Whittington Health
NHS Trust

Your fractured hip explained

A patient and carer's guide

This leaflet gives useful information following a hip fracture. Treatment is planned on an individual basis, so details can differ.

All staff members are happy to help, so if you have any concerns, please do not hesitate to contact us and ask questions.

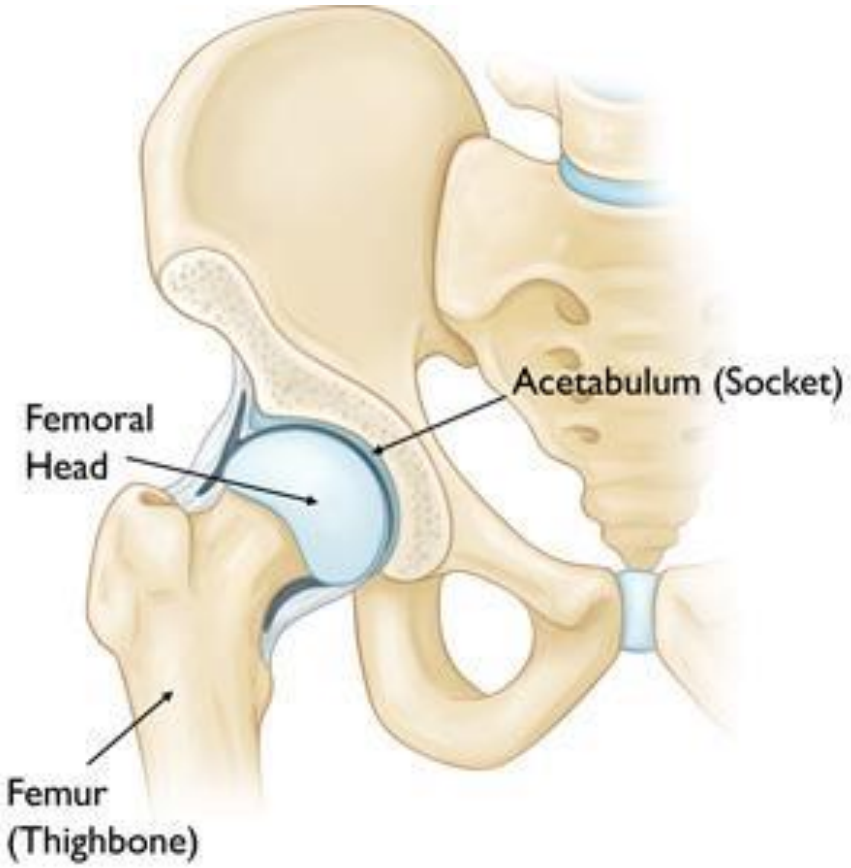
Coyle ward 020 7288 5446

Visiting time on the ward is 14:00-20:00 - maximum two visitors per patient.

The Whittington NHS Trust has signed up the **JOHNS CAMPAIGN** which allows carers and relatives to visit the patient outside standard visiting hours if they are supporting with care needs, feeding and aiding with management of delirium. Please discuss this with the Ward Manager.

What is a hip fracture?

The hip joint is a “ball and socket” joint, involving the femur and acetabulum.
A hip fracture refers to a break at the top of the femur bone, and rarely involves the socket.
The majority are usually the result of a fall and are likely to require surgery.
The particular type of surgery depends on where the bone has broken.



UK facts and figures

- 70,000 people in the UK sustain a hip fracture each year
- 70% are over 80 years of age
- Hip fractures are common in the frail elderly. However they can occur in patients who are otherwise healthy and independent

Research has shown that prompt, effective, multidisciplinary management can improve quality and at the same time reduce costs.

Key elements of good care include:

- Prompt admission to orthopaedic care
- Rapid comprehensive assessment – medical, surgical and anaesthetic
- Minimal delay to surgery
- Accurate and well-performed surgery
- Prompt mobilisation: usually first day post operatively
- Early multidisciplinary rehabilitation
- Early supported discharge and ongoing community rehabilitation
- Secondary prevention, combining bone protection and falls assessment (NHFD 2018)

Your journey through the hospital

What can I expect in Emergency department (ED)?

