Patient information leaflet

Royal Surrey County Hospital NHS
NHS Foundation Trust

Hip fracture

Information for patients, relatives and carers

Orthopaedics

Name of Patient:

Date of Admission:

This leaflet aims to provide helpful information following a hip fracture. Treatment is always planned on an individual basis, so some details may differ.

Staff members are happy to help so if you have any concerns, please do not hesitate to contact us and ask questions. We have a dedicated hip fracture specialist nurse to support you, and a multi-disciplinary team who are happy to help: their contact details are at the back of this leaflet.

Visiting times on the wards:

- 15h00-17h00
- 18h00-20h00

If relatives wish to participate in the day-to-day care of a patient eg. assisting at meal times, they may visit outside these times. Please discuss with the nurse in charge. Royal Surrey has a carer passort scheme available.

Who is involved in my care?

You will be under the care of a multi-disciplinary team (MDT) whilst receiving treatment for your hip fracture. The whole team meet together every Wednesday morning to discuss each patient in detail. We welcome any further information or concerns that you may have particularly in planning for discharge.

These are the healthcare professionals you will meet:

Orthopaedic Surgeons: Doctors specialising in the mechanics of the bones and joints. These doctors are surgeons, performing operations and checking for wound healing and bone stability afterwards.

Ortho-geriatric Doctors: These are medical doctors, experienced in the complex medical problems particularly affecting older patients in the context of an admission with a hip fracture. Their role includes an assessment of bone health and a review of falls.

Consultant: this is the senior doctor who is in overall charge of your care. You will have two Consultants, an orthopaedic and orthogeriatric consultant.

Ward Doctors: work alongside the Consultant to manage your care.

Nursing Staff: A team of both qualified nurses and health care assistants who assist patients in meeting their care needs whilst in hospital. There will be a nurse in charge of your care each shift as well as a senior nurse for any further enquiries or concerns.

Physiotherapists: Therapists who work with patients after their operation to improve balance, strength and mobility.

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

Social Care Team: Members of the MDT who assess and assist in arranging help with any ongoing care needs after discharge. They can advise you on any concerns about funding your care and whether you qualify for financial assistance.

Your Orthopaedic Surgeon:

Your Orthogeriatric Consultant:

Ward Doctors:

Your Physiotherapist:

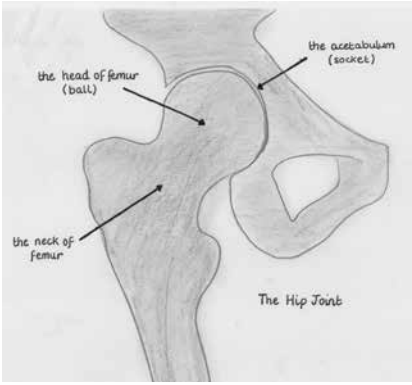
Your Occupational Therapists:

Your Social Services Care Manager:

What is a hip fracture?

The hip joint is an example of a “ball and socket” joint, involving the femur and acetabulum.

A hip fracture refers to a break at the top of the femur bone, and rarely involves the socket. The majority are usually the result of a fall and are likely to require surgery. The particular type of surgery depends on where the bone has broken, and the number of broken fragments.



UK Facts and Figures

70, 000 people in the UK sustain a hip fracture each year.

70% are over 80 years of age.

Hip fractures are common in the frail elderly. However, they can occur in patients who are otherwise healthy and independent.

Patients who are fit, well and active prior to surgery often recover well. However, not all patients get back to their previous level of independence, and may require a walking aid afterwards.

Those previously requiring a walking aid may struggle to mobilise; and may need some assistance with activities of daily living afterwards (e.g. dressing, toileting, meal times).

Hip fractures are common in frail, elderly patients in their last year of life, where medical problems are exacerbated following their fall and fracture.

Sources: National Osteoporosis Society and National Hip Fracture Database.

Please talk to your doctor if you are worried about how this may apply to you.

Your journey through hospital

1. What can I expect in A&E?

Patients are usually admitted via A&E and initially seen by a team of doctors and nurses who take a brief history of the events leading to your admission, and refer you on to the orthogeriatric team. An x-ray will be taken of your hip and chest. Fluids and medication are given intravenously (by drip) as required. You will be given pain medication, usually Paracetamol via injection and can have oral morphine in addition as required. You may also be offered an injection of local anaesthetic into the groin area, to numb the nerves in the hip region (also known as a fascia iliaca compartment block). Routine blood tests are taken and a tracing of your heart (ECG) will be performed.

