Audit group: People who have sustained a hip fracture

Inclusion criteria

All patients aged 50 years or older who have sustained a hip fracture (see guide on page three). These are usually sustained as the result of a traumatic injury such as a fall but can also be caused by repetitive strain (stress fracture) however these are more common in younger people.

Most hip fractures are so called fragility fractures where there is underlying pathology of the bone causing it to weaken. This is commonly caused by conditions such as osteoporosis, osteomalacia, Paget's disease, as well as bone tumours and cysts.

Include patients who are admitted directly from the Emergency Department (ED) and also those transferred directly into any ward.

Include patients who are current inpatients in any ward, who sustain a fall resulting in a hip fracture.

Include patients who attend the ED but die prior to ward admission or treatment.

There is no limit on the age of the fracture, i.e. if the patient originally attended ED but the fracture was missed, these should be discussed on a case by case basis.

The audit is based on episodes of injury rather than individual patients. If someone fractures one hip after another please complete a separate proforma for each episode. However if a patient presents with both hips fractured, only complete one form basing the surgery information on the operation for the first hip repair.

Patients who have sustained a hip fracture but are treated conservatively should also be included in the audit. Some of these patients may not be transferred to Orthopaedics and therefore may be challenging to identify, but the Local Audit Coordinators should endeavour to include them in the audit where possible. Some patients who are initially treated conservatively may in fact end up having a surgical repair.

Exclusion criteria

Exclude patients who do not have a hip fracture, such as fractures of the shaft of femur (including proximal), acetabulum, peri–prosthetic hip fractures or isolated greater trochanteric fractures. When excluding someone from the audit based on fracture type, please ensure that the diagnosis can be corroborated from several sources, e.g. x-ray reports, clinical notes and operation notes. This helps to ensure that people are excluded based on a robust diagnosis.

Patient identification

It is essential that no patient identifiable information is submitted to the audit team at ISD in order to maintain patient confidentiality. It is the responsibility of the MSk Local Audit Coordinators to ensure that submitted proforma do not contain details of this type.

In order to allow local re-identification and validation of patients, each eligible patient should be assigned an audit number. This number should be recorded in duplicate on the proforma and also on the audit cross-index.
Audit methodology

Record details of every patient eligible for audit on the audit cross-index (see example of a cross-index on page 5). It may also be useful to include excludable patients on your cross-index, along with the reason why you have excluded them (e.g. fractures of the shaft of femur (including proximal), acetabulum, peri–prosthetic hip fractures or isolated greater trochanteric fractures).

Complete a proforma for each patient with a hip fracture. If a patient is missed and is lost to audit, their details should still be entered in the cross-index and added to numbers in the monthly completeness spreadsheet. Patients should only be lost to audit in exceptional circumstances, the LACs should make every effort to access the notes for patients even if their attendance was when the LAC was on leave.

Some measures require recording of a date only if completed within a given number of days, for example:

- **Date into theatre, Comprehensive Geriatric Assessment (CGA)** – within 7 days of admission. If >7 days it is not necessary to collect a date.

- **Physiotherapy assessments** - within 4 days of surgery. If >4 days it is not necessary to collect a date.

- **Occupational Therapy assessments** - within 3 days of admission. As this is now recorded from admission, if >7 days it is not necessary to collect a date.

- **Date of discharge** - give the date of discharge and destination if this is available by the date that the form needs to be submitted. If this isn’t available because the patient was still an inpatient, code both variables as 88 provided the patient was still an inpatient on Day 21 post-admission.

If 21 days have not yet elapsed, leave the boxes blank (see more detail under Date of Discharge (Q40) and Discharge Destination (Q41).

Transferred patients – the audit measures care provided in the hospital which provides the majority of the orthopaedic care. Usually this is the hospital where the person had their operation. It is therefore good practice to alert the Local Audit Coordinator in the receiving hospital if you become aware of a hip fracture patient being transferred. **Only one form should be submitted, usually from the surgical hospital.**

60 day follow up

The LACs will be sent a spreadsheet on a monthly basis listing all patients audited 2 months (60 days) previously. Further details of these patients’ stays at home/ care home, or elsewhere in hospital (where, dates, reason), residence on Day 60, date of death if within 60 days, bone health medication and further fractures should be completed.
Submission process

Completed proforma for patients admitted in the previous month should be submitted by the 21st of each month, e.g. proforma for patients admitted in August should be submitted by the 21st September.

The data completeness spreadsheet should also be submitted on a monthly basis soon after the forms are posted to the central team.

Proforma must be anonymised prior to submission by removing the patient details strip at the top of the form.

Please ensure the proforma are posted in time as late submission can affect the monthly reporting of results.

Local Information Governance procedures should be followed for transport of data. These usually include double envelope, addressing and posting via a signed-for delivery service.

