AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Clinical Care Standards

Hip Fracture

Clinical Care Standard

September 2023

The Australian Commission on Safety and Quality in Health Care acknowledges the traditional owners of Country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to elders both past and present.

Te Tāhū Hauora The Health Quality & Safety Commission (Aotearoa New Zealand) acknowledges the tangata whenua of Aotearoa in providing the space and spirit as part of our work. Ka nui te mihi ki ngā tangata whenua o Aotearoa, a, ngā iwi Māori hei manaaki, hei tiaki i a tātou mahi kounga.

Published by the Australian Commission on Safety and Quality in Health Care

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ISBN: 978-1-922880-55-0

The Commission's preference is that you attribute this publication (and any material sourced from it) using the following citation:

Australian Commission on Safety and Quality in Health Care. Hip Fracture Clinical Care Standard. Sydney: ACSQHC; 2023.

First released 2016, revised 2023.

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The *Hip Fracture Clinical Care Standard* has been endorsed by Te Tāhū Hauora Health Quality & Safety Commission (Te Tāhū Hauora) and the following organisations:

Te Tāhū Hauora
Health Quality & Safety Commission

AUSTRALASIAN DELIRIUM ASSOCIATON

Australia & New Zealand Falls Prevention Society

ANZONA
AUSTRALIA NEW ZEALAND ORTHOPAEDIC NURSES' ALLIANCE

ANZCA
FPM

ANZBMS

ANZHFR
Australian & New Zealand Hip Fracture Registry

AAG
Australian Association of Gerontology

Australasian College for Emergency Medicine

acnp
australian college of nurse practitioners

Australian College of Nursing

ACORN
AUSTRALIAN COLLEGE OF PERIOPERATIVE NURSES

Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

AOA
AUSTRALIAN ORTHOPAEDIC ASSOCIATION

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

CRANA plus
improving remote health

NACCHO
National Aboriginal Community Controlled Health Organisation

HEALTHY BONES AUSTRALIA

IAHA Indigenous Allied Health Australia

NeuRA
Discover — Conquer — Cure

shpa

RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

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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.

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.

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.

4 **Timing of surgery**

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

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.

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.

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.

Indicators for local monitoring

The following indicators will support healthcare services to monitor how well they are implementing the care recommended in this clinical care standard and are intended to support local quality improvement activities.

1

Care at presentation

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

2

Pain management

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.

3

Orthogeriatric model of care

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.

4

Timing of surgery

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

5

Mobilisation and weight bearing

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

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.

7

Transition from hospital care

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

The definitions required to collect and calculate indicator data are specified online: **meteor.aihw.gov.au/content/780812**. More information about indicators and other quality improvement measures is provided in **Appendix B**.

Clinical care standards

Clinical care standards help support the delivery of evidence-based clinical care and promote shared decision making between patients, carers and clinicians. They aim to ensure that people receive best-practice care for a specific clinical condition or procedure, regardless of where they are treated in Australia and Aotearoa New Zealand.

A clinical care standard contains a small number of quality statements that describe the level of clinical care expected for a specific clinical condition or procedure. Indicators are included for some quality statements to assist healthcare services to monitor how well they are implementing the care recommended in the clinical care standard.

A clinical care standard differs from a clinical practice guideline. Rather than describing all the components of care for a specific clinical condition or procedure, a clinical care standard focuses on key areas of care where the need for quality improvement is greatest.

Clinical care standards aim to improve healthcare outcomes by describing key components of appropriate care, enabling:

- Patients and the community to understand the care that is recommended and their healthcare choices
- Clinicians to provide best-practice care
- Healthcare services to monitor their performance and make improvements in the care they provide.

Clinical care standards are developed by the Australian Commission on Safety and Quality in Health Care (the Commission), an Australian Government agency that leads and coordinates national improvements in the safety and quality of health care, based on the best available evidence. By working in partnership with the Australian Government, states and territories, the private sector, clinical experts, and consumers and carers, the Commission aims to ensure that the health system is better informed, supported and organised to deliver safe and high-quality care.

About the Hip Fracture Clinical Care Standard

Context

The *Hip Fracture Clinical Care Standard* was first released in 2016, in collaboration with the Te Tāhū Hauora Health Quality & Safety Commission. This bi-national clinical care standard is based on the *Australian and New Zealand Guideline for Hip Fracture Care*[1] and supported by the Australian and New Zealand Hip Fracture Registry (ANZHFR). The indicators related to the quality statements in the *Hip Fracture Clinical Care Standard* are collected by participants in the ANZHFR and reported annually. With data on more than 80,000 hip fractures collected between 2016 and 2022[2], the establishment and acceptance of the ANZHFR and the associated quality improvement activities have been a significant step towards achieving a better standard of care for people with a hip fracture.

The revisions to the care described in this updated standard, and to the supporting indicators, target additional areas for improvement. The revisions have been informed by known variations in care identified through the ANZHFR.

Goal

To improve the assessment and management of people with a hip fracture to optimise outcomes and reduce their risk of another fracture.

Scope

This clinical care standard relates to the care that people with a suspected hip fracture should be offered, from presentation to hospital through to completion of treatment and discharge from hospital. This also includes people who sustain a hip fracture while in hospital. The target age for this clinical care standard is 50 years and older.

The care described in this clinical care standard is also appropriate for people aged under 50 years who have a suspected hip fracture that is judged to be caused by osteoporosis or osteopenia.

Healthcare settings

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

In this document, the term 'clinician' refers to all types of healthcare providers who deliver direct clinical care to patients.

Updates in 2023

The evidence sources used to develop the first *Hip Fracture Clinical Care Standard* were reviewed for this update. The evidence base for this clinical care standard remained largely unchanged from the previous version.

This revised clinical care standard maintains the same scope and goal of the 2016 *Hip Fracture Care Clinical Care Standard.* Some changes have been made to align the quality statements and indicators with the evidence base and current practice. Key updates in the current version include:

- The addition of cultural safety and equity considerations
- Changes to
  - Quality statements 1 and 3 to include assessment and management of delirium, nutrition and frailty
  - Quality statement 2 to include the use of nerve blocks, and to align with the care described in the *Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard*[3]
  - Quality statement 4 and Indicator 4a to reduce the time to surgery from 48 hours to 36 hours
  - Indicator 1b (now 1a) on screening for cognitive impairment to align with Indicator 1b of the *Delirium Clinical Care Standard*[4]
  - Wording in other quality statements of a minor editorial nature

- Adding
  - Indicators 2b and 2c on the proportion of patients receiving a nerve block prior to surgery and prior to transfer from another hospital, where applicable
  - Indicators 3a and 3b on assessing for clinical frailty and delirium
  - Indicator 3c on the proportion of patients receiving protein and energy oral nutritional supplements
- Retiring
  - Indicator 1a 'Evidence of local arrangements for the management of patients with hip fracture in the emergency department'
  - Indicator 2a 'Evidence of local arrangements for timely and effective pain management for hip fracture'
  - Indicator 3a 'Evidence of orthogeriatric (or alternative physician or medical practitioner) management during an admitted patient's hip fracture episode of care'
  - Indicator 5b 'Proportion of patients with a hip fracture with unrestricted weight bearing status immediately post hip fracture surgery'
  - Indicator 5d 'Proportion of patients with a hip fracture returning to pre-fracture mobility'
  - Indicator 6b 'Proportion of patients with a hip fracture readmitted to hospital with another femoral fracture within 12 months of admission from initial hip fracture'
  - Indicator 7b 'Proportion of patients with a hip fracture living in a private residence prior to their hip fracture returning to private residence within 120 days post separation from hospital'.

