GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Broken Hip Information Booklet

What happens next?

A booklet for you and your family

Patient Name: _____

This is a specialist trauma orthopaedic ward where you will be cared for, by a team of professionals, following your fractured neck of femur.

Your team

Ward sister: _____

Orthopaedic Surgeon: _____

Orthogeriatric Consultant: _____

Clinical Nurse Specialist: _____

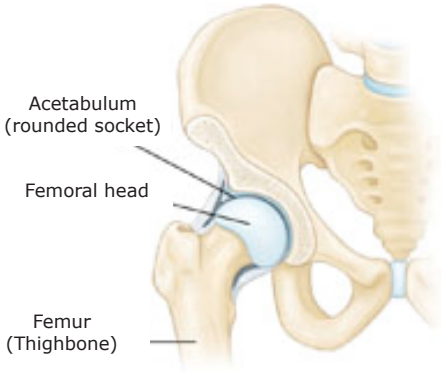
Physiotherapist: _____

Occupational therapist (OT): _____

This booklet has been designed to help you and your relatives have a better understanding of the type of injury you have sustained and the recovery process. It should guide you through your stay and answer any questions about what has happened to you and how you will be treated, as well as giving you an insight into what to expect on your journey and recovery.

If you have any further questions please do not hesitate to ask.

What is a hip fracture?



The hip is a ball and socket joint. The ball is formed by the head of the femur (thigh bone) and fits into the socket in the pelvis. The bone you have broken is the femur (thigh bone). The neck of femur is located at the top part of your thigh bone near to your hip joint.

The most common causes of injury to the femur are trauma, such as a fall, or can be exacerbated by osteoporosis (loss of bone density). There are many different types of fractures and these can vary in size and complexity. The majority of people that break their hip need an operation in order to allow them to get up on their feet, but some may be too unwell for surgery. Your Consultant will talk through the type of fracture you have and the management options available to you.

Before your operation

While in A&E you will have experienced a variety of tests (e.g. X-Rays, blood tests, ECG tracing of your heart) to help the doctors with their diagnosis, treatment plan, and to decide if you are fit enough for surgery. The team will aim to manage any pain that you are experiencing with appropriate pain relief.

At the earliest opportunity you will be admitted to the orthopaedic ward where you will be greeted by the nurse who will be looking after you. She/he will ask you a number of questions about your previous medical problems and social circumstances prior to your admission.

Your care on the ward will be provided by a team of Healthcare Professionals.
You will be overseen a Consultant team including Doctors and Nurse Practitioner.

Hip fractures can cause pain in the groin, thigh and knee, and is often worsened with movement. You will receive regular painkillers as prescribed to alleviate your symptoms. You will have regular observations. You may also need to have a small needle inserted into your arm (cannula) so that the nursing staff may give you fluids/medication as needed.
In some circumstances a blood transfusion may be given either before/after your operation. Whilst waiting for your surgery you will need to remain in bed.

The National Institute for Health and Care Excellence (NICE) provide evidence-based guidance, advice and information services for health, public health and social care professionals. They recommend that your surgery should take place on the day you come in to hospital or the following day. This may be delayed however, if there is an emergency or if you have an underlying medical condition which needs treatment to get you fit enough before your surgery. We appreciate that this can be distressing and we will take every measure to avoid this from happening.
In preparation for your surgery you will be required to remain nil by mouth. This means you will be unable to eat, chew or drink anything for a few hours before surgery.
It is important you adhere to this as if you eat or drink anything your operation will be cancelled and arranged for another day, delaying your recovery.

Before you are taken down to theatre an arrow will be drawn on your injured leg and you will be given a theatre gown to wear. Theatre porters will take you down to theatre on your bed. A compression stocking may be applied to your non-affected leg before surgery.

