King's College Hospital NHS
NHS Foundation Trust

Fractured neck of femur

Information for patients

This booklet aims to help you understand what is happening during your stay in hospital. It explains some of the things that may happen while you are with us and why.

Confirming your identity

Before you have a treatment or procedure, our staff will ask you your **name** and **date of birth** and check your **ID band**. If you don't have an ID band we will also ask you to confirm your address.

If we don't ask these questions, then please ask us to check.
Ensuring your safety is our primary concern.

Contents

Section 1:

Introduction

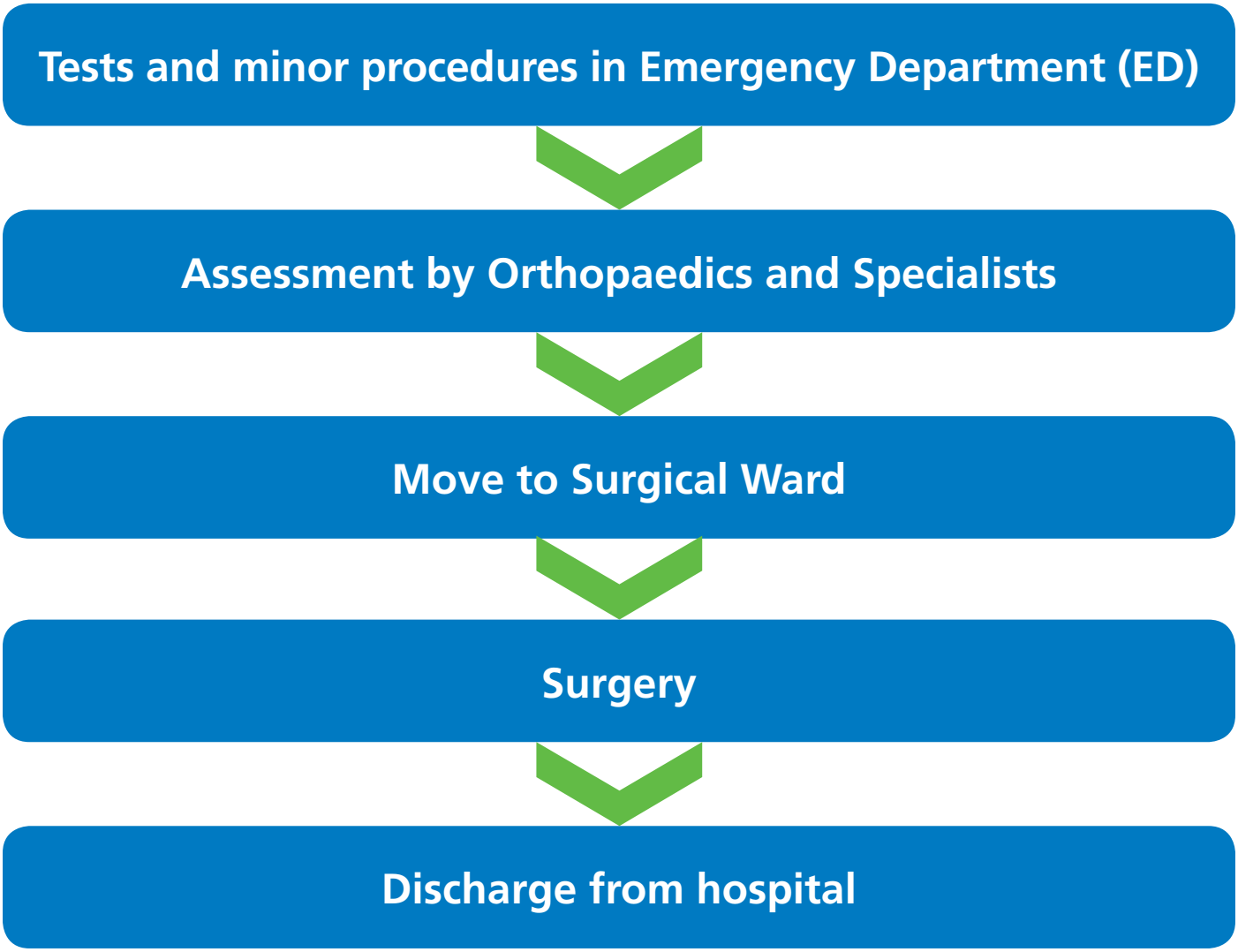
This booklet aims to help you understand what is happening during your stay in hospital. It explains some of the things that may happen while you are with us and why.