- Patients are usually admitted through the Emergency Department (ED) and initially seen by a team of doctors and nurses. They will take a history of the events leading to your admission and refer you to the Orthopaedic team once a fractured hip has been confirmed by x-ray.

- Fluids and pain medication are given intravenously (by drip) as required. You will also be offered an injection of a local anaesthetic into the groin area, to numb the nerves in the hip area. This is known as a fascia iliaca compartment block (FIB). Routine bloods are taken and a tracing of your heart (ECG). In some cases, a catheter may be inserted into your bladder in order to monitor your urine output.

- You will be admitted to the Orthopaedic ward (Coyle ward). If there are no beds available on the Coyle ward, you will be admitted to another ward and transferred to Coyle ward as soon as is possible.

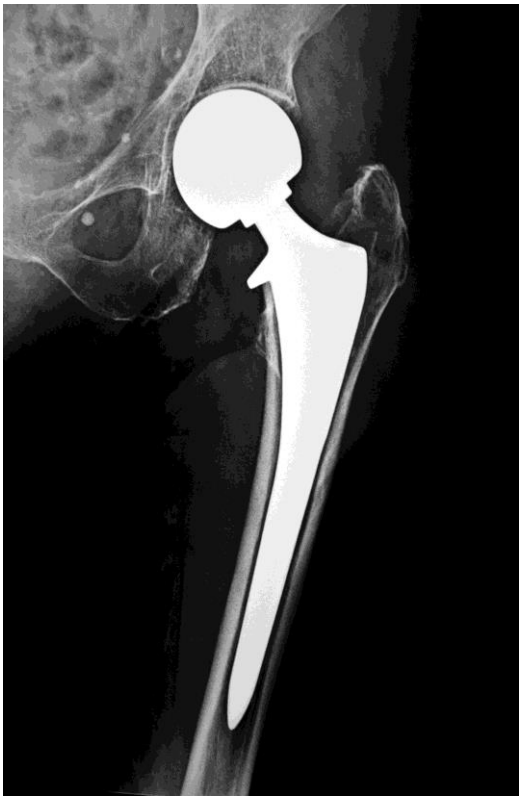
- In some circumstances you may go straight to Theatre from the ED and admitted to the ward following your surgery.

What operation will I have?

Almost all hip fractures require an operation and the surgery you have depends on the type of fracture you have sustained.

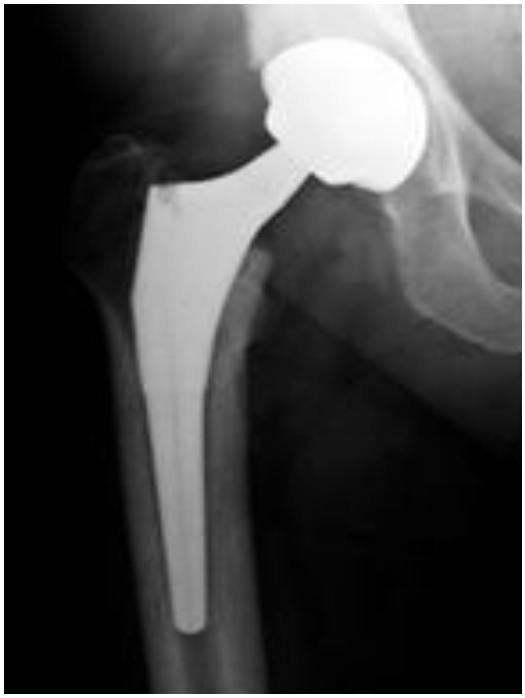
Hemiarthroplasty (half joint replacement):

A fracture of the neck of femur bone can damage blood supply to the head of the femur (hip joint). If this blood supply is damaged the bone will not heal. This operation involves removing the head and neck section of the bone above the fracture and replacing it with a metal ball and stem which fits into the top end of the thigh bone.