Evidence that underpins this clinical care standard

Key sources that underpin the *Hip Fracture Clinical Care Standard* are current clinical guidelines including:

- ***Australian and New Zealand Guideline for Hip Fracture Care***[1]
- National Institute for Health and Care Excellence clinical guideline ***Hip fracture: management***.[5]

A list of the evidence sources for this clinical care standard is available on the **Commission's website**.

Supporting resources

Clinical care standard resources

Supporting documents for this clinical care standard are available on the **Commission's website**.

These include the:

- Consumer guide
- Clinician fact sheet
- Healthcare services fact sheet.

Other Commission resources

Other Commission resources that are relevant to this clinical care standard include the:

- ***Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard***[3]
- ***Delirium Clinical Care Standard***[4]
- ***Venous Thromboembolism Prevention Clinical Care Standard***[6]
- ***National Safety and Quality Health Service Standards user guide for health service organisations providing care for patients with cognitive impairment or at risk of delirium***[7]
- **Hospital-acquired complications (HACs) FAQs and resources**.[8]

Other resources

A number of tools and resources are currently available on the **ANZHFR website**.[9]

These include:

- Annual reporting of indicator outcomes across the ANZHFR
- Resources for patients, carers and families
- Local protocols and clinical pathways for hip fracture care
- Access to information on secondary fracture prevention
- Links to useful websites.

How to use this clinical care standard

The quality statements in this clinical care standard describe the expected standard for key components of patient care. The standard explains what each quality statement means:

- **For patients**, so they know what care may be offered by their healthcare system and can make informed treatment decisions in partnership with their clinician
- **For clinicians,** to support recommendations about appropriate care
- **For healthcare services,** to inform them of the policies, procedures and organisational factors that can enable the delivery of high-quality care.

General principles of care

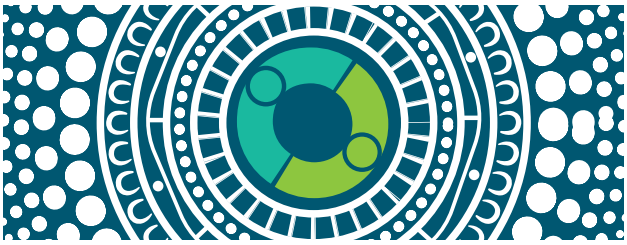
This clinical care standard should be implemented as part of an overall approach to safety and quality, incorporating the following principles that are the foundation for achieving safe and high-quality care:

- Person-centred care and shared decision making
- Cultural safety for Aboriginal and Torres Strait Islander people and other cultural groups
- Equity of care for people from diverse backgrounds
- Informed consent.

When applying the information contained in a clinical care standard, clinicians are advised to use their clinical judgement and to consider the individual patient's circumstances, in consultation with the person or their support people.

For more information and additional Commission resources, see **Appendix A**.

Cultural safety and equity



This clinical care standard highlights considerations for cultural safety and equity when caring for people with a hip fracture.

The Commission is committed to supporting healthcare services to deliver safe and high-quality care to the Australian community and recognises that culturally safe and responsive health care is critical to improving equitable access and outcomes for patients, families and communities.[10]

Person-centred care includes care that is respectful of cultural diversity and individual needs. Cultural safety is about overcoming the cultural power imbalances of places, people and policies to contribute to improvements in health, particularly for Aboriginal and Torres Strait Islander people.[11] Health consumers are safest when clinicians have considered power relations, cultural differences and patients' rights. Part of this process requires clinicians to review their own beliefs and attitudes.[10]

Although it is usually applied in the context of First Nations people, the concept of cultural safety can also be applied to the experiences of people with diverse cultural or social identities.

Cultural safety in health care is underpinned by the:

- **National Registration and Accreditation Scheme**, which aims to ensure that cultural safety is consistent within the codes of conduct for health professionals around Australia
- ***National Agreement on Closing the Gap***, which is built around four priority reforms for transforming the way governments work with, and for, Aboriginal and Torres Strait Islander people to improve outcomes

- ***Cultural Respect Framework 2016–2026***, which commits the Australian Government and all states and territories to embed cultural respect principles into their health systems[12]
- National Safety and Quality Health Service (NSQHS) Standards
  - Patient safety and quality systems – **Action 1.15**
  - Clinical performance and effectiveness – **Action 1.28**
  - Partnering with consumers – **Actions 2.11** and **2.13**.

In Aotearoa New Zealand, Te Tāhū Hauora is committed to achieving equity for Māori, as tangata whenua and partners with the Crown under te Tiriti o Waitangi, and the many populations and groups that make up the diverse population.[13]

Equity

Health inequities relate to differences in ethnicity, socioeconomic circumstances, geography, gender, sexuality, age and disability, sometimes in combination.

Social and cultural factors can contribute to health outcomes in ways that may be complex and interrelated.[14] Cultural and historical factors can affect a person's participation in health care, whether due to imbalances in power, differences in language, historical or intergenerational trauma, a lack of cultural safety, or racism and discrimination. Clinician biases regarding particular groups or individuals can affect the health care received by the groups concerned.[15]

In Australia, Aboriginal and Torres Strait Islander people generally experience poorer health outcomes than the rest of the population, with systemic racism being a root cause. The considerations for minimising cultural safety and equity issues throughout this clinical care standard focus primarily on overcoming cultural power imbalances, and addressing the many barriers Aboriginal and Torres Strait Islander people face in accessing and receiving health care.[11,12]

Embedding cultural safety in health care

Addressing inequity requires action at multiple levels, and recognition that people with different levels of advantage may require different approaches and resources to achieve the same healthcare outcomes.

There are a number of ways that healthcare services and individual clinicians can improve cultural safety and equity of outcomes.

Healthcare services can:

- Ensure that they are providing patient-centred care, including with respect to cultural identity
- Identify variation in healthcare provision or outcomes for the population groups they serve – for example, based on ethnicity[16]
- Disaggregate data by Aboriginal and Torres Strait Islander status when using the indicators included in this standard; this will improve accountability, and support the identification of access and outcome issues so that improvements can be made
- Implement and monitor the six specific actions for Aboriginal and Torres Strait Islander care outlined for acute care services in the NSQHS Standards, and equivalent actions in the Primary and Community Healthcare Standards.

As with patient safety, all healthcare providers have a role in ensuring culturally safe care. Clinicians can:

- Undertake cultural safety training
- Examine their implicit biases and how these affect the health care they provide and their interactions with people
- Ensure the use of interpreter services, cultural translators, or Aboriginal and Torres Strait Islander Health Workers or Practitioners when this will assist the patient.