Anaesthetic Options

The anaesthetist will see you before the operation to assess your fitness for surgery or if you require other treatments prior to your operation. The anaesthetist will discuss with you the different types of anaesthesia, answer any questions you may have and make recommendations as to which anaesthetic they feel is safest for you. There are two types of anaesthetic that are available. These are:

- **Spinal anaesthesia**
- **General anaesthesia**

There are other procedures that you can have in addition, which should reduce your pain and make the whole experience more comfortable. These are:

- A nerve block; which you also may have before the operation to reduce pain in your broken hip.
- Local anaesthetic infiltration (injections) around the joint and the wound.

Spinal anaesthetic:

A dose of local anaesthetic is injected into your lower back near to the nerves in your spine. You go numb from the waist downwards. You feel no pain during the operation, but you remain conscious. If you prefer, you may also have drugs that make you feel sleepy and relaxed (sedation).

Advantages – compared to a general anaesthetic:

- You are likely to have less sickness and drowsiness after the operation. You will usually eat and drink sooner. This means you will be ready to get up and start using your repaired hip sooner.
- You do not need additional pain relief medicine in the first few hours. This keeps you feeling well and ready to be active with your repaired hip.
- You remain in full control of your breathing. You breathe better in the first few hours after the operation.
- There is some evidence that less bleeding may occur during surgery, which would reduce your risk of needing a blood transfusion.

Disadvantages –

- You will not be able to move your legs properly for a while
- If pain-relieving drugs are given in your spinal or epidural as well as local anaesthetic, you may feel itchy
- Rarely you may suffer with a severe headache after the spinal anaesthetic and very rarely there can be damage to nerves sustained.
- You may not be able to receive a spinal anaesthetic if you are taking blood thinners or if you suffer from certain medical conditions. Your anaesthetist will discuss this with you when they visit.

General anaesthetic:

A general anaesthetic produces a state of controlled unconsciousness during which you feel nothing.
You will receive:

- Anaesthetic drugs (an injection and/or a gas to breathe)
- Oxygen to breathe
- Sometimes, a drug to relax your muscles.

You will need a breathing tube in your throat while you are anaesthetised, to make sure that oxygen and anaesthetic gases can move easily into your lungs. If you have been given drugs that relax your muscles, you will not be able to breathe for yourself and a breathing machine (ventilator) will be used. When the operation is finished, the anaesthetic is stopped and you regain consciousness.

Advantages

- You will be unconscious during the operation.
- If you have certain health conditions, this may be the safest mode of anaesthesia for you. Your anaesthetist will discuss this when they perform their pre-operative visit.

Disadvantages

- A general anaesthetic alone does not provide pain relief after the operation. You will need some kind of pain relief afterwards.
- Strong pain relief medicines may be used, which make some people feel quite unwell.
- You may combine the general anaesthetic with a nerve block, or with wound infiltration to help with pain afterwards.
- Sickness – treated with anti-sickness drugs
- Sore throat or damage to the lips or tongue
- Drowsiness, headache, shivering, blurred vision – may be treated with fluids or drugs

Reference: http://www.rcoa.ac.uk/system/files/PI-ACHKR-COL-2014_0.pdf

Treatment

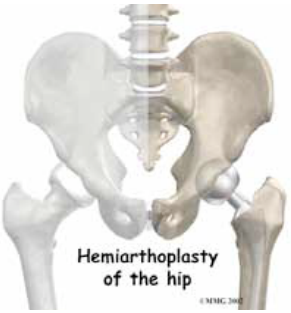
Hip fractures can be treated in a variety of ways depending on the site and severity of the fracture. The treatment for the majority of hip fractures is an operation to repair the break or replace the part of the hip.
It means that you can get back up on your feet after the operation to start the rehabilitation process.

Which operation?

There are five main types of operation used to manage a fractured neck of femur.

☐ Hemiarthroplasty

The whole ball is removed and replaced with a prosthetic implant, this is known as a hemiarthroplasty. The socket is not damaged and is therefore left intact. In the majority of cases you will be able to get up and walk on their operated leg.



