Tameside and Glossop Integrated Care NHS Foundation Trust

Enhanced Recovery Programme

Trauma & Orthopaedics – Hip Fracture

Hip Fracture – Hemiarthroplasty or Total Hip Replacement

Patient information Leaflet

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Date : August 2018

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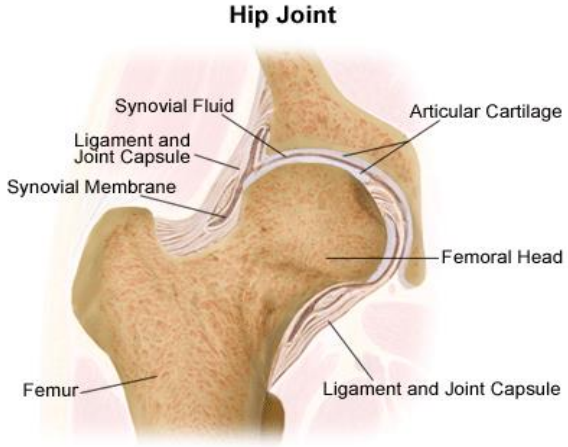
Introduction

Over 70000 people in the UK suffer a fracture of the hip region every year. Hip fractures are most common in women, and are usually the result of a fall.

The hip joint is a ball and socket joint. The ball is the head of the femur (at the top of the thigh bone) and the socket (acetabulum) is part of the pelvis. The joint is held together by a capsule, which also produces a fluid that lubricates the joint and facilitates movement.



Lesser trochanter

A hip fracture is a crack or break in the bone between the top edge of the femoral head, and up to 5cm below the lesser trochanter.

Most people with a hip fracture need an operation to fix it. The aim of the operation is to reduce the fracture, align the bone fragments and hold them together in the correct position. The type of fracture you have and its exact location will determine what operation you need (see pages 7 and 8 for more information about the types of fracture and the different operations).

Diagnosing your Hip Fracture

A suspected hip fracture is usually confirmed using x-rays. If the x-rays show nothing abnormal but your healthcare team remain concerned, you may be offered a magnetic resonance imaging (MRI) scan or computed tomography (CT) scan to confirm the fracture.

The Enhanced Recovery Programme

The Enhanced Recovery Programme aims to improve the experience and wellbeing of people who require surgery. The Enhanced Recovery promotes your health and wellbeing helping you to return to normal as soon as possible.

There is a great deal of research available on Enhanced Recovery After Surgery, which states that the sooner you get out of bed, begin to walk and start eating and drinking, the quicker the recovery.

With this new approach to care, recovery after surgery is more comfortable, easier and happens more quickly.

This approach involves:

- Pre-operative advice and information
- Carbohydrate rich drinks before surgery
- Tailored postoperative pain relief
- Early feeding after surgery
- Early walking after surgery

These elements speed up recovery and reduce the possibility of complications such as chest infections and muscle wastage.

The Enhanced Recovery aims where possible to ensure patients are involved in their own care.

We ask that you play an active role in your recovery and work in partnership with all of the orthopaedic team to achieve this.

Staff involved

The Enhanced Recovery programme focuses on providing the highest quality care using a multidisiplinary approach, which means you may receive input and care from several different members of staff throughout your stay, for example:

- Your Consultant and his team of Doctors
- Anaesthetist
- Theatre/Recovery Nurse
- Physiotherapist
- Occupational Therapist
- Ward Staff (Manager/Sister/Staff Nurses/Auxillaries)
- Casualty Staff (Doctors and Nurses)
- Discharge Co-ordinator
- Dietician
- Pain Team
- The Enhanced Recovery Team

The Emergency Orthopaedic Unit

The Emergency Orthopaedic Unit accommodates patients undergoing emergency orthopaedic procedures. Male and female patients are nursed in separate areas.

The visiting times are 1pm to 4pm and 6pm to 8:30pm every day. The ward has a quiet period every day after lunch to allow patients to rest and so is closed to visitors during this time.

Please nominate one person to ring the ward with any enquiries as answering multiple phone calls greatly impacts on time Nurses could spend with patients. Please advise your family members that specific details of your condition cannot be discussed over the telephone.

Please try and have the following items brought in for you:

- medications in their original packaging if possible
- day clothes- practical shoes/slippers which must have backs. Comfortable, loose clothing is recommended whilst in hospital- shorts, tracksuits or comfortable skirts are ideal
- Nightclothes, dressing gown and slippers (practical and well fitting, mule type slippers are **not** safe for walking around the ward after your operation)
- Toiletries and towels (please note there are no facilities for washing patient's belongings in the hospital)

We adivse that expensive jewellery, personal belongings and large amounts of money are NOT kept in hospital. We suggest that patients keep no more than £10 with them at any one time.

