Clinical Practice Guideline Department — Suspected Fractured Neck of Femur Emergency Department

Purpose
To provide clear and concise recommendations for emergency personnel in Frankston Emergency Department to ensure timely, quality care for emergency patients with a fractured neck of femur leading to improved outcomes and cost-effective care.

Scope
Nursing staff, Medical Staff and Allied Health staff in Emergency Department.

Definitions
NOF- Neck of Femur

Indications
Patients with a suspected fractured NOF without contraindications

Please note that NOT all components of this guideline may apply to all patients. Please use clinical judgement

Contraindications
Complicated fractures, Coagulopathy Issues, Medical issues e.g. Delirium, Uncontrolled Diabetes, Cardiac Arrhythmias, Abnormal Na/K, Hemoglobin less than 8

Guideline
Treatment in the Emergency Department
All patients that present at Frankston Emergency Department with a suspected fractured NOF should be triaged category 3 or if severe pain category 2. The triage Nurse will order the electronic Nursing Clinical Pathway for Suspected Fractured Neck of Femur which will prompt the responsible Nurse to complete the following assessments in collaboration with the Medical Officer.

- ABCD Survey
- Vital signs and checking of allergy status
- Neurovascular assessment and vital signs
- **Pain assessment on a pain scale within 30 mins of arrival and ensure the use of multimodal analgesia for pain management if needed. Review the patient's pain management within every 30 minutes until the patient is comfortable**
- X-ray – Appropriate side Hip x-ray. (This will include AP pelvis(Charnley view), side appropriate lateral view, and templating views as needed).
    - If no fracture NOF is identified on x-ray, and clinical suspicion for hip fracture remains high, consult the Emergency Consultant or Orthopaedic Registrar for the need of CT or MRI.
- **Consider early femoral/ fascia Iliaca nerve block by an experienced Medical Officer with or without confirmation of fracture**
- Cognitive and falls risk assessment. To remain non-weight bearing until approved by medical staff to do so
- Remain nil by mouth until approved by medical staff for diet and fluids
- If there is a confirmed fractured NOF in a person less than 60 years of age, an **URGENT** referral is required to the orthopaedic registrar on call (**including overnight**). Early surgery will minimize the risk of necrosis of the head of femur

- Confirmed fractures should also have

  - Chest X –ray
  - 12 Lead ECG
  - Pathology - FBE, U&Es, G&H, INR/APTT
  - Appropriate IV fluids ordered
  - Appropriate analgesia ordered

Admission process
Upon confirmation of a fractured NOF, the Emergency Medical Officer will contact the Orthopaedic Registrar on call and admit under the Orthopaedic Unit.
If acute medical issues are identified, the patient will be referred to the General Medical Registrar and may be admitted under General Medical Unit with Orthopaedic Unit input. Medical stabilisation may be required before surgery. (Refer to Appendix One)

The Nurse in Charge will complete appropriate processes on First Net as well as inform the Patient Services Manager of admission and any special requirements i.e., Single room, Bariatric, Pressure- relieving mattress, and Skin Traction. Patient Services Manager is to inform the Orthopaedic ward of patient admission and requirements.

The Nurse in Charge or Bedside Nurse must confirm fasting status with Orthopaedic Team and if they require placement of a urinary catheter. Urinary catheters negate the need for female patients to use a bed pain which can increase pain and the need for opioid analgesia. Catheters are ideally inserted as soon as practicable. The insertion of a catheter should not delay transfer to the ward.

Key Legislation, Acts & Standards
The Australian Council on Healthcare Standards Hip Fracture Clinical Care Standard

References
1) ANZHFR Annual report for Hip Fracture Care 2015, 2016
2) Australian & New Zealand Hip Facture Registry 2016
3) Jenson CS Mak, Ian D Cameron and Lyn M March, 2010, Evidence-based guidelines for the management of hip fractures in older persons: an update, Med J Aust; 192 (1): 37-41
4) Management of Hip Fracture in Older People, A National Clinical Guideline, 2009, Scottish Intercollegiate Guideline Network (SIGN)