☐ Cannulated screws

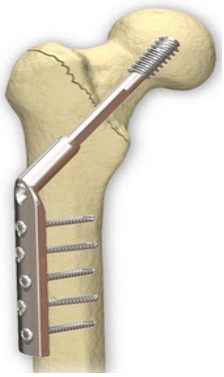
This is where the surgeon makes a small incision in your skin and uses metal screws to hold the bones in a good position.

If you have had multiple screws there may be weight bearing restrictions; this will be guided by your consultant.

☐ Dynamic Hip Screw

A metal plate is placed against the bone and held in place by a number of screws.
A large screw is inserted across the fracture site to hold the broken bone together.

If you have had a dynamic hip screw you will probably be allowed to walk on your operated leg after your surgery; this will be guided by your consultant.



☐ Intramedullary Nail

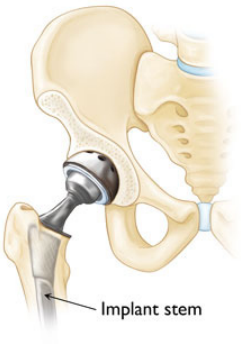
A metal rod is placed through the middle of the femur and screws are inserted across the fracture to hold it in place.

If you have had an intramedullary nail the amount of weight you can take through your leg will be guided by your consultant after your surgery.

☐ Total Hip Replacement

During this operation both the ball and the socket are replaced.
You will need to adhere to these hip precautions for **three months** post surgery:

1. **Do not twist on the operated leg.**
2. **Do not cross your legs or ankles.**
3. **Do not bend at the hip past 90°.**
4. **You must sleep on your back.**



After your operation

You may be away from the ward for a number of hours but the surgery itself normally takes approx 70-90 minutes. You will wake up in the recovery room and may feel disorientated. This is normally short-lived. You will be given oxygen via a face mask or plastic tube in your nose. You may have a foam wedge between your legs to keep your hip in the correct position and you may have a catheter in place.

Nursing staff will take you back to the ward where you will have your observations checked frequently. Once you feel well enough you will be encouraged to eat and drink. If you need anything please press your nurse call bell and they will assist you with your needs.

You may be wearing a pair of compression stockings after your surgery and may also be given an injection in your tummy each day. These help to reduce the risk of developing a blood clot [deep vein thrombosis (DVT)]. You may be taken for an X-ray to check the position of the fixation over the first couple of days after surgery.

Pain relief

It is important that your pain is controlled so that you are able to sleep well and participate in rehabilitation. The nursing staff will give regular prescribed medication to control your pain; this may come in tablet or liquid form.

If you find that you are still in a lot of pain, please let a member of staff know.

Diet

It is important that you have a nourishing diet to help with your recovery after your operation. This means eating enough calories and protein, and also drinking plenty of fluids to aid healing, prevent pressure sores from developing and prevent weight loss.

Appetite can be variable following an operation and as a result, you may lose weight. Drinking milk during your stay, which will be offered to you on the drinks trolley, is a nourishing drink that provides you with calories and protein and also keeps you well hydrated.

It can be helpful for family members and friends to bring in snacks that can be kept by the bedside. This is particularly helpful if your appetite is poor and you are not able to manage three hospital meals a day, as this allows you to have little and often. Snacks that provide high amounts of calories in small amounts include biscuits, chocolate and cake. It may also be useful for your family or friends to visit at meal times so they can help you with eating and drinking if this is required.

You may also need nutritional supplement drinks, which can provide you with further calories and protein. You may also be referred to a Dietitian in the hospital, if your nutritional intake remains poor. The Dietitian can further help you to make the most of your diet and suggest an increase or offer different nutritional supplement drinks to suit your preference.

Wound care

It is important that your wound is well looked after. The nursing staff will be checking your wounds and dressings regularly. For the first few days your dressings may be a little wet or blood stained but as your wounds heal this should dry up. The wound dressing,where possible, is left intact until the stitches are removed. Your stitches or clips will be removed by nursing staff on the ward or in your local GP surgery. This commonly occurs 10-14 days after surgery.

