NHS
Royal Cornwall Hospitals
NHS Trust

Fractured neck of femur

affix patient label

What is a fractured neck of femur?

A healthy hip joint is vital to normal walking and standing. You have fractured the thigh bone just below this joint. This is known as a hip or neck of femur fracture. Although some hip fractures will heal naturally this can involve prolonged periods of bed rest and significant discomfort as well as increased risks of other medical problems such as chest infections and blood clots. It also leads to muscle weakness. This is why it is recommended that almost all hip fractures are treated with an operation.

Why do I need it?

There are several operations used to treat hip fractures and your surgeon will discuss which one is appropriate for you. If the blood supply to the 'ball' of the 'ball and socket' joint is likely to be intact then the fracture can be fixed back into place and allowed to heal. This can be done with screws (Cannulated Hip Screws), a plate and screws (Dynamic Hip Screw) or a nail down the centre of the bone (Intramedullary Hip Screw). Which of these operations you have depends on the shape of the fracture and the surgeon's judgment.

If the blood supply is likely to be damaged the joint will need to be replaced. This can mean either replacing just the 'ball' of the 'ball and socket' joint (Hemiarthoplasty) or the 'socket' as well (Total hip replacement). Which of these operations you have will depend on your general health and how much load is expected to be placed on the joint in the future.

This information is provided for your interest and as a courtesy. You will not have to choose what type of surgery you have but you should feel free to ask questions about the surgery and why a particular operation is recommended. Occasionally, it is necessary to change the planned operation depending on findings during theF operation to ensure you get the best possible result.

The aim of all of these operations is to get you comfortable and back on your feet as soon as possible.

Are there any alternatives?

It is sometimes possible to treat hip fractures without surgery but this normally requires a prolonged period of bed rest. It carries risks of weakness, confusion, pressure sores and life threatening conditions such as chest infections and blood clots. Your mobility is also likely to be significantly worse without surgery. If you feel strongly that you don't want an operation you should discuss this with your surgeon.

How do I prepare for it?

Do **not** eat anything for at least **6 hours** before your operation. This is to make sure your stomach is empty when you have your anaesthetic. Drinks containing fats (eg tea or coffee with milk) and sweets all count as food. You **can** drink water or a drink without fats in it (eg black coffee) until **2 hours** before your operation. You may also have small sips of water to take tablets. There is a hospital leaflet about having an anaesthetic. Ask the staff if you would like one.

You may be given a general anaesthetic, or a spinal or epidural anaesthetic will be used where the area to be operated on is completely numbed by an injection into your back and you remain awake but drowsy. Often we will give both types of anaesthetic together. The anaesthetist will come and see you before your operation to discuss this with you. You will have an opportunity to ask them questions about the anaesthetic.

A member of the surgical team will also see you on the ward. Feel free to ask any questions you have about the operation or what will happen afterwards. They may examine you again. An arrow should be drawn on the leg to be operated on.

The Royal Cornwall Hospital is a busy centre for trauma and carries out over 500 operations for hip fracture each year. We try very hard to operate on all hip fractures within 24 hours but it is not possible to say at admission, exactly when your operation will be or who will do it. We are a teaching hospital and experienced trainees do operate here under careful supervision. Only an appropriately experienced surgeon will carry out your operation.

What does it involve?

Your position during the operation and the position of the incision on your thigh will vary according to the operation being done. Some operations require several small incisions. If the fracture is being fixed then X-rays are usually taken during the operation to check that everything is in the right position.

Once the surgeon is happy with the position of the implants the wound is closed. Sometimes a narrow tube (drain) is left in the wound to allow blood or fluid to drain. This can be removed painlessly on the ward after a day or two.

The skin may be closed with stitches or clips. These will usually be removed 10 to 14 days after surgery. Sometimes the stitches are dissolvable.

What happens afterwards?

When you wake up, you will feel sore around the hip. This is normal. It is important at every stage to let the staff know if you have pain and to ask for painkillers if you need them.

