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 4). 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 all patients admitted to your hospital with a hip fracture regardless of where their journey started (unless the patient is transferred to another LACs hospital for surgery). For example, the patient could have fallen and fractured their hip in another hospital or been taken to another hospital before transfer to your hospital. Data should be collected from the time the patient attended the first hospital or when the fall occurred in the first hospital. This information should be available in transfer information/electronic patient records but it may require local links to be made with colleagues in hospitals transferring patients to your hospital.

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 in any hospital, 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. discussion with orthopaedic surgeon/clinical team, 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:

- Comprehensive Geriatric Assessment (CGA) standard is that assessment should be done within 3 days of admission, however it is useful to know how close to achieving the standard the hospital is therefore this information should be recorded if within 7 days of admission. If >7 days it is not necessary to collect a date.

- Physiotherapy assessment standard is that assessment should be done within 2 days post-surgery - however it is useful to know how close to achieving the standard the hospital is therefore this information should be recorded if within 7 days of admission. If >7 days it is not necessary to collect a date.

- Occupational Therapy assessments - standard is that assessment should be done within 3 days of admission, however it is useful to know how close to achieving the standard the hospital is therefore this information should be recorded if within 7 days of 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 = Not applicable 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 (Q49) and Discharge Destination (Q50).

Transferred patients – the audit now measures care provided in the **first and operating hospitals**. The majority of the information will usually be collected from the operating hospital, i.e. the hospital where the patient had their hip surgically repaired. If a patient has been transferred from your hospital to another LACs hospital for surgery, it is good practice to alert the LAC in the receiving hospital. **Only one form should be submitted, usually from the operating hospital.**

**60 day review**

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.

**Appendix 1** provides you with an overview of the data items included in the 60 day follow up.

**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

- Extracapsular fracture
  - Trochanteric fracture
    - Sub-trochanteric fracture
  - Greater trochanter
- Intracapsular fracture
  - Lesser trochanter
- Femoral shaft

Pelvis
- Hip joint
- Femoral head

5 cm
Example cross-index

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>LAC hospital</td>
<td>MSk audit no</td>
<td>CHI</td>
<td>Forename</td>
<td>Surname</td>
<td>Date of admission</td>
<td>Reason if not audited</td>
</tr>
<tr>
<td>2</td>
<td>RIE</td>
<td>14563</td>
<td>2705461746</td>
<td>Jim</td>
<td>Bloggs</td>
<td>01/02/2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>RIE</td>
<td>14564</td>
<td>0705513853</td>
<td>John</td>
<td>Brown</td>
<td>01/02/2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>RIE</td>
<td>14565</td>
<td>1207288238</td>
<td>Mary</td>
<td>Green</td>
<td>02/02/2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>RIE</td>
<td>14566</td>
<td>1707407299</td>
<td>Tony</td>
<td>Scarlett</td>
<td>04/02/2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>RIE</td>
<td>14567</td>
<td>2605258491</td>
<td>Frank</td>
<td>Bruno</td>
<td>05/02/2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>RIE</td>
<td>14568</td>
<td>3103452272</td>
<td>Wendy</td>
<td>McNulty</td>
<td>07/02/2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>RIE</td>
<td>14569</td>
<td>0112627773</td>
<td>Marge</td>
<td>Gains</td>
<td>07/02/2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>RIE</td>
<td>14570</td>
<td>1606389420</td>
<td>Farock</td>
<td>Donnelly</td>
<td>07/02/2019</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## General Notes

1. If you are unclear about any aspect of the proforma, data collection 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).

2. 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.

3. 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.

4. 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.

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

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

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

---

<table>
<thead>
<tr>
<th>No.</th>
<th>Field Name</th>
<th>Definition</th>
<th>Variable required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Name</td>
<td>Record the patient’s first name and surname.</td>
<td>Free text field</td>
</tr>
<tr>
<td>2</td>
<td>CHI number</td>
<td>Record CHI, 10 digits. If you do not have CHI, give date of birth in the first six boxes.</td>
<td>Enter a 10 digit number (first six digits being the patients date of birth, i.e. DDMMYY)</td>
</tr>
</tbody>
</table>
| 3   | Audit number | Allocate the next sequential audit number. | Enter up to a 5 digit number.  
  
  Example: 11208 |
### Hospital code (of LAC)

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

### 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.

**Notes:**

- Use 999X X for postcodes outside UK.
- Please enter NFA for patients who have ‘No Fixed Abode’.

