Maidstone and Tunbridge Wells
NHS Trust

Trauma & Orthopaedics

Hip & Femur Fractures

Information for patients, relatives and carers

Orthopaedic Surgeon: ………………………………………………

Orthogeriatric Consultant: …………………………………………

Ward Doctors: ……………………………………………………..

Ward Manager: ……...………………………………………………

Physiotherapist: ...…………………………………………………...

Occupational Therapist: ...…………………………………….....

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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. 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.

Hip fracture is a very common injury, over 70,000 people in the UK sustain a hip fracture each year. Maidstone and Tunbridge Wells NHS Trust looks after approximately 600 new hip fractures a year. Over two thirds of patients are over 80 years of age. Hip fractures typically occur in frailer older people who may have many other medical problems. However, they can occur in patients who are otherwise healthy and independent. Patients who are fit, well and active prior to surgery often recover well.

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

Please be aware that a hip fracture is a very major injury. Although most people recover very well, across the UK 10% of people die after a hip fracture without leaving hospital and a further 20% die in the first year. Approximately 50% of patients fail to regain the mobility they had before the fracture and may require a walking aid. Those previously requiring a walking aid may struggle to mobilise; and may need some assistance with activities of daily living afterwards. 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 members are happy to help so if you have any concerns, please do not hesitate to contact us and ask questions. We have a multi-disciplinary team who are happy to help.

Who will be involved in my care?

You will be looked after by a group of heath care professionals each specialising in different areas of care. This group is known as a multi-disciplinary team (MDT). The team meet each morning to discuss each patient on the ward.

These are some of the healthcare professionals you will meet:

Orthopaedic surgeon: Doctors specialising in the diagnosis and treatment of disorders of the bones, joints, ligaments, tendons and muscles. These doctors are surgeons. They will visit you on your admission, before your surgery and after your operation to check your wound is healing and bone stability is satisfactory.

Ortho-geriatric doctor: Medical doctors who specialise in the complex medical problems affecting older patients in the context of an admission with a hip or femur fracture. Their role includes an assessment of bone health and a review of falls to prevent further injuries. They will manage any pre-existing medical conditions you have and any medical issues that arise after any surgery.

Anaesthetist: Doctors with specialist skills in administering anaesthetics and critical care.

Consultant: This is a senior doctor who is in overall charge of your care. You will have two Consultants, an Orthopaedic and Ortho-geriatric Consultant.

Ward doctor: These doctors work alongside the Consultant to manage your care.

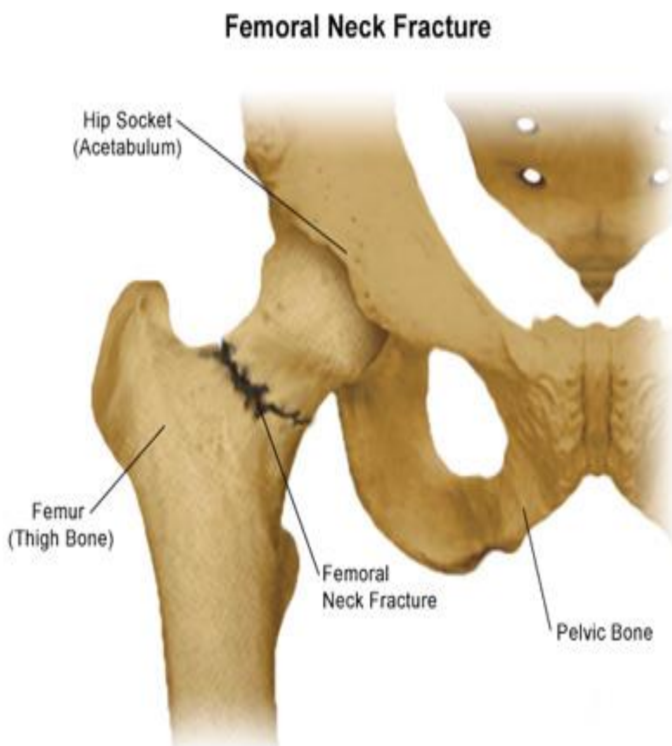
Nursing staff: A team of both registered nurses and clinical support workers, who assist you in meeting your care needs whilst in hospital. There will be a nurse in charge of your care each shift. The Ward Manager is a senior nurse who has overall responsibility for the nursing team and the ward environment.

Physiotherapist: Therapists who work with you after your operation to improve balance, strength and mobility. They help you regain mobility after your injury and subsequent surgery.

Occupational Therapist: Therapists who promote independence and assess your ability to manage everyday activities, helping to predict what level of care or assistance will be needed upon discharge.

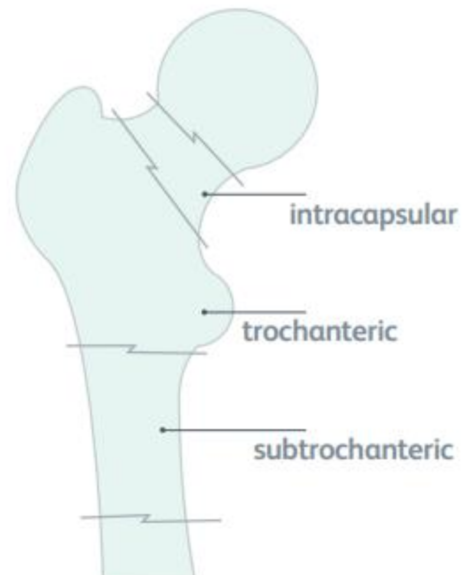
Flow Co-ordinator: A non-clinical member of the team who will organise your discharge or transfer. The flow co-ordinator will liaise with internal and external agencies such as cottage hospitals, including Tonbridge Cottage Hospital, care homes and care agencies to enable your safe discharge.

What Is A Hip Fracture?



The hip joint is an example of a ball and socket joint with the socket in the pelvis. The ball is part of the thigh bone called the femur. The ball, also called the head of the femur, is attached to the shaft of the femur by an area of bone called the neck of the femur. A hip fracture refers to a break at the top of the femur bone and is sometimes described as a 'fractured neck of femur' or 'fracture of the proximal femur'. The majority of fractures are usually the result of a fall and almost all require surgery. The particular type of surgery depends on where the bone has broken. Sometimes the fracture is fixed with a metal implant to allow it to heal. In other fractures a better result is obtained by replacing the head of the femur with a metal replacement.

Areas of the femur where different types of fracture commonly occur:



What causes a hip fracture?

You may have had a fall. Falls are common in older people, and one in three people over 65 will fall each year. Your bones may not be as strong as they used to be. Bone doesn't usually break with a simple fall. As we get older, however, our bones become weaker. Osteoporosis and other bone diseases can also make your bones weaker. This means that a fall even from standing height can cause a fracture.

What is Mental Capacity?

Having mental capacity means being able to make and communicate your own decisions.

Someone may lack mental capacity if they can't**:**

- understand information about a particular decision
- remember that information long enough to make the decision
- weigh up the information to make the decision
- communicate their decision.