Prior to sending, email the data support officer with details of the numbers of proforma being sent to allow a received receipt to be issued.
Types of Hip Fracture

- Greater trochanter
- Intracapsular fracture
- Lesser trochanter
- Sub-trochanteric fracture
- Femoral shaft
Example cross-index

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Audit no</td>
<td>Forename</td>
<td>Surname</td>
<td>CHI</td>
</tr>
<tr>
<td>3</td>
<td>10001</td>
<td>John</td>
<td>Brown</td>
<td>2222222222</td>
</tr>
<tr>
<td>4</td>
<td>10002</td>
<td>Jim</td>
<td>White</td>
<td>2222222223</td>
</tr>
<tr>
<td>5</td>
<td>10003</td>
<td>Mary</td>
<td>Green</td>
<td>2222222224</td>
</tr>
<tr>
<td>6</td>
<td>10004</td>
<td>Harry</td>
<td>Black</td>
<td>2222222225</td>
</tr>
<tr>
<td>7</td>
<td>10006</td>
<td>Bob</td>
<td>Smith</td>
<td>2222222226</td>
</tr>
<tr>
<td>8</td>
<td>10006</td>
<td>Rene</td>
<td>McDonald</td>
<td>2222222227</td>
</tr>
<tr>
<td>9</td>
<td>10007</td>
<td>Frank</td>
<td>McPhee</td>
<td>2222222228</td>
</tr>
<tr>
<td>10</td>
<td>10008</td>
<td>Margaret</td>
<td>McKay</td>
<td>2222222229</td>
</tr>
</tbody>
</table>
### Data Definitions

#### General Notes

i. If you are unclear about any aspect of the proforma or the data definitions please do not hesitate to contact the central audit, who will be happy to help you, by emailing the generic mailbox (NSS.isdmskaudit@nhs.net).

ii. All data entered on the MSk Hip Fracture Audit should be from information **documented and evident** in the patients’ records (either paper or electronic). As a general rule, **information provided anecdotally or through ‘word of mouth’ should not be included**. An exception to this would be, if for example the Fracture Liaison Service keep their own records and information about bone health can be gleaned from a discussion with them, this is acceptable but it should be recorded in the comments section of the proforma where this information has come from.

iii. The general categories ‘88=Not Applicable’ or ‘99=Not Recorded’ can both mean slightly different things depending on which information is being collected, and this is further explained under each piece of information below. Though ‘99=Not Recorded’ may be used in some fields to indicate that the notes were not seen, this should be avoided where possible. Every effort should be made to view the patient’s records in order to fully complete the audit and provide meaningful data.

iv. Please do not put '/' through boxes. All fields should either have an appropriate code from the definitions on the form, be coded as 88=Not Applicable or 99=Not Recorded.

v. All dates should be entered using a four digit format, i.e. DD.MM.YY e.g. 08.10.17

vi. All times should be entered using the 24 hour clock format, i.e. HH.MM e.g. 15.35

vii. If the 9=Other option is used please remember to add additional relevant information to the Comments section at the bottom of the proforma.

#### No. | Field Name | Definition | Variable required
--- | --- | --- | ---
1 | Name | Record the patient’s first name and surname. | Free text field
2 | Case note number | Record the patient’s allocated hospital record number. | Enter up to 10 characters. May contain numeric and/ or alpha characters. *Example: QEMH123456*
3 | CHI number | Record CHI, 10 digits. If you do not have CHI, give date of birth in the first six boxes. | Enter a 10 digit number (first six digits being the patients date of birth, i.e. DDMMYY)
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>
| 4 | Audit number | Allocate the next sequential audit number. | Enter up to a 5 digit number.  
  *Example:* 00234 |
| 5 | Hospital code | Enter the ISD code for the hospital where you are based.  
  **List of hospitals/ hospital codes:**  
  Aberdeen Royal Infirmary – N101H  
  Ayr Hospital – A210H  
  Borders General Hospital – B120H  
  Dumfries & Galloway Royal Infirmary – Y146H  
  Dr Gray’s Hospital, Elgin – N411H  
  Forth Valley Royal Hospital – V217H  
  Glasgow Royal Infirmary – G107H  
  Golden Jubilee National Hospital – D102H  
  Hairmyres Hospital – L302H  
  Inverclyde Royal Hospital – C313H  
  Ninewells Hospital – T101H  
  Perth Royal Infirmary – T202H  
  Queen Elizabeth University Hospital – G405H  
  Raigmore Hospital – H202H  
  Royal Alexandra Hospital – C418H  
  Royal Infirmary of Edinburgh – S314H  
  Stracathro Hospital – T312H  
  University Hospital Crosshouse – A111H  
  University Hospital Wishaw – L308H  
  Victoria Hospital, Kirkcaldy – F704H  
  Western Isles Hospital – W107H  
  Woodend General Hospital – N102H | List of hospital codes available in appendix A.  
  Enter appropriate code - *Example:* N101H |
| 6 | Postcode | Document part postcode for patient’s normal residence - first part and first digit of second part, e.g. ‘ML3 7’ or ‘ML10 6’.  
  Use home postcode if the patient is admitted from a home in which they are temporarily residing such as holiday or respite care.  
  Use the patient’s home postcode if they fell in an acute or rehab ward, But if admitted from NHS continuing care use the hospital’s postcode.  
  For postcodes outside UK use 999X X. | Enter up to 5 characters as per examples. |
<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>
| 7 | Audit number | Allocate the next sequential audit number. | Enter up to a 5 digit number.  
  Example: 00234 |
| 8 | Sex | Enter patient's gender status. | Enter one of the following codes:  
  1 = Male  
  2 = Female |
| 9 | Age | Record age at 1st presentation.  
  *Note: 88=Not applicable and 99=Not recorded should not be used in this field.* | Enter up to a 3 digit number. |
| 10 | Ortho Consultant | Allocate a number code to each consultant and keep the reference to this locally e.g. 1=Mr Smith, 2=Mr Brown, 3=Mr Cameron etc.  
  This code should reflect the consultant in charge of the patient's orthopaedic care. | Enter up to a 2 digit number. |
### Pre-fracture Residence

Record the current residence of the patient prior to fracture:

1. **Home** = when the patient is living at their usual residence, i.e. permanent address or if they are permanently living with a relative.