Enter up to 5 characters as per examples.
|   | **Audit number** | Allocate the next sequential audit number (same as Q3). | Enter up to a 5 digit number.  
*Example: 11208* |
|---|------------------|--------------------------------------------------|----------------------------------------------------------------|
| 7 | **Sex**          | Enter patient’s gender status.                   | Enter one of the following codes:  
1 = Male  
2 = Female |
| 8 | **Age**          | Record age at first presentation.  
*Note: 88 = Not applicable and 99 = Not recorded should not be used in this field.* | Enter up to a 3 digit number. |
| 9 | **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.  
*Note: This code should reflect the consultant in charge of the patient’s orthopaedic care.* | Enter up to a 2 digit number. |
<table>
<thead>
<tr>
<th></th>
<th>Pre-fracture Residence</th>
<th>Record the current residence of the patient prior to fracture:</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td></td>
<td>1. <strong>Home</strong> = when the patient is living at their usual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>residence, i.e. permanent address or if they are</td>
</tr>
<tr>
<td></td>
<td></td>
<td>permanently living with a relative. Also use this option</td>
</tr>
<tr>
<td></td>
<td></td>
<td>if the patient has fractured whilst on holiday or working</td>
</tr>
<tr>
<td></td>
<td></td>
<td>away from home.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. <strong>Care home</strong> = this can be a residential or nursing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>home provided it is the person’s permanent home.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. <strong>NHS continuing care</strong> = when the patient has</td>
</tr>
<tr>
<td></td>
<td></td>
<td>fractured in a ward where the clinical team is no longer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>attempting to get a patient home. The patient may be</td>
</tr>
<tr>
<td></td>
<td></td>
<td>awaiting a place in a nursing home or for funding, or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>may have become a permanent hospital patient, i.e. now in</td>
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<tr>
<td></td>
<td></td>
<td>a long term care bed. Before allocating this code, always</td>
</tr>
<tr>
<td></td>
<td></td>
<td>check with the nurse in charge of the patient’s care to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>determine the exact reasoning for the patient’s placement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and document in the Comments section. Include long term</td>
</tr>
<tr>
<td></td>
<td></td>
<td>elderly psychiatry as NHS continuing care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. <strong>Rehabilitation</strong> = when the patient has fractured in</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a dedicated rehabilitation ward or a bed in a ward where</td>
</tr>
<tr>
<td></td>
<td></td>
<td>rehabilitation occurs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. <strong>Acute hospital</strong> = when the patient has fractured in</td>
</tr>
<tr>
<td></td>
<td></td>
<td>an acute hospital ward. Include acute psychiatry wards as</td>
</tr>
<tr>
<td></td>
<td></td>
<td>acute hospital.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. <strong>Intermediate care – NHS funded bed</strong>. This code</td>
</tr>
<tr>
<td></td>
<td></td>
<td>should only be used when the patient is discharged to a</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHS funded bed in a care facility for ‘intermediate care’,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>i.e. the plan is still that the patient’s final</td>
</tr>
<tr>
<td></td>
<td></td>
<td>destination will be home.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. <strong>Intermediate care – non-NHS funded bed</strong>. This code</td>
</tr>
<tr>
<td></td>
<td></td>
<td>should only be used when the patient is discharged to a</td>
</tr>
<tr>
<td></td>
<td></td>
<td>care home or other non-NHS funded facility for ‘intermediate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>care’, i.e. the plan is still that the patient’s final</td>
</tr>
<tr>
<td></td>
<td></td>
<td>destination will be home.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9. <strong>Other</strong> = includes non-NHS respite care or hospice,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>prison, homeless or private hospital care. If using 9 =</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other, please add additional information to the Comments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>box at bottom of the proforma.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Notes:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use 99 = Not Recorded if pre-fracture residence is not</td>
</tr>
<tr>
<td></td>
<td></td>
<td>known or not recorded.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>People admitted from a Care of the Elderly (COE) ward</td>
</tr>
<tr>
<td></td>
<td></td>
<td>should be coded according to the type of bed (NHS continuing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>care = 3, Rehabilitation = 4 and Acute COE = 5).</td>
</tr>
</tbody>
</table>

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 – NHS funded bed
7. Intermediate Care – non-NHS funded bed
9. Other (specify in comments box)
99. Not recorded
<table>
<thead>
<tr>
<th>Examples of patient journeys:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Arrival at ED and admission to ward in same hospital (operating hospital)</td>
</tr>
<tr>
<td>ED data – collected from operating hospital.</td>
</tr>
<tr>
<td>IP data – collected from operating hospital.</td>
</tr>
<tr>
<td>E.g. Patient presents at Ninewells Hospital ED and is admitted to ward at Ninewells Hospital.</td>
</tr>
<tr>
<td>2. Arrival at ED in first hospital – transfer direct from ED (first hospital) to ED in operating hospital – admitted to ward in operating hospital.</td>
</tr>
<tr>
<td>ED data – combined data collected from first hospital and operating hospital.</td>
</tr>
<tr>
<td>IP data – collected from operating hospital.</td>
</tr>
<tr>
<td>E.g. Patient presents at Monklands ED, immediately transferred to Wishaw ED and then admitted to ward at Wishaw.</td>
</tr>
<tr>
<td>3. Arrival at ED in first hospital – transferred direct from ED in first hospital to ward in operating hospital.</td>
</tr>
<tr>
<td>ED data – collected from first hospital.</td>
</tr>
<tr>
<td>IP data – collected from operating hospital.</td>
</tr>
<tr>
<td>E.g. Patient presents at Caithness General ED and then is transferred and admitted directly to ward at Raigmore Hospital.</td>
</tr>
<tr>
<td>4. Arrival at ED in first hospital – admitted to first hospital overnight (or for a specified time) and is then transferred to operating hospital for admission (depending on transfer protocols the patient may be transferred directly to a ward or may have to stop briefly in ED if that is the pathway agreed in specific Board).</td>
</tr>
<tr>
<td>ED data – collected from first hospital. (If the patient stops briefly in ED in operating hospital during the transfer process this data would not be collected as part of the ED dataset).</td>
</tr>
<tr>
<td>IP data – combined data collected from first hospital and operating hospital.</td>
</tr>
<tr>
<td>E.g. Patient presents at Balfour Hospital and is admitted overnight due to adverse weather conditions. In the morning is transferred and admitted directly to ward at ARI (or via ED to ward at ARI).</td>
</tr>
<tr>
<td>5. Inpatient fracture at first hospital – patient who is an inpatient in a hospital other than the operating hospital falls and fractured hip is suspected or confirmed. Transfer is arranged via ambulance either to ED or ward at operating hospital.</td>
</tr>
<tr>
<td>ED data – collected from operating hospital – only if the patient was transferred to operating hospital's ED from first hospital.</td>
</tr>
<tr>
<td>IP data – combined data collected from first hospital and operating hospital.</td>
</tr>
<tr>
<td>E.g. Patient was inpatient in Stonehouse Hospital, fell and hip fracture was suspected. 999 ambulance called and patient transferred to Wishaw General ED (operating hospital). ED would be collected from Wishaw and IP data would be collected from both Stonehouse and Wishaw.</td>
</tr>
<tr>
<td>Note: if the patient that you are auditing does not fit into one of the above categories then please contact the central team to discuss whether the Patient Journey section should be completed.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>---</td>
</tr>
</tbody>
</table>
|11| Enter the ISD code for the FIRST hospital the patient attended. A list of local options will be made available for most common transfer origins. Please contact the central team for a first hospital code if the patient is transferred from a more unusual first hospital.  
**Note:** Use 88 = Not applicable if the patient was not transferred and leave the rest of this section (up to Q17) blank. | Record the date and time that the patient presented at the FIRST hospital with a hip fracture. This should be the arrival date/time or the earliest recorded date/time within the ED/MIU (or the ward area if the patient was admitted directly to a ward) or in the case of inpatient falls, the time the fall occurred/fracture was suspected/diagnosed.  
**Notes:**  
Use 99 = Not recorded if date or time is unknown/not recorded.  
Document additional information in the Comments section. | Record whether the patient first presented at ED/MIU after their fall, presented as a direct admission to a ward, or if they sustained their fracture after a fall as an inpatient.  
**Notes:**  
Use 1 = Presented to ED/MIU for patients who first present at small cottage hospitals or GP led units etc.  
Use 99 = Not recorded if the notes were not seen. | Record the patient's destination after arrival at the FIRST hospital.  
**Notes:**  
Use 1 = Admitted to first hospital if the patient was admitted there. This might occur for example due to transport difficulties, medical stabilisation or an initial decision to treat the patient conservatively.  
Only use 99 = Not recorded if the notes were not seen. |
|12| Enter appropriate code - Example: N101H | Enter date: DD.MM.YY  
*Example:* 11.09.17 | Enter one of the following codes:  
1 = Presented to ED/MIU  
2 = Inpatient fall/fracture in first hospital  
3 = Direct admission to ward  
99 = Not recorded | Enter one of the following codes:  
1 = Admitted to first hospital  
2 = Direct transfer to operating hospital  
3 = Direct transfer to ward in operating hospital  
99 = Not recorded |
### Scottish Hip Fracture Audit Guidelines