Lack of mental capacity can be caused by many things. It can be:

- Permanent: This could be because of a stroke or brain injury, severe dementia or learning disability
- Temporary: This could be because of a mental health problem, substance or alcohol misuse, or confusion, drowsiness or unconsciousness because of an illness or treatment.

What happens if I lose mental capacity?

The Mental Capacity Act is designed to protect you if you don't have mental capacity. It says:

- you have the right to make your own decisions if you have mental capacity
- it assumes you have mental capacity unless you've had an assessment showing you don't.
- you must be helped to make your own decisions
- any decisions made for you must be done in your best interests.
- No-one should decide you lack capacity, or make assumptions about what's in your best interests, based on your age, appearance, mental health diagnosis or other medical condition.

How can I plan ahead?

Loss of mental capacity can happen unexpectedly, so it's sensible to make plans in case you're unable to make your own decisions. You can:

- use a Lasting Power of Attorney (LPA) to appoint someone to make decisions on your behalf.
- make an advance decision to refuse treatment. This sets out the situations where you would want to refuse medical treatment if you lacked the capacity to make or communicate that in future. Advance decisions are legally binding.
- make an advance statement. This sets out your wishes about your care and treatment in case you're unable to communicate them in future. It isn't legally binding but can help family, friends and medical professionals make decisions on your behalf.

The NHS website has more information about the Mental Capacity Act:

www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/

Why do I need an operation?

If you have mental capacity the decision to proceed to surgery is yours and yours alone. You may change your mind at any time. Surgery is performed to reduce pain, and to allow early mobilisation to reduce the risks of prolonged immobility.

Does every patient have surgery or is there an alternative?

The vast majority of patients with a hip fracture are treated with an operation. There are a few exceptions where hip fractures are managed without an operation but this is unusual and will be discussed in detail with you if relevant to your circumstances.

What are the risks of not having surgery?

The main risks are ongoing pain and the potentially life-threatening complications associated with long periods of immobility. These complications can include chest infections, blood clots in the legs and lungs, and pressure ulcers of the skin. There is a significant risk of death (mortality) associated with not having surgery. Recent studies suggest a significantly higher 30-day and 1-year mortality in hip fracture patients treated without surgery.

What are the risks associated with surgery?

Hip and Femur fracture surgery are routinely done operations but are significant surgery. All surgical procedures have associated risks and complications.

Reduction in independence: This depends 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. 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.

Blood clots: A deep vein thrombosis (DVT) is a blood clot in a vein. This may present as a red, painful and swollen leg. DVTs can contribute to ulcers and swelling in the longer term. A DVT can pass in the blood stream and be deposited in the lungs; known as a pulmonary embolism or PE. This is a very serious condition which affects your breathing. Getting mobile is one of the best ways to prevent blood clots from forming. Blood thinning medication is given either as a daily injection or as a tablet is to reduce this risk.

Post-operative delirium: Some patients become confused after surgery. This is usually short term but rarely can persist. This complication is more frequent in patients with pre-existing dementia. It is also associated with; older age, infection, diabetes, kidney disease, blood transfusions, low blood oxygen levels, and sedation. You will be assessed and screened for delirium on admission and after surgery. Prevention includes encouraging fluids, nutrition, deep breathing, mobility, and management of pain. Using your glasses and hearing aids to ensure good sensory input can help.

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. Some people have persistent pain in their hip area after a fracture.

Chest infection: Also called pneumonia. Bed rest increases the risk of developing a chest infection. Getting out of bed, even upright in a chair, allows the lungs to work much better allowing you to breathe deeply and to cough to clear your chest frequently. A chest infection will require treatment with antibiotics and slows down progress after an operation.

Urinary retention: Most patients will have a tube called a catheter is passed into the bladder to allow urine to drain as passing urine with a broken hip or femur is difficult. Many patients struggle to pass urine after surgery and have a catheter. Rarely patients need to be discharged with a urinary catheter.

Pressure ulcers: Pressure ulcers are more likely to occur if pain from your hip fracture prevents you from moving in bed. First the area hurts, and then begins to blister, before turning into an open sore. These can become infected, and are difficult to heal if they are large. Common areas affected are your heels and your buttock. Prevention of pressure ulcers is key. Your nurses will encourage you to turn regularly, and will assist you if you are unable to change position yourself. Good nutrition is important in preventing pressure ulcers.

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. Shoe inserts can be helpful.

Hip stiffness: May occur after the operation, especially if movement after the operation is limited. Physiotherapy helps this

Nerve Damage: This may cause temporary or permanent altered sensation and 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. Stopping smoking helps wound healing.

Bleeding: This is usually minor and can be stopped during the operation. However, large amounts of bleeding may need a blood transfusion and/or a return to theatre to stop the bleeding and remove the collection of blood. Many patients suffer significant bruising down the leg following surgery. You may need a blood transfusion during or after the operation.

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 sometimes replaced at a later date. You will be given antibiotics just before the operation. The procedure will also be performed in sterile conditions with sterile equipment.

Constipation: Many patients develop constipation after a hip fracture and surgery. This is the result of many factors including; change of diet, immobility, dehydration, and painkillers. You will be offered regular laxatives and encouraged to take them. Increasing your fluid intake will also

help. The nurses can assist you by bringing a bed pan or a commode after the operation so please do not worry about not being able to get to the toilet.

Impaired kidney function: This can be a common problem after surgery particularly in elderly patients many of whom have pre-existing impaired kidney function. Blood tests are done to monitor kidney function and urine output is also measured. Rarely kidney function can be severely impaired following surgery.

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. Further surgery may be needed. Gentle exercise with less impact is encouraged. Occasionally metal work may become prominent with time.

Joint dislocation: Applies only to hemi-arthroplasty or hip replacement. This is the ball slipping out of the socket of the hip joint, sometimes a long time after the operation. The joint needs to be put back into place which usually needs an anaesthetic. Rarely if the hip keeps dislocating, a revision operation may be necessary. We advise avoiding extreme positions after replacement surgery, such as twisting or bending over 90 degrees.

Fracture non-union: Does not apply to hip replacement or hemiarthroplasty. This is where the bone fragments of the fracture do not heal together in the normal way. Further surgery may be necessary.

Avascular necrosis AVN: Does not apply to hip replacement or hemiarthroplasty. This is a loss of blood supply to the ball of the hip. This makes the bone weak, and can cause pain. Sometimes another operation is needed such as total hip replacement. Smoking can reduce blood supply to bones.

Leg swelling: This is common in the operated leg and can take several months to subside. It will improve as your mobility improves. If your leg becomes hot, red or increasingly painful please let your doctor know immediately.

Stroke: A rare complication that tends to affect older patients with other medical problems and smokers. If you normally take blood thinners these will be stopped before surgery. An alternative form of blood thinner called Dalteparin will be given via injection.

Death: A broken hip is a very serious condition. Nationally, 10% of people die in hospital and another 20% sadly do not survive a year. Most people, however, have a good result. Getting up and about as soon as possible is one of the best ways to keep your body working well.