You will be assigned a ward: usually either Bramshott or Ewhurst ward on Level C in the East Wing. Further bed moves may occur during your stay, but the orthogeriatric team will continue to look after you.

What operation will I have?

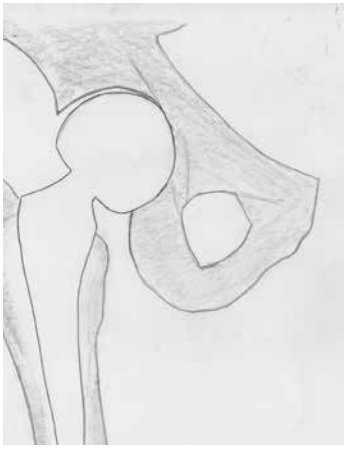
Your orthopaedic doctor will explain to you how your hip fracture will be treated and what this involves. Most patients require an operation with one of four types of hip surgery.

Your surgery has been marked below √

☐ **Hemiarthroplasty:**

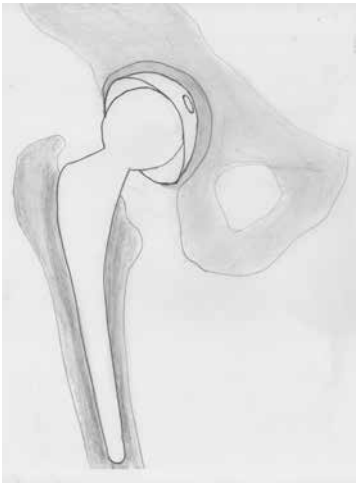
When the fracture involves the head of the femur, the broken piece of bone is removed and replaced with a metal prosthesis.

In effect, this is half a hip replacement: only the ball part of the joint is replaced.



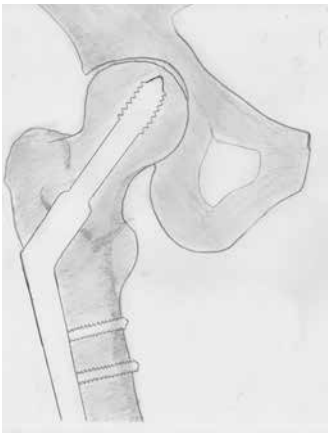
☐ **Total Hip Replacement:**

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

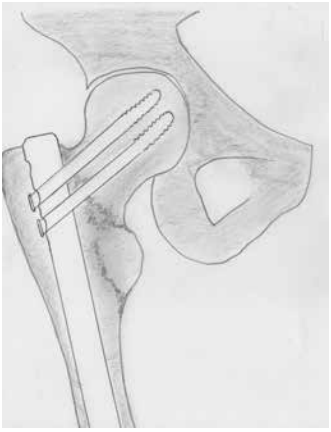


☐ **Dynamic Hip Screw (DHS):**

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



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



Frequently asked questions before the operation:

Why do I need an operation?

Surgery is usually performed to reduce pain, to allow early mobilisation and to reduce deformity.

Does every patient have surgery or is there an alternative procedure?

The vast majority of patients with a hip fracture will require an operation. There are a few exceptions where hip fractures are managed without an operation but this is unusual and will be discussed in detail if relevant to your circumstances. Occasionally undisplaced stable fractures are managed without surgery but there is a risk of displacement ie where the pieces of bone move apart. This can lead to an unstable fracture which will then require surgery.

What are the risks of not having surgery?

The main risks are ongoing pain and the potentially life-threatening complications associated with long periods of bed-rest and immobility (eg. chest infections, blood clots and pressure sores).

What are the risks associated with surgery?

The risks of surgery will be discussed with you when your orthopaedic doctor takes your consent. The main risks associated with the operation itself include blood loss, infection of the wound site and difficulty in establishing a good fixation especially in poor quality bone.

The risks of an anaesthetic are usually related to underlying medical conditions such as heart disease, lung problems and risk of stroke.