*Updated and circulated – April 2019*

*For implementation from 1st July 2019*

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
</table>
| 15 | Date/time decision was made to transfer patient | Record the date and time that a **decision was made to transfer** the patient **to another hospital**.
This should be the date/time documented in the notes that this decision was made, e.g. patient to be transferred to operating hospital, contact made with Ortho team in operating hospital, call made to SAS to arrange transfer etc.
**Notes:**
*Use 99 = Not recorded if date or time is unknown/not recorded or if the notes were not seen.*
*Document additional information in the Comments section.* |
| 16 | Date/time patient left FIRST hospital | Record the date/time the patient **left the FIRST hospital** for **transfer to the operating hospital** for surgery/orthopaedic care.
**Notes:**
*Use 99 = Not recorded if date or time is unknown/not recorded or if the notes were not seen.*
*Document additional information in the Comments section.* |
| 17 | Date/time of arrival at OPERATING hospital | Record the date/time the **patient arrived at the OPERATING hospital** following transfer.
This should be the arrival date/time or the earliest recorded date/time within the ED or the ward area if the patient was admitted directly to a ward.
**Notes:**
*Use 99 = Not recorded if date or time is unknown/not recorded or if the notes were not seen.*
*Document additional information in the Comments section.* |
## Scottish Hip Fracture Audit Guidelines

*Updated and circulated – April 2019*

*For implementation from 1st July 2019*

<table>
<thead>
<tr>
<th>ED</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>Date/time arrival at ED</td>
</tr>
</tbody>
</table>

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

**Notes:**

*If the patient has been transferred after presenting at another ED/MIU, this will be the same date/time as Q12.*

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

*Use 99 = Not recorded if date or time is unknown/not recorded or if the notes were not seen.*

*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:

88 = Not applicable

99 = Not recorded
19 | Time left ED | Record the time the patient left ED for transfer to a ward/theatre.  
**Notes:**  
Use 88 = Not applicable if the patient fell whilst in hospital with no attendance at ED.  
Use 99 = Not recorded if time is unknown/not recorded or if the notes were not seen.  
*It is important that this time is recorded accurately as the time left ED will be used to calculate achievement of several of the inpatient standards, e.g. inpatient bundle, time to theatre etc.*  
*If the patient has an inpatient fall and the time left ED is therefore Not Applicable, the clock will start for inpatient standards at the time of the fall/ fracture and/or Ortho team are informed.*  
*If the patient is a direct transfer from one ED to another the clock will start for inpatient standards at the time the patient left the second ED.*  
| Enter time: HH.MM  
Example: 13.15  
Or enter one of the following codes:  
88 = Not applicable  
99 = Not recorded |

20 | Fracture (#) suspected or confirmed in ED | Record whether or not the hip fracture was suspected or confirmed in ED.  
**Notes:**  
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 or confirmed in ED, or if the 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 information but confirm the attendance and the details of why the patient was not thought to have a hip fracture 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 |

21 | Analgesia | Record if analgesia was given or offered. Analgesia could be given pre—arrival at ED (e.g. by GP or Scottish Ambulance Service (SAS)) or in ED prior to transfer to second ED or to the ward.  
**Notes:**  
**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 1 = Analgesia given in ED (or SAS) if any type of analgesia was given including a nerve block.  
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 |
### Scottish Hip Fracture Audit Guidelines

