NHS National Services Scotland

Hip Fracture Workshop.

The Scottish Government

Friday 26th August 2016
Royal College Of Surgeons, Edinburgh

Programme

0930 - 1000	Registration and Refreshments Break	
1000 - 1005	Them's the Breaks	Graeme Holt
1005 - 1015	Break with Tradition	Catherine Calderwood
1015 - 1030	Hips don't Lie	Graeme Holt
1030 - 1100	Hips'ters	Anna and Kathleen Sweeney
1100 - 1115	The Hip Bone's connected to the…	Seng Wong
1115 - 1135	Morning Break	
1135 - 1150	When All Hell Breaks Loose	Annie Owens
1150 - 1205	Go for Broke	Jon Antrobus
1205 - 1220	Bad to the Bone	Graeme Holt
1220 - 1245	Joined at the Hip	Alastair MacLullich and Amy Harris
1245 - 1300	Joint Venture	Fiona Graham
1300 - 1350	Lunch Break	
1350 - 1420	Hip and Happening	Andy Ballantyne and Karen Goudie
1420 - 1435	Shoot from the Hip	Catherine Nivison
1435 - 1445	Bone Weary	Mayrine Fraser
1445 - 1500	Bone to pick	Ann Murdoch
1500 - 1525	Break the Habit	Claire Ritchie and Claire Rae
1525 - 1530	Take a Break	
1530 - 1600	Bone Dry	Graeme Holt, Karen Adam and All
1600	Break Free	

#ScotHipAudit

www.shfa.scot.nhs.uk

Patients' Understanding of Hip Fracture: A two-Centre Audit

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Introduction

1. 66,000 hip fractures a year [1]
2. set to double by 2050[1].
3. 30-day mortality is at 8.2%[2].
4. majority of orthopaedic trauma patients have **limited comprehension** of their condition, treatment options and postoperative instructions[3]
5. **significant improvement** in post-operative recovery and earlier mobilisation in hip fracture patients that receive tailored information[4].

Standards

10.3 CHECKLIST FOR PROVISION OF INFORMATION

This section gives examples of the information patients/carers may find helpful at the key stages of the patient journey. The checklist was designed by members of the guideline development group based on their experience and their understanding of the evidence base. The checklist is neither exhaustive nor exclusive.

Admission

- After admission, the following should be discussed with patients and carers:
  - history of falls
  - how the hip fracture will be managed
  - how long patients are likely to wait for an operation
  - what support is available at home – is there a carer who is willing and able to support the patient upon discharge
  - how the patient will be mobilised
  - the likelihood of bruising around the site of their operation, which may be extensive
  - whether or not a blood transfusion may be needed
  - how long the patient is expected to stay in hospital.
- Discuss how the patient may feel, for example, acknowledge that patient may feel anxious.
- Advise patients and carers whom they can ask for information within and outwith the hospital setting.
- Ensure families and carers are aware of their responsibilities regarding infection control.
- Make patients and carers aware of the hospital chaplaincy service.

Early mobilisation

- The importance of early mobilisation following a hip fracture operation should be emphasised:
  - let patients know in advance that it is likely that they will be encouraged to move with the help of a physiotherapist or other member of the healthcare team within 24 hours of their operation.
  - acknowledge that starting to walk again is a challenge and will be uncomfortable.

Discharge

- Hospital nurses should communicate with the multidisciplinary team and ensure that patients and carers are involved in discharge planning.
- Acknowledge the concerns associated with going home.
- Hospital staff should establish whether there is a carer who is willing and able to provide support to the patient upon discharge.
- Advise patients and carers about social services, acknowledging that there may be a cost involved for some home support services.
- Advise patients and carers (including care homes) of possible discharge dates.
- Discuss the possibility of further rehabilitation settings, for example, GORU.
- Ensure the patient agrees to sharing of assessment results between services.
- Advise patients and carers that a discharge letter will be sent to their GP.
- Provide patients and carers with written information on medication, mobility and useful sources of information.

Follow up

- Advise patients and carers of how they will be followed up, for example, by telephone calls from a liaison nurse, or appointments with their GP.
- Discuss with patients who are on anticoagulant therapy how this treatment will continue in the community.
- Encourage carers to inform their GP if they are having difficulty in maintaining the caring role.
- Highlight that carers are entitled to their own assessment for practical and financial support.

Prevention

- Patients should be encouraged to be active – a history of immobility is a significant risk factor for fracture.
- Falls prevention – identify any factors that might reduce the risk of the patient falling, for example:
  - hazards in the home environment – loose rugs, trailing flexes, poor lighting, stairs etc
  - have the patient's eyesight and hearing been tested recently?
  - would the use of walking aids be beneficial, or could their use be optimised?

Aims & Objectives

1. Assess patients' understanding of hip fracture
2. evaluate the effectiveness of a self-designed patient information leaflet as an intervention
3. assess patient's understanding of hip fracture post intervention

Methodology

1st Cohort

- All confirmed hip fracture patients identified through trauma list
- Prospectively over one month period at RIE & Ninewells Hospital

Exclusion Criteria

- Cognitive impaired (AMTS <6, 4AT >1)
- Visually impaired
- Acutely unwell at the point of time

Survey

- Patients given a 5 point Likert questionnaire assessing understanding of neck of femur fractures across 5 domains

Questionnaire

Domains tested:

1. General understanding
2. Causes
3. Treatment options
4. Complications
5. Prognosis

Hip Fracture Understanding Study

1. On a scale of 1 to 5, how much do you understand about a hip fracture? (please circle the answer you feel m strongly for)

1	2	3	4	5
Zero Understanding	Little Understanding	Some Understanding	Fair Understanding	Good Understanding

2. On a scale of 1 to 5, how much do you know about what causes a hip fractures?

1	2	3	4	5
Zero Understanding	Little Understanding	Some Understanding	Fair Understanding	Good Understanding

3. On a scale of 1 to 5, what is your understanding of the various treatment options for hip fracture?

1	2	3	4	5
Zero Understanding	Little Understanding	Some Understanding	Fair Understanding	Good Understanding

4. On a scale of 1 to 5, how much do you know about the complications of hip surgery?

1	2	3	4	5
Zero Understanding	Little Understanding	Some Understanding	Fair Understanding	Good Understanding

5. On a scale of 1 to 5, how much do you know about the long term outlook and long term treatment for a hip fracture?

1	2	3	4	5
Zero Understanding	Little Understanding	Some Understanding	Fair Understanding	Good Understanding

Methodology

2nd Cohort

- All confirmed hip fracture patients identified through trauma list
- Prospectively over one month period at RIE & Ninewells Hospital

Interven-tion

- patient information leaflet describing the causes and risk factors, treatment options, complications and outcomes of hip fracture
- According to components of SIGN Section 10.3

Re-survey

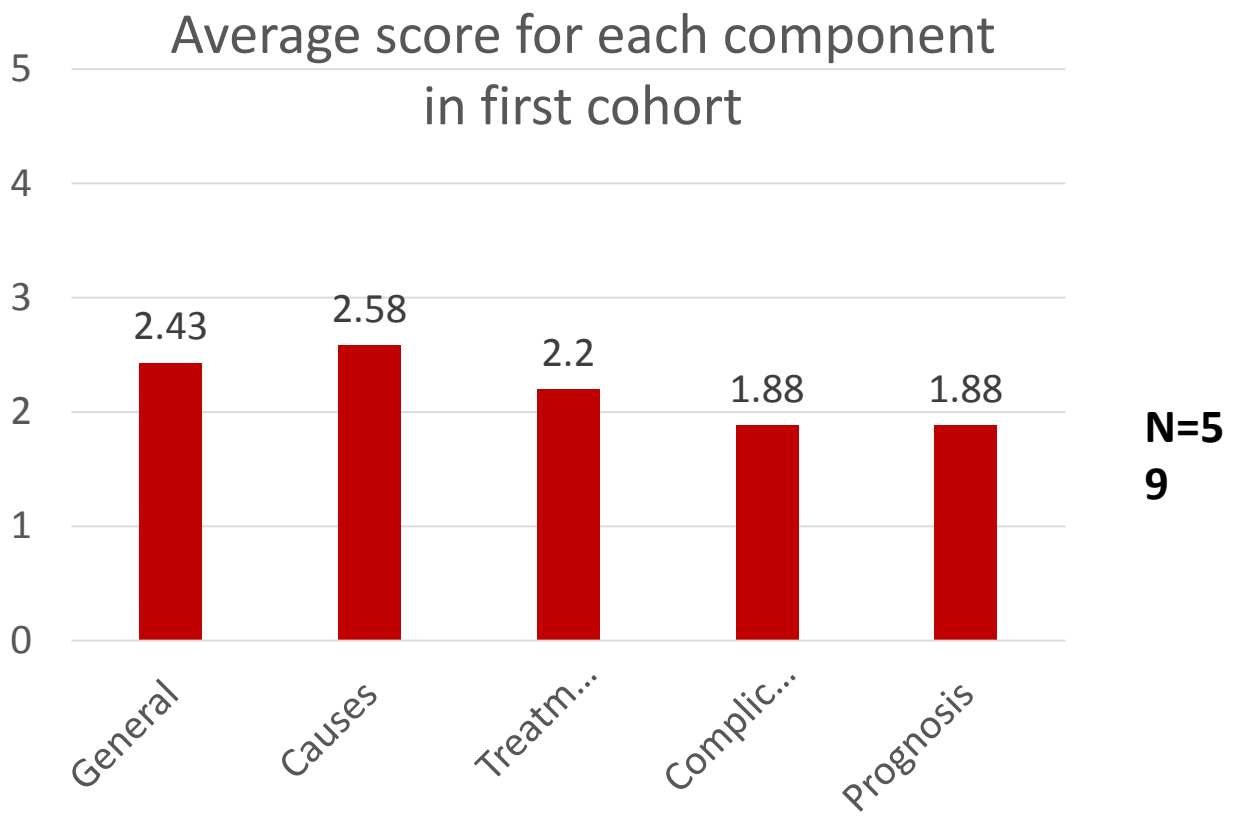
- Same 5 variable Likert questionnaire given to patients AFTER intervention
- Additional question asking patients to appraise the information leaflet

Results

Demographics of patients from first cohort

1. 59 patients were recruited
2. 47 females and 12 males
3. average age of the cohort was 78.7 years.

