AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Clinical Care Standards

INFORMATION
for clinicians

Hip Fracture

Clinical Care Standard

The *Hip Fracture Clinical Care Standard* aims to improve the assessment and management of patients with a hip fracture to optimise outcomes and reduce their risk of another fracture.

It contains seven quality statements describing the care that patients with a suspected hip fracture should be offered from presentation to hospital through to completion of treatment and discharge from hospital. This also includes patients who sustain a hip fracture while in hospital. The target age for the clinical care standard is 50 years and over.

1 Care at presentation

A person presenting to hospital with a suspected hip fracture receives care that is guided by timely assessment and management of medical conditions, including cognition, pain, nutritional status and frailty. Arrangements are made according to a locally endorsed hip fracture pathway.

Use a locally endorsed hip fracture pathway to guide the comprehensive clinical assessment and management of patients with a suspected hip fracture, including:

- Screening for malnutrition, frailty, cognitive impairment and risk factors for delirium
- Identifying comorbidities and medicines that may affect time to surgery or readiness for surgery
- Providing pain relief
- Assessing for underlying acute and chronic medical conditions that may have caused the fall
- Early assessment of bone health and consideration of calcium and/or vitamin D replacement where clinically indicated
- Excluding other injuries
- Conducting relevant diagnostic imaging and pathology.

Put in place interventions to prevent or manage delirium in accordance with the ***Delirium Clinical Care Standard***. Document the frailty assessment and use the results to guide care planning.

Ensure that the patient knows what is happening and what to expect from their treatment and recovery, and identify arrangements for substitute decision-making. Document and communicate processes as part of the patient's comprehensive care plan, to ensure effective management and clinical handover.

For hospitals that do not provide hip fracture surgery, organise prompt transfer and initiate the care pathway locally to optimise the patient's preoperative condition. There is an expectation that all patients will receive surgery within 36 hours of presentation to the first healthcare facility. In remote areas with no acute facilities, this expectation extends to the local service that is responsible for emergency care.

Cultural safety and equity

Consider personal biases, cultural and social factors, and communication barriers when assessing the patient.

Ask about and document:

- The person's Māori or Aboriginal and Torres Strait Islander identity, to ensure that the care provided meets their needs
- The person's preferred language and facilitate access to interpreters when required.

In a culturally safe way, explain to the patient and their family, carer or support people the reasons for assessment, tests and interventions. Understand what is important to the person and what their goals of care are.

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Consider cultural validation and suitability when selecting cognitive screening tools. For some people from culturally and linguistically diverse groups, the Rowland Universal Dementia Assessment Scale is relevant. The Kimberley Indigenous Cognitive Assessment (KICA) provides a more culturally appropriate measure of cognition, which may be useful for Māori and Aboriginal and Torres Strait Islander people.

Consider how cultural factors may influence who is suited to be a substitute decision-maker. Multiple decision-makers may be required for Aboriginal and Torres Strait Islander people.

2 Pain management

A person with a hip fracture is assessed for pain at the time of presentation to the emergency department and regularly throughout their acute admission. Pain management includes appropriate multimodal analgesia and nerve blocks, unless contraindicated.

Many patients with a hip fracture will have received analgesia in the ambulance. Assess and document the patient's pain:

- Immediately upon presentation to hospital
- Within 30 minutes of administering initial analgesia
- Hourly until the patient is settled and pain is well controlled
- Regularly as part of routine nursing and based on other clinicians' observations throughout the admission.

Use a standardised approach to assessing pain that:

- Incorporates functional assessment
- Specifically addresses the assessment of pain for patients with cognitive impairment or who are unable to communicate pain.

Provide appropriate pain management including multimodal analgesia, incorporating nerve blocks as part of perioperative pain management. Nerve blocks can reduce opioid dose requirements and accompanying side effects (such as sedation, respiratory complications and delirium).

For hospitals that do not provide hip fracture surgery, arrange appropriate analgesia and, if suitable, administer a nerve block prior to transfer.

If opioid analgesics are used:

- Prescribe immediate-release formulations at the lowest appropriate dose for a limited duration in accordance with the ***Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard***
- Plan for appropriate opioid analgesic use at the transfer of care when a patient is first prescribed, supplied or administered an opioid analgesic
- Follow a weaning and cessation protocol guided by assessment of the patient's functional activity and pain scores.

