AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Consultation Report

Draft Hip Fracture Care Clinical Care Standard

Clinical Care Standards

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Introduction

The Australian Commission on Safety and Quality in Health Care (the Commission) was created by Health Ministers in 2006 to lead and coordinate health care safety and quality improvements in Australia. *The National Health Reform Act 2011* established the Commission as an independent, statutory authority. It specifies that the Commission will formulate and monitor safety and quality standards and work with clinicians to identify best practice clinical care.

The *National Health Reform Agreement 2011* identifies that the Commission will work with clinicians to develop clinical standards for ensuring the appropriateness of care for people with specific clinical conditions, and that the Commission will recommend to Health Ministers the clinical standards suitable for implementation as national clinical standards.

The Commission has been working with consumers, clinicians, health managers and researchers to develop the Hip Fracture Care Clinical Care Standard.

It complements existing efforts that support hip fracture care, such as the Australian and New Zealand Hip Fracture Registry, and state and territory-based initiatives.

This report provides a summary of consultation findings regarding the draft Hip Fracture Care Clinical Care Standard.

About the consultation

The public consultation period took place from 25 May 2015 to 3 July 2015. The consultation was conducted in partnership with the Health Quality & Safety Commission New Zealand. A total of 205 responses from Australia and New Zealand were received by the Commission as part of this consultation process.

Consultation documents for this Clinical Care Standard included:

Draft Hip Fracture Care Clinical Care Standard –This document outlines key components of care that a person with a suspected hip fracture should receive from presentation to hospital to the completion of treatment in hospital. It covers care at presentation, pain management, treatment based on an orthogeriatric model of care, timely surgery if indicated, initiation of mobilisation, secondary fracture prevention, and an individualised care plan.

Summary of evidence sources – This document contains the evidence sources used to support the Clinical Care Standard, according to each quality statement.

Draft indicator specification – This document outlines a set of suggested indicators developed to assist with local implementation of this Clinical Care Standard. These indicators can be used by health services to monitor the implementation of the quality statements, and support improvement as needed.

Draft consumer and clinician fact sheets – These documents provide a summary of the quality statements for consumers and clinicians.

The purposes of the consultation process were to determine if the draft Clinical Care Standard covered the key components of care, to assess the relevance of suggested indicators and fact sheets, and to identify potential enablers and barriers regarding the use of the Clinical Care Standard.

Stakeholders across Australia and New Zealand were contacted by post and requested to submit feedback on the draft Clinical Care Standard. The consultation was also promoted via the Commission's web site, Twitter account, *On the Radar* weekly publication and email bulletin; as well as by members of the Hip Fracture Care Clinical Care Standard Topic Working Group, and the Health Quality & Safety Commission New Zealand.

Those contacted included medical colleges and societies, organisations, state and territory health departments, local hospital networks/local health districts, Primary Health Networks, consumer groups and private sector organisations. Feedback was received by either written response or online survey from a cross-section of these stakeholders.

The following sections of the report provide a summary of the consultation process and responses.

Consultation process

Consultation questions

The Commission asked stakeholders to respond to the following consultation questions:

1. How well does each quality statement describe the key aspects of care?
2. What factors (barriers) currently prevent the care described in this Clinical Care Standard from being achieved?
3. What factors (enablers) will support the practical application of this Clinical Care Standard?
4. How relevant are the suggested indicators in supporting the local monitoring of the quality statements?
5. What improvements would support data collection for the suggested indicators?
6. Do you have any other comments about this Clinical Care Standard?

Submissions received

A total of 205 responses were received by the Commission during the consultation period. Disregarding those that provided demographic data only without any feedback on the Clinical Care Standard, a total of 148 assessable responses were received: 107 by online survey and 41 by email, letter or at meetings.

A breakdown of the 148 assessable responses is provided below:

Respondent type	Number of assessable responses
Individual	91
Health professional education providers (including Colleges)	6
Jurisdiction [a] (state or territory response)	9
Local hospital network/ Local health district [b]	20
Other organisation:	
- General	15
- Primary health care	1
- Private health care	1
Committee	5
Unknown/not provided	0
Total responses	148

[a] State and territory health departments and/or agencies.
[b] Including public hospitals and other public health services

Assessment of submissions

Submissions were allocated an identification number and classified according to scope of the Clinical Care Standard, quality statement, indicator, consumer fact sheets, language/structure of the document, enablers/barriers, dissemination, and general comments.