Results


Average score for each component in first cohort
5
4
3
2
1
0
2.43
2.58
2.2
1.88
1.88
General
Causes
Treatm...
Complic...
Prognosis
N=59

Intervention

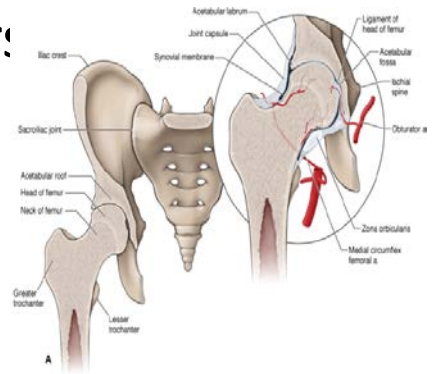
Domains covered:

1. General information
2. Causes and Risk Factors
3. Treatment options
4. Complications
5. Prognosis

Patient Information – Hip Fractures

A hip fracture is when the thighbone at your hip joint breaks. There are two main types of hip fractures.

The first type are intra-capsular fractures which affect the thigh bone inside the hip joint and the second type is extra-capsular which affects the thigh bone just outside the hip joint



Causes and Risk Factors

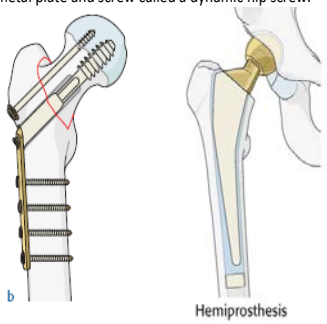
Hip fractures are very common and usually due to a fall. A condition called osteoporosis is the main reason people break their hips. Osteoporosis results in weakened bone, meaning they break much easier than normal

Treatment options

Most people who have a broken hip will need surgery. The type of surgery will depend on the type of hip fracture.

If you have an intra-capsular hip fracture, you will most likely need a hip replacement. This is when the top part of your thighbone is replaced with a metal one.

If you have an extra-capsular hip fracture, your fracture can be fixed using a metal plate and screw called a dynamic hip screw.



Complications of Surgery

Complications following surgery are generally uncommon.

Infections may occur following your surgery. This is usually treated with antibiotics. Some patients can develop a clot in their legs (called a deep vein thrombosis). All our patients get medicines to prevent this. Sometimes, there can be blood loss during the operation. This is can be treated by giving fluids or a blood transfusion through a drip.

Outlook

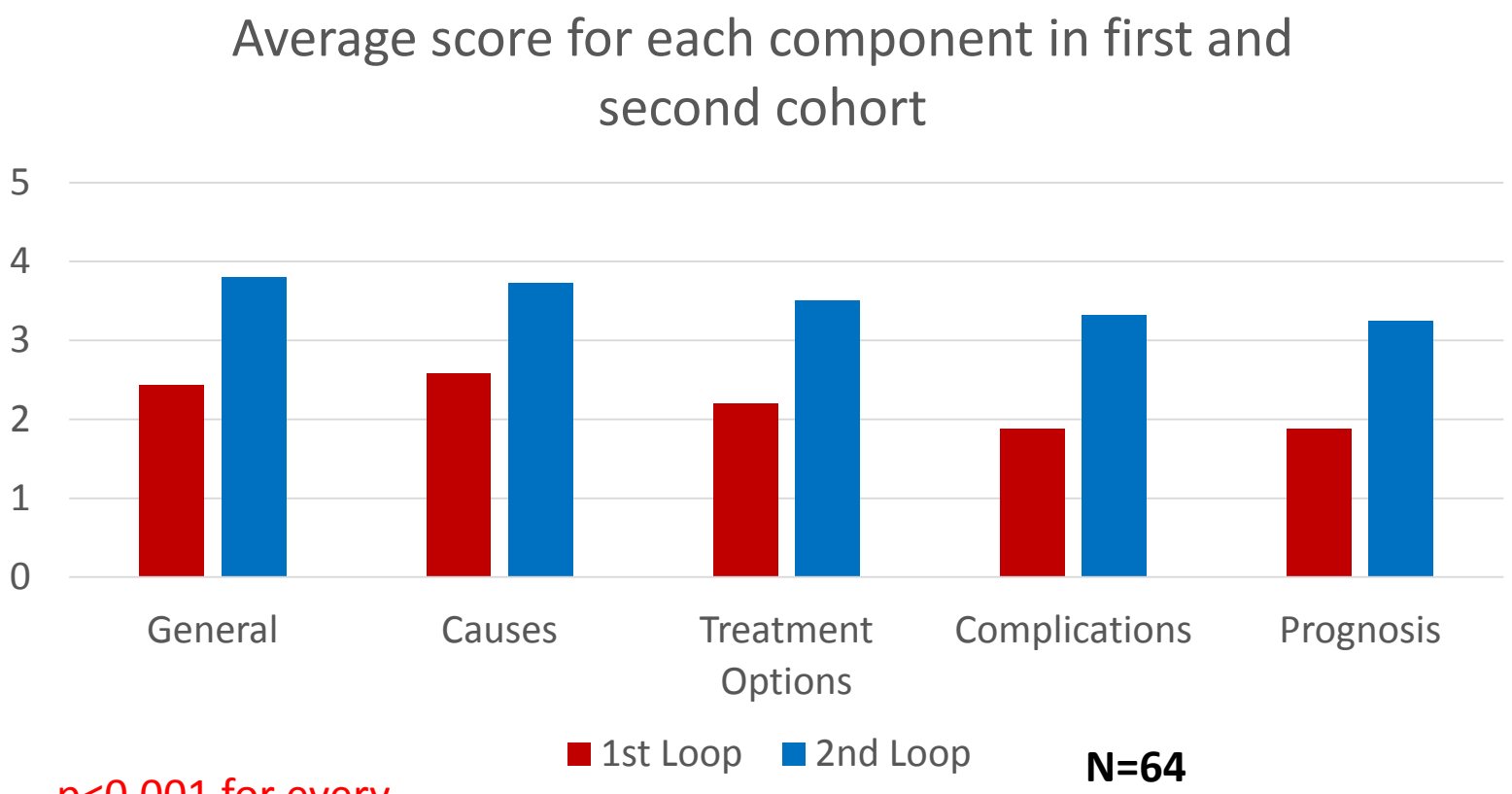
Hip fractures are treated very effectively with surgery, but some may find they have persistent pain in their hip. You may also notice that your mobility is reduced after the surgery. Many of our patients need physiotherapy and rehabilitation before leaving hospital.

Results

Demographics of patients from 2nd cohort:

1. 64 patients were recruited
2. 42 females and 22 males
3. average age of 81.3 years.

Results



p<0.001 for every component

Results

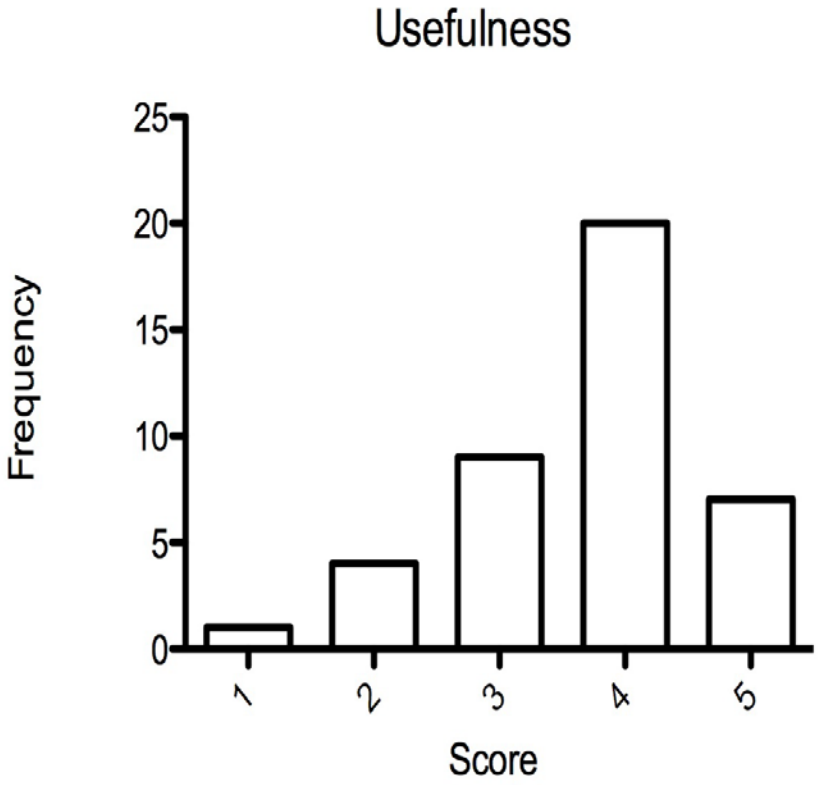


Figure 1 – Scores from the second cohort asking how useful they found the information leaflet. Score 1 = Not at all, Score 5 = Very much.

Discussion

1. Significant improvement in patients' understanding.
2. **alleviate the burden of covering certain topics** and at the same time provided **a source of reference for recalling information**.
3. simple and easily understandable information leaflet works best[5-7].
4. **accompanied by some explanation**[8] to prevent alarming patients instead.
5. to help patient's recall of information, facilitating informed consent[9].

What's happening currently?

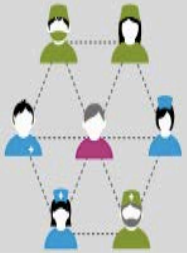
1. Varying Patient Information Leaflet throughout different trusts (some tend to focus more on rehabilitation after surgery, some on hip fracture itself, some more so on the complication)
2. Generally targeted at the patients and not relatives
3. A shift towards what patients really want for their care (Dr calderwood's annual report on Realistic Medicine, PROMS to PREMS,
4. Several studies pointing towards certain things what patients want(ideal physician behaviour, fast-track etc etc)

REALISTIC MEDICINE

CAN WE:

CHANGE OUR STYLE TO **SHARED DECISION-MAKING?**

BUILD A **PERSONALISED** APPROACH TO CARE?



REDUCE HARM AND WASTE?

REDUCE **UNNECESSARY VARIATION** IN PRACTICE AND OUTCOMES?

MANAGE RISK BETTER?

BECOME IMPROVERS AND INNOVATORS?

