

Fractures (complex): assessment and management

NICE guideline

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The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

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Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should [assess and reduce the environmental impact of implementing NICE recommendations](#) wherever possible.

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This guideline is the basis of QS166.

Overview

This guideline covers assessing and managing pelvic fractures, open fractures and severe ankle fractures (known as pilon fractures and intra-articular distal tibia fractures) in pre-hospital settings (including ambulance services), emergency departments and major trauma centres. It aims to reduce deaths and long-term health problems by improving the quality of emergency and urgent care.

The guideline should be read alongside the [NICE guidelines on major trauma, major trauma: service delivery, spinal injury and fractures \(non-complex\)](#).

Who is it for?

- Healthcare professionals and practitioners who provide care for people with complex fractures in pre-hospital and hospital settings
- People with complex fractures, their families and carers

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in [making decisions about your care](#).

[Making decisions using NICE guidelines](#) explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

Recommendations apply to both children (under 16s) and adults (16 or over) unless otherwise specified. Some recommendations on management depend on whether the growth plate of the injured bone has closed (skeletal maturity). The age at which this happens varies. In practice, healthcare professionals use clinical judgement to determine skeletal maturity. When a recommendation depends on skeletal maturity this is clearly indicated.

1.1 Pre-hospital settings

- 1.1.1 For recommendations on managing airways, recognising and managing chest trauma, controlling external haemorrhage and fluid replacement, see the [NICE guideline on major trauma](#). **[2016]**

Initial pharmacological management of pain

- 1.1.2 For recommendations on pain assessment in people with suspected complex fractures, see the [NICE guideline on major trauma](#). **[2016]**
- 1.1.3 For recommendations on the initial pharmacological management of pain in people with suspected open fractures, see the [NICE guideline on major trauma](#). **[2016]**

- 1.1.4 For recommendations on the initial pharmacological management of pain in people with suspected high-energy pelvic fractures, see the [NICE guideline on major trauma](#). **[2016]**
- 1.1.5 For recommendations on the initial pharmacological management of pain in adults with suspected low-energy pelvic fractures, see the [NICE guideline on hip fracture](#). **[2016]**
- 1.1.6 For recommendations on the initial pharmacological management of pain in adults with suspected pilon fractures and children with suspected intra-articular distal tibia fractures, see the [NICE guideline on non-complex fractures](#). **[2016]**

Using a pelvic binder

- 1.1.7 If active bleeding is suspected from a pelvic fracture following blunt high-energy trauma:
- apply a purpose-made pelvic binder, **or**
 - consider an improvised pelvic binder but only if a purpose-made binder does not fit. **[2016]**

Initial management of open fractures before wound excision

- 1.1.8 Do not irrigate open fractures of the long bones, hindfoot or midfoot in pre-hospital settings. **[2016]**
- 1.1.9 Consider a saline-soaked dressing covered with an occlusive layer for open fractures in pre-hospital settings. **[2016]**
- 1.1.10 In the pre-hospital setting, consider administering prophylactic intravenous antibiotics as soon as possible and preferably within 1 hour of injury to people with open fractures without delaying transport to hospital. **[2016, amended 2017]**

Splinting long bone fractures of the leg in the pre-hospital setting

1.1.11 In the pre-hospital setting, consider the following for people with suspected long bone fractures of the legs:

- a traction splint or adjacent leg as a splint if the suspected fracture is above the knee
- a vacuum splint for all other suspected long bone fractures. **[2016]**

Destination for people with suspected fractures

1.1.12 Transport people with suspected open fractures:

- directly to a major trauma centre (In some locations or circumstances, intermediate care in a trauma unit might be needed for urgent treatment, in line with agreed practice within the regional trauma network.) or specialist centre that can provide orthoplastic care if a long bone, hindfoot or midfoot are involved, **or**
- to the nearest trauma unit or emergency department if the suspected fracture is in the hand, wrist or toes, unless there are pre-hospital triage indications for direct transport to a major trauma centre. **[2016]**

1.1.13 Transport people with suspected pelvic fractures:

- to the nearest hospital if suspected pelvic fracture is the only pre-hospital triage indication
- directly to a major trauma centre (in some locations or circumstances, intermediate care in a trauma unit might be needed for urgent treatment, in line with agreed practice within the regional trauma network) if they also have other pre-hospital triage indications for major trauma. **[2016]**

1.2 Hospital settings

See recommendations 1.1.2 to 1.1.6 for advice on initial pharmacological management of pain.