Cultural safety and equity

Pain assessment and management should be done on an individual patient basis. Differences between ethnic and cultural groups should not be used to stereotype patients; these should only be used to inform of possible cultural preferences. Language should not be a barrier to appropriate assessment and management of pain. An interpreter can assist with administering pain scales and providing clinicians with useful information on cultural beliefs about expression of pain. Multilingual printed information and pain measurement scales are useful in managing patients with different cultural or ethnic backgrounds.

Ask about and record the person's Māori or Aboriginal and Torres Strait Islander identity with respect to providing care that meets their needs. For example, offer the involvement of a Māori Health Worker or an Aboriginal and Torres Strait Islander Health Worker, Practitioner or Liaison Officer to help with effective communication of words and concepts. Differences in non-verbal and behavioural expressions of pain may affect the clinician's perceptions of the patient's pain. When attempting to assess pain, verbal descriptor scales (for example, 'none', 'mild', 'moderate' and 'severe') or pain assessment tools using facial expressions are considered superior to numerical and visual analogue scales. Pain expression in Aboriginal and Torres Strait Islander people may not reflect what is expected by the clinician's cultural background. This places the onus on the clinician to understand nuances in pain expression and beliefs within such populations.

3 Orthogeriatric model of care

A person with a hip fracture is offered treatment based on an orthogeriatric model of care as defined in the *Australian and New Zealand Guideline for Hip Fracture Care*. A coordinated multidisciplinary approach is used to identify and manage malnutrition, frailty, cognitive impairment and delirium.

From the time of admission, offer patients with a hip fracture a formal orthogeriatric model of care that includes:

- Regular orthogeriatrician assessment, including medication review
- Management of patient comorbidities
- Optimisation for surgery
- Early identification of goals of care, in discussion with the patient and their family or support people, and documented in the comprehensive care plan
- Early assessment of the patient's nutritional status using a validated assessment tool and reassessment during the course of the admission with individualised interventions when required, including offering oral nutritional supplements and avoiding prolonged nil-by-mouth restrictions
- Management based on initial assessments for frailty, cognitive impairment and delirium
- Ongoing orthogeriatric and multidisciplinary review, including reassessment of cognition, delirium and malnutrition after surgery
- Assessment for venous thromboembolism (VTE) risk to determine the need for VTE prophylaxis
- Early assessment of bone health, including measurement of calcium and vitamin D, and supplementation where indicated
- Discharge planning liaison with primary care, including falls prevention and secondary fracture prevention
- Coordination of care to provide multidisciplinary rehabilitation aimed at increasing mobility and independence, facilitating return to pre-fracture residence and supporting longterm wellbeing, if appropriate and clinically indicated
- Early identification of the most appropriate service to deliver rehabilitation, if indicated.

Cultural safety and equity

Attend cultural safety training provided by your healthcare service or professional organisation.

If language or culture may be a barrier to involving patients in their care or the optimisation process for surgery, involve interpreting services, Māori Health Workers or Aboriginal and Torres Strait Islander Health Workers or Practitioners. Continuity of these services through the hip fracture journey can enhance the patient experience, and allows for appropriate planning of ongoing rehabilitation and support for discharge and the transition to home. Recognise that a history of trauma may affect behaviour, and provide trauma-aware and healing-informed care.

Language should not be a barrier to ensuring timely access to surgery. Fasting in some community groups means abstaining from specific foods only, so it may be necessary to advise the patient about what fasting means in the context of preparing for major surgery. An interpreter should be used to explain the reason for fasting to both the patient and their family when necessary.

Ensure that Aboriginal and Torres Strait Islander and Māori people remain connected with their respective physical, spiritual and cultural connections while in the hospital, particularly if they are off Country and a long way from home. Incorporate the person's family (whānau*), social worker and usual Community Controlled Health Service (if applicable) into care planning, to support transitions of care.

* Whānau is a Māori word for the family or extended group of people who are important to the patient.

4 Timing of surgery

A person with a hip fracture receives surgery within 36 hours of their first presentation to hospital.

Discuss treatment options with the patient. Explain the goals, benefits, risks and limitations of treatment options, taking into account the patient's medical conditions, goals of care and prior level of function. If a hip fracture complicates or precipitates a terminal illness, consider the role of surgery as part of a palliative care approach to alleviate symptoms and minimise suffering.

If clinically indicated and in accordance with patient preferences, surgery should be performed within 36 hours of the patient's first presentation to any hospital. If a patient sustains a hip fracture while in hospital, surgery should be performed within 36 hours of the fracture occurring. Prescribe surgical antibiotic prophylaxis and thromboprophylaxis according to current guidelines.