Next Steps

1. An all-purpose Patient Information Leaflet for patients AND relatives/carers

- with pre and post operative information
- plus support/contact details in the community when discharged home

2. A further study/interviews to find out what patients and relatives REALLY want from us

3. Improving patients' care and experience

References

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2. National Hip Fracture Database 2013 report. http://www.nhfd.co.uk/20/hipfractureR.nsf/0/53e99a0800e9d2fb80257bea000b5ec9/$FILE/NHFD%20Summary%20Report%202013.pdf . Last accessed 16/03/15.
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6. Fitzmaurice DA, Adams JL. A systematic review of patient information leaflets for hypertension. J Hum Hypertens. 2000 Apr;14(4):259-62
7. Kenny T, Wilson RG, Purves IN, Clark J Sr, Newton LD, Newton DP, Moseley DV. A PIL for every ill? Patient information leaflets (PILs): a review of past, present and future use. Fam Pract. 1998 Oct;15(5):471-9
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9. Ashraff S, Malawa G, Dolan T, Khanduja V. Prospective randomised controlled trial on the role of patient information leaflets in obtaining informed consent. ANZ J Surg. 2006 Mar;76(3):139-41

Thank you

Questions?

ANNIE OWENS

THE ROLE OF THE TRAUMA LIAISON NURSE IN ED

ROYAL ALEXANDRA HOSPITAL

PAISLEY

- Intervention in ED
- What difference has it made
- What challenges still lie ahead
- What is planned for the future

Royal Alexandra Hospital

- Busiest trauma unit in GG&C
- 4th Busiest in Scotland
- Approx 450 NOF admissions per year
- 9 on call consultants
- 4 weekday Trauma Liaison Nurses 0630 hrs – 2130 hrs.
- 7 day trauma theatre access

WHERE TO START?

- Identify areas for improvement
- Research!! MSK audits.
- MDT approach
- Disseminate information with clear goals

THE ‘BIG SIX’ INTERVENTIONS PRIOR TO TRAUMA LIAISON IN ED

- 2013 – No patient received all 6
- Documented cognitive screening - 0%
- Documented pressure area assessment – 0%
- Fluid intervention - <40%

- *Causing concern*
- ECGs
- Group & Save
- INR / Bone Profile
- Long femur views
- Kardex - analgesics
- Patient handover

How did we as a team change our pathway ?

Identify your goal..

Challenge the barriers..

Implement..

Scottish Government Funding

- Increased trauma liaison provision
  - 7 day, extended hours
  - SG funding
  - NOF priority role

- Consolidate and improve on previous gains

MDT APPROACH

- MDT meeting -
  - MSK audit data , MDT meeting to discuss areas of good practice and areas for improvement
  - Consultant, Trauma Liaison, Ortho Lead Nurse, Ward sister, Physio, OT, Audit Nurse, Anaesthetics, Theatres, GORU Consultant

Why ED?

- Management of admission
- Invaluable early contact with patient and relatives / carers
- Enable early recognition re pre op requirements
- Initiate NOF Proforma
- Enhanced communication with receiving team / Ward staff / anaesthetics
- Orthopaedic + AE working relationship improved.

Introduction new documentation

- ED TIMELINE
- TRAUMA LIAISON DOCUMANTATION
- WARD CHECKLIST – OVERNIGHT ADMISSIONS
- NECK OF FEMUR PROFORMAS

- CONTINUAL REVIEW

NOF PATHWAY

NECK OF FEMUR PATHWAY

CLINICAL PRESENTATION NOF ADMITTED TO AE

TRAUMA LIAISON CONTACTED
(CO ORDINATION OF ADMISSION BEGINS)

PROVISIONAL BED REQUESTED
(WITHIN 30MINS OF PRESENTATION TO AE)

CONFIRMATION OF NOF

TRAUMA LIAISON AND FY2 REVIEW
NOF CHECKLIST COMPLETED

T/L REVIEW IN AE DEPT
(ENABLING EARLY RECOGNITION RE FURTHER INVESTIGATION/INTERVENTION)

INIATATE NOF PROFORMA IN AE
ENSURES PATIENT CENTERED CARE DELIVERED INVOLVING THE 'BIG SIX'

PROVIDE EARLY CONTACT WITH PATIENT AND RELATIVES

TIME APT ADMISSION TO WARD

ENSURE ALL PRE OP REQUIREMENTS

CO ORDINATE REVIEWS/THEATRE

ED Fracture Neck of Femur
Fast Track Admission Timeline

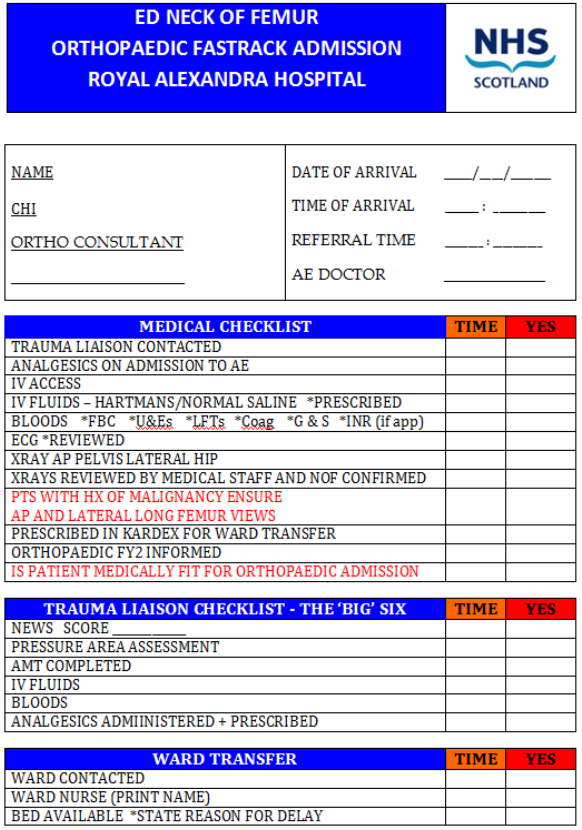
ONLY PATIENTS WITH CLINICALLY OBVIOUS NOF FRACTURE

NHS SCOTLAND

AE NOF PATIENT TIMELINE	Time
1. IDENTIFICATION POTENTIAL NECK OF FEMUR TRAUMA LIAISON INFORMED. BED REQUESTED.	15 mins
2. IV ACCESS/ANALGESICS/XR ORDERED	30 mins
3. NOF CONFIRMED - CLINICIAN ASSESSMENT	60 mins
4. SENIOR ED REVIEW/ORTHO FY2 + TRAUMA LIAISON INFORMED T/L WILL REVIEW IN AE	90 mins
5. TRANSFER TO ORTHOPAEDIC WARD	120 mins
6. ORTHO FY2 ASSESSMENT ON WARD	180 mins

Trauma Liaison Checklist – achieving our best practice..

- Checklist completed with every patient in ED
- Improving patient journey
- Timeline audited



ED NECK OF FEMUR
ORTHOPAEDIC FASTRACK ADMISSION
ROYAL ALEXANDRA HOSPITAL

NHS SCOTLAND

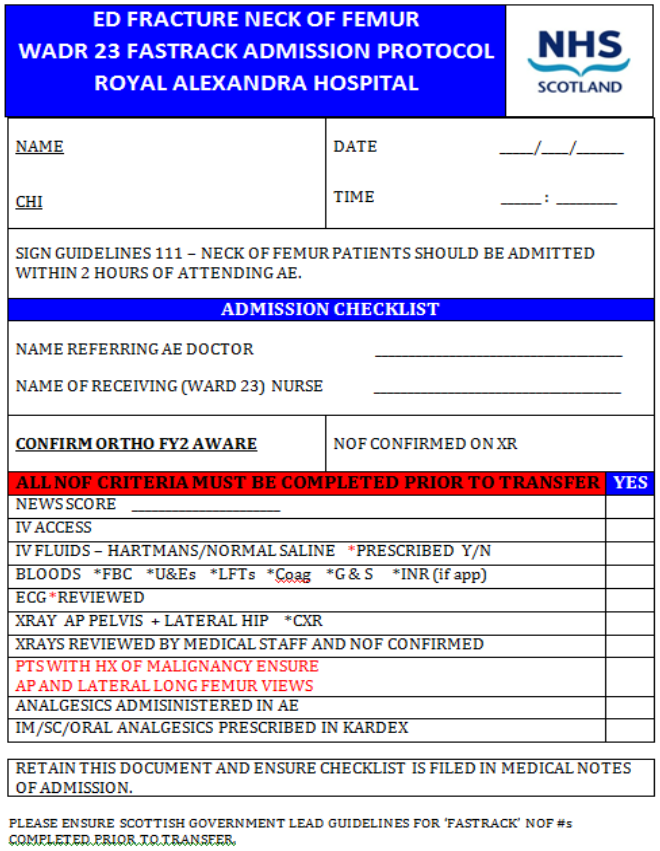
NAME	DATE OF ARRIVAL ___/___/____
CHI	TIME OF ARRIVAL ____ : _____
ORTHO CONSULTANT	REFERRAL TIME ____ : _____
_____	AE DOCTOR _____

MEDICAL CHECKLIST	TIME	YES
TRAUMA LIAISON CONTACTED		
ANALGESICS ON ADMISSION TO AE		
IV ACCESS		
IV FLUIDS – HARTMANS/NORMAL SALINE *PRESCRIBED		
BLOODS *FBC *U&Es *LFTs *Coag *G & S *INR (if app)		
ECG *REVIEWED		
XRAY AP PELVIS LATERAL HIP		
XRAYS REVIEWED BY MEDICAL STAFF AND NOF CONFIRMED		
PTS WITH HX OF MALIGNANCY ENSURE AP AND LATERAL LONG FEMUR VIEWS		
PRESCRIBED IN KARDEX FOR WARD TRANSFER		
ORTHOPAEDIC FY2 INFORMED		
IS PATIENT MEDICALLY FIT FOR ORTHOPAEDIC ADMISSION		

TRAUMA LIAISON CHECKLIST - THE 'BIG' SIX	TIME	YES
NEWS SCORE _____		
PRESSURE AREA ASSESSMENT		
AMT COMPLETED		
IV FLUIDS		
BLOODS		
ANALGESICS ADMIINISTERED + PRESCRIBED		

WARD TRANSFER	TIME	YES
WARD CONTACTED		
WARD NURSE (PRINT NAME)		
BED AVAILABLE *STATE REASON FOR DELAY		

Ward Admission Checklist



ED FRACTURE NECK OF FEMUR
WADR 23 FASTRACK ADMISSION PROTOCOL
ROYAL ALEXANDRA HOSPITAL

NHS SCOTLAND

NAME	DATE ___/___/_____
CHI	TIME ____ : _____

SIGN GUIDELINES 111 – NECK OF FEMUR PATIENTS SHOULD BE ADMITTED WITHIN 2 HOURS OF ATTENDING AE.

