Fractured Neck of Femur

Orthopaedics
**Introduction**

This leaflet has been designed to help you and your relatives have a better understanding of your injury, the operation you require and what to expect from your stay in hospital.

During your stay in hospital if you or your next of kin have any questions please do not hesitate to contact the ward sister or any of the team.

**What is a fractured Neck of Femur?**

The femur (thigh bone) is one of the largest and strongest bones in the body. A fractured neck of femur is when the top part of this bone is broken. This type of fracture will normally require surgery. The type of surgery will depend on where the fracture is.

Here are the more common types of operations:

- **Total Hip Replacement**
- **Per-trochanteric Fracture**
- **Intra-medullary Nail**
- **Dynamic Hip Screw**

Illustrations by Felicity Pease
People involved in your care

- Orthopaedic Surgeon - will perform your operation. The surgeon or a member of the team will review you throughout your hospital stay.
- Anaesthetist – will assess your health for an anaesthetic. They will look after you during surgery
- Medical Doctor – is ward based and will review you on a daily basis.
- Orthogeriatric Team – will review you on a weekly basis
- Nursing staff and Health Care Assistants – will look after all your care needs
- Physiotherapist - will assess you following your surgery to enable you to regain your mobility. They will provide you with the most appropriate walking aids and advise on any exercises needed.
- Occupational Therapist – will help you achieve independence in performing daily tasks such as washing and dressing and meal preparation. They will also organise any equipment you may need to assist you on your discharge from hospital.
- Social Worker – will organise any assistance on your discharge from hospital if required.

Other members of the Multi-Disciplinary Team may be involved in your care as required.
Pre-operatively (before your operation)

When you were in Accident and Emergency (A&E) you will have had an x-ray to confirm there is a fracture. Occasionally, fractures are not always clear on x-ray and a more detailed MRI or CT scan is needed. This will be arranged if required.

The hospital now has a policy to screen all patients aged 75 or over for memory problems and confusion. On admission, you will have been asked a simple question about your memory. If your response indicates that you might have a problem (which could be only temporary) you will then be asked the 10 questions that make up the Abbreviated Mental Test (AMT). You might be asked to fill in a ‘This is Me’ booklet, which allows the people who look after you in hospital to know you a little better. Your friend or family member can help with this.

A&E staff will have also taken blood tests and carried out an ECG that shows the rhythm of your heart. These investigations help us to make sure you are fit for surgery.

Prior to going to theatre you will need to remain in bed to prevent the fracture from worsening. Whilst in bed you may be at risk of developing pressure sores. In order to minimise this you may have a pressure relieving mattress. However, it is also essential that you change position regularly. The nursing staff will assist you to do this.

When you need the toilet, ring your bell and ask for a bedpan or urinal. Occasionally people find it difficult to pass urine when in hospital. If this is the case staff will discuss with you the option of a catheter; a small tube inserted into the bladder to drain urine. This will then be left in place until you are a little more mobile after your operation and your bowels are functioning normally.
You will be allowed to eat up to six hours prior to your operation. Clear fluids (including black tea and coffee) are allowed up to two hours before. Pre-operative supplement drinks may be prescribed to aid recovery by maintaining your strength and will assist with wound healing.

A ‘drip’ is a small needle inserted into your vein through which you will be given fluid. This continues until you are eating and drinking properly after your operation and it will help keep you hydrated.

**Consent**

Before you have your operation one of the surgeons will explain the procedure and discuss associated risks and complications.

You will get the opportunity to raise any concerns you may have and ask any questions. You will then be asked to sign a consent form and an arrow will be drawn on your leg.

When a patient lacks the capacity to give consent all effort is made to discuss the procedure with the next of kin. In the event that this is not possible, the surgeon responsible for their care will make the decision in the patient’s best interest.

**Your anaesthetic**

Anaesthesia stops you feeling pain and other sensations. It can be given in various ways and does not necessarily make you unconscious.

Before your operation you will be seen by an anaesthetist. They are doctors with specialist training who will discuss the different types of anaesthesia and agree a plan with you for your anaesthetic.
**General anaesthesia**

General anaesthesia is a state of controlled unconsciousness. It is essential for some operations. You are unconscious and do not feel anything at all.

**Spinal and regional anaesthesia**

A spinal or regional anaesthesia involves injections that numb a large or deeper part of the body. You stay conscious but free from pain. Sometimes sedation is given with local and regional anaesthesia to help you to relax.

**When will I get my operation?**

We aim to do your operation within 36 hours of admission unless you are not medically fit enough for surgery; this will be decided by a member of the anaesthetic team. If this is the case your surgery will be delayed until the team is happy you are well enough. You will be informed of this and every effort will be made to get your operation done as soon as it is safe to do so.