The risks of an anaesthetic are usually related to underlying medical conditions such as heart disease, lung problems and risk of stroke. Most of the complications that develop after surgery result from immobility. We will aim to reduce your risk by getting you up as soon as possible after your surgery.

Your consent

It is important that you understand the operation, the risks of surgery and what this entails before signing your consent form. If you lack mental capacity, your consultants can make this decision for you in your best interests, following discussion with your family or loved one where possible.

Before surgery

What can I expect in the Emergency Department (ED)?

Patients are usually admitted via the ED. You are initially seen by a team of doctors and nurses who undertake a clinical assessment and take a history of the events leading to your admission. An x-ray is taken of your hips and possibly your chest. A special tube called a cannula is placed into a vein in your arm allowing fluids and medication to be given by drip intravenously. You are given pain medication via your drip; further pain relief can be given if required. You may also be offered an injection of local anaesthetic into the groin area to numb the nerves in the hip region known as a fascia iliaca block. Routine blood tests are taken and a tracing of your heart, an ECG, is performed. You may have a tube passed into the bladder, a urinary catheter, and this will remain in place until after the surgery. You are assessed for the risk of blood clots and risk of bleeding and necessary medication is prescribed. You are assigned a ward, usually ward 31 or 30 at Tunbridge Wells Hospital on level 3 via the orange lifts. If appropriate, you are referred to the orthogeriatric team. Either in ED or the ward treatment will be discussed with you. If you are having surgery the orthopaedic surgeon will obtain written consent from you and draw an arrow on your leg with a marker pen. This is to ensure the correct leg is operated on.

What will happen before my surgery?

You may need further blood tests or other investigations. You will be unable to eat for at least six hours before your surgery. You will have fluid administered through an intravenous drip during this time and you will be offered a carbohydrate drink called Nutricia Pre-op. This helps to prevent you from feeling thirsty and may enhance your recovery after your operation.

Many patients are anxious about how much pain they will experience. You will be offered regular pain medication but please let the nurses know if it is not adequate or if you need additional medication in between regular drug rounds.

An anaesthetist will see you prior to your operation. There are two main types of anaesthetic:

- a general anaesthetic rendering you unconscious and supporting your breathing with a tube into your airway.
- a spinal anaesthetic prevents sensation from the waist down. This means the area to be operated on is completely numb. Usually you will be offered sedation however occasionally this may not be possible because of other medical conditions you may have.

There are advantages of a spinal anaesthetic over a general anaesthetic. These include patient safety and significant continued pain relief after the surgery. Occasionally for medical reasons we use a general anaesthetic. You will discuss this and the risks with the anaesthetist.

We aim to get you to surgery as soon as possible. In most cases your operation will be within 36 hours of admission. Common reasons why surgery is delayed are:

- If you are medically unwell and need further treatment prior to surgery.

- If you are on anticoagulation (blood-thinning medication such as Warfarin) which must be reversed prior to surgery to prevent excessive blood loss.
- If there are other people waiting for emergency surgery with life threatening injuries.
- If you require a specialist operation such as a total hip replacement.

If your surgery is delayed, you will be given food and drink as soon as possible and we will endeavour to keep both you and your family informed.

What operation will I have?

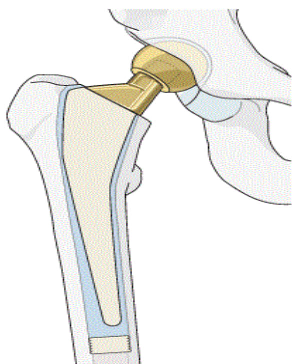
The operation recommended to you will depend greatly on exactly what part of your bone is fractured. Your orthopaedic doctor will explain to you how your hip fracture will be treated and what this involves. Most patients require an operation with one of four types of hip surgery.

Your surgery can be marked below ☑

Date of surgery:

Post-operative weight bearing (WB) status

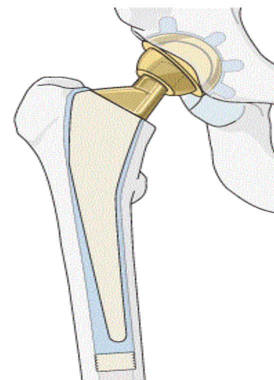
☐ **Full WB** ☐ **Partial WB** ☐ **Toe-touch WB** ☐ **Non-WB**



☐ **Hemi-arthroplasty:**

When the fracture involves the neck of the femur, the broken piece of bone is removed and replaced with a metal prosthesis. In effect, this is half a hip replacement: only the ball part of the joint is replaced.

☐ **Total Hip Replacement:**



When the fracture involves the neck of the femur and if the joint is likely to be affected by osteoarthritis via wear-and-tear in the near future, a total hip replacement is considered. Both the ball and socket are removed and replaced by a metal ball and stem, and a plastic cup respectively. 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.

☐ **Sliding Hip Screw or Dynamic Hip Screw (DHS):**

This is a larger metal screw which fixes the fracture and is held in place by a plate and a number of smaller screws. It holds the bones in position whilst they knit back together.

☐ **Intramedullary Nail:**

Fractures which extend down the femur need to be fixed with a metal rod passed down the middle of the bone, with additional screws to hold it in position.

After surgery:

You will be transferred from the operating theatre to a recovery room in the theatre complex. Here you will receive one to one nursing care. This allows us to monitor your recovery from the anaesthetic and surgery closely. Once you have recovered sufficiently from your anaesthetic, you will be transferred back to the ward. You will be offered regular pain medications and can ask for more as required. Hip operations can be associated with significant blood loss, if you are anaemic you may require a blood transfusion in the first few days. As soon as you feel able you may try something to eat and drink. If you feel sick, please tell the nurse who can give you medication to help. The day after surgery you will have blood tests and you may need to have another x-ray of your leg. The orthopaedic and orthogeriatric doctors will see you regularly. They will also complete a 'falls risk assessment' over the period of your stay and begin the process for optimising your bone health to reduce the risk of future fractures. The nurses will help you with personal care and at mealtimes; but you will be encouraged to do as much for yourself as you can. The intravenous drip is removed as soon as you are eating and drinking as normally. If you have a urinary catheter this will be removed once you are mobile and have opened your bowels.

Your family, friends and carers may be very helpful in supporting you to prepare for the first few weeks after discharge. 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.

Nutrition

It is important to eat well during this recovery time to aid healing. Poor appetite is common after surgery. If you or your family are concerned about your food intake, please speak to a nurse. Family are welcome to bring you in fruit and snacks and to come and assist at mealtimes, please arrange this with the Ward Manager.

Pain relief

A hip fracture is painful, but this should improve after your operation. You are likely to require regular painkillers for the first few weeks. It is very important that you take them regularly, as this will help you to move more easily and participate in physiotherapy, which will speed up your recovery. Please let the nurses know if you continue to be in pain: you do not have to wait until the next medicines' round.

How long will I be in hospital?

While the average stay in hospital after hip fracture is about 16 days, some patients are well enough to be discharged after only 5–7 days, while others will need to stay in hospital for a lot longer. If you are a West Kent resident and you are fit for discharge, we will transfer you to Tonbridge Cottage Hospital to complete your rehabilitation. We try to ensure you return to your own home. Sometimes due to a deterioration in mobility and your care needs this is not possible, which will extend your admission. If you already live in a residential or nursing home and have increased care needs you may need reassessment and occasionally re-settlement. 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.