2. **Care home** = this can be a residential or nursing home provided it is the person's permanent home.

3. **NHS continuing care** = when the patient has fractured in a ward where the clinical team is no longer attempting to get a patient home. The patient may be awaiting a place in a nursing home or for funding, or may have become a permanent hospital patient. Before allocating this code, always check with the nurse in charge of the patient's care to determine the exact reasoning for the patient's placement and document in the Comments section. Include long term elderly psychiatry as NHS continuing care.

4. **Rehabilitation** = when the patient has fractured in a dedicated rehabilitation ward or a bed in a ward where rehabilitation is planned.

5. **Acute hospital** = when the patient has fractured in an acute hospital ward. Include acute psychiatry wards as acute hospital.

9. **Other** = includes non-NHS respite care or hospice, prison, homeless or private hospital care. If using 9=Other, please add additional information to the Comments box at bottom of the proforma.

Use 99=Not Recorded if pre-fracture residence is not known.

**Note:** People admitted from a Care of the Elderly (COE) ward should be coded according to the type of bed (NHS continuing care=3, Rehabilitation=4 and Acute COE=5).
### 12 Transferred patients

Indicate if the patient was transferred to an orthopaedic ward from elsewhere i.e. another hospital/ receiving unit/ care facility within 24 hours of injury.

If the patient presented elsewhere and was transferred to your unit, code as:

1. **Yes** = if they were transferred into your orthopaedic ward within 24 hours of presenting elsewhere. This would include patients presenting at an ED in another hospital as well as patients who were already an inpatient and fell in a ward elsewhere.

2. **No** = if >24 hours.

Use 88=Not Applicable if the patient was not transferred from a different hospital/ receiving unit/ care facility.

Record relevant details in the Comments section.

Enter one of the following codes, in line with the descriptions opposite:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>88</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

### ED

The ED information in this section should be taken from the attendance at ED at your site:

i. If the patient has been transferred from another hospital via your ED record if analgesia was given prior to transfer.

ii. If a patient was transferred directly into a ward at your site or fell whilst in hospital with no attendance at your ED, code as 88 in the date/ time of arrival at ED and leave the rest of the ED boxes blank.

iii. If a patient had more than one presentation to ED before the hip fracture was diagnosed start the audit from the ED visit when the fracture was diagnosed and the patient was admitted to orthopaedic care. Record details of any previous ED attendance (dates/ times/ diagnosis) in your Comments section.

iv. If the hip fracture was not suspected until after the patient was admitted (e.g. to a medical ward), start the audit when the orthopaedic team were first made aware of the fracture (i.e. code ED date/ time as 88 - do not include further ED details).

### 13 Date/ time arrival at ED

Record the date and time that the patient attended your ED. This should be the arrival date/ time or the earliest recorded date/ time within the ED.

Use 88=Not Applicable if a patient is transferred directly into a ward at your site or fell whilst in hospital with no attendance at your ED.

Use 99=Not Recorded if date or time is unknown.

Document additional information in the Comments section.

Enter date: DD.MM.YY

*Example: 11.09.17*

Enter time: HH.MM

*Example: 13.15*

Or enter one of the following codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>88</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>99</td>
<td>Not Recorded</td>
</tr>
</tbody>
</table>

### 14 Time left ED

Record the time the patient left ED for transfer to a ward/ theatre.

Use 99=Not Recorded if time is unknown.

Enter time: HH.MM

*Example: 13.15*

Or enter:

99=Not Recorded
### Scottish Hip Fracture Audit Guidelines

Updated and circulated – June 2018

| 15 | Fracture (#) suspected/ confirmed in ED | Record whether or not the hip fracture was suspected/ confirmed in ED. Use 1=Yes if the fracture was confirmed or suspected in ED, even if it required further confirmation after admission. Only use 2=No if the fracture was not suspected in ED, or if any suspicion of a hip fracture had been ruled out after x-ray. In such cases patients may have been admitted to a medical ward or to orthopaedics with other injuries or non-hip related pain. If you use 2=No, record all other ED details as 88=Not Applicable, but confirm the attendance in the Comments section. Use 88=Not Applicable if the patient did not attend ED. | Enter one of the following codes, in line with the descriptions opposite: 1=Yes 2=No 88=Not Applicable |
| 16 | Destination from ED | Record where the patient was transferred to from ED. Use 9=Other if the patient died in ED and specify in Comments section. | Enter one of the following codes: 1=Ortho ward 2=Non Ortho ward 3=Theatre 9=Other (please specify) |

**Interventions in ED**

| 17 | Analgesia | Record if analgesia was given or offered in ED or from the Scottish Ambulance Service (SAS) (including by the General Practitioner (GP)) or prior to transfer. Use 1=Analgesia given in ED (or SAS) if a nerve block was given. **Entonox is not included** as a form of analgesia as it doesn't always provide adequate pain relief and its effects are very short lived. Use 99=Not Recorded if the notes were not seen, explaining use of 99 in Comments section. | Enter one of the following codes: 1=Analgesia given in ED (or SAS) 2=Not given – declined 3=Not given – no reason 9= Not given – other reason 99=Not Recorded |
| 18 | Nerve block given | Record whether or not a nerve block was given in ED. Use 99=Not Recorded if the notes were not seen, explaining use of 99 in Comments section. | Enter one of the following codes: 1=Yes 2=No 99=Not Recorded |
## Scottish Hip Fracture Audit Guidelines