Rehabilitation

Your rehabilitation begins the day of, or the day after, your operation when the nursing staff or the physiotherapists will help to move you to the chair next to your bed. Early mobilisation will reduce the risk of pressure sores and other complications.

Mobility and Falls Assessment

It is very important that you start to walk as soon as possible after your operation. This will help with the healing process and will prevent further complications such as chest infections and pressure areas.

The physiotherapists and nursing staff will work with you to increase your mobility. A walking aid, such as a zimmer frame, will be used initially.

The Orthogeriatric team (specialist in care of older people with hip fracture) led by a Care of the Elderly Consultant will assess and treat your medical conditions before and after the surgery to expedite recovery from hip surgery.
Orthogeriatric team will perform a comprehensive geriatric assessment which include falls assessment, medication review and bone health.
Detailed assessment of osteoporosis (brittle bone disease) will be done to prevent future fracture.

Discharge home

The time you will need to spend in hospital is difficult to predict. Some patients are well enough to be discharged after 5-7 days while others need longer, or increased levels of care. Various factors affect this including previous level of mobility and the support available to you.

Complications

Hip fracture in is a serious injury in elderly people and, even in the absence of any specific complications, this injury may result in permanent deterioration in general health and worsening of any co-existing medical conditions.
As with all surgery there are risks and complications which you need to know about.

General Complications of Any Operation

- **Complications of anaesthesia** – Your anaesthetist will be able to discuss with you the complications of having an anaesthetic.
- **Pain** – With the break fixed, you should feel more comfortable. You will be given regular medication to control your pain. Some discomfort is to be expected following any operation. A nurse will check your pain level regularly, and will give you additional painkillers if you need them.
- **Bleeding** – All patients lose some blood during a hip operation. Depending on your blood tests and general health, you may need a blood transfusion before, during or (more commonly) after your operation.
- **Infection** – You will be given antibiotics to prevent infection (such as wound infection) at the time of surgery. Wound infections usually settle with antibiotics but may require a further operation (Risk I in 60 patients).
- **Blood clots –** a deep vein thrombosis (DVT) is a blood clot in a vein, usually a leg vein. It can be caused by immobility. As you will be more immobile after a hip fracture, you are at increased risk (risk 1 in 150) of clinically developing a DVT. For this reason, you will be given medication and stockings to help prevent DVT until you are mobile. Occasionally (Risk 1 in100) a DVT may move in the blood stream to your lungs (pulmonary embolism/PE) making it difficult for you to breathe.
- **Difficulty passing urine –** You may need a catheter (tube) in your bladder for a day or two.
- **Urine infection –** (Risk 1 in 20) If this happens you may need antibiotics.
- **Chest infections –** (Risk 1 in 10) This can happen following surgery and a period of immobility. (Risk 1 in 10) Early appropriate surgery and early mobilisation help reduce the incidence of this. Treatment involves oxygen, antibiotics and physiotherapy.

- **Failure of the wound healing –** This can be due to poor state of health and general frailty of some hip fracture patients; a further hip operation may be necessary.

- **Pressure ulcers –** A pressure ulcer is an ulcerated area of skin caused by irritation and continuous pressure on part of your body. If you are not very mobile and are spending long periods in bed or in a chair, you are at increased risk of developing a pressure ulcer. Mobilisation helps reduce the risk.

- **Heart attack** (Risk 1 in 65) / Heart Failure (Risk 1 in 30) - Sometimes this can cause death.

- **Stroke – (**Risk 1 in 90) After your operation, you will be seen routinely by the medical team to minimise your risk of developing these complications. They can occasionally cause death.

- **Bleeding from the gut –** (Risk 1 in 125) This can happen because the injury and surgery causes stress. If the bleeding does not stop you may need further treatment. Heavy bleeding may sometimes cause death.

- **Confusion –** This is common (25%) in patients following hip fractures. Confusion in older people can be caused by many things, many of which are treatable. This is individual to each patient and will be addressed with the support of the medical staff. Usually it is mild and gets better by itself, but your doctor may need to do further tests or give further treatment if you become very confused. It is very important that relatives share with the nursing staff any knowledge about your state of mind prior to the fall that caused the fracture.