Vascular injury

- 1.2.1 Use hard signs (lack of palpable pulse, continued blood loss, or expanding haematoma) to diagnose vascular injury. **[2016]**
- 1.2.2 Do not rely on capillary return or Doppler signal to exclude vascular injury. **[2016]**
- 1.2.3 Perform immediate surgical exploration if hard signs of vascular injury persist after any necessary restoration of limb alignment and joint reduction. **[2016]**
- 1.2.4 In people with a devascularised limb following long bone fracture, use a vascular shunt as the first surgical intervention before skeletal stabilisation and definitive vascular reconstruction. **[2016]**
- 1.2.5 Do not delay revascularisation for angiography in people with complex fractures. **[2016]**
- 1.2.6 For humeral supracondylar fractures in children (under 16s) without a palpable radial pulse but with a well-perfused hand, consider observation rather than immediate vascular intervention. **[2016]**

Compartment syndrome

- 1.2.7 In people with fractures of the tibia, maintain awareness of compartment syndrome for 48 hours after injury or fixation by:
- regularly assessing and recording clinical symptoms and signs in hospital
 - considering continuous compartment pressure monitoring in hospital when clinical symptoms and signs cannot be readily identified (for example, because the person is unconscious or has a nerve block)
 - advising people how to self-monitor for symptoms of compartment syndrome, when they leave hospital. **[2016]**

Whole-body CT of multiple injuries

- 1.2.8 Use whole-body CT (consisting of a vertex-to-toes scanogram followed by CT from vertex to mid-thigh) in adults (16 or over) with blunt major trauma and suspected multiple injuries. Patients should not be repositioned during whole-body CT. **[2016]**
- 1.2.9 Use clinical findings and the scanogram to direct CT of the limbs in adults (16 or over) with limb trauma. **[2016]**
- 1.2.10 Do not routinely use whole-body CT to image children (under 16s). Use clinical judgement to limit CT to the body areas where assessment is needed. **[2016]**

Pelvic fractures

Secondary transfer to a major trauma centre or specialist centre

The [NICE guideline on major trauma: service delivery](#) contains a recommendation for ambulance and hospital trust boards, medical directors and senior managers on transfer between emergency departments.

- 1.2.11 Immediately transfer people with haemodynamic instability from pelvic or acetabular fractures to a major trauma centre for definitive treatment of active bleeding. **[2016]**
- 1.2.12 Transfer people with pelvic or acetabular fractures needing specialist pelvic reconstruction to a major trauma centre or specialist centre within 24 hours of injury. **[2016]**
- 1.2.13 Immediately transfer people with a failed closed reduction of a native hip joint to a specialist centre if there is insufficient expertise for open reduction at the receiving hospital. **[2016]**

Pelvic imaging

- 1.2.14 Use CT for first-line imaging in adults (16 or over) with suspected high-energy pelvic fractures. **[2016]**
- 1.2.15 For first-line imaging in children (under 16s) with suspected high-energy pelvic fractures:
- use CT rather than X-ray when CT of the abdomen or pelvis is already indicated for assessing other injuries
 - consider CT rather than X-ray when CT of the abdomen or pelvis is not indicated for assessing other injuries.
- Use clinical judgement to limit CT to the body areas where assessment is needed. **[2016]**

Controlling pelvic haemorrhage

The [NICE guideline on major trauma: service delivery](#) contains a recommendation for ambulance and hospital trust boards, medical directors and senior managers on interventional radiology and definitive open surgery.

- 1.2.16 For first-line invasive treatment of active arterial pelvic bleeding, use:
- interventional radiology if emergency laparotomy is not needed for abdominal injuries
 - pelvic packing if emergency laparotomy is needed for abdominal injuries. **[2016]**

Removing a pelvic binder

- 1.2.17 For people with suspected pelvic fractures and pelvic binders, remove the binder as soon as possible if:
- there is no pelvic fracture, **or**

- a pelvic fracture is identified as mechanically stable, **or**
- the binder is not controlling the mechanical stability of the fracture, **or**
- there is no further bleeding or coagulation is normal.