What can I expect after discharge?

Realising your limitations after surgery is often quite a shock when you get home. This is a normal feeling. It is important to continue to stay mobile and do the exercises you have been shown. There is significant improvement the first 12 weeks after surgery. Most patients will continue to improve for many months, and do not require ongoing physiotherapy. If you are concerned about your progress, you may wish to discuss this with your GP.

Patients with hip fracture are at increased risk of blood clots, and anticoagulation (blood-thinning) medication should continue for most patients for 28 days following surgery. This is usually a daily injection, which you or a family member can be taught to administer. Alternatively, a district nurse will visit you after discharge to help with this.

You are likely to be discharged on vitamin D supplements, as vitamin D is difficult for most people to take in adequate amounts in their normal diet. It is important to continue taking this to improve stability and help strengthen your bones. If you have difficulty taking these tablets, discuss with your GP about changing to the dissolvable powder or to caplet form. Many patients are also started on another medicine to strengthen their bones and prevent further fractures. Often this involves taking a tablet, Alendronate, once a week for about three years. Please discuss with your GP if you are having difficulty taking it. Alternatives are available for those unable to manage this including yearly injections.

What follow up will I need on discharge?

Most patients do not require further X-Rays, or any follow-up with the orthopaedic team. If you have concerns about the operation, or develop increasing pain, you should seek advice from your GP.

There is a national database of patients who have suffered a hip fracture, which all NHS Trusts submit data to. As part of the data collection you will receive a follow up call at 120 days after discharge enquiring about your progress, whether you are back in your usual residence, how well you are mobilising, and whether you are taking bone health medication. These calls are undertaken by a non-clinical person. If you would prefer not to be contacted please inform a member of your clinical team whilst you are in hospital and ask for this be registered on your electronic patient record.

Physiotherapy

What physiotherapy will I need?

You will be seen by a member of the physiotherapy team the day after your surgery. They will assess the safest way for you to transfer with the nursing staff and also teach you some exercises to aid your recovery. It is important you sit out in the chair every day; the multi-disciplinary team will be able to help you with this and will continue with your rehabilitation as advised by the physiotherapy team.

The physiotherapy team will review you on a regular basis and aim to progress your transfers and walking with the appropriate aids.

On your return home it is important you continue to stay mobile and do the exercises you have been shown.

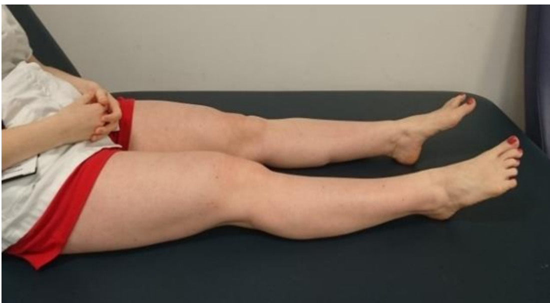
Exercises following hip surgery

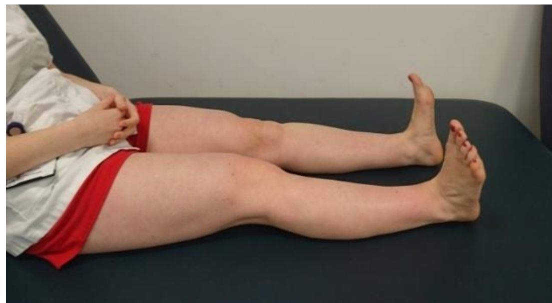
You will be taught exercises to aid circulation, help get your hip moving and improve your muscle strength. You will be expected to complete these exercises outside of your physiotherapy sessions; you may need a relative/friend to help you with these. If able please aim to complete all exercises on both legs, with emphasis on the operated leg.

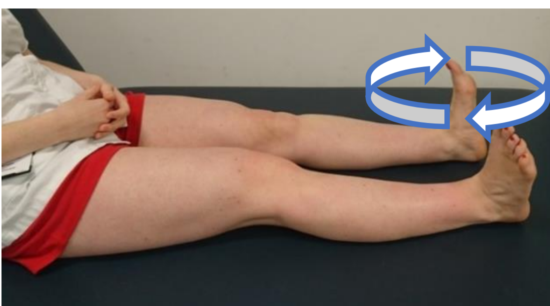
Bed exercises

Ankle pumps/ rotations

Point your toes towards the end of the bed and then pull them up towards your head.

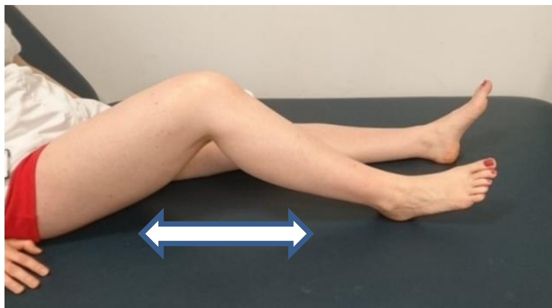






Rotate your feet in circular motions.

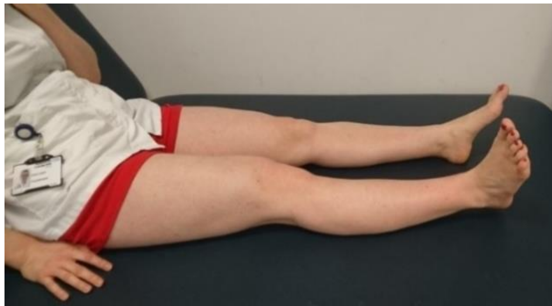
Repeat these little and often throughout the day.



Supported knee bends

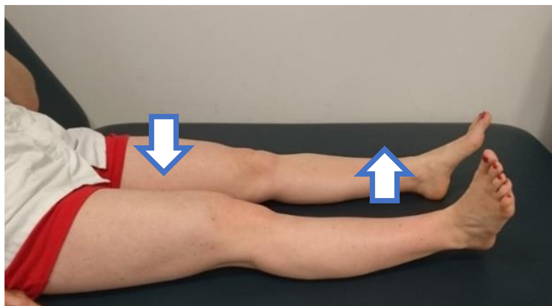
Bend your knee and try to slide your heel towards your buttocks. Do not let your knee roll inward.

Repeat 10 times, 3 - 4 times a day.