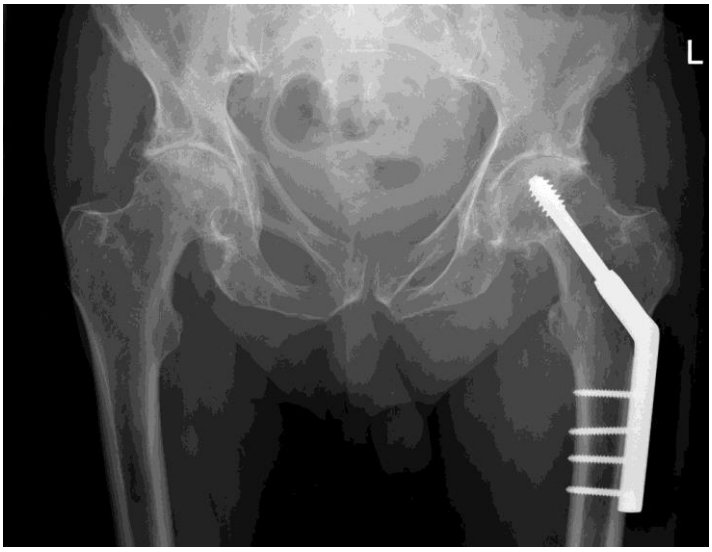
Total hip replacement

When the fracture involves both the head of the femur and the acetabulum, or if the joint is likely to be affected by osteoarthritis and wear-and –tear in the near future, a total hip replacement is considered. This operation requires careful consideration by the Surgeon due to the precautions in the post-operative phase.



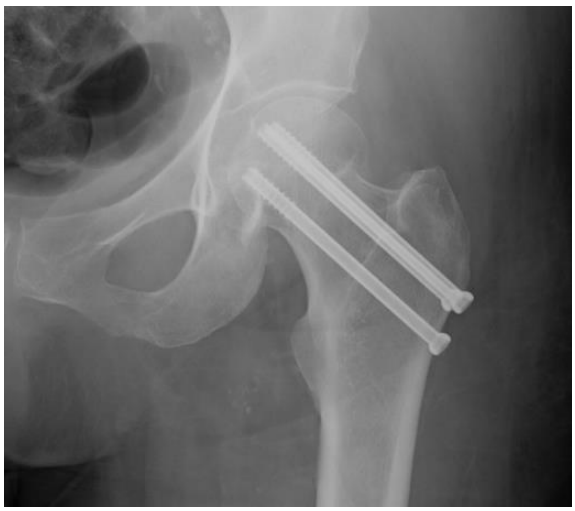
Dynamic hip screw (DHS)

If the fracture has occurred further down the femur (beyond the neck) a DHS is considered. This is a large stainless steel screw which fixes the fracture and is held in place by a plate and a number of smaller screws. It holds the bones in position whilst they knit back together.



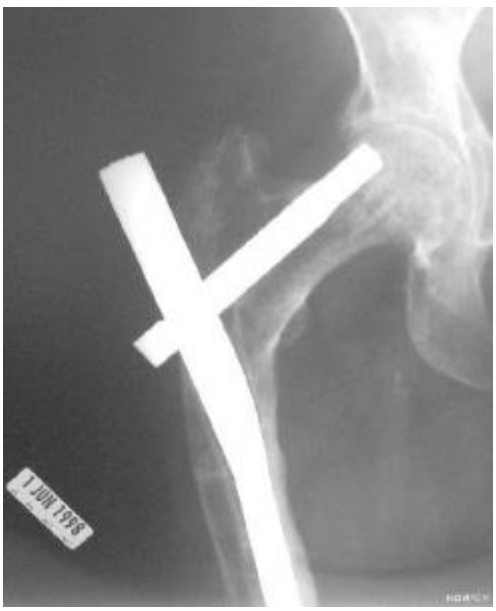
Cannulated screw (CS)

In some femoral neck fractures, the bones may not move apart, and the blood supply remains intact. In this instance the Surgeon may recommend CS. Three screws are used to hold the bone together whilst it heals.



