ED, participants
317 reflected on the impact on their lives, their future and the impact in would have on
318 their families. For one in particular, the experiences has perhaps turned a potentially
319 negative experience into a positive one, having a new appreciation for the fragility of
320 life and the opportunity to make a change: *"I know I have a long and rocky road but it*
321 *has made me realise I want a few changes in my lifestyle."* (P8). Whereas for other
322 participants there was a sense of coming out stronger *"Makes you very strong, you're*
323 *more determined to deal with it"*(P4).
324
325 However for one participant, who was a surgeon, who had broken his right
326 arm in an accident, was still worried about the impact it was going to have and
327 the potential for it to affect his career as a surgeon. However after the initial
328 injury when he was at the roadside, fearing for his life, concerned about major
329 bleeding from his pelvic injury, there was still a huge sense of relief that he
330 was alive*: "Despite the fact I know that these injuries are going to keep me off*
331 *work for a while, but yeah, its difficult to explain, huge sense of relief and I*
332 *guess the only persisting thing after that was my work. Was I ever going to be*
333 *able to operate again?"(P13).*
334
335 **Discussion**

336 This study of 13 trauma patients explored the experience of care in the ED
337 with the aim of providing insights about perceptions of care from the patients.

338 This study represents the first of its kind in the UK. It illuminated the complex
339 array of emotions that are experienced by trauma patients in the specific
340 context of the ED and demonstrates that many patients have a heightened
341 awareness of their environment in the ED. The interaction with the trauma
342 team is central to negating the initial fear, ambiguity and uncertainty
343 experienced by most patients.
344
345 Liminality is a term used to describe an experience of uncertainty and is used
346 to describe the state of being in-between (Bruce et al 2014). The betwixt and
347 between phase (van Gennep, cited in Turner 1967) emphases the
348 transitioning from one stage to another. Descriptions of liminality in health
349 literature focus on transitions and temporary experiences that patients work to
350 resolve and move beyond (Kelly 2008). In the context of life threatening
351 illnesses, liminality is used to describe a psychosocial space for people living
352 with end stage renal disease (Martin-McDonald and Biernoff 2002), HIV/AIDS
353 (Kelly 2008) and cancer (Miles et al 2008).
354
355 The concept of liminality can help illuminate aspects of the findings from this
356 study. Figure 1 has been developed from the findings using the stages of
357 liminality to depict the stages of experience within trauma. The diagrammatic
358 representation is intended to provide an overall picture of the trauma
359 experience from the initial trauma through to preparing for discharge back to
360 the outside world. The themes that emerged from the study can illuminate the
361 feelings and emotions that occur within each stage of this process and what
362 factors positively influence the experience.
363
364 *Separation* is the initial stage, relating to the immediate impact of the trauma
365 and primarily related to the "initial impact of the trauma" theme. These initial
366 emotions, feeling scared, are also identified in the studies by Jay (1996) and
367 O'Brien and Fothergill-Bourbonnais (2004). The participants' in the present
368 study also recalled an awareness that they had been in shock, for example
369 from a feeling of intense cold or their heart racing. Shock was also recognized
370 in the O'Brien and Fothergill-Bourbonnais (2004) study as a physical
371 phenomenon described as a feeling of intense cold.

372

373 The *transitional* stage is the time in the ED, primarily related to the
374 communication styles and environmental factors themes. Participants who
375 recalled emotions from their time in the ED often described emotions in terms
376 of a range of experiences from scared to safe. Being scared was related to a
377 loss of control, panic, anxiety, not knowing and being in pain, whilst feeling
378 safe was related to being reassured, comforted, informed, in addition to the
379 life-saving aspects of the ED such as the efficiency and competence of the
380 trauma team. There was no straight path on the emotional trajectory, all
381 participants' emotions fluctuated in the ED. Perceptions of compassionate
382 care, competent management and a clean environment were associated,
383 however, with reducing fear, worry and pain and increasing the feeling of
384 safety. This resonates with the findings of previous studies (O'Brien and
385 Fothergill 2004; Jay 1996; Wright 2011).
386
387 The impact of trauma and the admission to the ED has a small but emerging
388 body of research. Whereas critical illness and admission to intensive care
389 units has been well researched and patient memories of frightening
390 experiences has been shown to potentially threaten their later psychological
391 recovery (Adamson et al 2004; Schelling et al 1999). In general, traumatic
392 events are very clearly remembered by those that experience them and are
393 seldom or never forgotten (McNally 2005). Memories of traumatic or
394 frightening events usually persist for longer periods than emotional memories
395 (Lof, Berggren and Ahlstrom 2008). It is unknown if the vivid memories from
396 the trauma or the hallucinations resulting from analgesia reported by
397 participants will have a lasting impact.
398
399 Participants accepted that the health service providers were providing the
400 best available care, so whether they drove past the local hospital to get to the
401 MTC or they were transferred to the MTC following an initial assessment at
402 the local hospital, they were compliant with treatment pathway. This has not
403 been a factor in previous literature on patients' perceptions of trauma care in
404 the ED, due to the recent set up of the major trauma network.
405