Remove all pelvic binders within 24 hours of application. **[2016]**

- 1.2.18 Before removing the pelvic binder, agree with a pelvic surgeon how a mechanically unstable fracture should be managed. **[2016]**

Log rolling

- 1.2.19 Do not log roll people with suspected pelvic fractures before pelvic imaging unless:
- an occult penetrating injury is suspected in a person with haemodynamic instability
 - log rolling is needed to clear the airway (for example, suction is ineffective in a person who is vomiting). **[2016]**

When log rolling, pay particular attention to haemodynamic stability.

Open fractures

Management of open fractures before wound excision

- 1.2.20 Do not irrigate open fractures of the long bones, hindfoot or midfoot in the emergency department before wound excision. **[2016]**
- 1.2.21 Consider a saline-soaked dressing covered with an occlusive layer (if not already applied) for open fractures in the emergency department before wound excision. **[2016]**
- 1.2.22 In the emergency department, administer prophylactic intravenous antibiotics

immediately to people with open fractures if not already given. **[2016]**

Limb salvage in people with open fractures

1.2.23 Do not base the decision whether to perform limb salvage or amputation on an injury severity tool score. **[2016]**

1.2.24 Perform emergency amputation when:

- a limb is the source of uncontrollable life-threatening bleeding, **or**
- a limb is salvageable but attempted preservation would pose an unacceptable risk to the person's life, **or**
- a limb is deemed unsalvageable after orthoplastic assessment.

Include the person and their family members or carers (as appropriate) in a full discussion of the options if this is possible. **[2016]**

1.2.25 Base the decision whether to perform limb salvage or delayed primary amputation on multidisciplinary assessment involving an orthopaedic surgeon, a plastic surgeon, a rehabilitation specialist and the person and their family members or carers (as appropriate). **[2016]**

1.2.26 When indicated, perform the delayed primary amputation within 72 hours of injury. **[2016]**

Wound excision, staging of fixation and cover

1.2.27 Surgery to achieve wound excision, fixation and cover of open fractures of the long bone, hindfoot or midfoot should be performed concurrently by consultants in orthopaedic and plastic surgery (a combined orthoplastic approach). **[2016]**

1.2.28 Perform wound excision:

- immediately for highly contaminated open fractures

- within 12 hours of injury for high-energy open fractures (likely Gustilo–Anderson classification type IIIA or type IIIB) that are not highly contaminated
 - within 24 hours of injury for all other open fractures. **[2016]**
- 1.2.29 Perform fixation and definitive soft tissue cover:
- at the same time as wound excision if the next orthoplastic list allows this within the time to wound excision recommended in 1.2.28, **or**
 - within 72 hours of injury if definitive soft tissue cover cannot be performed at the time of wound excision. **[2016]**
- 1.2.30 When internal fixation is used, perform definitive soft tissue cover at the same time. **[2016]**
- 1.2.31 Use a temporary dressing that avoids wound desiccation and minimises the number of dressing changes after wound excision if immediate definitive soft tissue cover has not been performed **[2022]**.

For a short explanation of why the committee made the 2022 recommendation and how it might affect practice, see the [rationale and impact section on temporary dressings for open fractures after wound excision but before definitive tissue cover](#).

Full details of the evidence and the committee's discussion are in [evidence review A: negative pressure wound therapy for temporary closure of open fractures](#).

Pilon fractures in adults (skeletally mature)

- 1.2.32 Create a definitive management plan and perform initial surgery (temporary or definitive) within 24 hours of injury in adults (skeletally mature) with displaced pilon fractures. **[2016]**
- 1.2.33 If a definitive management plan and initial surgery cannot be performed at the receiving hospital within 24 hours of injury, transfer adults (skeletally mature)

with displaced pilon fractures to an [orthoplastic centre](#) (ideally this would be emergency department to emergency department transfer to avoid delay). **[2016]**

- 1.2.34 Immediately transfer adults (skeletally mature) with displaced pilon fractures to an orthoplastic centre if there are wound complications. **[2016]**

Intra-articular distal tibia fractures in children (skeletally immature)

- 1.2.35 Create a definitive management plan involving a children's orthopaedic trauma specialist within 24 hours of diagnosis in children (skeletally immature) with intra-articular distal tibia fractures. **[2016]**
- 1.2.36 If a definitive management plan and surgery cannot be performed at the receiving hospital, transfer children (skeletally immature) with intra-articular distal tibia fractures to a centre with a children's orthopaedic trauma specialist (ideally this would be emergency department to emergency department transfer to avoid delay). **[2016]**

1.3 Documentation

The [NICE guideline on major trauma: service delivery](#) contains recommendations for ambulance and hospital trust boards, senior managers and commissioners on documentation within a trauma network.