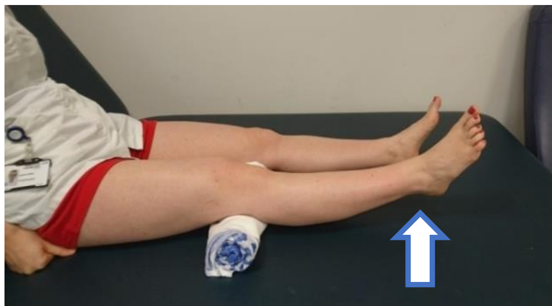
Static glutes/ buttock contractions

Tighten your buttock muscles and hold for 5 seconds. Repeat 10 times, 3 - 4 times a day



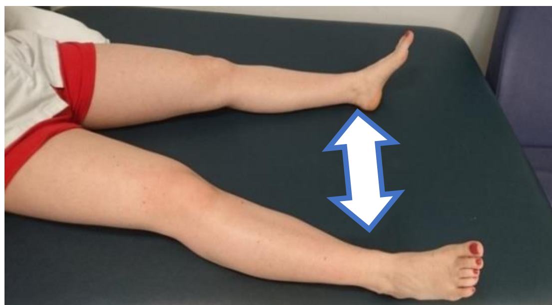
Static quadriceps

Keeping your leg straight, pull your toes up towards your head and push your knee down into the bed. Hold for 5 - 10 seconds. Repeat 10 times, 3 - 4 times a day.



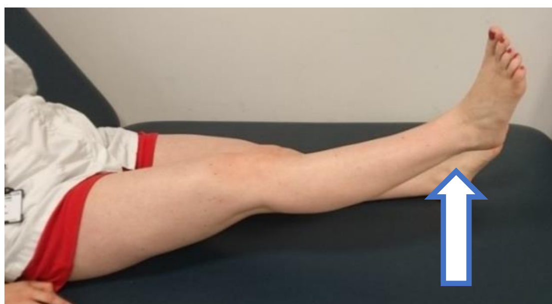
Inner range quadriceps

Roll up a towel and put it under your knee. Push your knee down into the towel, the bottom half of your leg should lift up away from the bed. Hold for 5-10 seconds. Repeat 10 times, 3 - 4 times a day.



Hip abduction

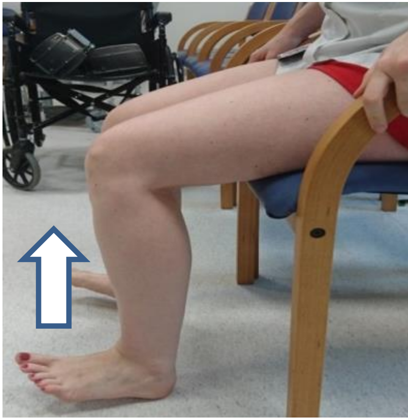
Slide your leg out to the side of the bed and then bring it back into the middle, be careful not to cross your leg over the midline. Repeat 10 times, 3 - 4 times a day.

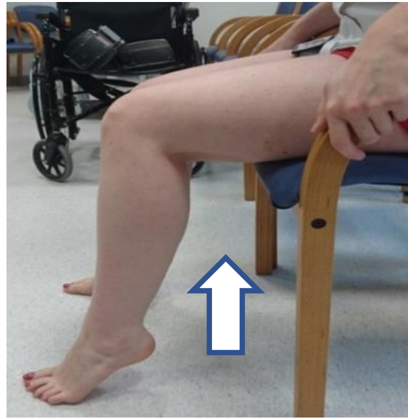


Straight leg raise

Keep your leg straight, tighten your thigh muscle and lift your leg off the bed. Hold for 5 seconds and lower slowly. Repeat 10 times, 3 - 4 times a day.

Seated exercises



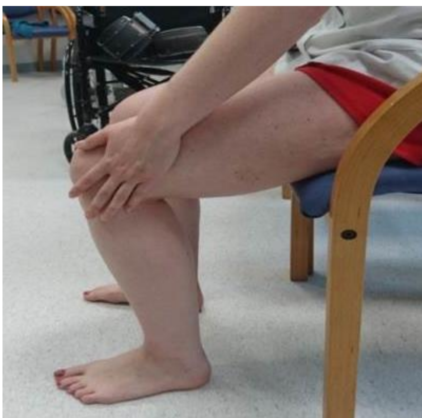


Ankle pumps

Bend and straighten your ankles. Repeat 10 times, 3 - 4 times a day.

Knee extension

Straighten your leg and hold it out in front of you for 5 seconds. Repeat 10 times, 3 - 4 times a day.

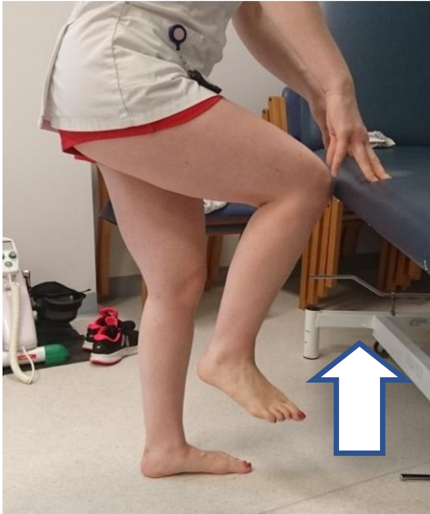


Hip abduction

Keep your feet on the floor and move your knees out to the side. You can use your hand on the outside of your knee to add some resistance. Repeat 10 times, 3 - 4 times a day.

Standing exercises

You will need to hold onto something for support i.e. a sturdy chair, kitchen worktop or walking frame.

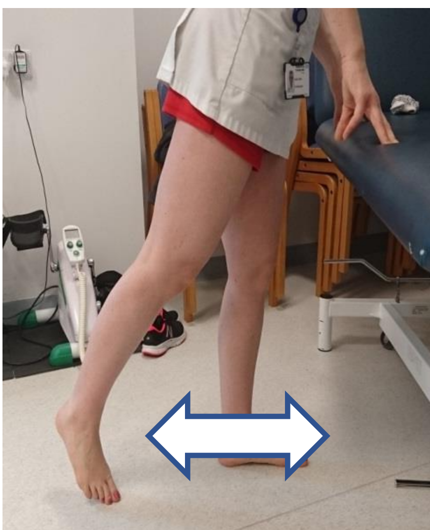


Knee raises

Lift your operated leg towards your chest. Then slowly lower it back to the floor. Repeat 10 times, 3 – 4 times a day.

Hip abduction

Keeping your trunk straight, lift your leg out to the side as far as you can. Slowly bring your leg back to the middle. Repeat 10 times, 3 - 4 times a day.



Hip extension

Keeping your trunk straight, lift your leg behind you as far as you can. Slowly bring your leg back to the middle. Repeat 10 times, 3 - 4 times a day.

Exercise Programme

You may find it helpful to photocopy the below timetable for keeping track of your exercises.

Exercise Programme	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Ankle pumps and rotations							
Supported knee bends							
Static glutes/buttock contractions							
Static quadriceps							
Inner range quadriceps							
Hip abduction							
Straight leg raise							
Seated ankle pumps							
Seated knee extension							
Seated hip abduction							
Standing knee raises							
Standing hip abduction							
Standing hip extension							

Stairs

Going upstairs

The circle denotes the operated side, in this case right.

Take one step at a time.

