

Email: tsdft.foirequests@nhs.net
Our Ref: TSD10643

Dear Sir/Madam,

Request for Information

We are writing to confirm that we have now completed our search for the information you requested.

A copy of the information is below:

1. Single-shot chest wall blocks in the Emergency Department

a. Does your Trust provide single-shot ultrasound-guided chest wall blocks (e.g. serratus anterior plane block [SAPB] or erector spinae plane block [ESPB]) for adults with traumatic rib fractures in the Emergency Department prior to hospital admission?

Yes

If yes:

b. Which specialty or specialties perform these blocks (e.g. Emergency Medicine, Anaesthetics, Critical Care)?

Anaesthetics at present

c. Are these blocks delivered as part of a formal pathway or standard clinical practice?

Yes

d. Following a single-shot block, is it standard practice for patients to be considered for escalation to a continuous chest wall catheter (e.g. SAPB or ESPB catheter) and/or epidural analgesia?

Yes

If not:

e. If single-shot chest wall blocks are not routinely performed in the Emergency Department, are they routinely performed later during the patient's admission for traumatic rib fractures?

Not applicable

f. Which specialty or specialties perform these blocks ?

Not applicable

2. Continuous chest wall catheter techniques

a. Does your Trust provide continuous chest wall catheter techniques (e.g. SAPB or ESPB catheters) for adults admitted with traumatic rib fractures?

Yes

If yes:

b. Which specialty or specialties perform these procedures?

Anaesthetics

c. In which clinical areas are these procedures typically performed (e.g. Emergency Department, Anaesthetic Room, Operating Theatre, Critical Care Unit, Ward)?

Anaesthetic Room

d. Are patient selection criteria used (e.g. STUMBL Score, Battle Score, RibScore, or other risk stratification tools)? If so, please specify.

Chest Injury score

3. Policy and guidance

a. Please attach a copy of all the specific guidelines and/or protocol and/or standard operational procedure for the chest wall blocks (including any competence/training/education if one is in place)

Please see our Chest Trauma; Assessment and Management in Adult Patients guidelines attached.

If no specific local guideline or SOP exists for this, please explicitly state 'No local guideline held'

Not applicable

4. Physiotherapy management of rib fractures

a. Does your Trust provide specific physiotherapy interventions for adults with traumatic rib fractures, including patients discharged directly from the Emergency Department?

Yes

Examples may include incentive spirometry, breathing exercises, respiratory physiotherapy, kinesiology taping (K-tape), or other structured interventions.

If yes:

b. Please describe the interventions provided.

Interventions include incentive spirometry, respiratory physiotherapy and breathing exercises.

c. Please provide copies of any associated guidelines, pathways, SOPs, patient information leaflets, or physiotherapy protocols.

If no such documents are held, please state: "No local guideline held."

[No local guideline held](#)

5. Other rib fracture management pathways

a. Please provide copies of any additional local guidelines, pathways, SOPs, protocols, or care bundles relating to the management of adults with traumatic rib fractures that have not already been provided in response to Questions 3 and 4. This includes the Emergency Department, inpatient, surgical, medical, trauma, critical care, and physiotherapy pathways.

If no additional documents are held, please state: "No other local guideline held."

[No other local guideline held](#)

6. Patient disposition

a. For adults with multiple traumatic rib fractures who do not require Level 2 or Level 3 care, to which ward or specialty area are they most commonly admitted?

[General surgical ward](#)

7. Specialty

a. In your Trust, which parent speciality or specialities (e.g. Emergency Medicine, Frailty, Respiratory, Trauma & Orthopaedics, Cardiothoracic, or General Surgery) mainly look after adults with multiple rib fractures from blunt chest wall trauma as an inpatient for the first 5-7 days?

[General surgery](#)

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If you wish to discuss any of the above, please contact us, quoting the FOI reference number above.

