Hip Fracture Clinical Care Policy for Multi-Purpose Service (MPS) and Small Hospital Sites

1. Background

The WACHS Hip Fracture Clinical Care Policy has been developed to ensure best practice care for patients with a suspected hip fracture who present to a WACHS Multi-Purpose Site (MPS) or Small Hospital site, and is designed to support the implementation of the Australian Commission on Safety and Quality in Healthcare (ACSQHC) Hip Fracture Clinical Care Standard (September 2016).

2. Policy Statement

The WACHS Hip Fracture Clinical Care Policy for MPS and Small Hospital Sites (WACHS Hip Fracture Clinical Care Policy) will ensure that clinical practitioners and care givers meet the requirements of the Australian Commission on Safety and Quality in Healthcare (ACSQHC) Hip Fracture Clinical Care Standard (September 2016).

The Policy recognises and seeks to consider the specific capacity constraints in terms of infrastructure limitations and site based clinical practice scope.

Capability will differ depending on the size and the remoteness of the site. However, all WACHS sites can actively participate in varying degrees to ensure optimisation of patient status prior to transfer to a Regional Resource Centre (RRC) or Tertiary Hospital and to maximise patient quality of care.

The aim:

- To optimise a patient's pre-transfer and peri-operative condition
- To ensure prompt surgical fixation (operate within 48 hours of admission)

2.1 Decision Making and Clinical Care

A decision-making pathway is provided in Appendix 1 for patients who present to an emergency department (ED) at an MPS site or Small Hospital with a suspected hip fracture.

The clinical care pathway in Appendix 2 provides a clear outline of the practice care guidelines (linked to the Quality Statements outlined in the ACSQHC Hip Fracture Clinical Care Standard), and the documentation and practice points for each stage of the patient journey.

The clinical care pathway considers:

- The need for assessment of contraindications
- Decision to palliate and consultation with family/care/representative

- Assessment by a GP, Resident Medical Officer (RMO) and/or direct communication with Emergency Telehealth Service (ETS) for decision to proceed to assessment for potential surgery
- Transfer and clinical care in transit to the nearest Regional Resource Centre and/or metropolitan tertiary hospital
- Anticoagulation.

2.2 Patient Centred Care and the Role of Carers and Family Members

The role of the patient, family members and carer/s in the decision-making process and clinical care choices is defined as the following:

- The person with the hip fracture should be an active partner in any decisions made in the hip fracture journey
- Family/carers should also be active partners unless the person with the hip fracture does not consent to their involvement
- The person with the hip fracture and their family/carers should be kept informed about the care they receive. Information and advice should be provided verbally as well as in printed form.

Use of professional interpreters is encouraged and printed information should be available in relevant community languages.

2.3 Assessment of Contraindications and Decision to Palliate

In some cases, patients with a suspected hip fracture, may be deemed 'unfit for surgery' based on a series of clinical investigations and ability to control co-morbid conditions and/or for cultural reasons.

At MPS and small hospital sites communication with the GP/ relevant RMO and ETS will assist in this process.

Best practice care requires that patient, family and/or carer are fully informed of the choices regarding the possibility of surgery and the decision to palliate.

3. Definitions

Australian Commission on Safety and Quality in Healthcare (ACSQHC)	Australian Commission on Safety and Quality in Health Care is a government agency which was established by the Commonwealth, with the support of State and Territory government, to lead and coordinate national improvements in safety and quality in health care across Australia.
Australian and New Zealand Hip Fracture Registry	The Australian Hip Fracture Register is a project of the www.anzhfr.org.au and is hosted with the UNSW Medical IT Department to ensure patient data is secure.
Multi-Purpose Service and Small Hospital site	Multi-purpose services and small hospitals typically have fewer than 50 beds, provide many different services and are geographically isolated from larger hospitals.

Regional Resource Centre (RRC)	RRCs generally have the resources to provide a broad range of healthcare including: • emergency care • mental health services • obstetrics • intensive care • paediatrics • geriatric care • rehabilitation.
Tertiary Hospital	• A major hospital that usually has a full complement of services, including paediatrics, obstetrics, general medicine, gynaecology, various branches of surgery and psychiatry or • A specialty hospital dedicated to specific sub-specialty care (paediatric centres, oncology centres, psychiatric hospitals). Patients will often be referred from smaller hospitals to a tertiary hospital for major operations, consultations with sub-specialists and when sophisticated intensive care facilities are required.

