Document Control

Title **Protocol for the Management of Chest Wall Injuries (over 12 years of age) in Minor Injury Units**			
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Directorate Emergency Services, Logistics and Resilience			**Department** Emergency Department
Version	**Date Issued**	**Status**	**Comment / Changes / Approval**
0.1	April 2015	Draft	Initial version for consultation
1.0	June 2016	Final	Approved by (Clinician) and (Clinical Director) June 2016 and published on Bob.
2.0	July 2019	Final	Approved by Drugs and Therapeutics Committee.
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Lead Director Medical Director			
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Superseded Documents Protocol for the Management of Chest Wall Injuries (over 12 years of age)			
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Consulted with the following stakeholders: (list all) • Emergency Department Consultants • MIU Leads			
Approval and Review Process • Lead Clinician for Emergency Department			
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Policy categories for Trust's internal website (Bob) MIU Standard Operating Procedures			**Tags for Trust's internal website (Bob)** None

1. Table of Contents

2. Purpose

This protocol is for the use by staff employed by Northern Devon Healthcare Trust who have achieved the agreed clinical competencies to work under this procedure.

3. Presenting Symptoms

- Pain
- Dyspnoea
- Haemoptysis
- Shortness of breath
- Erythema
- Bruising
- Laceration
- Abrasion
- Increasing pain since injury
- Tachypnoeic
- Raised respiratory rate
- Decreased oxygen saturations

4. History

Refer to protocol for documentation and history taking.

4.1. Document a full history, including:

- Mechanism of injury
- Blunt or penetrating injury
- Force involved
- Worsening symptoms on inspiration, sneezing, coughing

Consider trauma to cervical spine
Consider previous respiratory or cardiac history
Patients taking anticoagulants should be referred to a medical practitioner.

5. Clinical Examination

Baseline observations to include blood pressure, heart rate, respiratory rate, $Sa0_2$, temperature and capillary refill time.

5.1. Examine for:

- Bruising / abrasions / lacerations
- Shortness of breath / shallow breathing
- Chest symmetry / tracheal deviation
- Depth of inspiration / haemoptysis
- Consider associated injuries to spine and abdomen

- Palpate for tenderness and expansion
- Auscultate for breath sounds
- Percuss for resonance
- Record pain score administer analgesia as required and reassess pain after 20 minutes

5.2. Investigations:

- Nurse practitioners and emergency care practitioners are unable to request chest x-rays for trauma
- Chest x-ray not always indicated and are not routinely performed for suspected rib fractures

6. Treatment Pathway

- Analgesia as per Patient Group Direction (PGD)related to pain score
- Advise that the injury may take several weeks to get better
- Advise that there is no specific treatment for fractured rib, only analgesia and deep breathing
- If patient needs to cough the area is to be supported with a hand
- Advise patient that sleeping upright may be helpful
- Encourage regular over the counter medication (OTC) for pain relief
- Stronger analgesia may be required as per PGD
- Advise patient to contact GP if symptoms worsen or develops signs of a chest infection e.g. fever, expectorating sputum
- If required administer oxygen therapy
- Monitor patient closely if waiting for transfer to the secondary care

6.1. Refer to Emergency Department:

- All patients with non-traumatic chest pain
- Cardiac chest pain with associated symptoms
- Chest wall injury with raised NEWS 2 score
- Suspected underlying lung pathology e.g. pneumothorax, effusion, pulmonary embolus, fracture to sternum, several rib fractures
- Associated abdominal injury or spine injury
- Shortness of breath or dyspnoea
- Systematically unwell patients
- Be aware of the need for immobilisation of cervical spine injuries

7. Discharge Pathway

Ensure patient is issued with appropriate advice and that the patient understands the need to return if symptoms change or worsen.