ADMISSION CHECKLIST

NAME REFERRING AE DOCTOR _____

NAME OF RECEIVING (WARD 23) NURSE _____

CONFIRM ORTHO FY2 AWARE	NOF CONFIRMED ON XR

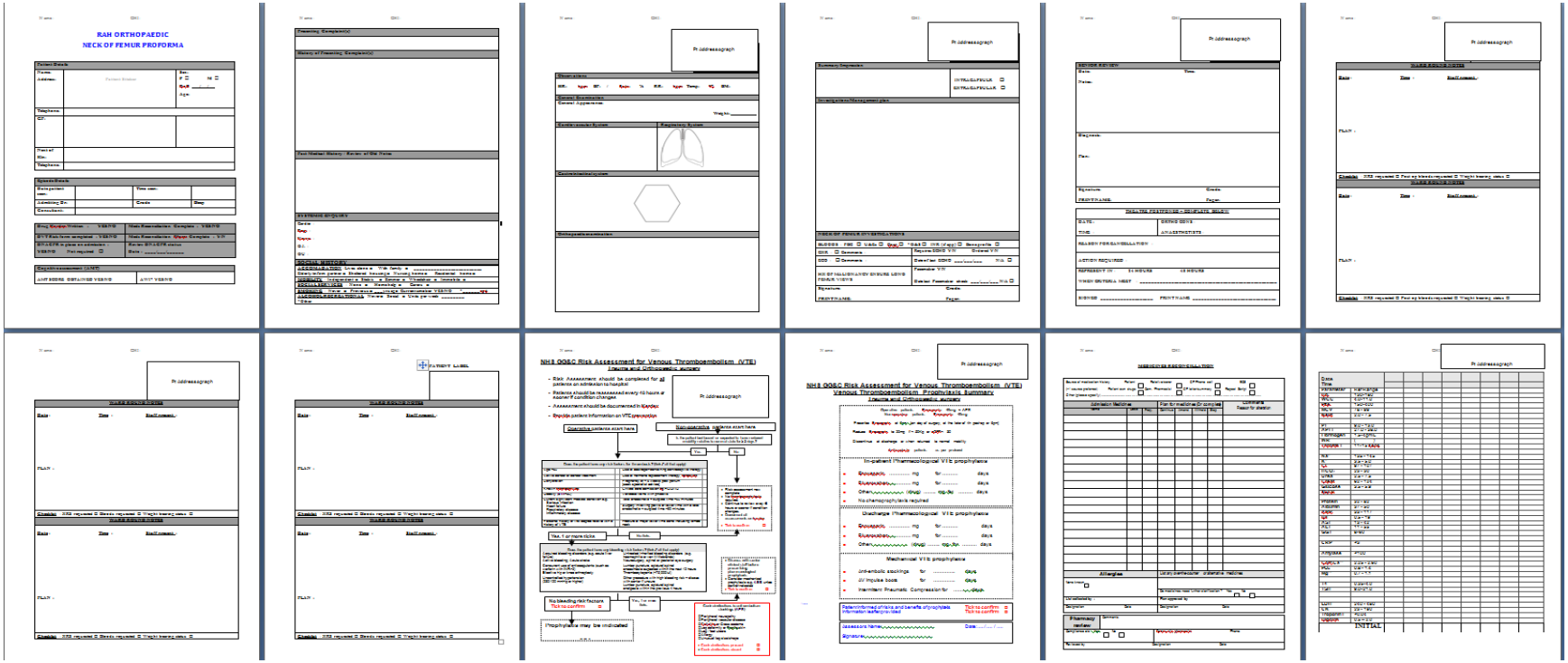
ALL NOF CRITERIA MUST BE COMPLETED PRIOR TO TRANSFER	**YES**
NEWS SCORE _____	
IV ACCESS	
IV FLUIDS – HARTMANS/NORMAL SALINE *PRESCRIBED Y/N	
BLOODS *FBC *U&Es *LFTs *Coag *G & S *INR (if app)	
ECG *REVIEWED	
XRAY AP PELVIS + LATERAL HIP *CXR	
XRAYS REVIEWED BY MEDICAL STAFF AND NOF CONFIRMED	
PTS WITH HX OF MALIGNANCY ENSURE AP AND LATERAL LONG FEMUR VIEWS	
ANALGESICS ADMISINISTERED IN AE	
IM/SC/ORAL ANALGESICS PRESCRIBED IN KARDEX	

RETAIN THIS DOCUMENT AND ENSURE CHECKLIST IS FILED IN MEDICAL NOTES OF ADMISSION.

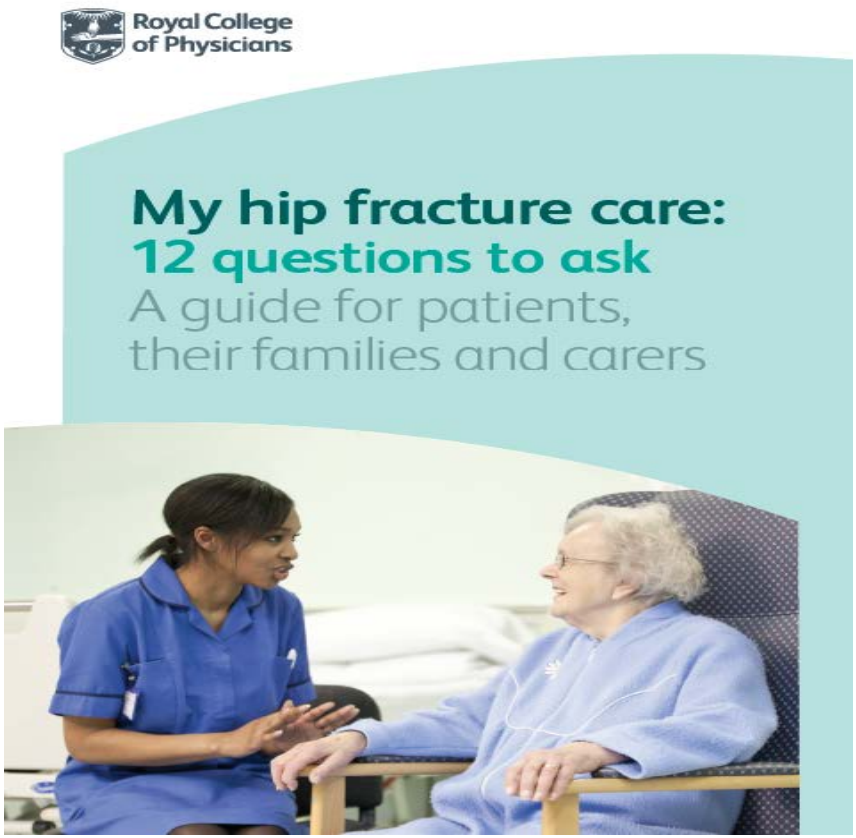
PLEASE ENSURE SCOTTISH GOVERNMENT LEAD GUIDELINES FOR 'FASTRACK' NOF #s COMPLETED PRIOR TO TRANSFER.

- Ward based checklist
- All patients for fast tracking OVERNIGHT
- Agreed with ED
- No admission unless complete

Admission Documentation-



Additional Work



- Working with the Hip Fracture Steering Group to introduce a patient / relative / carer information booklet
- Currently undertaking a further patient/relative satisfaction survey

Summary

- ED - sit down with your team – you all want the same outcomes.
- MDT approach
  - Need a willing group of participants
- Small changes have large effects
- One thing at a time

OUR GOAL – ACHIEVING BEST PRACTICE FOR *EVERY* PATIENT

THANK YOU

- QUESTIONS? ….

“Joined at the Hip”

Medicine of the Elderly in Orthopaedics

Amy Harris, Nurse Practitioner
Alasdair MacLullich, Consultant MOE
Royal Infirmary of Edinburgh

Background

NHS Lothian.

- Population 800,000.

Royal Infirmary of Edinburgh.

- Orthopaedics – Trauma & Elective.
- 139 Beds in 5 wards.
- 11 Trauma Consultants.
- Around 1000 Hip fractures / year.

Enhanced Liaison Model

Named Orthopaedic Consultant with overall responsibility for care.

Ortho MOE involvement with defined group of patients.

Ortho MOE Team

3 Consultants

2 Middle Grade Doctors

2 Nurse Practitioners

Available Mon – Fri
7am – 5pm

Where were we pre-2013?

Doctor-only MOE liaison service

Access to MOE liaison doctors

- Referral formats varied from verbal one-liners to emails
- Junior ortho docs unsure of role of MOE
- Poor communication between groups of staff

One-third of hip fracture patients had MOE contact

Nearly all MOE consultations were reactive, and post-operative

MOE not consistently directed at frailest/most unwell

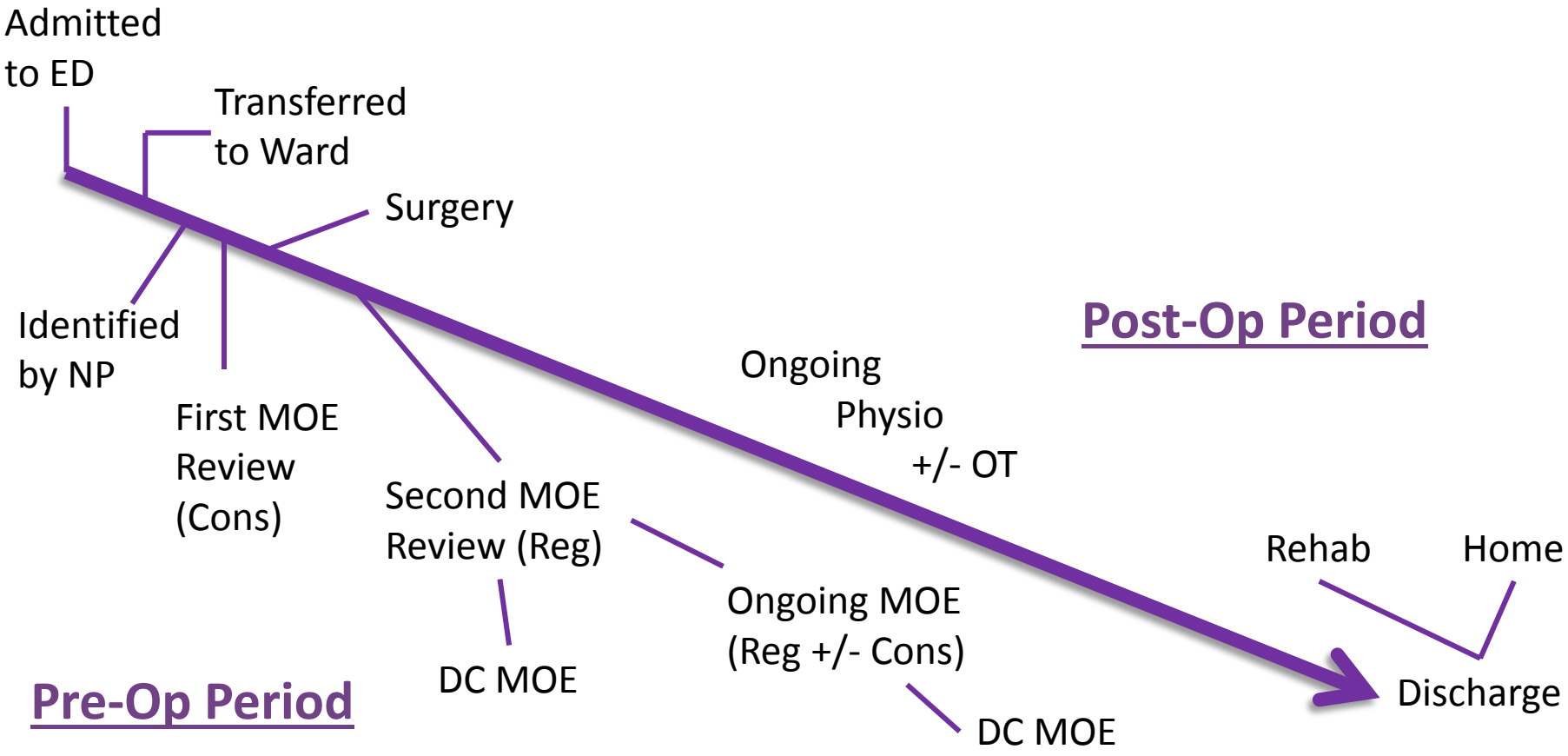
Where we were in 2013-14?