You will be able to eat normally up to 6 hours before your operation and be allowed clear fluids up to 2 hours before surgery, unless otherwise directed. Clear fluids means water/black tea or coffee or cordial ***no milky drinks are allowed***.

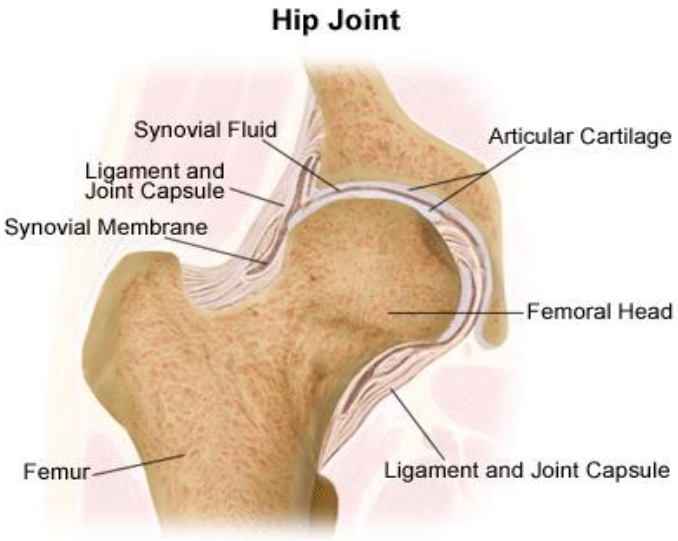
Organisation of your care

Whilst on the ward/unit you will be looked after by a multi-disciplinery team of healthcare professionals, including: Orthopaedic Drs/surgeons, Ortho-geriatrician/medical Dr, Nurses, Physiotherapists, Occupational therapists and if appropriate: social workers, dieticians, mental health liaison, pharmacists.

They will regularly assess your medical needs, abilities and circumstances; and will get you as well as possible both before and after your surgery.

Anatomy of the Hip

The hip joint is known as a ball and socket joint. The ball or 'head' is found at the top of the femur or 'thigh bone', and fits into the acetabulum or the socket of your pelvis. To keep the hip joint stable it is surrounded by a very tough capsule, which also produces synovial fluid which lubricates the joint and aids movement.



What is a Hip Fracture?

A hip fracture occurs when the hip breaks, this can occur in different parts of the hip joint or femur.

Intracapsular – This is when the fracture occurs within the joints capsule itself e.g. Head of the femur**.**

Extracapsular – This is where the break occurs outside the capsule e.g.Shaft of femur.

Non-displaced – This is where the broken bones have not moved and remain in the correct position.

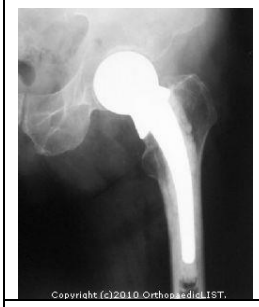
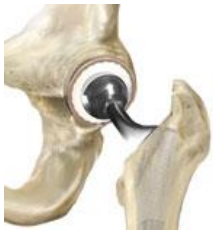
Displaced – This is where the broken bones have moved and need to be put back into the right position.

Treating a Hip Fracture

If you need an operation we aim to do this as soon after your admission as possible. The Dr/Surgeon will talk to you about your operation and you will be asked to sign a consent form to confirm you agree to the surgery and understand what the Surgeon is planning to do.

Types of Operation

Your hip will be fixed using one of the following operations:

Name of Surgery	***What it involves***	***Type of fracture it treats***
Hemiarthroplasty (Half a hip replacement) 	This surgery replaces the broken part of the hip joint i.e. the head of femur, with a metal one.	Most displaced intracapsular fractures.
Total Hip Replacement 	This surgery replaces both the ball and the socket of the hip joint are replaced with artificial parts.	Displaced intracapsular fractures; suitable for patients who were very fit and active before the fracture and who are well enough to have the operation

Diet and Pre Load

Research shows that if you are well nourished and hydrated before and after your surgery you will have a recovery more quickly. It is therefore important to try to eat as normally as possible up until your surgery. You will be able to eat normally up to 6 hours before your operation and be allowed clear fluids up to 2 hours before surgery, unless otherwise directed.