Related resources

Resources that can help healthcare services and clinicians improve cultural safety and equity include:

- The NSQHS Standards ***User guide for Aboriginal and Torres Strait Islander health***[10]
- The NSQHS Standards ***User guide for health service organisations providing care to people from migrant and refugee backgrounds***[14]
- NSW Health ***Communicating positively: A guide to appropriate Aboriginal terminology***[17]
- In Aotearoa New Zealand, the ***Health Equity Assessment Tool: A user's guide***.[18]

Measurement for quality improvement

Measurement is a key component of quality improvement processes. The Commission has developed a set of indicators to support clinicians and healthcare services to monitor how well they are implementing the care recommended in this clinical care standard. No benchmarks are set for these indicators. However, facilities can compare their performance on each quality indicator to the performance of other facilities, and to the national average in published ANZHFR annual reports and real-time dashboards. The indicators are intended to support local quality improvement activities.

The indicators are listed with the relevant quality statements. The definitions required to collect and calculate indicator data are available online at **https://meteor.aihw.gov.au/content/780812**.

Indicators to support overall monitoring of hip fracture care

Indicator 8a: Proportion of patients with a hip fracture who returned to pre-fracture walking ability within 120 days following surgery

Indicator 8b: Proportion of patients who returned to live in a private residence within 120 days following surgery

Indicator 8c: Survival 30 days from presentation to hospital for a hip fracture

Three indicators are recommended to support overall monitoring of the implementation of this clinical care standard. These indicators can be measured through the ANZHFR or linked datasets.

Australian and New Zealand Hip Fracture Registry

A minimum data set (MDS) was created for the ANZHFR Steering Group. The purpose of the minimum dataset and registry is to support consistent, local collection of data across Australia and Aotearoa New Zealand to enable facilities to compare practice and outcomes for hip fracture care against national clinical guidelines and standards of care. The MDS has been developed to capture information relevant to the *Australian and New Zealand Guideline for Hip Fracture Care* and this clinical care standard, and is comparable to the United Kingdom National Hip Fracture Database and other registries emerging around the world.

The MDS is outlined in the ***ANZHFR Data Dictionary***.[19]

More information about indicators and other quality improvement measures is provided in **Appendix B**.

Information on other quality measures, including patient-reported outcome measures and patient-reported experience measures, is provided in **Appendix C**.

In Aotearoa New Zealand, healthcare service providers are encouraged to consider data available to inform improvement.

Meeting the requirements of national standards and accreditation

In Australia, implementing this clinical care standard as part of a quality improvement activity can help healthcare services meet the requirements of the NSQHS Standards.

For more information about the NSQHS Standards, see **Appendix D**.

In Aotearoa New Zealand, providers of health services must be certified against the **Ngā Paerewa Health and Disability Services Standard**.[20] This Standard sets out the steps that providers must take to ensure that they are providing safe, high-quality services. It also outlines what people can expect from the services they receive.

Background: Hip fracture

A hip fracture is a break occurring at the top of the thigh bone (femur), near the pelvis. Hip fracture often signifies underlying ill health.[5] Most hip fractures occur in people aged 65 years and older, with an average age of 82 years across Australia and Aotearoa New Zealand.[2] Individuals with hip fracture are over 3.5 times more likely to die within 12 months of the fracture compared to non-injured individuals.[21] The ANZHFR reports that, in 2020, the adjusted mortality rate at 365 days was 22.1% in Australia and 27.6% in Aotearoa New Zealand.[2] This patient group also has a high rate of hospital-acquired complications, resulting in individual suffering, a longer hospital length of stay and unnecessarily high healthcare costs.

Hip fractures are usually associated with a fall. In Australia, falls are the most common cause of hospitalised injury and injury-related death among people aged 65 years and older.[22] In 2019–20, hip and thigh injuries accounted for 20% of all fall-injury hospitalisations. Among the 66,200 hospitalisations for fractures caused by a fall, the hip and thigh were the most commonly fractured body part (20,355 people, or 31% of all hospitalised fall fractures).[22] These presentations are projected to increase in the foreseeable future, as are the associated costs to individual patients, their families, the community and the healthcare system.[1]

There is a higher and increasing rate of hip fracture in Aboriginal and Torres Strait Islander people, among whom men are 50% more likely, and women 26% more likely, to experience a hip fracture than non-Indigenous Australians.[23,24] New South Wales hospitalisation data show that minimal-trauma hip fractures occur at a younger age in Aboriginal and Torres Strait Islander men and women than in non-Indigenous people.[25] In 2020–21, Aboriginal and Torres Strait Islander people were 1.4 times as likely as non-Indigenous Australians to be hospitalised due to a fall injury (after adjusting for differences in population age).[26] Currently, there are no studies explaining the mechanisms for increased falls and fracture risk in Aboriginal and Torres Strait Islander people.[23]

A 2019 report found inequities in the hip fracture care received between Māori and non-Māori in Aotearoa New Zealand.[13] Following a hip fracture, the percentage of Māori having an operation on the day of, or the day after, hospital admission decreased steadily between 2013 and 2016, while the rate for non-Māori steadily increased.[13]

Key markers of high-quality care in hip fracture, such as time to surgery, complication rates, hospital readmission rates and length of stay, can vary considerably between hospitals.[9] Due to their age, people who have a hip fracture are at greater risk of common hospital-acquired complications as identified by the Commission, such as pressure injuries and malnutrition.[27] The quality of care is influenced by, among other factors, the configuration of orthopaedic and geriatric medicine services, hospital protocols and processes, and the degree to which a multidisciplinary approach to care is taken.[10]

Progress in hip fracture care

The ANZHFR routinely reports on the results of audits against the *Hip Fracture Clinical Care Standard* indicators collected from participating hospitals across Australia and Aotearoa New Zealand. There has been significant progress in several domains since the clinical care standard was first released in 2016, but there is still variation between jurisdictions and individual sites.[28]

In 2022:

- 72% of patients aged 65 years and over had a preoperative assessment of cognition
- 65% of patients had a documented assessment of pain within 30 minutes of presenting to the emergency department
- 91% of patients were given the opportunity to mobilise on the day of, or the day after, surgery.[29]

Some areas that require improvement, as identified through the ANZHFR data, include:

- Reducing the average time to surgery
- Increasing rates of first-day walking
- Increasing the proportion of people on bone protection medication at discharge.

The latest revisions to the *Hip Fracture Clinical Care Standard* aim to ensure that a patient with a hip fracture receives optimal treatment, from presentation to hospital through to the completion of treatment and discharge from hospital. This includes timely assessment and management of a hip fracture, timely surgery if indicated, and the early initiation of a tailored care plan aimed at restoring movement and function and minimising the risk of another fracture.

1

Quality statement 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.

Purpose

To ensure that people presenting with a suspected hip fracture receive comprehensive clinical assessment and management.

To ensure that inter-hospital patient transfer for hip fracture surgery is safe, efficient and effectively coordinated.

What the quality statement means

For patients

When you arrive at hospital, the clinical team will assess you to see if you have a hip fracture (broken hip). They will also check any other health conditions so that you can have an operation quickly if you need one. As part of the assessment, you will need an X-ray and blood tests. Your clinician will:

- Check your overall health and ability to function before your injury
- Ask about any existing health conditions you may have
- Ask about any medicines that you are taking that may affect your surgery
- Make sure your pain is controlled
- Talk to you about possible reasons for your fall
- Check for any problems you may be having with your memory, thinking or communication that could mean you are at risk of delirium (a serious condition where there is a change in mental state that alters awareness, such as seeing or hearing things)
- Ask if you identify as Māori or Aboriginal and Torres Strait Islander, or need access to a translator.