Intramedullary nail / Gamma nail

Fractures which extend down the femur need to be fixed with a metal rod passed down the middle of the bone.



Why do I need an operation?

Surgery is performed to reduce pain, allow mobilisation and to reduce deformity.

The vast majority of patients with a hip fracture will require an operation to enable you to get back to your pre- fracture function. There are a few exceptions where hip fractures are managed without an operation, but this is unusual and will be discussed in detail if relevant to you. The risk of not having the surgery is ongoing pain and the potentially life-threatening complications associated with bed rest and immobility (chest infections, blood clots and pressure ulcers).

What is the risk associated with surgery?

The risks of surgery will be discussed with you or your family when the Orthopaedic doctor takes your consent for surgery. The main risk associated with the operation itself: include blood loss, infection and ensuring a good surgical fixation especially in poor quality bone.

The risks of an anaesthetic are usually related to underlying medical conditions such as heart disease, lung problems and the risk of stroke

Your consent

It is essential that you understand what operation you are having, the risks and what this entails before signing your consent form. If you are unable to give your consent, your consultant may make this decision for you in your best interests, following discussion with your next of kin where possible.

What happens before surgery?

- In most cases you will be admitted to the ward prior to surgery.
- You may require further blood tests or other investigations, and this will be determined by the Ortho-Geriatrician Consultant or Medical doctor (depending on your medical history).
- You will not be allowed to eat for six hours and drink for two hours prior to your surgery. You will have fluids through a drip in your arm to maintain hydration.
- You will be offered regular painkillers throughout this period but please tell the Nursing team if you need more.
- You may have a catheter (tube in bladder) inserted on the ward if it difficult for you to use a bed pan and it is felt that it is necessary. This will be removed at soon as you are able to transfer with assistance.

An Anaesthetist will see you before your surgery. There are two types of anaesthetic: a general anaesthetic and a spinal anaesthetic, and they will be discussed with you or your family.

We aim to operate as soon as possible, preferably within 36 hours.

Common reasons why surgery is delayed:

- If you are medically unwell and need further treatment prior to surgery.
- If you are on blood thinning medication which may need to be reversed prior to surgery.
- If there are other people waiting for emergency surgery with life threatening injuries.

What will happen after my operation?

Once you have recovered from your anaesthetic you will be transferred back to the ward. If you have been unwell or unstable during the operation you may need a higher level of care and may be transferred to the Critical Care Unit (CCU) for one or two days before coming back to the Orthopaedic ward.

- Initially following your surgery, you might feel a little sick and groggy. This can be controlled with anti -sickness medication.
- Pain is normal and to be expected, but we will aim to control it with painkillers.
- To reduce the risk of developing a deep vein thrombosis (DVT), which is a clot in your legs, you will be given an injection each evening; however, this does not totally eliminate the risk of you developing a clot. You will be encouraged to do some exercises whilst immobile to help minimise the risk.
- As soon as you feel able, you can eat and drink as tolerated. Intravenous fluids will be given overnight to ensure you are adequately hydrated.
- You will have a blood test the first day following surgery and an x-ray of your hip within the first couple of days.
- Pending on your blood results post-surgery you may require a blood transfusion, as hip operations are associated with a degree of blood loss.
- You will be reviewed daily by the Orthopaedic team and reviewed regularly by the Ortho-Geriatrician Consultant.
- You will be seen by the Physiotherapist in the afternoon following surgery and will assist you to sit out of bed and begin practicing to walk with a walking frame.
- The Therapy team will also ask you questions about your home environment and mobility prior to your admission so they can start planning your discharge.
- Your catheter (if you have one) will be removed as soon as possible after your operation (often at around three or four days). It is usually removed at night as most people pass urine first thing in the morning.
- The Nursing staff will help you with your personal care and, alongside the medical and therapy team, will promote your independence and encourage you to do as much for yourself as you can, progressing your independence daily.