- 1.3.1 Follow a structured process when handing over care within the emergency department (including shift changes) and to other departments. Ensure that the handover is documented. **[2016]**
- 1.3.2 Ensure that all patient documentation, including images and reports, goes with patients when they are transferred to other departments or centres. **[2016]**
- 1.3.3 Produce a written summary, which gives the diagnosis, management plan and

expected outcome, and:

- is aimed at and sent to the patient's GP within 24 hours of admission
- includes a summary written in plain English that is understandable by patients, family members and carers
- is readily available in the patient's records. **[2016]**

Photographic documentation of open fracture wounds

- 1.3.4 All trusts receiving patients with open fractures must have information governance policies in place that enable staff to take and use photographs of open fracture wounds for clinical decision-making 24 hours a day. Protocols must also cover the handling and storage of photographic images of open fracture wounds. **[2016]**
- 1.3.5 Consider photographing open fracture wounds when they are first exposed for clinical care, before wound excision and at other key stages of management. **[2016]**
- 1.3.6 Keep any photographs of open fracture wounds in the patient's records. **[2016]**

Documentation of neurovascular status

- 1.3.7 When assessing neurovascular status in a person with a limb injury, document for both limbs:
- which nerves and nerve function have been assessed and when
 - the findings, including:
 - sensibility
 - motor function using the Medical Research Council (MRC) grading system
 - which pulses have been assessed and when

- how circulation has been assessed when pulses are not accessible.

Document and time each repeated assessment. **[2016]**

1.4 Information and support for patients, family members and carers

The [NICE guideline on major trauma: service delivery](#) contains a recommendation for ambulance and hospital trust boards, senior managers and commissioners on providing information and support for patients, family members and carers.

Providing support

1.4.1 When communicating with patients, family members and carers:

- manage expectations and avoid misinformation
- answer questions and provide information honestly, within the limits of your knowledge
- do not speculate and avoid being overly optimistic or pessimistic when discussing information on further investigations, diagnosis or prognosis
- ask if there are any other questions. **[2016]**

1.4.2 The trauma team structure should include a clear point of contact for providing information to patients, their family members and carers. **[2016]**

1.4.3 If possible, ask the patient if they want someone (family member, carer or friend) with them. **[2016]**

1.4.4 Reassure people while they are having procedures for fractures under local and regional anaesthesia. **[2016]**

Support for children and vulnerable adults

- 1.4.5 Allocate a dedicated member of staff to contact the next of kin and provide support for unaccompanied children and vulnerable adults. **[2016]**
- 1.4.6 Contact the mental health team as soon as possible for patients who have a pre-existing psychological or psychiatric condition that might have contributed to their injury, or a mental health problem that might affect their wellbeing or care in hospital. **[2016]**
- 1.4.7 For a child or vulnerable adult with a complex fracture, enable their family members or carers to remain within eyesight if appropriate. **[2016]**
- 1.4.8 Work with family members and carers of children and vulnerable adults to provide information and support. Take into account the age, developmental stage and cognitive function of the child or vulnerable adult. **[2016]**
- 1.4.9 Include siblings of an injured child when offering support to family members and carers. **[2016]**

Providing information

- 1.4.10 Explain to patients, family members and carers, what is happening and why it is happening. Provide:
- information on known injuries
 - details of immediate investigations and treatment, and if possible include time schedules. **[2016]**
- 1.4.11 Offer people with fractures the opportunity to see images of their injury, taken before and after treatment. **[2016]**
- 1.4.12 Provide people with fractures with both verbal and written information on the following when the management plan is agreed or changed:
- expected outcomes of treatment, including time to returning to usual

activities and the likelihood of permanent effects on quality of life (such as pain, loss of function and psychological effects)

- amputation, if this is a possibility
- activities they can do to help themselves
- home care options, if needed
- rehabilitation, including whom to contact and how (this should include information on the importance of active patient participation for achieving goals and the expectations of rehabilitation)
- mobilisation and weight-bearing, including upper limb load bearing for arm fractures. **[2016]**