Your priorities and choices are important, and your clinical team will support these wherever possible. Let them know if there are family members, friends or carers that you would like to have included in decisions about your care.

For clinicians

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[1]
- 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***.[4] 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.[30]

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 – FOR CLINICIANS

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.

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[31] is relevant. The Kimberley Indigenous Cognitive Assessment (KICA)[32] provides a more culturally appropriate measure of cognition, which may be useful for Māori and Aboriginal and Torres Strait Islander people.

* Consider using the **Clinical Frailty Scale** to identify vulnerable older patients who require customised care.

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.

For healthcare services

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.

CULTURAL SAFETY AND EQUITY – FOR HEALTHCARE SERVICES

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.

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.

METEOR link: **meteor.aihw.gov.au/content/780818**

More information about this indicator and the definitions needed to collect and calculate indicator data can be found online at the above METEOR link. See **Appendix B** for other related indicators (including for delirium).

Related resources

- Resources including local protocols and clinical pathways for hip fracture care have been shared by hospitals that contribute to the ANZHFR; these can be found on the **ANZHFR website**.[9]
- The Australasian College for Emergency Medicine ***Care of older persons in the emergency department (Policy P51)*** relates to the recommended standards of care for older persons in the emergency department; it has been developed in consultation with, and endorsed by, the Australian and New Zealand Society for Geriatric Medicine.[33]
- People with hip fracture have a high risk of delirium; to prevent, diagnose and manage delirium in these people, they should be treated according to the ***Delirium Clinical Care Standard***.[4]
- The **4AT** has been validated for both cognitive impairment screening and delirium assessment, and is available in 17 languages.[4,28,34]
- Some validated tools for cognitive impairment screening include
  - Abbreviated Mental Test Score (AMTS), incorporated in the NSW Health **Delirium Screen for Older Adults** (available from the Agency for Clinical Innovation)[35]
  - **Kimberley Indigenous Cognitive Assessment tool**, available from the **Dementia Centre for Research Collaboration**.[32]
- The **Clinical Frailty Scale** can predict adverse outcomes in older people in hospital, including hospital-based harm, emergency department and inpatient length of stay, the need for placement in an aged care facility, and death.[36]

2 Quality statement 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.

Purpose

To provide people who have a hip fracture with safe, effective and timely pain management throughout their hospital stay.

What the quality statement means

For patients

If you have a hip fracture and come to the hospital by ambulance, you may be given medicines while in the ambulance to relieve your pain and nausea.[37] As soon as you arrive at the hospital, a doctor, nurse or other clinician will assess your pain and give you suitable medicines to relieve your pain. Your pain will also be assessed and managed throughout your hospital stay. Before surgery, you are likely to be offered an injection in the groin called a 'nerve block'. Nerve blocks can provide pain relief for several hours by numbing the area around your hip and thigh.[37]

If you need to travel to another hospital for surgery, you will be given pain relief before you are transferred, to make you as comfortable as possible.

For clinicians

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.[1,5]

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.[1]

Provide appropriate pain management including multimodal analgesia[1,38], incorporating nerve blocks as part of perioperative pain management.[5,39] Nerve blocks can reduce opioid dose requirements[5] and accompanying side effects[40] (such as sedation, respiratory complications and delirium).[1,41]

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[42] in accordance with the ***Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard***[3]
- Plan for appropriate opioid analgesic use at the transfer of care when a patient is first prescribed, supplied or administered an opioid analgesic[3]
- Follow a weaning and cessation protocol guided by assessment of the patient's functional activity and pain scores.[3,42]

CULTURAL SAFETY AND EQUITY – FOR CLINICIANS

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.[41] Language should not be a barrier to appropriate assessment and management of pain.[1] 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.[41]

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.[1] 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.[1] 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.[41]

For healthcare services

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***.[3]

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.[42]

CULTURAL SAFETY AND EQUITY – FOR HEALTHCARE SERVICES

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.[1]

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.

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.

METEOR link: **meteor.aihw.gov.au/content/780825**

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

METEOR link: **meteor.aihw.gov.au/content/780833**

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.

METEOR link: **meteor.aihw.gov.au/content/780840**

More information about these indicators and the definitions needed to collect and calculate indicator data can be found online at the above METEOR links. See **Appendix B** for other related indicators (including for opioid analgesic stewardship).

Related resources

- The ***Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard*** describes the key components of care that patients can expect when they are prescribed opioid analgesics for acute pain in acute care settings.[3]
- Pain scales support the identification of symptoms and signs associated with pain in people with altered cognition; examples include
  - **Pain Assessment in Advanced Dementia scale**[43]
  - **Abbey pain scale**.[44]
- Some pain assessment tools use facial expressions, such as the **Wong-Baker FACES pain rating scale**.[45]
- Some patients may have needs that require particular attention (for example, patients who are opioid-tolerant or have a substance use disorder, Aboriginal and Torres Strait Islander people, Māori, patients with cognitive behavioural and/or sensory impairments, and non-English speaking people); evidence-based information related to the management of acute pain in these patient groups and situations is included in the fifth edition of ***Acute Pain Management: Scientific Evidence***, published by the Australian and New Zealand College of Anaesthetists and the Faculty of Pain Medicine.[42]
- The Society of Hospital Pharmacists of Australia's ***Standard of practice in pain management for pharmacy services*** outlines important strategies to optimise pain management while minimising harm, including implementing opioid or analgesic stewardship services.[46]

3 Quality statement 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*.[1] A coordinated multidisciplinary approach is used to identify and address malnutrition, frailty, cognitive impairment and delirium.

Purpose

To ensure that, from the time of admission, the care of people with a hip fracture involves a multidisciplinary shared-care approach to optimising health and patient outcomes and is based on the person's goals of care. The goals of care should be informed by the person's preferences and agreed on by the patients and clinicians.

What the quality statement means

For patients

If you have a hip fracture, you and your family or carer are involved in important decisions about your care from the time you are admitted to hospital. This includes working out what you would like to achieve from your care, and the best way to achieve it. For example, extra steps may be needed so that it is medically safe for you to have surgery, or there may be different options for your surgery. A team of healthcare professionals will care for you. The team will have different areas of expertise, which may include:

- Care of older people (medical, nursing and allied health professionals)
- Orthopaedic (bone) surgery
- Pain management
- Mobility
- Nutrition
- Rehabilitation.

It is important that all of your health issues, needs and preferences (including cultural and language considerations) are taken into account, to give you the best chance of a full recovery.

Nutrition is very important for your recovery from a hip fracture. You will be assessed early in your admission to see if you are malnourished. You will be offered oral nutritional supplements to help increase your calorie and protein intake. If your clinician thinks you are malnourished, or at risk of malnutrition, they will also discuss with you how to improve your nutrition while considering your needs, culture and preferences.

There is a chance that you may develop a condition called delirium after a hip fracture. Delirium causes mental and physical changes such as confusion, or seeing or hearing things that are not there. Some people may get agitated or distressed, while others become very sleepy. You will be monitored for delirium throughout your hospital stay, and steps should be taken to prevent it. It is important for you and your support people to let your healthcare team know about any changes in your mental awareness, including feeling confused, being disoriented or having memory problems. Dealing with delirium quickly will help your recovery.

