

Hip Fracture - information for patients and carers

Your name:	
Your NHS/ hospital unit number:	
Your operation:	
Operation date:	
Your Consultant	
Suggested date of discharge	
Weight bearing status:	

This information is also available at:

www.esht.nhs.uk/leaflet/hip-fractures-information-for-patients-and-carers/

OR:

Go to: www.esht.nhs.uk - click "Service - Trauma and Orthopaedics"
click "patient information"

Hip Fractures

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Introduction

This information booklet is intended to give you a better understanding of your injury, the operation, rehabilitation, and the discharge process. Your choices are important and healthcare professionals will support these wherever possible. You should be treated with dignity and respect.

The aim of the whole team is to help you regain mobility and to support your discharge from hospital providing an appropriate level of assistance. Each person has different rehabilitation goals, and we will work with you to set personal achievable goals.

The aim is that you will stay in hospital for up to one week however sometimes people require a little longer to reach their goals. Some patients are transferred to another facility for rehabilitation.

Hip fracture is a very common injury, but typically occurs in frail older people, who may have many other medical problems. Care usually progresses along an "Integrated Care Pathway". The experienced team will plan how care needs to be adjusted for each individual, to make a patient-centred approach.

You will realise that every patient is different. The National Institute for Health and Clinical Excellence (NICE) recommends that we offer patients (or, as appropriate, their carer and/or family) verbal and printed information about treatment and care including:

- diagnosis
- choice of anaesthesia
- choice of analgesia and other medications
- surgical procedures
- possible complications
- postoperative care
- rehabilitation programme
- long-term outcomes
- healthcare professionals involved

There are headings so you can focus on the sections important to you.

Please use this information to start having the important discussions that you may wish to have with your family and supporters and with staff.

Involving family and carers

Your family, friends and carers may be very helpful in supporting you to prepare for the first few weeks after discharge. (Eg they may be asked to measure the heights of your bed, toilet and chair). Please ask friends or family to bring in a pair of supportive shoes or slippers from home as this will make it safer and easier for you to walk.

Please be aware that a hip fracture is a very major injury. Although most people recover very well, across the UK: 7% of people die after a hip fracture within the first 30 days. East Sussex has excellent results.

You may have to have difficult discussions about your health, getting or staying active, preventing other falls, the suitability of your home environment, your finances, how much help

you will need or whether you would want an attempt at resuscitation if you are found without a pulse.

If, during the course of your hospital stay, you are not able to make decisions about your care, your healthcare professionals may talk to your family or carers unless you have specifically asked them not to. Healthcare professionals should follow the Department of Health's advice on consent and the code of practice for the Mental Capacity Act. Information about the Act and consent issues is available from www.nhs.uk/conditions/dementia/legal-issues/

Staff who may be involved in your care:

Anaesthetist:	Doctor with specialist skills, training and experience in administering anaesthetics and critical care.
Nurse:	There are specialist nurses on the ward, in the operating theatre and in recovery to make sure you get the best possible care. The Health Care Assistants (HCAs) have great experience looking after patients following fractures.
Occupational therapist:	Help you reach your maximum level of function and independence after your hip fracture. They can help with any assessing your need for adaptations or equipment that may be needed around your home to allow you to return home safely.
Orthogeriatrician:	Senior doctor trained in medicine for elderly people especially those with fractures and at risk of falls.
Orthopaedic doctors:	Other doctors on the wards, often with other skills (eg looking after sick patients). Some are training in General Practice.
Orthopaedic surgeon:	A Consultant, Associate Specialist, Specialty Doctor or Specialty Registrar with training in operating and managing patients with fractures
Physiotherapist:	Helps you regain movements, power and strength. They help you re-learn how to walk.
Social worker:	Helps plan care for you at home, eg carers or assistance.
TADS team:	Trauma Assisted Discharge Scheme. Team members aim to help you get home . They may do a delerium assessment in the days after your operation as it is common to become confused.
Others:	Ward clerks, radiographers, Operating department personnel, phlebotomists, etc are all involved at different stages

Consent

The surgical team will explain the risks and benefits in your particular case. Unlike other sorts of surgery, you have very little choice, because hip fractures are usually very unstable and very painful unless you have an operation. Please note that we also put anonymised (i.e. personal details such as your name/ address/ date of birth/ etc are not disclosed) information about every single patient having a hip fracture into reports such as for the National Hip Fracture Database. This allows different hospitals to be compared, which should improve services for patients in the future.

You are usually asked to sign a consent form. If you have dementia or a mental incapacity, the doctors sign all the paperwork in your best interests, taking into account your relatives' or carers' opinions, unless you have assigned Lasting Power of Attorney to a particular person or people.

What are the expected benefits of treatment?

Surgical fixation of a hip fracture aims to reduce pain and to allow you to regain mobility and independence, where appropriate.

What are the potential risks and side effects?

Any operation carries risk. If you have a hip fracture, usually the risks of NOT operating are far higher than the risks of operating. We have a very experienced team who are aware of factors that help you have the best possible outcome.

What are the alternatives?

There are only a very few types of hip fracture that can be left without surgery (less than 5% of cases). Most people need surgery to reduce their pain and get them up and moving.

What is a hip fracture?