Specific Complications of this operation

- **Fracture non-union** – this is where the bone fragments of the fracture do not heal or join back together in the normal way.
- **Loosening or dislocation of a hemiarthroplasty** – the metal work might become loose (risk 1 in 40) or your hip may dislocate at a later stage after surgery (risk 1 in 500). If this happens you may require a further operation.
- **Damage to the hip nerves** – pain, weakness and numbness may happen but usually settles with time.
- **Damage to blood vessels around the hip** – if damage occurred this would normally be dealt with by your surgeon at the time of the operation.
- **Split in femur** – This can occur when the stem of a hemiarthroplasty is inserted (risk 1 in 50). It is more likely if your bone is weak.
  Your surgeon may need to put some wires around your femur, or use a different type of hemiarthroplasty.
- **Avascular necrosis** – this is more likely with certain types of hip fracture. The blood supply to the head of the femur (the thigh bone) is damaged by the fracture. Without blood, the bone tissue can die. This can lead to problems including chronic pain around the hip.
- **Developing a lump under the wound (haematoma)** – This is caused by a collection of blood (risk 1 in 60). If you develop a large haematoma you may need a second operation to have it drained.
- **Infection around the metal implant** – (Risk 1 in 100). This is usually a serious complication and you will usually need one or more further operations to control the infection.
  You may ultimately need to have the implant removed.
- **Failure** – sometimes the bone is too soft to hold the implant (risk 1 in 200). If this happens, you will usually need another operation to fix the fracture again.
- **Leg length difference** – This can happen because the pieces of bone push together as the fracture heals. This may require a shoe raise.

Are there any alternatives to surgery?

A few people may be best treated conservatively without an operation. In this case, after a prolonged period of bed rest, pain relief and sometimes traction (heavy weight fixed to the leg to pull the bones into position until they heal) they will be helped to start moving under careful supervision.

An operation reduces the serious complications of staying in bed for a long time. These include:

- Pressure ulcers
- Constipation
- Chest infection
- Deep vein thrombosis (blood clot in the leg)
- Infection
- Non-union of bones
- Pulmonary embolism (blood clot in the lungs).

The severity of these can be different in each person and all can affect the quality or length of life. These complications are still present if you undergo surgery but will be minimised once you have had your operation and become mobile.

Physiotherapy

The Physiotherapist will aim to see you prior to your operation to confirm all of your details and to plan your rehabilitation to avoid delays when you are ready to leave hospital. They will teach you exercises and it is very important to do these exercises regularly to reduce the risk of complications such as muscle weakness caused by bed rest and surgery.

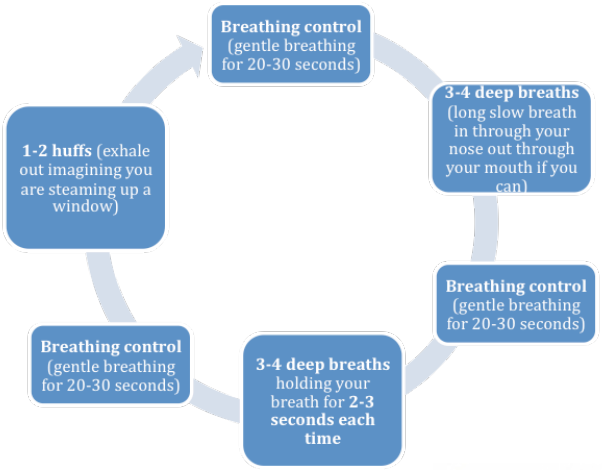
Exercise

Breathing exercises:

Chest care

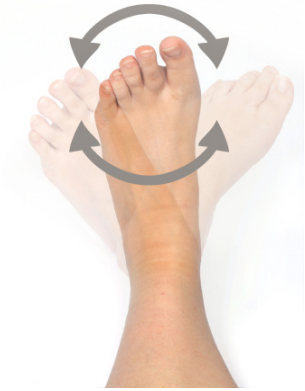
There is a risk of developing a chest infection after an anaesthetic as it can affect the way sputum (phlegm) is cleared out of the lungs. Pain can also make breathing deeply and coughing more difficult. It is important to ensure that air flows to the bottom of your lungs to prevent you from getting a chest infection.