For clinicians

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[5]
- Optimisation for surgery (see Box 1)
- Early identification of goals of care, in discussion with the patient and their family or support people, and documented in the comprehensive care plan[30]
- Early assessment of the patient's nutritional status using a validated assessment tool*[,47,48] and reassessment during the course of the admission with individualised interventions when required[1] (see Box 2), including offering oral nutritional supplements[49] and avoiding prolonged nil-by-mouth restrictions[48]
- 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[6]
- 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 long-term wellbeing, if appropriate and clinically indicated
- Early identification of the most appropriate service to deliver rehabilitation, if indicated.

* A validated assessment tool should be applied by an appropriately trained clinician. Examples of validated assessment tools include the:
  - Subjective Global Assessment
  - International Classification of Diseases (ICD) coding criteria
  - Global Leadership Initiative on Malnutrition (GLIM criteria).

Box 1: Optimisation for surgery

Identify and optimise correctable comorbidities immediately so that surgery is not delayed by:

- **Anaemia**
- **Anticoagulation**
- **Volume depletion**
- **Electrolyte imbalance**
- **Uncontrolled diabetes**
- **Uncontrolled heart failure**
- **Metabolic derangement**
- **Correctable cardiac arrhythmia or ischaemia**
- **Acute chest condition or exacerbation of chronic chest conditions.**

Source: *Australian and New Zealand Guideline for Hip Fracture Care*[1] and the National Institute for Health and Care Excellence *Hip fracture: management guideline.*[5]

Box 2: Nutritional assessment and management

Multimodal/multidisciplinary interventions may include:

- **Ensuring that the patient has their teeth in situ**
- **A swallowing assessment**
- **Cognitive and mood assessment**
- **Encouraging and assisting with feeding at mealtimes**
- **Appropriate medical management of nutritional impact symptoms (pain, constipation, nausea, vomiting, appetite)**
- **Avoiding prolonged Nil By Mouth restrictions**
- **Nutrition-related diagnosis and education**
- **Reviewing the nutritional content of the diet provided**
- **Advice on ensuring adequate calcium intake in the diet**
- **Clinical handover.**

Source: *Australian and New Zealand Guideline for Hip Fracture Care*[1] and *Orthogeriatrics: The Management of Older Patients with Fragility Fractures.*[48]

CULTURAL SAFETY AND EQUITY – FOR CLINICIANS

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.[1] Recognise that a history of trauma may affect behaviour, and provide trauma-aware and healing-informed care.[50]

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.[1]

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.

For healthcare services

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*.[1] 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.

CULTURAL SAFETY AND EQUITY – FOR HEALTHCARE SERVICES

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.

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

Indicators for local monitoring

Indicator3a: Proportion of patients with a hip fracture who had a clinical frailty assessment using a validated tool.

METEOR link: **meteor.aihw.gov.au/content/780847**

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

METEOR link: **meteor.aihw.gov.au/content/780850**

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

METEOR link: **meteor.aihw.gov.au/content/780908**

More information about these indicators and the definitions needed to collect and calculate indicator data can be found online at the above METEOR links. See **Appendix B** for other related indicators (including for delirium and VTE prevention).

Related resources

- People with hip fracture have a high risk of delirium; to prevent, diagnose and manage delirium in these people, they should be treated according to the ***Delirium Clinical Care Standard***.[4]
- The ***Venous Thromboembolism Prevention Clinical Care Standard*** supports clinicians and healthcare services to deliver high-quality care that prevents VTE from being acquired both in hospital and following discharge.[6]
- The Commission has developed several **resources** for clinicians, managers and executives, governing bodies and others that can help them adopt strategies that reduce the occurrence of hospital-acquired complications such as VTE, delirium and malnutrition.[27]
- The National Safety and Quality Health Service Standards **Comprehensive Care Standard** includes actions on nutrition and hydration (5.27 and 5.28), preventing falls and harm from falls (5.24 to 5.26) and preventing delirium and managing cognitive impairment (5.29 and 5.30).[30]

4 Quality statement 4 – Timing of surgery

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

Purpose

To ensure that people with a hip fracture undergo surgery, if clinically indicated, within 36 hours of their first presentation to any healthcare facility. This includes people presenting to smaller services and those in remote areas, for whom networks and systems should be in place to ensure coordinated transfer and timely surgery.

What the quality statement means

For patients

Your clinicians will discuss with you the treatment options for your hip fracture, including the possible risks and benefits. You should have surgery within 36 hours of arriving to hospital, unless your clinicians say that you should wait. The same time frame applies if you fracture your hip while in hospital. If you are in a remote location, surgery may be delayed while you are transferred to a hospital where the surgery can be done. However, you should still receive surgery as soon as possible.

Without surgery, recovery from a hip fracture is slow and you will be unable to walk, which can cause discomfort and other complications. However, for some people, it is decided that surgery is not the best option. You may not want to have surgery, or your clinicians may advise that it is better for you to not have surgery at all. Your family will also be involved in these decisions.

For clinicians

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.[1,5]

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.[1,5] 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.[6,51,52]

CULTURAL SAFETY AND EQUITY – FOR CLINICIANS

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.[1]

For healthcare services

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.

CULTURAL SAFETY AND EQUITY – FOR HEALTHCARE SERVICES

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.

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.

METEOR link: **meteor.aihw.gov.au/content/780920**

More information about this indicator and the definitions needed to collect and calculate indicator data can be found online at the above METEOR link.

5

Quality statement 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.

Purpose

To restore movement and function following injury and to reduce postoperative complications.

What the quality statement means

For patients

The aim of hip fracture surgery is to allow you to get up and put weight through your leg straight away.[37] Either the day of your surgery or the day after, you will be encouraged to sit out of bed and start putting as much weight through your leg as is comfortable, unless there are good reasons for you not to. It is common to feel some pain or weakness when you start walking. Starting to move early will prevent you from losing your strength and mobility, and help you regain your independence sooner. It will also help to avoid serious complications such as pneumonia, clots in the legs, pressure injuries to the skin, and delirium.[37]

If you are spending long periods in bed or in a chair without moving, you are at risk of developing a pressure injury (bedsore). Your risk of getting a pressure injury will be assessed regularly and you will be provided with the right kind of equipment (like a mattress and/or cushion) and advice on moving about to relieve the pressure.

For clinicians

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.[1,5] Mobilised means the person manages to stand and step transfer out of bed onto a chair or commode, or walk.[19] 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.[38]

Additional exercises, such as training of gait, balance and functional tasks can further improve patient outcomes.[53] For people with conditions preventing mobilisation, arrange for tailored advice from a physiotherapist or occupational therapist.[5]

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.[54]

CULTURAL SAFETY AND EQUITY – FOR CLINICIANS

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.[1]

For healthcare services

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.[54]

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.

METEOR link: **meteor.aihw.gov.au/content/780923**

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

METEOR link: **meteor.aihw.gov.au/content/780930**

More information about these indicators and the definitions needed to collect and calculate indicator data can be found online at the above METEOR links. See **Appendix B** for other related indicators (including for hospital-acquired complications).