If you are unhappy with the way in which we have handled your request, please contact the Data Protection and Freedom of Information Lead in the first instance. If you wish to make a formal complaint, you should write to our Complaints Manager at Torbay and South Devon NHS Foundation Trust, First Floor Bowyer Building, Torbay Hospital, Torquay TQ2 7AA or by email to tsdft.feedback@nhs.net

If you are not content with the outcome of your complaint or the internal review, you may apply directly to the Information Commissioner for a decision. Generally, the Information Commissioner will only make a decision once you have exhausted the complaints and/or internal review process provided by us. The Information Commissioner can be contacted at: The Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF or through this link <https://ico.org.uk/global/contact-us/>



Torbay and South Devon
NHS Foundation Trust

Yours sincerely,

Freedom of Information Team

Document Type:	Guideline	
Reference Number : 2334	Version Number: 2	Next Review Date: 31st March 2028
Title:	Chest Trauma; Assessment and Management in Adult Patients	
Document Author:	Clinical Service Lead for Major Trauma	
Applicability:	Adult patients (18 years and older) who have sustained suspected rib fractures in the context of trauma.	

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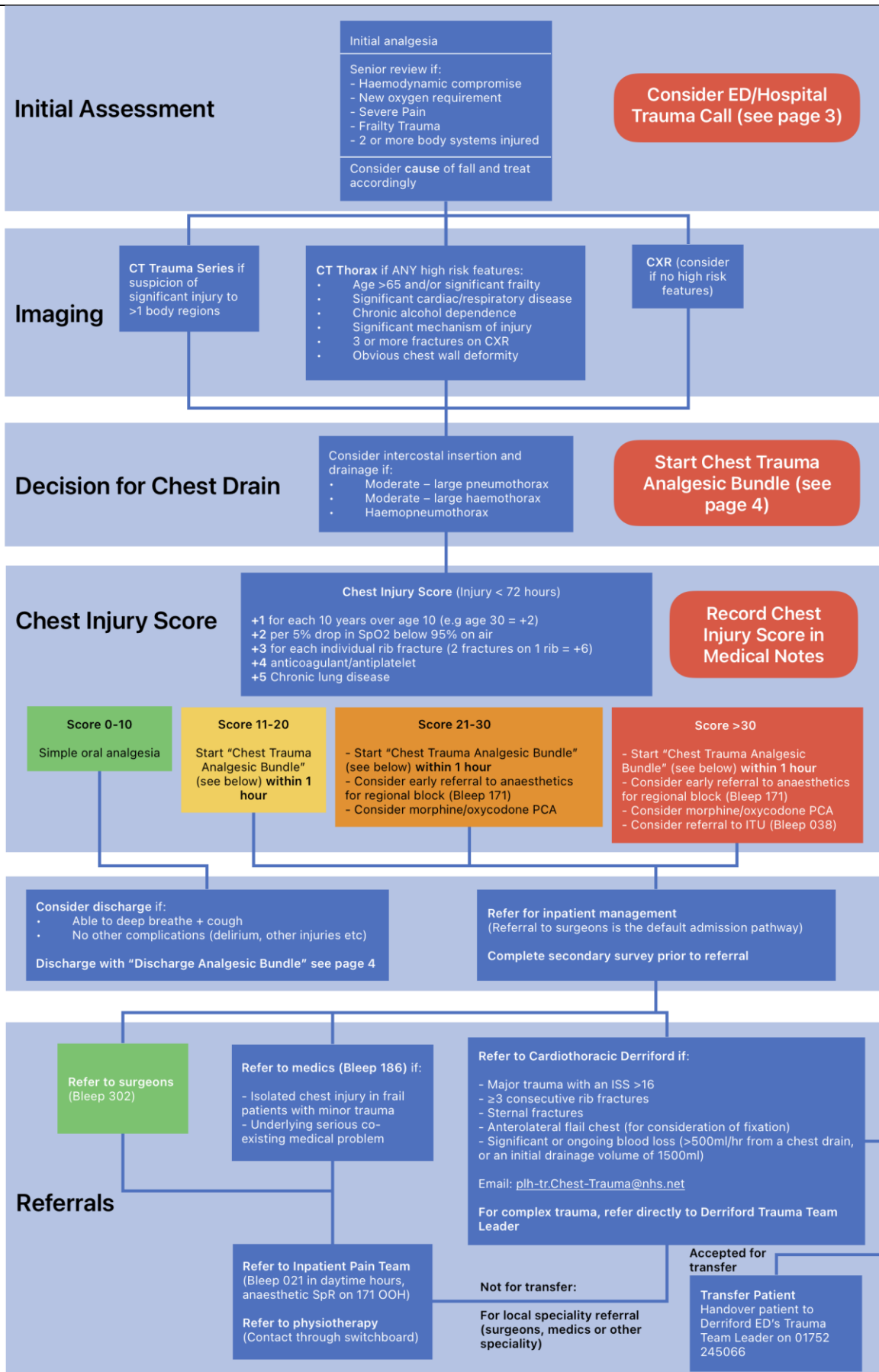
1.0 Chest Trauma Flowchart