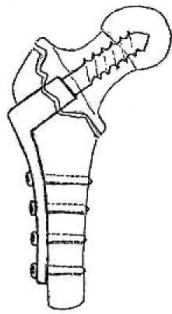
The hip joint is a ball-and-socket joint, with the socket in the pelvis. The ball is the top end of the thigh bone (femur). Sometimes the femur is described as having a "head" (the ball part) with a "neck" beneath.

A "hip fracture" is when the neck (top section) of the thigh bone (femur) breaks. It is also known as a "broken hip" or "fractured neck of femur" or "N.O.F.". This injury almost always requires surgery.

What types of hip fracture are there and what kind of operation?

There are two main types of hip fracture: Trochanteric fracture and subcapital fracture. Both types are equally common. The main difference is that fractures very near the head affect the blood supply and will not heal, so the head needs to be replaced. The operation you have will depend on the type of fracture.

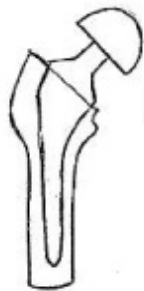
Trochanteric fracture occurs across the widest part of the neck. The blood supply here is good and generally this can be fixed with a plate and screws or “Dynamic Hip Screw” or “**DHS**”



“Subcapital” fracture occurs just below the head. Generally, the blood supply is poor and the whole head needs to be replaced:

Operation = **Hemiarthroplasty** - The broken head is replaced by a metal ball, with a stem going down the femur (thigh bone)

Figure 2: Subcapital fracture with hemiarthroplasty



Other operations that are considered, but are less common:

- Occasionally, a subcapital fracture is fixed with “**cannulated screws**” but there are risks of it not joining or not picking up a blood supply.
- **Intra-medullary nailing** involves putting a nail down the inside of the femur to hold the two parts.
- Occasionally, a subcapital fracture is treated with a **Total hip replacement**. This operation is more complex and has a higher risk of dislocation and more blood loss, so the additional risks are only worth taking if you are very active and medically very fit.



Figure 3: Total hip replacement

What are the possible risks, side effects and complications (of a hip fracture AND/OR of the operation)?

Possible risk	What is this?	How do we (and you) reduce the risk?
Reduction in independence	This can depend to some extent on how fit you were before you broke your hip. However, even for the fittest of people, a hip fracture can mean that you do not regain your full mobility afterwards. Some people may also have persistent pain in their hip area after a fracture. If you were less fit when you broke your hip, you may find that after a hip fracture, it becomes difficult for you to live independently.	Some people need extra care when they move back home after a hip fracture. Others move into a residential or nursing home so that they can get the extra care with mobility that they need.
Blood clots	DVT (deep vein thrombosis) is a blood clot in a vein. These may present as red, painful and swollen legs. DVTs can contribute to ulcers and swelling later. A DVT can pass in the blood stream and be deposited in the lungs (a pulmonary embolism – PE). This is a very serious condition which affects your breathing.	<ul style="list-style-type: none"> • Starting to walk and getting moving is one of the best ways to prevent blood clots from forming. • Most patients are given a daily injection under the skin for a period of time to try and limit this risk of blood clots forming. • A few people are asked to wear stockings but these are contra-indicated in many people as they can cause pressure ulcers (if the skin is thin, sensation is poor, or in dementia, heart failure, oedema, etc).
Acute confusion/ delirium / Cognitive decline	Delirium is an acute confusional state that affects people's brain for a variable period of time. It is very common especially in very elderly frail hip fracture patients. It is not always reversible.	We look, intervene and treat. We assess and screen on admission and post-operatively. Prevention includes encouraging fluids, nutrition, deep breathing, mobility and management of pain. Good sensory input can help (glasses and hearing aids). We look for other causes and treat them. We intervene and try to minimise the effects.
Pain	The hip will be sore after the operation. If you are in pain, it is important to tell staff so that medicines can be given. Pain will usually improve with time.	

Possible risk	What is this?	How do we (and you) reduce the risk?
Chest infection	Infection of the lungs or bronchii (tubes the air goes through) causing you to feel unwell. Often you have a cough or fast breathing as your body tries to get enough oxygen.	You should take deep breaths regularly. Cough up any mucus. We aim to get you up and about as this exercises the lungs too.
Catheterisation	If you have difficulty in passing urine immediately after the operation, the team may pass a tube into the bladder. This is usually temporary.	Catheterisation may be done before the operation.
Pressure ulcers	This is an area of skin that dies because there is not a good enough blood supply. Ulcers can be caused by irritation and/or continuous pressure on parts of your body. Common areas are your heels and your buttocks, but can include any bony area. If you are not very mobile and are spending long periods in bed or in a chair, you are at increased risk of developing a pressure ulcer.	The nursing staff assess each patient's risk regularly and provide the right kind of mattress/cushion and advice on moving about to relieve this pressure that causes the sores. They will also help to ensure that your skin stays clean and dry.
Altered leg length	The leg which has been operated upon, may appear shorter or longer than the other. This rarely requires a further operation to correct the difference or physiotherapy. Shoe inserts can be helpful.	After a DHS, it is common for the fracture to join with the leg slightly shorter. In replacement surgery, your Xrays are used for planning and during the operation further measurements are taken. It is, however, more important to get the tissues to be the correct tightness, so sometimes the leg has to be a little shorter or longer.
Hip stiffness	May occur after the operation, especially if movement post-operation is limited.	Physiotherapy helps this
Nerve Damage	This may cause temporary or permanent altered sensation or weakness of the leg.	
Bone Damage	The thigh bone may break when the metal is inserted. This may require fixation, either at the time or at a later operation.	
Wound healing problems	The wound may have problems healing	Ensure you get good nutrition in hospital and afterwards. See pages 20 – 26.

