BLRS GUIDANCE FOR UNITS DURING COVID-19 PANDEMIC 2020

BLRS members will continue to provide the best care possible but resources will be compromised during the pandemic. Patients should be kept informed of the current local situation but reassured that care and advice will still be available. All patient care including remote consultations should be documented in the context of a pandemic.

Patients already being treated with external fixation:

Remote consultations should be made available. Trusts should have their own preferred platforms. Avoid using your personal account (or withhold your caller ID). This can be combined with community radiographs which are linked to tertiary PACS. Face to face consultations should still take place when necessary such as dealing with problems such as snapped wires, infections not responding to oral antibiotics and judging time of healing, deformity correction and fixator removal. All these patients should be screened on entry to clinic area for COVID-19 and postponed if positive for symptoms. Clinics in a unit may be amalgamated to a single weekly session with physio and specialist nurse for increased efficiency. Access to pin site care leaflets and suitable websites should be maximised.

Frame removal:

This should be encouraged to take place in the outpatient setting rather than theatre if possible.

Acute fracture management

The BOA has advocated non-operative methods wherever possible, but when this is not a reasonable option the surgery should be carried out as efficiently as possible. Theatre rotas should be flexible to allow members to provide definitive care (including circular frames) at primary surgery rather than staged treatment. Orthoplastic collaboration is essential and early senior consultant decision-making is mandatory for attempted limb salvage or primary amputation and will take into account local resources. All described methods for treating bone and soft tissue loss such as acute deformation, cement spacers, as well as bone transport should be considered according to the resources available.

Tertiary referrals

Urgent referrals: Normal referral pathways may be compromised, but local trauma units should still be supported with communication and advice in dealing with more cases locally if required. Some tertiary centres may have more capacity than others and referrals can be diverted. If possible decentralise ambulatory trauma to elective hospitals and trauma units.

Non urgent referrals: It is likely that it will not be possible to see and treat routine limb reconstruction patients during the period of crisis. Referrals can be acknowledged by a standard letter and placed in a queueing system informing the referring team, GP and the patient that they will not be sent an appointment until the service resumes.