*Updated and circulated – April 2019*
*For implementation from 1st July 2019*

<p>| | | | |</p>
<table>
<thead>
<tr>
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</table>
| 22 | Nerve block first given | Record if the patient had a nerve block and if so, where it was **first** given. For example was it given in ED or in the ward? **Note:** Use 99 = Not recorded if the notes were not seen, explaining use of 99 in Comments section. | Enter one of the following codes:  
1 = Nerve block given in ED  
2 = Not given – declined  
3 = Not given – no reason  
4 = Nerve block given in ward  
9 = Not given – other reason  
99 = Not recorded |
| 23 | ECG carried out | Record whether the patient had an electro-cardiograph (ECG) carried out in ED. **Note:** 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 |
| 24 | Bloods taken | Record whether blood samples were taken in ED, e.g. Full Blood Count (FBC), Urea & Electrolytes (U&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.** **Note:** 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 |
| 25 | Pressure areas recorded | 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. **Note:** 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 |
| 26 | IV fluids | Record whether IV fluids were commenced in ED or by SAS or prior to transfer.  
*Notes:*  
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.  
Only use 1 = Yes, if there is *clearly documented evidence* that IV fluids have been *commenced in ED/ by SAS or prior to transfer, i.e. not just prescribed.*  
Only use 3 = Not required if there is *clearly documented evidence* that IV fluids are *not required.*  
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  
3 = Not required  
99 = Not recorded |
|---|---|---|---|
| 27 | EWS score recorded in ED | Record if an Early Warning System (EWS) score was recorded in ED.  
*Note:* 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 |
| 28 | Delirium Screening in ED | 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.  
*Other tools such as AMT4, MMSE, AMT10 and SQID are no longer acceptable as a delirium screen.*  
*Notes:*  
Record only if the 4AT was carried out in ED.  
Use 99 = Not recorded if the notes were not seen. | Enter two of the following codes:  
1 = Yes  
2 = No  
99 = Not recorded |
| 29 | Delirium Screening score in ED | If the 4AT assessment was carried out in ED record the 4AT score.  
*Notes:*  
Use 88 = Not applicable if there is no evidence that the 4AT has been carried out in ED.  
Use 99 = Not recorded if the 4AT was carried out but the score is unknown/ not recorded or if the notes were not seen. | Enter one or two digit number, i.e. 0-12  
Or use one of the following codes:  
88 = Not applicable  
99 = Not recorded |
Inpatient Stay

- Some patients may be temporarily admitted to the first hospital, due to their condition or transfer issues, prior to being transferred to the operating hospital. Combined data relating to their inpatient stay should be collected from both the first hospital and operating hospital.

- Some patients may sustain their hip fracture whilst already an inpatient in your hospital or another hospital. In these cases all of the data collected in the 'Inpatient Stay' section pertain to what happened after the fracture is suspected/diagnosed, rather than when orthopaedics become involved, i.e. in either hospital.

- If a patient is not admitted via ED, e.g. they fall and fracture on a ward (inpatient hip fracture) - some assessments should be re-done and recorded, e.g. falls, pressure area, delirium. It is accepted that there may not be a requirement to re-assess nutritional state immediately if already assessed in previous ward. However if the assessment was done >7 days ago the nutrition assessment should also be re-done.
The date/ time of admission will normally be:

- **For ED patients** – 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 suspected or confirmed in ED, i.e. the date/ time the patient arrives in the ward (first recorded date/ time in the ward). For transferred patients this would be the time transferred to a ward in the first hospital, or, if not admitted to a ward in the first hospital, the time admitted to a ward in the operating hospital.

- **For Inpatients** when the patient’s hip fracture is suspected/ diagnosed (often after a fall) the fall/ diagnosis time should be used rather than when the patient is transferred to Orthopaedics. For transferred patients who had inpatient falls, this would be the time the fracture was suspected/ diagnosed in the first hospital.

- **For patients admitted via their GP** - when a patient is clinically diagnosed with a hip fracture by a GP and is transferred directly into a ward in your hospital use the date/ time the patient was admitted to the ward.

- **For patients taken straight to theatre** from ED, use the date/ time the patient was admitted to theatre.

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 suspected/ diagnosed and subsequently reported to Orthopaedics.

**Notes:**

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

*Occasionally 99 = Not Recorded can be used for time (but not date) of admission if no time information is available (e.g. time when fracture suspected/ diagnosed after an inpatient fall is not recorded).*
### Scottish Hip Fracture Audit Guidelines

*Updated and circulated – April 2019*

*For implementation from 1st July 2019*

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<table>
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</table>
| **31** | Pathological fracture (#) | Record whether or not a pathological fracture was confirmed.  
**Notes:**  
Use 2 = No if there is no record in the notes that the fracture is pathological.  
If it is confirmed in the notes that the patient has had a pathological fracture, record which type using 3 = Atypical or 4 = Malignant.  
Use 3 = Atypical if for example, the cause is thought to be due to bisphosphonate use.  
Use 5 = Type unknown if it is confirmed the patient has had a pathological fracture but the type is not known/not recorded in the notes.  
Use 99 = Not recorded if the notes were not seen, explaining use of 99 in Comments section. |
| **32** | Falls Assessment timing | Record if the first falls assessment, e.g. Morse Fall Scale was done **within 24 hours of admission**, i.e. in relation to the time left ED (section 19)  
**Notes:**  
For patients not admitted through ED the timing of the falls assessment should be calculated in relation to the time the fracture was suspected/diagnosed within the hospital or the date/time of direct admission to the ward – section 30.  
**For inpatient falls, pre-fracture or pre-diagnosis falls assessments should not be included as the patient should be re-assessed following fracture/diagnosis.**  
If there is evidence in the notes of the patient having a falls assessment after the fall but before formal confirmation of the fracture or informing of the Ortho team this can be included as a falls assessment for the audit.  
Use 99 = Not recorded if insufficient data is recorded in the patient’s notes to allow you to calculate whether or not the falls assessment was done within 24 hours or if the notes were not seen. |
|   |   | Enter one of the following codes, in line with the descriptions opposite:  
2 = No  
3 = Atypical  
4 = Malignant  
5 = Type unknown  
99 = Not recorded |
<p>| | | | |</p>
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</table>
| 33 | Nutrition assessment timing | Record if the first nutritional assessment, e.g. Malnutrition Universal Screening Tool (MUST) was **done within 24 hours of admission**, i.e. in relation to the time left ED (section 19).  
**Notes:**  
For patients not admitted through ED the timing of the nutrition assessment should be calculated in relation to the time the fracture was suspected/ diagnosed within the hospital or the date/time of direct admission to the ward – section 30.  
**For inpatient falls, existing relevant pre-fracture or pre-diagnosis nutrition assessments should be included** as 1 = Yes provided they were done within the last 7 days. If > 7 days have elapsed since nutrition assessment then this should be redone.  
Use 99 = Not recorded if insufficient data is recorded in the patient’s notes to allow you to calculate whether or not the nutrition assessment was done within 24 hours or if the notes were not seen. | Enter one of the following codes:  
1 = Yes  
2 = No  
99 = Not recorded |
| 34 | Pressure area assessment timing | Record if the first formal pressure area assessment, e.g. Waterlow Score, was **done within 24 hours of admission**, i.e. in relation to the time left ED (section 19)  
Record **only formal assessments** rather than evidence of visual inspection only.  
**Notes:**  
For patients not admitted through ED the timing of the pressure area assessment should be calculated in relation to the time the fracture was suspected/diagnosed within the hospital or the date/time of direct admission to the ward – section 30.  
**For inpatient falls, pre-fracture or pre-diagnosis pressure area assessments should not normally be included** as the patient should be re-assessed following fracture/diagnosis.  
If there is evidence in the notes of the patient having a pressure area assessment after the fall but before formal confirmation of the fracture or informing of the Ortho team this can be included as a pressure area assessment for the audit.  
Use 99 = Not recorded if insufficient data is recorded in the patient’s notes to allow you to calculate whether or not the pressure areas assessment was done within 24 hours or if the notes were not seen. | Enter one of the following codes:  
1 = Yes  
2 = No  
99 = Not recorded |
### Delirium Screening on ward

