Hip fracture in adults

Quality standard
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Introduction and overview

This quality standard covers the management and secondary prevention of hip fracture in adults (18 years and older).

This quality standard covers only fragility fracture of the hip or fracture of the hip due to osteoporosis or osteopenia. Fragility fracture is defined as fracture caused by forces equivalent to a fall from standing height or less.

Introduction

Hip fracture is a major public health issue because of an increasing ageing population. It is the most common reason for admission to an orthopaedic trauma ward, usually for a ‘fragility’ fracture caused by a fall affecting an older person with osteoporosis or osteopaenia (a condition in which bones lose calcium and become thinner). About 70,000 to 75,000 hip fractures (proximal femoral fractures) occur annually in the UK, with a cost (including medical and social care) amounting to around £2 billion a year. Demographic projections indicate that the UK annual incidence will rise to 91,500 by 2015 and 101,000 in 2020, with an associated increase in annual expenditure. Most of this expenditure will be accounted for by hospital bed days and a further substantial contribution will come from health and social aftercare. At present about a quarter of patients with hip fracture are admitted from institutional care, and about 10–20% of those admitted from home ultimately move to institutional care.\[1\]

The National Hip Fracture Database reports the average age of a person with hip fracture as 84 years for men and 83 for women, and shows that 76% of fractures occur in women. Mortality is high - about one in ten people with a hip fracture die within 1 month and about one in three within 12 months. Most of the deaths are a result of associated comorbidities and not the fracture itself, reflecting the high prevalence of comorbidity in people with hip fracture. A fall and fracture often signals underlying ill health.

This quality standard describes markers of high-quality, cost-effective care that, when delivered collectively, should contribute to improving the effectiveness, safety and experience of care for people with hip fracture in the following ways:
• Preventing people from dying prematurely.

• Enhancing quality of life for people with long-term conditions.

• Helping people to recover from episodes of ill health or following injury.

• Ensuring that people have a positive experience of care.

• Treating and caring for people in a safe environment and protecting them from avoidable harm.

The NHS Outcomes Framework 2011/12 is available from [www.dh.gov.uk](http://www.dh.gov.uk)

It is important that the quality standard is considered by commissioners, healthcare professionals and patients alongside current policy and guidance documents listed in the evidence sources section.

**Overview**

The quality standard for hip fracture requires that services should be commissioned from and coordinated across all relevant agencies encompassing the whole hip fracture care pathway. An integrated approach to provision of services is fundamental to the delivery of high quality care to people with hip fracture.

The [National Hip Fracture Database](http://www.dh.gov.uk) is a clinically led, web-based national audit of hip fracture care and secondary prevention in England, Wales and Northern Ireland. Its aim is to improve hip fracture care. All 180 eligible hospitals are registered. Continuing upload of full and accurate data by hospitals to the [National Hip Fracture Database](http://www.dh.gov.uk) is currently considered part of the accepted methodology for the documentation and assessment of achievement of the quality measures, and is therefore an assumed element in the delivery of the quality standard.

[Data from NICE clinical guideline 124.](http://www.dh.gov.uk)
List of quality statements

Statement 1. People with hip fracture are offered a formal Hip Fracture Programme from admission.

Statement 2. The Hip Fracture Programme team retains a comprehensive and continuing clinical and service governance lead for all stages of the pathway of care, including the policies and criteria for both intermediate care and early supported discharge.

Statement 3. People with hip fracture have their cognitive status assessed, measured and recorded from admission.

Statement 4. People with hip fracture receive prompt and effective pain management, in a manner that takes into account the hierarchy of pain management drugs, throughout their hospital stay.

Statement 5. People with hip fracture have surgery on the day of, or the day after, admission.

Statement 6. People with hip fracture have their surgery scheduled on a planned trauma list, with consultant or senior staff supervision.

Statement 7. People with displaced intracapsular fracture receive cemented arthroplasty, with the offer of total hip replacement if clinically eligible.

Statement 8. People with trochanteric fractures above and including the lesser trochanter (AO classification types A1 and A2) receive extramedullary implants such as a sliding hip screw in preference to an intramedullary nail.

Statement 9. People with hip fracture are offered a physiotherapist assessment the day after surgery and mobilisation at least once a day unless contraindicated.

Statement 10. People with hip fracture are offered early supported discharge (if they are eligible), led by the Hip Fracture Programme team.

Statement 11. People with hip fracture are offered a multifactorial risk assessment to identify and address future falls risk, and are offered individualised intervention if appropriate.

Statement 12. People with hip fracture are offered a bone health assessment to identify future fracture risk and offered pharmacological intervention as needed before discharge from hospital.
In addition, quality standards that should also be considered when commissioning and providing a hip fracture service are listed in related NICE quality standards.
Quality statement 1: Hip Fracture Programme

Quality statement

People with hip fracture are offered a formal Hip Fracture Programme from admission.

Quality measure

Structure:

a) Evidence of local arrangements to ensure people with hip fracture are offered a formal Hip Fracture Programme from admission.

b) Evidence of local arrangements to ensure that the Hip Fracture Programme team includes a social care worker.