Most of the complications that develop after surgery result from immobility. We will aim to reduce your risk by getting you up as soon as possible after your surgery.

Your consent

It is important that you understand the operation, the risks of surgery and what this entails before signing your consent form. If you are unable to give consent, your consultants can make this decision for you in your best interests, following discussion with your next of kin where possible.

What will happen before surgery?

You may need further blood tests or other investigations.

You will be unable to eat for at least six hours before your surgery. You will have fluid through a drip during this time, and you will be offered a carbohydrate drink called Preload. It will help to prevent you from feeling thirsty and may enhance your recovery after your operation.

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

An anaesthetist will see you prior to your operation. There are two main types of anaesthetic: a general anaesthetic involves deep sedation and support of breathing with a tube into the airway or a spinal anaesthetic preventing sensation from the waist down which can be done awake or with mild sedation. Local nerve blocks are often used to help with pain relief in the immediate post-operative period.

We aim to get you to surgery as soon as possible. If you are admitted late in the day, your surgery is likely happen the following afternoon. In most cases your operation will be within 36 hours of admission.

Common reasons why surgery is delayed:

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

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

What will happen after surgery?

Once you have initially recovered from your anaesthetic, you will be transferred back to the ward. You may find a urinary catheter was inserted in theatre, and we aim to remove this within the first few days after surgery.

You will be offered regular pain medications and can ask for more as required. Antibiotics are given on the first day after surgery.

Hip operations are associated with significant blood loss (about two units on average). If you are vulnerable to anaemia you may require a blood transfusion in the first twenty four hours.

As soon as you feel able you may try something to eat and drink. If you feel sick, please tell the nurse who can give you medication to help.

You may need to have more blood tests taken and another x-ray of your leg after surgery.

The orthopaedic and orthogeriatric doctors will see you regularly. They will also complete a 'falls risk assessment' over the period of your stay and begin the process for optimising your bone health.

The nurses will help you with personal care and at mealtimes; but you will be encouraged to do as much for yourself as you can. The drip may be removed as soon as you are eating and drinking as normally.

Nutrition

It is important to eat well during this recovery time to aid healing. Poor appetite is common after surgery.

You will be prescribed nutritional supplements. These are often high-calorie drinks which you will be encouraged to sip in-between meals.

If you or your family are concerned about your food intake, please speak to a nurse. Family are welcome to bring you in fruit and snacks and to come and assist at mealtimes.

Pain relief

A hip fracture is often painful, but this should improve after your operation. You are likely to require regular painkillers for the first few weeks. We generally use a weekly patch called "Butrans". It is very important that you take them regularly, as this will help you to be able to move more easily and participate in physiotherapy which will speed up your recovery.

You will have painkillers prescribed. Please let the nurses know if you continue to be in pain: you do not have to wait until the next drug round.

Common problems after hip fracture

Bleeding: You may lose some blood during your surgery. Some people may require a blood transfusion or a course of iron tablets post-operatively.

Infection: Three doses of antibiotics are routinely given to all patients to prevent infection of the metalwork around the time of surgery. The orthopaedic team will monitor your wound for any signs of infection, which rarely requires further treatment.

Chest infection/Pneumonia: Bed rest increases the risk of developing pneumonia. Getting out of bed, even upright in a chair, allows the lungs to work much better. You will be encouraged to sit in a chair as soon as possible and to breathe deeply and to cough to clear your chest frequently. A chest infection will require treatment with antibiotics and may slow down progress after an operation.

Confusion (Delirium): This is not unusual following surgery and can be distressing for you and your relatives. Previous short-term memory problems or a history of dementia are associated with a high risk of post-operative confusion and disorientation. This can be worsened by:

- Medication: pain killers and anaesthetic drugs
- Infection
- Low oxygen levels
- Unfamiliar surroundings.

Confusion often worsens in the evenings. Relatives are encouraged to speak to the nursing staff about how they can help with delirium by re-orientating and bringing in familiar items. Relatives may also assist with feeding or taking part in physiotherapy sessions.

Constipation: This is a common problem, exacerbated by reduced mobility, medication, dehydration and hospital diet. The nurses will monitor this daily. You will be offered regular laxatives and encouraged to take them. Increasing your fluid intake will also help. The nurses can assist you in bringing a bed pan or a commode so please do not worry about not being able to get to the toilet.