The aim of the operation is to get you back on your feet and safely home as quickly as possible. The time this takes will depend on your general health and fitness before your injury. You will be seen by the physiotherapists on the ward who will help with standing and walking. Occupational therapists will assess your home circumstances and provide any aids such as walking frames, crutches and raised seats needed to get home comfortably and safely. Whilst on the ward you may need to have routine blood tests to check on your health following your operation and X-rays to check on your fracture.

Some patients need a little extra help and time before they can go home. In this instance you may be transferred to a community hospital or similar facility where specialists can give you the support you need.

What should I look out for?

The wound site may become red, hot and painful. There may also be a discharge of fluid or pus.
It is vital that you tell the medical staff if at any time you think you have an infection.

Are there any risks or complications?

Although all possible steps are taken to reduce these, all surgical procedures involve risks to the patient.

Common (happens in 2-5% of patients):
Blood clots: Blood clots can form in the veins after surgery. This is known as a Deep Vein Thrombosis or DVT. These can cause painful swelling of the leg and very rarely, put your life at risk by affecting your lungs. We will give you medicine to reduce this risk. Some surgeons will ask you to wear stockings on your legs. Starting to walk and getting moving is one of the best ways to prevent blood clots from forming.

Bleeding: This is usually minor and stopped during the operation. Some patients will need a blood transfusion and some need iron tablets. Rarely, the bleeding may form a blood clot or large bruise within the wound which may become painful and require an operation to remove.

Pain: Your hip will be sore after the operation. If you are in pain, it's important to tell staff so that pain can be controlled. Pain normally improves with time and for most patients the hip will become pain free. Sometimes, pain does not improve after surgery. Your surgeon will look for a reason and to see if it can be improved. Occasionally, no cause can be found and it is necessary to take painkillers in the long term.

Less common (happens in 1-2% of patients):
Infection: To minimise the risk of infection, you will be given antibiotics before surgery, ultra clean air theatres will be used and special precautions taken by the theatre staff with gowning and draping. Despite this infections can still occur. The wound site may become red, hot and painful. There may also be a discharge of fluid or pus. If caught early this can often be treated with antibiotics and an operation to wash the joint out. If caught late or if the infection is severe the implants may need to be removed and replaced at a later date. The infection can sometimes lead to sepsis (blood infection) requiring strong intravenous (IV) or long term antibiotics.

Rare (happens in <1% of patients):
Altered wound healing: the wound may become red, thickened and painful (keloid scar) especially in Afro-Caribbean people. Massaging the scar with cream when it has healed may help.

Nerve damage: Every effort is made to avoid this, however damage to the nerves around the hip can occur. This may cause temporary or permanent changes in the feeling of the leg or the strength of the leg muscles, particularly those around the ankle.

Bone damage: the thigh bone may be broken when the implant is put in. This may require fixation, either at the time or at a later operation. In procedures where the 'ball' of the 'ball and socket' joint is fixed rather than replaced there is a risk of loss of blood supply to the bone. This leads to the body reabsorbing this bone and the ball losing its shape, causing pain and loss of function. This is known as **AVN** and can happen up to 3 years after the injury and may require further surgery to address the problem. (**It is a common complication in Cannulated Hip Screws**).

Blood vessel damage: Rarely, the vessels around the hip may be damaged. This may require further surgery by the vascular surgeons.

Pulmonary Embolism: A PE is a consequence of a DVT. It is a blood clot that spreads to the lungs and can make breathing very difficult. A PE can be fatal.

Risk from the anaesthetic: The risk to a healthy patient of problems arising from an anaesthetic is very small. However each year in the UK several healthy people will die or suffer serious heart, lung or brain injury following an anaesthetic. This can be from problems or mistakes made during the anaesthetic or because of patient health problems. We will always take every possible step to keep you safe during your operation.

