



BRITISH ORTHOPAEDIC ASSOCIATION

STANDARDS for TRAUMA

January 2012



BOAST 1 Version 2

Background and Justification:

Over 70,000 hip fractures occur annually in the UK. The total cost of care is over £2 billion with 10% mortality at 30 days and up to 30% mortality at one year. Their care is dependent on close multidisciplinary relationships between many specialties due to the complex nature of these patients, both in terms of their medical co-morbidities and their ability to rehabilitate.

Inclusion: All patients sustaining a fragility hip fracture.

Standards for Practice

1. Secondary prevention, anti-resorptive therapy for osteoporosis and falls assessments are effective in reducing further fragility fractures and must be an integral part of the fracture care.
2. Hip fractures should be managed by a multidisciplinary team including orthogeriatricians, orthopaedic surgeons, anaesthetists, nursing and allied health professionals with expertise appropriate for these frail patients.
3. Patients who cannot weight-bear and who may have a hip fracture should be offered magnetic resonance imaging (MRI) if anteroposterior pelvis and lateral hip X-rays are negative; if MRI is not available within 24 hours or is contraindicated, consider computed tomography.
4. Assess the patient's pain and offer immediate analgesia on presentation at hospital and regularly as part of routine nursing observations throughout admission, including patients with cognitive impairment. Ensure analgesia is sufficient to allow movements necessary for investigations and for nursing care and rehabilitation.
5. Identify and treat correctable co-morbidities immediately so that surgery is not delayed. Intravenous fluids should be administered and appropriate blood tests undertaken. Preoperative assessment should follow local protocols including for those presenting on anticoagulants.
6. Perform hip fracture surgery on the day of, or the day after, admission on a planned trauma list. Consultants or senior staff should supervise trainee and junior members of the anaesthesia, surgical and theatre teams when they carry out hip fracture procedures.
7. Operate on patients with the aim to allow them to fully weight bear (without restriction) in the immediate postoperative period. Offer patients' mobilisation with a physiotherapist at least once a day and assessment on the day after surgery.
8. From admission, offer patients a formal, acute, orthogeriatric or orthopaedic ward-based Hip Fracture Programme that includes orthogeriatric assessment, rapid optimisation of fitness for surgery, early identification of individual goals for multidisciplinary rehabilitation to recover mobility and independence, and to facilitate return to pre-fracture residence and long-term wellbeing.
9. Assess patient's risk of delirium and dementia by actively looking for cognitive impairment when patients first present with hip fracture and perform regular re-assessment.
10. If a hip fracture complicates or precipitates a terminal illness, the multidisciplinary team should still consider the role of surgery as part of the palliative care.
11. Patients should be assessed and treated for their risk of venous thromboembolism and pressure sores.
12. Offer patients (or, as appropriate, their carer and/or family) verbal and printed information about treatment, care and rehabilitation.
13. Each hospital should submit data to the National Hip Fracture Database to monitor its performance against national benchmarks and quality standards.

BOA\ BGS Blue Book "Care of patients with a fragility fractures" 2007 (www.boa.ac.uk)

NICE clinical guidance 124 (2011) – The management of hip fracture in adults

NICE technology appraisal 161 (2011) – Secondary prevention of osteoporotic fragility fractures in postmenopausal women

NICE clinical guidance 103 (2010) – Delirium

NICE clinical guidance 42 (2006) – Dementia

NICE clinical guidelines 21 (2004) – Falls

stryker[®]