2.0 Trauma Call Criteria

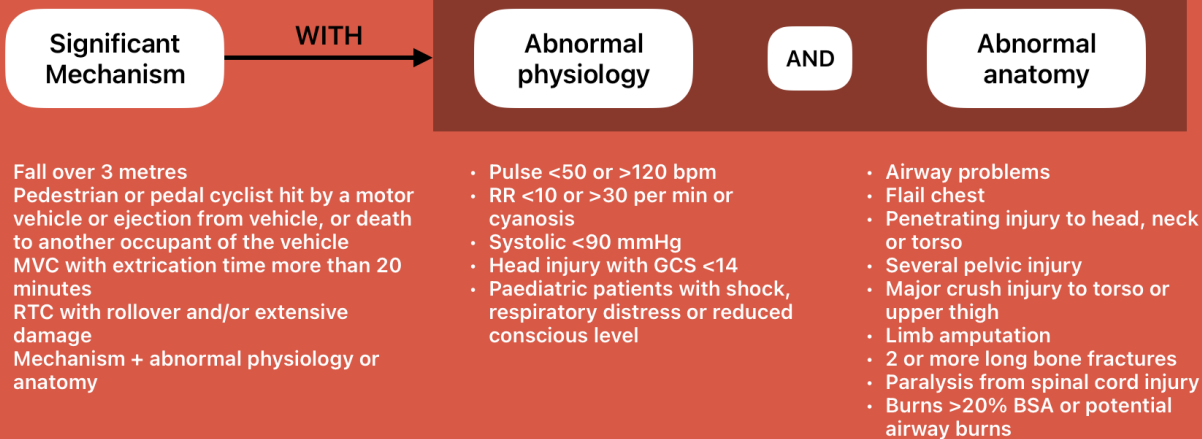
3.0 Chest Trauma Analgesic Bundle

4.0 Management of Chest Trauma in Adults

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- 4.13 Observations



Criteria for Hospital Trauma Call (2222)



Special circumstances = Multiple patients involved

Hospital trauma team:

ED senior doctor (Consultant)
ED junior doctor x2
ED nurse x2
Radiographer & radiology
Surgical registrar
Anaesthetic registrar
Orthopaedic registrar
(Paediatric registrar)

An ED Trauma Call should be considered for *any* patient with a significant mechanism of injury (see above) despite normal anatomy/physiology.

A Silver/Frailty Trauma Call should be considered for any patient over 65, or with significant frailty (CFS >4) with any history of trauma or a fall *and* abnormal physiology and/or anatomy meeting the criteria below:

Airway	Breathing	Circulation	Disability
Obstructed	RR >20	HR >90	GCS <15 (or normal for patient)
Requiring adjuncts	SpO2 <94%	SBP <110	Unequal pupils
	SpO2 <88% in known CO2 retention	Lactate >2.5	Abnormal pupillary response
Consider dentures, foreign bodies and facial fractures	Chest wall injury (bruising, tenderness or surgical emphysema)	Abdominal or pelvic pain or bruising Suspicion of long bone fracture Oral anticoagulant use	Focal neurological deficit Spinal pain
All patients should be reviewed by a senior clinician (ST4+) at the earliest opportunity.			
If none of the above are present that patient may be appropriate for standard care			

Chest Trauma

Analgesic Bundle

[Grab your reader's attention with a great

to focus the document on this point
anywhere on the page, just drag it.]