- Triage large numbers of patients.
- MOE review 50-70% of triaged patients (100% patients with Hip # reviewed).

Ortho MOE Team (2015 +)

- Identify & Prioritise new patients within 24hrs of admission (72hrs at weekends).
- >65yrs.
- Focus on Hip #'s.
- Also review patients with other injuries e.g. Pubic Rami #'s, Upper Limb #'s.
- Other injuries not actively triaged e.g. Dislocations, Infected Joints etc., but happy to review medical problems.

Hip # Patient Timeline



Something about me?

– I love to read.

Nurse Practitioner

- Initial identification & prioritisation of new admissions.

- Co-ordination of the Ortho MOE team.

- Attend ward rounds with Consultants / Middle Grade Dr.

- Able to initiate treatments quickly e.g. IVABs.

- Communication
  - Verbal -> nursing staff & junior doctors
  - Written -> nursing staff & Ortho MOE team.

- Independent NP review of ongoing patients.

Nurse Practitioner

- Discharge planning with MDT on trauma wards.

- NP review and referral of elective patients requiring rehab.
- NP review and referral of patients requiring boarding to await POC or non Ortho rehab.

- Ortho MOE Audit collection.
- Ongoing data collection.
- Analysis of data.

- PA type work – minutes of meetings etc.

2 things:

- Roots in Benbecula, Western Isles
- Guitarist

MOE Doctors

- Daily Consultant Ward Rounds (Mon-Fri)
  - focus on new patients.

- Daily Middle Grade Ward Rounds
  - focus on ongoing patients.

- Reviews pre- and post-op.

Medical review process

Summary of acute issues + <u>assess specifically for</u>:

- Pain
- Distress
- Delirium
- Dehydration, AKI
- Respiratory failure
- Constipation (esp later in admission)
- Urinary retention (we do a lot of bladder scans!)
- Drugs which need to be stopped / reduced / withheld

All patients:

- IVI pre-op, some post-op
- Paracetamol and oxycodone
- Laxatives

Analgesia protocol

Before 2014:

- Multiple drugs used, often in combination
- Varying dosage
- Opioid toxicity or inadequate analgesia very common

Since:

- Paracetamol 500mg or 1g qds
- Oxycodone orally 2mg tds + 2mg one-hourly as required
- Alfentanil 50mcg sc for severe acute pain
- Regular laxatives
- Ondansetron oral/im 4mg 8-hourly as required

Delirium detection and treatment

Before 2013:

- Term ‘delirium’ used infrequently. No standard process. Most delirium unrecognised.

From 2013:

- 4AT increasingly done (now in the majority of patients)
- Term ‘delirium’ now normal part of language of staff
- Less haloperidol used; most Rx is behavioural
- More delirium is prevented (rapid Rx of precipitants, IVI for all, oxycodone rather than morphine)
- Overall, less delirium, and less severe delirium

Where are we now?

- Evolving Ortho MOE service.
- Expanded team.
- Prioritise rather than triage.
- MOE review 90-100%.
- Audit – identifying areas for improvement.

Future developments

- Standardisation of bone health processes.
- More formal falls risk assessments and follow-up.
- More local audits of pain, delirium, AKI, etc.
- Increased consultant sessions (from 5.5 to 7.5, from Aug 2016).
- Weekend cover.
- ? Full Orthogeriatrics service.


NHS
Dumfries
& Galloway

GP in Orthopaedic Rehabilitation

‘The role is based in Dumfries & Galloway Royal Infirmary, providing Orthopaedic services to Dumfries and the surrounding catchment area with a population of approximately 150,000 people. This role will provide expert advice and care for older patients, following fracture, in the Orthopaedic wards with a particular focus on the medical management of patients with multi-morbidities in the immediate post fracture period and the longer term planning rehabilitation’

What do I do?

- Comprehensive geriatric assessment
- Discharge planning
- Osteoporosis assessment/management with CNS
- Frailty meetings with MDT
- Liaison with GP/family/carers
- Advance care planning/EOLC
- FY1 support/education (delirium, cognitive assessment, palliative care)

Positive

- Improved performance in audit
- Senior doctor based in orthopaedic ward/generalist skills
- Profile raising 'Cinderella' group of patients

  'hip fracture represents an effective 'tracer' condition as the management of this injury often requires a complex journey of clinical and social care involving many different disciplinary teams and community based services. As such, if we improve the quality of care for hip fracture patients, then we can expect to improve the care provided to other fragility fracture patients' Graeme Holt 2016
- Further development communication and team-working skills
- Improved links between community/hospital
- '*You remind us to be holistic*'

Negative

- Not a specialist
- Credibility (colleagues, patients, families)
- Different environment (IT, guidelines)
- Finding GPs
- Terms and conditions
- Person dependent

Reflections

- Transferability to other settings
- Transferability to other specialties
- Shape of Training review:

  'Patients and the public need more doctors who are capable of providing general care in broad specialties across a range of different settings. This is being driven by a growing number of people with multiple co-morbidities, an ageing population, health inequalities and increasing patient expectations'
- Quality of intervention – research methods
- Similar to palliative care in 20th century – improving the care of a 'neglected' group of patients who cannot easily advocate for themselves

Further developments

- Increased manpower
- Strengthen links with community hospitals
- Further development delirium awareness/ investigation/management and prevention
- Improving the identification/management of frailty
- Considering the place of the frail elderly in the new DGRI

Hip and happening

the hip fracture ward

Mr Andy Ballantyne
Ortho Cons NHS Fife
Aug 2016

Aims

- The Problem
- Where we started….
- Drivers for change…..
- What we have accomplished….
- Victim of our own success?

The Problem

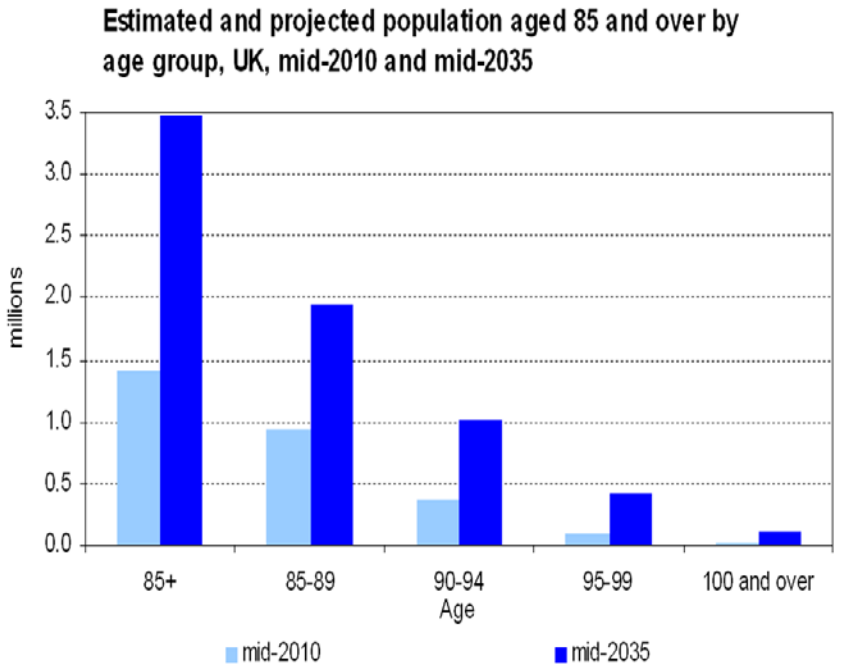
National

- 300,000 Fragility fracture/year in the UK
- Cost of care £2 billion
- Hip Fracture – lifetime risk
  - 11.1% males
  - 22.7% females
  - ~50% in patients >80yrs
- Hip fracture the central challenge to trauma units
  - "just a hip fracture"
  - Lack specialist interest…often the case to be cancelled
  - Care and rehabilitation poorly organised
- 70,000 per year (2007) to 91,500 in 2015 and 101,000 in 2020.

Office for National Statistics

Local (2010)

- Uncoordinated ortho-CoE service
- Reactive medical management
- Lack of continuity of care
- Prolonged LOSx
- Increasing workload



Where we started from….2010

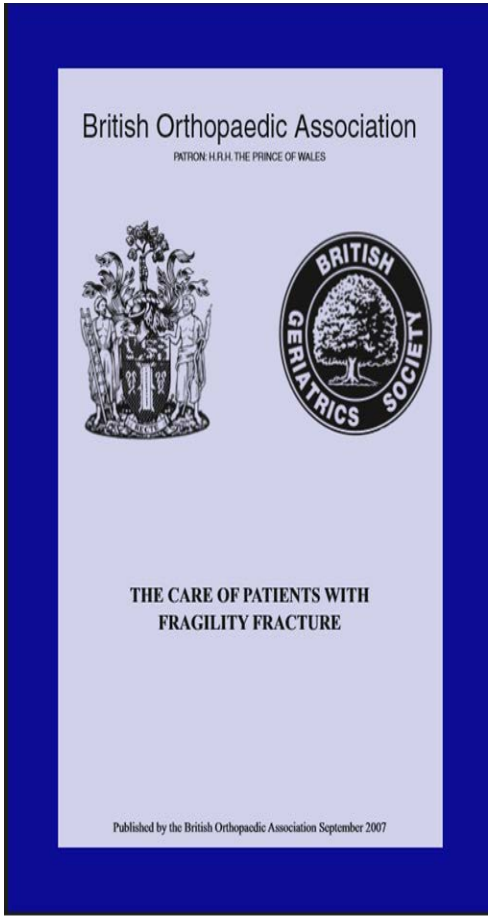
- 2 Trauma wards
- ~46 beds
- P/T CoE Staff Grade
- CoE Cons 1 session
  - MDT meeting
  - Discuss problem patients
  - NOF#s spread across wards mixed with other trauma
- Reactive service

Aspiration to change…..