**Possible risks and complications**

With any injury and operation there are always risks. Although you need to be aware of these, they are just possibilities. Your risk of developing complications will depend on your age and general health prior to admission.

**Acute confusion**

An episode of confusion is quite common following an operation. This will be related to the change of environment, medication, blood imbalance, low oxygen levels and the anaesthetic. This can be a distressing time for both you and your family, though please be aware that this is usually only short term. You will be closely monitored during this period.
**DVT**

Deep Venous Thrombosis (DVT) is a blood clot in a vein that can travel through the blood stream into the lungs where it causes a pulmonary embolism (PE). The best way to prevent blood clots is to get up and moving as soon as possible. In addition, it is advisable to do regular circulatory exercises. These involve pulling your toes up to the ceiling and then pointing your toes repeatedly thirty times every hour.

**Pressure sores**

As your mobility is reduced you are at greater risk of pressure sores both before and after your operation. The areas most at risk are your sacrum (bottom), elbows and heels. The best way to prevent pressure sores is to get up and moving as soon as you are advised. Your pressure areas will be checked regularly by a member of staff and it is important that you report any sore areas as soon as possible.

**Swelling of the legs**

Swelling of the legs is very common following this type of injury and operation. It is essential that you keep moving in order to reduce the swelling. You are advised to rest in bed for a couple of hours in the afternoon to help reduce swelling.

**Bleeding**

There is always some bleeding during your operation. Sometimes, blood loss is sufficient to need a blood transfusion.
Infection

Wound:
There is always a risk of infection with any invasive procedure although we will do all we can to reduce this risk. You will be given antibiotics into your vein just before your operation begins and again after it is completed.

Despite this, a small number of patients develop wound infections causing increased redness, pain and swelling to the wound. There may also be some discharge from the area. If this does develop, you will be given a course of antibiotics either in tablet form or directly into your vein. On occasions, antibiotics may not be enough to get rid of the infection and a further operation to wash out the joint may be required. In a small number of cases the metalwork used to fix your fracture may have to be removed and replaced at a later date.

Chest:
There is a risk of developing a chest infection or other respiratory complications. The best way to avoid a chest infection is to get up and moving as soon as advised.

When you are in bed it is important that you sit up as much as possible, take three deep breathes and hold the breath in for three seconds, repeat every hour, cough regularly, spitting out any phlegm.

Urine:
There is a risk or developing an infection in your bladder due to a number of factors. Tell the nurses if you have pain passing urine, increased frequency or loss of control. Urine infections are generally simply treated with antibiotics.

Dislocation
If your operation involved the ball within the joint being
replaced, then there is a small risk of dislocation (the ball coming out of socket). This may require a further operation.

**Post operatively (after your operation)**

When your operation is over you will wake up in recovery. Once you have recovered from the anaesthetic you will return to the ward. You may still feel very tired and may sometimes feel disorientated. You may have an oxygen mask on to aid your breathing and to help you to wake up.

One of the nursing team will monitor your temperature, blood pressure, pulse and oxygen levels regularly over the next few hours.

Your pain will be assessed and you will be offered pain relief regularly. It is very important that you take regular pain relief as this will mean you will find it easier to start moving again. If you feel the pain relief is not adequate please let one of the team know and they can adapt your medication accordingly.

You will be allowed to eat and drink once the anaesthetic has worn off. You will first be offered water and then a hot drink and something to eat.

The following timetable is intended as a GUIDE after your surgery. All patients are different and progress will vary from patient to patient.

**DAY 1**
- You will have a blood test
- You may have an X-ray
- You may have a urinary catheter into your bladder
- Do your circulatory and deep breathing exercises regularly in the day
- If you are well enough, you will be helped out of bed
and encouraged to take a few steps using the most appropriate mobility aid, and will be seated in an armchair

- Most patients are able to put all their weight through their operated leg. However, depending on the type of surgery you may have had, this may be restricted. The physiotherapist will discuss this with you if appropriate.
- To help you to move more comfortably, we strongly advise you to take painkillers regularly

**DAY 2/3 onwards**

- You will be assessed by a member of the Physiotherapy team who will encourage you to gain more independence with your walking and if needed teach you specific exercises
- The Physiotherapy team will advise you on the most suitable walking aid and encourage you in returning to your previous level of mobility
- Continue to practice your walking with supervision/assistance as advised. It is essential you get up and walk regularly
- REMEMBER: walking with the physiotherapists is not enough and you should use opportunities to practise your walking with other members of staff. The Physiotherapists will advise you when you are safe to walk without assistance/supervision.
- The Occupational Therapist (OT) will ask you, or the person who will look after you on discharge, more specific details about your home environment and how you managed your day to day activities prior to your hip fracture
- You may be issued with a Furniture Height form by the OT. Please ask a relative or friend to complete the form with the details of heights of your chair/bed/toilets at home and return it to the ward as soon as possible.
- Ask your family/friends to bring in suitable day clothes for you, they should be comfortable and allow easy access to
the wound. Suitable footwear is also essential. Footwear that is ‘worn in’ will be more comfortable and easier to get on as your feet and ankles will swell after surgery.