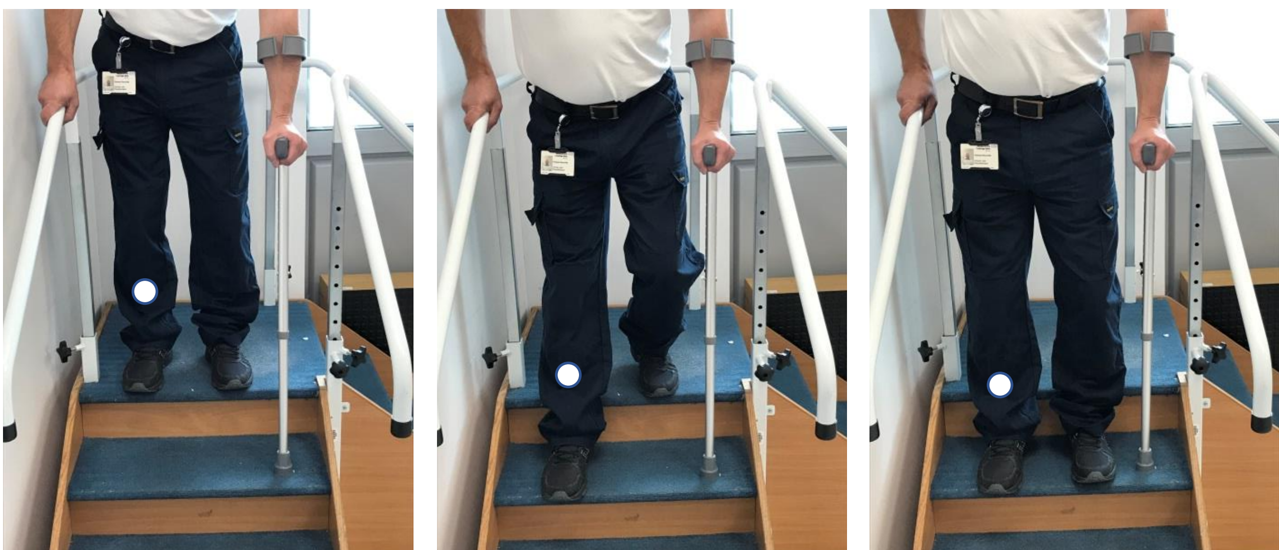
Un-operated leg first, followed by operated leg, and then the walking aid.

Going downstairs

The circle denotes the operated side, in this case right.

Take one step at a time.

Walking aid first, followed by the operated leg, and then the un-operated leg.



Occupational therapy (OT)

What occupational therapy will I need?

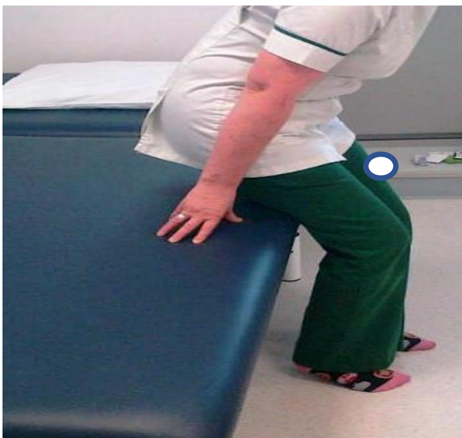
Occupational Therapists assess your ability to manage everyday activities. Your Occupational Therapist will meet with you on the ward following your surgery and will talk to you about your home set up and how you were managing prior to your admission to hospital.

As your mobility begins to improve, the Occupational Therapy team will continue their assessments and make recommendations about how to manage your daily activities once you return home. We may suggest minor changes to your home environment, loan of basic equipment and referrals to other services for support at home if required.

Whether you are discharged directly from Tunbridge Wells Hospital or from the Community Hospital, the Occupational Therapists will ensure you are safely set up and able to manage as independently as possible before you are discharged home.

Advice for managing your daily tasks

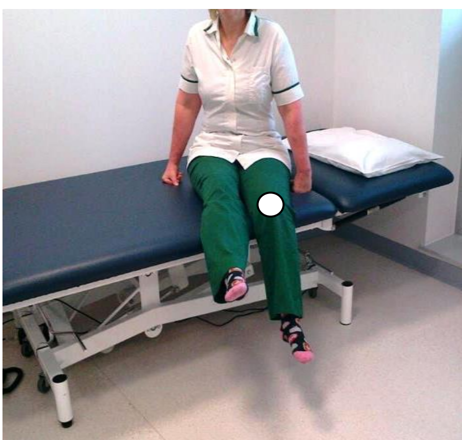
Transferring on and off a bed



The circle denotes the operated side, in this case left.

Position yourself at the side of the bed, two thirds of the way up. Make sure you can feel the bed on the back of your legs before you try to sit down.

Try to get onto the bed leading with your non-operated leg if possible



The circle denotes the operated side, in this case left.

Support your upper body with your arms and slide your bottom as far back onto the bed as you can. Bring your non-operated leg onto the bed.

The circle denotes the operated side, in this case left.

Bring the operated leg up onto the bed gradually and use your upper body to move yourself further up the bed.

Try to get out of bed on the same side, leading with your operated leg, reversing the steps above.

Transferring on and off a chair

- Position yourself in front of the chair so that you can feel it on the back of your legs.
- Reach back for the arms of the chair. Straighten your operated leg out in front of you and lower yourself down gently into the chair.
- When getting out of the chair, shuffle your bottom forwards and push up using both hands. Make sure you are balanced before taking your hands off the chair and onto your walking aid.

Driving and getting in or out of a car

This can depend on which leg has been operated on and whether you drive a manual or automatic car. You must ensure you are not a risk to yourself and other road users. If you are able to stamp the affected side foot hard on the floor, try performing an emergency stop in a stationary car with the engine off. We would advise you discuss driving with your consultant and you will need to contact your insurance company to inform them of your recent surgery.

When transferring in or out of a car as a passenger, we advise:

- The passenger seat should be slightly reclined and as far back as possible to allow for maximum leg room. If necessary put a cushion on the seat to raise it.
- Sit on the seat before lifting your legs into the foot well. You may find it useful to grip the door frame whilst someone holds the door steady so you can lower yourself gently onto the seat.

Getting in and out of the bath or shower

Following hip surgery, you may find it difficult to get in and out of the bath. Your ability to use a shower safely will depend on the style of your shower, equipment available and what walking aids you are using. Please discuss further with your Occupational Therapist.

For safety and independence, it is usually advised that you strip wash initially on discharge and sit to dress. The following page contains some guidelines on dressing post hip surgery.

How to use long handled aids following hip surgery

You can purchase the following aids which may be helpful after your surgery:

Helping hand

Long handled shoe horn

Long handled sponge

Sock aid (please note this cannot be used with anti-embolism stockings)

We recommend sitting on a suitable height chair or perching stool to wash and dress. Always dress your operated leg first for ease.

To use long handled aids to dress your lower half:

- Hold the waist band of your clothing with the helping hand and lower to the floor. You can use the hooked end of a long handled shoe horn to open the leg hole of the clothing.
- Using the helping hand, guide the clothing over your leg and up to your knees, where you can safely reach it.
- You can now carefully stand to a walking aid to finish dressing your lower half.
- Undress your non-operated leg first.