- 2009 – 2014
  - 2009 Patient pathways
    - Orthopod engagement
  - 2010 ward redesign - enhanced care area
    - Poor planning
    - Naivety
    - Wrong staffing numbers
- Blocks
  - Lack of targets associated with hip fracture
  - Not a managerial priority
  - “disinterest” generally
  - Dislike of change
  - “we’ve always done it this way”
  - Limited funding to support change

2011 Grand Round Ortho-Geriatrics

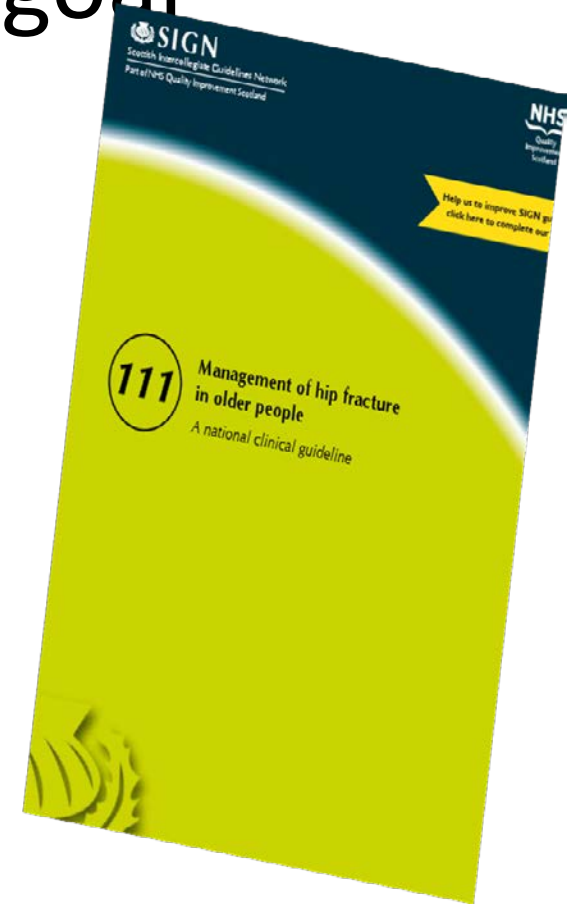
- Dr John McKenzie
- BGS/BOA
  - Set standards of care
  - 200 hip fractures require 4 sessions CoE care
  - Fife – 400 fractures – 8 sessions
  - **2012: Development of Orthogeriatric services for Patients Sustaining Fragility Fractures in NHS Fife: the need to comply with national standards**



The acute hip fracture ward

- “The establishment of an orthogeriatric unit. This is the preferred option and the current recommended model of care from the BGS……. high level features in this sort of model are pre op assessment, the potential development of specialist roles such as hip fracture nurses……chances of a discharge home are felt to be optimized using this model “

…..driver that made change a realistic goal



Reallocation of resources 2014 - present

		Outcome
Staff Grade surgeon salary (retiral)	2 Fragility Nurse Practitioners	Appointed. Undertaking independent ward rounds
Staff Grade Surgeon salary (retiral)	P/T Ortho CoE Cons	No applications – 30 Unfilled CoE posts in Scotland
HAN nurse secondment	1 yr to support training	
CoE Staff Grade	Continue to support ward P/T	
Ortho Cons ward round	2 Cons contribute – review all patients in addition to routine cons ward rounds	Ensure regular review
Cons CoE	2 sessions/wk. Support the training and education of the fragility	August – increase to 4 CoE sessions/wk

Aims of the Ward

- Concentrate Hip Fracture Patients in one area
- Dedicated Acute Hip Fracture Ward –a first in Scotland
- Ensure most efficient use CoE input
- Robust ward protocols
  - Delirium
  - Falls
- Establish ward culture that recognises the challenges of hip fracture patient care and supported by relevant protocols
  - Scottish Standards Care acute hip fractures
  - Delirium, Falls, Cognition

Successes

- Proactive medical care
- Reduced LOSx (approximately 7 days)
- Protocol driven management delirium/falls
- Anticipatory Care forms introduced
  - Improved communication out of hours
  - Reduction in futile interventions

Fig. 8.1 Time until geriatric input

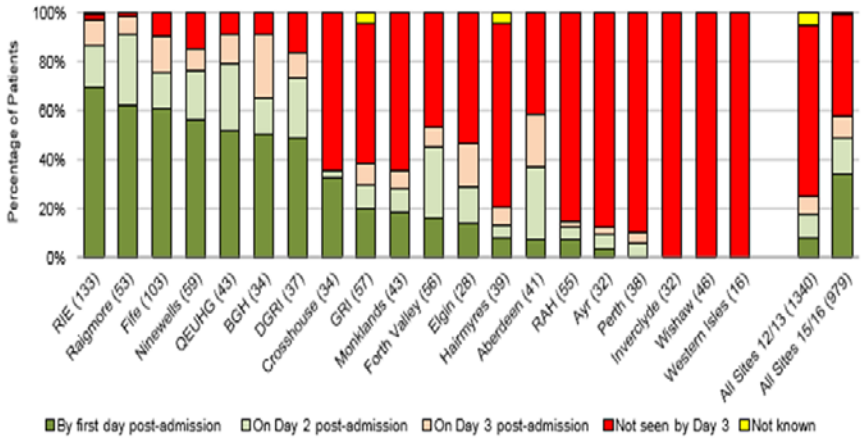
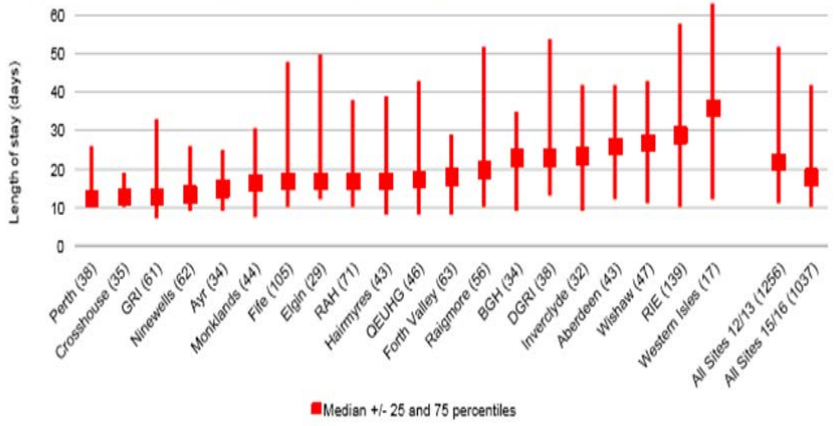


Figure 12.2 Median length of total hospital stay



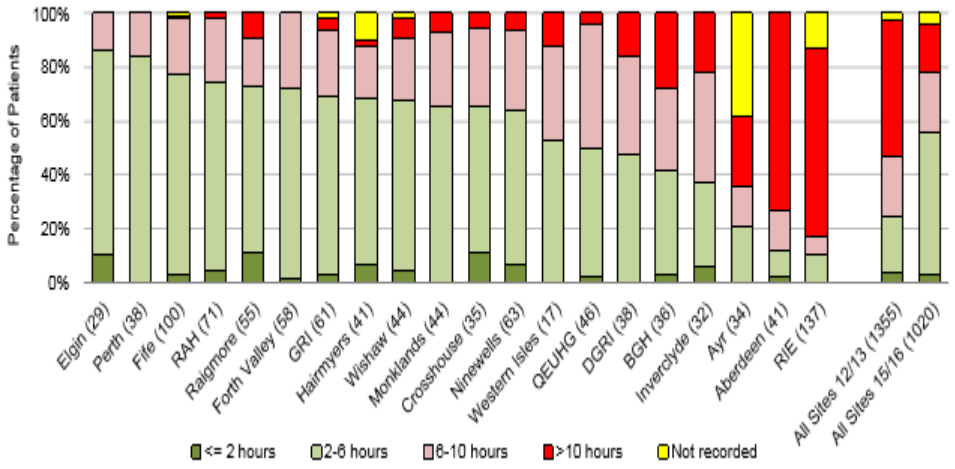
How were improvements achieved

Regular MDT meeting to discuss MSK audit

Staff committed to implement change and look for improvements

Good management relationships

Fig. 5.2 When were clear oral fluids stopped prior to induction of anaesthetic?



An example:

Fasting/Fluids – national problem

- ~~Admission documents~~
- ~~Recording trauma list~~
- ~~Stickers~~
- Golden patient

- Took responsibility from the surgeons
  - OT/PHYSIO ask the question for every hip fracture

Ongoing challenges…..

- Inclusion of all fragility fractures
  - Recent changes to improve access of other fragility fractures
- Priority can still be given to “speciality trauma” over hip fracture
- CoE input assumed by surgical staff
  - Lack engagement with patient management after theatre
- SHDU access – “hypotensive patient” in recovery
  - Reluctance to put patients in SHDU
  - Elevated EWS – DATIX, SBAR, REI, SAER……

Impact changes

Most obvious: Reduction patient bed days

£600 per day
7 day reduction LOSx
400 hip fractures/year

Cost savings: £1,680,000
Patient beds days saved: 2,800
(in acute care)

- Improvements in audited metrics of the MSK audit
  - ED limited engagement
    - Different directorate
    - Different priorities
  - Hip# Tracer condition
    - Reflects how a hospital is working overall

- Softer endpoints (less easily measured)
  - Quality of care
  - Communication
  - Proactive management
  - Anticipatory care

Victim of our own success?

- 46 trauma beds
  - 17/100,000 pop. (Fife)
  - 24.6/100,000 pop. (national)

Trauma occupancy reduced (2800pateitn beds days fewer approx.)