Deep Vein Thrombosis (DVT) / Pulmonary Embolism (PE): DVT (a blood clot in the calf) may occur in patients after a hip fracture. Rarely, a clot can break off and travel to the lungs (PE). Immobility, dehydration and other underlying illnesses increase the risk of clots. Blood-thinning medication, either as a daily injection or as a daily tablet is given to reduce this risk, and is usually continued for 28 days following surgery.

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

Pressure Ulcers (bed sores): Lying on a bed can lead to pressure building up in certain areas of the body. This pressure stops the blood flow to the skin by closing off tiny blood vessels.

Pressure sores are more likely to occur if pain from your hip fracture prevents you from moving, and the pressure stays constant in one area. The pressure causes the skin to die, in a similar way to a burn. First the area hurts, and then begins to blister, before turning into an open sore. These can become infected, and are difficult to heal if they are large.

Prevention of pressure sores is key. Special air-flow mattresses help to distribute weight evenly on the bed. These are used for those at high risk (e.g. patients with diabetes and other previous medical conditions). Your nurses will also encourage you to turn regularly, and will assist you if you are unable to manage yourself.

Dislocation: this is an occasional complication with hemi-arthroplasty or total hip replacement. Those undergoing total hip replacement will be given certain precautions to prevent dislocation.

Complex fractures: sometimes fractures may not mend fully (this is called non-union) or the metal implant may fail, requiring further surgery. These fractures can be difficult to fix. Rarely patients may not be allowed to put weight through the leg for up to six weeks, to allow the bone to start healing.

Frequently asked questions during the recovery period

How long will I be in hospital?

You will be in hospital for approximately 7-14 days depending on your progress. Many patients can continue their recovery and rehabilitation at home once they are independent getting to the toilet with our community team involvement.

In-patient rehabilitation may be considered for those unable to be independent within two weeks who have potential to improve with more time and active rehabilitation.

If it is anticipated that you are unlikely to be able to return to living independently in your own home further assessments of care needs will need to be done which often extend the admission. Similarly individuals from residential homes with increasing care needs may need re-assessment and occasionally re-settlement.

Where possible we try to predict length of stay from the point of admission and set an estimated date of discharge for all parties to work towards. This may need to be adjusted depending on progress.

What physiotherapy will I need?

The physiotherapists will see you the day after your operation. They will teach you some exercises to get your hip moving, improve muscle strength and aid circulation. We hope to be able to get you sitting out in a chair on the first day after your operation.

Exercises following hip surgery

Your physiotherapist will teach you exercises to increase the range of movement and improve your muscle strength. They will ensure that you are walking correctly with the appropriate walking aids. You will be seen regularly, depending on your progress, but it is up to you to practice your exercises in order to speed up your recovery.

Only do the exercises marked with √ and discuss with your physiotherapist if you have any queries.

Bed/chair exercises

☐ **Sitting upright** on a chair or in the bed, take a slow deep breath in through your nose and out through your mouth. Keep your shoulders relaxed, and try to get air to the bottom of your lungs.

☐ **In the chair or bed** move both your ankles up and down in a pumping action to aid circulation. If your heels are sore, elevate your legs using a pillow so that heels do not rub on the bed.

Repeat as often as possible.

☐ **On the bed** squeeze your buttocks firmly together. Hold for 5 seconds and relax.

Repeat ..... times a day.

☐ **On the bed**, bend your good leg so that your foot is flat on the bed. Push through that foot, and lift your bottom off the bed. Repeat as often as possible, to reduce the risk of pressure sores. This can also be done in the chair, pushing up on the arms of the chair.

☐ **On the bed**, slide foot of the operated leg up and down slowly

Repeat ..... times a day.

☐ **On the bed**, slide the operated leg out to side and back keeping knee straight. Keep it slow and controlled and keep foot pointing to ceiling.

Repeat ..... times a day.

☐ **On the bed** lying on your back or sitting up, pull your ankles towards ` you and push your knees firmly down against the bed. Hold for 5 seconds and then relax.

Repeat ..... times a day increasing repetitions slowly.

Standing exercises

If you are not allowed to put full weight through your operated leg, do not start these exercises until advised by your physiotherapist. Always ensure you are holding onto a firm support when you are practising these exercises, for example a kitchen work surface and maintain a good posture throughout.