Everyone is different, so some parts of this booklet may apply to you more than others. Your care and treatment may be slightly different to what is described here but most of it will be broadly similar. If you have any memory problems, please let us know so we can give you more support to help you understand what is happening. We know that if you already have memory problems you are more likely to develop further temporary confusion (delirium) during your stay. Letting us know will help us to plan and care for you better.

What should I do if I have any questions?

You can make notes as you go along and ask members of our team your questions at any time.

Your stay in hospital



Section 2:

About your operation and giving consent

In this section we explain what a hip fracture is, the type of surgery and anaesthetics you may have, and the benefits of having this operation. We also list the main risks. We will discuss all of these with you and your relatives or carers before asking for your consent to the operation.

What is a fractured neck of femur?

Your hip joint is a ball and socket joint that sits between your pelvis and your thigh bone (femur) (diagram A).

A hip fracture is a break at the top of your thigh bone. It is also known as a neck of femur fracture. Both of these terms describe a range of different fractures at the top of your femur. The operation you will have depends mainly on which part of the top of your thigh bone is fractured.

Why do I need surgery?

We almost always recommend that you have an operation to fix the fracture. We aim to do it either on the day you come into hospital or the next day. The earlier we fix your broken bone, the better your recovery in the longer term. Your operation might be delayed if, for example, you have other medical conditions that we need to treat first, to make the operation safer.

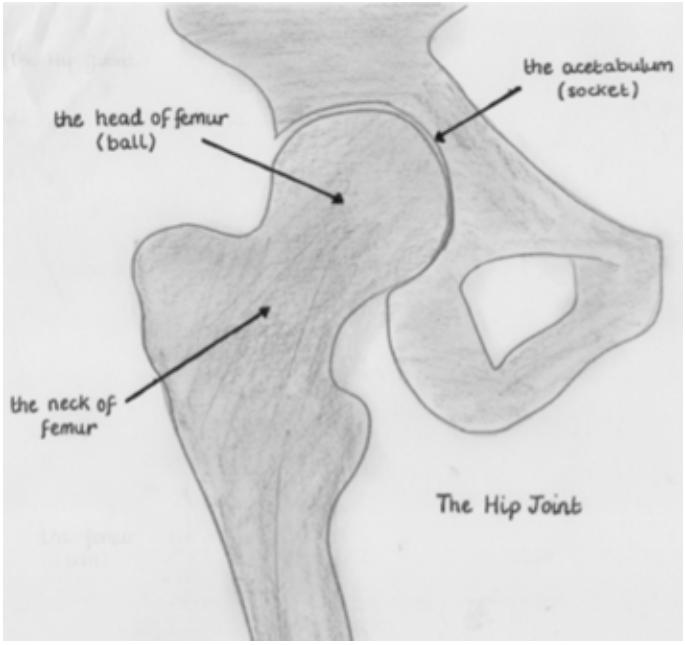


Diagram A: The hip joint

What type of surgery will I have?

This depends on how severe your hip fracture is and which part of your femur is affected.
If the head (ball) or the neck (top part of your thigh bone, just before the ball) is affected and there is little or no displacement of your fracture, surgery involves stabilising the head with screws or a dynamic hip screw. This is a very uncommon break and we will make every attempt to do this type of surgery if possible to keep your natural femoral head.

More usually the break happens at the head and the neck and it is displaced, which means the bones break and move out of place. In this case we will replace the head (ball) of the femur because the results are better.

This can be done in one of two ways:
1 Total hip replacement – replacing both the ball and the socket (diagram B)
2 Hip hemi-arthroplasty – replacing just the ball (diagram C)