4. Roles and Responsibilities

MPS sites and small hospitals have a responsibility to have knowledge and understanding of the entire clinical care pathway to ensure the best possible outcome for the patient.

Regional Medical Directors and Regional Nurse Directors are:

- Responsible for ensuring that all medical and nursing staff involved in provision of care of people who present with a suspected hip fracture have access to this policy and have acknowledged its content
- Accountable for ensuring compliance with this policy

All clinical staff are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be.

5. Compliance

This policy is a mandatory requirement under the *Health Services Quality Improvement Act* 1994 and the *Health Services Act* 2016.

Failure to comply with this policy document may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

6. Evaluation

- Monitoring of compliance with this document is to be carried out by individual sites and regions.
- Audit of number of admitted patients who are placed on an appropriate care pathway for fractured neck of femur.
- Sites can use the clinical indicators in the Hip Fracture Clinical Care Standard to monitor implementation against the quality statements.
- Benchmarking can occur at individual sites against the Australian and New Zealand Hip Fracture Registry (ANZHFR)

7. Standards

National Safety and Quality Health Service Standards

Clinical Governance Standard: 1.1, 1.3, 1.6, 1.8, 1.10 and 1.27

Partnering with Consumers Standard: 2.4, 2.5, 2.6, 2.7 and 2.10

Comprehensive Care Standard: 5.2, 5.3, 5.4, 5.5, 5.6, 5.7, 5.9, 5.10, 5.11, 5.12, 5.13, 5.15, 5.16 and 5.20

Communicating for Safety Standards: 6.4, 6.5, 6.7, 6.8, 6.9, 6.10 and 6.11

Recognising and Responding to Acute Deterioration Standard: 8.3, 8.4, 8.5, 8.6, 8.7, 8.8, 8.9, 8.10, 8.11 and 8.13

Aged Care Quality Standards – 1, 2, 3, 6, 7, 8

8. Legislation

Health Services Quality Improvement Act 1994 (WA)
Health Services Act 2016 (WA)

9. References

- Australian Commission on Safety and Quality in Health Care - Hip Fracture Clinical Care Standard – Sydney, ACSQHC, 2016.
- Australian and New Zealand College of Anaesthetists (ANZCA). Position Statement on the use of slow-release of opioid preparations in the treatment of acute pain (March 2018).
- Australian and New Zealand Hip Fracture Registry (ANZHFR) Steering Group. Australian and New Zealand Guideline for Hip Fracture Care: Improving Outcomes in Hip Fracture Management of Adults. Sydney: Australian and New Zealand Hip Fracture Registry Steering Group (2014).
- Australian and New Zealand Hip Fracture Registry (ANZHFR) Annual Report for Hip Fracture Care 2016 (July 2018).
- WA Health Clinical Services Framework 2014-2024. Perth: Department of Health, Western Australia 2014.

10. Related Forms

MR1 WACHS Emergency Department Notes
MR124 WACHS Braden Scale and Pressure Injury Risk Assessment
MR124B Comprehensive Skin Assessment
MR140A Adult Observation and Response Chart (A-ORC)
MR170.1 Medication History and Management Plan
MR171 WA Hospital Medication Chart – Adult Long Stay
MR184 WACHS Inter-Hospital Clinical Handover Form
MR521 WACHS Falls Risk Assessment and Management Plan (FRAMP)
MR60.1.8 WACHS Mini Nutrition Assessment - Short Form (MNASF)
MR66.17 WACHS 4A Test Rapid Assessment Test for Delirium

11. Related Policy Documents

WACHS Clinical Observations and Assessments Clinical Practice Standard
WACHS Cognitive Impairment Clinical Practice Standard
WACHS Documentation Clinical Practice Standard
WACHS Interhospital Transfer Envelope Checklist
WACHS Pressure Injury Prevention and Management Policy

12. Related WA Health System Policies

MP 0015/16 Information Access, Use and Disclosure Policy
MP 0095 Clinical Handover Policy
MP 0086/18 Recognising and Responding to Acute Deterioration Policy MP 0086/18
OD 0657/16 Consent to Treatment Policy

13. Policy Framework

Clinical Governance Safety and Quality
Clinical Services Framework 2014-2024

14. Appendices

Appendix 1: Decision - Making Pathway – Fractured Neck of Femur
Appendix 2: Clinical Care Pathway – the Patient Journey