Most participants' in this study expressed satisfaction with the teamwork and appreciated rapid attention. Baldursdottir & Jonsdottir (2002) conducted a study to identify which nurse caring behaviours are perceived by patients in an ED as important indicators of caring and found that patient rated clinical competence as the most important of nurses caring behaviours. The organization, attitude and competence of the trauma team brought patients a sense of safety and security (O'Brien and Fothergill-Bourbonnais 2004). Wiman et al (2007) also found that competence generated feelings of comfort, confidence and satisfaction. Several studies have shown that the presence of staff and the caring relationship that is formed is an important factor with regards to the trauma patients coping with the traumatic injury, the unknown, their sense of security, hope and sense of well-being (O'Brien and Fothergill 2004; Jay 1996; Wright 2011).

The findings of the present study have found that participants felt that they were treated with kindness, compassion, respect and with humanity in the ED. However Holbery (2014) identified emotional intelligence to be lacking amongst the trauma team in her reflective account of her experience of being both a relative of a trauma patient and a nurse. Holbery (2014) found care to be mechanical and protocol driven. None of the participants in this present study expressed feelings of vulnerability.

Compassion and competence of the trauma team were intertwined in the findings of this study. Caring is an essential element of nursing (Benner and Wrubel 1989). The DoH (2012) states that care is our core business and that of our organisations, and the care we deliver helps the individual person and improves the health of the whole community. Engagement with healthcare professionals is influenced by the emotional intelligence (EI) of the individuals within the trauma team. EI is defined by Salovey and Mayer (1990, p189) as a subset of social intelligence that involves 'the ability to monitor ones own and others feelings and emotions to discriminate among them and use this information to guide ones thinking and actions'. The findings of the present study have found that participants felt that they were treated with kindness, compassion, respect and with humanity in the ED.

440
441 Participants completed their narratives with reflections and resolutions for the
442 future, looking forwards to discharge, family and work life after their trauma.
443 Many patients see the journey through the ED as a transition and the
444 experience generates new perspectives on their lives as they exit. This
445 represents their re-assimilation, in the final stage of the liminal period.
446 Emotionally, participants were relieved to be okay and appreciative of care
447 received. This resonates with findings in Wright (2011) who found that the
448 majority of participants interviewed expressed appreciation and thanks for
449 providing care in a time of duress. O'Brien & Fothergill-Bourbonnais (2004)
450 also found that the traumatic event has lead to a reawakening, giving a new
451 appreciation for the fragility of life which is supported by the findings in this
452 study.
453
454 **Limitations**
455 As in most studies, all participants volunteered their time to be interviewed,
456 which may suggest that they are generally more proactive and interested in
457 scientific research. This could potentially mean that the participants had
458 stronger views on the experience of care. When it comes to the content of the
459 patients' descriptions of their experiences in the ED, similar results have been
460 reported in other studies and this partly confirms the transferability of the
461 results (O'Brien and Fothergill-Bourbonnais 2004; Wiman et al 2007). The use
462 of qualitative semi-structured interviews enables participants to describe their
463 experiences. The researchers knowledge and experience are important to
464 understand and interpret the material. A second person was involved in the
465 analysis of a sample of transcripts and the same themes identified, indicating
466 that the interpretation was authentic. The researcher was a novice in
467 conducting interviews, which may have impacted on the depth and breath of
468 the narratives analysed. Patient groups that were discharged from the ED and
469 those admitted directed to theatre or ICU from the ED were excluded. It is
470 possible that different perspectives may be voiced from these groups.
471 However the aim of the study was to explore the range and diversity of
472 perspectives rather than make generalisations as a whole.
473

474

475 ## Conclusion

476 The study corroborates existing literature linking competent and
477 compassionate care with patients' sense of safety. This study illuminated the
478 multifaceted array of factors that influence the patients' experience of care in
479 the ED. This combination of factors and the influence it has on their emotions
480 differs between individuals and is likely to be influenced by multiple factors
481 including age, gender, mechanism and severity of injury, recovery and
482 treatment course as well as personal circumstances.

483

484 Participants in the liminal period entered the ED scared, in pain and in shock. For
485 participants to feel safe, secure and reassured in the ED it was important for staff to
486 quickly build rapport with the participants. With this rapport, trauma teams are able
487 to communicate not only essential information, but also provide reassurance, show
488 respect and humanity. Trauma teams working in a MTC are exposed to trauma on a
489 daily basis, competence in the management of trauma is shown to the patients in
490 the speed and precision in which tasks are completed. Compassion in care is
491 remembered by patients and forms part of the picture they remember about their
492 trauma experience.

493

494 Liminality is a useful construct that can help make sense of ambiguous experiences.
495 Understanding liminality helps us to understand what it is that trauma patients seek
496 from the healthcare service. An understanding of the patients experiences and
497 emotions in the ED has implications for how nurses interact with patients and raises
498 opportunities for strengthening holistic nursing care and also raises challenges
499 around what can be improved.

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