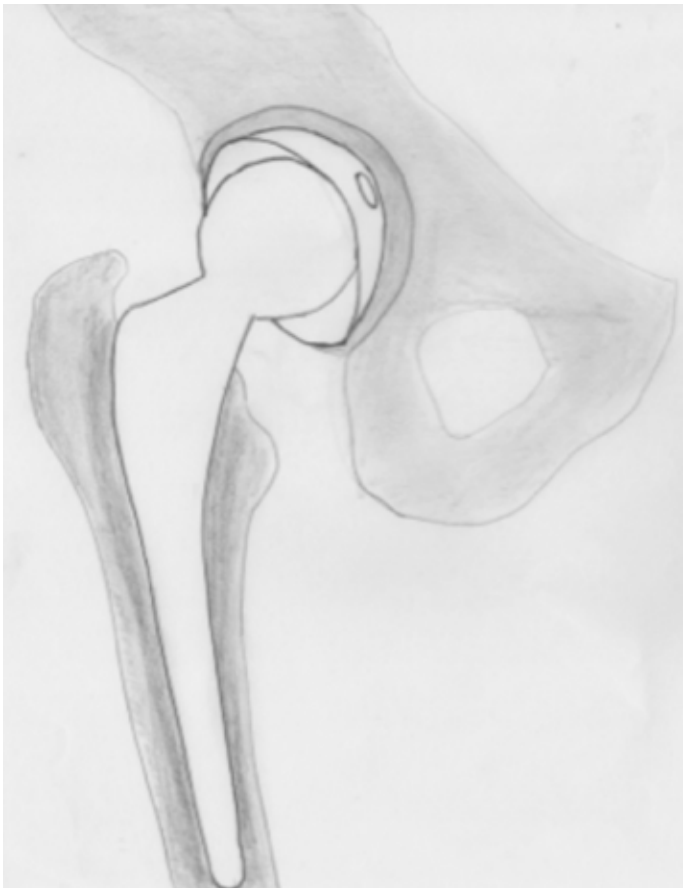


Diagram B: Total hip replacement

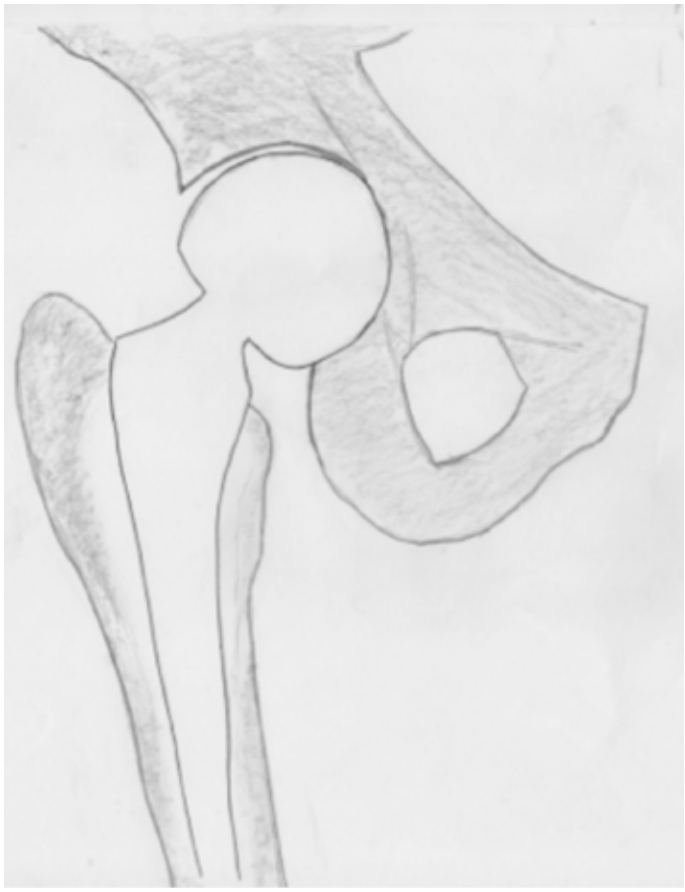


Diagram C: Hip hemi-arthroplasty

In both these operations, we remove the broken part of the femur containing the head (ball). We replace it with a metal head, which comes attached to a 'stem' which we insert into your healthy femur, usually with special cement, so the stem holds well inside your bone.

In a total hip replacement, we also replace the socket (acetabulum). This is a bigger operation that national guidelines advise us to offer only to people who need little assistance outdoors and who have a good understanding of the rehabilitation process.

If your fracture is below the neck of the femur, we do not need to replace any of your head bone. We usually fix this break in place using a large screw and a plate. This is called a dynamic hip screw (DHS) (diagram D, see page 6). Sometimes, if the break is lower, we use a long metal rod inside your thigh bone instead. This is called an intramedullary nail (IM nail) (diagram E, see page 6).

After any of these procedures you usually have a scar over the side of your hip 4-8 inches (10-20cm) long. All metalwork stays in your hip for the rest of your life.

