NHS
Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Hip Fractures

Version number: **4**
Last modified date: **03rd July 2026**

Hip Fractures

Patient Information

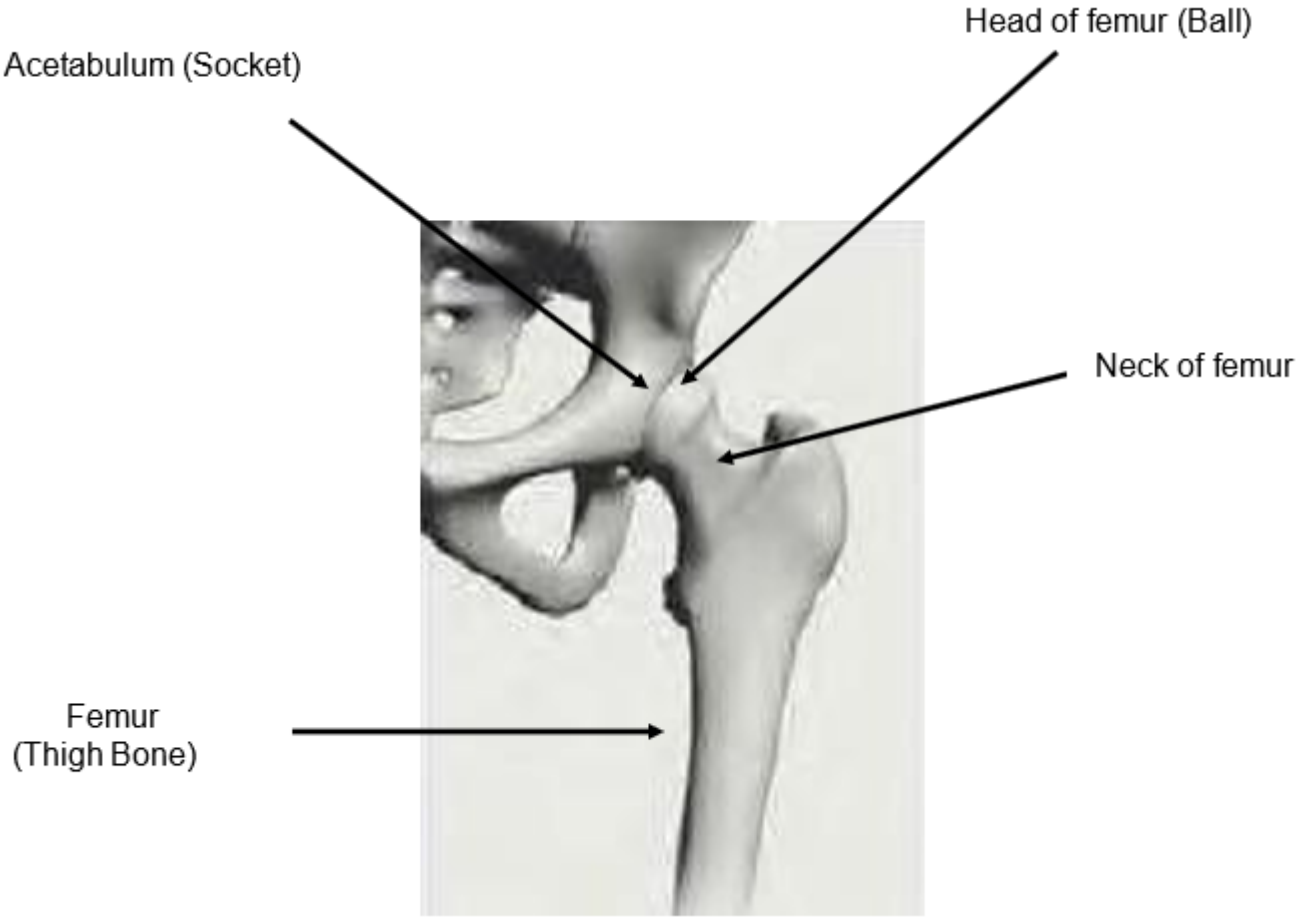
Trauma and Orthopaedic Department

- Author ID: GO/JO
- Leaflet ref: Musc 045
- Version: 4
- Leaflet title: Hip Fractures
- Last review: June 2024
- Expiry Date: June 2026

Introduction

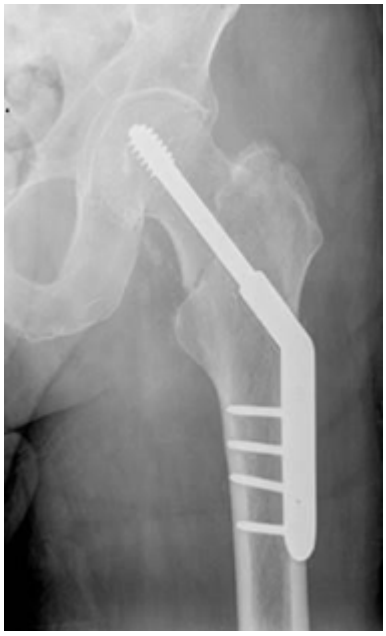
This booklet has been designed as a guide to help you and your friends/family/carers to have a better understanding of the potential treatment you will receive whilst you are in hospital.