Process:

a) Proportion of people with hip fracture who receive a formal Hip Fracture Programme from admission.

Numerator: the number of people in the denominator who receive a formal Hip Fracture Programme from admission.

Denominator: the number of people with hip fracture.

Outcome: Continuous inpatient spell.

What the quality statement means for each audience

Service providers ensure systems are in place that offer all people with hip fracture a formal Hip Fracture Programme from admission.

Healthcare professionals offer all people with hip fracture a formal Hip Fracture Programme from admission.

Commissioners ensure that they commission hip fracture services with a formal Hip Fracture Programme in place for all people with hip fracture from admission.
People admitted to hospital with hip fracture are offered a programme of care, called a Hip Fracture Programme, from admission that includes regular assessment and continued rehabilitation from a range of healthcare professionals with different skills.

**Source guidance**

NICE clinical guideline 124 recommendations 1.8.1 (key priority for implementation), 1.8.5 and 1.8.6.

**Data source**

**Structure:**

a) and b) Local data collection.

**Process:** Local data collection. The National Hip Fracture Database contains an important but partial audit standard for this measure based on the following from the 2007 British Orthopaedic Association and British Geriatrics Society 'The care of patients with fragility fracture ('blue book')':

Standard 4 All patients presenting with a fragility fracture should be managed on an orthopaedic ward with routine access to acute orthogeriatric medical support from the time of admission.

Also contained within NICE audit support for hip fracture (NICE clinical guideline 124): Hip Fracture Programme, criterion 1.

**Outcome:** Local data collection.

**Definitions**

NICE clinical guideline 124 recommendation 1.8.1 states that people with hip fracture should be offered from admission a formal, acute orthogeriatric or orthopaedic ward-based Hip Fracture Programme that includes all of the following:

- orthogeriatric assessment
- rapid optimisation of fitness for surgery
- early identification of individual goals for multidisciplinary rehabilitation to recover mobility and independence, and to facilitate return to pre-fracture residence and long-term wellbeing
• continued, coordinated, orthogeriatric and multidisciplinary review

• liaison or integration with related services, particularly mental health, falls prevention, bone health, primary care and social services

• clinical and service governance responsibility for all stages of the pathway of care and rehabilitation, including those delivered in the community.

NICE clinical guideline 124 (full version) defines a Hip Fracture Programme as formal 'orthogeriatric' care – with the geriatric medical team contributing to joint preoperative patient assessment, and increasingly taking the lead in postoperative medical care, multidisciplinary rehabilitation and discharge planning.

Multidisciplinary rehabilitation is a key component of a Hip Fracture Programme. NICE clinical guideline 124 (full version) defines multidisciplinary rehabilitation as rehabilitation after hip fracture that incorporates assessment and management, including medicine, nursing, physiotherapy, occupational therapy and social care, and may also include dietetics, pharmacy and clinical psychology.

NICE clinical guideline 124 states that the Hip Fracture Programme should be based in an orthopaedic or orthogeriatric ward in the acute hospital. However for those patients clearly considered by the Hip Fracture Programme team to require intermediate care (continued rehabilitation in a community hospital or residential care unit) for an optimal and maximally efficient outcome, the criteria are outlined in recommendation 1.8.5, which states intermediate care should only be considered if all of the following criteria are met:

• intermediate care is included in the Hip Fracture Programme and

• the Hip Fracture Programme team retains the clinical lead, including patient selection, agreement of length of stay and ongoing objectives for intermediate care and

the Hip Fracture Programme team retains the managerial lead, ensuring that intermediate care is not resourced as a substitute for an effective acute hospital programme.

Equality and diversity considerations

NICE clinical guideline 124 recommendation 1.8.6 states that patients admitted from care or nursing homes should not be excluded from rehabilitation programmes in the community or hospital, or as part of an early supported discharge programme.
Quality statement 2: Continuity of clinical and service governance

Quality statement

The Hip Fracture Programme team retains a comprehensive and continuing clinical and service governance lead for all stages of the pathway of care, including the policies and criteria for both intermediate care and early supported discharge.

Quality measure

Structure: Evidence of local arrangements (including a written operational policy and governance procedures) to ensure the Hip Fracture Programme team retains a comprehensive and continuing clinical and service governance lead for all stages of the pathway of care, including the policies and criteria for both intermediate care and early supported discharge.

Process: Proportion of people with hip fracture transferred from hospital for early supported discharge or intermediate care for whom the Hip Fracture Programme team makes (and documents the reasons for) the decision to transfer.

 numerator: the number of people in the denominator for whom the Hip Fracture Programme team makes (and documents the reasons for) the decision to transfer.

Denominator: the number of people transferred from hospital for early supported discharge or intermediate care.

What the quality statement means for each audience

Service providers ensure systems are in place for the Hip Fracture Programme team to retain a comprehensive and continuing clinical and service governance lead for all stages of the pathway of care, including the policies and criteria for both intermediate care and early supported discharge.

Health and social care professionals in the Hip Fracture Programme team retain a comprehensive and continuing clinical and service governance lead for all stages of the pathway of care, including the policies and criteria for both intermediate care and early supported discharge.