1. ☐ Lift your leg sideways keeping your toes facing forwards and bring it back, keeping your trunk straight throughout the exercise.

   Repeat ..... times.

2. ☐ Lift your leg backwards off the floor, keeping your knee straight. Do not lean forwards.

   Repeat ..... times.

3. ☐ Lift your leg off the floor a few inches in front of you by bending your knee, then lower your leg back to the floor.

   Repeat ..... times.

4. ☐ Bend your knee as far as possible by raising your heel towards your buttocks. Do not twist your leg inward or outward.

   Repeat ..... times.

5. ☐ Raise heels off the floor, coming onto your toes, clench your buttocks and then lower yourself back down

   Repeat …….. times.

Planning for discharge

The MDT will begin plans for your discharge soon after you are admitted. You will probably need extra support from your family, friends and carers for the first few weeks.

Members of the social care or discharge teams may visit you or your family on the ward if your discharge destination is likely to change, or if you are likely to need more care following discharge.

Occupational therapists may also talk to you and your family about your set-up at home, and how you were managing previously. They will assess your ability to manage daily activities. Patients admitted from care homes do not usually require these assessments.

How can I manage everyday activities?

It may take time for you to get used to everyday activities again. Your occupational therapist will discuss how you will manage your daily activities once you return home, and may suggest some equipment to help you regain your independence.

Your physiotherapist and occupational therapist will go through the following with you, but here are some guidelines:

Getting dressed

Your occupational therapist will demonstrate and practice getting dressed using the appropriate dressing gadgets (these can be purchased from the occupational therapists on the ward). We recommended sitting in a chair with arms or on the edge of the bed for dressing.

For pants/trousers the operated leg is dressed first by using the helping hand to bring the pants/trousers over the foot and up to the knee. When undressing, the operated leg is undressed last.

Getting into bed

Stand with your back to the bed. Slide your operated leg in front of you, reach down with your hands and gently lower yourself onto the bed. Using your arms, pull yourself up the bed, moving your legs one at a time, until you are comfortable.

Getting out of bed

Either lift your operated leg with your hand or push it with your other leg until both legs are over the side of the bed. Then push yourself up with your arms.

Sitting on a bed or chair

Step backwards until you feel the chair on the back of your leg. Place your hands onto the arm rests. Keep your operated leg out in front of you and gently lower yourself into the chair. Your Occupational Therapist will advise you on the correct furniture heights for your home.

Standing from a bed or chair

Once again, use your arms and un-operated leg to take most of your weight when pushing up from a chair.

Stairs

“Take one step at a time”

- Going up: un-operated leg first, followed by operated leg and walking aid.
- Coming down: walking aid first, followed by the operated leg, then the un-operated leg.

Use the banister (if available) as advised by your physiotherapist.

Driving and getting in and out of a car

- No driving for 6 weeks, or until you are safely able to make an emergency stop! Under most circumstances you do not have to inform the DVLA but you are advised to inform your insurance company.
- To get in and out of a car it is best to use the front passenger seat. Ensure that the seat is pushed back as far as possible, and angled so that it is partially reclined.
- Wind down the window and use the door and the door-frame to lower yourself down onto the seat.
- Lift one leg in at a time.

- Don’t get into the car off a kerb.
- If you are going on a long journey (more than one hour), stop regularly and have a walk around.

What can I expect after discharge?

Realising your limitations after surgery is often quite a shock when you get home. It is important to continue to stay mobile and do the exercises you have been shown.

At this stage, most patients will continue to improve, and do not require on-going physiotherapy. If you are concerned about your progress, you may wish to discuss this with your GP. You may be discharged with painkillers possibly in a plaster / patch form. You can withdraw these over a few weeks, but regular Paracetamol (two tablets, up to four times a day) can be continued indefinitely without any problems.

Patients with hip fracture are at increased risk of blood clots, and blood thinning medication should continue for most patients for 28 days following surgery. This is commonly a daily injection, which you or a family member can be taught to administer. Alternatively, a district nurse will visit you after discharge to help with this. You are likely to be discharged on calcium and vitamin D supplements. Both are difficult for most people to get in adequate amounts in their normal diet. It is important to continue taking these to improve stability and help strengthen your bones. If you are having difficulty chewing these chalky tablets, discuss with your GP about changing to the dissolvable powder or to caplet form. Many patients are also started on another drug to strengthen their bones and prevent further fractures. Often this involves taking a tablet once a week (Alendronate) for about five years. Please discuss with your GP if you are having difficulty taking it.