*Updated and circulated – June 2018*

<table>
<thead>
<tr>
<th>19</th>
<th>ECG carried out</th>
<th>Record whether the patient had an electro-cardiograph (ECG) carried out in ED. Use 99=Not Recorded if the notes were not seen, explaining use of 99 in Comments section.</th>
<th>Enter one of the following codes: 1=Yes 2=No 99=Not Recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Bloods taken</td>
<td>Record whether blood samples were taken in ED, e.g. Full Blood Count (FBC), Urea &amp; Electrolytes (U&amp;E) etc. If nothing is documented in the ED notes, check the Results Reporting System. If checking this system then it is important to accurately check the time to ensure that the bloods were taken when the patient was in ED. Use 99=Not Recorded if the notes were not seen, explaining use of 99 in Comments section.</td>
<td>Enter one of the following codes: 1=Yes 2=No 99=Not Recorded</td>
</tr>
<tr>
<td>21</td>
<td>Pressure Areas recorded</td>
<td>Record whether a pressure area inspection was carried out in ED. This can include a visual inspection as well as completion of a formal assessment tool such as Waterlow Score. Evidence of this being done should be clearly documented in the patient’s notes for it to be included in the audit. Use 99=Not Recorded if the notes were not seen, explaining use of 99 in Comments section.</td>
<td>Enter one of the following codes: 1=Yes 2=No 99=Not Recorded</td>
</tr>
<tr>
<td>22</td>
<td>IV fluids</td>
<td>Record whether IV fluids were commenced in ED or from SAS or prior to transfer. <strong>Note:</strong> Oral fluids are not included as IV fluids. In some circumstances it may be clinically appropriate that patients do not have IV fluids. This should be documented in the patient’s notes by medical or specialist nursing staff. Use 3=Not Required only if there is <strong>clearly documented evidence</strong> that IV fluids are not required. Use 99=Not Recorded if the notes were not seen, explaining use of 99 in Comments section.</td>
<td>Enter one of the following codes: 1=Yes 2=No 3=Not required 99=Not Recorded</td>
</tr>
<tr>
<td>23</td>
<td>EWS score recorded in ED</td>
<td>Record if an Early Warning System (EWS) score was recorded in ED. Use 99=Not Recorded if the notes were not seen, explaining use of 99 in Comments section.</td>
<td>Enter one of the following codes: 1=Yes 2=No 99=Not Recorded</td>
</tr>
</tbody>
</table>
# Inpatient Stay

**Please note:**

i. Some patients may sustain their hip fracture whilst already an inpatient. All of the data collected in the ‘Inpatient Stay’ section pertain to what happened after the orthopaedic team are made aware of the patient.

*Example: A patient in a Care of the Elderly ward falls overnight sustaining a hip fracture; Ortho reviews the patient in the morning and arranges surgery and transfer to Ortho post-operatively - only record interventions that occur after Ortho are made aware of the patient.*

ii. If a patient is not admitted via ED, e.g. they fall and fracture on a ward (inpatient hip fracture) - falls, nutrition or pressure area assessments should still be reassessed and recorded.

| 24 | Date/ time of admission | The date/ time of admission will normally be:

- **ED patient** – when the patient is transferred from ED and arrives in the ward (usually orthopaedic, but also holding wards, or other medical wards) provided the hip fracture has been diagnosed or suspected in ED, i.e. the date/ time the patient arrives in the ward (first recorded date/ time in the ward) not the date/ time they left ED.

- **Inpatient** - when a patient has a hip fracture diagnosed whilst in hospital, often as a result of a fall (the date/ time of when Orthopaedics are made aware of the patient should be used rather than when the patient is transferred to Orthopaedics).

- **Transferred patient** - when a patient with a diagnosed hip fracture is transferred directly into your hospital, e.g. from another hospital, or via their GP.

In all of the above cases other injuries or conditions may be a priority for care and the patient may not be treated in an orthopaedic ward, but the date/ time of admission would still reflect the inpatient time when the hip fracture had been diagnosed and subsequently reported to Orthopaedics.

If the patient is transferred direct to theatre from ED, record as the date/ time of admission to the Ortho ward following surgery.

Use 88=Not Applicable if the patient is not admitted to hospital (e.g. discharges from ED and doesn’t re-present)

99=Not Recorded should never be used for Date of Admission as this is a key point of reference for the audit. Discuss with the central team if unsure.

Occasionally 99=Not Recorded can be used for Time of Admission if no time information is available (e.g. time when orthopaedics were informed after an inpatient fall not recorded).

**Enter date:**

DD.MM.YY

**Example:** 11.09.17

**Enter time:** HH.MM

**Example:** 13.15

Or enter one of the following:

88=Not Applicable

99=Not Recorded
### 25 Falls Assessment timing

Record the timing of the first falls assessment, e.g. Morse Fall Scale, in relation to the date/time of admission (section 24).

For patients not admitted directly to an orthopaedic ward from ED: the timing of the falls assessment should be calculated in relation to the date/time of admission as in section 24, i.e. not when the patient was eventually transferred to an orthopaedic ward.

