

# 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.**

The *Hip Fracture Clinical Care Standard* 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.

This standard applies to care provided in all hospital settings, including public and private hospitals and subacute facilities.

A set of indicators is provided to support health services to monitor how well they are implementing the care recommended in this clinical care standard and to support local quality improvement activities. The definitions required to collect and calculate indicator data are specified online: [meteor.aihw.gov.au/content/780812](https://meteor.aihw.gov.au/content/780812).

Monitoring the implementation of this clinical care standard will help healthcare services to meet the requirements the National Safety and Quality Health Service (NSQHS) Standards for acute healthcare services.

### 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.

Ensure that systems are in place to support clinicians to provide timely and effective assessment and management based on a locally endorsed hip fracture pathway. Systems should include transfer protocols, including consideration of straight-to-ward arrangements for inter-hospital transfers.

For hospitals that do not perform hip fracture surgery, ensure that the pathway is commenced with attention to stabilising medical conditions in readiness for surgery.

For hospitals receiving transfer patients with a hip fracture, ensure that both hospitals are using the same pathway and that the expectations for referral and receiving of patients are clear.

#### Indicator for local monitoring

**Indicator 1a:** Proportion of patients with a hip fracture who were screened for cognitive impairment using a validated tool on presentation to hospital.



### Cultural safety and equity

Recognise potential barriers to people accessing care, including language differences, being from a remote or vulnerable community, and a lack of cultural safety within healthcare services. Support clinicians to address potential barriers to care by having systems in place that facilitate access to Māori Health Workers, Aboriginal and Torres Strait Islander Health Workers or Practitioners, liaison officers, cross-cultural health workers and interpreters whenever cultural differences may be a barrier to the person's experience and outcomes of care.

## 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.

Ensure that pain management protocols are in place to provide pain assessment and management for patients with a hip fracture that:

- Align with current guidelines
- Support the appropriate use of multimodal analgesia and nerve blocks
- Support appropriate prescribing of opioid analgesics in accordance with the [\*Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard\*](#).

For services that will be transferring the patient for surgery, ensure that protocols for appropriate pain management (including nerve blocks) are established and activated prior to transfer.

Ensure that systems are in place to monitor appropriate adherence and regularly evaluate effectiveness of acute pain management.

### Indicators for local monitoring

**Indicator 2a:** Proportion of patients with a hip fracture who either received analgesia within 30 minutes of presentation or did not require it according to an assessment of their pain.

**Indicator 2b:** Proportion of patients with a hip fracture who received a nerve block prior to surgery.

**Indicator 2c:** Proportion of patients with a hip fracture who were transferred from another hospital for treatment who received a nerve block prior to transfer.



### Cultural safety and equity

As pain management is a critical component of care, ensure that translated resources (such as the word 'pain' and appropriate pain scales) that are suitable to the local population are available to aid assessment and management. Ensure that there is access to professional interpreting services, including for those who are deaf.

Whenever cultural differences may be a barrier to the patient's experience of care, involve people who can assist in the social aspects of care, such as Māori Health Workers or Aboriginal and Torres Strait Islander Health Workers, Practitioners and Liaison Officers; cross-cultural health workers; or translators.

### 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.

Ensure that systems are in place to offer treatment to hip fracture patients that is based on an orthogeriatric model of care as recommended in the *Australian and New Zealand Guideline for Hip Fracture Care*.

For hospitals that do not have a geriatric medicine service available, care should be shared between an orthopaedic surgeon and an anaesthetist and/or another physician, using the orthogeriatric model of care.

For hospitals that do not perform hip fracture surgery, it is important that the orthogeriatric model of care is commenced while patients wait for hospital transfer.

#### Indicators for local monitoring

**Indicator 3a:** Proportion of patients with a hip fracture who had a clinical frailty assessment using a validated tool.

**Indicator 3b:** Proportion of admitted patients with a hip fracture who were assessed for delirium after surgery.

**Indicator 3c:** Proportion of admitted patients with a hip fracture who received protein and energy oral nutritional supplements during their admission.



### Cultural safety and equity

Recognising a person's culture can improve both the clinical care provided and the person's experience of care. To help achieve this:

- Ensure that clinicians have received cultural safety training
- Enable the involvement of Māori Health Workers; Aboriginal and Torres Strait Islander Health Workers or Practitioners and Liaison Officers; translators; and others who can assist in the social aspects of care when this is what the person would prefer and when cultural differences may be a barrier to their clinical care or experience of care.