Possible risk	What is this?	How do we (and you) reduce the risk?
Blood vessel damage	The vessels around the hip may rarely be damaged. This can cause a blood collection in the tissues (Haematoma). This may require further surgery.	
Infection	Despite all precautions, infections occur (national figures are: 1 to 2½%). The wound may become red, hot and painful. There may also be a discharge of fluid or pus. This is usually treated with antibiotics, but an operation to washout the joint may be necessary. In rare cases, the prosthesis may be removed and replaced at a later date.	You will be given antibiotics just before the operation. The procedure will also be performed in sterile conditions (theatre) with sterile equipment.
Death	A broken hip is a very serious condition. Nationally, 7% of people die within 30 days and another 20% sadly do not survive a year. Most people, however, have a good result. (In the past, before surgery, people would be on traction for months and most did not survive.)	Getting up and about as soon as possible is one of the best ways to keep your body working well. East Sussex Healthcare NHS Trust has excellent results on the National Hip Fracture Database.
Metal failure/ prosthesis wear/ loosening	It is important to keep everything moving, but sometimes the thousands of movements every day contribute to wear or loosening of the implant. Rarely, further surgery is needed.	Modern operating techniques and new implants mean that after the operation, the leg is usually stronger than before the fracture! We advise avoiding jogging after hip surgery. Gentle exercise with less impact is encouraged.
Joint dislocation (only in hemiarthroplasty or replacement)	This is the ball flipping out of the socket, sometimes a long time after the operation. The joint needs to be put back into place, which sometimes needs an anaesthetic. Occasionally a hip brace is required. Rarely if the hip keeps dislocating, a revision operation may be necessary.	We advise avoiding extreme positions after replacement surgery, twisting or bending over 90 degrees. Talk to the physiotherapist.
Fracture non-union (not in replacement or hemiarthroplasty)	This is where the bone fragments of the fracture do not heal or join together in the normal way.	Further surgery is possible
Avascular necrosis AVN (not in replacement or hemiarthroplasty)	This is a loss of blood to the head of the femur (the thigh bone). This makes the bone weak, and can cause pain. Sometimes another operation is needed (eg total hip replacement)	Smoking can reduce blood supply to bones. Most cases have no reason identified.

Types of anaesthetic

An anaesthetic stops you from feeling any pain during your operation. Your healthcare team should talk with you about the risks and benefits of the different types to help you to decide which type of anaesthetic is right for you. In addition, you may also be offered a nerve block for the operation.

	Spinal anaesthesia	General anaesthesia
What is it?	This is a type of regional anaesthetic (that is, it works only in one area). An injection of anaesthetic into your lower back numbs your spinal nerves so that you will not feel anything from the waist down for a number of hours.	An injection into a vein that causes unconsciousness, which is maintained throughout the operation, usually with the use of an anaesthetic gas or continuous drugs through a tube into a vein.
What are its main advantages?	It is suitable for most people. It is particularly good for people with COPD or lung problems.	You aren't aware of what is happening during the operation.
What are its main disadvantages?		Pain relief has to be provided by another method. It may be unsuitable for people with poor general health. Potential increased risk of postoperative delirium, i.e. feeling "muddled"

Achieving satisfactory pain relief:

Step 1	At first, you should be offered paracetamol every 6 hours (unless you cannot take paracetamol for some reason).
Step 2	<p>Nerve block:</p> <p>A nerve block is an injection that numbs an area of the body for a limited time. Blocking nerve fibres in the groin can numb the area around your hip and thigh. This is also known as 'Fascia Iliaca Compartment Block' or 'F.I.C.B.' It may not be possible if you have heart block, previous vascular surgery, obesity, agitation or anticoagulation medication.</p>
Step 3	Your pain will be assessed. You may be offered opioids as well. Opioids are stronger painkillers that work in a different way to paracetamol.
	NICE (the National Institute for health and Care Excellence) has said that non-steroidal anti-inflammatory drugs are not recommended for patients who have a hip fracture.

Things that happen once the fracture is diagnosed:

- We do everything possible to make sure you are as fit as possible for your operation.
- You will be started on a drip.
- Blood tests and heart tracings will be taken.
- If there is an abnormality in any tests or on examination, we will attempt to correct this.
- You will have pain relief.
- You will be assessed for risk of blood clots and risk of bleeding and necessary medication prescribed.
- The surgery itself requires a very large and specialist team, so it is usually best to stabilise and prepare a patient and then operate on the next day's "trauma list", within 36 hours, but not at night.
- It is routine practice to discuss with patients what they would want in the case of an emergency. You may have already discussed this with your GP. If a patient lacks capacity, this may be discussed with a relative. In this Trust we follow the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) process.