Pre Load is a carbohydrate powder which is given to you 2 hours prior to your operation. It is used to prevent dehydration and tiredness/weakness and can help you recover quicker. It has a neutral taste when diluted in water.

After your surgery you should eat and drink as soon as you feel able, and try to continue to eat as normally as possible. This will help you in your recovery. If you have difficulty eating the nurses will monitor your intake, and refer you to a dietician.

Analgesia/pain relief

Before Surgery

You will be offered a local anaesthetic injection which is given in your groin on the side of your injury,which should help to reduce your pain for up to 24 hours and can be repeated as necessary until you attend theatre. You will aslo be prescribed regular medication to control the pain, which will be prescribed according to your requirements. It is important

that you inform staff if you are experiencing pain, which is not relieved by the medication provided. Severe pain on rare occasions could indicate a change in your condition and therefore should be reported to staff.

During and after Surgery
The majority of patients undergoing orthopaedic surgery, will receive either a general anaesthetic or sedation with a spinal to help ensure your pain is controlled during and following your surgery. An anaesthetist may see you prior to your operation to discuss the best option for you.

What Is A Spinal?
A local anaesthetic drug is injected through a needle into the small of your back to numb the nerves that supply the lower half of your body for a few hours.

How Is A Spinal Performed?
1. Your anaesthetist will ideally discuss the procedure with you, before your surgery.
2. You will meet an anaesthetic nurse who will stay with you throughout your time in theatre. They will assist you when getting into the correct position for the spinal. You will be asked to either sit upright on a trolley with your feet on a stool or lie on your side, curled up with your knees tucked up towards your chest. In both cases the nurse will support you and reassure you during the spinal.
3. The anaesthetist will explain what is happening throughout the procedure so that you are aware.
4. As the spinal begins to take effect, your anaesthetist will measure your progress and test how well the spinal is working.

What Will I Feel?
Usually a spinal should cause no unpleasant feelings and should take only a few minutes to perform. However as the medicine is given into your back you may feel pins and needles or a sharp tingle in one of your legs **– if you do, try to remain still, and tell your anaesthetist about it.**

When the injection has been completed you will be lay flat as the spinal works quickly and usually works within 5 – 10 minutes. To begin with the skin usually feels numb to the touch and the leg muscles feel weak. When the spinal is working fully you will be unable to move your legs or feel any pain below your waist. Oxygen is usually given during this procedure to improve the level of oxygen in your blood stream.

What Are The Benefits Of Having A Spinal?

- Reduced blood loss during surgery and less need for a blood transfusion.
- Less risk of blood clots forming in the leg veins
- Less risk of chest infections after surgery
- Less effect on the heart and lungs
- Good pain relief immediately after surgery
- Less need for strong pain relieving drugs
- Less sickness and vomiting
- Earlier return to drinking and eating after surgery
- Less confusion after the operation in older people

Nursing Observations

Following your spinal the nurses will regularly assess how effective the spinal is in controlling your pain. They will also monitor your other observations such as blood pressure, pulse and pain score. This enables them to monitor the effectiveness of your spinal and identify when it is beginning to wear off.

After Your Spinal

It takes approximately 1½ – 4 hours or maybe longer for the feeling to return to the area of your body that has been numbed. If you have any worries about this please speak to the staff. As the sensation/feeling returns you may experience tingling in the skin as the spinal wears off. At this point you may start to feel discomfort at the site of your operation, and it is important that you let the nurses know so that they can give you some more pain relief to prevent the pain from becoming too severe.

As the spinal wears off you will also need to ask the staff for help when first getting out of bed, to ensure that you do not fall.

What Are The Alternatives To Spinals?

Patient Controlled Analgesia: This system relies on a special pump, which contains opiates and sometimes anti-sickness medication. The pump is connected to a hand held button, which when pressed by yourself gives a small amount of pain relieving medicine straight into a vein usually in your arm or hand.

Epidural Analgesia: This is a method by which a small tube is placed close to the spinal cord. The tube is then connected to a machine, which gives drugs, to numb the nerves at and around the site of the operation.

Peripheral Nerve Block: Local anaesthetic is injected around tissues and nerves in and around the site of your operation, to numb them. These drugs continue to work for a number of hours post-surgery.

What Are The Side Effects Of Spinals?
Very common and common side effects – Affects 1 in 10 people

Headache
When the spinal wears off and you begin to move around there is a risk of a headache occurring, but it is easily treated with fluids and pain relieving tablets.

