Hip Fractures

Patient Information
Introduction

This booklet has been designed as a guide to help you and your friends/family/carers to have a better understanding of the potential treatment you will receive whilst you are in hospital.

A fractured neck of femur is a break of the top end of the femur (thigh bone), just below your hip joint. The hip can be broken in a number of places therefore the type of operation you require is determined by the type of fracture you have, your age, how active you were before the fracture and the condition of your bones due to factors such as arthritis or osteoporosis (weak bones). The image below represents a healthy hip joint.
There are numerous types of procedures which are performed following a fractured neck of femur, mainly:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
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<tbody>
<tr>
<td>A Dynamic Hip Screw (DHS)</td>
<td>A sliding screw and plate fixation device to hold the fracture in place.</td>
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<tr>
<td>Cannulated Hip Screw</td>
<td>Fixing two or three screws to secure the fracture site.</td>
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<tr>
<td>Hemiarthroplasty</td>
<td>The common types being a Thompson or an Austin Moore prosthesis. In this fixation the ‘ball’ part of the ball and socket hip joint is replaced by the prosthesis.</td>
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<tr>
<td>Intramedullary Nailing</td>
<td>A nail down the middle of the thighbone fixed into position with pins.</td>
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If your consultant recommends a Total Hip Replacement (THR) you will be issued with a separate patient information booklet, as this surgery will need you to follow hip precautions after your surgery for 3 months.

**Your operation has been** .................................................................

**How much weight you can put through your operated leg (your weight bearing status)**

is ................................
A fractured hip can be both a life changing and a life threatening condition and usually requires surgery.

Fractured neck of femur is the most serious consequence of falls among older people, with a mortality rate of 10% at one month after a fall, 20% at four months and 30% at one year.

The aim of an operation is to repair the broken parts of your hip. Benefits from having an operation are both reducing your pain and improving your mobility.

Your orthopaedic surgeon will discuss the best treatment with you. Please do not hesitate to discuss any queries or concerns with a member of the multidisciplinary team (MDT).

Your Multidisciplinary Team (MDT) consists of:-

- Orthopaedic Surgeon
- Ortho-Geriatrician
- Anaesthetist
- Trauma Co-ordinator
- Nursing Staff
- Phlebotomist (take blood samples)
- Occupational Therapist
- Physiotherapist
- Therapy Assistant
- Social Worker

Our MDT is made up of many members who will help to co-ordinate your care and plan your discharge.

Before Your Surgery

The orthopaedic doctors, along with yourself, will discuss the appropriate operation, why it is being recommended and the potential risks and complications involved with the operation. If you agree to the operation you will be asked to sign a consent form to enable the surgeon to carry this out.

We aim for you to have your surgery within 36 hours of your arrival at our hospital. You will first have a pre-operative assessment to check your overall health and make sure you are ready for the operation. During your assessment you will be asked about any medication you are currently taking. Any necessary tests and/or investigations will also be carried out. You will also have a routine swab of your skin taken so that we can test for MRSA; every patient has this done. Furthermore, you will be prescribed intravenous fluids as you will not be able to have anything to eat or drink 4-6 hours before your operation.

You will also be seen by our orthogeriatrician, who specialises in looking after patients who have had hip fractures, to assess and treat any underlying medical conditions. Your surgery may be delayed until you are in a stable condition.
Before your operation, you will be reviewed by our anaesthetist, who will also discuss any medical problems you may have: this will help us to make sure you are medically fit for your operation and what kind of anaesthetic will be the most suitable for you.

Before your operation, the risks of the operation will also be discussed with you.

**Risks of Surgery**

Fracture neck of femur surgery is generally a very successful operation: there are, however, risks and complications which can occur, some of which are listed below.

**Blood Clots**

- Deep vein thrombosis (DVT) (blood clot in the leg)
- Pulmonary embolism (PE) (blood clot in the lung)

Blood clots can occur after any operation but are more likely to happen following operations to the legs. When these clots occur a blockage can develop in the veins of the leg causing swelling, pain and warmth. Swelling in the leg after surgery is very common and can take time to resolve. However, an increase in swelling, pain or warmth can be a clue that something else is occurring. If in doubt please inform a member of staff on the ward who will seek the doctors’ advice. If at home please seek the advice of your GP.

A blood clot in the lungs is called a pulmonary embolus (PE). In rare circumstances (1 in 1000 people) this can cause death. Symptoms of a PE include shortness of breath, sharp chest pain and blood coughed up in your phlegm. If you think you have a blood clot you should contact a medical professional as soon as possible.

**Preventative Measures**

1. We aim to help people to walk on the day after surgery if they are well enough to try. This has the advantage of increasing blood flow to the leg and maintaining circulation.