On the day of surgery

- You should not eat anything for 6 hours before surgery. You should also not eat sweets or chew gum during this time.
- You may drink "clear fluids" (water, black tea, black coffee, squash without bits or nutritional drinks) for at least 2 hours before surgery.
- You will be helped to wash and will be given a theatre gown to wear.
- You will meet the anaesthetist administering your anaesthetic
- You will meet the surgeon doing the operation. S/he may not be your own Consultant but will have training or supervision to perform the surgery.
- You will have an arrow drawn on your injured leg unless this has been done already.
- Because trauma lists are not predictable, we may not know when your operation may be, so you may be asked to stop drinking in advance, so we can utilise every operating theatre slot.
- You will be taken to theatre on your bed.
- Please note that there is always the possibility of your operation being cancelled if a more urgent case is admitted or the anaesthetist may feel that you require another treatment to ensure you are fit enough to have an anaesthetic. The nurses will tell you and your family if this happens.

What happens immediately after the operation?

- Your wound will be monitored and dressed as required.
- You will be offered supplementary drinks pre and post operatively.
- After the operation there is a possibility that you may become confused and disorientated. This confusion tends to be short lived.
- Your catheter will be removed as soon as possible after your operation (often at 3 days) it is usually removed at night as most people pass urine first thing in the morning.
- Sometimes a drain may be used to draw off excess blood. This will be removed as soon as the seepage has slowed to an acceptable level.
- To reduce the risk of developing a deep vein thrombosis (DVT), which is a clot in your legs, you may be given an injection every day; however this injection does not eliminate the risk of you developing a clot.

What happens on the days following the operation?

You will be assisted out of bed to sit in your chair on the first day after your operation. This helps to protect your pressure areas and prevent chest infections and helps you to return to normal activity quicker.

You must help the nursing staff to move you in bed by following their instructions when you need to be moved. They are not allowed to lift you but are happy to assist. It is important to change your position regularly to protect the skin around your pressure areas. A nurse call bell is available for you to ask for assistance.

Many patients have other medical problems, along with their broken hip. For this reason, we have a dedicated medical team led by experienced Ortho-geriatricians. All patients should be reviewed by an Ortho-geriatrician, some before their operation to make them as fit as possible, others for on-going medical care.

The physiotherapist, occupational therapist and nursing staff on the ward will all be working together to help you get as strong as possible. It is very important that you start to walk as soon as possible. If appropriate, you will be seen by a physiotherapist who can advise you on exercises to help you build up strength in your leg. It is important to continue these exercises when you return home as they help to strengthen specific muscle groups and aid your recovery. The team will make a plan with you and your family to get the best possible outcome.

Once you have recovered from the anaesthetic please try to eat a healthy diet, as this will help the wound to heal. If possible try to drink an adequate amount to keep hydrated and flush the anaesthetic out of your system

Your drip will be removed once you are drinking normally. An x-ray may be taken of your hip before you are discharged home (unless you have had a DHS, as Xrays are used in the operating theatre).

There is a possibility that, due to painkillers and lack of mobility, you may become constipated. This is quite normal, and you will be offered laxatives to rectify this.

A hip fracture is a significant injury and often accompanies other illnesses. A proportion of patients with this injury may become significantly more unwell. We aim to treat these illnesses to the best of our ability but occasionally we are unable to cure them. We encourage patients and close relatives of patients to consider how they would like to be managed if this occurs. We use the ReSPECT process. This includes discussing and reaching a shared understanding about: the person and their current and likely future health; preferences for care; clinical recommendations for care and decisions around attempting resuscitation.

Some people will have very limited goals for rehabilitation.

We usually do not arrange a follow up appointment in clinic.

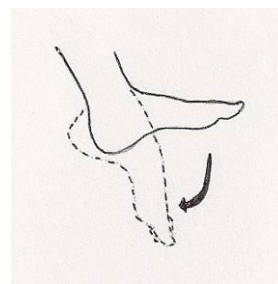
What physiotherapy exercises should I do to aid my recovery?

The following exercises should be performed as demonstrated by your physiotherapist to:

- Improve your circulation
- Strengthen the muscles surrounding your hip
- Regain movement of your hip

Ankle exercises

Briskly and regularly bend your ankles up and down.



Buttock exercises

Tighten your buttock muscles by squeezing them together. Hold for a count of 5 and relax.

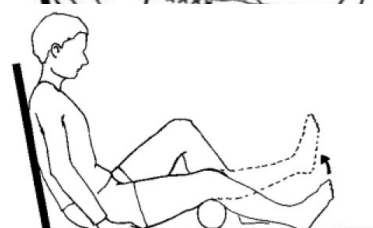
Thigh exercise (1)

Sitting with your legs out in front of you, pull your toes up towards you and push your knee down onto the bed, tightening your thigh muscles. Hold for a count of 5 and relax.



Thigh exercise (2)

Position your knee over a rolled towel. Push your knee down into the towel, tightening your thigh muscles. Straighten your knee, lifting your heel off the bed. Hold for a count of 5 and relax.



Hip bending

Lying with your legs out in front of you, slowly bend your knee by sliding your foot up the bed then gently lower your knee back to the bed. Keep your knee and toes pointing towards the ceiling throughout the exercise.



