

Audit tool for SIGN Guideline 111: management of hip fracture in older people

This audit tool is based on recommendations from the guideline.

Aim

- to help measure current practice and assist in implementation of the SIGN guideline on management of hip fracture in older people

Target patient group

- older people with a hip fracture

Healthcare setting

- tertiary care/emergency department/orthopaedic or geriatric care

Instructions

This audit tool is designed to examine three areas of practice crucial to successful treatment and rehabilitation from hip fracture, grouped as Operational (o), Risk assessment (r), and multidisciplinary team related (m). This is arbitrary, but may allow individual units to identify particularly problematic areas of practice. We would suggest weekly collation of scores OVERALL (maximum 20), as well as total RISK ASSESSMENT score (maximum 11), total MULTIDISCIPLINARY score (maximum 4), and total OPERATIONAL score (maximum 5). The median score overall, and in the 2 domains, can then be collated for each audit cycle – and should be uploaded back to SIGN, if desired, after a minimum of 2 audit cycles.

The risk assessment items require interrogation of ED/paramedic documents, clerking, MDT discussion in trauma meetings, and nursing admission notes including risk assessment charts eg waterlow if used etc. Overall, the forms are usually completed most easily around 24 hours post-op.

Background

The 'Scottish Hip Fracture Audit' is a longstanding, comprehensive national project and this tool does not mean to replace it. Rather, it is hoped that this tool may allow interested individuals eg rotating junior doctors, nurse practitioners, to audit their own local practice against the SIGN guideline.

This audit tool was trialled in a large tertiary centre trauma unit, and changes made on the basis of recommendations from junior medical staff using the original forms.

Acknowledgements

SIGN is grateful to Dr Wendy Craig who was instrumental in designing and piloting this audit tool and accompanying information.

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Patient ID (including DOB and CHI number)	
Name of person completing this form	

OPERATIONAL

Did medical staff assessment, whether ED or ward, take place within an hour of arrival?

Score 1 for YES, 0 for NO

Was there an unnecessary delay in the timing of SAFE surgery for a fit patient?

If patient unfit score as NO, 1 point as delay here is OK

If patient fit score 1 for NO, 0 for YES

Did the patient receive their operation out of hours (0000-0800)?

Score 0 for YES, 1 for NO

Did the anaesthetist in charge of the patient have an interest in trauma orthopaedic/elderly medicine?

Score 1 for YES, 0 for NO

Was a supported discharge package used, where applicable in the case management?

Score 1 for YES, 0 for NO

TOTAL OPERATIONAL SCORE /5

RISK ASSESSMENT

Did the first formal assessment of the patient include (r)

Pressure sore risk

Hydration and nutrition

Fluid Balance

Pain

Core body temperature

Continence

Coexisting medical problems

Mental State

Previous mobility

Previous functional ability

Social circumstances/carer arrangements

(Score 1 for each Y)

TOTAL RISK ASSESSMENT SCORE /11

MULTIDISCIPLINARY INPUT

Was a dedicated geriatrician physician available routinely within the unit for ongoing patient management?

Score 1 for YES, 0 for NO

Was the patient's postoperative mobilisation and rehabilitation begun within 24 hours of the post operative period?

Score 1 for YES, 0 for NO

If not fit at 24 hours due to comorbidity, score YES if no delay in achieving mobilisation at acceptable time scale for that patient

Was there clear documentation of multidisciplinary discussion and planning in this patient's progress notes towards rehabilitation?

Score 1 for YES, 0 for NO

Was there multidisciplinary input to the discharge planning?

Score 1 for YES, 0 for NO

TOTAL MULTIDISCIPLINARY SCORE /4

OVERALL TOTAL SIGN-COMPLIANCE SCORE /20