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 several 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.



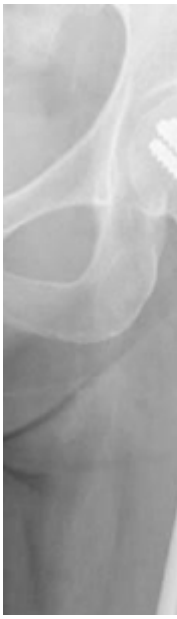
There are numerous types of procedures which are performed following a fractured neck of femur, mainly:

A Dynamic Hip Screw (DHS) which is a sliding screw and plate fixation device. to hold the fracture in place.



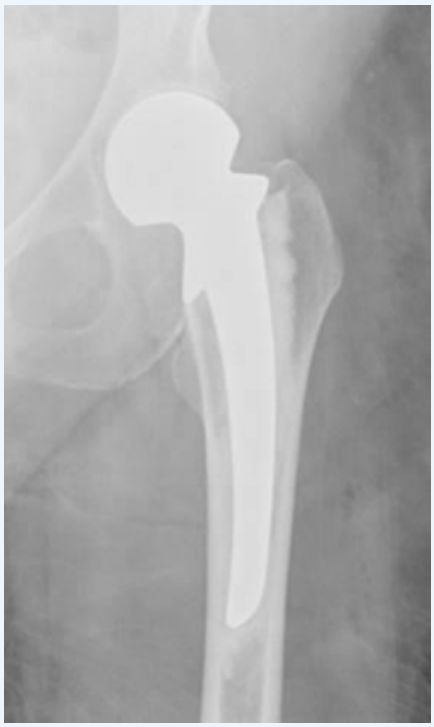
Dynamic Hip Screw

Cannulated Hip Screw which involves fixing two or three screws to secure the fracture site.



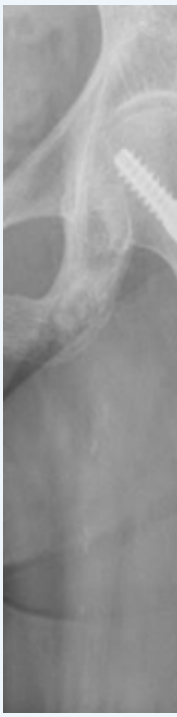
Cannulated Scre

Hemiarthroplasty, the common types being a Thompson or an Austin Moore Implant. In this fixation, the ‘ball’ part of the ball and socket hip joint is replaced by the prosthesis.



Hemiarthroplasty

Intramedullary nailing, which involves a nail down the middle of the thighbone fixed into position with pins.



Intramedullary Na

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 (death) rate of 30% after one year. 50% are left with a disability. i.e. reduction or change in mobility and some decline with general health.

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 and your support system. Please do not hesitate to discuss any queries or concerns with a member of the Multidisciplinary Team (MDT).

Your 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. If you take any blood thinner medication such as Rivaroxaban or Apixaban, your surgery may be delayed 24 hours for safety reasons to prevent complications during surgery.

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 methicillin-resistant staphylococcus aureus (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 six hours before your operation.

You will also be seen by our Orthogeriatrician if you are aged over 65, 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

Fractured 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 doctor's advice. If at home, please seek the advice of your General Practitioner (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. If this is outside normal working hours you should attend the Emergency Department.

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.

1. We assess all our patients' individual risk of blood clots (as recommended by the National Institute of Health and Care Excellence (NICE)). Following the risk assessment, most patients are advised to take blood thinning agents.

A low molecular weight heparin injection, sometimes referred to as Fragmin, is used for most patients and is required for up to 35 days following their operation. This is a daily blood thinning injection which further reduces your risk of blood clots. On discharge, you, or a family member, if confident to do so, will be taught how to administer the low molecular weight heparin injection. Otherwise, a District Nurse will be arranged on discharge.

If you already taking blood thinning medication, we restart these 48 hours post operatively. (for example: Apixaban, Edoxaban, Rivaroxaban or Warfarin).