Managing kitchen tasks

Your Occupational Therapist will discuss how you are going to manage your kitchen tasks safely on discharge. It is advised that you use easy meals initially and build up gradually to your usual cooking routine.

You are likely to be discharged home using a walking aid which will affect your ability to carry items. Your Occupational Therapist will discuss the set-up of your kitchen at home and identify any equipment that may help to increase your safety and independence with managing your food and drink preparation.

Managing household tasks

During your recovery period, you may need some help with managing household tasks such as housework, laundry and gardening. If you do not have any family or friends that may be able to help, please discuss with your Occupational Therapist as they may be able to signpost you to suitable charities and services who can provide this type of support on discharge.

Reducing trip hazards

Most hip fractures occur as the result of a simple fall. Falling is not an inevitable result of ageing, but the risk of falls increases as we get older. During your admission, your orthogeriatric doctor will have carried out a fall's risk assessment trying to uncover any medical problem which make you more likely to fall. Changes to your home environment may be suggested by your Occupational Therapist to reduce your risk of further falls. This advice may include:

- Ensure you use the correct walking aid to provide stability when mobilising
- Remove or secure any rugs or loose-fitting carpet
- Ensure non-slip mats are used in the bathroom
- Remove or secure any loose wires
- Ensure lighting is adequate, particularly for night time toileting
- Reduce clutter
- Wear appropriate footwear
- Organise your home to reduce the need to bend, stretch and climb
- Advice on installation of emergency buttons (lifeline) to quickly alert others in event of a fall
- Ensure you have regular eye tests

What is osteoporosis?

Osteoporosis is a disease, often without symptoms, in which there is gradual loss of bone tissue and bone density that makes bones fragile so that they break more easily.

If you need to have any dental work (especially surgery), tell the dentist ahead of time if you are receiving treatment for osteoporosis. You may need to stop taking the medicine for a short time.

Who is at risk?

We all at risk of developing osteoporosis with age, though it is more common in women and Caucasians. The following increase your risk of developing osteoporosis:

- Early menopause
- Previous fracture after a minor fall or accident
- Family history
- Being severely underweight
- Immobility or sedentary lifestyle
- Steroid therapy (e.g. Prednisolone)
- Smoking
- High alcohol intake
- Lack of Vitamin D likely due to little sunlight exposure or poor diet
- Medical conditions including overactive thyroid, or those that affect mobility including stroke

How is osteoporosis diagnosed?

Osteoporosis is often first diagnosed when you break a bone after a fall from a standing height and no further scan is required. You may be referred for a DEXA (Dual Energy X-ray Absorptiometry) scan to confirm osteoporosis. We routinely refer all men and women under the age of 75 years for a DEXA scan.

Your orthogeriatric consultant will arrange to see you in clinic or write to you with an appointment. A fifteen minute scan of your hip and lumbar spine is done usually six to eight weeks after discharge. The results will usually be sent to your orthogeriatric consultant who will write to you and your GP with advice about any further treatment.

What are the symptoms and effects of osteoporosis?

There are no true symptoms of osteoporosis, rather it presents itself after fractures, commonly in the wrist, hip and spine following falls. Compressed bones in the spine, vertebral fractures, can lead to loss of height and a stooped posture, and can happen spontaneously without a fall.

What can I do to reduce the onset of osteoporosis?

Regular weight-bearing exercise can help to prevent or slow down bone loss. Adequate calcium and vitamin D intake are important for healthy bones. If you smoke, you should make every effort to stop, and cut down on alcohol if you drink heavily.

What are the treatments for osteoporosis?

The treatment of osteoporosis depends on a number of factors including your age, gender and medical history. The aim is to strengthen existing bone, prevent further bone loss, and reduce the risk of broken bones. Once medication for osteoporosis is started, it is likely that you will need it for at least five years and sometimes lifelong. If you experience any side-effects please discuss with your doctor before stopping medication. An alternative drug may be more suitable for you.

a) The bisphosphonates are a group of drugs that include a weekly Alendronate tablet or a once yearly Zolendronic Acid injection via a drip. These are the most commonly used drugs to treat osteoporosis and work on the bone-making cells. The most common side-effect with Alendronate is indigestion.

c) Denosumab (Prolia) is a protein that targets specific cells in the body. It works to block the cells that break down bone, allowing the bone-making cells to build up bone mass. It is given as a six monthly injection, which can be given at your GP practice or by the Osteoporosis service.

d) Vitamin D tablets are commonly prescribed in addition to one of the above medicines.

Some treatments for osteoporosis are very rarely associated with a complication involving bone loss in the jaw bone, known as osteonecrosis.

Smoking

Smoking increases the likelihood of you having osteoporosis. Smoking has a very big impact on bone and tissue healing. Smoking slows healing down by reducing the blood flow to damaged tissues. It raises the risks of complications after surgery very significantly. If you smoke we recommend you stop. We can offer you help and advice on achieving this. Quitting smoking is the best thing any patient who smokes can do to improve their surgical outcomes and future health. Free friendly support to stop smoking and free nicotine replacement therapy is available on: Tel: 0300 123 1220
email: oneyoukent@nhs.net
www.oneyoukent.org.uk

CPR and Do Not Attempt CPR orders (DNACPR)

What is CPR?

CPR is treatment that is used to try to restart someone's heart and breathing when one or both of these has stopped. CPR includes:

Repeatedly pushing down very vigorously on the centre of the chest.

Blowing air or oxygen into the lungs, using either a mask or a tube inserted into the throat.

Using electric shocks to try to restart normal heartbeats.

What is the chance of CPR restarting my heart and breathing?

When CPR is attempted in hospital, on average about 2 out of 10 patients survive to leave hospital.

Is CPR tried on everybody whose heart and breathing stop?

No. When someone is coming to the end of their life and the heart and breathing stop as part of the natural process of dying, CPR will not prevent their death. If CPR does restart the heart and breathing in these circumstances it can leave a dying person with more distress or worse health in the last hours or days of their life. For others, receiving CPR would deprive them of dignity during the very last moments of their life. For these reasons many people choose not to receive CPR when they know that they are coming close to the end of their life.

Do people make a full recovery after CPR?

Of the two out of ten people who survive, many do make a full recovery. Some still have poor health, and some people will be left in worse health after CPR. In some cases, a person may be left with permanent brain damage or in a coma. CPR can cause unwanted effects such as bruising, broken ribs and infrequently damage to internal organs such as the lungs or liver.

Will I be asked whether I want CPR?

This will depend on your circumstances: Where no decision has been made in advance about whether or not CPR should be performed, it will be assumed that CPR should be attempted. If that is not what you want, it's important to discuss your wishes with your healthcare team.

If CPR will not prevent your death should your heart and breathing stop, your healthcare team will decide not to attempt CPR. They will explain the decision to you and the reasons for it, unless they believe that telling you will cause you physical or psychological harm. If you wish, your family or close friends can be involved in these discussions. If you disagree with a decision about CPR, you can request a second opinion.

Can my family decide for me?