65 years old and below

Paracetamol 1g QDS (weight adjust if appropriate)

Ibuprofen 400mg QDS

Tramadol 50-100mg QDS OR **Codeine** 30mg-60mg QDS
Oxynorm 5mg-10mg, 2-4 hourly PRN

Pregabalin 75mg BD for 2 weeks

Lidocaine 5% Plasters - up to 3 plasters on at any one time. 18 hours on, 6 hours off for 2 weeks

65-75 years old

Paracetamol 1g QDS (weight adjust if appropriate)

Ibuprofen 400mg QDS

Tramadol 50-100mg QDS OR **Codeine** 30mg-60mg QDS
Oxynorm 2.5mg-5mg, 2-4 hourly PRN

Pregabalin 75mg BD for 2 weeks

Lidocaine 5% Plasters - up to 3 plasters on at any one time. 18 hours on, 6 hours off for 2 weeks

75-85 years old

Paracetamol 1g QDS (weight adjust if appropriate)

Ibuprofen 5% gel PRN

Tramadol 50mg QDS OR **Codeine** 15mg-30mg QDS
Oxynorm 1.25mg-2.5mg, 2-4 hourly PRN

Pregabalin 50mg BD for 2 weeks

Lidocaine 5% Plasters - up to 3 plasters on at any one time. 18 hours on, 6 hours off for 2 weeks

85 years old and above

Paracetamol 1g QDS (weight adjust if appropriate)

Ibuprofen 5% gel PRN

Tramadol 25mg-50mg QDS OR **Codeine** 15mg TDS
Oxynorm 1.25mg, 4 hourly PRN

Pregabalin 25 mg BD for 2 weeks

Lidocaine 5% Plasters - up to 3 plasters on at any one time. 18 hours on, 6 hours off for 2 weeks

Consider early referral to anaesthetics for regional block

Renal Impairment (eGFR <30)

eGFR <60

Paracetamol 1g QDS (weight adjust if appropriate)

Avoid NSAIDs

Tramadol 25mg-50mg TDS OR **Codeine** 15mg TDS
Oxynorm 1.25mg, 4 hourly PRN

Pregabalin 25 mg BD for 2 weeks

Lidocaine 5% Plasters - up to 3 plasters on at any one time. 18 hours on, 6 hours off for 2 weeks

Discharge Analgesic Bundle (ED only)

Advise regular **paracetamol** and **ibuprofen**

Codeine 15-30mg TDS for 2 weeks

Oromorph 5-10mg PRN (if required oromorph/oxynorm during attendance)

Lidocaine 5% Plasters - up to 3 plasters on at any one time. 18 hours on, 6 hours off for 2 weeks (from OP pharmacy in-hours, FP10 if out-of-hours)

NB: lidocaine 5% patches are **licenced for 12 hours on 12 hours off use**, aspects of this guidance support off licence prescribing of this preparation in line with pain team common practice.

Management of Chest Trauma (including rib fractures) in Adults

1. Introduction

This guideline should be referred to in patients that have blunt chest trauma or rib fractures. Any suspected or confirmed penetrating chest trauma are not covered in this guideline.

Chest trauma is a common presentation to hospital, particularly in the elderly community where frailty and risk of falls are more frequent. There is a high mortality associated with chest trauma, typically due to inadequate analgesia, physiotherapy and impeded respiratory function. Mortality rate can be up to 15% in high-risk groups, with a complication rate of 35% within 48 hours of the injury if inadequately managed.

Some patients are particularly high risk, and those with the following risk factors have a mortality closer to 20%.

- ≥ 3 rib fractures
- Underlying respiratory disease
- Underlying cardiac disease
- Alcohol dependence
- Age >65

Patients may present to the emergency department with a clear history of chest injury, but many are only identified later. These patients are typically frail and may be admitted under the medical take following a collapse. In these instances, diagnosis may be delayed, which puts patients at an increased risk of complications.

2. On arrival

Patients presenting to the emergency department (ED) with chest trauma should trigger a trauma call as per the ED guidelines (See page 3).

After assessing for injuries, consider the cause of the fall e.g. Postural hypotension, cardiogenic syncope etc. and treat any reversible causes.

