

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

Clinicians and health services can use this Clinical Care Standard to support the delivery of high quality care.

## UNDER THIS CLINICAL CARE STANDARD



### 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.



### 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.



### 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*.



### Timing of surgery

A patient presenting to hospital with a hip fracture, or sustaining a hip fracture while in hospital, receives surgery within 48 hours, if no clinical contraindication exists and the patient prefers surgery.



### Mobilisation and weight-bearing

A patient with a hip fracture is offered mobilisation without restrictions 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.



### 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.



### Transition from hospital care

Before a patient leaves hospital, the patient and their carer are involved in the development of an individualised care plan that describes the patient's ongoing care and goals of care after they leave hospital. The plan is developed collaboratively with the patient's general practitioner. The plan identifies any changes in medicines, any new medicines, and equipment and contact details for rehabilitation services they may require. It also describes mobilisation activities, wound care and function post-injury. This plan is provided to the patient before discharge and their general practitioner and other ongoing clinical providers within 48 hours of discharge.

More information on the Clinical Care Standards program is available from the Australian Commission on Safety and Quality in Health Care website at [www.safetyandquality.gov.au/ccs](http://www.safetyandquality.gov.au/ccs)

The Australian Commission on Safety and Quality in Health Care has produced this Clinical Care Standard to support the delivery of appropriate care for a defined condition. The Clinical Care Standard is based on the best evidence available at the time of development. The particular circumstances of each patient should be taken into account by healthcare professionals when applying information in the Clinical Care Standard.