Hip abduction

Lie on the bed with your legs out in front of you. Keeping your knee straight and your toes pointing towards the ceiling, slide your leg out to the side, leading with your heel (you may need some help at first) and bring it back to the middle.



Each exercise should be performed at least 10 times and repeated at least 4 times a day

Walking

You will be taught how to walk with an appropriate walking aid. Members of the team will continue to monitor your progress and provide advice during your hospital stay. You may be progressed onto crutches or sticks if appropriate. This may happen after you return home.

Standing - Holding on to a firm handhold (e.g. a solid chair, worktop or kitchen sink), stand side on with the operative leg facing outwards

Walking with crutches:

From standing:

(a) first put both crutches forward, about shoulder width apart, and

(b) place the operated leg between them

(c) Step through the crutches with the good leg so that your foot goes in front of the operated leg.

Repeat steps (a), (b), (c).



(a) Crutches forward



(b) operated leg between crutches



(c) Good leg step forward

It is important that you practice walking with the nurses to and from the toilet/bathroom where possible, to get you back into your normal daily routine. This will help to build your strength and confidence.

Please ask friends or family to bring in a pair of supportive shoes or slippers from home as this will assist your walking.

How much weight can be taken through the operated leg?

Your surgeon may decide that you need to protect your hip after surgery by instructing you to take less weight through your operated leg when standing or walking. The following weight-bearing terms may apply:

Full Weight Bearing	100% of weight through the affected leg Aim for heel-toe of normal walking pattern
Partial Weight Bearing	Walking pattern with up to 50% of weight through the affected leg
Minimal Weight Bearing	Walking pattern with up to 25% of weight through the affected leg
Non Weight Bearing	No body weight is to be placed through the affected leg

The physiotherapist will explain and practice the appropriate weight bearing status with you. Usually after a hip fracture operation you may weight bear as much as you can.

Stairs

If you have steps or stairs at home, the physiotherapist will show you the correct way of going up and down. If you have a hand-rail, the safest way to climb stairs is to use a rail in one hand and a crutch / stick in the other. If you are on your own, carry the spare crutch on the outside of the other crutch handle.

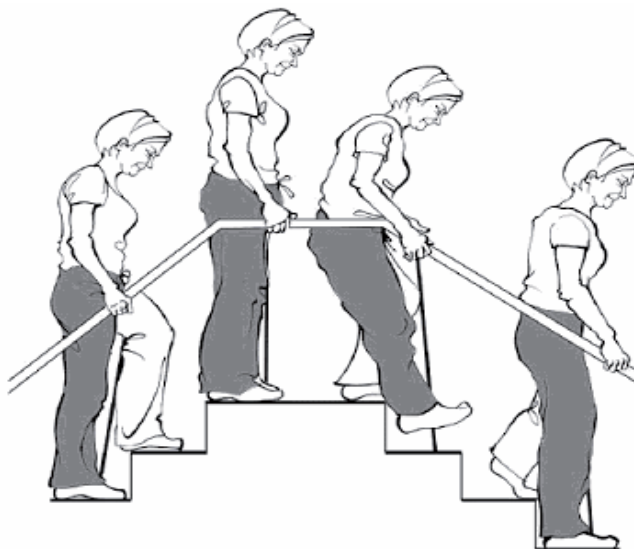
Hold the rail in one hand and your stick/crutch in the other.

Going upstairs - Take one step at a time. Lead with the leg that **has not** been operated on.

Going downstairs - Take one step at a time. Lead with the leg that **has** been operated on.

“Good leg leads up”

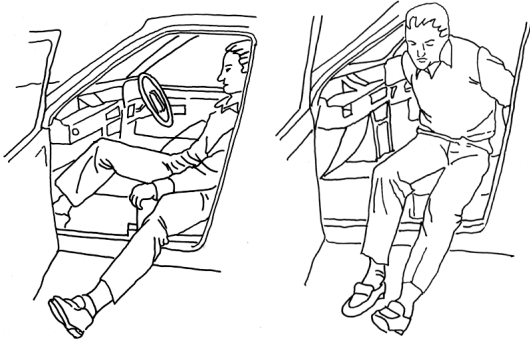
“Bad leg leads going down”



Travelling by car

You should not drive for at least six weeks following surgery, but you may travel as a passenger in a car providing you are confident that you can manage transfers.

Getting Into the Passenger Seat - Get somebody to push the seat back as far as possible and slightly recline it. A firm pillow should be placed on the seat to make it higher. Ensure that you are on a level to start preferably standing on the road not on the kerb.



Lower yourself down slowly to the edge of the seat with your back towards the driver's door. Keep your knee out straight in front of you and push yourself backward towards the driver's seat. Keep leaning backwards so that you do not bend your hip more than a right angle.

Putting a plastic sheet or carrier bag on the seat often helps as it enables you to slide more easily.

Still keeping the leg straight, turn carefully and slide the leg into the well of the car so that you are facing forwards.

To get out of the car, reverse the above procedure. Make sure that you have your operated leg out in front of you and that you are sitting on the edge of the seat before rising.

Occupational therapy

The Occupational Therapy Team will assess your ability to manage at home independent (if applicable) and where necessary, give advice regarding equipment for your home to enable you to move and participate in daily tasks with more independence. The team can advise you of services available to support you following your admission if required.

