Hip Fracture
An information guide
Hip Fracture

Introduction
Hip Fractures – What are they?
Fractures occur to the upper of the end thigh bone (femur). This is usually associated with a fall and can indicate thinning of the bone which is called osteoporosis.

The types of fractures are:
- across the neck – intracapsular (1)
- in between two bony prominences – intertrochanteric (2)
- below the neck – subtrochanteric (3).

The treatment for each is slightly different due to the blood supply to the area affected.

Undisplaced intracapsular fractures require fixation with screws or a pin and plate (dynamic hip screw).

Displaced intracapsular fractures require replacement in the form of half a hip replacement (hemiarthroplasty) or a full hip replacement.

Intertrochanteric fractures require a pin and plate (dynamic hip screw) or a nail in the middle of the bone (cephalomedullary nail).
Subtrochanteric fractures require a nail in the middle of the bone (cephalomedullary nail) or pin and plate fixation.

**Do I need to have an operation?**

If you sustain a hip fracture and do not have an operation you will require bed rest for 6-8 weeks in order for the fracture to heal enough to get you out of bed. This increases your risks of what we term “decubitus complications”. These include conditions such as: chest infections, water (urinary) infection, pressure sores, blood clots in the veins of the leg or lung and other conditions. Medical and surgical doctors agree that if we can get our patients as stable as possible with their pre-existing medical conditions then an operation allows for pain free mobilisation and reduces the risks of these complications which are associated with a high risk of death.

**Operation**

**What will happen before my operation?**

After you are admitted via Accident and Emergency (or the ward) you will be admitted to the Trauma Unit as soon as a bed is available. The doctors will obtain a detailed history, carry out an examination and the nurses will perform assessments for your planned care. You will have blood tests, heart tracings (ECG) and other tests such as a chest xray if required. You will be prescribed pain killers and fluids to maintain hydration and will be started on anti-thrombosis (blood clot) medication in the form of an injection.

Once you are stable the doctors will discuss the diagnosis and the most appropriate treatment with you. They will ask you to sign a “consent form” saying that you agree to have the operation and it has been explained to you. This can also be discussed with your relatives/carers if you wish and any questions will be answered.

The consultant surgeon whose care you will be under will meet you on the following day’s morning ward round.
What anaesthetic will I have?

Provided you are medically stable, we aim to perform your operation within 36 hours of your admission depending on available surgeons and theatre space.

The anaesthetist will visit you before your operation to discuss what sort of anaesthetic is the most suitable for you and to answer any questions you may have. They may also talk to your close family if you wish. If there are particular risks associated with the anaesthetic, then the anaesthetist will discuss this with you.

It is common to perform hip fracture surgery under a spinal anaesthetic. This involves an injection in your back which numbs your hips and legs. With this sort of anaesthetic you might be awake or given medication to feel drowsy (sedation) for your surgery.

It is also common to have a general anaesthetic, where you are completely asleep for the surgery. The anaesthetist will discuss these options with you, before deciding on which is the most suitable option for you.

You may also receive a nerve block from the anaesthetist to help with the pain relief after surgery. Some patients may also require a blood transfusion during or after their operation if their blood count becomes low (anaemia).

What happens when I am taken to theatre?

You will be escorted from the ward with a staff member. In the reception area of the theatre complex you will asked a few questions and several check lists are completed for your safety. You will be asked to confirm what you are having done. Once the theatre is ready you will be taken to the anaesthetic room to be anaesthetised. You will be placed on monitors for your heart and breathing and may require another drip to be placed in your arm. Everything will be explained to you as it happens.
Spinal anaesthetic is an injection in the spine which makes your legs heavy with no sensation. If the anaesthetist feels that sedation would be helpful, this will be offered to you. Sedation will make you drowsy but allow you to breathe for yourself.

If you have a general anaesthetic, you will be fully asleep and have a tube in your airway to allow you to breathe.

Once you are fully anaesthetised you will be transferred to the theatre and onto the theatre table.

What happens after the operation?

Once your surgery is finished, you will be taken in your bed to the recovery area. You will be nursed on this unit until you are stable from the operation and your pain is well controlled. When you have recovered sufficiently the ward staff will come and take you back to the trauma ward.

If you have been unwell or unstable during the operation you may need a higher area of care such as the high dependency unit or intensive care.

You will be allowed to rest, your observations will be regularly monitored and you will be provided with pain killers, fluids and food when you are ready to eat. You will be started on blood thinning medicine to prevent a blood clot and gentle laxatives as constipation is very common after such an injury and with taking strong pain killers.
Post-Operative Care
What should I expect in the post-operative period?

Day 1 – if you are well enough you will be assisted out of bed by the ward staff or physiotherapists. You will be shown some exercises to perform and will have a formal physiotherapy session at your bedside. Blood tests will be taken and an X-ray will be ordered if required. You will be encouraged to walk for a few steps around your bed under supervision using a zimmer frame.