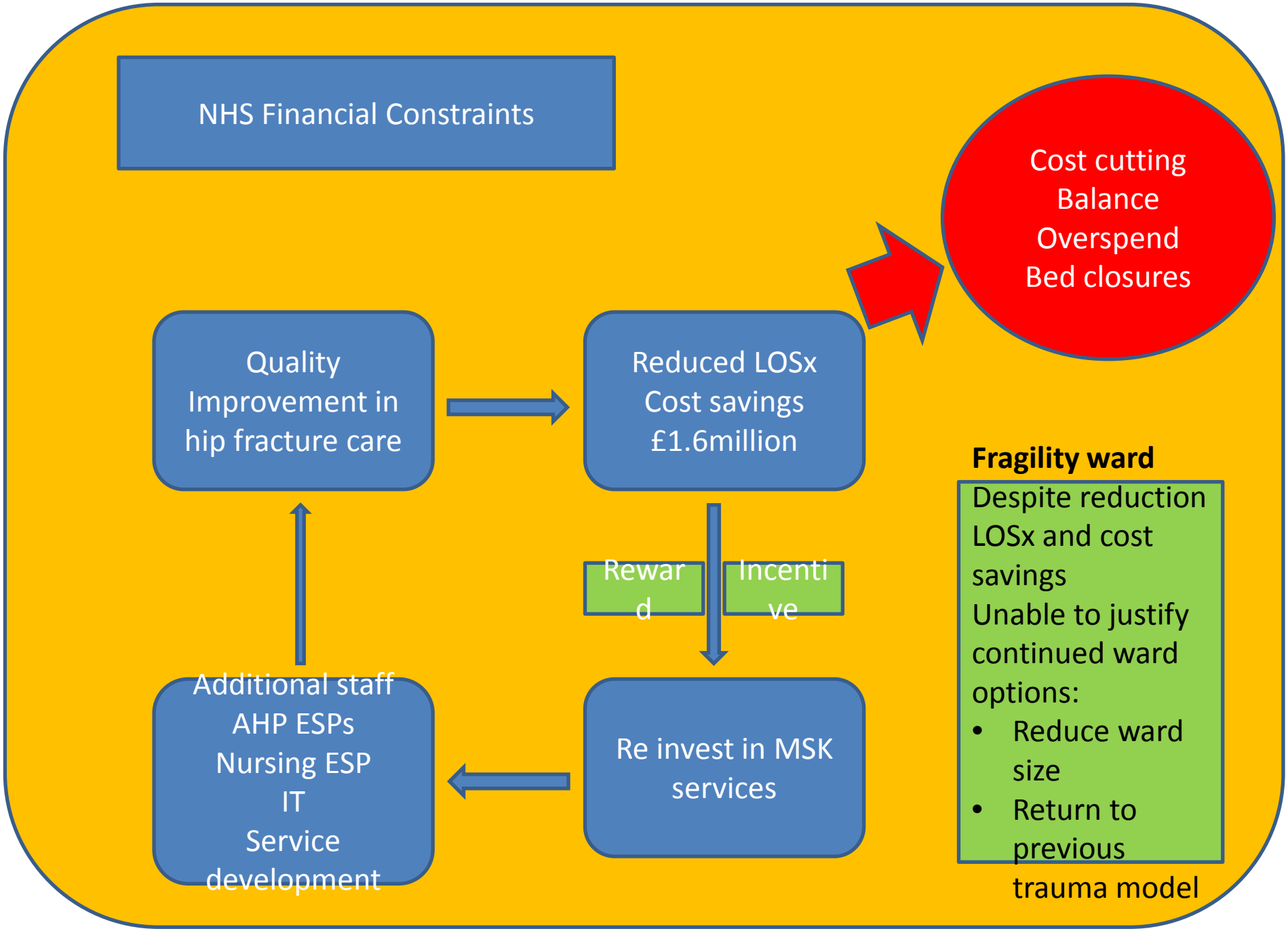
36 trauma beds (Aug 2016)

- Only works if no emergency boarders
- Assumptions based on mean trauma numbers and 100% occupancy

NHS Fife Strategic review

- Increased requirement for fragility fracture care

- Quality improvement
- Reduced LOSx
- Reduce trauma beds
- First 3 weeks of the change bed template we have been allocating significant amounts of consultant/administrative micromanaging trauma admissions.


NHS Financial Constraints
Cost cutting
Balance
Overspend
Bed closures
Quality Improvement in hip fracture care
Reduced LOSx
Cost savings
£1.6million
Reward
Incentive
Re invest in MSK services
Additional staff
AHP ESPs
Nursing ESP
IT
Service development
Fragility ward
Despite reduction LOSx and cost savings
Unable to justify continued ward options:
• Reduce ward size
• Return to previous trauma model

- MSK audit has been hugely effective and positive
  - Other ways of driving change other than financial incentives (NHFA)
  - Continues to improve quality of care
  - Audit must continue and evolve
    - Hip #- tracer condition, increasing rates predicted, resource costly
    - As important as SAP
- Future Directions
  - Look at community care
    - variation in LOSx
  - Develop anticipatory care
    - Reduce futile investigations
  - Which patients should we treat non operatively
  - Audit patients dying with 48hrs theatre?
  - SHDU access?

Thank you

National Osteoporosis Society

Standard 11: Every patient who has a hip fracture should have an assessment of their bone health prior to leaving the acute orthopaedic unit

Mayrine Fraser
National Development Manager, Specialist Nurse Scotland

Rationale:

- A previous fracture will approximately double the risk of a subsequent fracture
- The greatest risk occurs in the first year following a fracture
- Evidence that bisphosphonates and other osteoporosis treatments reduce future fracture risk by up to 50%
- NOS - Every person aged over 50 who breaks a bone is assessed for osteoporosis and managed appropriately.
- SIGN 142 - Patients over 50 with a fragility fracture should be managed within a formal integrated system of care that incorporates a fracture liaison service.

Conclusions:

- Some hospitals appear to assess all hip fractures whereas for some it is less than 50% - even as low as 20%
- Some hospitals look bad but this may be due to lack of documentation rather than lack of assessment
- Bone health assessments/treatments are carried out by a variety of people and vary between hospitals
  - FLS team
  - COTE team
  - Orthopaedics – hip fracture nurse, nurse practitioner
  - Protocol

Conclusions:

- Since 2012/2013 - improvement in people having a bone health assessment before leaving an acute orthopaedic ward
- Significant variation across Scotland
- Some pts have an assessment following discharge – return to FLS clinic
- 75% of hip fracture pts have a bone assessment carried out (may be higher)

Recommendation:

- Every hospital should have systems in place to ensure that each patient with a hip fracture has a bone assessment carried out and relevant treatment started during their acute admission, or soon after discharge, aimed at reducing fracture risk.

Contact information

- Mayrine Fraser
- National Osteoporosis Society
- Camerton
- Bath
- BA2 0PJ

- Tel: 07515 574789
- Email: m.fraser@nos.org.uk
- Website: www.nos.org.uk

- **Free phone Helpline: 0808 800 0035**

Hip # Pathway
&
Social Work

Edinburgh 24th August 2016

Ann Murdoch

Aims

- What do social workers do?
- Is social work relevant in the Hip # MDT?
- Reasons to refer to social work.
- Reasons for specific/dedicated social work in

What is your experience or knowledge of social work?

- For the next couple of minutes please turn to your neighbour and share your thoughts on this question. ☺
- Were your thoughts …. Positive, negative, indifferent?
- Brief feedback!

The Boss!

- *Image of Bruce Springsteen*

Social Work Definition

- ‘The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work”

(British Association of Social Work – BASW - 2001)

Key Points

- “problem solving”
- “Empowerment”
- “enhance well-being”
- “social work intervenes at points where people interact with their environment”

Social Work statutory duties

- Protect vulnerable adults/children at risk from abuse, neglect, accident and self-harm.
- Local Authority social worker's work these statutory duties under various Acts of Parliament;
- Social Work (Scotland) Act 1968
- Children's (Scotland) Act 1995
- Adult Support and Protection (Scotland) 2007
  (Statutory duties & powers to local authorities investigate in cases of suspected harm to adults)
- Social Care [SDS] Scotland Act 2003 (A more person centred assesment promoting greater involvement & choice)

Health Services (& SW) Legal Framework

Health and Social Work are in partnership within this legislation

- National Health Service Act 1972

(obliges Local Authorities to provide a social work service to the health service)

- Chronically Sick & Disabled Person Act (Scotland) 1072

(Placed a duty on Local Authorities to provide services to 'disabled persons')

- NHS & Community Care (Scotland) Act 1990

(Places duty on Local Authority to provide an assessment of care needs. Availability of resources is taken into account when prioritising services)

What can a ‘specific SW’ do for the Hip # Patient

- Meet at point of admission in A&E and commence …
- A psychosocial assessment which would be …
- A ‘holistic’ assessment of the patient involving communication with family, carers, community services and relevant others in conjunction with the MDT assessment and discharge planning.
- This SW assessment identifies issues necessary not only for discharge but ongoing well-being i.e. finance/benefits, housing issues, anxiety & stress relating to the trauma and subsequent treatment, loss of confidence etc.
- Not all these issues may need resolving before discharge but early identification and onward appropriate referral can lead to better outcomes for the patient.

Better Outcomes? … Bruce dancing with an 89 year old!!!

Reason for Referral to a Specialist Orthopaedic Social Worker

- Holistic psychosocial assessment starting at point of admission.
- Immediate liaising with families/carers & community services.
- Working within the MDT for complex discharge planning as well working towards avoiding inappropriate admissions.
- Saving OT & Nursing time.
- More positive outcomes for both patient and NHS if LOS reduction.

