Virtual Fracture Clinic Protocol – ED SUMMARY

Referral Pathway

1. Patient attend ED
2. ED manage the emergency (analgesia, reduction, splinting, information)
3. ED completes VFC referral form if patient eligible (see exclusion criteria)
4. Referring doctor MUST complete VFC referral form and ensure patient is added to VFC Clinic list
5. VFC Clinic list will be accessible to ED Receptionist who needs to add patient to the list on SEMA
6. VFC Referral forms with copy of ED Cas Card will need to be kept in ED reception in marked tray.
7. Every morning a member of the fracture clinic team must retrieve all the files and bring them to the Fracture Clinic (or office where the VFC will be)

Inclusion/Exclusion Criteria

All patients with MSK injuries should be considered for VFC referral. If there are any concerns regarding referral, please consider the following:

Between 0800 and 2000 – Call Oncall Registrar

Between 2000 and 0800 – Refer to following day Face to Face fracture clinic (normal fracture clinic)

Patients of concern include

- ⇒ Wounds/Lacerations/Open Fractures
- ⇒ Language barrier (non-English speaking)
- ⇒ Safeguarding issues (domestic abuse, violence, vulnerable children, homeless)
- ⇒ Prisoners

All other patients should be optimally managed in ED however if there are any clinical concerns please liaise as needed with the Trauma team. Please review the ED Management Guide.

Patient Safety

Concerns about patient safety with any change are always legitimate. However, efforts to minimise this with organisation and contingencies make this a safe process

Safety Structure 1 – Emergency Department

The ED will be provided with a departmentally approved Emergency Management Guidance which will give a full list of cases and the management/referral expectation

Safety Structure 2 – Emergency Department

There will still be provision of an oncall team for trauma which will provide support in any cases of clinical concern.

Safety Structure 3 – Emergency Department

Out of hours (2000-0800) the ED will have an option to refer patients to the face to face clinic if cases of clinical concern

Safety Structure 4 – Trauma Team @ VFC

All referrals need to be cross-checked against the SEMA VFC clinic list. Any discrepancy needs to be immediately chased up.

Safety Structure 5 – Learning

Any identified error (perceived or otherwise) needs to be reviewed within a week, and this needs to be prospectively recorded.

Safety Structure 6 – Feedback Pathways

Robust pathways to be finalised between Trauma, ED and Therapy teams to ensure that all learning points are shared openly and constructively.

Safety Structure 8 – Documentation

The referral documentation from ED and the VFC documentation from clinic needs to be perfect. This is a habit and will require positive reinforcement.

Practical Elements

- ⇒ The VFC will run alongside a reduced F2F fracture clinic so staff available may include 2 consultants (potentially upper limb and lower limb partnership)
- ⇒ ED need to fully engage with the process, the risk to patients can be high unless documentation is complete, thorough and more importantly the clinical treatment has to be the best possible i.e. fractures need to be reduced to a good position before discharge not just plastered.
- ⇒ All injuries that are manipulated must have a post manipulation xray
- ⇒ **VTE Prophylaxis in Lower Limb Injuries – TO BE DISCUSSED**
    - ED should be given guidance as to provision of prophylaxis. This is going to need to be a joint venture because ED usually provide enough VTE to cover patients till their fracture clinic appointment.

VFC Governance

Until the implementation of IT solutions to allow for ED referrals to be viewed by VFC staff this has to be done robustly using paper forms.

Accountability

- ⇒ Until a patient has been reviewed in VFC accountability for appropriate management rests with ED. This will be supported, as requested, by Trauma.
- ⇒ ED must ensure that the VFC form is completely legibly in a through way with documentation of time, date and identity of clinician including GMC
- ⇒ The evaluating clinician must ensure that the patient has been added to the SEMA list.
- ⇒ If at the beginning of VFC there is a discrepancy between the SEMA VFC list and the physical referral forms, then this must be resolved to ensure no patients are missed.
- ⇒ Following a VFC review the accountability rests with the Trauma team.

Protocols & Education

- ⇒ Protocols of management need to standardised at a departmental level
- ⇒ All protocols must have the following elements
    - 1 – Emergency Management → information targeted at ED staff
    - 2 – VFC Initial Management → Information for the general T&O Clinic
    - 3 – Specialist Advice → for ongoing decision making and management
    - 4 – Rehabilitation & Discharge planning → Collaboration with therapies
    - 5 – Patient information sheet
- ⇒ The above document elements 1 to 4 will allow for the development of document 5 which will be a publicly available
- ⇒ The protocols will need to be developed and reviewed within each subspecialty group.
- ⇒ They should be written in a manner that reflects the target audience knowledge and experience.