3. Imaging

The gold standard investigation is a CT thorax (non-contrast). This should be performed in all patients that are over the age of 65 or meet any other high-risk criteria. This should be performed urgently, and analgesia should not be delayed whilst awaiting imaging. Patients with multiple body areas injured should have a CT trauma scan.

Young, stable patients with a low energy mechanism of injury may be appropriate for a CXR. If they are then found to have over 3 ribs fractures or any additional complications, they should subsequently be referred for a CT scan.

4. Analgesia

(Refer to the Chest Trauma Analgesic Bundle for prescriptions on page 4)

Patients need to be sufficiently comfortable to be able to take deep breaths, cough, and comply with physiotherapy to reduce respiratory complications. Low risk patients may be able to manage with simple analgesia in the community.

All patients who are being admitted need referral to the inpatient pain service (IPS) for assessment within 12 hours and consideration of an early regional anaesthesia either in theatre or in the emergency department. Regional anaesthesia should be performed by appropriately trained staff.

To contact the IPS, bleep 021 in daytime hours, anaesthetic registrar on bleep 171 OOH. Another option is to find the acute pain nurse at the anaesthetic handover in theatres at 0800 each morning.

All patients should have sufficient analgesia to permit deep breathing while awaiting IPS review, including paracetamol, NSAIDs, opioids, lignocaine patches, pregabalin, and PCA (where appropriate for, and tolerated by, the individual patient).

Consider early regional block if:

- Significant injury with known frailty
- Unable to deep breath despite initiating chest trauma analgesia

Patients who have their pain controlled on the analgesic bundle and are able to deep breath, cough, move and raise their arms above their heads comfortably will not need to be assessed for a regional nerve block or local anaesthetic infusion.

5. Referral to MTC

Patients that meet criteria for automatic acceptance and secondary transfer should be discussed with the Trauma Team Leader (TTL) at Derriford.

Patients who have severe injuries isolated to the chest wall should be discussed directly with cardiothoracics and transfer considered:

- Major trauma with an ISS >16
- ≥3 consecutive rib fractures
- Sternal fractures
- Anterolateral flail chest (for consideration of fixation)

-
- Significant or ongoing blood loss (>500ml/hr from a chest drain, or an initial drainage volume of 1500ml)

Email plh-tr.Chest-Trauma@nhs.net including:

- Patient name
- Patient DOB
- NHS number
- Mechanism of injury and details of injuries sustained

If accepted by cardiothoracics, the patient needs to be handed over to Derriford's Trauma Team Leader (TTL) by calling 01712 245066. A preliminary Injury Severity Score (ISS) should be calculated (via MDCalc) and included in the handover.

Transfer should be organised by the ED clinician via urgent blue light ambulance transfer with support from the ED coordinator.

6. Admission

In low risk patients whose pain can be managed with simple analgesics consider discharge.

Patients requiring admission should be admitted under the surgeons unless the following apply:

- The patient is transferred to Derriford rather than being admitted.
- Isolated chest wall injury in a frail patient with minor trauma (i.e. does not meet the criteria for a trauma call). These patients should be admitted under the medical team. All patients referred to the medical team require discussion with the medical registrar on-call (bleep 186).
- There is a more serious co-existing problem requiring the intervention of another specialty (e.g. fractured neck of femur), in which case they may be admitted under that specialty only with the agreement of the consultant.

Where there is not a clear history of an obvious traumatic mechanism the circumstances surrounding the injury should be ascertained. Those patients where a medical cause for their collapse is suspected, who are not admitted under the medical team, should be discussed with the medical registrar on-call so that they can be reviewed and reason for their fall can be investigated.

The final decision regarding admission rests with the most senior clinician of the referring team. In cases where admission pathway is not clear, a consultant-to-consultant discussion should be made.

7. Chest drains

Patients who require surgical chest drains should have these inserted by a suitably trained professional. These patients should ONLY be admitted to Allerton (if under the Surgical team), Midgley (if under the Medical team) or ITU.

8. Physiotherapy

All patients who are admitted should be referred to the physiotherapy team for incentive spirometry and early intervention. This can only take place if their pain is appropriately controlled. Refer to the on-call physiotherapist (available through switchboard) for review within 12 hours.