Regularly breathing deeply and coughing to remove this phlegm from your lungs (before and after your operation) can help to reduce this risk of developing a chest infection and make breathing easier. Your Physiotherapist may teach you the technique below to breathe and cough more effectively which will assist sputum clearance. Try to do this regularly throughout the day.



Ankle exercises:

Move the ankles up, down and in circles to help with your circulation and to prevent blood clots while you are less mobile than usual.



Thigh exercises:

repeat five-ten times on each leg

Tighten your thigh muscles by squeezing the back of your knee downwards. Hold for five seconds.

Buttock exercises:

repeat five-ten times

Clench your bottom and hold for five seconds.

Hip abduction exercises:

repeat five-ten times

Slide your leg out to the side keeping your toes pointing upwards and your knee straight.

Hip flexion exercises:

repeat five-ten times

Slide your heel up towards your bottom and then straighten your knee.

***Remember your hip precautions if applicable**

Advanced strengthening exercises:

The physiotherapist will advise you if the following exercises are suitable for you to practice.

Standing hip abduction: Repeat five-ten times

Standing hip extension: Repeat five-ten times

Standing hip flexion: Repeat five-ten times

****It must be remembered that these are guideline exercises only. Each person having a hip operation has their own particular needs.**
The physiotherapist will advise you on what is appropriate for you. **

Going upstairs:

1. Take one step at a time.

2. If you have a rail, hold onto the rail and use one stick or elbow crutch.

3. If you have two rails use them.

4. Step up with your un-operated leg first, then your operated leg and then finally lift the stick.

Going downstairs:

- Take one step at a time.
- If you have a rail, hold onto the rail and use one stick.
- Place the stick onto the step below you, then step down with your operated leg and finally your un-operated leg.

How can I reduce my risk of injury in the future?

There are several things you can do to prevent further problems after a hip fracture.

Future fall prevention

There are a number of ways to reduce the chances of having a fall.

They include:

- Looking at any particular hazards that you may have in your home, such as loose rugs or furniture.
- Ensuring your home is well lit.
- Having a regular check of your eyesight. Eye tests are free if you are aged 60 years or over.
- Seeing your doctor regularly for a review of your medication, your blood pressure and your general health.
- Keeping active! Being afraid of participation in activities because you are worried about falling can make you weaker or more at risk of falls.

If you are concerned that you are at risk of falling, you should discuss this with your Doctor.

Although most falls occur after a simple trip, some may be due to an underlying problem. These may be treatable, making you less likely to fall over in the future. After a short assessment while you are in hospital, we may suggest that you are referred to a 'Falls Clinic' for further review. The arrangements will be made for you.

Osteoporosis Treatment

Every patient will be assessed and will be prescribed treatment, if appropriate for osteoporosis (fragile bones) in the form of tablets or injections. Ward pharmacist will provide clear instructions on how to take the osteoporosis medications and duration of the treatment.

Future preventative measures include:

- Regular weight-bearing exercise such as brisk walking, aerobics, dancing, running, etc.
- Ensuring adequate calcium and vitamin D intake in your diet (and possible supplements for those who may be deficient).
- Smoking and alcohol – chemicals from tobacco in your bloodstream can affect your bones and make bone loss worse. If you smoke, you should make every effort to stop, as well cutting down on alcohol if you drink heavily.

- There are several types of drugs available that can stop your bones thinning more and sometimes actually strengthen the bone, making another break less likely in the future. If necessary you will be started on these tablets during your hospital stay. It is important that you get more tablets from your family doctor.
  People with osteoporosis usually remain on bone strengthening tablets and calcium tablets for many years.