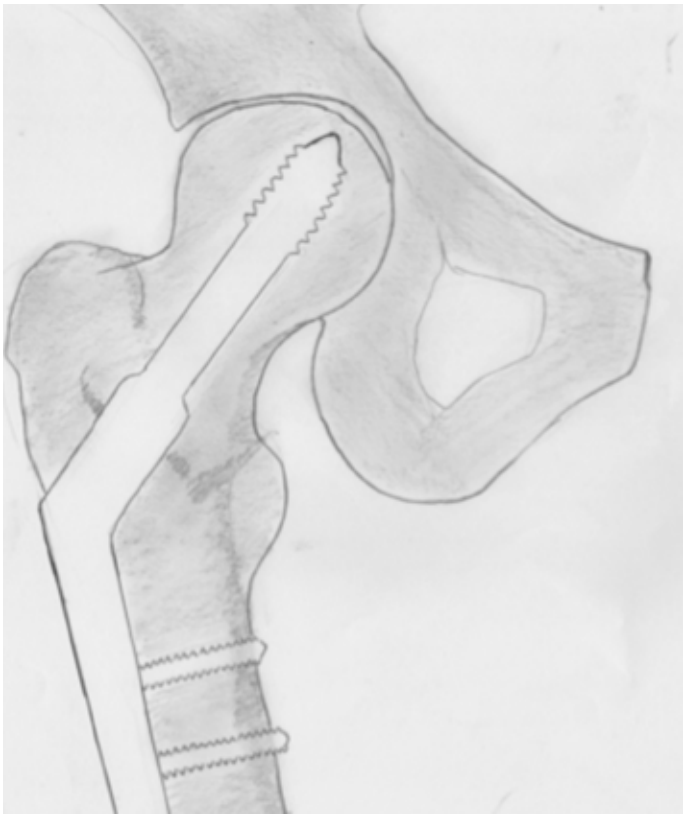


Diagram D: Dynamic hip screw (DHS) in place

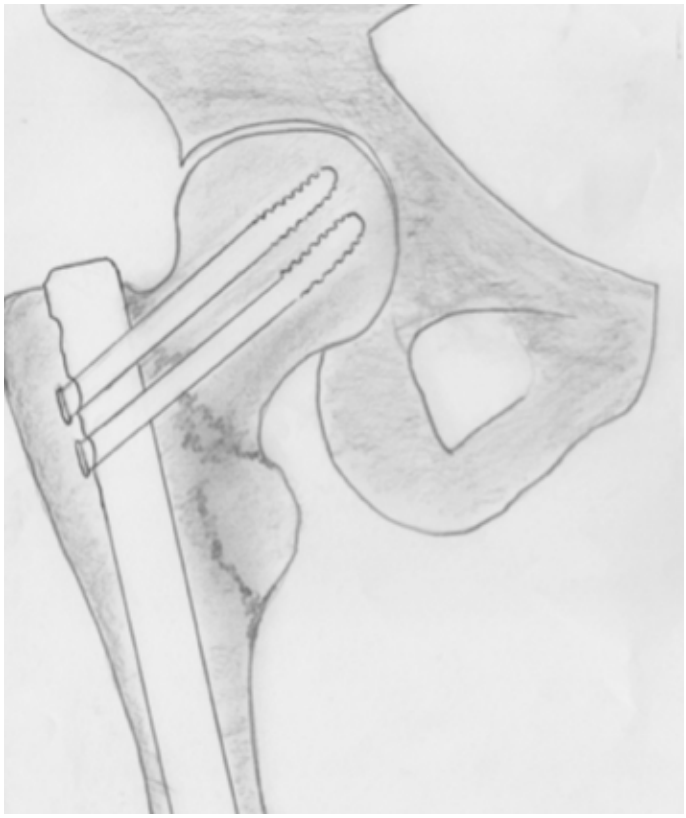


Diagram E: Intramedullary nail (IM nail) in place

What are the benefits?

The operation aims to:

- enable you to stand, walk and put weight on your injured leg again
- relieve your pain and discomfort.

What are the risks?

Here we list the main risks of having this operation. Some of these are more common - and some more serious - than others. Because everyone is different, we will discuss your individual risks with you and your relatives or carers.

Wound infection

There is a small risk of infection at your wound site. We will put a dressing over the area to keep it clean and keep an eye on it in the first week to check if it becomes wet or discoloured. There is no need to redo the dressing every day, and doing this can increase the risk of infection.

Bleeding

All operations carry a small risk of bleeding. Before your operation, you will have a blood test to check your blood count (haemoglobin). You may need a transfusion if you lose blood either during or after your surgery.