Feedback was themed for analysis and then assigned into the following categories:

1. Consider now: Comments in this category were those relating to the scope of the Clinical Care Standard and the focus of each quality statement, terminology used, specificity, clarity of language particularly in the 'what it means' section, relevance of the proposed indicators, supporting evidence, and barriers and enablers relating to implementation.

2. Consider in the future: Comments in this category were those suggesting extending the current scope of the Clinical Care Standards (e.g. extending the Clinical Care Standard into the pre-hospital setting).

3. No action: Comments in this category expressed agreement and/or support for the Clinical Care Standard. Comments in this category also related to personal experience or suggestions to include background information that was out of scope of a Clinical Care Standard.

Following this assessment, this information was provided to the Hip Fracture Care Clinical Care Standard Topic Working Group for further refinement of the Clinical Care Standard.

Summary of consultation feedback

Overall, there was strong support for the development of the Hip Fracture Care Clinical Care Standard, and agreement with the proposed standards of care. Respondents noted that the Clinical Care Standard will play an important role in supporting the delivery of evidence-based patient care for patients with a hip fracture as well as reducing unwarranted variation in care, and promoting shared decision making between patients, carers and clinicians.

Below is a summary, although not exhaustive, of the responses received.

Structure and language

The documents were seen as well-structured and easy to navigate. The information in the Clinical Care Standard was seen as concise, easy to read and informative.

Some respondents thought that the language in the Consumer fact sheet was too complex and needed to be simplified.

Suggested improvements included incorporating the wording from the 'What it means for clinicians' section into the Clinicians fact sheet. A suggestion on the design of the Consumer fact sheet indicated that the use of aqua text on aqua background may be hard to read for older patients.

Scope and context

Feedback suggested that the scope could benefit from defining an age group. It was acknowledged that younger patients would not necessarily require care according to an orthogeriatric model of care; specifying an age would help focus efforts to implement the Clinical Care Standard and would also be consistent with most local policies for hip fracture care.

It was also suggested that the type of hip fracture should be stated, that is hip fractures as a result of a fall.

Comments were received on the acute focus of the Clinical Care Standard, stating a concern for a lack of guidance in the pre-hospital setting, particularly for pain management and stabilisation. Comments stated a lack of emphasis on involvement of primary care during the acute episode of care and on transition from hospital. Suggestions included further detail on the role of community and ambulatory rehabilitation for transition of care.

Quality statements

Draft quality statement 1: Care at presentation

A patient presenting to hospital with a suspected hip fracture receives care guided by timely assessment and management of medical conditions, including diagnostic imaging, pain assessment and cognitive assessment.

There was overall support for collaboration between the emergency department and local orthogeriatric services for effective management and timely admission of a patient.

Suggestions included specifying assessment of other risk factors for delirium in addition to cognitive assessment.

Regarding diagnostic imaging, timely review of the imaging to facilitate timely surgery was highlighted as a key component of the imaging process.

Regarding pain management, there was agreement that pain management is required beyond care at presentation. Pain management at presentation and throughout the hospital stay is covered under quality statement 2.

Draft quality statement 2: Pain management

A patient with a hip fracture is assessed for pain at the time of presentation and regularly throughout their hospital stay, and receives pain management including the use of multimodal analgesia if clinically appropriate.

There were a small number of comments (less than 10) on quality statement 2. Comments specified the importance of pain assessment for patients with cognitive impairment, and suggested including how pain should be assessed for patients with altered cognition.

There was agreement on the need for appropriate prescribing of analgesics to support minimising the use of opioids. Suggestions included referring to adding non-pharmacological pain management strategies such as physiotherapy, and including consultation with a pain medicine specialist and/or rehabilitation physician.

Draft quality statement 3: Orthogeriatric model of care

A patient 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.

The majority of comments focused on the importance of basic care for older patients such as nutrition, indwelling catheter management and constipation. In particular, a number of respondents stated the role of nutrition screening, assessment and intervention in optimising care for patients with a hip fracture.

Comments suggested that younger patients usually do not require hip fracture care under the orthogeriatric model and that the quality statement may imply all patients with a hip fracture should receive care under this model.

Concern was raised that surgery may be delayed if waiting for an orthogeriatric assessment prior to surgery, and that in the absence of a geriatrician, other physicians like anaesthetists or other medical practitioners can perform the assessment, particularly in rural, remote and smaller hospitals.