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. Everyone that is admitted to our trust is screened for MRSA. If you are found to have this, you should be isolated.

During the operation, you will be given intravenous antibiotics.

Your operation will take place in an advanced air-flow operating theatre, which helps 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. We monitor the infection levels in your bloods while you are an inpatient with us and investigate the cause and treat if they are raised. 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 ongoing 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 you do fail at catheter removal, we will reattempt 3 times. If the

catheter is still required, you may be sent home with a catheter in and referred to the Urology Team. The Urology Team will reattempt the removal of the catheter later. If you are discharged with a new catheter, we will refer you to the District Nurses for the nursing management of this and they can help you when you're back home.

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 you 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 low molecular weight heparin injection daily; this is a small blood thinning injection. This thins your blood which further reduces the risk of blood clots.

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. Practising 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, the 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 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 this 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 stitches 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. Most of our hip dressings are waterproof and should be durable through a shower. If yours is not we will supply further dressings and refer you to the District Nurses to come and change this.

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.

Complete these exercises 3-4x daily

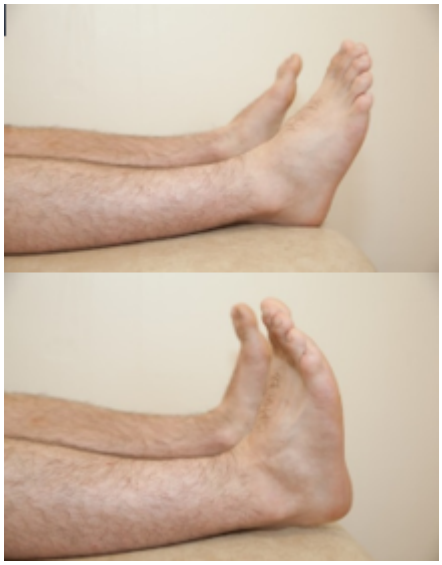
Some discomfort is normal; if your pain is severe or becomes significantly worse, please stop the exercises and let your physiotherapist or nurse know.

Ankle Pumps and Circles

- Sit or lie with your knees straight

- Briskly pull your foot toward you then point your toes, moving your ankle
- Sit or lie with your knees straight
- Circle your ankles clockwise then anti-clockwise

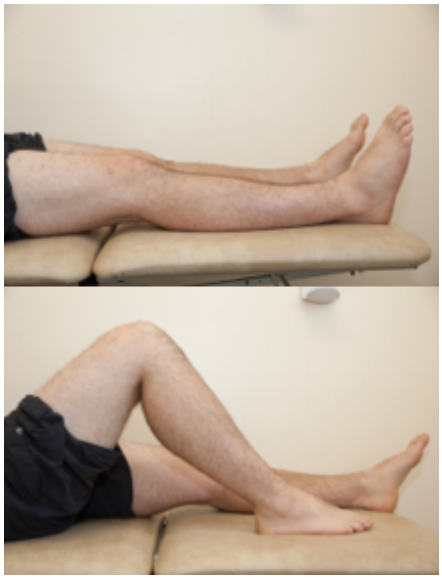
Repeat x20



Knee Flexion

- Sit or lie with your legs out straight or sit on a chair
- Keep your heel in contact with the floor or bed
- Bend your knee as far as you are able and hold for 5 seconds. Aim for full movement
- Slowly fully straighten your leg

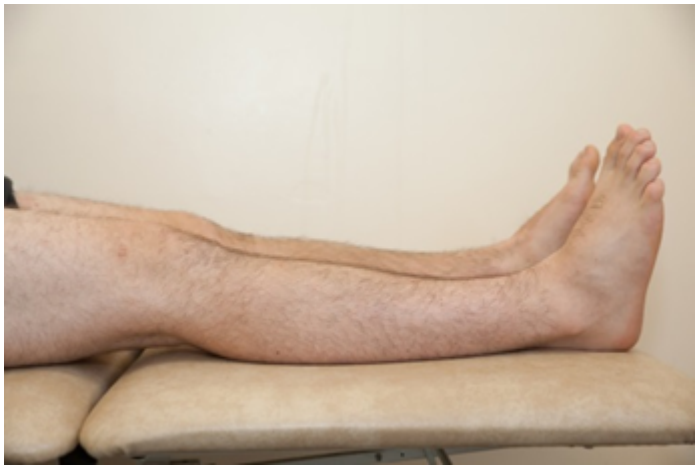
Repeat x10



Static Quads

- Sit or lie with your legs out straight
- Push your knee down towards the bed
- Tighten your thigh muscle and hold for 5 seconds.
- Relax the muscle