Related resources

- The Commission has developed several **resources** for clinicians, managers and executives, governing bodies and others that can help them adopt strategies that reduce the occurrence of hospital-acquired complications and provide comprehensive care, including for pressure injury.[27]
- The National Safety and Quality Health Service Standards **Comprehensive Care Standard** includes actions on preventing and managing pressure injuries (5.21 to 5.23).[30]

6 Quality statement 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.

Purpose

To reduce the risk of another fracture for people who have sustained a hip fracture.

What the quality statement means

For patients

As you get older, your bones become weaker and are more likely to break easily. People who have had a hip fracture are more likely to have another fracture in the future. Before you leave hospital, your risk of having another fracture anywhere in your body will be assessed. Your clinician will consider your bone health, and help to identify the possible reasons for your fall and ways to prevent future falls. You may be offered calcium and/or vitamin D supplementation as well as bone protection medicine to improve your bone strength and reduce the chance of another fracture.

You will also be given written information and advice on exercises and may be referred to a physiotherapist or exercise program. A regular exercise program should ideally include exercises to improve both your balance and your strength in a way that is safe for you. It is important that you continue to work on preventing another fracture after you leave hospital. Discuss your care plan with your general practitioner, other regular clinicians, Aboriginal Community Controlled Health Organisation (ACCHO)*, Māori Organisation or care providers. You may be offered a follow-up appointment at the hospital or with a bone specialist as part of the plan to reduce your risk of another fracture.

For clinicians

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.

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* Where the Aboriginal Community Controlled Health Sector is referenced, this includes Torres Strait Islanders.

CULTURAL SAFETY AND EQUITY – FOR CLINICIANS

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.[1] 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.

For healthcare services

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.[55] 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.

CULTURAL SAFETY AND EQUITY – FOR HEALTHCARE SERVICES

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.[1]

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.

METEOR link: **meteor.aihw.gov.au/content/780936**

More information about this indicator and the definitions needed to collect and calculate indicator data can be found online at the above METEOR link.

Related resources

- The Australian and New Zealand Hip Fracture Registry fact sheet ***Reducing the risk of future fractures: Osteoporosis and fall prevention***.[56]
- Healthy Bones Australia **resources and fact sheets** about osteoporosis, treatment, diet, exercise and falls; this information can be used by clinicians in discussions with patients when developing a plan to reduce the risk of another fracture.[57]
- The ***Clinical Standards for Fracture Liaison Services in New Zealand*** underpin a nationwide strategy to prevent older adults who sustain a fragility fracture from breaking other bones in the future.[55]
- The Therapeutic Guidelines ***Osteoporosis and minimal-trauma fracture*** guideline includes information on assessing and interpreting bone status and preventing minimal-trauma fracture.[58]
- The National Safety and Quality Health Service Standards **Comprehensive Care Standard** includes actions on preventing falls and harm from falls (5.24 to 5.26).[30]

7 Quality statement 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, this plan is provided to the person and communicated with their general practice and other ongoing clinicians and care providers.

Purpose

To ensure that people with a hip fracture have an individualised care plan before they leave the hospital. This is separate to a clinical discharge summary.

What the quality statement means

For patients

Before you leave hospital, your clinician will talk with you about your recovery and the ongoing care you will need. They will work with you to develop a plan that is in a format you understand. The plan describes:

- Medicines you may need to take
- Information on how to prevent future fractures
- Nutrition care
- Rehabilitation services and equipment you require.

You will get a copy of your plan before you leave hospital. The information in your plan will also be communicated to your general practitioner, ACCHO or Māori Organisation, and other regular clinicians and care providers. Take your plan with you to future appointments, along with any questions you would like to discuss.

For clinicians

Develop an individualised care plan with the patient before they leave hospital (for example, see the ANZHFR ***Hip Fracture Care Guide***[37] or Te Tāhū Hauora Health Quality & Safety Commission's ***Recovering from a Hip Fracture***[59] 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 – FOR CLINICIANS

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.[60]

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.

For healthcare services

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.

CULTURAL SAFETY AND EQUITY – FOR HEALTHCARE SERVICES

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.

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.

METEOR link: **meteor.aihw.gov.au/content/780939**

More information about this indicator and the definitions needed to collect and calculate indicator data can be found online at the above METEOR link.

Related resources

- The ANZHFR *My Hip Fracture Guide: Information and Individual Care Plan*[37] is a guide for patients, carers and families that provides important information about care after a hip fracture; the guide has been translated into 15 languages and is available on the **ANZHFR website**.
- Te Tāhū Hauora has helped to develop the ***Recovering from a hip fracture: Pikinga ora i tētahi whainga hope***[59] information booklet to meet the needs of the population in Aotearoa New Zealand; an important part of the booklet is for the patient to be able to work through and document a personal plan with their healthcare team before discharge from hospital.

Appendix A: General principles of care

This clinical care standard aligns with key principles that are the foundation for achieving safe, high-quality care. When implementing this clinical care standard, healthcare services should ensure that quality improvement activities support these principles.

Person-centred care

Person-centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers.[61,62]

Clinical care standards support the key principles of person-centred care, namely:

- Treating patients with dignity and respect
- Encouraging patient participation in decision-making (see 'Shared decision making')
- Communicating with patients about their clinical condition and treatment options
- Providing patients with information in a format that they understand and encouraging them to participate in decision-making.

Shared decision making

Shared decision making involves discussion and collaboration between a consumer and their clinician. It is about bringing together the consumer's values, goals and preferences with the best available evidence about benefits, risks and uncertainties of treatment, to reach the most appropriate healthcare decisions for that person.

Involving support people

The ***Australian Charter of Healthcare Rights*** (second edition)[63] describes the rights that consumers, or someone they care for, can expect when receiving health care.

Patients have the right to involve the people they want in planning and making decisions about their health care and treatment. This could be a family member, carer, friend or consumer advocate such as a social worker. Many healthcare services employ different types of liaison officers, such as Aboriginal and Torres Strait Islander Liaison Officers or cross-cultural workers, who can provide patients with advocacy, information and support.

This clinical care standard does not specifically refer to carers and family members, but statements that refer to clinicians' discussions with patients about their care should be understood to include support people if this is what the patient wishes, or a substitute decision-maker if the person is unable to provide their consent.

Informed consent

Informed consent is a person's voluntary and informed decision about a healthcare treatment, procedure or intervention that is made with adequate knowledge and understanding of the benefits and risks, and the alternative options available. More information is available in the Commission's **informed consent fact sheet for consumers**.

Action 2.04 in the National Safety and Quality Health Service (NSQHS) Standards requires health service organisations to ensure that informed consent processes comply with legislation and best practice.[61]

Appendix B: Indicators to support local monitoring

The Commission has developed a set of indicators to support clinicians and healthcare services in monitoring how well they implement the care described in this clinical care standard. The indicators are a tool to support local quality improvement activities. No benchmarks are set for any indicator.

The process to develop the indicators specified in this document comprised:

- A review of existing Australian and international indicators
- Prioritisation, review and refinement of the indicators with the topic working group.

All the data underlying these indicators are collected from local sources, through prospective data collection or retrospective chart audits, or review of policies and protocols.