How will I manage my personal care?

Consider wearing loose fitting and light clothing to reduce aggravating the wound on your hip and for improved comfort when completing your exercises.

When getting dressed: it is recommended that you dress your operated leg first and undress it last. Being seated when dressing is recommended.

You are advised not to get into a bath for the first 6 weeks after your operation. If you have a walk in shower you will be able to use this as soon as the wound is dry, otherwise it is recommended that you have a strip wash until the stitches /clips have been removed and your wound is dry.

How can I prepare my home environment?

Your family and friends may need to prepare your home environment for your discharge from hospital, especially if you live alone or live with someone who will be unable to help you at home.

For example:

- Remove rugs and ensure a clear area for safe mobility around your home and ensure your home is clutter-free
- Stock up on store food items e.g. tins, UHT milk, microwave ready meals
- If possible, ensure your home has been well cleaned
- Consider who can support you with your shopping and cleaning initially.

How will I manage my food shopping?

- Avoid busy times and do a little at a time
- Consider telephone shopping
- Consider internet shopping – someone else can do this for you and have the items delivered to your home at a time slot that you decide.
- If in a supermarket, use a trolley, do not carry a basket.
- Most supermarkets have their own wheelchairs if you feel unable to walk around the shop

What are the options for discharge?

The multi-professional team, consisting of the nurses, therapy staff and social services will work closely with you to agree realistic and achievable goals for a supportive and safe discharge from hospital.

You will be asked about your personal situation such as who you live with, if you have any stairs or steps to manage and whether you have any community help. This information, along with your progress on the ward, will help us to agree on an appropriate discharge plan with you.

Once medically fit to leave hospital there are a variety of options to support your discharge.

Home

If you have achieved your agreed goals to return home, you may be referred for further rehabilitation or support. Our Trauma Assisted Discharge Scheme (TADS) may make recommendations to progress your mobility to try and regain your independence.

A referral can be made to Adult Social Care services to discuss appropriate options for discharge where disability may make return to pre-admission living circumstances difficult.

You will find that chairs with arms are better. Higher chairs and higher beds are easier to get into or out of. Your family may wish to measure these for you:

Height of bed	
Height of toilet	
Height of chair	

Short-term residential rehabilitation

If your team consider you need a little longer to achieve your goals with regard to mobility and/or personal daily activities, they may refer you to an intermediate care unit. You may stay as a resident in the unit for a short period.

Discharge

We aim to discharge you from hospital as soon as you are mobile and safe for discharge back to your usual place of residence. Some patients are not able to manage at home so alternative arrangements may need to be arranged. The nursing staff will make a referral to social services to assist you with this process if required. You may require a longer period of rehabilitation at a rehabilitation unit.

It is important you and your family should be prepared for your return home and transport arrangements made.

A week's supply of medicine including pain relief may be given to you on discharge from the ward.

Points to Remember

- Try to sleep lying on your back or your OPERATED side. If you must lie on your “good side” e.g. for removal of stitches, make sure that you have a couple of firm pillows between your knees.
- Sit only in a high chair that is suitable for you.
- Do not cross your legs.
- When you are turning take lots of small steps do not swivel on your operated leg
- You should not get into a bath for 6 weeks following your surgery.
- You may use a walk in shower as soon as your wound is dry.
- Take regular exercise – “little and often” is better than too much all at once. Gradually progress how much you do.
- Your operated leg will be swollen for up to 6 weeks after the operation, and in some cases even longer, this is quite normal and can be expected. It is advisable to elevate the leg whenever sitting for any length of time
- If your leg or feet are swollen, rest on your bed for at least an hour each afternoon

Travelling by car

See page 19 of this booklet

Travelling by bus, train or plane

You can travel on a bus or train when you feel comfortable to do so providing you take care. Travelling on a plane is not recommended for the first 3 months. You may wish to discuss this further with your GP.

Dressings, the wound, swelling and inflammation

Most surgical wounds heal without problems. Everybody is different. Any break in the skin's protective layer can allow micro-organisms to enter the area.

- If your wound is dry and you have a waterproof dressing, it is usually possible to shower about 48 hours after your operation. Ask your nurse for advice.
- Showering is preferable to bathing as your wound does not soak in water.
- Do not use soap, shower gel, body lotion, talcum powder or other skin products directly onto your healing wound.
- Do not rub the wound excessively. This may be painful and could delay the healing process.
- Dry the surrounding area carefully by patting gently with a clean towel but allow your wound to air dry.
- Leave your dressing in place providing that it is dry and not soaked with blood.
- If your nurse says to remove or replace your dressing yourself: firstly wash your hands with soap and water, then carefully take the dressing off and dispose of it. Try not to touch the wound or the inside surface of the new dressing when replacing.

After surgery, swelling of the leg is common. Blood vessels expand in the operated area and white blood cells flood out to clean and protect your wound. Also, because you are moving less, blood and tissue fluid are not “pumped” back to your heart as efficiently. Swelling can cause discomfort.

