Traumatic brain injury (TBI) Adult acute toolkit

ACC processes | Hospital management moderate/severe TBI | Hospital management mild TBI | Discharge processes

ACC processes
(NB: Aside from lodging the ACC45 first, the steps do not need to be completed in this order)

Complete ACC45 and submit with an accurate injury list in order of severity, including concussion code if diagnosed

Complete ACC18 for:
Updated injury list with new diagnoses in order of severity, including concussion.
Fitness to work if patient is employed and eligible for weekly compensation

Complete the ACC7422 for major trauma patients who will require intensive ACC support on discharge, noting why intensive support is required

If the claim has been allocated into ACC recovery team member (RTM) they will contact patient/ representative and multi-disciplinary team (MDT) to support discharge planning

If the patient is not being allocated to a RTM, this will be advised to the MDT. Any allocation concerns can be raised to the local ACC client recovery team lead

For patients being discharged home (at least 48 hours before discharge), notify ACC of support required via ACC705

EMERGENCY DEPARTMENT PRESENTATION
Commence Abbreviated Westmead Post Traumatic Amnesia (A-WPTAS) for any injury involving the head, neck or face, or if the person has two system injuries. Mechanism of injury may also indicate assessment, particularly high velocity and following interpersonal violence presentations

SEVERE GCS 3-8 PTA >7 days
MODERATE GCS 9-12 PTA 1-6 days

Admit to ICU or ward as clinically indicated.
When appropriate complete full Westmead (unless passed A-WPTAS) and symptom screen questionnaire (eg, Rivermead or BIST); full MDT review as required (including functional assessments)

Multi-disciplinary team (MDT) identifies if the patient is likely to require specialist TBI rehabilitation

MDT to notify TBI inpatient provider (within 24-72 hours of admission); will need an approved ACC45 claim to do this

Regardless of discharge destination rehabilitation continues

Discharge planning
Is intensive inpatient rehabilitation required?

Yes

TBI providers visits patient and & contributes to discharge planning

DISCHARGE to TBI inpatient rehabilitation with discharge summary and MDT handover

No

If community rehabilitation is required, refer for this via the ACC705 (following usual ACC705 processes) at least 48 hours before discharge, outlining intensity of input needed, goals and MDT representation

DISCHARGE home with discharge summary and patient education

SUSPICION OF MILD TBI (with negative radiology)
GCS 13-15 PTA <24 hours

A-WPTAS within 24 hours of injury and symptom screen questionnaire (eg, Rivermead post concussion symptoms questionnaire or the Brain Injury Screening Tool - BIST)

Post traumatic amnesia or significant symptom burden?

Yes → Admit to ICU or ward as clinically indicated. When appropriate complete full Westmead (unless passed A-WPTAS) and symptom screen questionnaire (eg, Rivermead or BIST); full MDT review as required (including functional assessments)

No

Clinical concerns? (see page 2)

No → DISCHARGE home with Recovery advice Whakaora Tohutohu for patients booklet (ACC8319), for follow-up with GP

Yes

Directly refer to concussion service via ACC7988

Concussion services acknowledges referral, provides results of case review and next steps by secure email to hospital referrer

If patient SELF DISCHARGES without appropriate services in place:
- Notify ACC RTM or if this person is not known please contact Provider Help on 0800 222 070.
- Inform ACC of the severity of TBI to support decision making.
- Highlight support needs at the point of discharge.
- Notify patient's GP.

Clinical concerns for consideration of direct referral to concussion services:

- Presence of vestibular ocular issues.
- Self discharges in PTA.
- Emotional or psychological trauma associated with injury (e.g. multi-traumas, natural disaster, home invasion, assault, fatal car accident, interpersonal violence).
- Prolonged loss of consciousness (eg, >10 minutes).
- Socially isolated or lack of social supports to monitor recovery.
- Prior neurological history (evidence of neurodevelopmental disorder, epilepsy, migraine).
- History of mental health issues and or substance abuse.
- High-risk jobs: consideration of role, safety and work environment.

NB: For more detail on weighting of clinical concerns please see: Brain Injury Screening Tool: a guide to TBI assessment – tbin.aut.ac.nz

Under-served populations

Some populations experience disparities in health care outcomes in New Zealand, including Māori and Pacific peoples, disabled people, refugee and minority ethnic communities, those who speak English as a second language, those who live in low socioeconomic areas or rural or remote locations, and those with mental health comorbidities.

Following a head injury, the following is recommended to support under-served populations.

Use a proactive approach to ensure equitable access to ACC

- Ensure all required details in ACC forms are completed in a timely manner, and provide support as necessary.
- If travel or co-payment costs of community services is likely to be a barrier to access, highlight this with ACC to discuss the most suitable options available for the patient.

Early engagement with additional support services

- **Māori health services,** where possible, assist with connecting whānau with appropriate community support services. They support health services to meet the needs of Māori whānau.
- **Pacific health services** empower Pacific peoples in their recovery. They support health services to meet the needs of Pacific whānau.
- **Interpreting and translation services** should be made available for people who do not speak English as a first language. For people with hearing loss, make New Zealand Sign Language available.

Help to access services

- **Primary health care:** People not enrolled with a GP will need tailored advice around follow-up for their injury. Where possible, health professionals should provide advice on how to find a primary health care provider that is enrolling new patients.
- **Rural and/or remote:** Alternatives to face-to-face (ie, phone consults or via video calling) appointments should be offered to help access community rehabilitation. Patient preference, phone connectivity, wi-fi coverage and general needs to be discussed with the patient before discharge.
- **Accessible options:** Services should be accessible to all, regardless of any existing or new impacts to functional, physical or cognitive status. Clinical areas must accommodate physical disabilities, including easy access to locations, and information provided in accessible formats.

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