For respiratory physiotherapist referral within normal hours (8am-4pm), bleep 226.
For out-of-hours urgent referral, refer to the respiratory physiotherapist via switchboard.
For out-of-hours non-urgent referral, leave a message on 01803 655341 for an early review in the morning.

Patients should be encouraged to sit up in bed, sit out of bed and mobilise as much as they are able to.

9. Referral to Critical Care

High risk patients should be referred to the critical care outreach team. Those with severe injuries should be reviewed by the ITU doctor on admission. In daytime hours Critical Care Outreach can be reached on #6439. Out of hours bleep 154 (surgical).

10. Tertiary survey

All patients should have a tertiary survey performed on the first post admission ward round. The consultant in charge of their care should decide on the most appropriate person to perform this and refer accordingly.

A tertiary survey should include a review of the patients notes, blood tests, imaging and any other tests that have been performed.

11. Constipation

Patients receiving opioids are likely to become constipated. Consider prescribing prophylactic regular laxatives.

12. Venous thromboembolism prophylaxis

Before prescribing or administering enoxaparin consider whether the patient is likely to need an epidural. An epidural cannot be performed for 12 hours following enoxaparin, and enoxaparin should be withheld until 4 hours after an epidural has been sited. Other traumatic injuries should be considered prior to commencing VTE prophylaxis as these may convey an increased risk of bleeding.

13. Observations

All patients should have observations a minimum of four hourly, including:

- Heart rate
- Blood pressure
- Temperature
- Respiratory rate
- Oxygen saturations
- Oxygen requirements
- Pain score

Document Control Information

This is a controlled document and should not be altered in any way without the express permission of the author or their representative.

Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.

If printed, this document is only valid for the day of printing.

This guidance has been registered with the Trust. The interpretation and application of guidance will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using clinical guidance after the review date, or outside of the Trust.

Ref No:	2334		
Document title:	Chest Trauma – Assessment and Management in Adult Patients		
Purpose of document:	To provide guidance in the assessment and management of patients with suspected rib fractures for assessing clinicians.		
Date of issue:	1 st April 2025	Next review date:	31 March 2028
Version:	2	Last review date:	31 March 2025
Author:	Clinical Service Lead for Major Trauma		
Directorate:			
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief		
Committee(s) approving the document:	Clinical Service Lead for Major Trauma		
Date approved:	`		
Links or overlaps with other policies:	Major Trauma guidelines: https://icon.torbayandsouthdevon.nhs.uk/corp_doc_mgmt/Clinical%20Effectiveness/G0157.pdf#search=major%20trauma Enoxaparin (Inhixa) prescribing guidelines: https://icon.torbayandsouthdevon.nhs.uk/areas/pharmacy/Pages/Enoxaparin.aspx Pleural Procedures; Key Safety Recommendations For: https://icon.torbayandsouthdevon.nhs.uk/corp_doc_mgmt/Clinical%20Effectiveness/G1706.pdf#search=chest%20drain Intercostal Chest Drain Check List and Report: https://icon.torbayandsouthdevon.nhs.uk/corp_doc_mgmt/Clinical%20Effectiveness/Intercostal%20Chest%20Drain%20checklist.pdf#search=chest%20drain		

Have you identified any issues on the Rapid (E)quality Impact Assessment. If so please detail on Rapid (E)QIA form.	Yes ☐	
	<i>Please select</i> Yes No	
Does this document have implications regarding the Care Act? <i>If yes please state:</i>	☐	☐
Does this document have training implications? <i>If yes please state:</i>	☐	☐
Does this document have financial implications? <i>If yes please state:</i>	☐	☐
Is this document a direct replacement for another? <i>If yes please state which documents are being replaced:</i>	☐	☐

Document Amendment History

Date	Version no.	Amendment summary	Ratified by:
17 August 2018	1	New	Clinical Lead for accident and Emergency Clinical Director of Pharmacy
1 April 2025	2	Reviewed with amendments	Clinical Lead for accident and Emergency Clinical Director of Pharmacy

The Mental Capacity Act 2005

The Mental Capacity Act 2005 provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future.

It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions.

There is a legal duty placed upon all staff to apply the Mental Capacity Act 2005 in all circumstances where a person is required to consent to 'acts in connection with care and treatment' and where there is reason to doubt the person's mental capacity to do so.