In this document, the indicator titles and hyperlinks to the specifications are included with the relevant quality statement under the heading 'Indicator(s) for local monitoring'. Full specifications for the *Hip Fracture Clinical Care Standard* indicators can be found in the Metadata Online Registry (METEOR) at **meteor.aihw.gov.au/content/628043**.

METEOR is Australia's web-based repository for national metadata standards for the health, community services and housing assistance sectors. Hosted by the Australian Institute of Health and Welfare, METEOR provides users with online access to a wide range of nationally endorsed data and indicator definitions.

In Aotearoa New Zealand, health service providers are encouraged to consider **data** available to inform improvement.

Other Commission-endorsed indicators to support local monitoring

The Commission recommends other quality improvement indicators to support monitoring, including:

- ***Delirium Clinical Care Standard*** – definitions required to collect and calculate indicator data are available online at **meteor.aihw.gov.au/content/745804**
- ***Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard*** – definitions required to collect and calculate indicator data are available online at **meteor.aihw.gov.au/content/755544**
- ***Venous Thromboembolism Prevention Clinical Care Standard*** – definitions required to collect and calculate indicator data are available online at **meteor.aihw.gov.au/content/697224**.

Hospital-acquired complications

A hospital-acquired complication (HAC) refers to a complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.[64] The HACs list comprises 16 agreed-upon, high-priority complications for which clinicians, managers and others can work together to improve patient care. Each of the HACs has a number of associated diagnoses and codes that allow further exploration of the data. Data for HACs are derived from the admitted patient data collection.

The HACs list includes:

- Pressure injury
- Falls resulting in fracture or intracranial injury
- Healthcare-associated infections
- Surgical complications requiring unplanned return to theatre
- Venous thromboembolism
- Delirium
- Malnutrition.

The specifications for the HACs list, which provide the codes, inclusions and exclusions required to calculate rates, are available on the **Commission's website**.

Appendix C: Measuring and monitoring patient experiences

Systematic, routine monitoring of patients' experiences of, and outcomes from, health care is an important way to ensure that the patient's perspective drives service improvements and person-centred care. This is the case in all healthcare services.

Patient-reported experience measures

While this clinical care standard does not include indicators specific to measuring patient experiences, the Commission strongly encourages healthcare services to use the Australian Hospital Patient Experience Question Set (AHPEQS). This is a 12-question generic patient experience survey that has been validated in both day-only and admitted hospital patients across many clinical settings. The **instrument is available for download** to both private and public sector healthcare services.

The ANZHFR 'My Hip My Voice' project is also collecting information on patient and carer experience of hip fracture care. A set of questions has been developed to enable patients to provide feedback on their care experience directly to the hospital that cared for them. The 'My Hip My Voice' participant information sheet can be found on the **Australian and New Zealand Hip Fracture Registry's website**.

Patient-reported outcome measures

In Australia, patient-reported outcome measures (PROMs) are an emerging method of assessing the quality of health care. The Commission is leading a national work program to support the consistent and routine use of PROMs to drive quality improvement.

PROMs are standardised, validated questionnaires that patients complete, without any input from healthcare providers. They are often administered at least twice to an individual patient – at baseline and again after an intervention, or at regular intervals during a chronic illness. The information contributed by patients filling out PROMs questionnaires can be used to support and monitor the movement of health systems towards person-centred, value-based health care.

PROMs are being used to evaluate healthcare effectiveness at different levels of the health system, from the individual level to service and system levels. There is growing interest across Australia and internationally in the routine interrogation of patient-reported outcome information for evaluation and decision-making activities at levels of the health system beyond the clinical consultation.

Appendix D: Integration with National Standards

National Safety and Quality Health Service Standards

Monitoring the implementation of this clinical care standard will help organisations to meet some of the requirements of the National Safety and Quality Health Service (NSQHS) Standards (second edition).[65]

The NSQHS Standards aim to protect the public from harm and improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.

Within the NSQHS Standards, the Clinical Governance Standard and the Partnering with Consumers Standard combine to form the clinical governance framework for all healthcare services that applies to all other standards. The aims of the Clinical Governance Standard and the Partnering with Consumers Standard are as follows:

- The Clinical Governance Standard aims to ensure that systems are in place within healthcare services to maintain and improve the reliability, safety and quality of health care
- The Partnering with Consumers Standard aims to ensure that consumers are partners in the design, delivery and evaluation of healthcare systems and services, and that patients are given the opportunity to be partners in their own care to the extent that they choose.

Action 1.27b and Action 1.28

Under the Clinical Governance Standard, healthcare services are expected to support clinicians to use the best available evidence including clinical care standards (see Action 1.27b), and to monitor and respond to unwarranted clinical variation (Action 1.28).

Action 5.27 and Action 5.28

Under the Comprehensive Care Standard, healthcare services are expected to have systems in place to manage the nutrition and hydration needs of all patients, and ensure appropriate nutritional assessments as part of routine care for hip fracture patients.

Healthcare services are expected to implement the NSQHS Standards in a way that suits the clinical services provided and their associated risks.

Information about the NSQHS Standards is available on the **NSQHS Standards website**.

Glossary

Term	Definition
Aboriginal Community Controlled Health Organisation (ACCHO)	Primary healthcare service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health care to the community that controls it, through a locally elected Board of Management.[66]
Aboriginal Medical Service (AMS)	Healthcare service funded principally to provide services to Aboriginal and Torres Strait Islander individuals. These services may or may not be community controlled.
assessment	A clinician's evaluation of a disease or condition, based on the patient's subjective report of the symptoms and course of the illness or condition and the clinician's objective findings. These findings include data obtained through laboratory tests, physical examination and medical history; and information reported by carers, family members and other members of the healthcare team.[65]
care plan (individualised)	A written agreement between a consumer and health professional (and/or social services) to help manage day-to-day health. This information is identified in a health record.
carer	A person who provides personal care, support and assistance to another individual who needs it because they have a disability, medical condition (including a terminal or chronic illness) or mental illness, or they are frail or aged. An individual is not a carer merely because they are a spouse, de facto partner, parent, child, other relative or guardian of an individual, or live with an individual who requires care. A person is not considered a carer if they are paid, a volunteer for an organisation, or caring as part of a training or education program.[67]
clinical practice guidelines	Recommendations on how to diagnose and treat a medical condition. Clinical practice guidelines are systematically developed documents created with a validated methodology. They are mainly written for doctors, but are also relevant for nurses and other healthcare professionals.[68]
clinician	A trained health professional who provides direct clinical care to patients, including registered and non-registered practitioners. Clinicians may provide care within a healthcare service as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements. They include nurses, midwives, medical practitioners, allied health professionals and other clinicians who provide health care, and students who provide health care under supervision.
cognition	The mental process of knowing, including aspects such as awareness, perception, reasoning and judgement.[69]

