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Hip Fracture Care in the Emergency Department: It's Time to Push Fast-Track

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Dear Editor,

Hip fracture is the commonest serious injury amongst older people[1]. The Irish Hip Fracture Standard One (IHFS1) requires that patients with hip fracture be admitted to an orthopaedic ward within four hours of presentation to the emergency department (ED)[2]. There is limited published data on the impact of coexisting acute medical issues at presentation and achieving this standard. This study aimed to quantify this burden of acute medical issues, as possible obstacles to safely fast-track patients with hip fracture from ED. Patients presenting with hip fracture to our hospital over one year (2019) were identified from the Irish hip fracture database (IHFD). A data collection proforma was created to record medical, radiological and laboratory details. Registration with the hospital audit research committee was sought. Data was anonymised, and analysed using Excel.

185 patients with hip fracture were included. 70% were female and median age was 81years. Altered mental status, syncope/seizure or acute coronary syndrome was documented in 2%, 0.5% and 0% respectively. Only 3% required review by the on-call medical team, one patient required review by a cardiologist in the ED. Significant abnormality was noted in fewer than 2% across all clinical vital signs. We noted an acute drop in haemoglobin (under 8g/dl) in 3%, raised white cell count (>15 10x5/L) in 6% and abnormal coagulation screen in 1% of cases. Mild derangement of sodium and potassium was noted in 0.5% and 6.5%, respectively. 89% had a chest radiograph; airspace or interstitial abnormalities were seen in a minority (7%). Computed tomography brain imaging was performed in 18% of patients, with acute abnormality (haemorrhage) reported in one. Despite the low prevalence of co-existent acute medical abnormalities in this cohort, a minority (12%) was fast-tracked to the orthopaedic ward within 4 hours. No other unavoidable reasons for delay were noted.

Demographics of this hip fracture cohort are similar to those described elsewhere[2,3,4]. Our results show that, even with age and multi-morbidity, almost our entire hip fracture cohort presented without serious acute coexisting medical issues. Despite this, only one in nine patients was successfully fast-tracked in line with national policy. To improve compliance with IHFS1 in our hospital, we have designed a hip fracture clerking booklet to record timelines, improve accountability and promote efficiency. Ongoing and consistent whole team collaboration and excellent communication are essential components for a successful well-coordinated pathway; patients in ED with hip fracture deserve this care.

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