Day 2 – ongoing rehabilitation will be encouraged with physiotherapy and occupational therapy input. Exercises will be shown to you and worksheets provided.

Day 3-4 – most patients are medically stable by this stage. If fit enough and you need some more rehabilitation you will be assessed for intermediate care. If you have some minor medical issues requiring review you will be assessed for inpatient rehabilitation at North Manchester General or ward 18 at Fairfield General Hospital. Social work assessment will be performed to ensure you have appropriate care in the home setting.

Will I make a full recovery?

Suffering with a hip fracture is a serious condition particularly in elderly frail patients. Many patients will regain their independence to a certain level. Some patients will require care and help in coping with their activities of daily living and may have an element of reduced mobility afterwards.

How long will I be in hospital?

Recovery after a hip fracture is a very personal thing. Some patients recover very quickly and regain mobility early. However, if you have other medical problems you may require a longer time to regain confidence and strength to rehabilitate from this injury. In patients with good pre-injury level of independence we estimate 7 days; if we estimate a longer period then we refer patients early to social
workers and rehabilitation, to allow patients to be discharged within approximately 14 days after admission from the acute ward.

**Where will I be discharged to?**

A full social work, physiotherapy and occupational therapy review will have been performed to assess the best type of care for you to progress to. We will not transfer you home until it is safe to do so. Some patients will require a period of time at an Intermediate Care Centre. Here you will have your own room and will be encouraged to mobilise and care for yourself with help at hand if required. Some patients will be admitted to a care home for a period of time. If you were admitted from a nursing home you will be transferred back there when medically stable.

**Will I have stitches that need taking out?**

You will have either metal clips or stitches that require removal 12-14 days after the operation. This will be arranged for you if you have already been discharged from the hospital.

**How can I reduce the risk of a blood clot?**

Compression stockings will be provided if your skin is in good condition and should be worn for 6 weeks. You will also have clexane blood thinning injections for four weeks in total after the operation. If you have had a previous blood clot in the leg or lung you may require warfarin treatment for 3-6 months.

**Will I be reviewed in clinic?**

The department arranges follow-up for fractures according to their treatment and this will be arranged prior to your discharge. The majority of patients who have had fixation of the fracture will be reviewed in fracture clinic at 3 months. Patients not requiring a formal clinic appointment and patients having a hemiarthroplasty (see page 3 for explanation) will be followed up by telephone consultation with the Trauma Nurse. Some patients may receive an earlier appointment if the team of doctors request this. Patients
having a total hip replacement will be followed up as per individual surgeon protocol.

**When can I drive again?**

Usually after 6 weeks. Ensure you can perform an emergency stop and inform your insurance company of your injury prior to driving again.

**Ward information**

On admission to the ward you will be introduced to the different staff members. The team looking after you wear uniforms with the nurses in blue, healthcare assistants in purple, physiotherapists in blue trousers and occupational therapists in green trousers. You will meet various team members during your admission at different stages.

The ward usually has a female and a male bay with separate toilets. There are side rooms that are either sex.

**Mealtimes are protected and are between 12:00-13:00 and 17:00-18:00 on all wards.**

Visiting times for relatives in all hospitals is open, however we ask if you can avoid mornings and mealtimes as noted above and to vacate at about 20:00.

We suggest that only children over 12 years should visit.
Rehabilitation – Physiotherapy, Occupational Therapy

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

A hip fracture can be a life changing event. Few patients return to their usual ability and there can be long term mobility issues. This can be due to muscle or ligament damage as a result of the fracture.

Hip fractures tend to occur in people who have several medical conditions or are otherwise frail. The effects of these conditions or the overall frailty can affect your overall recovery.

How will I get back on my feet again?

We will try to get you out of bed on the day or the day after the operation. You will be advised on bed exercises to perform to strengthen the muscles around the hip. Getting up sooner helps to reduce the risks of complications that can occur from lying in bed too long.

In some fractures the surgeon may restrict how much weight you can put on your hip until the bone heals.

What exercises will I do?

The physiotherapists, occupational therapists and the nurses will help you to regain your confidence and ability in walking and you will have plenty of supervised practise. We encourage patients to walk to the bathroom when possible with supervision if required.

What help will I have with rehabilitation?

Getting back to a normal life is a very personal experience. Some people need more time than others. You are the key person in promoting your return to your usual ability. You may find it helpful to set small goals, gradually increasing the amount you do each day. Within the ward the physiotherapists, occupational therapists and nurses will support your progress.

We will encourage you to start putting your clothes on as soon as you are able to sit out again. Please ensure that your relatives/
friends bring some loose fitting day clothes. There is no personal laundry service on the ward.

Some patients will be able to return home with the support of the local community rehabilitation team and/or carers. There may be a small charge for carer support. The team will continue rehabilitation in your own home or in the outpatient setting.

The home team can help with washing and dressing until you are more independent and can arrange for meals to be delivered until you are able to manage again.