Cultural safety and equity

Cultural safety remains important, even during time-sensitive care. Language should not be a barrier to shared decision making or informed consent. The use of Māori Health Workers; Aboriginal and Torres Strait Islander Health Workers or Practitioners; Liaison Officers; cross-cultural health workers; and translators is strongly encouraged to help:

- Patients navigate the service and their treatment options
- With translation of words and adaptations of concepts.

5 Mobilisation and weight bearing

A person with a hip fracture is mobilised without restrictions on weight bearing, starting the day of, or the day after, surgery, and at least once a day thereafter, according to their clinical condition and agreed goals of care.

Improving mobility after a hip fracture is key to recovery. Mobilise patients the day of, or the day after, hip fracture surgery, and at least once a day thereafter unless contraindicated. Mobilised means the person manages to stand and step transfer out of bed onto a chair or commode, or walk. Allow patients to bear weight as tolerated, but avoid weight bearing if there is a clinical concern about the fracture, the fixation or the likelihood of healing.

Additional exercises, such as training of gait, balance and functional tasks can further improve patient outcomes. For people with conditions preventing mobilisation, arrange for tailored advice from a physiotherapist or occupational therapist.

For people at risk of pressure injuries, conduct comprehensive skin inspections and provide pressure injury prevention and care in accordance with best-practice guidelines, including implementing a mattress support surface to meet individualised requirements.

Cultural safety and equity

Language should not be a barrier to early mobilisation. Professional healthcare interpreters can help clinicians explain why mobilisation is important for rehabilitation, and to navigate any cultural beliefs that may be influencing the patient and their family (whānau). Consideration needs to be given to the development of culturally relevant goals and how these can be achieved to support the wellbeing of the patient.

6 Minimising risk of another fracture

Before a person leaves hospital after a hip fracture, they receive a falls and bone health assessment and management plan, with appropriate referral for secondary fracture prevention.

People with a hip fracture are at risk of another fracture. Educate the patient on specific exercises to improve balance and muscle strength by discussing risk factors for falls and providing written information.

Discuss the need for bone protection medicines. Administer or prescribe treatment prior to discharge when clinically appropriate.

Ensure that the management plan:

- Includes the need for ongoing bone protection medicine and, if started, the next review date; this is especially important for medicines where the dose interval is time critical, such as denosumab
- Recommends that bone protection medicine is started in the community if it has not been possible to initiate in hospital
- Is included in the patient's discharge summary and care plan.

Where available, consider referring the person to a fracture liaison service (FLS). Upload information regarding secondary fracture prevention to the patient's My Health Record.

Cultural safety and equity

Ensure that the information and education you provide is culturally safe and appropriate. Use an interpreter if needed, and provide written information in the person's preferred language and in a way that they can understand. Apply understandings of family (whānau) and involve Māori Health Workers, Aboriginal and Torres Strait Islander Health Workers or Practitioners and Liaison Officers. Consider the home environments and lived realities of patients, including services accessible to them and community infrastructure.

7 Transition from hospital care

Before a person leaves hospital after a hip fracture, an individualised care plan is developed that describes their goals of care and ongoing care needs. This plan is developed in discussion with the person and their family or support people. The plan includes mobilisation activities and expected function post-injury, wound care, pain management, nutrition, fracture prevention strategies, changed or new medicines, and specific rehabilitation services and equipment. On discharge, the plan is provided to the person and communicated with their general practice and other ongoing clinicians and care providers.

Develop an individualised care plan with the patient before they leave hospital (for example, see the ANZHFR ***Hip Fracture Care Guide*** or Te Tāhū Hauora Health Quality & Safety Commission's ***Recovering from a Hip Fracture*** booklet). The individualised care plan is separate to a clinical discharge summary and should:

- Identify any changes in medicines (including any new medicines) or ongoing pain management
- Identify any rehabilitation equipment needed and the contact details for rehabilitation services, and refer as required
- Describe mobilisation activities, wound care and function post-injury
- Provide information and recommendations for secondary fracture prevention, including contact details for services, where appropriate
- Recommend bone protection medicines to the patient and their general practitioner if they have not been started in the hospital.

Provide the care plan to the patient and confirm that they understand the plan before they leave the hospital. Include an overview of the care discussed within the discharge care summary and provide to their general practice, and other regular clinicians and care providers on discharge. Enable uploading to the patient's My Health Record. This allows other clinicians to access details about the patient's care, which can be vital for informing ongoing care in the community.

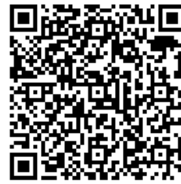
Cultural safety and equity

Consider cultural needs, preferences and goals and their impact on the individualised care plan. This is especially true for the discharge process and the transition to home. It is important for the care plan to reflect the lived realities of the person and consider what supports are available within the family and community.