Commissioners ensure they commission services where the Hip Fracture Programme team retains a comprehensive and continuing clinical and service governance lead for all stages of the pathway of care, including the policies and criteria for both intermediate care and early supported discharge.
People with hip fracture are cared for by the Hip Fracture Programme team, who coordinate all aspects of care and rehabilitation both in hospital and after discharge.

**Source guidance**

NICE clinical guideline 124 recommendation 1.8.1 (key priority for implementation).

**Data source**

**Structure:** Local data collection.

**Process:** Local data collection.
Quality statement 3: Cognitive assessment

Quality statement

People with hip fracture have their cognitive status assessed, measured and recorded from admission.

Quality measure

Structure: Evidence of local arrangements to ensure people with hip fracture have their cognitive status assessed, measured and recorded from admission.

Process:

a) Proportion of people with hip fracture receiving recorded preoperative cognitive assessment and measurement using a validated tool.

Numerator: the number of people in the denominator who receive a recorded preoperative cognitive assessment and measurement using a validated tool.

Denominator: the number of people with hip fracture.

b) Proportion of people with hip fracture who have undergone surgery receiving a recorded postoperative cognitive assessment and measurement using a validated tool.

Numerator: the number of people in the denominator who receive recorded postoperative cognitive assessment and measurement using a validated tool.

Denominator: the number of people with hip fracture who have undergone surgery.

What the quality statement means for each audience

Service providers ensure systems are in place for people with hip fracture to have their cognitive status assessed, measured and recorded from admission.

Healthcare professionals assess, measure and record cognitive status for people with hip fracture from admission.
Commissioners ensure they commission services for people with hip fracture to have their cognitive status assessed, measured and recorded from admission.

People with hip fracture receive an assessment to check for any understanding or memory problems at admission to hospital and are monitored and reassessed throughout their hospital stay.

Source guidance

NICE clinical guideline 124 recommendation 1.8.1 (key priority for implementation) and 1.8.3.

NICE clinical guideline 103 recommendations 1.1.1 and 1.2.1 (key priorities for implementation), and 1.1.2.

Data source

Structure: Local data collection.

Process:

a) Local data collection. The National Hip Fracture Database records the Abbreviated Mental Test score. Also contained in NICE audit support for delirium (NICE clinical guideline 103), criteria 1 and 2.

b) The Royal College of Physicians' National audit of falls and bone health records whether a formal assessment of cognitive function was performed within 72 hours of surgery.
Quality statement 4: Analgesia

Quality statement

People with hip fracture receive prompt and effective pain management, in a manner that takes into account the hierarchy of pain management drugs, throughout their hospital stay.

Quality measure

Structure: Evidence of local arrangements, including a written clinical protocol, to ensure people with hip fracture receive prompt and effective pain management, in a manner that takes into account the hierarchy of pain management drugs, throughout their hospital stay.

Process:

a) Proportion of people with hip fracture who receive a formal, recorded pain assessment immediately on admission to the emergency department and within 30 minutes of initial analgesic administration.

Numerator: the number of people in the denominator who receive a formal, recorded pain assessment immediately on presentation to the emergency department and within 30 minutes of initial analgesic administration.

Denominator: the number of people with hip fracture.

b) Proportion of people with hip fracture who are offered paracetamol as first-line analgesia on admission to the emergency department and every 6 hours preoperatively, unless contraindicated.

Numerator: the number of people in the denominator who are offered paracetamol as first-line analgesia on admission to the emergency department and every 6 hours preoperatively.

Denominator: the number of people with hip fracture and without contraindications to paracetamol.

c) Proportion of people with hip fracture who are offered paracetamol every 6 hours postoperatively.
Numerator: the number of people in the denominator who are offered paracetamol every 6 hours postoperatively.

Denominator: the number of people with hip fracture who have undergone surgery.

**Outcome:** Patient satisfaction with pain management.

**What the quality statement means for each audience**

**Service providers** ensure systems are in place for people with hip fracture to receive prompt and effective pain management, in a manner that takes into account the hierarchy of pain management drugs, throughout their hospital stay.

**Healthcare professionals** give people with hip fracture prompt and effective pain management, in a manner that takes into account the hierarchy of pain management drugs, throughout their hospital stay.

**Commissioners** ensure they commission services for people with hip fracture that include prompt and effective pain management, in a manner that takes into account the hierarchy of pain management drugs, throughout their hospital stay.

**People with hip fracture** are given prompt and effective pain relief medication throughout their hospital stay, starting with paracetamol and using stronger drugs if needed.

**Source guidance**

[NIce clinical guideline 124](#) recommendations 1.3.1, 1.3.2, 1.3.3, 1.3.4, 1.3.5, 1.3.7, 1.3.8, 1.3.9.

**Data source**

**Structure:** Local data collection.

**Process:**

a) Local data collection. The Royal College of Physicians' [National audit of falls and bone health](#) records whether there was a documented assessment of pain severity (for example, a pain score) within the place of first presentation. Also contained in [NIce audit support for hip fracture](#) (NIce clinical guideline 124): analgesia, criterion 1.