2. We assess all our patients’ individual risk of blood clots (as recommended by the National Institute of Clinical Excellence (NICE)). Following the risk assessment, most patients are advised to take blood thinning agents.

   A heparin medication called Fragmin is used for most patients and is required for up to 35 days following their operation. On discharge, you or a family member, if confident to do so, will be taught how to administer the Fragmin. Otherwise a district nurse will be arranged on discharge.

**Wound/Joint Infection**

You will be screened for infectious bacteria such as MRSA to reduce the chance of infections. This enables the necessary treatment to be carried out, reduce complications and the risk of infection to you and to others.
During the operation you will be given intravenous antibiotics.

Your operation will take place in advanced air-flow operating theatres which help to reduce the bacterial levels.

Deep infection is a very serious complication. More commonly a person can develop a superficial infection on the surface of the skin but occasionally this can progress to a deeper level. Any infection is taken extremely seriously; therefore early treatment can help to reduce this risk. If you think you have an infection you should contact a medical professional, such as your GP.

There is also evidence that smoking increases your chances of infection with the wounds taking longer to heal.

**Medical Problems**

There is a small risk of developing a medical problem following your operation. These include heart attacks, strokes and pneumonia. There is a small risk of death associated with this type of operation: such risks will be discussed with you at the time when you are being assessed by the surgeon and anaesthetist. If there are any concerns your doctors may transfer your care to another speciality for on-going treatment.

**Nerve Injury**

There are several nerves located around the hip and these can be damaged during your operation. These nerves supply skin sensation and power the muscles in the leg. Normally the nerves recover over a period of weeks and months. Occasionally the problems can be permanent and may lead to pain, weakness and loss of sensation.

**Urinary Incontinence**

Depending on the type of anaesthetic that you have, or if you are considered to have individual risk factors, a bladder catheter may be inserted. A small number of people develop urinary incontinence. This is usually temporary and resolves itself within a few hours of your operation. If you have had a catheter inserted this is removed within 72 hours after your operation. Sometimes reinsertion of the bladder catheter is necessary if you cannot pass urine. If this continues to be a problem you will be referred to see a specialist urology doctor.

**Pain**

You may experience discomfort from your surgical wound, pain around the groin and knee, which can be accompanied by muscle spasms. You may also experience some swelling and stiffness. Regular pain relief will be offered during your stay and is prescribed to be given at regular intervals.

**Summary**

Surgery to treat a fractured neck of femur is usually very successful but, as with any other operation, there are risks of complications which affect a small number of patients.
If you are not considered to be well enough (medically fit) for surgery your surgeon will discuss alternative treatments.

If at any point, you have any concerns, please do not hesitate to ask.

After Your Surgery

A nurse will come and take you back to your ward from the recovery room once you are well enough. You will have:-

- An intravenous drip which provides the necessary fluids to keep you hydrated.
- A face mask or tubes for your nose which will give you oxygen.
- Catheter or bladder tube may be inserted into your bladder to enable the nurses to closely monitor your fluid intake and output.
- A dose of antibiotics will be given during your operation to help to reduce the risk of infection.

The nurse will keep you comfortable following your operation as you may experience some discomfort around your hip and groin area; painkillers will be given to help ease the pain.

You may have some water soon after returning to the ward and can eat and drink when you feel able.

Your blood pressure, pulse and temperature will be recorded throughout your stay. Your wound and dressings will be checked regularly. To minimise the risk of infection the dressing is not changed unless there is any leakage.

Initially after your operation, the nursing staff will help you to go to the toilet, using a bed pan and they will also help you with your personal hygiene.

You will be prescribed Fragmin daily which is a small blood thinning injection. This thins your blood which further reduces the risk of blood clots.

Following a fracture of the neck of femur a calcium supplement may be prescribed by the consultant.

You may have visitors after your operation but we advise that they phone the ward first as rest is very important after your operation.

What Happens Next?

It is essential to have good pain control to allow you to become mobile again. Please inform the nurse looking after you if you have pain or if your medication is not working for you.

It is very beneficial and helpful for relatives to bring in casual clothing that is easy to put on and does not restrict movement. Practicing getting dressed is part of your recovery.
Please bring well-fitting comfortable flat shoes to walk in and some comfortable slippers. There may be some swelling to your feet after your surgery so please consider this when selecting suitable footwear: shoes without backs are not recommended. If you have a shoe raise, make sure this is with you whilst in the hospital.

Occasionally, following your operation, you may become constipated due to the medication, change in eating pattern and reduced mobility. Please inform the nurse if this occurs as laxatives may be required to alleviate your symptoms.

Your intravenous drip will be removed once you are eating, drinking and passing urine in adequate amounts, and until all medication which requires the drip is completed e.g. antibiotics.

Nutritional supplements may also be offered to ensure adequate nutrition is taken to aid your recovery.