7.1. DOCUMENTATION TO BE COMPLETED

- Clinical treatment record as per Documentation and Record Keeping policies. Copy of clinical treatment record to General Practitioner; to be sent to surgery as per Record Keeping Policy.
- For patients being transferred to secondary care, ensure a copy of the clinical treatment record is sent with patient. A copy will also be sent to surgery in normal manner.

7.2. BEFORE DISCHARGE ENSURE:

- Those patients who have been referred for further acute intervention have appropriate transport to meet their needs, all relevant treatment has been prescribed and administered and correct information and documentation is given to the patient or sent electronically.
- The patient understands that if condition deteriorates or they have further concerns they should seek further advice.
- The patient demonstrates understanding of advice given during consultation.

- The patient demonstrates an understanding of how to manage subsequent problems.

8. References

- Bickley S (2013) Bates' Guide to Physical Examination and History Taking (11th Edition) Lippincott Williams & Wilkins, London
- British National Formulary, online edition via
- https://www.new.medicinescomplete.com
- Consent Policy (2018) NDHCT
- Emergency Department Guidelines (2012) NDHCT
- Patient Group Direction Policy (2016) NDHCT
- Medicines Policy (2018) NDHCT
- Patients at Risk of Deterioration Policy (2019) NDHCT
- Safeguarding Children Policy (2018) NDHCT

APPENDIX A – Essential Documentation for All Patients Attending Unit or Centre

Adults Consent

Gain consent to be seen by a nurse practitioner
Gain consent for treatment and sharing information and document.

Clinical Presentation

If unwell assess for:

- Airway
- Breathing
- Circulation
- Disability
- Exposure

Document a full set of observations including neurological observations including Glasgow coma score if applicable.

Record NEWS 2 for handover to secondary care.

Document pain score using numeric rating scale. For cognitively impaired patients document any signs of pain (e.g. grimaces or distress).

Safeguarding

- Ask the domestic abuse question, ‘do you feel safe at home?)
- Assess for learning disability and whether patient has a hospital passport in place.
- Assess for mental capacity and if the person is a vulnerable adult.
- Assess falls risk. Complete falls referral if applicable.

APPENDIX B – Essential Documentation for All Patients Attending Unit or Centre

Child and Young Persons under 18 Years Old Consent
Gain consent to be seen by a nurse practitioner
Gain consent for treatment and sharing information
Assess and document competence according to Fraser guideline if applicable.
Document name of person(s) accompanying patient

Clinical Presentation

If unwell assess for:

- Airway
- Breathing
- Circulation
- Disability
- Exposure

Record PEWS: if any one parameter is triggered transfer to secondary care or seek advice from medical practitioner.

Use guideline Traffic Light System (NICE) 2013 if applicable.
Use guideline Feverish Illness (NICE) 2013 if applicable.
Document pain score using FLACC, Wong Baker Faces or numeric rating scale.

Safeguarding

- Complete the safeguarding children's questions (NICE 2003)
- Any injury or bruise on a non-mobile infant or child: follow Safeguarding Children Policy (2018). These children must be reviewed by a Consultant in Emergency Medicine or a Consultant Paediatrician and a MASH (multi agency safeguarding hub) referral must be made.

DOCUMENT ALL FINDINGS IN THE CLINICAL TREATMENT RECORD AND ACT ON THEM FOLLOWING NDHCT GUIDELINES.

APPENDIX C – Training Competency Form

Management of Chest Wall Injury (over 12 years of age)

Procedure operational from July 2019 and expires end of July 2022

The registered health professional named below, being employees of Northern Devon Healthcare Trust based at ……. have received training and are competent to operate under this procedure

NAME *(please print)*	PROFESSIONAL TITLE	SIGNATURE	AUTHORISING MANAGER *(please print)*	MANAGER'S SIGNATURE	DATE

Keep original with the authorising manager and send a copy to: Karen Watts, Emergency Department, Northern Devon Healthcare Trust NHS, Raleigh Park, Barnstaple, Devon, EX31 4JB