Thrombosis (blood clots)

Blood clots (usually in your legs) are more common if you have had an operation or if you are less able to walk around than previously. Your risk is increased by having had a broken hip. We will offer you a blood-thinning injection every day to make this less likely to happen. The dose is quite small so it does not usually affect your risk of bleeding after the operation; if it does, we may stop the injections.

Dislocation
Dislocation is when the head (ball) of the hip replacement comes out of the hip socket. This is very rare and your physiotherapist will show you exercises to minimise the risk of this happening and strengthen the muscles around your hip. They will also give you an information leaflet with advice on exercises to do and activities to avoid.

Delirium (confusion)
It is common both for those with and those without memory problems before the operation to have a temporary period of confusion. There are a number of different symptoms. For example, may feel more disorientated than you normally would, find it difficult to remember things that people are telling you and need to have things repeated. You may feel agitated or hyperactive, or you might become more sleepy than usual. We will check you for subtle and early signs of this type of confusion, as well as for what caused it. Common causes include constipation, pain, infections, new medications, and often simply the operation itself or not being in a familiar environment.

The good news is that most people who have delirium in hospital get better. It is only temporary and you usually recover quickly, although sometimes it can take longer to improve. Your relatives can help you by visiting and by filling in the 'This Is Me' document with the ward staff. This tells us all about your usual personality, your likes and dislikes, so we can care for you better while you are not feeling yourself.

If you do not usually have memory problems, having delirium can sometimes be an early sign of them developing. For this reason, if you have delirium we may suggest that you have an assessment of your memory once you have had time to fully recover and settle back in to your everyday life. You usually have this three to six months after you leave hospital.

Constipation
It is very likely that you will be more constipated than usual while you are in hospital. You will not be eating your normal diet and you will be moving around less and taking strong painkillers. We will offer you laxatives routinely from when you are first admitted. Do not be embarrassed: let us know if there is a laxative that has worked well for you before, or if the one we have prescribed is not working, because we can change it.

Chest infections
These are more common if you have not been able to get up out of bed and walk much after the operation. This is because your lungs cannot expand as much when you breathe in. Poor pain control causes a similar problem because it makes your breathing shallow. Sometimes there is no clear cause other than that your body has just been through a major operation and is weaker than usual.
You usually need a course of antibiotics to treat a chest infection.

Pressure sores
If you have found it difficult to get up and walking or to move around in bed, you can develop pressure sores in the areas where your weight is in contact with the bed. We treat these by trying to ease the pressure. This includes improving your mobility, if possible, and giving you a pressure-relieving mattress. The nursing staff will check your skin regularly for early signs of these developing so that they can be treated straight away.

Being more dependent on others when you go home

We do our very best to keep you as independent as possible. But despite the best surgery and therapy, you may not be able to get around and do things for yourself as easily as you did before you broke your hip. For some people this is a minor change but for others it can be more dramatic. You may need extra support when you leave hospital, either assistance with care at home or moving to a more supported environment. Whatever your circumstances, we will help you to arrange this.

Increased risk of dying

Breaking your hip and having surgery to repair it are major traumas to your body and they can be life threatening. If you break your hip, you have a greater risk of dying in the following year, even if the operation is as successful as it can be. This is usually because the fall that caused the injury is a sign that your body has been getting weaker or frailer for some time. The trauma of an operation can put even more strain on your body and make it harder to recover.

It is our policy to routinely talk to you or your family openly and honestly about this, if you wish. In particular, we will talk to you about attempts to resuscitate you if your heart or lungs should stop working. The success of resuscitation depends a lot on the reasons why your heart or lungs stopped in the first place. Your doctor can talk to you about this and what it would specifically mean for you. If you would prefer not to talk about this, please tell us and we will respect your decision.

What are the risks of having an anaesthetic?

There are several types of anaesthesia and each has different benefits and risks. You may have more than one and the choice will depend on our assessment of your condition and the type of surgery you are going to have. We will take care to decide which is the safest and most appropriate for you and explain our decision to you. Here we describe the main types.

General anaesthesia

You will be completely asleep during the operation with this type of anaesthetic. You are given the drugs through a drip line into a vein, usually in your arm (intravenously) and/or drugs that you can breathe in, before and while you are having the surgery.

Neuraxial block

This puts local anaesthetic around the nerves supplying your hip, high up as they leave your spine, in your back. You are given it either as one injection into your spine or as an epidural, which involves having a thin plastic tube (catheter) put into your back. It keeps you comfortable throughout the surgery and can also be used after the operation to ease pain. You will be awake, but under sedation, during the operation. You will not be able to feel any pain. You may feel the surgeon pushing on your hip area but this should not feel uncomfortable.

