McLaren Oakland Elderly Hip Fracture Protocol

Trevor Crean, DO

Current ACS Guidelines

- "…Once diagnosed with a hip fracture, these patients are typically admitted to the hospital, medically optimized, and should be surgically treated as soon as able, ***preferably within 48 hours***."

  -ACS TQIP Best Practices Orthopedic Trauma

Goal

- Safely and effectively evaluating, optimizing and addressing patients with elderly hip fractures in a timely manner that ideally is within 48 hours of presentation, per current ACS guidelines.

Time of Presentation

- Acute care trauma team notified of at least Level 3 page
- Orthopedic on-call resident notified

- Both evaluate patient in a timely fashion based off standard Trauma activation criteria

Trauma Team

- After evaluation, patient is admitted with the trauma team as the primary service
- VTE Prophylaxis initiated
- Consults to:
  - Orthopedics (likely already involved with care)
  - Anesthesia (in-house)
  - Internal Medicine Team (in majority of cases)
- Additional necessary consults placed as seen fit by Trauma team and/or anesthesia team IF it is felt that additional medical testing/optimization is necessary prior to OR

Orthopedic Surgery Team

- After evaluating the patient, on-call resident coordinates with:
  - Orthopedic Attending
  - OR Scheduling desk
  - Vendor Reps
  - Trauma/Anesthesia to discuss any need for further consultation/testing

OR Scheduling

- Upon scheduling, case is flagged as “Time-Sensitive”
- Once Patient is deemed optimized:
  - IF OR time available, case scheduled when surgeon available within next 24-48 hours
  - IF OR time unavailable within first 24-36 hours after patient admission, case not becomes urgent/emergent, and if necessary, elective block surgeon’s will be bumped based off agreed upon OR policy

Why it works

- Both trauma attending and anesthesia attending in house 24/7
  - Admissions to medicine service may take up to 12 hours for attending level evaluation of patient as no attending hospitalist in-house 24/7
  - Prevents admissions from stand-alone ER from “slipping through the cracks”
- Anesthesia able to prepare for case early
  - Can recommend additional testing/consults as they see fit
  - Echo/Cardiology consults kept to only higher risk patients and decrease unnecessary testing
  - Added patient benefit of regional block, if indicated, while patient is still in ER
- OR Scheduling is monitoring case from beginning to optimize OR workflow, especially during busy elective-heavy days