**Outcome:** Local data collection.

**Definitions**

NICE clinical guideline 124 (full version) recommends a logical hierarchy for the use of analgesic agents. Although not all stages are applicable, an adapted World Health Organization pain relief ladder for cancer may be used. Adapted for hip fracture, this would involve the initial use of non-opioids (for hip fracture this would be paracetamol) and then directly moving to strong opioids such as morphine if non-opioids are not effective.

NICE clinical guideline 124 recommendations 1.3.5 and 1.3.8 state that patients should be offered additional opioids if paracetamol alone does not provide sufficient pain relief.

**Equality and diversity considerations**

NICE clinical guideline 124 recommendation 1.3.2 specifies that the recommendations on timely analgesia apply to patients with cognitive impairment.
Quality statement 5: Timing of surgery

**Quality statement**

People with hip fracture have surgery on the day of, or the day after, admission.

**Quality measure**

**Structure:** Evidence of local arrangements to ensure people with hip fracture have surgery on the day of, or the day after, admission.

**Process:** Proportion of people with hip fracture who receive surgery on the day of, or the day after, admission.

Numerator: the number of people in the denominator who receive surgery on the day of, or the day after, admission.

Denominator: the number of people with hip fracture having surgery.

*What the quality statement means for each audience*

**Service providers** ensure systems are in place for people with hip fracture to have surgery on the day of, or the day after, admission.

**Healthcare professionals** perform hip fracture surgery on the day of, or the day after, admission.

**Commissioners** ensure they commission services for people with hip fracture to have surgery on the day of, or the day after, admission.

**People with hip fracture** have their surgery carried out on the day of, or the day after, admission to hospital.

**Source guidance**

[NIce clinical guideline 124](#) recommendations 1.2.1 and 1.2.2 (key priorities for implementation).
Data source

Structure: Local data collection.

Process: Local data collection. The Health and Social Care Information Centre's **Compendium of Clinical and Health Indicators** records emergency hospital admissions and timely surgery: fractured proximal femur. The **National Hip Fracture Database** records data on patients with hip fracture who are medically fit who have surgery within 48 hours of admission, and during normal working hours. Contained in **NICE audit support for hip fracture** (NICE clinical guideline 124): timing of surgery, criteria 1 and 2.

Definitions

**NICE clinical guideline 124** (full version) states that it should be anticipated that many patients with hip fractures will be frail and have comorbidities, and that although rarely this may lead to a delay in surgery, provided these problems are identified and measures initiated to correct them are taken promptly, the majority of patients can be optimised within 24 hours. **NICE clinical guideline 124** recommendation 1.2.2 (key priority for implementation) therefore states that comorbidities should be identified and treated so that surgery is not delayed by:

- anaemia
- anticoagulation
- volume depletion
- electrolyte imbalance
- uncontrolled diabetes
- uncontrolled heart failure
- correctable cardiac arrhythmia or ischaemia
- acute chest infection
- exacerbation of chronic chest conditions.
Quality statement 6: Planning the theatre team

Quality statement

People with hip fracture have their surgery scheduled on a planned trauma list, with consultant or senior staff supervision.

Quality measure

Structure: Evidence of local arrangements to ensure that people with hip fracture have their surgery scheduled on a planned trauma list, with consultant or senior staff supervision.

Process:

a) Proportion of people with hip fracture who receive surgery on a planned trauma list.

Numerator: the number of people in the denominator who receive surgery on a planned trauma list.

Denominator: the number of people with hip fracture having surgery.

b) Proportion of people with hip fracture having surgery who receive surgery with consultant or senior staff supervision.

Numerator: the number of people in the denominator who receive surgery with consultant or senior staff supervision.

Denominator: the number of people with hip fracture having surgery.

What the quality statement means for each audience

Service providers ensure systems are in place for people with hip fracture that schedule their surgery on a planned trauma list, with consultant or senior staff supervision.

Healthcare professionals schedule hip fracture surgery on a planned trauma list, with consultant or senior staff supervision.

Commissioners ensure they commission services for people with hip fracture that schedule their surgery on a planned trauma list, with consultant or senior staff supervision.
People with hip fracture having surgery go onto a planned list of daily operations, with senior surgeons, anaesthetists and theatre staff supervising the surgery.

**Source guidance**

NICE clinical guideline 124 recommendations 1.5.1 (key priority for implementation) and 1.5.2.

**Data source**

**Structure:** Local data collection.

**Process:**

a) The National Hip Fracture Database records the proportion of patients having surgery within 48 hours and during normal working hours.

b) The Royal College of Physicians’ National audit of falls and bone health records the percentage of patients operated on by consultant surgeons.

**Definitions**

NICE clinical guideline 124 (full version) states that a planned trauma list is one with a rostered senior anaesthetist, senior surgeon and dedicated theatre time. It consists of a period of time allocated to the surgical management of patients with unplanned admissions following musculoskeletal injury.

NICE clinical guideline 124 (full version) states that the level of supervision required for a trainee or junior staff member for a particular case depends on two main factors: the junior's ability and the complexity of the case. It is therefore implicit that the senior staff responsible for the trauma list must have knowledge of both of these factors before determining the level of supervision required.
Quality statement 7: Intracapsular fracture

**Quality statement**

People with displaced intracapsular fracture receive cemented arthroplasty, with the offer of total hip replacement if clinically eligible.