This document can be made available in alternative formats on request for a person with a disability

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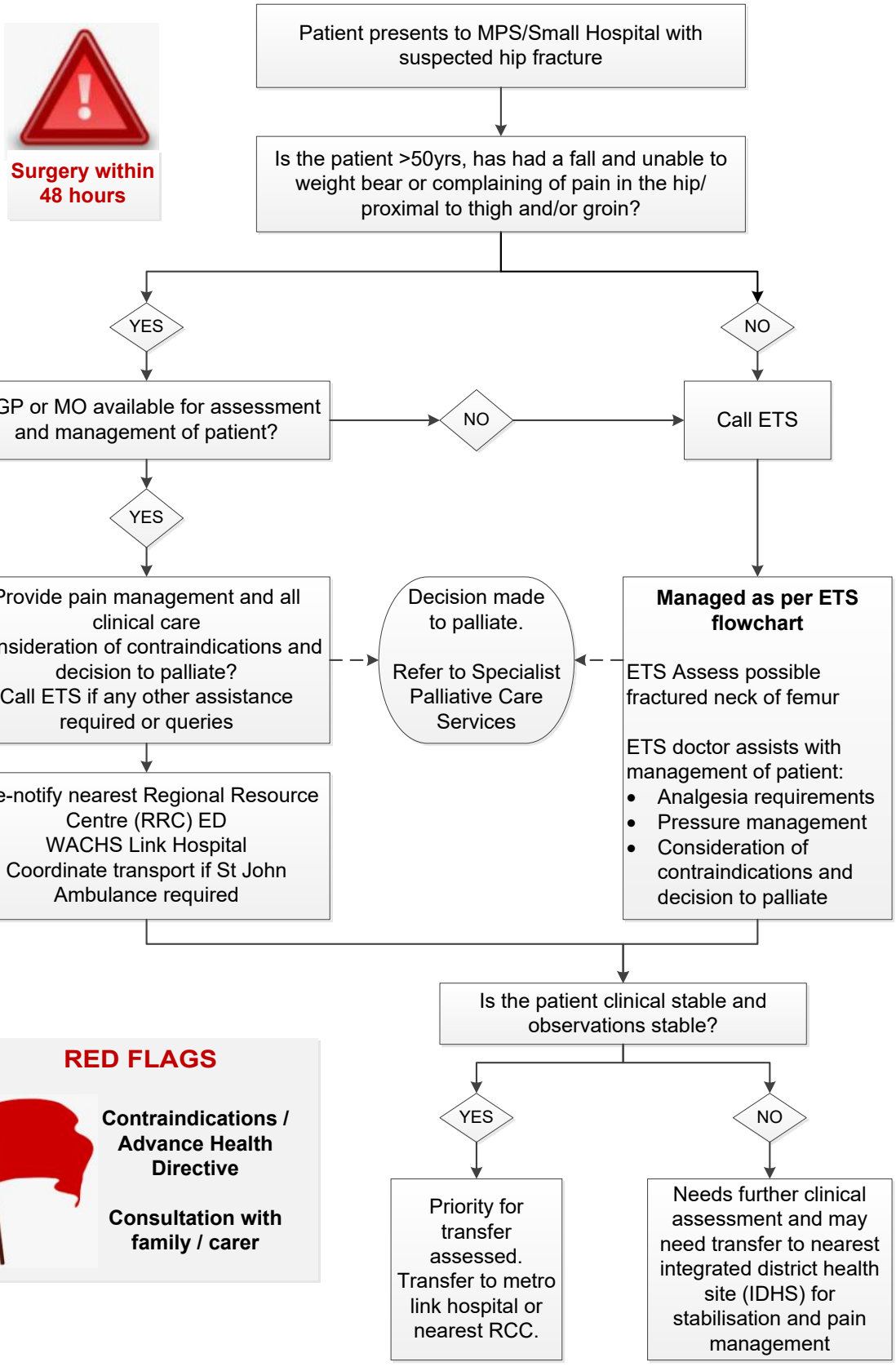
Appendix 1: Decision - Making Pathway - Fracture Neck of Femur