Low blood pressure
As the spinal starts to work, it can lower your blood pressure and make you feel faint or sick. This can be controlled with fluids given by a drip and by occasionally giving you medicines to increase your blood pressure.

Itching
This may occur as a side effect of the Morphine like drugs used in the spinal. If you experience itching, please let staff know so that they can give you something to ease it.

Difficulty passing water (urinary retention)
You may find it difficult to empty your bladder normally for as long as the spinal lasts. Once the spinal has worn off, you should be able to pass water normally. Occasionally a tube (catheter) may be placed into your bladder temporarily, either until the spinal wears off or as part of your operation.

Pain during the injection
As previously mentioned, you should tell your anaesthetist immediately if you feel any pain or pins and needles in your legs or bottom as this may indicate irritation or damage to a nerve and the needle will need to be repositioned.

Rare Complications – affects 1 in 10,000 people
Nerve Damage
This is a rare complication of spinal anaesthetics. Temporary loss of sensation, pins and needles and sometimes muscle weakness may last for a few days or even weeks but almost all patients who have these symptoms make a full recovery in time. Permanent nerve damage is even rarer. In the unlikely event that you experience persistent tingling, heaviness or weakness in your legs after the spinal has worn off or you have an increasing pain in your back, whilst in hospital inform the ward nurse immediately.

If There Is A Problem
In the unlikely event that you experience persistent tingling, heaviness or weakness in your legs after the spinal has worn off or you have an increasing pain in your back, whilst in hospital inform the ward nurse immediately so they can contact a doctor or the acute pain team. If you experience any of these symptoms and have been **discharged** it is important that you **contact the on call anaesthetist** at the hospital **immediately via switchboard on 0161 922 6000**. After speaking to the on call Anaesthetist they may arrange to see you in the Accident and Emergency Department in order to examine you.

AFTER SURGERY

You will probably wake up in the recovery room, where you will be continually monitored. You will have oxygen and a drip in situ and may also have a wound drain in place which will be removed when your consultant instructs usually 24-48 hours after surgery. You will also have a triangular wedge between your legs and 'flowtron boots' around your calves which inflate and deflate and are designed to reduce the incidence of blood clots in your legs (DVT's). You will also be given a small injection each day for 35 days which thins your blood and helps to reduce the risk of DVT's.

Once the Recovery Nurse is happy you are stable enough, you will be transferred back to the ward/Unit, where you will again be closely monitored. The ward nurse will regularly check your vital signs (blood pressure, heart rate, breathing rate, oxygen levels, temperature, urine output), and wound site. Please be aware that these observations are important and you may be woken in the night so the staff can continue to monitor you.

Blood tests and x-rays will be ordered in the days following your surgery by the team of Doctors on the ward, who will also review your progress on a daily basis.

Diet and Fluid
You can eat and drink as normal to your tolerance- we may monitor your intake to ensure you are eating and drinking enough to enable you to recover.

Sickness
Sometimes people experience nausea and/or vomiting. If you do so, please inform the staff so they can give you some medication to help relieve this.

Pain
You will be provided with regular medication to control the pain, which will be prescribed according to your requirements. It is important that you inform staff if you are experiencing pain which is not relieved by the medication provided. As adjustments can be made. Severe pain on very rare occasions could indicate a problem with the surgery and therefore should be reported to staff.

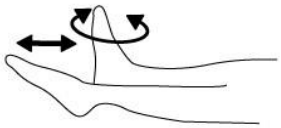
POST-OPERATIVE PHYSIOTHERAPY INFORMATION:

Exercises

After your surgery it is important that you try to perform some circulation and breathing exercises. They are important as blood clots can develop in the legs following surgery. They will help to increase the circulation in your legs and help prevent blood clots. These excercises will also improve the muscle strength in your legs. (Some patients can experience some muscle pain following surgery please advise your Nurse/Physio if this occurs.)

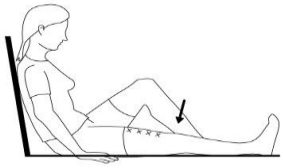
Calf Pumps

- briskly move your feet up and down, and round in circles, from the ankles for 1 minute



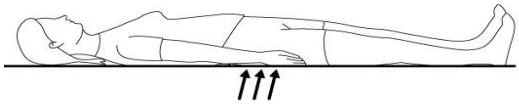
Static Quadriceps

- lie on your back with your leg straight
- tighten your thigh muscle and push the back of your knee down into the bed then pull your foot up towards you
- hold for 5 seconds, relax
- repeat x 10



Gluts Squeezes

- tense/squeeze your buttocks
- hold for 5 seconds, relax
- repeat x 10



Deep breathing

- take 4-6 deep breaths in and out
    - breathe in through your nose and out through your mouth

Rehabilitation

Rehabilitation starts in hospital and may also continue beyond your stay if required. Your Physiotherapist will talk to you about which operation you have had, whether there are any special rules you need to follow to protect your hip and how much weight you will be allowed to take through your operated leg when walking.