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 (time calculated from when the patient left ED, section 19)’.

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.

Other tools such as AMT4, MMSE, AMT10 and SQID are no longer acceptable as a delirium screen.

**Notes:**

Record only if the 4AT was carried out within 24 hours of ward admission, i.e. the time the patient left ED, section 19.

For patients not admitted through ED the timing of the delirium screening should be calculated in relation to the time the fracture was suspected/diagnosed within the hospital or the date/time of direct admission to the ward – section 30.

Use 99 = Not recorded should if insufficient data is recorded in the patient’s notes to allow you to calculate whether or not the delirium screening was done within 24 hours or if the notes were not seen.

### Delirium screening score on ward

If the 4AT assessment was carried out within 24 hours of admission record 4AT score.

**Notes:**

Use 88 = Not applicable if there is no evidence that the 4AT assessment has been carried out within 24 hours of admission.

Use 99 = Not recorded if the 4AT was carried out but the score is unknown/not recorded or if the notes were not seen.

Enter one or two digit number, i.e. 0-12

Or use one of the following codes:

88 = Not applicable

99 = Not recorded
### Comprehensive Geriatric Assessment (CGA) date

| 37 | 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 time the patient left ED as recorded in section 19.  
**Notes:**  
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 time left ED (section 19). There is no need to continue to look for appointments occurring more than a week after admission.  
Use 99 = Not recorded if the date of the assessment is not known/ not recorded or if the notes were not seen explaining use of 99 in Comments section. |

### Assessed by

| 38 | Assessed by | Record who did the patient’s first CGA, i.e. which discipline.  
**Notes:**  
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.  
Only use 88 = Not applicable if the patient has **not had a CGA**.  
Use 99 = Not recorded if the person that completed the assessment is not known/ not recorded or if the notes were not seen 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  
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 time left ED (section 19). There is no need to continue to look for appointments occurring more than a week after admission.  
Use 99 = Not recorded if the date of the assessment is not known/ not recorded or if the notes were not seen explaining use of 99 in Comments section.  
Only use 88 = Not applicable if the patient has **not had a CGA**.  
Use 99 = Not recorded if the person that completed the assessment is not known/ not recorded or if the notes were not seen explaining use of 99 in Comments section.
<p>| | | |</p>
<table>
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</thead>
</table>
| **39** | **Date/time into theatre** | Record the date and time the surgical repair commenced – defined as ‘induction of anaesthetic’. This information should be taken from the anaesthetic/ theatre/ surgical record.  
**Notes:**  
Use 88 = Not applicable if the patient was not treated surgically within the first week of admission.  
Use 99 = Not recorded if the date/time into theatre is unknown/not recorded or if the notes were not seen.  
If the patient does not go to theatre immediately, continue to monitor until at least day 8, e.g. if patient admitted on 4\textsuperscript{th} February, continue to monitor until 12\textsuperscript{th} February, so that you can be sure they have not gone to theatre in the first week. |
| **40** | **ASA grade** | Record the American Society of Anaesthesiologists (ASA) grade as documented by the anaesthetist.  
**Notes:**  
American Society of Anaesthesiologists (ASA) grades:  
1 = Normal healthy individual  
2 = Mild systemic disease that does not limit activity  
3 = Severe systemic disease that limits activity but is not incapacitating  
4 = Incapacitating systemic disease which is constantly life-threatening  
5 = Moribund – not expected to survive 24 hours with or without surgery  
Or use additional codes identified specifically for this audit:  
6 = Not ever fit for theatre – a decision has been made that the patient is not ever likely to be fit for theatre (e.g. palliative care only/ end of life care pathway has been agreed).  
7 = Surgery not required – a decision has been made that the fracture does not require surgery and the patient is to be conservatively managed (e.g. old fractures).  
Use 99 = Not recorded if the ASA grade is not known/not recorded or if the notes were not seen. |
Main reason for Theatre Delay greater than 36 hours