Guidance can be accessed via [Pages - Mental Capacity Act \(torbayandsouthdevon.nhs.uk\)](https://www.torbayandsouthdevon.nhs.uk/pages-mental-capacity-act)

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

Rapid (E)quality Impact Assessment (EqIA) *(for use when writing policies)*

Policy Title (and number)		Version and Date	
Policy Author			
An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.			
Who may be affected by this document?			
Patients/ Service Users ☐		Staff ☐	Other, please state... ☐
Could the policy treat people from protected groups less favourably than the general population? <i>PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below</i>			
Age	Yes ☐ No ☐	Gender Reassignment	Yes ☐ No ☐
Race	Yes ☐ No ☐	Disability	Yes ☐ No ☐
Gender	Yes ☐ No ☐	Pregnancy/Maternity	Yes ☐ No ☐
Is it likely that the policy could affect particular 'Inclusion Health' groups less favourably than the general population? (substance misuse; teenage mums; carers ¹ ; travellers ² ; homeless ³ ; convictions; social isolation ⁴ ; refugees)			Yes ☐ No ☐
Please provide details for each protected group where you have indicated 'Yes'.			
VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion			
Is inclusive language ⁵ used throughout?			Yes ☐ No ☐ NA ☐
Are the services outlined in the policy fully accessible ⁶ ?			Yes ☐ No ☐ NA ☐
Does the policy encourage individualised and person-centred care?			Yes ☐ No ☐ NA ☐
Could there be an adverse impact on an individual's independence or autonomy ⁷ ?			Yes ☐ No ☐ NA ☐
EXTERNAL FACTORS			
Is the policy a result of national legislation which cannot be modified in any way?			Yes ☐ No ☐
What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)			
Who was consulted when drafting this policy?			
Patients/ Service Users ☐	Trade Unions ☐	Protected Groups (including Trust Equality Groups) ☐	
Staff ☐	General Public ☐	Other, please state... ☐	
What were the recommendations/suggestions?			
Does this document require a service redesign or substantial amendments to an existing process? <i>PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below</i>			Yes ☐ No ☐
ACTION PLAN: Please list all actions identified to address any impacts			
Action	Person responsible	Completion date	
AUTHORISATION:			
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them			
Name of person completing the form		Signature	
Validated by (line manager)		Signature	

Please contact the Equalities team for guidance:

For Devon CCG, [REDACTED]

For Torbay and South Devon NHS Trusts, [REDACTED]

This form should be published with the policy and a signed copy sent to your relevant organisation

Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user

² Travelers may not be registered with a GP - consider how they may access/ be aware of services available to them

³ Consider any provisions for those with no fixed abode, particularly relating to impact on discharge

⁴ Consider how someone will be aware of (or access) a service if socially or geographically isolated

⁵ Language must be relevant and appropriate, for example referring to partners, not husbands or wives

⁶ Consider both physical access to services and how information/ communication is available in an accessible format

⁷ Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy

Clinical and Non-Clinical Policies – Data Protection

Torbay and South Devon NHS Foundation Trust (TSDFT) has a commitment to ensure that all policies and procedures developed act in accordance with all relevant data protection regulations and guidance. This policy has been designed with the EU General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA 18) in mind, and therefore provides the reader with assurance of effective information governance practice.

The UK data protection regime intends to strengthen and unify data protection for all persons; consequently, the rights of individuals have changed. It is assured that these rights have been considered throughout the development of this policy. Furthermore, data protection legislation requires that the Trust is open and transparent with its personal identifiable processing activities and this has a considerable effect on the way TSDFT holds, uses, and shares personal identifiable data.

Does this policy impact on how personal data is used, stored, shared or processed in your department? Yes ☐ No ☐

If yes has been ticked above it is assured that you must complete a data mapping exercise and possibly a Data Protection Impact Assessment (DPIA). You can find more information on our [GDPR](#) page on ICON (intranet)

For more information:

- Contact the Data Access and Disclosure Office on dataprotection.tsdf@nhs.net,
- See TSDFT's [Data Protection & Access Policy](#),
- Visit our [Data Protection](#) site on the public internet.