Other patients may need a period of hospital rehabilitation which may be at a different hospital from admission. There are some rehabilitation facilities in the community setting called intermediate care.

In order to avoid delay in returning home we assess the help you may need at discharge soon after you are admitted.

The occupational therapists (OT) need to know information on heights of your furniture at home and your family/friends will be given paperwork to complete, particularly in the case of hemiarthroplasty or total hip replacement patients. If your furniture is at the correct height there is less chance your hip will dislocate. If they are not at the correct height the OT can arrange for adaptive equipment to be delivered.

The team of nurses and therapists will assess your progress daily and advise you and your family at an early stage how long you are likely to be in hospital.
How can I protect my hip after a hemiarthroplasty or a total hip replacement?

To reduce the risk of dislocation we advise:

• avoid crossing your legs, in bed try to sleep on your back with a pillow between your knees
• avoid more than 90 degree bend at the hip e.g. reaching below your knees. You may need furniture adaptation’s or equipment for reaching
• avoid twisting at the waist – turn around completely instead.

How should I get in and out of my car?

• get in from the road rather than the pavement
• sit in the front passenger seat and recline it. Position a cushion on it.
• slide the seat as far back as it can go
• get in bottom first keeping the operated leg straight in front of you and lift both legs in together if you can
• reposition the seat to semi reclined
• perform this in reverse for getting out of the car.

Orthogeriatrics Assessment

You will be seen by a doctor from the Orthogeriatrics Team. They will do 3 things:

• sort out any medical problems
• do an assessment of why you fell and whether there is anything that can be done to reduce the risk of falls in the future. This may include changing some of your medication.
• do a Vitamin D and bone strength (osteoporosis) assessment. There is more information about this in the next paragraphs.
Vitamin D

• vitamin D is important for healthy bones
• your vitamin D levels will be measured
• you will be given treatment with vitamin D and calcium
• if you required big doses of vitamin D, we will write to you a month later to have your calcium level checked.

DXA Scans

This scan will give some indication of the strength of your bones. It involves taking a special type of x-ray in the radiology department.

• women over 75 years old will usually be started on osteoporosis (bone strengthening) treatment without the need for a DXA scan
• other patients will need to have a DXA scan first. (Unless they are very frail and there would be problems getting them on and off the DXA scan table)

• DXA scans are done at the Royal Oldham Hospital
• DXA scans are done approximately 3 months after any surgery for a hip fracture

• you will receive a letter through the post from the Royal Oldham Hospital about your DXA scan appointment. If this does not happen, please contact Dr Gibson’s secretary on 0161 720 2789 for North Manchester or Dr Parikh’s secretary on 0161 627 8480 for Royal Oldham

• after your DXA scan you should receive a letter from Dr Gibson/Dr Parikh with the result. This letter will also tell you whether you are likely to benefit from treatment for osteoporosis. If this does not happen, please contact the relevant secretary.
Bone strengthening treatments for osteoporosis
There are treatments which can significantly reduce the risk of you having a broken bone (fracture) in the future.

There are 3 main treatments available. These are:

• once weekly tablet (called Alendronic Acid or Fossamax)
• once a year intravenous infusion (called Zoledronic Acid) for 5 years. This is usually used for people with heartburn
• twice a year injection under the skin (called Denosumab). This is usually used for people whose kidneys do not function well enough for the other treatments.

The orthogeriatrics doctors will decide which treatment is the most appropriate for you.

The treatments will be discussed with you first (particularly the intravenous infusion and injection under the skin).

Letters
We will send you copies of the letters that we send to your GP.

If you have any suggestions about how we can improve our communication (including letters) with patients please let us know.
Contact information
If you have any questions or concerns please contact:

**North Manchester General Hospital**
Alison Clarke – Trauma co-ordinator and NOF link nurse - 0161 625 8285
Ward I5 - 0161 720 2552 / 0161 922 3392
TASU - 0161 778 5256
Dr Gibson secretary - 0161 720 2789

**Royal Oldham Hospital**
Julie Walton/Amanda Woodall - Trauma Co-ordinators and NOF link nurses – 0161 778 5833
Ward T7 – 0161 778 5825
Dr Parikh’s Secretary – 0161 627 8480

**Other information**

Patient Advice & Liaison Service - PALS - 0161 604 5897
NHFD website - http://www.nhfd.co.uk
If English is not your first language and you need help, please contact the Ethnic Health Team on 0161 627 8770

Jeżeli angielski nie jest twoim pierwszym językiem i potrzebujesz pomocy proszę skontaktować się z załogą Ethnic Health pod numerem telefonu 0161 627 8770

For general enquiries please contact the Patient Advice and Liaison Service (PALS) on 0161 604 5897

For enquiries regarding clinic appointments, clinical care and treatment please contact 0161 624 0420 and the Switchboard Operator will put you through to the correct department / service

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