**Pre-fracture or pre-diagnosis assessments should not be included** as the patient should be re-assessed following fracture/diagnosis.

If the falls assessment is done at exactly 4 hours post admission, use the lower code, i.e. 2=0-4 hours post admission or if the assessment is done at exactly 24 hours post admission use the lower code, i.e. 3=4-24 hours post admission.

Use 99=Not recorded if date/time is not recorded in the patient’s notes meaning you cannot work out when the falls assessment was done.

If the date of assessment has been recorded and indicates that the assessment was done within 24 hours, but no time has been recorded to confirm whether the assessment was done within 4 hours, use 3=4-24 hours post-admission.

Enter one of the following codes:

- 1=ED
- 2=0-4 hours post admission
- 3=4-24 hours post admission
- 4=24-72 hours post admission
- 5=Not done within 72 hours
- 99=Not Recorded

### 26 Nutrition assessment timing

Record the timing of the first nutritional assessment, e.g. Malnutrition Universal Screening Tool (MUST), in relation to the date/time of admission (section 24).

For patients not admitted directly to an orthopaedic ward from ED: the timing of the nutrition assessment should be calculated in relation to the date/time of admission as in section 24, i.e. not when the patient was eventually transferred to an orthopaedic ward.

**Pre-fracture or pre-diagnosis assessments should not normally be included** as the patient should be re-assessed following fracture/diagnosis.

If the nutritional assessment is done at exactly 4 hours post admission, use the lower code, i.e. 2=0-4 hours post admission or if the assessment is done at exactly 24 hours post admission use the lower code, i.e. 3=4-24 hours post admission.

Use 99=Not recorded if date/time is not recorded in the patient’s notes meaning you cannot work out when the nutrition assessment was done.

If the date of assessment has been recorded and indicates that the assessment was done within 24 hours, but no time has been recorded to confirm whether the assessment was done within 4 hours, use 3=4-24 hours post-admission.

Enter one of the following codes:

- 1=ED
- 2=0-4 hours post admission
- 3=4-24 hours post admission
- 4=24-72 hours post admission
- 5=Not done within 72 hours
- 99=Not Recorded
### Pressure Areas assessment timing

Record the timing of the first formal pressure area assessment, e.g. Waterlow Score, in relation to the date/ time of admission (section 24). Record only formal assessments rather than evidence of visual inspection only.

For patients not admitted directly to an orthopaedic ward from ED: the timing of the pressure areas assessment should be calculated in relation to the date/ time of admission as in section 24, i.e. not when the patient was eventually transferred to an orthopaedic ward.

**Pre-fracture or pre-diagnosis assessments should not normally be included** as the patient should be re-assessed following fracture/diagnosis.

If the pressure area assessment is done at exactly 4 hours post admission, use the lower code, i.e. 2=0-4 hours post admission or if the assessment is done at exactly 24 hours post admission use the lower code, i.e. 3=4-24 hours post admission.

Use 99=Not recorded if date/ time is not recorded in the patient’s notes meaning you cannot work out when the pressure areas assessment was done.

If the date of assessment has been recorded and indicates that the assessment was done within 24 hours, but no time has been recorded to confirm whether the assessment was done within 4 hours, use 3=4-24 hours post-admission.

<table>
<thead>
<tr>
<th>Enter one of the following codes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1=ED</td>
</tr>
<tr>
<td>2=0-4 hours post admission</td>
</tr>
<tr>
<td>3=4-24 hours post admission</td>
</tr>
<tr>
<td>4=24-72 hours post admission</td>
</tr>
<tr>
<td>5=Not done within 72 hours</td>
</tr>
<tr>
<td>99=Not Recorded</td>
</tr>
</tbody>
</table>

### Delirium Screening

**Please note:**

i. Some patients may sustain their hip fracture whilst already an inpatient. All of the data collected in the ‘Inpatient Stay’ section pertain to what happened after the orthopaedic team are made aware of the patient.

*For example: A patient in a Care of the Elderly ward falls overnight sustaining a hip fracture; Ortho reviews the patient in the morning and arranges surgery and transfer to Ortho post-operatively - only record interventions that occur after Ortho are made aware of the patient.*

ii. If a patient is not admitted via ED, e.g. they fall and fracture on a ward (inpatient hip fracture) – delirium screening should still be reassessed and recorded.
<table>
<thead>
<tr>
<th>28</th>
<th>Delirium Screening</th>
</tr>
</thead>
</table>
|     | The Scottish Standards for Hip Fracture Care state that ‘delirium screening must occur on arrival i.e. in ED and again within 24 hours of ward admission’. The Rapid Clinical Test for Delirium (4AT) is the delirium assessment tool which is most commonly used in Scotland and is the tool of choice advised in the Scottish Standards of Care for Hip Fracture Patients. Record only the use of 4AT in the Delirium/ Cognition section. Record the first two periods of time (i.e. using the timing codes provided) in which 4AT was carried out. If the 4AT is used more than once in the same time period, e.g. twice in ED, or twice within any of the post-admission time periods only include this once. *For example: Patient has 4AT in ED and 4AT 6 hours after admission to ward - complete the double box on the proforma as follows - 4AT=1 3.*
|     | **There is no need to record any information about any other tools used** (please ignore the AMT4, MMSE/AMT10 and Other fields and note that SQID will no longer be accepted as a delirium screen). Use 88=Not applicable if 4AT has not been used in ED or after admission. Use 99=Not recorded if the notes are not seen. If the assessment is done at exactly 4 hours post admission, use the lower code, i.e. 2=0-4 hours post admission or if the assessment is done at exactly 24 hours post admission use the lower code, i.e. 3=4-24 hours post admission. If the date of assessment has been recorded and indicates that the assessment was done within 24 hours, but no time has been recorded to confirm whether the assessment was done within 4 hours, use 3=4-24 hours post-admission. Enter two of the following codes: 1=ED 2=0-4 hours post admission 3=4-24 hours post admission 4=>24 hours post admission 88=Not Applicable 99=Not Recorded |
29 **Comprehensive Geriatric Assessment (CGA) date**