You will be expected to get up and out of bed usually within the first 24 hours after your surgery: the Physiotherapy team will help you to do so the first time; after that the Nursing staff will assist you into/out of bed each day.

The Rehabilitation team (Physiotherapists and Occupational Therapists) will try to see you daily to:

- assist you to walk (initially with the help of a walking frame, potentially with curtches as you get stronger)
- practice transferring to/from the bed/chair/toilet/etc (if you are struggling)
- provide you with strengthening exercises to do
- provide you with equipment to assist you at home with activities of daily living (and to help protect the hip if you have the hemi- or total hip arthroplasty operation)

It is important that you try to practice what the Rehab team teach you with the Nursing staff throughout the days.

MOBILISATION:

Getting out of bed:

Your Physiotherapist will assist you to stand from the bed. You should get out on the operated side to avoid crossing your legs:

- using your hands, push yourself to the edge of the bed
- allow your leg to gently bend over the side of the bed as you come forward

Sit to stand:

- slide your operated leg slightly forward
- using your arms beside you (on the bed or chair arms), push up into standing <u>before</u> reaching for your walking aid

Walking:

Your Physiotherapist will tell you how much weight you can take through your operated leg. To begin with, you will use a walking frame (and then maybe progress to crutches if appropriate).

The correct sequence when walking is:

1. move the walking aid forwards/in front first
2. step the operated leg forward
3. step the un-operated leg forward, so it is level with the other

When turning you must always be careful not to twist your hip: always step round towards your good/un-operated hip, picking up your feet.

Sitting down:

- always ensure you have turned and backed up to the chair/bed so that it is aligned behind you ie. never twist into the chair
- let go of your walking aid
- feel for the chair arms
- slide the foot of your operated leg forwards as you slowly lower yourself down

Getting into bed:

- sit on the edge of the bed
- using your hands beside you, push yourself back to sit far enough back on the bed so that the operated leg is supported
- turn to position yourself on the bed

Start the following exercises as directed by your Physiotherapist:
(perform these 3 x daily in addition previous exercises)

Standing Hip Flexion

- hold onto something for support
- lift your operated leg forwards, up and in front of you, bending at the hip and knee
  *do not go past 90° degrees
- slowly lower down
- repeat x 5-10

Standing Hip Extension:

- hold onto something for support
- tense your buttock
- lift your operated leg up and backwards behind you, keeping the knee as straight as possible
- slowly lower down
- repeat x 5-10

Standing Hip Abduction:

- hold onto something for support
- tense your buttock
- lift your operated leg up and sideways away from you, keeping the knee as straight as possible
- slowly lower down
- repeat x 5-10
  ensure the pelvis remains level i.e. do not 'hitch' the hip up

TACKLING STAIRS/STEPS:
If appropriate, before you go home you will be taught to use stairs safely.

Going up:
1. hold onto the banister/handrail
2. step up with your good/unoperated leg
3. bring up your bad/operated leg
   (bring your crutch up last if using one).

Going down:
   (place your crutch down onto the step below if using one)
1. slide your hand down the banister/handrail
2. lower your bad/operated leg down first
3. bring your good/un-operated leg onto the same step

Initially, you are advised to sleep on your back. After the clips have been removed from your wound, you may try sleeping on the operated side, if it is comfortable to do so.

POST-OPERATIVE OCCUPATIONAL THERAPY INFORMATION

FOR PATIENTS WHO HAVE HAD EITHER: HEMIARTHROPLASTY OR TOTAL HIP REPLACEMENT

The following precautions must be followed for the 12 weeks after your hip operation:

1. DO NOT FLEX THE HIP BEYOND 90°

2. DO NOT CROSS YOUR LEGS

3. DO NOT TWIST THE HIPS

To assist you to manage independently at home you will be assessed by the Occupational Therapist who will provide equipment to help you prevent dislocation of your new hip.

DO NOT FLEX THE HIP BEYOND 90°
Do not lean forward from the waist or let the hands reach below the knees.