Regional nerve block

This puts local anaesthetic directly around the nerves in the hip. To do this accurately and safely we use either an ultrasound scan to guide us or a peripheral nerve stimulator. A regional nerve block keeps you comfortable throughout your surgery. You will be awake, but under sedation, during the operation. You will not be able to feel any pain. You may feel the surgeon pushing on your hip area but this should not feel uncomfortable.

Are there any alternatives?

We cannot mend your hip without an operation. The bone takes many weeks to repair by itself, during which time you would not be able to walk on the affected leg and it might be very painful. This means you would be bed bound for a long time, increasing your risk of chest infections and pressure sores. There would need to be a very good reason for your surgeon not to offer you an operation, and this would be only if the risks of surgery were very high for you.

Consent

We must by law obtain your written consent to any operation and some other procedures beforehand. Staff will explain the risks, benefits and alternatives before they ask you to sign the consent form. If you are unsure about any aspect of the procedure or treatment proposed, please do not hesitate to speak with a senior member of staff again.

The team caring for you

Orthopaedic (bone) surgeon and their team. They specialise in operations on bones and will be the main team caring for you. They will co-ordinate information from other teams caring for you until you get better.

Senior nurse co-ordinators (trauma nurse or neck of femur nurse) are specialist nurses who will co-ordinate the work of several of the teams involved in your care.

Medical specialists will review your progress regularly to assist the surgical team with any medical problems that you might have.

Nurses and healthcare assistants are based on the ward and help you to recover from the operation and get better.

Physiotherapists support you to build up your muscle strength and get walking again.

Occupational therapists help you with any changes you might need to make in your everyday life, so you can be as independent as possible.

Pharmacists will review your medications when you are admitted to hospital and when you are discharged.

Anaesthetists help the surgical team to plan and carry out a safe operation. They may also give you different types of pain control for the operation.

Section 3:

Before your operation

This section explains what happens before your operation, where you will be treated and why. When you first come into hospital, the doctors and nurses in the Emergency Department (ED) will look after you. They will assess you and then refer you to the orthopaedic (bone) surgeons who will be responsible for your care. You will then meet an anaesthetist who will help the surgeons decide the safest way to do your operation. You will also be assessed by a medical team that specialises in caring for people over 65 with surgical conditions such as broken hips.

What happens in the Emergency Department (ED)

The doctors and nurses in the Emergency Department (ED) will assess you by doing some basic investigations to diagnose your broken hip. They will also treat your pain and make you more comfortable. Here we explain some of the tests and procedures that usually happen while you are in ED and why you have them.

Hip x-ray

An x-ray allows the doctors to confirm that your bone is broken. Sometimes it can be difficult to see a small fracture on an x-ray image. If there is any doubt, the emergency or orthopaedic doctor may arrange for you to have a CT or MRI scan as well.

Chest x-ray

People often break their hip because of a fall. A chest x-ray allows us to see if you have a chest infection that may have caused this. The anaesthetist will also use this x-ray to help plan the safest type of anaesthetic for your operation.

Electrocardiogram (ECG)

This shows us how well your heart is working. We attach sticky sensors to your chest which send signals from your heart to a machine. This helps us to find out why you might have fallen over and to plan your operation safely.

Pain relief (analgesia)

Broken hips are painful so we will offer you painkillers such as paracetamol, ibuprofen, codeine and morphine. It is important to us that you are not in pain, so please tell us if you are uncomfortable when you are moving or lying still.

We might offer you an injection in the groin for the pain called a nerve block. This is a local anaesthetic which we inject around the nerves supplying your leg using an ultrasound scan to guide us. This will numb your leg but also make it difficult to move it. The numbness will wear off in about 12-24 hours and should not be a problem as you will not be able to walk on your injured leg before the operation.

Catheterisation
A catheter is a thin, flexible plastic tube used to drain your bladder and collect urine (pee) in a bag. It is usually put into the tube (urethra) that carries urine out of your bladder.

After your operation, you will not be able to walk or get to the toilet. We will offer you a bedpan until you are walking again but this can often be quite painful to move onto. Having a catheter put in means that you do not have to worry about this.

Sometimes we use a catheter to check how much urine you produce. For example, if you are very dehydrated or to see how well your kidneys are working. We will take it out as soon as possible after the operation.