**Quality measure**

**Structure:** Evidence of local arrangements to ensure people with displaced intracapsular fracture receive cemented arthroplasty, with the offer of total hip replacement if clinically eligible.

**Process:**

a) Proportion of people with displaced intracapsular fracture who receive cemented arthroplasty.

Numerator: the number of people in the denominator who receive cemented arthroplasty.

Denominator: the number of people with displaced intracapsular fracture.

An audit standard of less than 100% should be expected for process measure a), to allow for cases where the practitioner considers it not in the best interests of the person to have surgery.

b) Proportion of people with displaced intracapsular fracture who are offered total hip replacement if clinically eligible.

Numerator: the number of people in the denominator who are offered total hip replacement.

Denominator: the number of people with displaced intracapsular fracture who are clinically eligible for total hip replacement.

**What the quality statement means for each audience**

**Service providers** ensure systems are in place for people with displaced intracapsular fracture to have cemented arthroplasty, with the offer of total hip replacement if clinically eligible.

**Healthcare professionals** perform cemented arthroplasty, with the offer of total hip replacement if clinically eligible.
Commissioners ensure they commission services for people with displaced intracapsular fracture to have cemented arthroplasty, with the offer of total hip replacement if clinically eligible.

People with a hip fracture that is within (rather than outside) the hip joint receive either a half replacement of the hip joint or a full hip replacement if they were fit and active before the fracture and are well enough to have the operation.

Source guidance

NICE clinical guideline 124 recommendations 1.6.2, 1.6.3, (key priorities for implementation) and 1.6.5.

Data source

Structure: Local data collection.

Process:

a) Local data collection. Contained in NICE audit support for hip fracture (NICE clinical guideline 124: surgical procedures, criteria 2 and 5.

b) Local data collection. Contained in NICE audit support for hip fracture (NICE clinical guideline 124: surgical procedures, criteria 3 and 5.

a) and b) The National Hip Fracture Database records procedure type for intracapsular displaced fracture and cementing of arthroplasties.

Definitions

NICE clinical guideline 124 recommendation 1.6.3 states that people with a displaced intracapsular fracture should be offered (and are therefore clinically eligible for) total hip replacement if they:

- were able to walk independently out of doors with no more than the use of a stick and
- are not cognitively impaired and
- are medically fit for anaesthesia and the procedure.
Quality statement 8: Extracapsular fracture

**Quality statement**

People with trochanteric fractures above and including the lesser trochanter (AO classification types A1 and A2) receive extramedullary implants such as a sliding hip screw in preference to an intramedullary nail.

**Quality measure**

**Structure:** Evidence of local arrangements to ensure people with fractures above and including the lesser trochanter (AO classification types A1 and A2) receive extramedullary implants such as a sliding hip screw in preference to an intramedullary nail.

**Process:** Proportion of people with trochanteric fractures above and including the lesser trochanter (AO classification types A1 and A2) who receive extramedullary implants such as a sliding hip screw.

Numerator: the number of people in the denominator who receive extramedullary implants such as a sliding hip screw.

Denominator: the number of people with trochanteric fractures above and including the lesser trochanter (AO classification types A1 and A2).

**What the quality statement means for each audience**

**Service providers** ensure systems are in place for people with trochanteric fractures above and including the lesser trochanter (AO classification types A1 and A2) to receive extramedullary implants such as a sliding hip screw in preference to an intramedullary nail.

**Healthcare professionals** use extramedullary implants such as a sliding hip screw in preference to an intramedullary nail in people with trochanteric fractures above and including the lesser trochanter (AO classification types A1 and A2).

**Commissioners** ensure they commission services for people with trochanteric fractures above and including the lesser trochanter (AO classification types A1 and A2) that use extramedullary implants such as a sliding hip screw in preference to an intramedullary nail.
People with a hip fracture that is outside (rather than within) the hip joint receive an implant, consisting of a screw mounted on a plate, to hold the broken part of the thigh bone in place while it is healing.

**Source guidance**

[NICE clinical guideline 124 recommendation 1.6.7 (key priority for implementation).](#)

**Data source**

**Structure:** Local data collection.

Quality statement 9: Physiotherapy and mobilisation

Quality statement

People with hip fracture are offered a physiotherapist assessment the day after surgery and mobilisation at least once a day unless contraindicated.

Quality measure

Structure: Evidence of local arrangements to ensure people with hip fracture are offered a physiotherapist assessment the day after surgery and mobilisation at least once a day unless contraindicated.

Process:

a) Proportion of people who receive a physiotherapist assessment the day after surgery unless contraindicated.

Numerator: the number of people in the denominator who receive a physiotherapist assessment the day after surgery.

Denominator: the number of people with hip fracture who have undergone surgery and have no contraindications for physiotherapy.

b) Proportion of people who receive physiotherapist-led daily mobilisation from the day after surgery unless contraindicated.

Numerator: the number of people in the denominator who receive physiotherapist-led daily mobilisation from the day after surgery.

Denominator: the number of people with hip fracture who have undergone surgery and have no contraindications for physiotherapy.