1.4.13 Document all key communications with patients, family members and carers about the management plan. **[2016]**

1.4.14 Ensure that all health and social care practitioners have access to information previously given to people with fractures to enable consistent information to be provided. **[2016]**

Providing information about transfer from an emergency department

1.4.15 For patients who are being transferred from an emergency department to another centre, provide verbal and written information that includes:

- the reason for the transfer
- the location of the receiving centre and the patient's destination within the receiving centre
- the name and contact details of the person responsible for the patient's care at the receiving centre
- the name and contact details of the person who was responsible for the patient's care at the initial hospital. **[2016]**

1.5 Training and skills

These recommendations are for ambulance and hospital trust boards, medical directors and senior managers within trauma networks.

- 1.5.1 Ensure that each healthcare professional within the trauma service has the training and skills to deliver, safely and effectively, the interventions they are required to give, in line with the [NICE guideline on non-complex fractures, complex fractures, major trauma, major trauma services](#) and [spinal injury assessment](#). [2016]
- 1.5.2 Enable each healthcare professional who delivers care to people with fractures to have up-to-date training in the interventions they are required to give. [2016]

Terms used in this guideline

Delayed primary amputation

A procedure that is carried out when amputation is chosen as preferable to attempting reconstructive surgery for limb salvage, but not performed as an emergency operation.

Orthoplastic centre

A hospital with a dedicated, combined service for orthopaedic and plastic surgery in which consultants from both specialties work simultaneously to treat open fractures as part of regular, scheduled, combined orthopaedic and plastic surgery operating lists. Consultants are supported by combined review clinics and specialist nursing teams.

Wound excision

Also known as debridement, this refers to the separation of tissues that are contaminated or non-viable from those that are healthy and viable.

Recommendations for research

The guideline committee has made the following key recommendations for research.

1 Temporary dressings for up to 72 hours between wound excision and definitive soft tissue cover

What is the most clinically and cost effective temporary (up to 72 hours) dressing (including negative pressure dressings) for open fractures after wound excision for:

- minimising the number of dressing changes or supplementary dressings
- minimising the number of associated bedding changes
- acceptability for patients, for example, in terms of minimising pain
- minimising nursing time.

For a short explanation of why the committee made this recommendation for research, see the rationale section on temporary dressings for open fractures after wound excision but before definitive tissue cover.

Full details of the evidence and the committee's discussion are in evidence review A: negative pressure wound therapy for temporary closure of open fractures.

2 Cystourethrogram

How accurate is the first CT scan with contrast (trauma scan) for detecting bladder injuries in people with suspected bladder injuries after a traumatic incident?

Why this is important

Bladder injuries usually occur in people with high-energy pelvic fractures after a traumatic incident. Currently people with suspected bladder injuries have a CT scan with intravenous contrast (a trauma scan) to diagnose non-bladder injuries. People who do not have injuries

needing urgent treatment may then either be given another CT scan or a fluoroscopic cystogram to check for bladder injury. People with injuries needing urgent treatment (for example, bleeding or a neurological injury) are taken to the resuscitation room after the initial CT scan (trauma scan). Once the person's condition is stabilised they are taken to either the CT or fluoroscopy suite for a retrograde cystogram to check for bladder injury. The guideline committee agreed that these strategies are accurate for the diagnosis of bladder injuries, but felt that there were advantages to a strategy that did not involve a second set of images. The guideline committee was interested in whether the first CT scan with intravenous contrast (trauma scan) could accurately diagnose bladder injuries.

3 Pilon fractures

In adults with closed pilon fractures, what method of fixation provides the best clinical and cost effectiveness outcomes as assessed by function and incidence of major complications at 2 years (stratified for timing of definitive surgery early [under 36 hours] versus later [over 36 hours])?

Why this is important

Pilon fractures involve a significant proportion of the weight-bearing surface of the distal tibia. The damaged joint surface is vulnerable to degeneration. Therefore, the injury can lead to long-term disability, most commonly arthritis with pain and stiffness. Surgery can improve outcomes, allowing reduction and fixation of the fracture and early movement of the ankle joint. However, it has a high incidence of serious complications, particularly related to the vulnerability of the soft tissues around the ankle. The potential for life-changing adverse consequences of both the injury and its treatment is known, but the best management strategy to minimise these consequences is unclear.

Rationale and impact

This section briefly explains why the committee made the recommendation dated 2022 and how it might affect practice.