Term	Definition
cognitive impairment	Deficits in one or more of the areas of memory, communication, attention, thinking, problem solving and judgement. Cognitive impairment can be temporary or permanent. It can affect a person's understanding, their ability to carry out tasks or follow instructions, their recognition of people or objects, how they relate to others and how they interpret the environment. Dementia and delirium are common forms of cognitive impairment seen in older people in all healthcare settings. Cognitive impairment can also be a result of several other conditions such as acquired brain injury, stroke, intellectual disability, licit or illicit drug use, or medicines.[70]
comorbidities	Coexisting diseases (other than that being studied or treated) in an individual.[1]
consumer	A person who has used, or may potentially use, healthcare services, or is a carer for a patient using healthcare services. A healthcare consumer may also act as a consumer representative to provide a consumer perspective, contribute consumer experiences, advocate for the interests of current and potential healthcare service users, and take part in decision-making processes.[61]
cultural safety	Identifies that health consumers are safest when health professionals have considered power relations, cultural differences and patients' rights. Part of this process requires health professionals to examine their own realities, beliefs and attitudes. Cultural safety is not defined by the health professional, but is defined by the health consumer's experience – the individual's experience of the care they are given, and their ability to use services and raise concerns. The essential features of cultural safety are: ▪ An understanding of one's culture ▪ An acknowledgement of difference, and a requirement that caregivers are actively mindful and respectful of difference(s) ▪ That it is informed by the theory of power relations; any attempt to depoliticise cultural safety is to miss the point ▪ An appreciation of the historical context of colonisation, the practices of racism at individual and institutional levels, and their impact on First Nations people's living and wellbeing, both in the present and past ▪ That its presence or absence is determined by the experience of the recipient of care, and not defined by the caregiver.[61]
delirium	A disturbance of consciousness, attention, cognition and perception that develops over a short period of time (usually hours or days) and tends to fluctuate during the course of the day. Recovery is expected to be complete if the underlying cause (for example, physical illness, drug toxicity) is promptly corrected or self-limited.[4]
fall	An event that results in a person coming to rest (by accident) on the ground, floor or another lower level.
fracture liaison service	A service model that delivers high-quality secondary preventive care for fragility fracture sufferers, with the aim of preventing future fractures. This preventive care is delivered through identification, investigation and intervention.[55]
frailty	A state in which an individual is more vulnerable to increased dependency and/or mortality when exposed to a physiological or psychological stressor.[71]

Term	Definition
healthcare record	Includes a record of the patient's medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records and medication charts for an episode of care.[61]
healthcare service	A separately constituted health service that is responsible for implementing clinical governance, administration and financial management of a service unit or service units providing health care at the direction of the governing body. A service unit involves a group of clinicians and others working in a systematic way to deliver health care to patients. It can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, practices and clinicians' rooms.[61]
hospital	A licensed facility providing healthcare services to patients for short periods of acute illness, injury or recovery.[61]
informed consent	A process of communication between a person and healthcare professional about options for treatment, care processes or potential outcomes. This communication results in the patient's authorisation or agreement to undergo a specific intervention or participate in planned care. The communication should ensure that the person understands the care they will receive, all the available options and the expected outcomes, including success rates and side effects for each option.[70]
malnutrition	Deficiencies, excesses or imbalances in a person's intake of energy and nutrients.[72]
medicine	A chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease, or otherwise improving the physical or mental wellbeing of people. These include prescription, non-prescription, investigational, clinical trial and complementary medicines, regardless of how they are administered.[70]
model of care	A configuration of services and staff designed to provide care for a particular health issue. A model of care takes into account both the evidence to support an approach to care and the context in relation to delivery of a service.[1]
multimodal analgesia	The use of more than one pharmacological class of analgesic medication targeting different receptors along the pain pathway, with the goal of improving analgesia while reducing individual class-related side effects.[73]
nerve block (local anaesthetic)	A short-term block, usually lasting hours or days, where an anaesthetic and other medications (such as steroids) are injected onto or near a nerve.[1]
nutrition	The process of taking in food and using it for growth, metabolism and repair.[74]
orthogeriatric model of care	In Australia and Aotearoa New Zealand, this involves a shared-care arrangement for hip fracture patients between the specialties of orthopaedics and geriatric medicine. The geriatrician is involved in the preoperative optimisation of the patient in preparation for surgery, and then takes a lead in the postoperative medical care and coordinates the discharge planning process. Many aspects of basic care are implicit in this role, including nutrition, hydration, pressure care, bowel and bladder management and monitoring of cognition.[1]

Term	Definition
pain management	The use of pain-controlling agents (such as long-acting local anaesthetic agents, opiates and other pain-modulating drug strategies) to normalise preoperative, postoperative and ongoing pain states.[75]
patient	A person who is receiving care in a healthcare service.[61]
presentation to hospital	Care received by patients on entry to the hospital system including the emergency department, preadmission clinic, acute assessment unit, ward and day surgery. For some remote areas, this may include primary health clinics.
procedure	The set of instructions to make policies and protocols operational, which are specific to an organisation.[61]
protocol	A set of rules for the completion of tasks or a set of tasks.[61]
quality improvement	Aims to make a difference to patients by improving safety, effectiveness and experience of care by: ▪ Using understanding of the complex healthcare environment ▪ Applying a systematic approach ▪ Designing, testing and implementing changes using real-time measurement for improvement.[76]
risk factor	A characteristic, condition or behaviour that increases the possibility of disease, injury or loss of wellbeing.
shared decision making	A consultation process in which a clinician and a patient jointly participate in making a health decision, having discussed the options and their benefits and harms, and having considered the patient's values, preferences and circumstances.[77]
side effects	Unintended effects from a medicine, treatment or device.
system	The resources, policies, processes and procedures that are organised, integrated, regulated and administered to accomplish a stated goal. A system: ▪ Brings together risk management, governance, and operational processes and procedures, including education, training and orientation ▪ Deploys an active implementation plan; feedback mechanisms include agreed protocols and guidelines, decision support tools and other resource materials ▪ Uses several incentives and sanctions to influence behaviour and encourage compliance with policy, protocol, regulation and procedures. The workforce is both a resource in the system and involved in all elements of systems development, implementation, monitoring, improvement and evaluation.[61]
unrestricted weight bearing	When a patient can mobilise and have full use of the affected limb to bear weight as pain allows.[19]
whānau	The family, extended family or group of people who are important to the consumer.[78]

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Acknowledgements

Many individuals and organisations have freely given their time and expertise in the development of this document. In particular, the Commission wishes to thank Te Tāhū Hauora The Health Quality & Safety Commission (Aotearoa New Zealand), the Hip Fracture Care Topic Working Group and other key experts who have given their time and advice. The Commission wishes to thank the National Aboriginal Community Controlled Health Organisation (NACCHO), Indigenous Allied Health Australia, CRANAplus and other key experts who provided feedback on the cultural safety and equity aspects. The involvement and willingness of all concerned to share their experience and expertise is greatly appreciated:

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- Professor Jacqui Close (Co-Chair)
- Professor Ian Harris (Co-Chair)
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A number of Commission staff were also involved in the writing and review of this publication, and the Commission wishes to acknowledge:

- Dr Alice Bhasale
- Ms Suzanna Henderson
- Ms Christina Lane
- Ms Leslie Trainor.

The above artwork used throughout the document was designed by Ms Lani Balzan, a Wiradjuri artist from the south coast of New South Wales. The central symbol is the logo for the clinical care standards program, which began at the Commission in 2013. The outer four circles of the artwork represent the four priority areas of patient safety; partnering with patients, consumers and communities; quality, cost and value; and supporting health professionals to provide care that is informed, supported and organised to deliver safe and high-quality health care. The outer dots represent growth, healing, change and improvement.

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