Surgical review
The orthopaedic doctors will review you in the ED before you move to the surgical ward. They will assess your injuries and decide which type of operation you need (see page 4).

Do I need to prepare for the operation?

You can eat and drink up to six hours before the operation and drink clear fluids up to two hours before. After this time, we usually give you fluids intravenously through a drip line, a thin tube that is put into vein in your arm.

What happens before the operation?

One of our anaesthetic team will come and see you to decide the best anaesthetic for you and the operation you are having.

They will ask you some questions about your heart and lungs, any previous neurological problems and how much exercise you can normally do without getting out of breath. They will also ask you about any regular medications you take because some can affect how anaesthetics work. The anaesthetist will also examine you, in particular assessing your airway and spine.

The anaesthetic you have also depends on the results of some of the routine tests you had earlier (see page 10). Sometimes we need to do more detailed tests on your heart or lungs to make the decision safely. If you need these, we will explain them to you in more detail.

Section 4:

After the operation

In this section we explain what happens over the first few days after your surgery, while you are recovering in hospital.

The surgical and medical teams will come to see you after your operation. You will also meet a team of therapists whose aim is to get you as mobile as possible, as quickly as possible.

While you wake up from the operation, you will be on the recovery ward. If we need to observe you more closely straight after surgery, you may stay here a little longer or be moved to the high dependency area of the Intensive Care Unit until you are well enough to return to the general ward again.

When will I start rehabilitation?

This starts straight away. The aim of surgery is to enable to you to put weight through your injured leg and start using your hip again the very next day. On the first morning, a physiotherapist will supervise you while you get out of bed for the first time. They will then provide personalised instructions to the nursing team so they can help you with this from then on.

The therapists will aim to see you almost every day during your rehabilitation. In between sessions, they will give you exercises to do yourself, if you are able. It is important to remember that everyday things you could do easily before the injury may now take much more effort. Rehabilitation is all about getting used to doing these things again and your therapy sessions are just one part of this. As you progress in the first few days after your surgery, the physiotherapists and occupational therapists will work with you to set goals for you, depending on what you could do before the operation.

What painkillers will I be given?

To be able to take part in rehabilitation, it is essential that your discomfort is well controlled at all times: when you are lying still, moving in bed, getting out of bed and especially while walking. Everyone has a different pain tolerance threshold. If your painkillers are not enough, please tell a nurse or doctor so they can change your prescription.

In addition to regular paracetamol, we will prescribe you a morphine-based drug. We will start you on a small dose until we work out how much you need and how often.

Some people worry about becoming addicted to painkillers so try to avoid them. You have had a very painful injury for which most people need strong painkillers. So it is normal to need to take painkillers. If you notice that you want painkillers when you are not in pain, this is a sign that you may be becoming psychologically dependent on them. If you think this may be happening, please let us know. We can work around it with you. It is still no reason for you to be in pain.

While taking strong painkillers, some people have funny sensations, such as hallucinations or confusion. If this happens, we can alter the medication and find one to suit you.

When will I have my medical review?

A member of the medical team specialising in caring for people over 65 having surgery will come to see you. This is usually before you operation or up to three day after your arrival in hospital. They will want to find out any medical (non-surgical) problems - current or past - that may affect the surgery or your recovery. They will also be interested in why you fell and whether or not you have osteoporosis. They will do a general physical examination and an assessment of your memory. They will ask about the medications that you take normally and why. This is important because you may need to stop taking some medications for a short time around the operation.

Here we explain some of the things that they will be looking at.

Cause of your fall

It is important to know why you fell over if it was not a simple trip. Often there is a reason that we can treat or help to correct, to prevent you from falling over again. We will speak to you, and sometimes your family too, about how and why you fell. If you have been falling over regularly, we can do something to help. We will also do some blood tests and discuss the results with you. Occasionally, if you need special tests, we can arrange these after you have left hospital, and will follow up the results with you in clinic.

Bone health (osteoporosis)

As you have broken your hip, you may have osteoporosis, a condition which makes your bones weaker. You may have this without knowing it. Broken bones are often the first sign of this condition, so we will assess you for this while you are in hospital. This involves having some simple blood tests and asking you some questions about your lifestyle and other medical problems.

We will then give you a personal management plan, which may involve taking medication to help strengthen your bones while you are in hospital. You may need more tests when you are better. This is usually a quick scan called a DEXA (Dual Energy X-ray Absorptiometry), which measures the strength of your bones. We often do this for you as an outpatient, after you have left hospital.