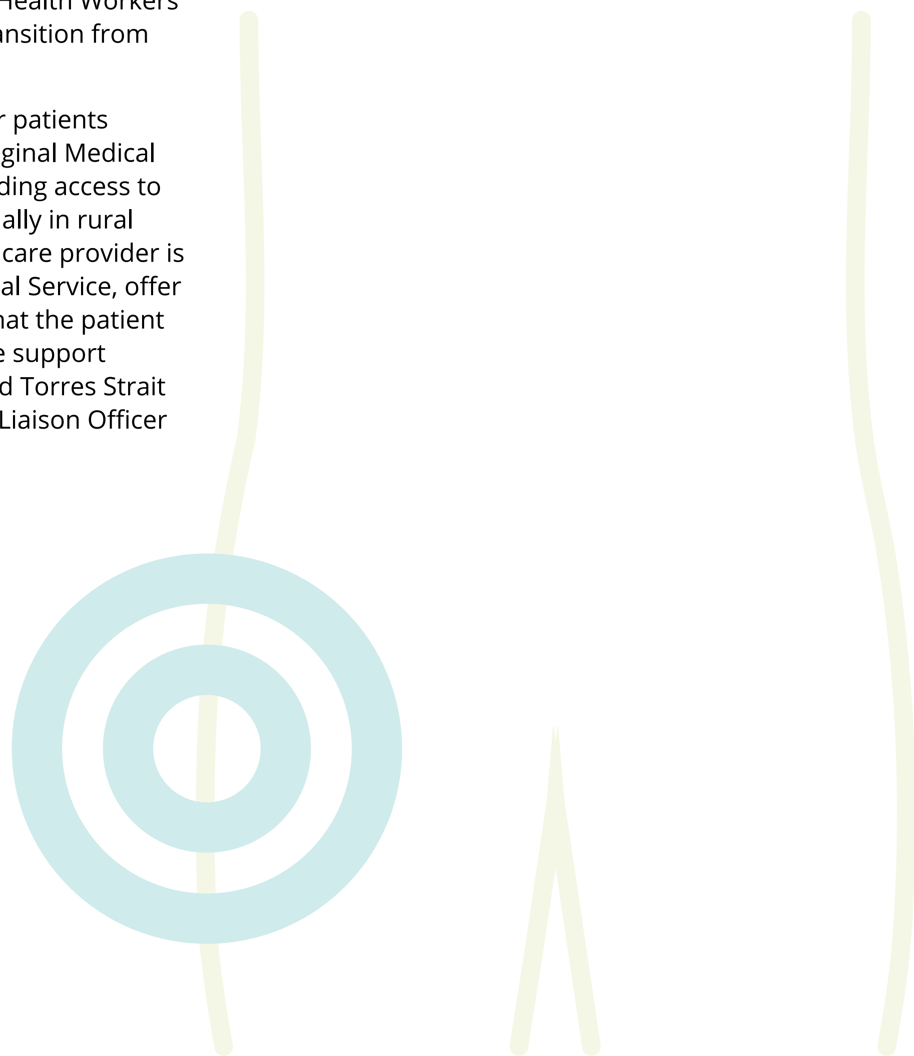
For Māori patients and whānau, acknowledge hauora (overall physical, mental, emotional, environmental and spiritual health) and involve Māori Health Workers to provide additional support during transition from the hospital.

For Aboriginal and Torres Strait Islander patients and support people, ACCHOs and Aboriginal Medical Services play an important role in providing access to relevant support after discharge, especially in rural and remote areas. If the person's usual care provider is based in an ACCHO or Aboriginal Medical Service, offer to contact the care provider to advise that the patient is being discharged and discuss suitable support arrangements. Involve an Aboriginal and Torres Strait Islander Health Worker, Practitioner or Liaison Officer when this is the patient's preference.

Questions?



Find out more about the *Hip Fracture Clinical Care Standard* and other resources. Scan the QR code or use the link: **safetyandquality.gov.au/hipfracture-ccs**.



The Australian Commission on Safety and Quality in Health Care has produced this clinical care standard to support the delivery of appropriate care for a defined condition. The clinical care standard is based on the best evidence available at the time of development. Healthcare professionals are advised to use clinical discretion and consideration of the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian, when applying information contained within the clinical care standard. Consumers should use the information in the clinical care standard as a guide to inform discussions with their healthcare professional about the applicability of the clinical care standard to their individual condition.

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