Your family and friends are not allowed to decide for you unless they have been appointed as your legal attorney, deputy or guardian. Whenever possible, the healthcare team looking after you will ask them about your known or likely wishes.

I know that I don’t want anyone to try CPR on me. How can I make sure they don’t?

If you don’t want CPR, you can refuse it and if they know of this refusal the healthcare team must follow your wishes.

If it is decided that CPR won’t be attempted, what then?

This is often called a “Do Not Attempt Cardiopulmonary Resuscitation” or “DNACPR” decision. Together with the reasons for the decision, it is recorded on a special form.

What about other treatment?

A DNACPR decision is about CPR only and you will receive all the other treatment that you need. You may want to discuss with your healthcare team what other types of treatment you would not want to be considered for if your health deteriorates.

What if I change my mind or my situation changes?

Your healthcare team will keep the decision about CPR under review, in particular if your condition changes, if you move to a different care setting or go home, or if you want to change your mind.

Original wording taken from a leaflet produced by the Resuscitation Council (UK): https://www.resus.org.uk/sites/default/files/2020-06/2016_07_25_CPRdecisions_patientinfo_FINAL.pdf

Frequently Asked Questions:

What can be done if I have memory problems?

If you had a problem with your memory before you broke your hip, you may find that it gets worse for a while after your operation, so please let staff know as soon as possible. Surgery and medication can also cause some people to experience a condition known as delirium, which is a state of mental confusion. Delirium often starts suddenly and can be frightening, but usually improves when the condition causing it gets better.

When will I have surgery?

It is unpleasant and uncomfortable to be confined to bed with a hip fracture, so the sooner you have surgery, the sooner you'll be able to start moving and walking again. Providing you're well enough for surgery, the operation to repair your hip should take place on the day after your admission to hospital.

When will I be able to eat and drink normally again?

You won't be able to have any food or drink, known as 'nil by mouth', for a few hours before your surgery. Once you've had your operation, however, it's very important that you eat well and drink lots of fluids, as food and drink are key to making a good recovery from your hip fracture and surgery.

What if I find it difficult to eat or drink?

If you're unable to move around in bed and get into a comfortable sitting position at mealtimes, staff will be happy to assist you. Do let staff know if you find eating and drinking difficult at any time. Your family and friends may also be able to help you at mealtimes, so speak to staff to see if this is possible.

How soon after surgery will I get out of bed and start physiotherapy?

The aim of your operation is to allow you to get up and put weight on your hip straight away, usually the day after your surgery. You may have some pain and discomfort to start with, and may also feel weaker than usual. This is perfectly normal and should improve as you continue to recover. Pain relief will also make getting up and moving around easier.

What can I do if I am having problems with my bladder?

Problems with bladder control can occur when you're in hospital recovering from hip fracture surgery. If you have any problems with your bladder, be sure to let the staff on the ward know. If you already had problems with your bladder before breaking your hip, even if your symptoms haven't got any worse while you've been in hospital, it's still worth mentioning this to staff to see if anything can be done to improve or solve them.

How will I be kept informed of my progress?

The team looking after you will keep you updated with information on your progress and on the plans for your discharge. With your permission, they'll also be happy to discuss this with your family or friends, especially anyone who plans to assist you once you're back at home.

What will be done to help reduce my risk of falling in the future?

Most hip fractures happen after a fall so it's important that you avoid having a fall in future. With this in mind, staff should assess your risk of falling when planning your rehabilitation and discharge. This will normally include:

- a review of your medication
- physiotherapy to improve your strength and balance
- an assessment by an occupational therapist of your home environment to make sure that you can manage day-today activities safely.

Can anything be done to strengthen my bones?

Most people who suffer a hip fracture will have osteoporosis, which means their bones have become weaker. Treatment is available for osteoporosis in the form of tablets, drips or injections that strengthen your bones. Unfortunately, without this treatment, one in five people will have another hip fracture. There are many different types of drug treatments and more information about these can be found on the Royal Osteoporosis Society website theros.org.uk

When will I be discharged?

While the average stay in hospital after hip fracture is about 16 days, some patients are well enough to be discharged after only 5–7 days, while others will need to stay in hospital for quite a lot longer.

Will I need to attend an outpatient appointment after I leave hospital?

Surgical repair of hip fractures is so successful that, for most patients, this is no longer necessary. As part of the data collection you will receive a follow up call at 120 days after discharge enquiring about your progress. These calls are undertaken by a non-clinical person. If you would prefer not to be contacted please inform a member of your clinical team whilst you are in hospital and ask for this be registered on your electronic patient record.

Useful contacts

Ward 31 ☎ **01892 635626**

Ward 30 ☎ **01892 635868**

Physiotherapy Maidstone & Tunbridge Wells Hospitals ☎ **01892 635298**

Email: **mtw-tr.physiotherapy@nhs.net**

Occupational Therapy Maidstone & Tunbridge Wells Hospitals ☎ **01892 635608**

Email: **mtw-tr.occupationaltherapy@nhs.net**

Tonbridge Cottage Hospital ☎ **01732 353653**

Further information and advice can be obtained from:

The Royal Osteoporosis Society ☎ **0808 800 0035**

www.theros.org.uk

Kent enablement at home ☎ **01843 873517**

www.kent.gov.uk/social-care-and-health/care-and-support/help-to-live-at-home/carers-and-assistants/enablement

Age UK ☎ **0800 055 6112**

www.ageuk.org.uk

National Hip Fracture database

www.nhfd.co.uk

Hip Fracture Carers Guide

www.rcplondon.ac.uk/projects/hip-fracture-guide-family-carers

Carers Trust

www.carers.org

ShopmobilityUK

www.shopmobilityuk.org

British Red Cross Wheel Chair hire

www.redcross.org.uk/get-help/hire-a-wheelchair

NHS online

www.nhs.uk/conditions/hip-fracture/

NHS 111 ☎ 111

Free smoking cessation advice and nicotine replacement ☎ 0300 123 1220

Email: oneyoukent@nhs.net
www.oneyoukent.org.uk

MTW NHS Trust is committed to making its patient information accessible in a range of languages and formats. If you need this leaflet in another language or format please ask one of your clinical care team or the Patient Advice and Liaison Service (PALS). We will do our best to arrange this.

Maidstone and Tunbridge Wells NHS Trust welcomes all forms of feedback from our service users. If the standard of service you have received from the Trust does not meet your expectations, we want to hear from you. Please speak with the ward manager or the nurse in charge in the first instance, or you can contact the:

Patient Advice and Liaison Service (PALS) on:

Telephone: ☎ 01622 224960 or ☎ 01892 632953

Email: mtw-tr.palsoffice@nhs.net

or visit their office at either Maidstone or Tunbridge Wells Hospital between 9.00am and 5.00pm, Monday to Friday.

You can be confident that your care will not be affected by highlighting any areas of concern or making a complaint. The Trust will retain a record of your contact, which is held separately to any medical records. If you are acting on behalf of a patient, we may need to obtain the patient's consent in order to protect patient confidentiality. More information on PALS or making a complaint can be found on the Trust's website: www.mtw.nhs.uk or pick up a leaflet from main reception.

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