What the quality statement means for each audience

Service providers ensure systems are in place for people with hip fracture to have access to a physiotherapist assessment the day after surgery and mobilisation at least once a day unless contraindicated.
Healthcare professionals offer people with hip fracture a physiotherapist assessment the day after surgery and mobilisation at least once a day unless contraindicated.

Commissioners ensure they commission services for people with hip fracture that provide a physiotherapist assessment the day after surgery and mobilisation at least once a day unless contraindicated.

People with hip fracture are offered a physiotherapist assessment the day after surgery and are offered exercises to promote movement, strength and recovery at least once a day, unless there are medical or surgical reasons for this not to occur.

Source guidance

NICE clinical guideline 124 recommendations 1.7.1 and 1.7.2 (key priorities for implementation).

Data source

Structure: Local data collection.

Process:


b) Local data collection. The Royal College of Physicians National audit of falls and bone health records whether an attempt was made within 24 hours of surgery to mobilise the patient. Contained in NICE audit support for hip fracture: mobilisation, criteria 2 and 3.

Definitions

NICE clinical guideline 124 (full version) defines mobilisation as the process of re-establishing the ability to move between postures (for example sit to stand), maintain an upright posture, and to ambulate with increasing levels of complexity (speed, changes of direction, dual and multi-tasking).

The 'hands-on' role of the physiotherapist after initial assessment is discretionary by agreement with physiotherapist and other healthcare professionals (for example nursing staff).
Quality statement 10: Early supported discharge

Quality statement

People with hip fracture are offered early supported discharge (if they are eligible), led by the Hip Fracture Programme team.

Quality measure

Structure: Evidence of local arrangements to ensure people with hip fracture are offered early supported discharge (if they are eligible), led by the Hip Fracture Programme team.

Process: Proportion of people with hip fracture who receive early supported discharge (if they are eligible), led by the Hip Fracture Programme team.

Numerator: the number of people in the denominator who receive early supported discharge led by the Hip Fracture Programme team.

Denominator: the number of people with hip fracture who are eligible for early supported discharge.

Outcome: Number of people receiving early supported discharge readmitted to any acute hospital within 30 days of discharge.

What the quality statement means for each audience

Service providers ensure systems are in place for people with hip fracture to be offered early supported discharge (if they are eligible), led by the Hip Fracture Programme team.

Health and social care professionals offer people with hip fracture early supported discharge (if they are eligible), led by the Hip Fracture Programme team.

Commissioners ensure they commission services that offer people with hip fracture early supported discharge (if they are eligible), led by the Hip Fracture Programme team.

People with hip fracture are offered the option to go home soon after their operation (if they are fit enough to be discharged from hospital) with ongoing support and involvement from the Hip Fracture Programme team to continue rehabilitation.
Source guidance

NICE clinical guideline 124 recommendations 1.8.1, 1.8.4 (key priorities for implementation) and 1.8.6.

Data source

Structure: Local data collection.

Process: Local data collection. The Royal College of Physicians National audit of falls and bone health records whether the patient had rehabilitation or support at home from a specialist early supported discharge team. The Health and Social Care Information Centre's Compendium of clinical and health indicators contains annual hospital episode statistics-based indicators plus trends on timely return to usual place of residence.

Outcome: Local data collection.

Definitions

NICE clinical guideline 124 (full version) defines a Hip Fracture Programme as formal 'orthogeriatric' care, with the geriatric medical team contributing to joint preoperative patient assessment, and increasingly taking the lead in postoperative medical care, multidisciplinary rehabilitation and discharge planning.

NICE clinical guideline 124 recommendation 1.8.1 (key priority for implementation) states that a Hip Fracture Programme includes the following:

- orthogeriatric assessment
- rapid optimisation of fitness for surgery
- early identification of individual goals for multidisciplinary rehabilitation to recover mobility and independence, and to facilitate return to prefracture residence and long-term wellbeing
- continued, coordinated, orthogeriatric and multidisciplinary review
- liaison or integration with related services, particularly mental health, falls prevention, bone health, primary care and social services
• clinical and service governance responsibility for all stages of the pathway of care and rehabilitation, including those delivered in the community.

NICE clinical guideline 124 (full version) defines early supported discharge as when patients are discharged home from the acute trauma ward, or in some cases a subsequent rehabilitation ward within the hospital, with a supported 4–6 week rehabilitation package.

NICE clinical guideline 124 recommendation 1.8.4 suggests that early supported discharge should be considered as part of the Hip Fracture Programme, provided the Hip Fracture Programme multidisciplinary team remains involved, and the patient:

• is medically stable and
• has the mental ability to participate in continued rehabilitation and
• is able to transfer and mobilise short distances and

has not yet achieved their full rehabilitation potential, as discussed with the patient, carer and family.

Equality and diversity considerations

NICE clinical guideline 124 recommendation 1.8.6 states that patients admitted from care or nursing homes should not be excluded from rehabilitation programmes in the community or hospital, or as part of an early supported discharge programme.
Quality statement 11: Falls risk assessment

Quality statement

People with hip fracture are offered a multifactorial risk assessment to identify and address future falls risk, and are offered individualised intervention if appropriate.

