BRITISH ORTHOPAEDIC ASSOCIATION

STANDARDS for TRAUMA (BOAST)

August 2013

BOAST 7: FRACTURE CLINIC SERVICES

These guidelines are for the standard of care patients should expect following significant, acute soft tissue or bone injury that requires specialist treatment from a Trauma and Orthopaedic Surgeon in the outpatient setting (fracture clinic). They provide standards that can be audited to evaluate the quality of an outpatient fracture service. They cannot be comprehensive as local facilities and geography will require variation in the configuration of these services. However, the British Orthopaedic Association believes that these are the care standards that all patients in the United Kingdom can expect.

1. Following acute traumatic orthopaedic injury, patients should be seen in a new fracture clinic within 72 hours of presentation with the injury. This includes referrals from emergency departments, minor injury units and general practice.
2. Fracture clinics must be consultant-led clinics. All new fracture patients must be seen in a clinic by senior orthopaedic staff or by junior staff directly supervised by these senior staff. If extended scope practitioners are seeing patients, they must have evidence of adequate training and be directly supervised by a consultant orthopaedic surgeon.
3. All new fracture clinic appointments must lead to a management plan, including any clinical interventions, which is communicated to both the general practitioner and patient in writing.
4. Plaster room facilities and the ability to perform plain radiographs must be available during all fracture clinics.
5. Should patients require further imaging, (for example ultrasound, computed tomography (CT) or magnetic resonance imaging (MRI)); this should be performed and reviewed by the clinical team within an appropriate time scale. Surgery in many cases is time-critical and waiting time for imaging must not result in undue delay. Local referral and reporting protocols should be in place to avoid delays.
6. In fracture clinics, there should be the ability to make direct referrals to physiotherapy and occupational therapy departments.
7. Patients being seen in follow-up fracture clinics should be under the care of a named consultant with all images and medical records available to ensure continuity of care. When transfer of care is appropriate (either due to the nature of the injury or geography), then all images and medical records should be available to the subsequent clinic.
8. Fragility fracture and falls prevention (Fracture Liaison Services) should be fully integrated into fracture clinics, allowing screening of all patients and onward referral where appropriate.
9. There must be a system in place that allows patients rapid access back to the fracture clinic if they have problems related to their initial presenting injury.
10. For common injuries, patient information booklets and exercise sheets should be provided. When the treatment involves cast splintage, slings or appliances, then written care instructions should be provided.
11. Complex Regional Pain Syndrome should be identified early and there should be an agreed protocol for analgesia and therapy with the local pain clinic.
12. Patients seen in fracture clinic who require operative intervention, should have a planned admission for their treatment within a maximum time period set by the surgeon(s) that will not compromise patient safety or outcome.
13. There should be local referral guidelines for fracture clinics and any re-design that deviates from these recommendations should be prospectively evaluated to support the change of practice.

Evidence Base: This guideline is based upon professional consensus, as there are very few scientific studies in this area.