Guidance For Older Patients With Hip Fractures

Expectations of Older Orthopaedic Patients (together with, where applicable, their family, carer and/or advocate) who have broken their hip

There are now over 89,000 older patients who break their hips in England every year. For some this will mean the loss of mobility & independence, and if not treated quickly and appropriately may lead to death. It is therefore very important that these patients are treated quickly and appropriately. Current UK guidelines state that patients who are admitted with a broken neck of femur should be operated on with 36 hours.

Additionally it is recognised that many of these patients may have a number of other pre-existing conditions including some form of mental impairment which may be worsened following the hip fracture operation and recovery.

To *reduce* the risk of deteriorating co-morbidities, the risk of bedsores and fluid imbalance and to *improve* pain management, remobilisation and return to independence the sooner the patient can go to theatre the better. However timing depends on several factors, one of the most important being the physical health of the patient on admission.

Broadly speaking there are four patient groups:

1) Immediate. In some younger patients, occasionally older, a procedure is performed within 6 hours to preserve the femoral head. This scenario will be discussed with the hip fracture lead clinician.

2) Fit patients. Despite the concerns a reasonable number of patients will be fit for an anaesthetic on the first available trauma list usually within 12 to 24 hours. Occasionally some patients will be transferred to an elective unit for a total hip replacement and the 36 hours also allows for this.

3) Unfit patients. This is where 36 hours mainly comes in. If a patient is submitted to surgery and various anaesthetics before being 'optimised' for that

procedure the mortality is very high. This would include things like dehydration, hypothermia etc. Clearly a high standard of nursing care is required to prevent morbidity such as pressure sores etc. prior to that intervention. The 36 hours allows for the day of admission and an overnight to the next available trauma list. If you inflict 24 hours some patients would have to go to theatre in the middle of the night, which strongly goes against the recommendations of NCEPOD, NICE and other groups.

4) Patients deemed unfit for surgery. Very occasionally there are patients in this group who will be treated conservatively. They have a high morbidity and mortality either way.

In light of this information and in addition to the Expectations and Responsibilities listed in other documents on the BOA Patient Liaison web site - www.boa.ac.uk - as an Older Patient suffering a hip bone break (or fracture) I would expect:

1. That on arrival at a Hospital I am admitted to an appropriate ward within four hours.

2. That I am assessed by a senior doctor and their team before surgery, and have my operation carried out by an appropriately skilled surgical and anaesthetic team within 36 hours, if appropriate to my medical condition.

3. That I am assessed by an orthogeriatric specialist as soon as possible and certainly within 72 hours from admission.

4. That the underlying cause of the trauma is identified and I am assessed for possible medical causes for my fall.

5. That my mental and physical needs are addressed immediately with attention to my dignity and in an appropriate environment. This includes pain relief, checking on my skin's integrity to ensure I don't develop bedsores, my fluid balance and nutritional status.

6. That I am respected as an individual and communicated with in a way that I and my family fully understand.

7. That I am treated in a single sex ward on an orthopaedic or orthogeriatric unit.

8. That after surgery I have full access to rehabilitation therapy that is delivered in a sympathetic way.

9. That I am assessed and cared for so that my risk of developing blood clots and pressure sores is minimised.

10. That there is an agreed Patient Journey Plan that includes my admission, my hospital treatment and my return into the community with the necessary support. It should also include:

    i. That my dietary, ethnic, religious and privacy needs are catered for.

    ii. That my nutritional needs are dealt with on a personal basis.

    iii. That I have an appropriate, timely and controlled departure from Hospital.

    iv. That I am given appropriate and ongoing support in the community.

11. That I am told about and placed on Osteoporosis Management and Falls Prevention Programmes as appropriate.

Osteoporosis Management and Fragility Fracture Prevention Programmes

Prevention is better than cure and therefore I, as a patient, should expect to be entered onto an Osteoporosis Management or Fragility Fracture Prevention Programme with the aim of avoiding bone fracture and hospitalisation.

Whilst acknowledging my own responsibility to follow any advice I would expect:

1. That the Blue Book (as published by www.boa.ac.uk) is adhered to.

2. That training in Falls Prevention is carried out by a NHS Primary Care Team in both community and home settings, e.g.: regular exercises to reduce risk of injury from falls, including exercises that maintain or improve balance.

3. That risk factors such as osteoporosis and life style are identified and addressed.

4. That I will be entered into a local Falls Registry Programme run by the local NHS Clinical Commissioning Group.

5. That I have regular medicines review.

6. That I have yearly eye examinations.

7. Continued pharmaceutical treatment of any osteoporosis I may have and my other conditions. To help facilitate this I would expect there to be:

    - Clinicians with training in orthogeriatrics in all Hospital Trusts dealing with Trauma patients with the aim of delivering a high quality of fracture care.

    - A Quality and Outcomes Framework (QOF) measure that includes Falls Prevention training to all female patients over the age of 60 with osteoporosis prevention as one of its measures.

    - A consistency of delivery across the NHS including oral bisphosphonates prescribed in an appropriate manner.

    - Co-ordination between Primary Care, Secondary Care, Social Services and the Community Pharmacist to create a clear agreed plan which is understood and accepted by I, the patient and my family/carers.

    - Access and enrolment onto a nationally agreed audit such as the National Hip Fracture Database.