Quality measure

Structure: Evidence of local arrangements to ensure people with hip fracture are offered a multifactorial risk assessment to identify and address future falls risk, and are offered individualised intervention if appropriate.

Process:

a) Proportion of people with hip fracture who receive a multifactorial risk assessment of future falls risk.

Numerator: the number of people in the denominator who receive a multifactorial risk assessment of future falls risk.

Denominator: the number of people with hip fracture.

b) Proportion of people with hip fracture assessed to be at risk of falls who receive individualised intervention.

Numerator: the number of people in the denominator who receive individualised intervention.

Denominator: the number of people with hip fracture assessed to be at risk of falls.

What the quality statement means for each audience

Service providers ensure systems are in place for people with hip fracture to have a multifactorial risk assessment to identify and address future falls risk, and to have individualised intervention as appropriate.

Health and social care professionals offer people with hip fracture a multifactorial risk assessment to identify and address future falls risk, and offer individualised intervention as appropriate.
Commissioners ensure they commission services for people with hip fracture that provide a multifactorial risk assessment to identify and address future falls risk, and that provide individualised intervention as appropriate.

People with hip fracture are offered an assessment to identify their risk of falling in the future, and are offered help tailored to their circumstances to reduce these risks if needed.

Source guidance

NICE clinical guideline 21 recommendations 1.3.2 (key priority for implementation), 1.2.2 and 1.3.1.

Data source

Structure: Local data collection.

Process:

a) The National Hip Fracture Database records specialist falls assessment criteria based on standard 4 in the 2007 British Orthopaedic Association and British Geriatrics Society Care of patients with fragility fracture ('blue book'):

Standard 4: All patients presenting with a fragility fracture following a fall should be offered multidisciplinary assessment and intervention to prevent future falls.

b) Local data collection.

Definitions

NICE clinical guideline 21 recommendation 1.2.2 states that multifactorial assessment may include the following:

- identification of falls history
- assessment of gait, balance and mobility, and muscle weakness
- assessment of osteoporosis risk
- assessment of the older person's perceived functional ability and fear relating to falling
- assessment of visual impairment
assessment of cognitive impairment and neurological examination

assessment of urinary incontinence

assessment of home hazards

cardiovascular examination and medication review.

**NICE clinical guideline 21** recommendation 1.3.1 states that the following components are common in successful multifactorial intervention programmes:

- strength and balance training
- home hazard assessment and intervention
- vision assessment and referral
- medication review with modification/withdrawal.
Quality statement 12: Bone health assessment

Quality statement

People with hip fracture are offered a bone health assessment to identify future fracture risk and offered pharmacological intervention as needed before discharge from hospital.

Quality measure

Structure: Evidence of local arrangements to ensure that people with hip fracture are offered a bone health assessment to identify future fracture risk and offered pharmacological intervention as needed before discharge from hospital.

Process:

a) Proportion of people with hip fracture who receive a bone health assessment before discharge from hospital.

Numerator: the number of people in the denominator who receive a bone health assessment before discharge from hospital.

Denominator: the number of people with hip fracture.

b) Proportion of people aged 74 years and under with a hip fracture, in whom a dual-energy X-ray absorptiometry (DXA) scan is either completed prior to discharge or is scheduled post discharge from hospital.

Numerator: the number of people in the denominator in whom a DXA scan is either completed prior to discharge from hospital or is scheduled post discharge from hospital.

Denominator: the number of people with hip fracture aged 74 years and under.

c) Proportion of people aged 75 years and over with a hip fracture, who are discharged on appropriate medication to help prevent further fractures.

Numerator: the number of people in the denominator who are discharged on appropriate medication to help prevent further fractures.
Denominator: the number of people aged 75 years and over with a hip fracture.

What the quality statement means for each audience

Service providers ensure systems are in place for people with hip fracture to have a bone health assessment and pharmacological intervention as needed before discharge from hospital.

Health and social care professionals offer people with hip fracture a bone health assessment to identify future fracture risk and pharmacological intervention as needed before discharge from hospital.

Commissioners ensure they commission services for people with hip fracture that offer a bone health assessment to identify future fracture risk and pharmacological intervention as needed before discharge from hospital.

People with hip fracture are offered an assessment of their risk of further fractures, and offered bone-strengthening drugs if the assessment suggests they are needed, before discharge from hospital.

Source guidance

NICE technology appraisal guidance 161.

NICE technology appraisal guidance 204.

Data source

Structure: Local data collection.

Process: a), b), and c) The NICE menu of Quality and Outcomes Framework indicators contains the following:

- The practice can produce a register of patients: 1. Aged 50–74 years with a record of a fragility fracture after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 years and over with a record of a fragility fracture after 1 April 2012.

- The percentage of patients aged between 50 and 74 years, with a fragility fracture, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent.
The percentage of patients aged 75 years and over with a fragility fracture, who are currently treated with an appropriate bone-sparing agent.

Definitions

A bone health assessment involves the generation of a skeletal risk score based upon the FRAX tool. However, the exact content of an assessment will depend on local clinical judgement.