Nutrition

It is important that you eat a well-balanced diet to help your recovery; however poor appetite is common after surgery. You will be monitored closely to ensure that you are eating adequately. If we or your family are concerned about your food intake, you will be prescribed nutritional supplements and referred to the Dietitian. Family and friends are encouraged to bring in snacks and favourite foods.

Pain relief

A hip fracture is painful, and this is to be expected, but we will try and control your pain with painkillers. It is important that you take them regularly as this will help you move more easily and participate with your rehabilitation.

The pain will subside but please let the Nursing team know if you continue to be in pain and we will review and change your medication if needed.

What are the possible risks and complications of a hip fracture?

Bleeding: You may lose some blood during your surgery. If you become very anaemic (low blood count), you may require a blood transfusion post operatively.

Infection: Despite all precautions, infections occur (National figures are: 1 to 2½%). You will be given antibiotics just before the operation and the Orthopaedic and Nursing team will monitor your wound for any signs of infection: You will be informed if there are any concerns and plans for treatment.

Chest infection/Pneumonia: Bed rest and immobility increases the risk of developing pneumonia. Getting out of bed and sitting upright in a chair, allows your lungs to work much better. You will be encouraged to sit in a chair as soon as possible, to breathe deeply and to cough to clear your chest frequently. A chest infection will require treatment with antibiotics.

Delirium (confusion) This is not unusual following surgery and can be very distressing for you and your family. Previous short-term memory problems or a history of dementia are associated with a high risk of delirium. This can be made worse by

- Medication: painkillers anaesthetic drugs
- Infection: Urinary tract infection/chest infection
- Unfamiliar surroundings
- Poor mobility
- Pain
- Dehydration and malnutrition

Relatives are encouraged to speak to the Nursing and Medical team about how they can help with delirium: such as bringing in familiar objects from home and supporting to re orientate.

Constipation: This is a very common problem, made worse by reduced mobility, medication, hospital diet and dehydration. The Nursing team will monitor this on a daily basis. You will be given laxatives and encouraged to drink plenty of fluids.

Deep vein thrombosis (DVT) / Pulmonary Embolism (PE): DVT (a blood clot in the calf) may occur after a hip fracture. A DVT can pass in the blood steam and be deposited in the lungs (PE). Immobility, dehydration and underlying illnesses increase the risk of clots. You will be given blood thinning medication, as a daily injection to reduce this risk, and this is continued for 28 days following surgery. Starting to walk and getting moving is one of the best days to prevent blood clots forming.

Pressure ulcers: Pressure ulcers are caused by the pressure from the weight of your body pressing down on your skin. They usually occur when a place where you have bone close to your skin (a bony prominence) is pressed against a surface such as a chair or a bed. This compresses your skin and your underlying tissues and can also damage blood vessels. Rubbing (friction) of your skin can also play a part in the formation of a pressure ulcer.

Special air mattresses are used for all patients who have fractured their hips; early mobilisation and a healthy balanced diet are important in pressure ulcer prevention. Nursing and Therapy staff will monitor the condition of your skin and help you to move regularly to minimise the risk of developing pressure ulcers.

Dislocation: This is an occasional complication with hemi-arthroplasty or total hip replacement. Those who have a Total hip replacement will be given particular instructions to help dislocation.

Non-union: Sometimes fractures may not mend fully (this is called non-union) or the metal work might fail, requiring further surgery.

Death: A broken hip is a very serious condition. Nationally, 10% of people die in hospital and another 20% sadly do not survive a year. Most people however have a good result and getting up and about as soon as possible is one to the best ways to keep your body working well.

Frequently asked questions during the recovery period

Will my hip be as good as new after the operation?

A hip fracture is a life changing event. Although some patients may return to their previous ability, some do not. Hip fractures often occur in people who have several medical conditions or who are otherwise frail. The effect of these conditions or frailty can affect your overall recovery.