Conclusion

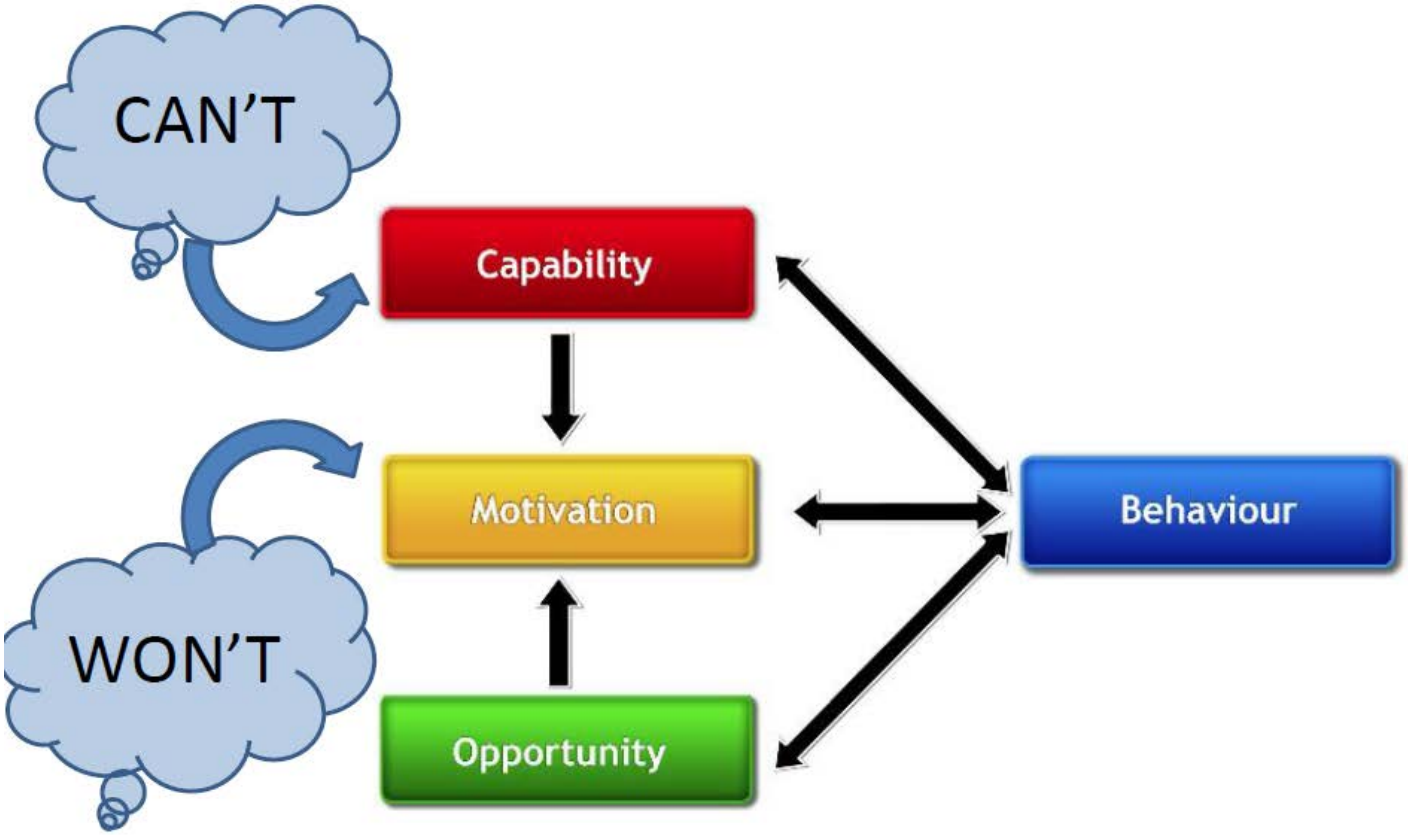
- Specific ‘dedicated’ Orthopaedic social worker’s time should be ‘ring fenced’ for working only with orthopaedic patients.
- A positive addition to the MDT.
- Assisting with complex discharge planning and close liaising with community colleagues & services.
- Improving the patient pathway with holistic assessments which should enhance quality of life and well-being.
- Beneficial for carers & families.

Thank you!

Break The Habit Lanarkshire's Story

Claire Ritchie & Claire Rae

What is the habit ?



The COM-B model, Michie et al (2011)

@sheffielddoc

Adverse consequences of hospital admission

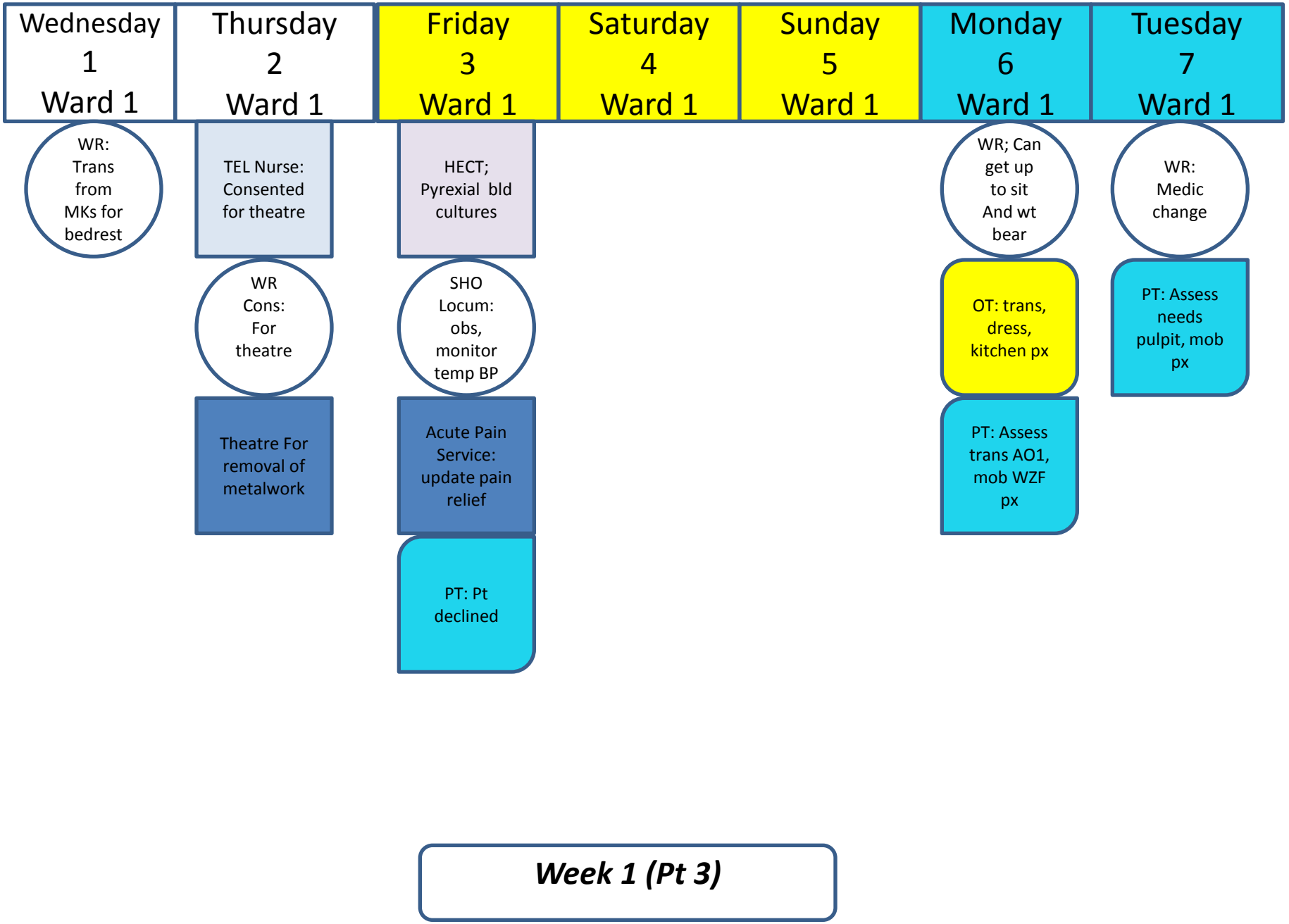
- 12% of patients decline in ADL function between admission and discharge
- Delirium after admission 4-29%
- 500 patients/ year fracture hip in hospital in England and Wales
- Hospital acquired infections (5-10%)
- One or more adverse drug reaction in 19% of inpatients

Patient 3
(Ward 1)

- Miss C is a 69 yr old lady admitted post fall, second stage revision of hip.(THR)
- PMH; MS, Osteoporosis, Hypothyroidism, Depression, IBS, Rt Hip replacement (DHS)
- Pre Admission Barthel: 100, post admission: 45/100
- No services prior to admission, Lives alone, Ramp access, stairlift, previously totally independent.
- No EDD

Observations of Patient 3
Ward 1

- Nurse (137 mins): included direct care delivery, assessments, discussion
- OT: 0 mins
- PT(20 mins): included mobility practice, assessments with pulpit
- Medical staff: (3 mins): discussion around care
- Other staff (28 mins): including domestic/portering staff


Wednesday 1 Ward 1
Thursday 2 Ward 1
Friday 3 Ward 1
Saturday 4 Ward 1
Sunday 5 Ward 1
Monday 6 Ward 1
Tuesday 7 Ward 1
WR: Trans from MKs for bedrest
TEL Nurse: Consented for theatre
WR Cons: For theatre
Theatre For removal of metalwork
HECT; Pyrexial bld cultures
SHO Locum: obs, monitor temp BP
Acute Pain Service: update pain relief
PT: Pt declined
WR; Can get up to sit And wt bear
OT: trans, dress, kitchen px
PT: Assess trans AO1, mob WZF px
WR: Medic change
PT: Assess needs pulpit, mob px
Week 1 (Pt 3)

To Summarise Pt 3
Ward 1

- Miss C was admitted post falls, was in theatre twice once for removal of metalwork and then for DHS insertion
- She was seen by the PT x 33, for transfer, mobility px and gait re-education
- The OT provided input x15 for transfer and dress px and had a kitchen assessment completed
- The HECT saw her on 2 occasions and she was treated for infections
- The Acute Pain Service saw her once post-op
- She was discharged on day 57
- The community OT has provided follow-up and is awaiting equipment/modifications
- This lady could not be contacted for feedback about her stay in hospital

Home First Approach

- Evidence from Sheffield.
- Ethos – Discharge to Assess
- Hospital @Home

Breaking the habit

- NHSL Orthopaedic redesign – 48 bed reduction
- Review of current DC planning
  - –EDD?
  - –Pt centred?
  - –Communication?

Test of change

- EDD day 1
- Minimal goal for DC set
- Pt/carer involved
- MDT Daily board rounds
- Designated DC coordinator/ACE nurse
- 2 x band 4 generic workers

Challenges Along The Way

- Change of work culture/mindset –
- Communication – blurring of roles
- Lack of 7/7 AHP services
- Lack of reablement at ward level
- Community

Results to date

	May - Aug 16	April 15-April16	Improvement	May - Aug 16	April 15-April16	Improvement		
	ALOS			MLOS			Ward	
MK	4.95	6.07	1.12	2	2	0	10	
WG	4.02	6.91	2.89	2	2	0	15	
HM	4.46	9.03	4.57	2	3	1	5	

Plans ahead

- DC plan early ? Day 0
- Reablement focus as a team approach
- Use of Technology for ex prescription
- Acute staff providing sessions in community