Caring for your wound:

You can lessen the risk of problems occurring if you

- Do not smoke. For advice see: <http://smokefree.nhs.uk> or our pharmacist can help.
- Eat a nutritious, well balanced diet. Healing needs extra energy, vitamins and protein.
- Take extra care of conditions that affect healing e.g. diabetes, disorders requiring steroids or anticoagulants, peripheral vascular disease, chronic obstructive pulmonary disease (COPD) or immune conditions.
- Drink sufficient fluids. Dehydration lengthens the healing process.
- Take sufficient rest and sleep. Sleep and rest optimise healing.
- Take sufficient exercise even if slow and restricted at first. Regular exercise pumps extra oxygen to everywhere requiring healing and recovery.

Things to look out for:

We hope that your recovery will be uneventful. Your doctors and nurses will do everything they can to prevent problems occurring but it is important that you know how to tell if you could be developing complications after you go home.

But it is a good idea to be prepared and know what to look out for:

1. Problems with the wound. Ask for advice if the wound:
 - Becomes increasingly more painful
 - Looks increasingly red, hot or swollen
 - Leaks or weeps liquid, pus or blood
 - Smells unpleasant
2. If you are generally feeling unwell and not picking up after a few days at home or if you have a high temperature.
3. Pain and swelling in the calf muscle. A certain amount of pain must be expected but if the calf muscle is painful to squeeze and very swollen it could mean a thrombosis is occurring (DVT).
4. Increased pain in the hip or inability to put your weight on to the operated leg. These are signs that something could be amiss and you should seek medical advice.

If you have any of these symptoms contact your GP or Trauma Assisted Discharge Scheme. In the event of any wound leakage ask them to consider sending a sample or swab to the laboratory at the hospital for analysis. Wound infections can usually be treated quickly and successfully if causes are identified and treated with the most appropriate antibiotic.

If you have any concerns following your discharge from hospital, call your General Practitioner (GP) and explain the problem and ask him/her to visit you at home. Remember that travelling could be difficult for you at this stage.

Inflammation is not always caused by infection and in the event of a wound being inflamed but not infected, antibiotics will not always be a necessary part of your treatment.

Future activities

Following discharge from hospital do not be surprised if you feel very tired or sleep for long periods. You will get over this within a few days of being home. In order to stretch the muscles at the front of your hip it is advisable to lie completely flat on your back with your hips and knees straight, for at least one hour each day. This will also help prevent excessive swelling in your legs.

If your wound has stitches that need removing or clips, these will be removed at around 10-12 days, either in hospital or by your district nurse or GP practice nurse. Some wounds have dissolvable stitches and glue. Try not to touch your wound dressing as this can cause infection; re-dressings will be done as necessary.

To reduce the risk of developing clots in your leg veins or lungs we give you a daily injection unless there is a special reason not to use it in your case. This will continue until you are 28 days following your operation, you or a carer/family member will be taught how to administer these. If this is not possible a District Nurse will be arranged.

If you have been given "Anti-Embolism stockings", these should be changed every 3 days to maintain elasticity. A member of the family or a friend will have to do this for you once you are home. Please try to make arrangements before you are discharged from hospital.

Gradually increase the amount of walking that you do, indoors at first and then out of doors once you are confident. Continue with your exercises as advised by the physiotherapist

Continue to avoid vigorous, forceful hip movements which cause excessive pain.

Do not move around the house without using your sticks or crutches for support, however, you can stand without these to work at the sink or cooker for short periods unless otherwise instructed. You will find that you are not able to carry items with crutches or a frame: ask someone to carry things for you, speak with your occupational therapist if you are concerned.

You can begin to resume normal household activities but avoid heavy chores such as using the vacuum cleaner for the first six weeks. You will need assistance with certain tasks such as laundry and bed making.

Sexual activity may be resumed after 6 weeks after the operation. You may need to try different positions (eg being the more "passive" partner, underneath).

You can gradually resume more normal physical activities at three months, for example: swimming, cycling, bowls, gardening and dancing. Jogging has high impact and may cause a hemi-arthroplasty or total hip replacement to fail earlier, so we advise against regularly running a large number of miles. Being active is good for building your bone and muscle strength to reduce future problems with osteoporosis.

Preventing future problems from osteoporosis and falls:

Osteoporosis means bones of low density (= weak bones). Many people get this especially as they get older without realising until a bone breaks with little trauma. Your fracture will heal just as quickly whether you have osteoporosis or not. The following advice is to prevent **future** fractures, not to help your current fracture.

If you have the kind of bones where a fracture happens with little trauma, you should see if there is anything you can improve to make your bones stronger. This may prevent another hip fracture in a few years, or spinal wedge fractures.

- Smoking reduces bone density - The NHS stop smoking service is free on: <http://smokefree.nhs.uk> or tel. 0300 123 1044
- Exercise improves bone strength, muscle strength and reaction times. (Walking every day, cycling, climbing stairs, yoga and Tai chi are good.) Keep moving!
- Sunlight helps your body make vitamin D. Many people don't have enough vitamin D and have weak bones and painful muscles because of this. (If you are out more than one hour: wear a hat and/or sunscreen to protect you from sunburn and skin cancers.)
- Excessive alcohol makes bones weak. Try a glass of soft drink between alcoholic drinks or limit the times when you drink alcohol or the amount you drink each occasion.
- Most patients who have had a hip fracture are prescribed medication to improve bone strength and reduce the risk of future fractures.
- All patients should have an assessment for osteoporosis.
- If you have severe osteoporosis, are on steroids or over 75 years, you will have medication prescribed.
- If you are under 75 years, the fracture liaison team will review your case and contact you if appropriate.