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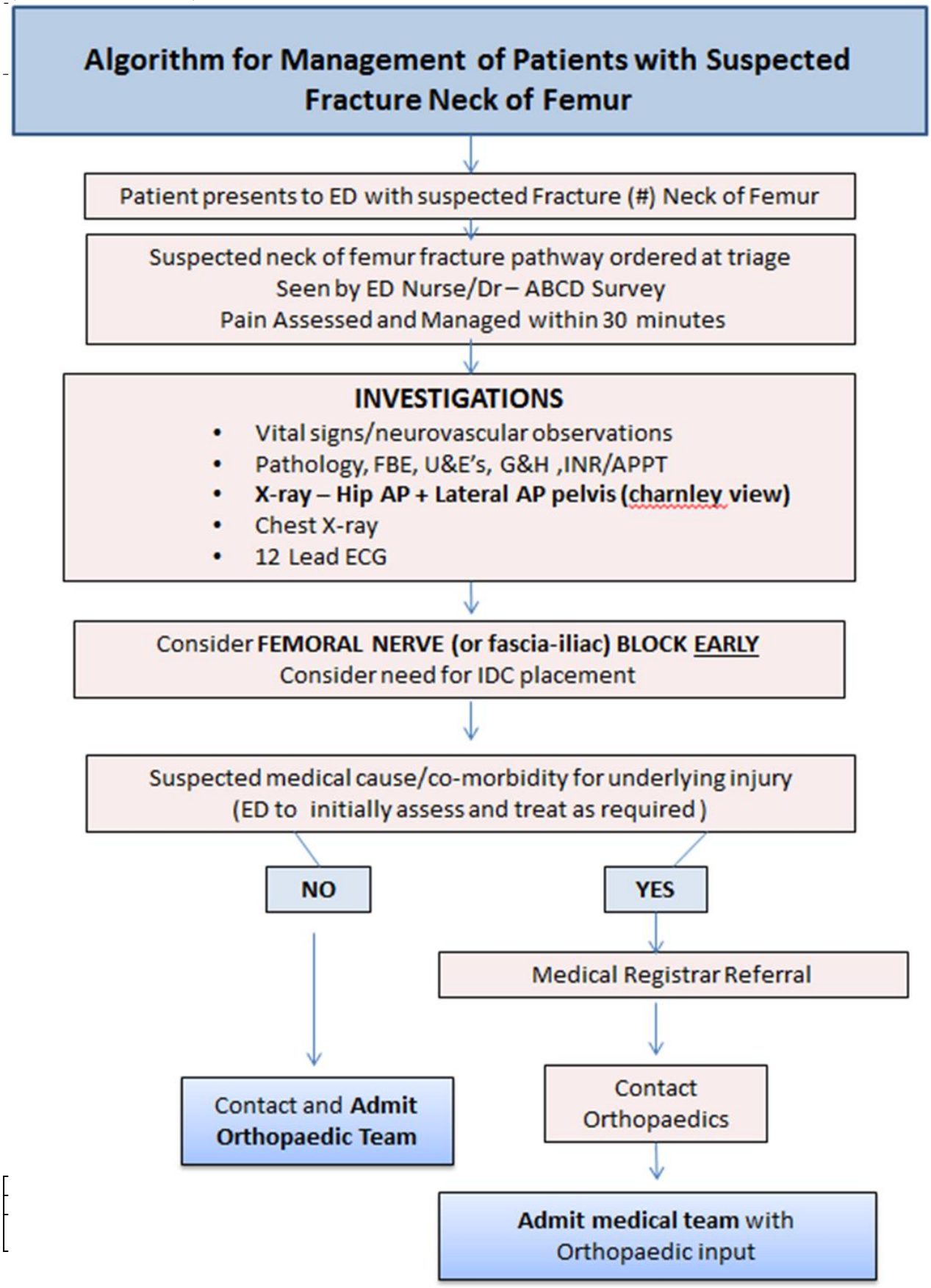
Algorithm for Management of Patients with Suspected Fracture Neck of Femur
Patient presents to ED with suspected Fracture (#) Neck of Femur
Suspected neck of femur fracture pathway ordered at triage
Seen by ED Nurse/Dr – ABCD Survey
Pain Assessed and Managed within 30 minutes
INVESTIGATIONS
Vital signs/neurovascular observations
Pathology, FBE, U&E's, G&H ,INR/APPT
X-ray – Hip AP + Lateral AP pelvis (charnley view)
Chest X-ray
12 Lead ECG
Consider FEMORAL NERVE (or fascia-iliac) BLOCK EARLY
Consider need for IDC placement
Suspected medical cause/co-morbidity for underlying injury
(ED to initially assess and treat as required)
NO
YES
Medical Registrar Referral
Contact and Admit Orthopaedic Team
Contact Orthopaedics
Admit medical team with Orthopaedic input