Occupational therapy (OT)

The role of an Occupational Therapist (OT) is to assist in maximising your independence, so that you are able to cope with all your usual activities at home. Each person is individually assessed and advice given according to their needs. The occupational therapist may provide you with some equipment to help you manage at home. This equipment is available on a temporary loan basis and should be returned following the loan period. Your occupational therapist will discuss this with you.

The occupational therapist will ask you some questions about how you were managing at home before your admission and about your home environment. They will also request the height of your furniture at home to check you will manage on discharge – a form will be provided.

Depending on the type of surgery you had, you may have to be careful with certain movements whilst your hip is healing. The occupational therapist will discuss this with you and advise you of ways of maintaining your independence during this time and give you further written information.

Advice on daily activities

Getting dressed

After your operation your hip is likely to be slightly stiff and uncomfortable, which may make it difficult to bend and dress your lower half. If so you may find it helpful to use some small aids such as a 'helping hand', long handled shoe horn or sock aid. The occupational therapist can show you how to dress your lower half and advise you where the small aids can be purchased.

If you feel unable to dress yourself independently, please discuss this with your occupational therapist as they can refer you for community services at home.

- Always sit down whilst dressing.
- Take your time.
- **Dress your operated leg first and undress it last.**
- Always wear flat, supportive, well fitting footwear.

Getting in/out of chairs

You will be shown the correct way to sit and stand from an armchair and advised on a suitable chair height for you. A firm upright chair with arms should be used. Avoid low soft settees and armchairs or wheeled/office style chairs.

To sit:

1. Feel for the chair with the back of your legs and place your hands on the arms of the chair.
2. Slide your operated leg straight out in front of you.
3. Lower yourself down gently.

To stand:

1. Bring yourself to the edge of the seat.
2. Slide your operated leg straight out in front of you.
3. Push up on the arms of the chair.

Toileting

Getting on and off the toilet will be practised with you and advice given according to your needs and ability. It is advised not to use the sink, bath, radiator or door handle to assist you getting on and off the toilet.

Bathing/showering

It is recommended that you do not sit in the bath following your operation. You can use walk-in shower if suitable or have a strip wash.
You may need to find someone to help you with this task.
The occupational therapist will discuss this with you.

Getting in/out of bed

You will be shown how to get in/out of bed safely and advised on a suitable bed height. It may be necessary to consider having a bed brought downstairs whilst recuperating, depending on progress with therapy.
This will be discussed with you by your occupational therapist or physiotherapist.

Domestic tasks

In the kitchen:

The following are a few suggestions to help you in the kitchen, which your occupational therapist will discuss with you:-

- Stock up your cupboards/freezer.
- Store everyday kitchen equipment on the worktop to prevent excessive bending.
- Place more commonly used items higher in the fridge, eg milk, butter.
- Put tea/coffee making equipment and utensils together. Plug the kettle in as close to the fridge as possible; leave mugs, cups, sugar, tea, coffee and teaspoons on the worktop; use a jug to top up the kettle with water.
- Have plates and cutlery near to both the cooker and microwave to save extra journeys around your kitchen.
- If your oven is low, make as much use as possible of the hob, eye level grill or microwave (as long as this is positioned on the worktop).
- You will be using walking aids and may find carrying items difficult.

  You may need to eat your meals at your kitchen table or at your worktop, in which case a stool is advised. If space is restricted the occupational therapist will discuss alternative ways of managing with you.
- It may be advisable to make hot fluids up into a thermos flask or other suitable container ie drinks or soups. This would make transporting fluids from room to room safer.
- Slide objects along the worktop to avoid lifting and carrying.
- You may find using an apron with a large pocket, a shoulder bag or small rucksack useful for carrying some items from room to room.

Laundry, housework and shopping:

Vacuuming, heavy housework, laundry and changing the bed should be avoided. Light activities like dusting and washing dishes are acceptable.
You may need help with these activities. In some areas there are community services that can help you with these tasks; however there may be a charge for their services.

Hobbies and leisure activities

During the initial weeks after your surgery, activities like gardening and sport should be avoided.