Record the date and time the patient first had a Comprehensive Geriatric Assessment (CGA) after the patient had been admitted for hip fracture, i.e. the date/time recorded in section 24.

The CGA would usually be carried out by either a geriatrician or a specialist nurse.

Documentation that the patient was 'not fit' for assessment is not classed as a CGA.

Use 66=Local Protocol if an assessment has not been done and the local protocol does not require a CGA (e.g. age <75, or fell while skiing).

Use 88=Not Applicable if the patient did not have a CGA by 7 days following the date/time of admission (section 24). There is no need to continue to look for appointments occurring more than a week after admission.

Use 99=Not Recorded if the notes were not seen or if the date of the assessment was not recorded, explaining use of 99 in Comments section.

Enter date: DD.MM.YY
Example: 11.09.17
Enter time: HH.MM
Example: 13.15
Or enter one of the following:
66=Local Protocol
88=Not Applicable
99=Not Recorded

30 **Assessed by**

Record who did the patient’s first CGA, i.e. which discipline.

1=Geriatrician - need not be a consultant, but must be a member of a dedicated Care of the Elderly team, e.g. Specialist Trainee.

3=GPWSI - GP With Special Interest

If 9=Other is used give full details in the Comments section.

Use 88=Not Applicable if the patient has not had a CGA.

Use 99=Not Recorded if the notes were not seen or if the person that completed the assessment was not recorded, explaining use of 99 in Comments section.

Enter one of the following codes:
1=Geriatrician
2=Specialist Nurse
3=GPWSI
9=Other
88=Not applicable
99=Not recorded

Surgery

31 **Date/time into theatre**

Record the date and time the surgical repair commenced – defined as **when ‘knife to skin’ occurs**.

This information should be taken from the anaesthetic/theatre/surgical record.

Use 88=Not Applicable if the patient was not treated surgically **within the first week of admission**.

Use 99=Not Recorded if the notes were not seen or if the date/time was not recorded.

If the patient does not go to theatre immediately, continue to monitor until at least Day 8, e.g. if patient admitted on 4th February, continue to monitor until 12th February, so that you can be sure they have not gone to theatre in the first week.

Enter date: DD.MM.YY
Example: 11.09.17
Enter time: HH.MM
Example: 13.15
Or enter one of the following:
88=Not Applicable
99=Not Recorded
<table>
<thead>
<tr>
<th>32</th>
<th>How many times was patient fasted?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Record the total number of periods of enforced fasting that the patient had prior to surgery. As well as fasting for the actual surgery, include periods of fasting when surgery did not take place, e.g. prior to a previous cancelled surgery, or fasted after a late admission for possible surgery in the morning, noting that in order to be <strong>classed as fasted</strong>, the patient must have <strong>missed at least one meal</strong>.</td>
</tr>
<tr>
<td></td>
<td><em>Examples:</em> patient admitted and fasted from 3am, cancelled at 11.30am but missed breakfast would be classed as fasted x1. Patient admitted at 9pm, fasted overnight, reviewed at 8am, not for theatre and given breakfast would not count as a fasting period as had breakfast and did not miss a meal.</td>
</tr>
<tr>
<td></td>
<td>Use 88=Not Applicable if the patient was admitted nil by mouth (NBM) due to swallowing problems and explain in the Comments section.</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> it should be clearly documented in the patient’s records that they have been fasted for surgery. It <strong>should not be assumed</strong> that if the patient went to theatre shortly after admission or in the first 24 hours that they were fasted once.</td>
</tr>
<tr>
<td></td>
<td>Enter up to a 2 digit number. 88=Not Applicable</td>
</tr>
</tbody>
</table>
If the patient was delayed for surgery by more than 36 hours from the date/time of admission to orthopaedic care (section 24) record the main reason for the delay:

<table>
<thead>
<tr>
<th>Code</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td><strong>No delay</strong> = surgery within 36 hours of admission.</td>
</tr>
<tr>
<td>1</td>
<td><strong>Medically unfit</strong> = this can include clear documentation of a clinical decision that the patient is not fit for theatre as well as evidence that ongoing intervention is the reason for delay, such as correction of anti-coagulants, treatment of infection etc. The reason for the patient being medically unfit needs to be clearly documented in the patient’s records before it can be included in the audit.</td>
</tr>
<tr>
<td>2</td>
<td><strong>Lack of theatre time</strong> = if a lack of theatre time/capacity is clearly documented in the patient’s records.</td>
</tr>
<tr>
<td>3</td>
<td><strong>Initial conservative treatment</strong> = if the patient was initially being treated conservatively due to uncertainty about longer term outcomes.</td>
</tr>
<tr>
<td>4</td>
<td><strong>Delayed diagnosis</strong> = awaiting MRI/bone scan to confirm diagnosis.</td>
</tr>
<tr>
<td>5</td>
<td><strong>Delayed consent</strong> = if the patient has requested additional time to consider surgery.</td>
</tr>
<tr>
<td>6</td>
<td><strong>Wait for Total Hip Replacement (THR)</strong> = in some cases a total hip replacement is the preferred treatment option, use this code if there was a delay because of this.</td>
</tr>
<tr>
<td>9</td>
<td><strong>Other</strong></td>
</tr>
</tbody>
</table>

Use 99=Not Recorded if the notes were not seen or for long delays (4+days) without recorded reason. Explain use of 99 in Comments section.