The following common complications apply only to hemiarthroplasty and total hip replacement:

Altered leg length: The leg which has been operated upon, may feel shorter or longer than before. This may feel strange initially but usually feels normal after a short time. Occasionally, this can be a persistent problem, treated with shoe raises or rarely, further surgery.

Joint dislocation: The two sides of a hip replacement are held together by the muscles and ligaments around the hip. They can dislocate, particularly in the first few weeks after surgery. If this occurs, the joint can usually be put back into place without a further operation but you may be asked to wear a brace for a few weeks. Sometimes a further operation is required to put the hip back into joint or rarely to change the alignment of the implant.

If you would like this leaflet in large print, Braille, audio version or in another language, please contact the General Office on 01872 252690

Patient copy

CONSENT FORM 1
PROCEDURE SPECIFIC PATIENT AGREEMENT

NHS
Royal Cornwall Hospitals
NHS Trust

NHS number: .....
Name of patient: .....
Address: .....
Date of birth: .....
CR number: .....

AFFIX PATIENT LABEL

_____ side Fractured neck of femur

Tick the expected procedure:

- Hemiarthroplasty (including bipolar) ☐
- Total hip replacement ☐
- Dynamic hip screw ☐
- Intramedullary hip screw ☐
- Cannulated hip screws ☐

STATEMENT OF HEALTH PROFESSIONAL (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained the intended benefits and summarised the risks, as below:

- *To get you comfortable and back on your feet as soon as possible*

Significant, unavoidable or frequently occurring risks:

- *Blood clots, bleeding, pain*

Uncommon but more serious risks:

- *Infection sometimes requiring further surgery, strong IV or long term antibiotics*

Rare but serious risks:

- *Altered wound healing, nerve damage, bone damage, blood vessel damage, pulmonary embolism*
- *Anaesthetic risk which includes a very small risk to life or limb from complications such as heart attack and stroke*

Any extra procedures which may become necessary during the procedure:

- *Blood transfusion (rarely necessary)*
- *Other (please specify):*

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

I have given and discussed the Trust's approved patient information leaflet for this procedure: Fractured neck of femur CHA3236 which forms part of this document.

I am satisfied that this patient has the capacity to consent to the procedure.

This procedure will involve: ☐ General and/or regional anaesthesia ☐ Local anaesthesia ☐ Sedation

Health Professional signature: ..... Date: .....

Name (PRINT): ..... Job title: .....

STATEMENT OF INTERPRETER (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe he/she can understand.

Interpreter signature: ..... Name (PRINT): ..... Date: .....

affix patient label

STATEMENT OF PATIENT

Please read this form carefully. If your treatment has been planned in advance, you should already have a copy of the patient information leaflet which describes the benefits and risks of the proposed treatment. If not, you will be given a copy now. If you have any further questions, do ask - we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I understand that tissue samples will only be taken in relation to the procedure explained to me. No samples will be taken for quality control, clinical education or research purposes.

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion.

.....

I have received a copy of the Consent Form and Patient Information leaflet: Fractured neck of femur CHA3236 which forms part of this document.

Patient signature: ..... Name (PRINT): ..... Date: .....

A **witness** should sign below if this patient is unable to sign but has indicated his or her consent.
Young people / children may also like a parent to sign here (see guidance notes).

Witness signature: ..... Name (PRINT): ..... Date: .....

CONFIRMATION OF CONSENT (to be completed by health professional when the patient is admitted for the procedure, if the patient has signed the form in advance).

On behalf of the team treating the patient, I have confirmed with the patient that they have no further questions and wish the procedure to go ahead.

Health Professional signature: ..... Date: .....

Name (PRINT): ..... Job title: .....

Important notes (tick if applicable):

☐ See advance decision to refuse treatment ☐ Patient has withdrawn consent (ask patient to sign/date here)

Patient signature: ..... Name (PRINT): ..... Date: .....

Filed within Legal Section

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Date of birth: .....
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Cannulated hip screws ☐

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CHA3236 V3
Reviewed 06/2020 Review due 06/2023

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