<table>
<thead>
<tr>
<th>No.</th>
<th>Reason</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.</td>
<td><strong>No delay</strong></td>
<td>Surgery within 36 hours of admission.</td>
</tr>
<tr>
<td>1.</td>
<td><strong>Medically unfit</strong></td>
<td>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. <strong>Please not the reason the patient is ‘medically unfit’ in the comments box.</strong></td>
</tr>
<tr>
<td>2.</td>
<td><strong>Lack of theatre time</strong></td>
<td>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></td>
<td>If the patient was initially being treated conservatively due to uncertainty about longer term outcomes.</td>
</tr>
<tr>
<td>4.</td>
<td><strong>Further fracture (#) investigation</strong></td>
<td>E.g. awaiting MRI/bone scan to confirm diagnosis/type of fracture.</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> That this should not be applied to patients whose fracture is not yet suspected/diagnosed, only to those whose fracture is suspected/diagnosed and who are thereafter delayed due to a wait for an investigation.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td><strong>Delayed consent</strong></td>
<td>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></td>
<td>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>
<td>Use 99 = Not recorded if the reason for delay has is not known/not recorded or the notes were not seen. Explain use of 99 in Comments section.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>No delay</td>
</tr>
<tr>
<td>1</td>
<td>Medically unfit</td>
</tr>
<tr>
<td>2</td>
<td>Lack of theatre time</td>
</tr>
<tr>
<td>3</td>
<td>Initial conservative treatment</td>
</tr>
<tr>
<td>4</td>
<td>Further # investigation</td>
</tr>
<tr>
<td>5</td>
<td>Delayed consent</td>
</tr>
<tr>
<td>6</td>
<td>Wait for Total Hip Replacement (THR)</td>
</tr>
<tr>
<td>9</td>
<td>Other</td>
</tr>
<tr>
<td>99</td>
<td>Not Recorded</td>
</tr>
</tbody>
</table>
| 42 | How many times was patient fasted? | 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 **classed as fasted**, the patient must have missed at least one meal.

**Examples:** 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.

**Notes:**

Use 88 = Not applicable if the patient was admitted nil by mouth (NBM) due to swallowing problems and explain in the Comments section.

It should be clearly documented in the patient’s records that they have been fasted for surgery. **It should not be assumed** that if the patient went to theatre shortly after admission or in the first 24 hours that they were fasted once. | Enter up to a 2 digit number. 88 = Not applicable |
### Scottish Hip Fracture Audit Guidelines

*Updated and circulated – April 2019*

*For implementation from 1st July 2019*

<table>
<thead>
<tr>
<th>43</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.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1. <strong>Cannulated screws</strong> = AO screw or nail. <strong>Note:</strong> cannulated screws may be used as a component of a hemiarthroplasty.</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 (THR)</strong> = 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>
</tbody>
</table>

**Notes:**

Use 88 = Not Applicable only if the patient was not treated surgically.

For further information please refer to the Decision Log, this will be circulated with the MSk newsletter.

<table>
<thead>
<tr>
<th>44</th>
<th>Type of anaesthetic</th>
<th>Record the type of anaesthetic used.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Notes:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use 3 = Both spinal and General Anaesthetic (GA) given – use this code if there is no documented evidence that a GA was performed because of an ineffective spinal.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use 4 = Failed spinal progressing to GA if a spinal anaesthetic was attempted and failed and a decision was made to progress to GA.</td>
</tr>
<tr>
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<td></td>
<td>We are primarily interested in whether the patient had a spinal or a GA therefore if they had for example a GA with a block, then you would code this as a GA.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use 88 = Not applicable only if the patient was not treated surgically <strong>within the first week of admission.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use 99 = Not recorded if the type of anaesthetic is not known/not recorded or if the notes were not seen.</td>
</tr>
</tbody>
</table>

Enter one of the following codes:

1 = Spinal
2 = General
3 = Both spinal and GA
4 = Failed spinal progressing to GA
9 = Other
88 = Not applicable
99 = Not recorded
| 45 | Bone health assessed | The aim is that all patients continue on bone protection medication, are 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 acute orthopaedic care.

**Notes:**

*Use 1 = Yes* if bone health has been considered and relevant medication reviewed and/or continued and/or new bone protection medication commenced, or if a referral has been made for FLS/DEXA/OS. *This needs to be clearly documented in the patient's records.*

*Use 2 = No* if there is no evidence of a bone protection medication review/continuation of medication or referral for bone health assessment. Also record as No if the patient is documented 'not fit' for bone health review.

*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.

| 46 | Post-op mobilisation | Record when the patient first mobilised after their operation.

**Notes:**

This includes mobilisation by the physio or other member of the team, e.g. nurses.

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 providing the patient has stood and taken weight through their legs. For example, *the use of a sling support would not be classed as mobilisation.*

This information should be recorded in the nursing or physiotherapy notes or the integrated care pathway.

1 = By first day post-op, includes patients that were mobilised on day of surgery.

Only use 9 = Not for mobilisation for patients who were not mobile pre-fall/surgery, for example, a patient who was wheelchair or bed bound before having their fractured hip, and describe fully in Comments.

Use 88 = Not applicable if the patient was treated conservatively.

Use 99 = Not recorded if when the patient was first mobilised is not known/not recorded or if the notes were not seen.

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

1 = Yes
2 = No

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
9 = Not for mobilisation
88 = Not applicable
99 = Not recorded
### 47 Date assessed by physio

Record the date the patient was **first assessed post-operatively** by a member of the physiotherapy team.

**Notes:**
- 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.**
- If the patient is admitted to ITU/HDU immediately post-operatively and has a full assessment i.e. not just a respiratory assessment by a physiotherapist whilst in ITU/HDU then record the date they were first assessed.
- 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 7 days of surgery. 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 known/not recorded, or the notes were not seen.

<table>
<thead>
<tr>
<th>Enter date: DD.MM.YY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: 11.09.17</td>
</tr>
<tr>
<td>Or enter one of the following:</td>
</tr>
<tr>
<td>88 = Not applicable</td>
</tr>
<tr>
<td>99 = Not recorded</td>
</tr>
</tbody>
</table>

### 48 Date assessed by OT

Record the date the first time **after admission** that there was Occupational Therapy (OT) input in the patient's care. This can be by any member of the OT team.

**Notes:**
- 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.**
- 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 patient’s records that the OT has discussed the patient’s 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. You can also use code 88 if the patient wasn’t seen by an Occupational Therapist within 7 days of admission. There is no need to continue to look for the first assessment date after this.
- Use 99 = Not recorded if the date of first OT input was not known/not recorded, or the notes were not seen.