Appendix 2: Clinical Care Pathway – the Patient Journey

PATIENT JOURNEY	WACHS PRACTICE CARE GUIDELINES	DOCUMENTATION and PRACTICE POINTS	SERVICE ROLE (for non-tertiary hospitals)
PRESENTATION	**TIMELY DIAGNOSIS (Quality Statement 1)**	• Can patient weight bear? • Examine for passive external rotation of the leg. • Examine for leg shortening. • Assess for medical reason for the fall. • Assess for any associated injuries. Note: MPS sites unlikely to confirm diagnosis with x-ray	**ACTIVE GP/MO on-call ETS**
	PAIN ASSESSMENT and PAIN RELIEF (Quality Statement 2)	Pain should be assessed immediately and pain relief administered immediately. Paracetamol regime to be commenced. If attended by a paramedic, patient will be given initial analgesia.	**ACTIVE**
	PAIN MANAGEMENT (Quality Statement 2)	Elderly patients are very susceptible to the side effects of narcotic analgesia (e.g. sedation, delirium, constipation etc.). Commence with a low dose, short acting narcotic (e.g.: endone 2.5 – 5 mg pm).[2,3] Oral analgesia: Paracetamol every 6 hours with additional opioids if required and if not contra-indicated. Caution is advised when considering the use of non-steroid anti-inflammatory drugs. Opioid analgesia: should not be withheld at the expense of inadequate pain relief if required by patient. Femoral Nerve Block under ultrasound guidance if within scope of practice (This is first choice if possible).	**ACTIVE for oral analgesia**
PRE-TRANSFER	**COGNITIVE ASSESSMENT (Quality Statement 1)**	All patients with a hip fracture should have a cognitive assessment. AMT 4 Sticker; WACHS Cognitive Impairment Flowchart; WACHS Cognitive Impairment CPS	**ACTIVE**
	DELIRIUM ASSESSMENT AND MANAGEMENT (Quality Statement 1 and Quality Statement 5)	Patients with a hip fracture are at a high risk of delirium. Potentially reversible causes should be looked for and treated accordingly. Clinical escalation if indicated from AMT 4 Non-pharmacological measures should always be first line management: • Maintain low level sensory stimulation	**ACTIVE**

PATIENT JOURNEY	WACHS PRACTICE CARE GUIDELINES	DOCUMENTATION and PRACTICE POINTS	SERVICE ROLE (for non-tertiary hospitals)
		• Single room if possible • Staff to calmly engage, distract and supervise the patient • Avoid confrontation • Consider 1:1 companion • Encourage family to stay and assist.	
	NUTRITION ASSESSMENT (Quality Statement 3)	All patients with a hip fracture are to have a nutrition assessment completed.[5]	**ACTIVE**
	GOALS OF CARE (Quality Statement 3)	All patients with a hip fracture should have "Goals of Care" discussion. This should include discussion on resuscitation status and limitations of treatment and documented in patient's health record.	**ACTIVE**
	BOWEL MANAGEMENT (Quality Statement 3)	All patients that are prescribed narcotic analgesia must have regular aperients prescribed. (Note: this is considered Best Practice, however bowel prep pre-operatively is considered too painful for the patient so should be managed post-operatively)	**ACTIVE**
	BLADDER MANAGEMENT (Quality Statement 3)	Patients with a hip fracture are NOT to receive indwelling urinary catheter unless clinically indicated or if long transfer journey. Patients should have 4 – 6 hourly bladder scans and IMCs as required to prevent urinary retention.	**ACTIVE**
	PRESSURE CARE (Quality Statement 1)	Pressure injury risk screening and assessment to be undertaken and documented as soon as possible.	**ACTIVE**
	CLINICAL OBSERVATIONS (Quality Statement 3)	Blood Pressure; fluid management; oxygen therapy (Clinical Observations and Assessment Clinical Practice Standard)	**ACTIVE**
TRANSFER	**MANAGEMEN OF CO-MORBIDITIES (Quality Statement 4)**	If patient on blood thinners consider time to theatre: Warfarin Reversal – may have to withhold doses if for surgery Bridging Anti-coagulation Direct oral anti-coagulation management Venous Thromboembolism (VTE) Prophylaxis	**ACTIVE**
	DECISION TO TRANSFER (Quality Statement 4)	Time to surgery within 48 hours. Communication processes and transport providers in place to expedite transfer for surgery to occur within 48 hours.	**ACTIVE**

PATIENT JOURNEY	WACHS PRACTICE CARE GUIDELINES	DOCUMENTATION and PRACTICE POINTS	SERVICE ROLE (for non-tertiary hospitals)
		Conservative: Palliative Care	