Temporary dressings for open fractures after wound excision but before definitive soft tissue cover

[Recommendation 1.2.31](#)

Why the committee made the recommendation

The evidence showed that use of negative pressure wound therapy (NPWT) after wound excision if immediate definitive soft tissue cover has not been performed is not more clinically effective than other dressings and is unlikely to be cost effective. However, the committee agreed that most of the evidence related to the use of NPWT as a therapy rather than as a temporary dressing (which is what it is used for in the UK) and therefore most of the long-term outcomes were not relevant to the UK context. Furthermore, the cost effectiveness of NPWT is unclear. They agreed that, on that basis, it was not appropriate to make a 'do not routinely use' recommendation.

The committee agreed that, in their experience, compared to other dressings, NPWT could:

- reduce the number of times dressings are changed or supplemented and reduce the number of associated bedding changes, thereby saving nursing time
- reduce the pain and discomfort of changing or supplementing dressings, thereby improving patient satisfaction.

They also noted that NPWT is useful for wounds that are heavily exuding where other dressings may need to be changed or supplemented more often.

The committee agreed that there are several types of dressing that can remain in situ until definitive soft tissue cover is performed up to 72 hours later. NPWT is not the only choice.

They also agreed it was important to ensure the correct application of dressings.

The committee agreed to replace the 2016 recommendation on NPWT with a recommendation to apply a temporary dressing that avoids wound desiccation and minimises dressing changes.

They were not able to recommend specific dressings because the evidence they considered only related to NPWT, so they discussed whether to make a recommendation for research on specific temporary dressing for open fractures after wound excision but before definitive soft tissue cover. Since they could not be sure that this evidence did not already exist (because it was not searched for as part of this update) they agreed to ask stakeholders at consultation. Stakeholders did not raise any objection and so the committee proceeded to make a recommendation for research on temporary dressings.

How the recommendations might affect practice

NPWT is widely used as a temporary dressing for open fractures before definitive soft tissue cover, however other temporary dressings can be effective in providing temporary coverage and may be more cost-effective. The updated recommendation stipulates the use of a temporary dressing that prevents desiccation and minimises the number of dressing changes. This may reduce the use of NPWT.

[Return to recommendation](#)

Context

Complex fractures make up the minority of the 1.8 million fractures that occur in England each year, but are associated with considerable morbidity and are a large burden on healthcare resources. The treatment of complex fractures is often complicated and usually involves multiple healthcare professionals and specialists.

This guideline covers the triage, initial and acute stage assessment and management, imaging, referral to specialist care and treatment of complex fractures in children (under 16s) and adults (16 or over). It includes recommendations in the following key clinical areas:

- management in pre-hospital settings
- immediate destination for people with suspected complex fractures
- initial assessment and management in acute care
- imaging and haemorrhage control of pelvic fractures
- management of open fractures
- management plan and referral for adults with pilon fractures and children with intra-articular distal tibia fractures
- documentation
- information and support for people with complex fractures and their families and carers.

The guideline does not address all potential situations for every individual complex fracture. It is based around topics that should be considered as representative of an evidence-based guide to the general management of complex fractures. It provides recommendations on open fractures, pelvic fractures, pilon fractures in adults and intra-articular distal tibia fractures in children. It does not cover the prevention and follow-up of complex fractures, and the management and follow-up of dislocations and conditions such as osteoporosis and osteoarthritis.

The guideline does not cover non-complex fractures, skull fractures, hip fractures and

spinal injuries. These are covered by other NICE guidelines.

Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the [NICE topic page on injuries, accidents and wounds](#).

For full details of the evidence and the guideline committee's discussions, see the [full guideline and evidence review](#). You can also find information about [how the guideline was developed, including details of the committee](#).

NICE has produced [tools and resources to help you put this guideline into practice](#). For general help and advice on putting our guidelines into practice, see [resources to help you put NICE guidance into practice](#).

Update information

November 2022: We reviewed the evidence on negative pressure wound therapy, and updated recommendation 1.2.31. Recommendations marked **[2016]** last had an evidence review in 2016. For some recommendations we have replaced the word 'debridement' with 'wound excision'.

November 2017: Recommendation 1.1.10 was amended to change the wording from 'administer prophylactic antibiotics' to 'consider administering prophylactic antibiotics'.

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