<table>
<thead>
<tr>
<th>Enter date: DD.MM.YY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: 11.09.17</td>
</tr>
<tr>
<td>Or enter one of the following:</td>
</tr>
<tr>
<td>88 = Not applicable</td>
</tr>
<tr>
<td>99 = Not recorded</td>
</tr>
</tbody>
</table>
| 49 | Date of discharge | Record the date of discharge from acute orthopaedic care.  
**Notes:**  
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 30) 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).  
Use 99=Not recorded if the date of discharge was not known/ not recorded, or the notes were not seen. | Enter date:  
DD.MM.YY  
Example: 11.09.17  
Or enter one of the following:  
88 = Not applicable  
99 = Not recorded |
### Scottish Hip Fracture Audit Guidelines

*Updated and circulated – April 2019*

*For implementation from 1st July 2019*

<table>
<thead>
<tr>
<th>Code</th>
<th>Discharge destination</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>Record the place that the patient was discharged to from acute orthopaedic care:</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Home</strong> = when the patient is discharged home, i.e. permanent address or if they are permanently living with a relative. This <strong>should include</strong> when the patient is discharged home with support from the <strong>Hospital at Home</strong> team.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><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>
<td></td>
</tr>
<tr>
<td></td>
<td><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. <strong>This should include</strong> patients being returned to or transferred to <strong>long term elderly psychiatry</strong> (see notes below).</td>
<td></td>
</tr>
<tr>
<td></td>
<td><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>
<td></td>
</tr>
<tr>
<td></td>
<td><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 below).</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Intermediate care – NHS funded bed</strong>. This code should only be used when the patient is discharged to a NHS funded bed in a care facility for ‘intermediate care’, i.e. the plan is still that the patient’s final destination will be home.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Intermediate care – non-NHS funded bed</strong>. This code should only be used when the patient is discharged to a care home or other non-NHS funded facility for ‘intermediate care’, i.e. the plan is still that the patient’s final destination will be home.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Other</strong> = includes non-NHS respite care or hospice, prison, homeless, or private hospital care. Please provide further details in Comments section.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Died</strong> = the person died prior to leaving the acute orthopaedic ward.</td>
<td></td>
</tr>
<tr>
<td>Enter one of the following codes, in line with the descriptions opposite:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 = Home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 = Care home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 = NHS continuing care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 = Rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 = Acute hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 = Intermediate care – NHS funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 = Intermediate care – non-NHS funded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 = Other (specify in comments box)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 = Died</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99 = Not recorded</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Notes:

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).

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).

Only use 99 = Not recorded when discharge details are not known/not recorded or notes were not seen.

**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 30) 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.
Appendix 1 - 60 Day Review Data Definitions

<table>
<thead>
<tr>
<th>Field</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>51</td>
<td>Audit Number</td>
</tr>
<tr>
<td>52</td>
<td>Required data available</td>
</tr>
<tr>
<td>53</td>
<td>Hospital</td>
</tr>
</tbody>
</table>
| 54 | Pre-fracture residence | Pre-populated field from data entered on original proforma. Only re-enter the pre-fracture residence if the original entry is incorrect or missing. Please select appropriate code according to definitions outlined in Q10 above. 

**Note:**

*Only use ‘unknown’ if the pre-fracture residence for the patient is not known.* |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter one of the following: Home Care home NHS continuing care Rehabilitation Acute hospital Intermediate care – NHS funded Intermediate care – non-NHS funded Other Unknown</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 55 | Discharge destination | Pre-populated field from data entered on original proforma. Only re-enter the discharge destination if the original entry is incorrect or missing. Please select appropriate code according to definitions outlined in Q50 above. 

**Notes:**

*Use ‘Not discharged within 60 days’ if the patient is still an inpatient at this stage.*

*Only use ‘unknown’ if the next destination for the patient is not known, e.g. patient returned home abroad or transferred to a hospital outwith Scotland.* |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter one of the following: Home Care home NHS continuing care Rehabilitation Acute hospital Intermediate care – NHS funded Intermediate care – non-NHS funded Not discharged within 60 days Other Died Unknown</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>56</th>
<th>Date of admission</th>
<th>Pre-populated field from data entered on original proforma. Only re-enter the date of admission if the original entry is incorrect or missing. Please select appropriate code according to definitions outlined in Q30 above.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter date: DD.MM.YYYY Example: 11.09.2017</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Scottish Hip Fracture Audit Guidelines

