CLINICAL PRACTICE GUIDELINE (CPG): Hip Fracture Guideline

DATE OF ORIGIN: 10/18/2024
REVIEWED/UPDATED: Online Vote 3/12/2025

PHYSICAN CLINICAL JUDGEMENT SUPERSEDES THIS GUIDELINE

PURPOSE: The purpose of this guideline is to facilitate timely and appropriate management of geriatric hip fractures with low energy mechanism of injury.

PROCEDURE: use this guideline to apply principles of geriatric trauma co-management to ensure best patient care for geriatric patients with hip fractures.

1. ED physician to evaluate patient and obtain orthopedic/trauma consult as appropriate.
    a. Modified geriatric considerations (*See Trauma Team Activation Guidelines (PCECT-620) for additional details) for trauma team activation includes:
        i. *Current use of anticoagulant or platelet inhibitor (excluding ASA)*
        ii. *>1 medical co-morbidities (DM, HTN, CAD, COPD)*
        iii. *Acute alteration in mental status, GCS <15 or (+) LOC with associated head trauma*
        iv. *SBP <110 with traumatic mechanism*
2. ED physician, orthopedic surgeon, or trauma surgeon to obtain hospitalist consult when appropriate.
3. Strongly consider hospitalist consultation.

DEFINITIONS:

Geriatric – Defined for this document as greater than or equal to 65

Low energy mechanism – patient fall from standing height or less

Hip fracture – Femoral head, femoral neck, intertrochanteric/pertrochanteric, and subtrochanteric (w/in 5cm to the lesser trochanter).

POD – Post-Op Day

GUIDELINE:

I. Initial Management (Emergency Department):
    a. Admission determination:
        i. Poly-trauma: **Trauma admit**
        ii. Isolated hip fracture (<65) with no medical problems and no medical cause for fall (i.e. mechanical fall): **Orthopedic admit**
        iii. ≥65 and/or multiple medical comorbidities: **Hospitalist admit**
        iv. Patient with medical issue causing fall (i.e. syncope, cardiac event, stroke, etc.) to be admitted by appropriate specialty service.
        v. Patients with isolated hip fractures and multiple co-morbidities are appropriate for hospitalist admit
        vi. Orthopedic admission for patients not meeting either of the above 2 criteria
    b. Definitive surgical stabilization to be performed within 48 hours of admission

c. If admitted to medical service and NOT a trauma team activation:
   i. Consider a trauma consultation for patients with additional injuries
d. If Not admitted by medical service:
   i. Strongly consider medical consult for:
      1. ≥65 years of age
      2. Multiple medical comorbidities
e. Consider fascia iliaca block for refractory pain
   i. Consult ED physician (if available) or anesthesia

II. Pre-operative management
   a. Consideration for femoral nerve block. Determined by anesthesia team prior to operative intervention.
      i. Consider nerve block to be done in the ED for:
         1. Tensor fascia lata
         2. Iliacus block
   b. Cardiac consultation and echocardiogram are **NOT** routinely indicated unless cardiac event precipitates fall. Indications for cardiac consultation should be limited to unstable coronary syndromes, decompensated heart failure, significant arrythmias, and severe valvular disease.
   c. DVT chemoprophylaxis to be started on day of admission and continued throughout hospital course.
   d. Urinary catheter not to be placed unless clinically indicated for other reasons (i.e. home catheter, etc.).
   e. Begin discharge planning the day of admission.
   f. Follow all advance directive and POLST documentation.
   g. Consider a goals of care discussion, particularly in ≥65 years of age with multiple medical comorbidities, prior to intervention.

III. Post-operative management
   a. Occupational and Physical therapy to work with patient no later than POD 1.
   b. If present, urinary catheter to be removed POD 1, unless extenuating circumstances dictate otherwise.
   c. Utilize multimodal analgesia to control pain.
   d. Utilize methods for delirium prevention/management
      i. Refer to Lippincott Procedures: ***Delirium, care of patient***
      ii. Order: *H-ADULT Delirium Prevention Protocol*
   e. Nutrition consultation to be obtained prior to discharge.
   f. Consider osteoporosis screening if not already diagnosed.

REVIEWED BY:

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REFERENCES

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