Blood samples will be taken to assess your general state of health and to check if you are anaemic after the operation. If so, you may require a blood transfusion.

Depending on the type of operation performed you may require an x-ray of your new joint in the first few days to allow the surgeon to check it is in a satisfactory position.

Your skin will be checked regularly to make sure you are not getting any sore areas and will be recorded regularly on a chart for the nursing staff to monitor.

Remember, by moving yourself and doing your bed exercises you will help to reduce the risk of developing pressure sores, chest infections and DVTs (blood clots). Please inform a member of staff immediately if you feel any pressure, discomfort or altered feeling on your skin so the appropriate action can be taken before the skin breaks down.

You will have a wound to the thigh which will be held together by sutures or staples and covered by a dressing. The dressing will be reviewed and changed as necessary after surgery. The clips or stitches are removed about 14 days after surgery. This can be done by the nurse at your GP surgery or by a district nurse. The ward nursing staff will arrange this for you.

**Exercises**

It is essential that you commence the following exercises as soon as you can after your operation and whenever you are resting to help to prevent blood clots.

**Ankle Exercises**

Move your ankles in a circular motion, including up and down. This should be done every hour for approximately 5 minutes or longer if possible. This helps maintain the circulation in your calf muscles. If you experience any pain or tenderness in the calf please contact the nursing
staff immediately. At first you may not be able to do this until the spinal anaesthetic has worn off. This is normal and the movement will return in time.

**Deep Breathing Exercises**

This helps to keep your chest as clear as possible. Take 3 or 4 deep breaths, trying to breathe as deeply as possible: after the last breath try to “huff” out the air. This may stimulate a cough. Some people may experience a productive cough after the anaesthetic. A productive (‘wet’ or chesty) cough is when you have a cough that produces mucus or phlegm (sputum). You may feel congested and have a ‘rattly’ or ‘tight’ chest.

**Rehabilitation**

As every person is different you will recover at different rates, dependent upon your response to the operation and anaesthetic, any underlying medical condition and how fit you were before your hip was broken. So, to help to maximise your recovery it is very important that you start to walk as soon as possible: it has been shown that early mobilisation of a new or repaired joint ensures better results. Early mobilisation also helps with healing and will help to reduce any further complications.

Remember, you are the main person involved in your recovery and progress; we can advise, assist and encourage you. You will also be encouraged to return to normal activities, including completing your exercises independently throughout the day.

Your surgeon will decide how much weight you can place through the hip after your operation. The physiotherapy team, occupational therapy team and nursing staff will help you to walk and carry out activities of daily living in accordance with the surgeon’s directions, using the necessary walking aids and equipment.

**Walking**

The day after the operation the physiotherapist will visit and assess you. They may teach you exercises to improve your general muscle strength, ability to move around and assist yourself in/out of bed.

Getting out of bed and walking will initially be with the help of the Therapy Team and nursing staff. If safe to do so, they will help to progress your walking. They will help you to use aids such as hoists (to assist standing and transfers), walking frames and elbow crutches. This will be assessed on an individual basis.

When walking the sequence should be:

- Move your walking aid
- Step forwards with your operated leg
- Step forwards with your un-operated leg

It is important when turning to remember to maintain your balance and avoid a twist or pivot movement.
The physiotherapist can assist and advise on your posture, walking pattern and additional exercises as necessary.

**Stairs**

According to your needs you will be taught how to manage stairs or a step:

- Take one step at a time
- Going upstairs: use the banister on one side and the crutch/stick on the other side. Leading with your non-operated leg, first place your foot on the step; then with your operated leg, place your foot on the same step, and lastly your crutch/stick.

- Going downstairs: use the banister on one side and the crutch/stick on the other side. Place your crutch/stick first on to the step, then your operated leg onto the step and then the non-operated leg onto the same step.
Activities of Daily Living
The occupational therapist (OT) will see you on the ward and assess you as necessary. These assessments can include:

- Your ability to perform everyday activities (activities of daily living), how you will manage at home on a day to day basis and help you to develop strategies to maximise your independence, offering advice and recommendations as necessary.

- Changing positions (transfers) such as getting on/off the bed, and sit to stand from the bed, chair and toilet to make sure you will manage at home.

- Identifying any necessary equipment to help you once you return home to maintain your independence.

If you require equipment or furniture to be raised at home can you please ensure a key holder is available for delivery of the equipment or arrange to collect the prescribed items with your local loan store prior to discharge. Please be aware some home furniture items cannot be modified, in this case you need to arrange a suitable alternative. The OT can advise you on this in more detail.