Alternatives including six monthly injections (Denosumab) are available for those unable to manage this.

What follow up do I need after discharge?

Most patients do not require further X-Rays, nor any follow-up with the orthopaedic team. If you have concerns about the operation, or develop increasing pain, you should seek advice from your GP.

If your surgical clips or stitches have not been removed before discharge, this can be arranged at your GP practice.

Some patients will be followed up in the Geriatric Medicine Outpatients or Day Hospital if there are further concerns about medical conditions.

All patients are routinely followed up via a telephone clinic at three months and a year following hip fracture. You can expect a telephone call to enquire about your progress, ensure you are managing bone health tablets and to discuss any ongoing issues.

What is osteoporosis?

Bone is made of collagen fibres (tough, elastic fibres) and minerals (gritty, hard material). Bone is a living tissue and contains cells that constantly build new bone, whilst breaking down the old. Up to our mid-20s the construction cells are working to strengthen our skeleton. After our mid-40s, the demolition cells become more active, and we begin to lose bone density.

Osteoporosis is a silent disease in which there is gradual loss of bone tissue or bone density that makes bones fragile so that they may break under the slightest strain.

Who is at risk?

We all have some risk of developing osteoporosis with age, though it is more common in women.

The following increase your risk of developing osteoporosis:

- Early menopause
- Previous fracture after a minor fall or accident
- Family history
- BMI <19 (severely underweight)

- Immobility or sedentary lifestyle
- Steroid therapy (e.g. Prednisolone)
- Smoking
- High alcohol intake
- Lack of Vitamin D (likely due to little sunlight exposure, poor diet)
- Medical conditions including: overactive thyroid, or those that affect mobility including stroke.

How is Osteoporosis diagnosed?

Osteoporosis is often first diagnosed when you break a bone after a fall from a standing height. You may be referred for a DEXA (Dual Energy X-ray Absorptiometry) scan that uses special X-ray machines to check the bone density and confirm osteoporosis. This may be unnecessary after a hip fracture in a woman over 75 years for whom the diagnosis may be made clinically. We routinely refer all men and women under the age of 75 years for a DEXA scan. Your orthogeriatric consultant who will arrange to see you in clinic or write to you.

The 15 minute scan of your hip and lumbar spine is done at St Peters as well as the Nuffield Hospital and Mount Alvernia usually 6-8 weeks after discharge. You will receive an appointment in the post. The results will usually be sent to your orthogeriatric consultant who will write to you and your GP with advice about any further treatment.

What are the symptoms and problems of osteoporosis?

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

What can I do to overcome the onset of Osteoporosis?

Regular “weight-bearing” exercise can help to prevent or slow down bone loss. Adequate calcium and vitamin D are important for healthy bones.

If you smoke, you should make every effort to stop, and cut down on alcohol if you drink heavily.

What are the treatments of osteoporosis?

The treatment of osteoporosis depends on a number of factors including your age, sex and medical history. The aim is to strengthen existing bone, prevent further bone loss, and reduce the risk of broken bones.

Once medication for osteoporosis is started, it is likely that you will need it for at least five years and sometimes lifelong. If you experience any side-effects please discuss with your doctor before stopping medication. An alternative drug may be more suitable for you.

a) The bisphosphonates are a group of drugs that include weekly Risedronic acid (Risedronate). These are the most commonly used drugs to treat osteoporosis, and work on the bone-making cells. The most common side-effect is indigestion.

b) Strontium ranelate (Protelos) appears to affect both cells that build bone and those that break it down. It is a useful alternative drug for some patients when bisphosphonates are not suitable. The most common side-effect is diarrhoea in the initial period after starting the drug, which settles in most patients.

c) Denosumab (Prolia) is a monoclonal antibody, which is a protein that targets specific cells in the body. It works to block the cells that break down bone, allowing the bone-making cells to build up bone mass. It is given as a 6 monthly injection, which can be given at your GP practice.

d) Calcium and vitamin D tablets are commonly prescribed in addition to one of the above drugs.

