**SUBJECT:** Orthopedic Trauma Hip Fracture Guideline **PAGE:** 1 of 2
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**PURPOSE**:
To facilitate appropriate and timely management of elderly patients with low energy hip fractures and apply principles of geriatric trauma co-management.

**DEFINITIONS:**

- Fractures about the hip can be subdivided into femoral head, femoral neck, intertrochanteric/pertrochanteric, and subtrochanteric (within 5cm distal to the lesser trochanter).
- Elderly patients for the purpose of this CPMG will be considered to be greater than or equal to 65 years of age.
- Low energy mechanism will be considered to be from standing height or less.

**GUIDELINES:**

I. Initial Management (Emergency Department):
   A. Orthopedic consult team to evaluate patient within 30 minutes
   B. Anesthesia block team consultation prior to disposition from ED (in development)
   C. Hip fracture medicine team consultation. Admission to orthopedic service unless active medical issue caused low energy trauma (syncopal fall, stroke, cardiac event, etc.) at the discretion of orthopedic attending and medicine service
   D. At discretion of orthopedic attending, consideration will be made for transfer to TOSH for surgical fixation prior to disposition from ED. TOSH transfer protocol will be followed per hospital policy.
   E. Definitive surgical stabilization to be performed within 24h of admission

II. Pre-operative management
   F. Femoral nerve block to be performed at the discretion of the anesthesia team pre-operatively
   G. 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.[1]
   H. DVT prophylaxis to be started on day of admission and continued throughout hospital course.
   I. Urinary catheter not to be placed unless extenuating circumstances exist (home catheter).
   J. Early discharge planning will begin day of admission
   K. Patients that have an advance directive will be followed.
   L. Patients with terminal illness or at high risk for 90 day mortality will consider palliative care consult for goals of care discussion.

III. Post-operative management
   A. Physical therapy to work with patient on POD 1 at the latest. Preferably work with patient POD 0 as long as discharged from PACU prior to 1500. Order for PT should be placed as “femur pathway”.
   B. If present, urinary catheter to be removed POD 1, unless extenuating circumstances dictate otherwise.
   C. Nutrition consultation to be obtained prior to discharge

D. Consider bone metabolic outpatient referral if within 1 hour drive radius of UAMS and PCP not already following for osteoporosis management.

**PERFORMANCE IMPROVEMENT MONITORING:**
Outcomes will be tracked in the UAMS trauma database. The primary goal is treatment of hip fracture within 24 hours of admission.

**REFERENCES:**
[1] https://www.ahajournals.org/doi/10.1161/CIRCULATIONAHA.107.185699?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed#d1e626