How long will I be in hospital?

Our aim is for you to be discharged within 7-14 days depending on your progress. This is not always feasible for everyone, and all patients are treated individually. The Multi-disciplinary team (MDT) will review your progress daily and where possible try to predict your length of stay and set an estimated discharge date and arrangements to be made. This may need to be adjusted depending on the progress made.

Some patients can return home quickly with the support of our Re enablement Team. In this case you will need to be able to walk a few steps by yourself with a walking aid. The team will continue your rehabilitation at home. If you need ongoing assistance, the Community Team will assess this, and refer to Social Services to provide the care.

Other patients may need a longer period of rehabilitation and may well need to be referred to a rehabilitation unit within their borough, for ongoing therapy and discharge planning.

If it is anticipated that you are unlikely to be able to return to living independently in your own home, further assessments of care needs will need to be done, which may extend your time in hospital. Similarly, individuals from Residential Homes with increasing care needs may need re assessment and occasionally a new placement or care home may be required.

What exercises will I do?

The Physiotherapists, Occupational therapists (OT) and Nurses will help you start to regain your confidence and ability with walking by helping you practice on the ward.

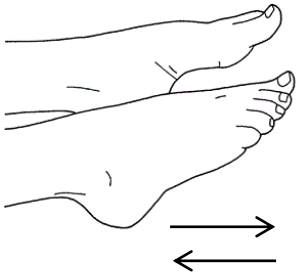
This starts, when possible, within 24 hours after your operation (if you are medically stable). Beginning exercises as early as possible assists in reducing any complications. Initially you will require a walking frame to assist you with walking. During your first few sessions, if you are unable to step around to the chair with the walking frame and assistance, the Physiotherapist may use different pieces of equipment to get you sitting out within 24 hours of your operation.

We encourage patients to walk to the bathroom whenever possible (with someone) to increase your mobility and to promote your independence. The Physiotherapists will give other specific exercises that you may need to do to increase the range of movement and improve your muscle strength.

You will be seen daily by the Physiotherapy team, but it is essential for you to practice your mobility between these sessions, either with the Nursing team or with your family.

Exercises

This is a selection of exercise that you can do independently to enhance your recovery. They are designed to improve your range of motion and strength.

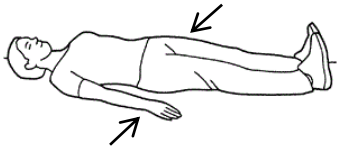


Ankle Pump

Lying on your back or sitting.

Bend and straighten your ankles briskly. If you keep your knees straight during the exercise you will stretch your calf muscles.

Repeat 10-15 times

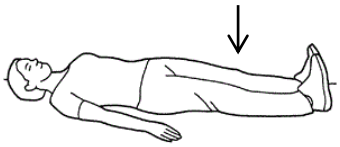


Gluteal Squeeze

Lying on your back or sitting

Squeeze your buttock muscles together. Hold for up to 5 seconds.

Repeat 10-15 times

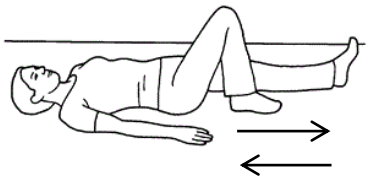


Static Quads

Lying on your back.

Tighten your thigh muscle and push your knee down into the bed. Hold for up to 5 seconds.

Repeat 10-15 times.

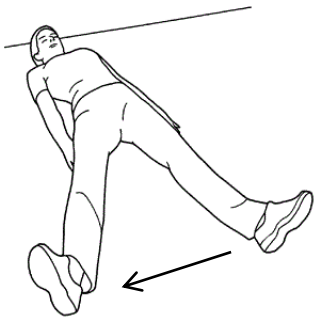


Heel Slide

Lying on your back.

Slide your heel towards you, bending your knee up. Hold for 1-3 seconds and then straighten your leg.

Repeat times.

