Improving Service Involving Ceiling of Care in Frail Hip Fracture Patients- Quality Improvement Project

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INTRODUCTION:

Ceiling of care in frail elderly patients, who are admitted with a hip fracture, can be challenging at times. It is good practice that such decisions are made upon admission, prior to the surgery, involve patients and family members and are consultant led, whenever possible. British Orthopaedic Association (BOA) has issued a national guidance focusing on the same. The aim was to do a quality improvement project (QIP) focusing on the clinical practice surrounding appropriateness of “resuscitation/no resuscitation order” in frail hip fracture patients.

METHODS:

Initially, an audit was registered and undertaken locally to investigate the current practice and compliance. Patients > 75 years with hip fractures were included. Afterwards, the results of the audit were presented in the departmental audit meeting and suggestions noted. Key interventions introduced to improve compliance included: “mandatory section on resuscitation in hip fracture clerking proforma”, posters in emergency and Orthopaedic department as visual prompts, positive reinforcements in trauma meetings and handovers and spreading awareness in induction programs for new starters. A second audit was done to investigate improvement, if any.

RESULTS:

There were 49 and 51 patients in first and second cycle respectively. Mean age was 85 years (range 75-104) and 85 years (range 75-95) in first and second cycle respectively. Decision on “resuscitation/DNAR” pre-surgery was made in 53% and 100% cases in first and second cycle respectively. Consultant led DNAR decisions were 65% and 100% in first and second cycle respectively. Discussion with family pre-surgery improved from 47% in first cycle to 80% in second cycle.

DISCUSSION AND CONCLUSION:

This QIP showed marked improvement in the clinical service involving difficult decision-making of ceiling of care/resuscitation in frail hip fracture patients. Simple interventions were enough to achieve the same. This can lead to a better and healthier relation between patients/family members and health care teams and can minimise the problem of complaints and litigation. This also reduces pressures on “on-call teams” who would sometimes have to make such complex decisions out of hours, which is both inappropriate and unsafe.