*Updated and circulated – April 2019*

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<table>
<thead>
<tr>
<th>No.</th>
<th>Field Description</th>
<th>Details</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| 57  | Date of Discharge | Pre-populated field from data entered on original proforma. Only re-enter the date of discharge if the original entry is incorrect or missing. Please select appropriate code according to definitions outlined in Q49 above. | Enter date: DD.MM.YYYY  
Example: 11.09.2017 |
| 58  | Length of acute stay (days) | Pre-populated field  
*Calculated form date of admission to date of discharge.* | Digits |
| 59  | Bone health assessed (1) | Pre-populated field from data entered on original proforma. Only re-enter ‘bone health assessed’ if the original entry is incorrect. Please select appropriate code according to definitions outlined in Q45 above. | Enter one of the following, in line with the descriptions opposite:  
Yes  
No |
| 60  | Bone health assessed (2) | The aim is that all patients continue on bone protection medication, are 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 following discharge from acute care.  
**Notes:**  
*Use 1 = Yes if bone health has been considered and relevant medication reviewed and/ or continued and/ or new bone protection medication commenced, or if a referral has been made for FLS/ DEXA/ OS. This needs to be clearly documented in the patient’s records.*  
*Use 2 = No if there is no evidence of a bone protection medication review/ continuation of medication or referral for bone health assessment. Also record as No if the patient is documented ‘not fit’ for bone health review.*  
*Use ‘unknown’ if post-discharge bone health assessment is unknown rather than leave the field blank. If the field is left blank a missing data message will appear in the validation status field after the routine validation has been run.*  
*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.* | Enter one of the following, in line with the descriptions opposite:  
Yes  
No  
Unknown  
Not applicable |
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|   | Date assessed/referred | If the answer to Q60=Yes - enter the date of any assessment of, or referral for bone health following discharge from acute care. | Enter date: DD.MM.YYYY
Example: 11.09.2017 |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>62</td>
<td>Known</td>
<td>Field will default to ‘No’ when first enter form. Using check boxes on left side of field – click on box to enter ‘Yes’ to indicate that information regarding additional fractures is known.</td>
<td>Automatically populated field: Yes No</td>
</tr>
<tr>
<td>63</td>
<td>Wrist</td>
<td>Field will be blank when first enter form. Using check boxes on left side of field – click on box to enter ‘Yes’ to indicate that the patient had a wrist fracture.</td>
<td>Automatically populated field: Yes No</td>
</tr>
<tr>
<td>64</td>
<td>Hip</td>
<td>Field will be blank when first enter form. Using check boxes on left side of field – click on box to enter ‘Yes’ to indicate that the patient had a hip fracture.</td>
<td>Automatically populated field: Yes No</td>
</tr>
<tr>
<td>65</td>
<td>Vertebrae</td>
<td>Field will be blank when first enter form. Using check boxes on left side of field – click on box to enter ‘Yes’ to indicate that the patient had a vertebrae fracture.</td>
<td>Automatically populated field: Yes No</td>
</tr>
<tr>
<td>66</td>
<td>Other</td>
<td>Field will be blank when first enter form. Using check boxes on left side of field – click on box to enter ‘Yes’ to indicate that the patient had another fracture. If ‘Other’ is selected - add additional information to comments section of form in free text.</td>
<td>Automatically populated field: Yes No</td>
</tr>
<tr>
<td>67</td>
<td>Known</td>
<td>Field will default to ‘No’ when first enter form. Using check boxes on left side of field – click on box to enter ‘Yes’ to indicate that information regarding bone medication is known.</td>
<td>Automatically populated field: Yes No</td>
</tr>
<tr>
<td>68</td>
<td>Calcium</td>
<td>Field will be blank when first enter form. Using check boxes on left side of field – click on box to enter ‘Yes’ to indicate that the patient was prescribed Calcium.</td>
<td>Automatically populated field: Yes No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>68</strong></td>
<td>Bisphosphonate</td>
<td>Field will be blank when first enter form. Using check boxes on left side of field – click on box to enter ‘Yes’ to indicate that the patient was prescribed a Bisphosphonate.</td>
<td></td>
</tr>
<tr>
<td><strong>69</strong></td>
<td>Vitamin D</td>
<td>Field will be blank when first enter form. Using check boxes on left side of field – click on box to enter ‘Yes’ to indicate that the patient was prescribed Vitamin D.</td>
<td></td>
</tr>
</tbody>
</table>
| **70** | Comments | Field will be blank when first enter form. Enter a short summary of additional information in free text if for example:  
- Any pre-populated data is changed  
- Anything unusual happens, e.g. re-admission the same day  
- Patients transfer out of Scotland  
- Patients are lost to audit  
- LAC is waiting for data from another NHS Board  

Text field |
| **71** | Stay number | Field will contain a number 1 when first entered. When information in row 1 is completed an additional row containing a number 2 will appear and so on. |
| **72** | Stay type | Enter where the patient has been for the 60 days since admission. Please select appropriate code according to definitions outlined in Q10 above.  

**Note:** Only use ‘unknown’ if it is unclear in any part of the pathway where the patient was.  

Enter one of the following:  
Home  
Care home  
NHS continuing care  
Rehabilitation  
Acute hospital  
Intermediate care – NHS funded  
Intermediate care – non-NHS funded  
Not discharged within 60 days  
Other  
Unknown |
| 73 | Stay start date | Enter the date the patient moved to the ‘stay type’ coded in Q72.  
*Note:* Use ‘unknown’ if the stay start date is unknown rather than leave the field blank. If the field is left blank a missing data message will appear in the validation status field after the routine validation has been run. | Enter date: DD.MM.YYYY  
Example: 11.09.2017  
Or enter: Unknown |
|---|---|---|---|
| 74 | Stay reason | Enter one of the following reasons for the stay in the residence coded in Q72.  
- Surgical complications requiring re-operation  
- Surgical complications not requiring re-operation  
- Medical complication related to hip fracture  
- Unlikely/failed to manage at place of origin for non-acute reason  
- Admitted for reasons not related to hip fracture  
- Return to place of origin  
- Other  
- Unknown  
*(NB: wording to be reviewed prior to launch of new dataset in July 2019)* | Enter one of the codes in the section opposite. |
| 75 | Residence at 60 days | Enter where the patient was residing at 60 days post admission.  
*Note:* This should match the last ‘stay type’ noted in Q72. | Enter one of the following:  
Home  
Care home  
NHS continuing care  
Rehabilitation  
Acute hospital  
Intermediate care – NHS funded  
Intermediate care – non-NHS funded  
Not discharged within 60 days  
Other  
Died  
Unknown |
|   | Date of death | Enter the date the patient died.  
**Note:**  
*Use 'unknown' if the date of death is unknown rather than leave the field blank. If the field is left blank a missing data message will appear in the validation status field after the routine validation has been run.* | Enter date:  
DD.MM.YYYY  
**Example:**  
11.09.2017  
Or enter:  
Unknown |
|---|---|---|
| 76 | Stay history completed | Enter Yes if all ‘stay types’ have been entered and the LAC is happy this is complete.  
Enter No if data remains incomplete. | Enter one of the following:  
Yes  
No |
| 77 | 60 day review date | Pre-populated field.  
This field states the earliest possible date the LAC should complete the 60 day review spreadsheet, i.e. 60 days after the date of admission. | DD.MM.YYYY  
**Example:**  
11.09.2017 |
| 78 | Validation status for this record | This field is automatically calculated by the spreadsheet and is not for user input.  
The field will update with a validation message when either the “Save & validate” button is pressed or the “Audit number” field is selected.  
The contents of the message will vary depending on the validation errors identified (if any) in the record. | Automatically populated text field |