In those people aged 75 years and older who have sustained a fragility fracture, a diagnosis of osteoporosis may be assumed if the responsible clinician considers a DXA scan to be clinically inappropriate or unfeasible. Pharmacological treatment may be offered without confirmation of osteoporosis using DXA scan.

NICE technology appraisal guidance 161 and NICE technology appraisal guidance 204 contain more information on pharmacological interventions for bone health.
Using the quality standard

It is important that the quality standard is considered alongside current policy and guidance documents listed in the development sources section.

Commissioning support and information for patients

NICE has produced a support document to help commissioners and others consider the commissioning implications and potential resource impact of this quality standard. Information for patients using the quality standard is also available on the NICE website.

Quality measures and national indicators

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of healthcare. They are not a new set of targets or mandatory indicators for performance management.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so aspirational achievement levels are likely to be 100% (or 0% if the quality statement states that something should not be done). However, it is recognised that this may not always be appropriate in practice taking account of patient safety, patient choice and clinical judgement and therefore desired levels of achievement should be defined locally.

We have indicated where national indicators currently exist and measure the quality statement. National indicators include those developed by the NHS Information Centre through their Indicators for Quality Improvement Programme. For statements where national quality indicators do not exist, the quality measures should form the basis for audit criteria developed and used locally to improve the quality of healthcare.

For further information, including guidance on using quality measures, please see 'What makes up a NICE quality standard'.

Diversity, equality and language

Good communication between health and social care professionals and people with hip fracture is essential. Treatment and care, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning
disabilities, and to people who do not speak or read English. People with hip fracture should have access to an interpreter or advocate if needed.
Development sources

Evidence sources

The documents below contain clinical guideline recommendations or other recommendations that were used by the TEG to develop the quality standard statements and measures.


Denosumab for the prevention of osteoporotic fractures in postmenopausal women. NICE technology appraisal 204 (2010; NHS Evidence accredited).

Alendronate, etidronate, risedronate, raloxifene, strontium ranelate and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women. NICE technology appraisal guidance 161 (October 2008; amended January 2010 and January 2011; NHS Evidence accredited).


Policy context

It is important that the quality standard is considered alongside current policy documents, including:


**Definitions and data sources**

References included in the definitions and data sources sections can be found below:

British Orthopaedic Association and British Geriatrics Society (2007) Care of patients with fragility fracture ('blue book').


Hospital Episode Statistics (2012) Hospital Episode Statistics.


Related NICE quality standards

When commissioning and providing a high-quality service for hip fracture, the following related quality standards should also be considered:

Patient experience in adult NHS services. NICE quality standard (2012).

Venous thromboembolism (VTE) prevention. NICE quality standard (2010).
The Topic Expert Group and NICE project team

**Topic Expert Group**

**Mr Tim Chesser**  
Consultant Trauma and Orthopaedic Surgeon, North Bristol NHS Trust

**Mr Tony Field**  
Patient/lay member

**Mr Bob Handley**  
Consultant Trauma and Orthopaedic Surgeon, Oxford Radcliffe Hospitals NHS Trust

**Mrs Karen Hertz**  
Advanced Nurse Practitioner, The University Hospital of North Staffordshire NHS Trust

**Ms Pamela Holmes**  
Practice Development Manager, Social Care Institute for Excellence (SCIE)

**Dr Tessa Lewis**  
General Practitioner, Principal, Blaenavon, Gwent

**Dr Iain Moppett**  
Consultant Anaesthetist, Nottingham University Hospitals NHS Trust

**Professor Opinder Sahota**  
Professor in Orthogeriatric Medicine and Consultant Physician, Nottingham University Hospitals NHS Trust

**Professor Cameron Swift (Chair)**  
Professor of Health Care of the Elderly, King’s College, London

**Mrs Heather Towndrow**  
Integrated Schemes Manager, Retford Hospital

**Mr Martin Wiese**  
Consultant in Emergency Medicine, University Hospitals of Leicester NHS Trust
**NICE project team**

**Nick Baillie**  
Associate Director

**Tim Stokes**  
Consultant Clinical Adviser

**Andy McAllister**  
Programme Manager

**Carl Prescott**  
Lead Technical Analyst

**Esther Clifford**  
Project Manager

**Lucy Spiller**  
Coordinator
About this quality standard

NICE quality standards are a set of specific, concise statements and associated measures. They set out aspirational, but achievable, markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions. Derived from the best available evidence such as NICE guidance and other evidence sources accredited by NHS Evidence, they are developed independently by NICE, in collaboration with NHS and social care professionals, their partners and service users, and address three dimensions of quality: clinical effectiveness, patient safety and patient experience.

The methods and processes for developing NICE quality standards are described in the healthcare quality standards process guide.

We have produced a summary for patients and carers.

Changes after publication

May 2015: Minor maintenance.

April 2015: Minor maintenance.

June 2014: Updated information about the National Hip Fracture Database in the Overview section.

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Contact NICE

National Institute for Health and Clinical Excellence

Level 1A, City Tower, Piccadilly Plaza, Manchester M1 4BT

www.nice.org.uk
Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- National Osteoporosis Society
- Royal College of Nursing
- Society and College of Radiographers