- Practice getting dressed in your day clothes. If you have any problems, inform a member of the OT team.
- The OT will discuss with you how you will manage to complete day to day activities, for example, getting washed and dressed, meal preparation.
- As your mobility improves you may progress to walking with crutches or sticks
- As you progress with your rehabilitation the OT will assess whether you require any assistive equipment, for example, toilet raise, chair raisers to enable you to be as independent as possible on discharge. Should equipment be needed the OT will discuss this with you.
- The nursing staff will check your wound regularly
- Before you go home, you will practice any steps or stairs (if relevant) with the Physiotherapy team
- You will need to consider how you will get home from hospital. Do you have any relatives or friends who can collect you?
- Ask family and friends to help with heavy domestic tasks, for example, shopping, vacuuming, and bed changing.
- If you are concerned about managing at home following your discharge from hospital, ask to speak to a member of the Social Work Team.

Your wound

The nursing staff will monitor your wound. If you have clips or stitches, they will be removed 10-14 days after your operation. This can be done by a practice or district nurse, a member of our community team or a ward nurse if you are still in hospital.
Reducing the risk of blood clots

As mentioned previously there are a number of ways in which to reduce the risk of clots. The most important one for you to remember is to keep moving!

However, there is also medication that is used to further reduce this risk. This injection is given daily into your stomach; it is very short and feels like a bee sting. This will need to be given for a total of 28 days. If you unable to administer this yourself you will be referred to a practice or district nurse. This injection is not suitable for all patients.

Bone health

After your operation you will be seen by the Orthogeriatric team. They will talk to you about why/how you sustained your injury and ask about any previous fractures.

Due to the fact that you have suffered a broken hip it is possible that you have a very common condition known as osteoporosis.

If you are over 75 you will be treated for this condition with medications that strengthen the bones. There are a number of treatment options each given differently. The most appropriate medication will be discussed with you. It is essential that you continue to take this medication as stopping it may increase your risk of further fractures.

If you are younger than 75, a bone scan may be arranged in order to look at the density of your bone. This is usually done as an outpatient.

As well as starting new medication to protect your bones, the doctor may discuss diet and lifestyle factors and change other medication you are taking. This is because some medications can make you feel unsteady and increase the risk of falls.
Discharge

Planning for your discharge will begin shortly after you are admitted to hospital. Our aim is to ensure as many people as possible are discharged safely back to their original place of residence. Should the therapy team feel that you would benefit from some additional rehabilitation once you have been discharged, they will refer you to a Community Rehabilitation Team who will arrange to visit you at home.

If you live alone, you may wish to organise someone to stay at home with you initially on discharge.

In some circumstances we refer people to a community hospital closer to their home. This is the best option for those patients who require an extended period of rehabilitation before returning home or those with complex rehabilitation issues. Should this be required the nursing or therapy staff will discuss this with you. If possible, we ask that you arrange with a relative or friend to collect you from the hospital when you are ready to be discharged. If you have any concerns about transport home, please speak to the nursing staff.

Reduce your risk of falls

Falling is one of the most common causes of hip fractures. However, there are a number of ways in which to reduce the likelihood of falling at home;
- Keep warm! Cold muscles do not work as well and contribute to accidents.
- Keep active! A little exercise will keep you fit and stronger.
- Remove or secure loose rugs to prevent tripping.
- Secure any loose cables and wires.
- Ensure your home is well lit.
- Make sure your footwear is flat and supportive.
- See your GP if you have any faint or dizzy spells.
**General advice**

If you develop pain in your calf or chest or if your wound becomes increasingly red, hot and painful, contact your GP or go to your local emergency department urgently.
Visiting times on the wards are 2pm - 4pm and 6pm - 8pm. We ask that patients have a maximum of 2 visitors at any time.
Please ask your visitors to use the chairs located at the end of each bay.

**Contact information**

Portman Ward; 1st floor of Queens building:
Telephone 01823 343020

Gould Ward; 2nd floor of Queens building:
Telephone 01823 343024

Occupational Therapy Team:
Telephone 01823 342247

Physiotherapy Team:
Telephone 01823 344965

Somerset Direct:
Telephone 0845 345 9133

Red Cross:
Telephone 01823 273746