Enter one of the following codes, in line with the descriptions opposite:
- 0=No delay
- 1=Medically unfit
- 2=Lack of theatre time
- 3=Initial conservative treatment
- 4=Delayed diagnosis
- 5=Delayed consent
- 6=Wait for Total Hip Replacement (THR)
- 9=Other
- 99=Not Recorded
<table>
<thead>
<tr>
<th>34</th>
<th>Type of operation</th>
<th>Record the type of operation that was carried out to repair the hip fracture. This information can usually be found in the operation notes. Further information:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1. <strong>Cannulated screws</strong> = AO screw or nail.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. <strong>Intramedullary (IM) fixation</strong> = IM nailing, gamma nail, ender nail, Affixus femoral nails.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. <strong>Pin and plate</strong> = includes Dynamic Hip Screw (DHS).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. <strong>Hemiarthroplasty (Hemi) cemented</strong> = Thompsons, Hastings, Exeter hemi.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. <strong>Hemiarthroplasty (hemi) uncemented</strong> - Austin Moore.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. <strong>Hemiarthroplasty cement not specified</strong> – please make every effort to find out whether cement has been used or not.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. <strong>Total Hip Replacement</strong> (THR) = Exeter, Exeter/ Ogee, c-stem marathon, Corail pinnacle ceramic, CPT/ ZCA.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9. <strong>Other, please</strong> add additional information to Comments section.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use 88=Not Applicable only if the patient was not treated surgically.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For further information please refer to the Decision Log, this will be circulated with MSk newsletter.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enter one of the following codes, in line with the descriptions opposite:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1=Cannulated screws</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2=Intramedullary fixation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3=Pin and plate (includes DHS)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4=Hemi-cemented</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5=Hemi-uncemented</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6=Hemi-cement unspecified</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7=THR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9=Other (specify in comments)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>88=Not Applicable</td>
</tr>
</tbody>
</table>
### 35 Bone health assessed

The aim is that all patients are either started on treatment during their acute admission or have an assessment planned for this in the early discharge period. Record the details of any assessment of, or referral for bone health prior to leaving the acute orthopaedic ward.

1. **Yes** = if bone health has been considered and relevant medication reviewed and/or new bone protection medication commenced. **This needs to be clearly documented in the patient’s records.**

2. **No** = No evidence of a bone protection medication review or referral for bone health assessment. Also record as No if the patient is documented ‘not fit’ for bone health review.

3. **No, referred** = No evidence of a bone protection medication review but **there is evidence that they have been referred** for a DXA scan, to a Fracture Liaison Service or to an Osteoporosis Service. **If this information is provided by the FLS or other service from their records verbally or otherwise, this should be noted in the comments section of the proforma so that an audit trail of where the information was found is available.**

**Do not assume** that if local policy/standard practice is to refer patients, that they have been referred, unless it is **clearly documented** in the patient’s records or confirmed by the FLS or other service.

**Note:** If the answer to this question is ‘No’ you will be asked to check again for evidence of referral in the 60 day review.

Enter one of the following codes, in line with the descriptions opposite:

1=Yes  
2=No  
3=No, referred

### 36 Post-op mobilisation

Record when the patient first mobilised after their operation. This can include getting out of bed to use the toilet as well as more formal mobilisation, i.e. up to stand/ up to sit out of bed. This information should be recorded in the nursing or physiotherapy notes or the integrated care pathway.

**Note:** 1=By first day post-op, includes patients that were mobilised on day of surgery.  
Use 88=Not Applicable if the patient was treated conservatively.  
Use 99=Not Recorded if mobilisation not documented.

Enter one of the following codes:

1=By first day post-op  
2=Second day post-op  
3=Third day post-op or later/ not mobilised  
88=Not Applicable  
99=Not Recorded
|   | Date assessed by physio | Record the date the patient was **first assessed post-operatively** by a member of the physiotherapy team.  
**Note:** The patient may have been assessed by a physiotherapist but not mobilised due to the patient being unfit to get out of bed. **Record the date the first assessment took place.**  
Use 88=Not Applicable if the patient was treated conservatively. You can also use code 88 if the patient wasn't seen by a physiotherapist within 4 days of surgery (e.g. by the 7th if patient had surgery on the 3rd). There is no need to continue to look for the first assessment date after this.  
Use 99=Not Recorded if the date of assessment was not recorded, or the notes were not seen. | Enter date:  
**Example:** 11.09.17  
Or enter one of the following:  
88=Not Applicable  
99=Not Recorded |
|---|---|---|
|   | Date assessed by OT | Record the date of the first time that there was Occupational Therapy (OT) input in the patient’s care, **post-admission**. This can be by any member of the OT team.  
**Note:** this measure is the start of the OT assessment process and may include formal physical assessment as well as gathering of information regarding the patient’s functional status prior to the hip fracture.  
Therefore an entry recorded as ‘not fit’ or ‘patient unavailable’ is **not regarded** as the start of this process and reasons why input has not been commenced by day 3 post admission should be recorded – see question 39.  
There must be evidence of consideration of an individual’s OT requirements regardless of their normal place of residence.  
For example, if the patient’s normal place of residence is a care home and there is evidence in the patients records that the OT has discussed the patients requirements with the care home staff, record the date of OT input as when this discussion took place.  
If there is no record in the patient’s notes that this has happened, please use 88= Not Applicable.  
Use 99=Not Recorded if the date of first OT input was not recorded, or the notes were not seen. | Enter date:  
**Example:** 11.09.17  
Or enter one of the following:  
88=Not Applicable  
99=Not Recorded |
| PB3  | Reason why OT input not commenced by day 3 post admission. | Record the reason why OT input was not commenced by day 3 post admission. Use the following codes to describe the reason documented for this:

1. **Not fit.**
2. **No staff available** – this must be **clearly documented** in the patient’s records that this was the reason the patient was not assessed by day 3.
3. **Local policy** – for example, age-related or from Nursing Home.
9. Other – record additional information in Comments box.

Use 99=Not Recorded if no evidence of reason documented.

**Note:** Do not assume lack of staff however do not be afraid to record as such if clearly documented in the patient’s records.

Enter one of the following codes, in line with the descriptions opposite:

1=Not fit  
2=No staff available  
3=Local Policy  
9=Other  
99=Not Recorded

| 39   | Date of discharge | Record the date of discharge from **acute orthopaedic care.** If the patient was transferred to a rehabilitation ward (or an acute or NHS Continuing Care ward) prior to discharge from hospital, use the date of transfer from the orthopaedic ward to the other ward as the date of discharge.

**If you need to submit your forms before the discharge date is known:**

- Use 88=Not Applicable if the patient has been an inpatient (as per orthopaedic admission date, section 24) for at least 21 days.

- Leave blank if still an inpatient but 21 days have not yet elapsed before you need to submit the form (you will be asked for this further information at validation).

Enter date: DD.MM.YY

*Example: 11.09.17*

Or enter one of the following:

88=Not Applicable  
99=Not Recorded

<table>
<thead>
<tr>
<th>40</th>
<th>Discharge destination</th>
<th>Record the place that the patient was discharged to from acute orthopaedic care:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1. <strong>Home</strong> = when the patient is discharged home, i.e. permanent address or if they are permanently living with a relative. This should include when the patient is discharged home with support from the Hospital at Home team.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. <strong>Care home</strong> = this can be a residential or nursing home provided it’s the person’s permanent home/ usual place of residence.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. <strong>NHS continuing care</strong> = when the clinical team is no longer attempting to get a patient home. The patient may be awaiting a place in a nursing home or for funding, or may have become a permanent hospital patient. Before allocating this code, always check with the nurse in charge of the patient’s care to determine the exact reasoning for the patient’s placement and document in the Comments section. This should include patients being returned to or transferred to <strong>long term elderly psychiatry</strong> (see note i below)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. <strong>Rehabilitation</strong> = when the patient is transferred either to a dedicated rehabilitation ward or to a bed in a ward where rehabilitation is planned.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. <strong>Acute hospital</strong> = when the patient is discharged to another acute ward such as general medicine, critical care, acute psychiatry or care of the elderly (see notes i and ii below).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. <strong>Intermediate care</strong> – should only be used when the patient is discharged to a care home or other facility for ‘intermediate care’, i.e. the plan is still that the patient’s final destination will be home.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9. <strong>Other</strong> = includes non-NHS respite care or hospice, prison, homeless, or private hospital care. Please provide further details in Comments section.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10. <strong>Died</strong> = the person died prior to leaving the acute orthopaedic ward.</td>
</tr>
</tbody>
</table>

**Note:**

i) Transfers to Psychiatry should be coded according to type of bed, for example, acute=Acute Hospital (5), long term psychiatry/ elderly=NHS Continuing Care (3)

ii) Transfers to a Care of the Elderly (COE) ward should be coded according to type of bed, for example, Rehabilitation=4, NHS continuing care=3, Acute COE=5).

99=Not recorded should only be used when discharge details are not available.

Enter one of the following codes, in line with the descriptions opposite:

1=Home
2=Care home
3=NHS continuing care
4=Rehabilitation
5=Acute hospital
6=Intermediate care
9=Other (specify in comments box)
10=Died
99 = Not recorded
### 40 Discharge destination (cont)

If you need to submit your forms before the discharge destination is known:
- Use 88=Not Applicable if the patient has been an inpatient (as per orthopaedic admission date, section 24) for at least 21 days.
- Leave blank if still an inpatient but 21 days have not yet elapsed before you need to submit the form.

<table>
<thead>
<tr>
<th>Project Boxes 1-6</th>
<th>Use as advised in guidelines above and or as per local arrangement. PB3 is currently being used to record the reason why OT input was not commenced by day 3 post admission.</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 day review</td>
<td>Please note that these data are collected in an excel workbook which will be sent to LACs every month.</td>
</tr>
</tbody>
</table>