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

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

Further information is available from The National Osteoporosis Society.

How can I prevent further falls?

Most hip fractures occur as the result of a simple fall. Falling is not an inevitable result of ageing, but the risk of falls increases as we get older. During your admission, your orthogeriatric doctor will have carried out a fall's risk assessment: trying to uncover any medical problem which might make you more likely to fall (e.g. abnormal heart rhythms, fall in blood pressure on standing).

However, you can also take measures to help prevent falling, and reduce the risk of further broken bones.

Keep all rooms clear of clutter, and check for hazards such as trailing wires and slippery floors.

Clear away loose rugs or tape down the edges, to prevent trips.

Ensure your home is well lit, especially stairwells. Consider leaving a night light on if you have to get up frequently at night.

Wear supportive, low-heeled shoes even at home, avoid walking in socks, stockings or floppy, backless slippers.

Have your eyesight checked regularly. Eye tests are free if you are aged 60 or over. In many cases this can be done in your own home, if you are not able to travel. Contact your local optician for further advice. Care should be taken wearing Bifocal lenses and reading glasses which can make objects appear closer, and are associated with an increased risk of falls.

For further information on falls please see the *Falls in the Elderly* patient information leaflet (PIN131114–843).

Why a National Hip Fracture Database?

Hip fracture is a common injury, and caring for patients with hip fracture is an important part of the work of the NHS. This hospital takes part in the National Hip Fracture Database (NHFD), which has been set up to improve the care of patients who have broken a hip.

Information gathered about care in hospital and about recovery afterwards enables us to measure the quality of that care and helps us to improve the services we provide.

Reports based on NHFD data are made to our clinical staff to assist them in improving care here. NHFD national reports show how different hospitals compare, thus helping to improve standards of care nationally.

Information about your care and progress will be entered into the database during your hospital stay. You will also be contacted after discharge so longer term progress is also captured.

All information collected is confidential and will never be made public. All NHFD information is stored, transferred and analysed securely – both in this hospital and within the national database – in keeping with the provisions of the Data Protection Act (1998).

Participation is voluntary. If you do not wish to take part please tell your doctor. However, the more people take part, the more helpful NHFD will be in improving care.

More details are available at **www.nhfd.co.uk**

Key reference sources

- www.nhfd.co.uk
- National Osteoporosis Society – www.nos.org.uk
- *Falls in the Elderly* patient information leaflet (PIN131114–843)

Contacts details

Royal Surrey County Hospital *Egerton Road, Guildford GU2 7XX*	**01483 571122** (switchboard)
■ Bramshott Ward	**ext** 4065 / 4064
■ Ewhurst Ward	**ext** 4073 / 4075
■ Specialist Hip Fracture Nurse	**Bleep** 71-6941 (via switchboard)
■ Physiotherapy Department	**ext** 4153
■ Occupational Therapy Department	**ext** 4766
■ Social Care Team	**ext** 4008
■ Department of Orthogeriatrics	**01483 464105**

Age Concern

- **Telephone:** 01483 503414
- www.acsurrey.org.uk
- A range of services for older people to help them make the most of life.

Dial-a-ride

- **Telephone:** 01483 458052
- www.surreycc.gov.uk
- Transport for people with mobility difficulties

NHS 111

- www.nhsdirect.nhs.uk
- Health information and advice

National Osteoporosis Society

- **Telephone:** 0845 450 0230
- www.uos.org.uk
- Support for people at risk of osteoporosis

Red Cross

- **Telephone:** 0844 4122 786
- www.redcross.org.uk
- Equipment loan and home from hospital care

This leaflet was compiled by the Orthogeriatric Team.
Dr Frittelli and Dr Wilson.

PALS and Advocacy contact details

Contact details of independent advocacy services can be provided by our Patient Advice and Liaison Service (PALS) who are located on the right hand side as you enter the main reception area. PALS are also your first point of contact for health related issues, questions or concerns surrounding RSCH patient services.

Telephone: 01483 402757

Email: rsc-tr.pals@nhs.net

Opening hours: 9.00am–3.00pm, Monday to Friday

If you would like information documents in large print, on tape or in another language or form please contact PALS.

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