You will be provided with the following dressing aids:
- HELPING HAND – used to dress lower limbs e.g. putting trousers on, underwear and shoes

- LONG HANDLED SHOE HORN – used to put shoes on

- SOCK OR TIGHT AID – used to put socks, stockings or tights on

- LONG HANDLED SPONGE - used to wash below the knees and feet
  These dressing aids must be used for 12 weeks after surgery.

DO NOT TWIST THE HIPS

To dress sit on the edge of bed or on a chair. Position clothes so they are in reach and you don't have to twist or reach across your body.
Always lift the foot, do not swivel. Do not twist your operated leg round.

DO NOT CROSS YOUR LEGS

The operated leg must not cross the mid-line of the body. Dress the operated leg first, undress it last. Wear well-fitting shoes OR slippers. Avoid shoes with laces.

Heights of Furniture

It is important to measure the heights of your furniture to avoid bending the hip beyond 90°. If your knee is higher than your hip when you are seated, you are breaking this rule. Please ask your relatives/carers to complete the measurement form provided.

CHAIR: the chair may need to be raised either with additional cushions or chair raisers.

TOILET: the toilet can be raised with a Raised Toilet Seat

BED: the bed can be raised with an additional matress or bed raisers

If any equipment is required it will be loaned to you, free of charge for as long as you need it.

Bathing

Your OT will discuss this with you after your surgery. You should not sit in the bottom of the bath for 12 weeks.

If you have a shower over the bath, a shower board may be assessed for and provided. This depends on the shape of your bath and your ability to use the equipment safely without breaking the precautions. If you have a shower cubicle avoid standing for too long

Domestic and Kitchen Tasks

- Do not stand for too long. Take regular rest breaks. A stool or chair of the correct height may be used
- Do not twist or over reach e.g. no hoovering.
- Do not bend forward from the waist to pick things up off the floor. Use your helping hand
- Do not use a step ladder or kneel
- Do not reach to low controls on a gas-fire or low plug sockets
- Remove all loose rugs and mats to avoid risk of trips or falls

DISCHARGE

When your consultant thinks you are fit to leave the acute hospital setting, the healthcare/multi-disciplinery team will liaise with you (and your relatives/carers as appropriate) to plan your discharge from hospital.

There are a number of options for discharge depending on: how well you progress in the early post-operative phase, what your baseline ability was, what your weight-bearing status is and how much potential you have to further progress in the short-term.

A member of your Rehab team will discuss possible rehabilitation with you.

a) You may still need some rehabilitation as an *in-patient*, to help you to regain your independence and function before going home.

   If this is the case a referral will be completed and faxed to the community team, where you will be placed on the waiting list until a bed becomes available at one of the two rehabiliation centres: Shirehill and the Lakes. You will be allocated a bed at whichever centre has an empty bed first. Your nurse will inform you when there is a bed available and they will also inform your next of kin.

   You can stay at the rehabilitation centre for up to 6 weeks, where you will be constantly assessed and independence encouraged. A discharge date will be agreed with you following your daily assessments and progress. You will be expected to get dressed on a daily basis.

b) You may have progressed enough to have further rehabilitation *at home*; if this is the case, a member of your Rehab team will discuss the options with you.

If There Is A Problem

If you have any questions do not hesitate to ask a ward therapist or the ward nurse.

Keeping family informed

Please share this information with your family members/ next of kin.

Useful Contacts

Below are several useful contact numbers you can call for advice:

Emergency orthopaedic Unit	0161 922 6613	(24 hours)
Rosscare Equipment Service	0161 344 0482	(Mon-Fri 9am-4pm)
Go to Doc (GP service)	0161 785 0805	(out of hours)
NHS Direct	0845 46 47	(24hr helpline)
Emergency Services	999	

You can also contact your own GP or District Nurses for advice.

Source of good practice

In compiling this information leaflet a number of recognised professional bodies including the Department of Health, NHS improvement - Enhanced Recovery, NHS Choices, Royal College of Anaesthetists have been used.

If you have any questions you want to ask, you can use this space below to remind you

If you have a visual impairment this leaflet can be made available in bigger print or on audiotape. If you require either of these options please contact the Patient Information Centre on 0161 331 5332

আপনি যদি এই তথ্য পড়তে বা বুঝতে না পারেন,তাহলে অনুগ্রহ করে এথনিক হেল্থ টিমের সাথে টেলিফোনে যোগাযোগ করুন 0161 331 5149/5150 এই নাম্বারে, তখন তারা আপনাকে সাহায্য করতে পারবে।

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