It was suggested that the elements of the orthogeriatric model are specified, including details on the multidisciplinary roles within this model.

Draft quality statement 4: Timing of surgery

A patient presenting to hospital with a hip fracture, or sustaining a hip fracture while in hospital, receives surgery on the day of or the day after where clinically indicated and surgery is preferred by the patient.

There was agreement with the provision of timely surgery although concerns were raised regarding the suggested wording used to convey the recommendation, that is, "the day of or day after" (presentation). These concerns included:

- a lack of clarity on the timeframe
- potential for unrealistic expectations for patients based on the time of presentation (e.g. if a patient presents at 23:45 it is unrealistic that surgery will occur in the recommended timeframe)
- inconsistency with some jurisdictional standards that have time to surgery based on hours. It was also suggested that using 'hours' to state the timeframe for surgery would assist with monitoring and evaluating the implementation of the recommendation.

Draft quality statement 5: Mobilisation and weight-bearing

A patient with a hip fracture is offered mobilisation without restriction on weight-bearing the day after surgery and at least once a day thereafter, depending on the patient's clinical condition and agreed goals of care.

There was general agreement of the need to initiate mobilisation the day after surgery and at least once a day thereafter from the small number of responses on this quality statement. The main comments were about the importance of the multidisciplinary roles involved in mobilising patients.

Some respondents suggested specifying the role of physiotherapists and occupational therapists in promoting best practice for patient mobilisation. Feedback was also received about the limited access to workforce, particularly on weekends, and the impact this has on provision of mobilisation for patients.

Suggestions included providing guidance on how patients get in and out of bed; and that a recommendation for thromboprophylaxis is needed.

Draft quality statement 6: Minimising risk of another fracture

Before a patient with a hip fracture leaves hospital, they are offered a falls and bone health assessment, and a management plan based on this assessment to reduce the risk of another fracture.

The majority of comments were on the importance of nutrition in minimising the risk of another fracture. It was suggested to include a focus on nutrition screening, assessment and intervention.

Feedback highlighted the importance of also undertaking a falls risk assessment for patients on admission, in line with the National Safety and Quality Health Service (NSQHS) Standards, to identify the risk for patients falling in hospital.

Draft quality statement 7: Individualised care plan

Before a patient leaves hospital, the patient and their carer are involved in the development of an individualised care plan that describes the ongoing care that the patient will require after they leave hospital. The plan includes a summary of any changes in medicines, any new medicines, mobilisation, wound care and function post-injury, recommendations for future fracture prevention and referral to ongoing rehabilitation if clinically indicated. This plan is provided to the patient before discharge and to their general practitioner or ongoing clinical provider within 48 hours of discharge.

Feedback highlighted the importance of multidisciplinary and collaborative involvement in preparing the individualised care plan for ongoing care, in particular the need for general practitioner involvement in development of the individualised care plan. There was concern that a copy of the plan may not be provided to a patient's general practitioner if the patient is transferred to rehabilitation following the acute episode of care. It was suggested that the plan should be provided to the general practitioner in all circumstances and ideally provided within 24 hours (rather than 48 hours) of discharge.

Other suggestions were to specify the type of services for ongoing care such as strength and balance programs following rehabilitation, home safety and home visits, and pharmacy outreach services.

There was agreement for the involvement of carers in the discussion of the patient's future needs.

Feedback on indicators

The Commission received 62 comments on the indicators from a number of organisations and individuals. Respondents were asked to comment on the following two questions:

- How relevant are the suggested indicators in supporting the local monitoring of the quality statements?
- What improvements would support data collection for the suggested indicators?

Relevance of indicators

Feedback on the indicator specification was generally supportive. More than 60% of survey respondents considered all the indicators relevant, and more than 90% considered all the indicators either relevant or somewhat relevant.

There were a few comments related to implementation or guideline development, which were beyond the purpose of this consultation. The suggestions related to specific guideline development and/or local implementation issues that are out of scope for the Clinical Care Standard.

The main themes emerging from the consultation feedback were:

- **Indicator 3b: Proportion of patients with hip fracture receiving orthogeriatric (or alternative physician or medical practitioner) assessment before hip fracture**

  One respondent suggested to include 'anaesthetists' to the list of clinicians specified to perform this assessment to indicate that in the absence of a geriatrician, an anaesthetist can perform an orthogeriatric assessment to ensure that a patient's time to surgery is not delayed.