An acceptable activity should:-

- **Start slowly:** You should start slowly with rest periods and build up the activity gradually.
- **Produce no pain:** Pain should not be felt during the activity or within 24 hours afterwards.
- **Avoid jarring or sudden impact:** Shoes should have cushioned heels and/or insoles. Your hip should not be put under excessive strain.
- **Be pleasurable:** You may wish to continue the same activities you have enjoyed for years or try new activities.

Discuss any activity with your Consultant at your first out -patient appointment after discharge.

Work

Returning to work will depend on the type of work that you do.
This should be discussed with your Consultant.

Getting in/out of the car

The car must be parked away from the kerb, so that you are always standing on the road, with the passenger seat back as far as possible and slightly reclined. If you feel the car seat is too low or bucket shaped a cushion or pillow can be placed on the seat to raise the height and level of the seat. Long journeys should be avoided unless regular breaks are planned. If using a people carrier or 4x4 vehicle getting in and out will be discussed with you as the technique is different.

To get into the car:

- Turn your back to the seat and get into the car with your bottom first. Gently lower yourself down. Remember to keep your operated leg straight out in front of you and take care not to bend forward too much.

- Slide backwards towards the drivers' seat and turn your body around leaning backwards in order to bring your legs into the car.
- Straighten yourself up, keeping your operated leg straight out in front of you.
- If you sit on a polythene bag, you may find this assists when you slide in and turn around. Remove bag before commencing your journey.
- To get out of the car, reverse the procedure and make sure your operated leg is out in front of you before rising from the seat.

Driving

It is recommended that you should not drive for six weeks after surgery, but you can be a front seat passenger. You are advised to contact your insurance company before you start to drive again.

Discharge

Our aim is to plan your discharge from an early stage. It is important to remember that everybody is different and everybody recovers at a different pace. There are a number of options for when you are discharged from this ward.
If you are progressing well and the team are happy that you will cope well at home, you may be discharged straight home from this ward. There are dedicated community teams who can be enlisted to assist you with any hygiene needs or meal preparations if required. Your occupational therapist will discuss these options with you. We aim for you to able to return to your own home within 7 days after your operation.

Your Physiotherapist will help you to decide how you will continue with your physiotherapy care. In some circumstances you may need Physiotherapy treatment at home. Otherwise an appointment will be made for you at your local out-patients department and they will contact you after you are discharged home.

Some people require time in a rehabilitation ward before going home.
These wards are smaller and are located in hospitals which are closer to your home. There are Physiotherapy and Occupational therapy facilities and the staff will continue to work with you to help you regain your strength and confidence, and ensure that you will be able to cope safely at home.

Our rehabilitation wards are located at the following hospitals: St Woolos, County/Panteg, Chepstow, Ysbyty Ystrad Fawr and Ysbyty Aneurin Bevan.
We will endeavour to transfer you to your nearest hospital, however if a suitable rehabilitation bed becomes available it may not be at the hospital nearest your home.
If you live outside of the Health Board boundary you will be referred to your nearest hospital. Under some circumstances the team may discuss with you the possibility of moving to a nursing or residential home.

Why a National Hip Fracture Database?

The National Hip Fracture Database

~ and why information about your care is important.
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.
So, information about your care and progress is important, and will be collected during your hospital stay. And, because your progress after you leave hospital matters to us, you may be contacted later about how you are getting on.

All information collected is confidential, and no information is ever made public about you or about any other patient. 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, of course, voluntary; and you are free, if you so wish, not to take part - tell your doctor if you do not wish to participate. However, the more people take part, the more helpful NHFD will be in improving care.

NHFD is supported by the National Clinical Audit Support Programme, a division of the Information Centre for Health and Social Care.
More details are available at www.nhfd.co.uk

Follow up phone calls

As part of the NHFD we conduct a follow up phone call, 120 days after admission to hospital with your broken hip.

We will ask you a range of questions about how you are managing after your broken hip.

Patient Questions to Team?

Patient Journal

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