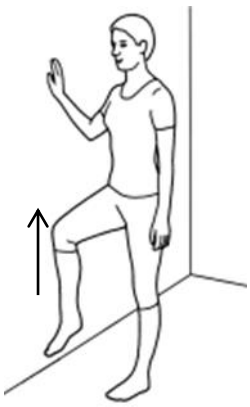


Hip Abduction

Lying on your back.

Bring your leg out to the side and then return to a neutral position.

Repeat times



Hip Flexion in Standing

Lift your knee forward lifting your foot from the ground; try to hold up for 5 seconds and slowly lower to the ground.

Repeat times

Hip Abduction in Standing

Standing straight with a sturdy support to hold onto.

Lift your leg sideways and bring it back keeping your trunk straight throughout the exercise

Repeat times

Knee Extension in Standing

Standing straight with a sturdy support to hold onto. Keep your back up straight and still.

Extend leg behind

Repeat times

What support do I have with my rehabilitation in hospital?

Getting your confidence back after a fall is a very personal experience. Some people need more time than others.

From what you learn in you Physiotherapy session, you can practice throughout the day until your next session, so that progress can be made which will increase your confidence.

You may find it helpful to set small daily goals, gradually increasing the amount you do each day on the ward.

Within the ward the Multi-Disciplinary Team will support your progress. You will be encouraged to get dressed into day clothes as soon as you are able to sit out. Please ask relatives/friends to bring in loose fitting clothes and flat well-fitting slippers. You will also need nightwear and toiletries.

The Occupational therapist (OT) will discuss with you and your family about your set-up at home and how you were managing prior to your admission. They will also discuss how you will manage your daily activities once you return home and suggest equipment that you may need to promote your independence. It may also be necessary for them to gain access to your property, which they will discuss with you. This is to enable them to ensure that your home environment is safe for you to return to**.**

During your admission, the Physiotherapist and the Occupational therapist will go through in detail with you:

- Hip precautions if needed
- How to get dressed
- Getting in and out of bed and sitting on a bed or chair
- Standing from a bed or chair
- Stairs
- Getting in and out of a car (information leaflet)
- Driving

What can I expect after discharge?

Appreciating your limitations after surgery can often be quite a shock when you are at home. It is important to continue if able to stay mobile and do the exercises you have been shown. At this stage, most people will continue to improve, and do not require on-going physiotherapy.

Some people may be slower than others to progress on the ward; therefore, a short amount of time (two to six weeks) may be required at a Rehabilitation unit. This is based on specific criteria which your Physiotherapist can discuss with you.

Community Physiotherapy may have been discussed prior to your discharge and arrangements put into place if required. However, if you have concerns about your progress, you may wish to discuss this with your GP.

You will be discharged with regular painkillers, and these can be reduced over the coming weeks. You may wish to discuss repeat prescriptions or concerns regarding your pain with your GP.

Having a hip fracture means you are at higher risk of developing a blood clot, and you will be discharged with blood thinning medication. This is usually a daily injection for four weeks after your operation, which you or a family member can be taught to administer. Alternatively, a District Nurse may administer it and the ward will arrange this.

Follow up post discharge

Most patients do not need a follow-up with the Orthopaedic team.

If you are discharged before 12 days a District Nurse will be booked to remove any stitches and wound dressing.

Some patients require a three-month review by the Ortho-Geriatrician and this will be arranged prior to discharge. You will receive the appointment by post

If there is no follow up required you can expect a telephone call at around 3 months to enquire about your progress, ensure you are managing your bone health tablets and to discuss any ongoing issues.

Preventing further falls

It is important to find out why you fell as some causes of falls, due to poor balance, variable blood pressure and abnormal heart rhythms might be prevented in the future. Whilst you are in hospital you will be seen by the Ortho-Geriatrician and the Therapists who will ask you about your fall and any other recent falls you may have had.

They will also ask about any problems or concerns with your memory, eyesight or hearing. The doctors will also examine you and review your medication. If necessary, they will arrange further investigations and an appointment with the Ortho-Geriatrician.