- **Indicator 4a: Proportion of patients with a hip fracture receiving surgery on the day of or day after presentation.**

  A number of respondents requested to have the timing of surgery specified in hours rather than 'day of or day after surgery'. Feedback suggested that this would support monitoring and data collection.

- **Indicator 5d: Proportion of patients with a hip fracture returning to pre-fracture mobility.**

  One respondent suggested that some patients may be advised to continue to mobilise with a walking aide at 120 days post fracture as a falls prevention strategy. In this case, a return to pre-fracture mobility of independent mobility would be detrimental to patient safety.

- **Indicator 6c: Proportion of patients with a hip fracture readmitted to hospital with another fracture.**

  Feedback suggested that monitoring fracture rates affecting the hip rather than all fractures may provide more robust data regarding secondary fracture prevention. The concern was that data on all other fractures may not be captured as not all fractures are universally admitted to hospital.

Improvements to support data collection

Respondents had a range of suggestions for supporting data collection of the indicators, as summarised below:

Improvements to data capture

- National standardised database
- Standardised audit tools
- Adequate IT infrastructure/computer systems
- Integration of electronic medical records

Data collection tools/databases

- Use of applications on IPad/tablet
- Web based databases

Staff training and education

- education and training of staff in data collection, coding and auditing
- dedicated staff for data collection

Barriers and enablers to care identified in the Clinical Care Standard

The barriers identified can be summarised as follows:

- **Systems/Operational:** lack of standardised systems to facilitate documentation and clinical handover such as the use of hybrid systems (electronic medical record and paper); lack of prioritisation of theatre time as well as clinical resources for orthogeriatric and multidisciplinary care; inconsistent use of local pathways and processes for improved integration, limited availability to senior clinical staff, admission and assessment processes after hours; community services to support discharge and ongoing care, particularly services suitable for frail and cognitively impaired patients.

- **Staff training and education:** lack of knowledge and skills for providing care relating to: delirium, cognitive impairment, surgical nursing, pain management and mobilisation; lack of understanding of the processes for integrating primary care, and poor awareness of referral options to support appropriate and timely referral for ongoing care coordination; lack of multidisciplinary team coordination affecting timely management of the patient.

- **Communication:** inadequate communication and coordination between facilities and across clinical teams; inability to engage consumers; language and cultural issues; lack of clarity regarding the integration of national and state/territory standards and confusion about prioritisation for implementation.

- **Leadership:** lack of priority on patient-centred care; lack of support by professional bodies to advocate for sustainable and innovative funding models.

Enablers identified can be summarised as follows:

- **Policies and procedures:** discharge referral policy to support liaison with primary care, particularly for patients with ongoing management of complex health needs; fast track protocols for surgery.

- **Resources:** tools to support data collection, monitoring and evaluation; tele-medicine in rural and remote services and community rehabilitation services; consumer information sheets available in a range of languages; funding and allocated time for up-skilling of the clinical workforce to support the delivery of geriatric medicine.

- **Staff education and training:** training of the clinical workforce in patient and carer engagement to support shared-decision making, and patient-centred care; sessions on the standards to raise awareness amongst clinical staff; training, sponsorship opportunities and specialist courses on geriatric medicine and care for older patients.

- **Organisational:** prioritisation relating to the fundamental aspects of care for older patients; dedicated admission streams in urban services for rural/remote referrals to support access to timely surgery; state-wide clinical networks and primary health networks to advocate for and support clinical involvement in health service planning; adequate communication between clinical teams to support a multidisciplinary and team approach.

Next steps

Feedback from the consultation process was collated and analysed, and a summary of key findings was presented to the Hip Fracture Care Clinical Care Standard Topic Working Group. Following this, the Clinical Care Standard was revised and finalised for submission to the Commission's various committees.

The endorsement process for Clinical Care Standards involves passage through the Commission's governance committees, and then endorsement from the Australian Health Ministers' Advisory Council and the Council of Australian Governments Health Council; two national committees that lead coordination of health services across Australia.

It is envisaged that the Commission will provide some high-level implementation support for this Clinical Care Standard, with activities and resources to be identified in the coming months.

Further information about this Clinical Care Standard can be found at www.safetyandquality.gov.au/ccs.

If you would like to be kept informed about the work of the Commission, sign up to the Commission's newsletter online, or follow the Commission on Twitter @ACSQHC.