

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Proximal femoral fracture guidelines

Aims

To apply early effective surgery with streamlined hospital care, to achieve early discharge, with minimal complications.

Patient needs

A hip fracture (proximal femoral fracture) is the most common reason for an acute admission to an orthopaedic ward, with a reported annual incidence of about 65,000 in England. The condition is associated with significant mortality, and is a major use of health service resources. This group of patients should be treated by adopting a multidisciplinary team approach.

(SIGN; 2005, 2002, 1997, United They Stand, 1995).

Newcastle General Hospital

Newcastle General Hospital provides a trauma service for a Newcastle resident population of 260,000. The trauma orthopaedic unit comprises of 2 acute wards, and a rehabilitation ward, ward 35 has 31 mixed sex beds, ward 21 has 30 mixed sex beds, and ward 20 has 19 female beds. From April 2005-March 2006, 244 patients were admitted onto the unit with this injury.

A total of 8 orthopaedic consultants operate an on-call rota system for acute orthopaedic admissions. One geriatric consultant, specialist registrar, and SHO (F2), also provide medical/social/rehabilitation input.

The Trauma/Acute and Elderly care nurse practitioners also provide medical and nursing input for this group of patients.

Guidelines for patient management

Accident & Emergency

The patient will be seen by the triage nurse, and then medical staff/nurse practitioners. AP pelvic and lateral hip x-rays will be requested.

A fast track protocol exists whereby patients are clerked on the ward, and should be admitted to the ward within 2 hours (refer to fast track guidelines).

Anaesthetic guidelines exist which suggest pre-operative management, i.e. patient medically stable, administer adequate analgesia, cannulate, full blood count, Urea and electrolytes, first group and save, bone chemistry, 12 lead ECG, (remove electrode stickers once this has been carried out), chest x-ray, commence intra-venous therapy (refer to anaesthetic guidelines).

Admission to ward

Patients should be clerked using the elderly trauma patient assessment document. The anaesthetic guidelines should be followed i.e. nursing assessment including oxygen saturation levels and respirations, commence oxygen therapy if Sa O₂ <95%, intra-venous therapy, Deep vein thrombosis prophylaxis; aspirin 150mg, on admission for 35 days, plus low molecular weight heparin (refer to DVT guidelines), adequate analgesia, antibiotic cover, check HB at 48 hours and 5 days post operatively (refer to anaesthetic guidelines).

Iliacus fascia blocks may also be used for pain relief.

Recent randomised controlled trials have indicated there is no need for traction.

Delays to surgery

Wherever possible surgery should be performed within 24 hours of admission, usually the day after admission, (SIGN; 2005, 2002, UTS 1995). This allows time for pre-operative assessment, and resuscitation. Surgery should not be delayed further unless there is an specific medical condition which can be improved (refer to Trust guidelines, local warfarin guidelines).

Surgery

Surgery should be carried out by suitably trained members of the medical and anaesthetic teams, and junior staff should have adequate supervision (SIGN 2005, 2002, 1997).

Type of implant

Undisplaced intracapsular fractures, and some displaced intracapsular fractures may be fixed using internal fixation with 3 screws, inserted percutaneously, or 2 hole DHS. Displaced intracapsular fractures may require a Thompson's hemiarthroplasty, inserted using a lateral/posterior approach.

Extracapsular fractures may be fixed using Dynamic hip screw, or an intramedullary device.

Cemented bipolar hemiarthroplasty, and total hip replacement, may be carried out for specific patients, where fixation is not possible (SIGN 2005).

Post operative care, mobilisation

All patients are mobilised the day after surgery, generally fully weight bearing, unless otherwise specified by the consultant (e.g. younger patients with screw fixation).

Restricted bed rest, nursing patient flat, restricting hip movements, or the use of Charnley wedges, is not routine practice, unless specified by the consultant.

Post operative check x-rays are routinely required following arthroplasty, however, waiting for x-rays to be seen should not prevent early mobilisation.

All patients will be seen by the physiotherapy team who will assess each patient and plan care accordingly i.e. walking aids. Patients will also be given exercise instructions to restore knee and ankle movements, and stair practice is necessary.

Patient information

Many patients fear that hip fracture results in loss of independence and even death. Early and comprehensive assessment is therefore essential to enable the multidisciplinary team, and the patient/carer, to plan care.

Patients should be given copies of the appropriate patient information leaflets (Trust intranet).

Rehabilitation

Female patients with rehabilitation potential may be transferred to ward 20, once they have recovered from the acute post operative phase. This may include patients with limited rehabilitation goals. To determine a plan of care, assessment of pre-existing levels of function, social circumstances, and mental function, must be stated on the clerking document.

Patients from nursing homes should be transferred back when they have made a post-operative recovery.

Patients may be discharged back to their own place of residence with the additional support of the orthopaedic discharge team.

The occupational therapy service will also undertake assessment of patient needs, and support and facilitate safe discharge.

Secondary prevention

All patients should have an assessment of falls, and osteoporosis (refer to clerking document, nursing documentation, regional and NICE guidelines).

Patient follow up

All hip fracture patients are reviewed, at least once, in the nurse led hip clinic. Intracapsular fractures, treated with internal fixation, are followed up for up to 2 years.

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