Discharge from Hospital – When Can I Go Home?
You will be discharged once your acute phase of illness is over and you no longer require medical care from hospital. The multidisciplinary team (doctor, nurse, therapists and social worker) will discuss discharge plans/destination. We will do this in full consultation with you and your family/carers to ensure a smooth transition from hospital.
The time you are in hospital averages between 7-15 days. However this is only a guide and is dependent upon the type of operation you have, your progress made and your home circumstances.

Individual goals will be set with you and the therapy team, taking the above into account. Goals may include:

- Walking safely with a walking aid e.g. zimmer frame / crutches,
- Being able to get in / out of bed and on / off the chair / toilet
- Be able to get up / down stairs if required at home
- Have all the equipment / help necessary at home

**How you or your family can prepare for your discharge home**

- Organise transport home, discuss this with the ward staff
- Ensure you have your house keys or have a contact for a key holder
- Prepare your home and try to get help to:
  - Move commonly used items to accessible places
  - Remove things that may trip you up (trip hazards) i.e. loose rugs, wires etc.
  - Consider a light by your bed, a table in kitchen, a stool in bathroom if space allows
- Family to consider preparing meals and stock your freezer.
- Identify someone to help with shopping/housework/medication/exercises
- If you usually have home help/services, make sure you stop them whilst in hospital and have the contact details to hand for you to restart them for your return.

**Further Rehabilitation**

Where possible we aim for patients to be discharged to their own homes/ place of residence. This can be supported by additional community based therapy services such as community physiotherapy, occupational therapy or reablement. This will be discussed with you before you go home.

Depending on individual circumstances and progress, some people may require further support in their own homes and require a package of care which will be arranged by a social worker.

If it is felt you need further rehabilitation, whilst in hospital before you go home, there are currently two local intermediate care residential settings for patients with a Wigan GP:-

Alexander Court – Pemberton (40 rehabilitation beds)
Richmond House – Leigh (10 rehabilitation beds)

If you do not have a Wigan GP, the necessary steps will be taken to arrange further rehabilitation within your local area.
Discharge Advice

Wound Care

- Keep your wound area clean and dry. A dressing will be applied in the hospital and should be changed as necessary.

- Please ensure your wound is covered by a dressing before showering.

- You will be referred to the district nurse for removal of your sutures or staples. This may either be in a GP surgery, nearby clinic or in your own home.

- Notify your GP/nurse if your wound appears red, begins to drain fluid or you have an increased temperature.

Medication

Only take the medication you have been given when you go home. As your pain eases try to gradually reduce your painkillers. Please contact your GP if you require any further advice or information regarding your medication.

General Advice

It is normal for healing tissues to be swollen. The swelling may last for many months. When you take a step the calf muscle works to help pump blood back to the heart. If you are not putting full weight on your leg the pump does not work as well and you may get swelling around the ankle, especially at the end of the day. You may also find that bruising starts to come out in the first few weeks following surgery. This is normal.

To help to improve this do your circulation exercises as advised. When resting keep the leg elevated.

This is a major operation and you may tire quickly. This is normal and your strength will gradually return over the next few months.

Follow Up

A follow up appointment with the consultant after hip surgery is NOT routinely arranged. If you do require a follow up appointment with your consultant, the nurses on the ward will inform you.

The trust is part of the National Hip Fracture Database (NHFD). Following your discharge from hospital you will be contacted by one of the Trauma Co-ordinators at approximately:

- 30 days (1 month)
- 120 days (4 months) and
- One year after your operation
These phone calls can include asking about your mobility, if your wound has healed, if you are taking the calcium tablets prescribed during your hospital stay.

The information gathered is used to measure quality of care and helps us to improve the service we provide.

All information provided is confidential. For more information regarding the National Hip Fracture Database please visit the website at: www.nhfd.co.uk

**Useful Contact Numbers**

Aspull Ward 01942 822066
Shevington Ward 01942 822597
Trauma Co-ordinator 01942 773065
Physiotherapy: 01942 822100
Occupational therapy: 01942 822300
Patient Advice and Liaison Service (PALS): 01942 822376
Hospital Switch Board 01942 244000
Comments, Compliments or Complaints

The Patient Relations/Patient Advice and Liaison Service (PALS) Department provides confidential on the spot advice, information and support to patients, relatives, friends and carers.

Contact Us

Tel: 01942 822376 (Monday to Friday 9am to 4pm)

The Patient Relations/PALS Manager
Wrightington, Wigan and Leigh NHS Foundation Trust
Royal Albert Edward Infirmary
Wigan Lane
Wigan WN1 2NN

Ask 3 Questions

Become more involved in decisions about your healthcare. You may be asked to make choices about your treatment. To begin with, try to make sure you get the answers to three key questions:

1. What are my options?
2. What are the pros and cons of each option for me?
3. How do I get support to help me make a decision that is right for me?

This leaflet is also available in audio, large print, Braille and other languages upon request. For more information call 01942 773106.