Repeat x10



Static Glutes

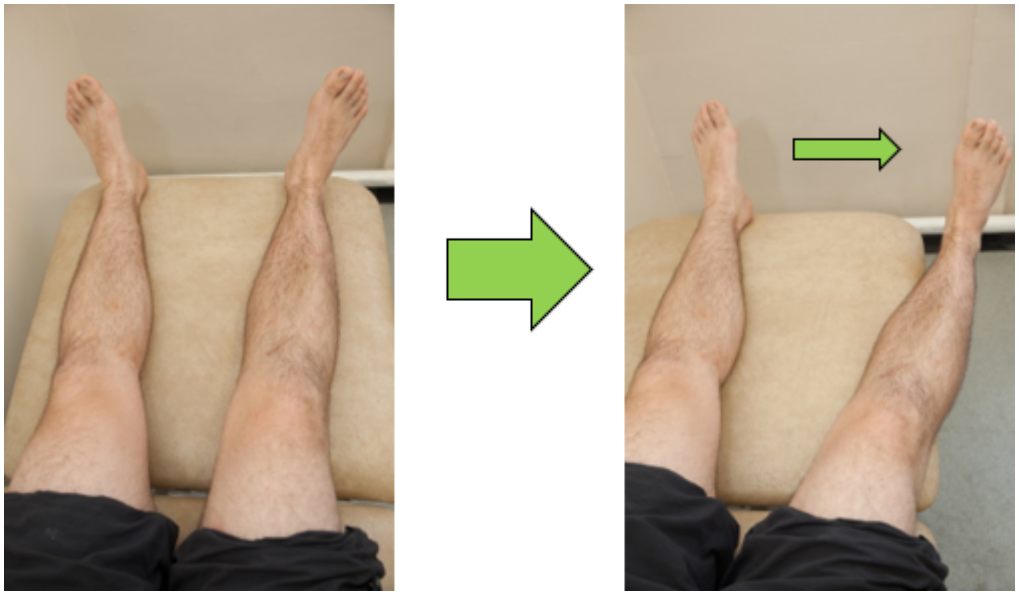
- Sit or lie with your legs out straight
- Squeeze your buttocks together
- Hold for 3-5 sec and then relax

Repeat x10

Hip Abduction/ Adduction

- Sit up in bed with your legs out straight
- Pull your toes up towards you
- Lift your leg out towards the edge of the bed then back to the middle

Repeat x5



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 Surgeons’ 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 you 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
- Then 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.

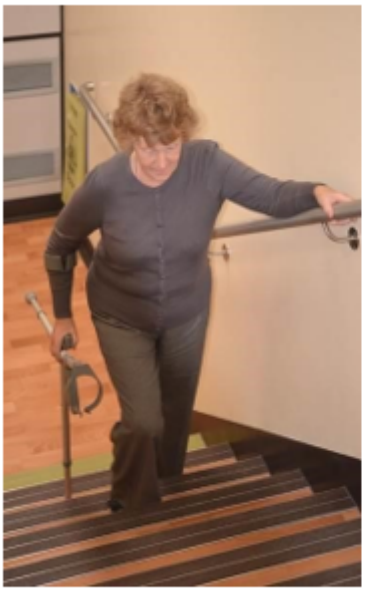
Stairs

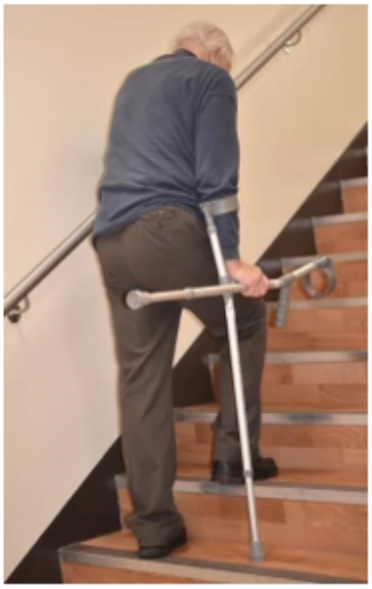
According to your needs, you will be taught how to manage stairs or a step:

- Take one step at a time

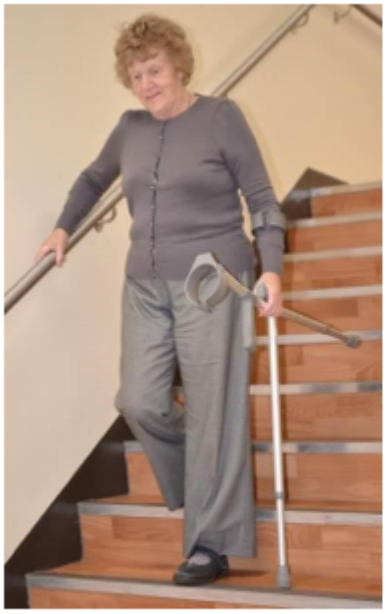
- Going upstairs: use the banister on one side and the crutch/stick on the other side

- If needed the Therapists will show you how to carry a second crutch/stick
- 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

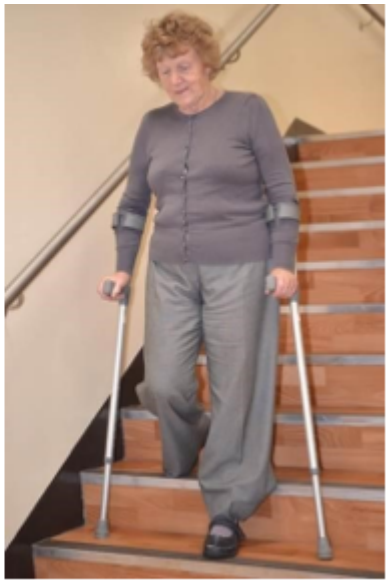




- Going downstairs: use the banister on one side and the crutch/stick on the other side. Place your crutch/stick first on to the step, then your operated leg onto the step and then the non-operated leg onto the same step



- Steps without rails or kerbs: as above but use both crutches/sticks together



Activities of Daily Living

The Occupational Therapist 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 they will 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 you can 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 Occupational Therapist can advise you on this in more detail.

Discharge from Hospital – When Can I Go Home?

Once you are medically fit for discharge and no longer require medical intervention, a conversation with the Therapy Team will be had with yourself and your family/carers regarding discharge options 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

- Being able to get up/downstairs if required at home
- Having 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 stocking your freezer
- Identify someone to help with shopping/housework/medication/exercises
- If you usually have home help/services, make sure you cancel 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, reablement service or a package of care. This will be discussed with you before you go home.

If it is felt you need a further period of rehabilitation whilst in hospital before you go home, there are a few intermediate care facilities for patients who have a Wigan GP.

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

The above will be discussed with you and your family/carers in more detail, if highlighted as necessary by the Therapy Team.

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.

Bone Health Medications

During your stay, you may have been started on a medication called Adcal D3; this is a chewable tablet which will supplement you with vitamin D and calcium.

You may have also been commenced on Alendronic acid; this medication is a bisphosphonate medication to enable bone health protection, which prevents you from fracturing again during your recovery and rehabilitation. These medications must be taken once a week on an empty stomach (when you wake in the morning) with a glass of water, and you must sit upright after taking them for 30 minutes. The medication must be taken on an empty stomach without food to aid absorption and prevent irritation of the oesophagus; should you develop any gastrointestinal symptoms including constipation, diarrhoea, abdominal pain/cramping and nausea, please stop taking the medication and consult your GP.

If you are not commenced on oral medications, you may have been started on some other medication such as Zoledronic acid, which will be infused in the Planned investigations unit (PIU) or Denosumab which will be administered by the Same Day Emergency Care Unit (SDEC).

All the above medication carries a risk of osteonecrosis of the jaw (ONJ); this is an extremely rare jaw problem in which there is delayed healing in the mouth, usually following invasive dental procedures. The general advice is to maintain good oral hygiene and receive routine dental check-ups; please let your dentist know that you have been commenced on these medications.

If you have been requested to attend for a DEXA (dual energy x-ray absorptiometry) scan, you will receive the results in our bone health clinic; if there is anything urgent on the results, we will contact you before the planned appointment; if you do not hear from us before then, there is no urgency to contact you sooner, and you will hear from us at your telephone appointment. If you have any concerns, please contact the Aging and Complex Medicine secretaries' telephone numbers listed at the back of this booklet.

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)

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
Astley Ward	01942 822526
Trauma Co-ordinator	01942 773065/773064
Physiotherapy	01942 822100
Community Physiotherapy Team	01942 807700
Community Response Team	01942 481221
Occupational Therapy	01942 822300
Patient Advice and Liaison Service (PALS)	01942 822376
Hospital Switch Board	01942 244000
Aging and Complex Medicine Secretaries	01942 822966/822390
SDEC	01942 822631
Planned Investigation Unit (PIU)	01942 822941

Version number: **4**
Last modified date: **03rd July 2026**