Once at home you can also take simple measure to help prevent falling and reduce the risk of further broken bones.

- Keep all rooms clear of clutter, and check for hazards such as trailing wires and slippery floors.
- Clear away loose rugs or tape down the edges, to prevent trips
- Ensure you home is well lit, especially stairwells; consider leaving a night light on.
- Wear supportive low-heeled shoes; avoid walking in socks stockings or backless slippers.
- Have your eyesight checked regularly. Eye tests are free if you aged 60 or over.

Preventing further fractures

Osteoporosis (OP brittle bones) is a condition that weakens bones, making them fragile and more likely to break. It develops slowly over several years and is often only diagnosed when a minor fall or sudden impact causes a bone to break.

How is it diagnosed?

OP is often first diagnosed when you break a bone after a fall, but it is a chronic condition and will require treatment. The Ortho-Geriatrician will assess whether a DEXA (dual energy x-ray absorptiometry) scan is required. This will be done as an outpatient and the results discussed with your GP or at a hospital clinic appointment.

Further in-depth information is available from the National Osteoporosis Society and leaflet displayed in the patient information area.

In most cases the medical team will recommend regular Vitamin D± Calcium along with a specific osteoporosis tablet. The treatment depends on several factors including your age, sex and medical history. The aim is to strengthen existing bone, prevent further bone loss and reduce the risk of broken bones.

Once the medication for osteoporosis is started, it is likely that you will need it for at least five years and sometimes lifelong. If you experience any side effects, please discuss with your doctor before stopping medication as an alternative drug may be more suitable for you. You will be given leaflets about these medications from the pharmacist before your discharge from the hospital.

Why a National Hip Fracture Database?

Hip fracture is a common injury and caring for patients with a hip fracture is an important part of the work of the NHS. This hospital takes part in the National Hip Fracture Database (NHFD), which has been created to improve the care of patients who have broken a hip.

Information gathered about care in hospital and about recovery afterwards enables us to measure the quality of that care and how we compare to other units
.
Reports are presented to our clinical staff to help improve the care provided.

Certain information about your care and progress will be entered into the database during your hospital stay. All information collected is confidential and anonymous and NHFD is stored, transferred and analysed in accordance with the Data protection Act (2018).

Participation is voluntary; if you do not wish to take part, please speak to the ward staff. However, the more people take part, the more helpful NHFD will be in improving care

More details are available at www.nhfd.co.uk

The NHFD in conjunction with the Royal College of Physicians, have released a booklet to support patients undergoing hip fracture treatment, called “My hip fracture care: 12 questions to ask-A guide for patients, their families and carers”.

Key reference sources

- ✓ www.nhfd.co.uk
- ✓ National Osteoporosis society www.nos.org.uk
- ✓ NICE guideline: Dementia: management and support CG 97 https://www.nice.org.uk/guidance/ng97
- ✓ NICE guideline: Hip fracture management CG
- ✓ https://www.nice.org.uk/guidance/cg124
- ✓ NICE guideline: Osteoporosis assessing the risk of fragility fractures CG 146
- ✓ https://www.nice.org.uk/guidance/cg146
- ✓ NICE guideline: Falls in the older person, assessing risk and preventions CG 161 https://www.nice.org.uk/guidance/cg161

Patient advice and liaison service (PALS)

If you have a compliment, complaint or concern please contact our PALS team on 020 7288 5551 or whh-tr.whitthealthPALS@nhs.net

If you need a large print, audio or translated copy of this leaflet please email whh-tr.patient-information@nhs.net. We will try our best to meet your needs.

Twitter.com/WhitHealth
Facebook.com/WhittingtonHealth

Whittington Health NHS Trust
Magdala Avenue
London
N19 5NF
Phone: 020 7272 3070
www.whittington.nhs.uk

Date published: 21/05/2024
Review date: 21/05/2026
Ref: SC/Orthopaed/YFHE/04

© **Whittington Health**
Please recycle