Establish systems for patients who identify as Māori or Aboriginal and Torres Strait Islander to identify relevant community care providers (for example, the person's Aboriginal Community Controlled Health Organisation), and involve them in the patient's care planning where appropriate or possible.

### 4 Timing of surgery

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

Ensure that systems are in place for clinicians to perform hip fracture surgery within 36 hours of the patient's first presentation to a healthcare facility.

For healthcare services covering some remote areas, networks and systems should be in place to ensure coordinated interfacility transfer of people with a hip fracture, to facilitate surgery within 36 hours of the first clinical presentation. Consider the cultural or familial support a person may require if they are transferred from a rural or remote location.

Ensure that there is a palliative pathway available for people who sustain a hip fracture that complicates or precipitates a terminal illness.

#### Indicator for local monitoring

**Indicator 4a:** Proportion of admitted patients with a hip fracture who received surgery within 36 hours of presentation to first hospital.



### Cultural safety and equity

Support clinicians to provide respectful and culturally safe care by having systems in place that facilitate involvement of Aboriginal and Torres Strait Islander Health Workers or Practitioners; Liaison Officers; cross-cultural health workers; and translators.

## 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.

Ensure that systems and protocols are in place for:

- Patients to be mobilised the day of, or the day after, hip fracture surgery, and at least once a day thereafter unless contraindicated
- Pressure injury prevention and wound management that is consistent with best-practice guidelines.

Ensure that equipment and devices are available to enable mobilisation and decrease the risk of pressure injuries.

### Indicators for local monitoring

**Indicator 5a:** Proportion of admitted patients with a hip fracture who were mobilised the day of, or the day after, their hip fracture surgery.

**Indicator 5b:** Proportion of admitted patients with a hip fracture who experienced a new Stage II-or-higher-pressure injury.

## 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.

Ensure that systems are in place for routine assessment of a person's fracture risk and follow-up for secondary fracture prevention. This includes:

- Providing education to address modifiable risk factors, including patient education materials (such as for reducing falls risk and specific exercises to improve balance and muscle strength)
- Prescribing or administering bone protection medicines prior to discharge where clinically appropriate
- Ensuring clear communication (including in the discharge summary) that a new medication was started; this is particularly important for medicines where the dose interval is time critical such as denosumab
- Referring when appropriate, including specialist referral for consideration of anabolic bone medicines for a person already using bone protection medicines at the time of the hip fracture.

Where a FLS exists within the health service, establish processes to systematically identify people after a fracture and arrange follow-up, as described in the [\*Clinical Standards for Fracture Liaison Services in New Zealand\*](#). Where no FLS exists, a model of care should include systems and resources to:

- Identify at-risk patients
- Conduct investigations
- Assess and manage future fracture risk
- Refer to the appropriate treatment provider(s) for secondary fracture prevention care that cannot be provided during the hospital stay.

In Australia, this may involve liaison with Primary Health Networks to develop appropriate models of care.

### Indicator for local monitoring

**Indicator 6a:** Proportion of admitted patients with a hip fracture who received bone protection medicine while in hospital or a prescription prior to separation from hospital.



## Cultural safety and equity

Written information that highlights the pathway for hip fracture care should be provided in languages that reflect the make-up of the local population. Any written material for Māori or Aboriginal and Torres Strait Islander populations should be developed in partnership with the community and people with expertise in Indigenous health issues. Validated methods for developing written information should be used to the greatest extent possible.

## 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.

Ensure that systems are in place to support clinicians to develop an individualised care plan with patients prior to discharge, and to refer patients to the relevant services as required.

Ensure that clinical information systems support clinicians in providing the care plan to the patient, and communicating the content to their general practitioner, Aboriginal Medical Service, ongoing clinical providers, or community providers responsible for the person's clinical care (such as residential aged care facilities). Where local clinical information systems

allow, upload information to the patient's My Health Record. Sharing information on the care provided in hospital is especially important if the person is discharged to interim care (rehabilitation hospital or respite aged care) before returning home or consulting their usual general practitioner.

### Indicator for local monitoring

**Indicator 7a:** Evidence of local arrangements for the development of an individualised care plan for hip fracture patients prior to separation from hospital.



## Cultural safety and equity

Ensure that services are in place to enable effective communication with patients that considers their culture and location of care. Aboriginal and Torres Strait Islander people, Māori people and whānau, and others who have completed acute treatment away from their community may need structured support to ensure that they safely return to their place of residence. Establish appropriate, culturally safe networks and arrange access to services, support and contacts for people who have been transferred from remote locations.

## 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](https://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.