We will invite you to a osteoporosis clinic for a follow-up appointment two to three months after you go home. We will review your condition and check how you are getting on with your medication, if you have already started it.

If you would like to know more about osteoporosis, please ask a member of staff. They can provide you with detailed leaflets from the National Osteoporosis Society.

Section 5:

Going home

Where will I continue my recovery?

How long you stay in hospital depends on many things, such as how well you could walk before the operation, your general health and any complications after your surgery.

As you improve over the first few days, the therapists will recommend the most suitable place for you to continue your rehabilitation. This is usually in your own home, if you are able, with help from carers and therapists. This is called **Home Based Intermediate Care Therapy (ICT)**.

Sometimes your progress will be slower or you will need more assistance during the day, so being at home would not be practical at this point. In this case, you have two options: you can move to a special rehabilitation unit which offers **Bed Based ICT**, or continue your rehabilitation in hospital. This will depend on whether the borough where you live has a Bed Based ICT facility and whether you are medically stable enough to leave hospital.

Sometimes you may need to continue your rehabilitation in hospital for a longer time. This could be for a number of reasons. For example, if you need ongoing medical attention or nursing care, or if your borough does not have a rehabilitation unit. In this case, you will usually stay on the orthopaedic ward or be moved to a specialist ward that cares for older people if we think that would help you more.

When will I have the clips taken out of my wound?

We usually use metal clips to hold your surgical wound together. These should stay in place until your wound looks like it is healing well, with no signs of infection. The clips are usually taken out 10-14 days after your operation.

Will I have to take new medications?

While you are in hospital, we may give you new medications. The doctors and pharmacists on the ward will explain what they are for and how to take them. When you leave hospital we will give you two weeks' supply of all of your medications. We will send a letter to your GP (home doctor) so they can give you repeat prescriptions.

How long will it take to get back to normal?

It may take you many months to get back to normal after surgery. You will probably be on painkillers when you leave hospital and you should continue taking these for as long as you need to. It is important for your rehabilitation that pain does not limit your movement. As the pain gets better, you will be able gradually to take less of the painkillers and eventually stop them.

The leg on the side of your broken hip may be swollen for several weeks after surgery. This is normal and is because you will naturally use this leg less. If your leg becomes very swollen, red, and painful,

this can be a sign of a serious condition called deep vein thrombosis (DVT). It is important that you contact your GP or go to your local (ED) as soon as possible for medical advice.

When can I drive again?

You usually cannot drive for about six weeks after your operation. It is then a good idea to test your hip to see if driving will cause it any undue strain. Without turning on the engine, get in your car, sit in the driving seat and firmly press the pedals. If you feel pain during or after this exercise, you are not ready to drive yet. You must be able to freely perform an emergency stop before you are safe to drive again.

You must also check with your insurance company when they will legally cover you to start driving again. This depends on the company but it is often a number of weeks.

For three weeks after surgery, avoid sitting in a car too long as this position can put strain on the muscles and tissues around your hip.

If you are a bus or lorry driver, please contact the DVLA for advice.

When can I fly again?

The Civil Aviation Authority (CAA) recommends that you wait three months after a hip replacement before flying, but airlines often have their own rules so you should check with your airline before flying.

Outpatient clinic appointments

With orthopaedic surgeons

Date: .....

Time: .....

With osteoporosis clinic

Date: .....

Time: .....

Letter goes to GP

Date: .....

Time: .....

Section 6:

Contacts

Who can I contact with queries and concerns?

- For routine queries, contact your GP.
- In an emergency, go to your local hospital.
- Hospital contact: Consultant Secretary
  Tel: **020 3299 6085**

Where can I find more information?

Age UK
www.ageuk.org.uk

National Osteoporosis Society
www.nos.org.uk

Care provided by students

We provide clinical training where our students get practical experience by treating patients. Please tell your doctor or nurse if you do not want students to be involved in your care. Your treatment will not be affected by your decision.

PALS

The Patient Advice and Liaison Service (PALS) is a service that offers support, information and assistance to patients, relatives and visitors. They can also provide help and advice if you have a concern or complaint that staff have not been able to resolve for you.

PALS at King's College Hospital, Denmark Hill, London SE5 9RS
Tel: **020 3299 3601**
Email: **kch-tr.pals@nhs.net**

You can also contact us by using our online form at **www.kch.nhs.uk/contact/pals**

If you would like the information in this leaflet in a different language or format, please contact PALS on 020 3299 1844.

www.kch.nhs.uk
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