Reducing risk of falls:

All patients should have a falls risk assessment. Some patients are referred for further Orthogeriatrician or GP assessment of the cause of the fall. Some patients are referred to the Falls prevention team. There are things you can do:

- Looking at any particular hazards that you may have in your home, such as loose rugs or furniture.
- Having a regular check of your eyesight
- Seeing your doctor regularly for a review of your medication, your blood pressure and your general health.
- Keeping physically active so your muscles are able to react quickly.
- If you are concerned that you are at risk of falling, you should discuss this with your doctor or social worker.

Sources of information:

We are grateful to other organisations for their information:

- National Hip Fracture Database - www.nhfd.co.uk
- NICE (2017) NICE clinical guideline No 124: The management of hip fracture in adults - www.nice.org.uk/guidance/cg124
- BOAST (2019) British Orthopaedic Association - www.boa.ac.uk, British Geriatrics Society, National Hip Fracture Database (www.nhfd.co.uk), Fragility Fracture Network The Care of the Older or Frail Orthopaedic Trauma Patient - www.boa.ac.uk/standards-guidance/boasts.html
- NICE clinical guidance 103 (2019) – Delirium - www.nice.org.uk/guidance/cg103/
- NICE clinical guidance 184 (2019) – Dementia - www.nice.org.uk/guidance/qs184

- NICE clinical guidelines 161 (2013) – Falls - www.nice.org.uk/guidance/cg161
- NICE clinical guideline 92- On Venous thromboembolism - www.nice.org.uk/CG92
- NICE Osteoporosis standard QS149 (2017) - www.nice.org.uk/guidance/QS149
- NICE (2019) Surgical site infection: - www.nice.org.uk/guidance/ng125
- UK Resuscitation Council (2019) ReSPECT - www.resus.org.uk/respect/
- Brighton and Sussex University hospitals (2012) Recovering from a broken hip:
- Royal Berkshire hospital NHS Foundation Trust (2011) Information for patients and relatives: you have been admitted with a hip fracture.
- Ashford and St Peter's hospital NHS foundation hospitals NHS Trust (2012) Fractured neck of femur
- Royal United hospitals Bath (2005) Recovering from a broken hip
- Dorset County Hospital NHS Trust (2013) Fractured neck of femur
- North Lincolnshire & Goole Hospitals (2012) 'Hip-Hop' back to Health for Patients following Surgery for a Hip Fracture

Sources of further information:

National Osteoporosis Society, 0845 450 0230 - www.nos.org.uk

National Hip Fracture Database - www.nhfd.co.uk

NHS Website - www.nhs.uk - for more information.

NICE has produced separate advice for assessing and preventing falls in older people - www.nice.org.uk/guidance/cg161

Important information

The information in this leaflet is for guidance purposes only and is not provided to replace professional clinical advice from a qualified practitioner.

Hand hygiene

We are committed to maintaining a clean, safe environment. Hand hygiene is very important in controlling infection. Alcohol gel is widely available at the patient bedside for staff use and at the entrance of each clinical area for visitors to clean their hands before and after entering.

Your comments

We are always interested to hear your views about our leaflets. If you have any comments, please contact the patient experience team on 0300 131 4784 or esh-tr.patientexperience@nhs.net.

Other formats

If you require any of the Trust leaflets in alternative formats, such as large print or alternative languages, please contact the Equality and Human Rights Department.

Tel: 0300 131 4500 Email: esh-tr.AccessibleInformation@nhs.net

After reading this information are there any questions you would like to ask? Please list below and ask your physiotherapist, nurse or doctor.

Reference:

With thanks to many members of the team for their input, especially

Dr Charlotte Willis Consultant Orthogeriatrician

Karin Knowles Trauma Pathway Facilitator and Practice Educator

The directorate group that has agreed this patient information leaflet:
Diagnostics, Anaesthetics and Surgery

Next review date: September 2025

Responsible clinician: Prof Scarlett McNally, Consultant Orthopaedic surgeon

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Useful telephone numbers

	Telephone No.
General Practitioner	
District Nurse	
Adult Social Care	0345 60 80 191
Age UK	0800 169 6565

	Conquest Hospital	Eastbourne DGH
Main switchboard	0300 131 4500	0300 131 4500
Emergency Orthopaedic ward	Benson Trauma ward 0300 131 4979	
Emergency Orthopaedic ward	Egerton ward 0300 131 4983	
Planned Orthopaedic ward	Cookson Devas Elective ward 0300 131 4500 Extension 770490	
Occupational Therapy	0300 131 5181	
Physiotherapy	0300 131 4770	
Trauma Assisted Discharge Team "TADS"	Via Benson ward 0300 131 4979	
Patient Advice and Liaison Service	0300 131 4606	

We have dedicated meal times to help with recovery and nutrition, followed by a rest time. Rest is also a very important part of recovery.

From 12 noon to 2.30pm, visitors are **not usually** allowed to come to the ward.

Usual visiting times are 2.30pm to 8.00pm on all Orthopaedic wards

Information updated during the COVID-19 pandemic to ensure that patients with injuries have information, support and care despite social distancing.