Biography for Dr Karen Harding:

Dr Karen Harding MB ChB, FRCP

Consultant Orthogeriatrician at North Bristol NHS Trust since 2001

Member of the British Geriatric Society / British Orthopaedic Association steering group to establish a National Hip Fracture Database 2005-2007

Member of the Department of Health Falls and Fragility Fractures advisory group, representing the British Geriatric Society

Member of the National Hip Fracture Database Scientific and Publications Committee 2009 -2019

Abstract:

My presentation will cover the evolution of the Orthogeriatric Service at North Bristol NHS Trust and our experience of trying to improving hip fracture care (good and bad!) over the last decade. We have seen our Trust go from 2 acute sites (Frenchay and Southmead) with Trauma and Elective Orthopaedics on different sites to 1 new build hospital on the Southmead site which opened in May 2014 with a reduction of around 150 acute beds. In addition to these large infrastructure changes we have had to deal with the challenges being a Major Trauma Unit presents for hip fracture care. These include competing standards / priorities for limited theatre time e.g. British Orthopaedic Association Standard (BOAST) 4 open fracture debridement should occur:

- immediately for highly contaminated wounds or when there is an associated vascular compromise

- within 12 hours of injury for other solitary high energy open fractures

- within 24 hours of injury for all other low energy open fractures.

These can lead to hip fracture cases taking lower priority on trauma lists or falling off lists when higher priority cases are admitted or earlier cases take longer than expected.

Extending outcome data beyond the acute episode – how do we get reliable data on our patients at 4 months and a year to know whether or not our rehabilitation and secondary prevention strategies have been effective? Does follow up need to be incentivised?

Learning from the Hip Fracture Review visits.

The British Orthopaedic Association (BOA) offers Hip Fracture Review visits to units that have 30 day mortality rates > 2 standard deviations above the national mean on age and case-mix adjusted data (funded by the unit`s Trust). The visiting team consists of a Consultant Orthopaedic Surgeon (Chair), Consultant Anaesthetist, Consultant Orthogeriatrician and a patient representative. Pre-visit information on how the local pathway works, model of care, numbers treated and rehabilitation is circulated to the team. The visit is conducted over 2 days. The team assemble around lunch time at the site and meet with key members of the local team and get their perspective. The team attend the morning trauma meeting on the second day and “walk” the patient pathway from ED, to acute ward, theatres, recovery, post-op and rehabilitation. Perspectives from staff of all grades and professions are obtained in this way. At the end of day 2 the visiting team feedback key findings and suggestions for improvement verbally to the local team and executives. A formal written report is produced, ideally within 2-4 weeks.

I have taken part in several visits, as the Consultant Orthogeriatrician, in the last few years.

The process is designed to be supportive and highlights areas of good practice as well as areas for development. The visiting team find they usually come away with ideas for improvement / evolution of the service in their own units too.

In my experience units have a good idea of where problems exist in their pathway / barriers to change having prepared for the visit. Ensuring a swift and focussed pathway through ED enables rapid diagnosis and appropriate pain management to be instituted. Femoral or fascia iliacus nerve blocks are often undertaken here and ED has good access to CT if plain x-ray is not diagnostic and patient remains unable to weight bear post-fall. MRI is the “gold standard” investigation but in practice the vast majority of hip fractures can be diagnosed on CT pelvis and in a time efficient and patient centred manner.

Admission to an acute orthopaedic bed within 4 hours is ideal to minimise time spent on a trolley, access a calmer environment and ensure the appropriate specialist staff are completing pre-operative assessment and planning for theatre.

Observation of the trauma meeting enables the visitors to see how cases are prioritised, how trauma co-ordinator and / or specialist nurses function and how well anaesthetic, orthopaedic and orthogeriatric teams work together.

The Anaesthetic and Orthopaedic team members follow the process in theatres and the Orthogeriatrican and patient representative spend time on the ward with nurses, AHPs and the junior doctors. How and where post-acute rehabilitation occurs and NHFD data is gathered is also assessed.

Some themes from visits I have taken in part in have been:

Issues with split site operating

Provision of an appropriate surgeon to perform THR

Anaesthetic engagement as part of the multi-disciplinary team at governance and M+M meetings

Inadequate Orthogeriatrician time / leadership / acuity

Some examples of resistance to change / difficult personalities

In summary, hip fracture care has improved dramatically over the last decade but improvement is a continuous process and standards / practice will continue to evolve.

The key to this process is good multi-disciplinary working, engaging leads from all specialities involved in the pathway and regular reflection on what could be improved.