BRITISH ASSOCIATION
OF HAND THERAPISTS

# Standards of hand therapy practice in the rehabilitation of surgically and non-surgically managed distal radius fractures.

***Endorsed by:***
*British Association of Hand Therapists*
*Devised by the Rehabilitation of the Distal Radius Fractures Working Group*
*Further information is available from: https://www.hand-therapy.co.uk*
***This BAHT Standard has been developed to compliment the respective BSSH Standard of Care in Hand Trauma. It is based on research and expert opinion.***

**Definition:**

These standards relate to rehabilitation after a distal radius fracture (DRF), regardless of the initial management, and after referral for hand therapy. A DRF is a common injury affecting all ages but is more typical in the older age group. A DRF is often associated with co-morbidities and complications of injury. A DRF has the potential to result in both short and long-term functional limitations and reduced quality of life. The aim of therapy

is to optimise wrist and hand musculoskeletal performance, restore function, and appropriately action injury-associated risk factors, such as falls and bone health.

Treatment of young children (<10years) with fractures of the distal radius should be carried out by a therapist with experience of working with this age group. Assessment and treatment must be adapted with engaging age-appropriate activity. Competency for management of children following DRF should be considered.

Implementation of these standards should be used to guide therapists in the clinical setting following referral to therapy services. It is recognised that care may be influenced by factors including access to hand therapy, nature of injury, patient characteristics, and surgical management. Locally agreed clinical guidelines, evidence-based practice, professional judgement, and clinical reasoning will guide the rehabilitation of surgically and non-surgically managed distal radius fractures.

**Core Standards**

- Following a decision to request rehabilitation, patients should be referred to an appropriately trained therapist or specialist hand therapist experienced in the management of surgically and non-surgically managed DRF for assessment and formulation of a treatment plan.

- Patients should be provided with sufficient information, in an appropriate format (written, verbal and/or electronic) to enable informed decision making, gain consent for assessment and treatment and to optimise engagement with the rehabilitation regime.

- Individual patient factors such as pain, psychological distress, values, expectations, occupations and hand function requirements should be discussed and considered in a joint decision-making process.

- Hand therapists may provide specific advice on return to work including the use of an ‘AHP Health and Work Report’ or provision of a ‘Fit Note’ (Med 3 Certificate) if deemed appropriate, and if within their individual scope of practice in accordance with local policy.

- Virtual appointments and patient-initiated follow-up can be used to support rehabilitation following agreement between the clinician and patient and based on clinical need.

- There should be easy communication and rapid access to the Consultant team if the therapist has concerns at any point in the rehabilitation pathway.

- Clinical documentation should meet The Health and Care Professions Council (HCPC) and locally agreed standards.

- Where an orthosis is provided, this should meet MHRA requirements in line with BAHT published MDR recommendations 2021.

- A recognised patient reported outcome measure should be used at appropriate stages during therapy, and on discharge, in addition to clinically relevant objective measures.

- In the absence of a satisfactory outcome, the patient may be offered referral to a hand surgeon to discuss treatment options.

- In the case of chronic pain and/or long-term physical deficit, there should be a focus on functional restoration using a person-centred holistic approach with consideration of onward referral to other specialist services if appropriate.

- Outcome data and patient satisfaction feedback should be evaluated in conjunction with the BAHT Trauma Standards to optimise patient care.

**Specific Standards**

Timing of initial appointment

1. Both surgically and non-surgically managed DRFs should be seen within 14 days of referral.

2. Patients referred with any specified complications, including those still in cast, should be seen within 7 days of referral.

Mechanism and complications of injury

3. Patients with an injury mechanism of falling should be routinely asked about their history of falls. Those with an identified risk of further falls should be referred to a local falls service and/or GP as appropriate. Falls education literature should be provided.

4. Patients with low energy fractures and/or suspected of having reduced bone density, should be referred to the local fracture liaison service or GP as per local pathway.

5. Patients who require support with essential activities of daily living and/or can no longer undertake any significant caring/parenting role, should be signposted to the appropriate services, such as community rehabilitation services and adult social care.

6. Therapists should be competent in identifying and assessing complications. Examples include fracture non-union or significant malunion, CRPS, tendon rupture, joint instability, carpal tunnel syndrome and psychological distress.

7. Therapists should be competent in selecting and applying appropriate therapy modalities to address any emerging complications and/or refer for medical opinion and/or signpost for pain relief.

Injury education

8. All patients should be given relevant individualised information appropriate to the injury and stage of rehabilitation. Information should include advice on the injury and healing process, swelling and pain, exercise guidance, timely return to usual activities, expectations for functional outcome, cosmesis and signs/symptoms of complications. This list is not exhaustive.

9. All patients should be provided with time-framed contact details for emerging concerns and/or patient-initiated follow-up.

10. Patients should be offered individualised and clinically reasoned rehabilitation that addresses the patient's identified clinical needs and functional goals for home, work and leisure.

11. Treatment can be one to one, group based or self-directed depending on individual needs and service resources.

12. Rehabilitation for DRF should include, as standard, an appropriate home exercise program, injury education and service contact details. See injury education section.

13. All other rehabilitation modalities selected should be based on best available evidence and/or locally agreed guidelines and resources. Examples include exercise therapy, oedema management, manual therapy, splinting, wound and scar care, pain management and functional rehabilitation, including occupation-based exercises.

14. Hand therapists should identify, address and/or appropriately refer onwards any other related musculoskeletal issues, such as shoulder pain and stiffness.

15. Non-complicated DRFs may not require routine follow-up in hand therapy following initial appointment. See points 8 and 9.

Pre-referral patient education considerations

16. Hand therapists are encouraged to support referring services with the provision of good quality patient education early in the injury management to limit the development of injury-associated complications.

17. DRF education might include how to recognise the signs and symptoms of complications (such as altered sensation, infection, Complex Regional Pain Syndrome), pain and oedema management, upper quadrant exercises and encouragement to use the injured limb for light functional activities such as typing and self-care (unless specific fracture management plan prevents this).

18. This information should include details of how to contact the fracture clinic or plaster room in case of concerns.

**Core Standards Supporting References**:

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BAHT Statement on MHRA Compliance https://www.hand-therapy.co.uk/_userfiles/pages/files/baht_mhra_statement_aug_2021.pdf

Fit Note Gov.UK 2023 https://www.gov.uk/government/collections/fit-note

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NICE. Fractures (Non-complex): Assessment and Management, NG382016. https://www.nice.org.uk/guidance/ng38

NICE. Falls in older people: assessing risk and prevention CG161 2013. https://www.nice.org.uk/guidance/cg161

NICE. Osteoporosis: Assessing the risk of fragility fracture CG146, 2012. https://www.nice.org.uk/guidance/cg146

NICE. Patient experience in adult NHS services: improving the experience of care for people using adult NHS services, NG138, 2012. https://www.nice.org.uk/guidance/cg138

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Field Code Changed

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