

# Minor Injuries

## Authors

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## Introduction

Minor injuries is a branch of practice of Emergency Medicine that refers to injuries that do not normally need admission to hospital. The name minor injuries has been unnecessarily pejorative, as inadequate diagnosis and treatment can result in substantial disability. Fractures, dislocations, joint injuries and amputations account for around 5% of all emergency department attendances.

## Standards

1. Written patient information about common musculoskeletal injuries, such as sprained or fractured ankle, wound care, small burns, must be easily available. Digital versions, for example utilising QR codes is an alternative if this is the patient's preference.
2. Clear pathways must be available to outpatient specialist clinics, such as fracture clinic and eye units.
3. Staff working in minor injury units must have easy access to senior decision-making clinical advice supported by image transfer and / or telemedicine so that patients are not transferred unnecessarily solely for opinions.
4. There must be a clear pathway to physiotherapy for people who will benefit after an acute injury.
5. Emergency departments should support the provision of virtual fracture clinics, as well as the traditional face to face clinics.
6. A clinical area that treats patients with minor injuries must have ready access to x-ray facilities and equipment to enable the assessment and treatment of common eye injuries. The minor injury area should have a separate clinical space for plastering and plaster removal which is compliant with the relevant health and safety legislation. Wound assessment and treatment should be performed in an appropriate clinical environment which minimises the risk of nosocomial infection.
7. All ED plain radiography should be reported by either a radiologist or reporting radiographer, ideally in real time. EDs must have systems in place to ensure all radiology reports are checked.
8. Provision of a Statement of Fitness for Work must be issued by the ED to those patients who are clearly not going to be fit for work after the 7 day 'self-certification' period.
9. Departments must ensure appropriate safeguarding arrangements are in place for potential vulnerable patients presenting with 'minor injuries' eg. children, the elderly, victims of domestic violence etc.

## Recommendations

- 1.** A type 1 emergency department should have a minor injury unit co-located or very close to allow easy streaming and transfer.
- 2.** Patients who suffer an injury away from their local hospital that requires fracture clinic follow up should be referred by their initial treating emergency department to their follow up hospital. The initial treating ED should ensure either the electronic transfer or that a copy accompanies the patient of the relevant clinical information eg. ED notes, X-rays.
- 3.** Departments are encouraged to use alternatives to Nitrous Oxide (for example Pentrox®) for short lasting painful procedures in view of its adverse effect on the environment.

Summary of bony injuries that do not routinely need follow up in a face to face fracture clinic. These can be discharged with written advice and appropriate removable splinting or slings.

### Shoulder

Undisplaced acromio-clavicular joint Injuries  
Clavicle fractures in children under 12 years of age

### Elbow

Undisplaced radial head or neck fractures  
Traumatic elbow effusions

### Wrist

Isolated triquetral fractures (all ages)  
Paediatric torus and buckle fractures

### Hand

Fifth metacarpal neck fractures without rotatory deformity

### Foot and Ankle

Isolated fibular tip fractures  
Base of fifth metatarsal fractures except for Jones fracture  
Closed distal toe phalanx fractures except hallux

## Example poster with suggested management advice

### Specific fracture managements in the Emergency department

Clavicle to elbow			
Diagnosis	Initial treatment	Follow up	Specific info required of MPFC
Fractured clavicle Paediatric under 12 years of age	Broad arm sling for 3 weeks with regular shoulder, elbow and wrist exercises	Leaflet and discharged. Likely time to return to normal activities 5 weeks	If displaced / off ended refer to fracture clinic
Acromio – clavicular joint sprain / separation	AP and axillary views. Broad arm sling for 3 weeks with regular shoulder, elbow and wrist exercises	Leaflet and discharged. Likely time to return to normal activities 5 weeks	If separated > 100% width of clavicle to go to fracture clinic
Fractured head / neck of radius	Broad arm sling for 4 weeks with regular shoulder, elbow and wrist exercises	Leaflet and encourage movement. Likely time to return to normal activities 8 weeks	If multi – fragmented or displaced > 2mm refer to fracture clinic

Forearm to Hand			
Diagnosis	Initial treatment	Follow up	Specific info required of MPFC
5 <sup>th</sup> Metacarpal neck fracture	Bedford finger splint or neighbour strapping for 4 weeks with regular hand wrist exercises	Leaflet and discharged. Likely time to return to normal activities 8 weeks	Check rotation or angulation > 45 degrees and if present refer to first on call
Mallet finger injury non bony	X ray, mallet splint with taping to allow full flexion / extension of middle IPJ. Encourage finger exercises	Leaflet and discharged to hand therapy for splint for 8/52. Can remove splint for gentle washing	If bony mallet more than 25% of joint surface to refer to fracture clinic
Distal radius torus / Buckle fracture Paediatric	Below elbow soft cast / wrist splint. Parents to remove splint / cast at home at 4 weeks	Leaflet and encourage movement. Likely time to return to normal activities 8 weeks	If > 30 degrees angulation refer to fracture clinic. Make sure pure torus not undisplaced bi – cortical fracture (this goes to fracture clinic)

Foot and ankle			
Diagnosis	Initial treatment	Follow up	Specific info required of MPFC
Ankle sprain / soft tissue injury / avulsion fracture	Consider walking boot and crutches. Mobilise full weight bearing as pain allows. To slowly wean from boot over 6 weeks. Encourage elevation and icing. Encourage ROM exercises out of the boot	Leaflet and discharged. May remove boot for washing and sleeping as pain allows	Consider physiotherapy referral for rehabilitation
Avulsion fracture 5 <sup>th</sup> metatarsal base	Consider walking boot and crutches. Mobilise full weight bearing as pain allows. To slowly wean from boot over 6 weeks. Encourage elevation and icing. Encourage ROM exercises out of the boot DARCO shoe	Leaflet and discharged. May remove boot for washing and sleeping as pain allows	
All closed toe fractures (metatarsal to distal phalanx)	Consider DARCO shoe/walking boot. Mobilise full weight bearing as pain allows. To slowly wean from the boot over 6 weeks. Encourage elevation and icing. Encourage ROM exercises out of boot	Leaflet and discharged. May remove shoe / boot for washing and sleeping as pain allows. Likely time to return to normal activities: 8 weeks	

## References

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