Neck of Femur
Enhanced Recovery Programme

NOFERP

James Paget University Hospitals NHS Foundation Trust

Anthony Morgan, Physiotherapist, Orthopaedic Therapy Team Leader,
James Paget University Hospitals NHS Foundation Trust
NHFD meeting Peterborough 12th March 2014
Enhanced Recovery Programmes in elective surgery

- Professor Henrik Kehlet, Copenhagen
  Multimodel approach to control postoperative pathophysiology and rehabilitation Br J Anaesth 78 (5) 606-617 (May 1997)

- Paget Enhanced Recovery Programme (PERP) introduced at JPUH – project start July 2010 and first patient 2nd November 2010

- JPUH project group considered programmes at
  - Golden Jubilee National Hospital, Glasgow
  - Hexham General Hospital, Northumberland
  - Norfolk & Norwich University Hospital
JPUH Enhanced Recovery Programmes in elective joint replacement surgery

- Senior Trust management
- All patients
- All consultants: orthopaedic & anaesthetic
- Nursing & therapies
- Education and preparation
- Integrated Care Pathway
- Spinal anaesthesia
- Peri-operative local anaesthetic infiltration (Ropivacaine)
- Post-op analgesia
- Out of bed 2 hours after return from PACU
- Intensive mobilisation
- Home 3 days later
Extend Enhanced Recovery to #NOF patients?

- Neck of Femur Enhanced Recovery Programme (NOFERP) first considered Jan 2011 with PERP established
- First patient 9th May 2011: evolving process
- All patients
- All consultants
- Integrated Care Pathway – many changes
- #NOF Keyworker
- Orthogeriatrician
- Perioperative LA infiltration
- Postop pump (later discontinued as PERP)
- Out of bed POD 1
Order of events

- BBA – possibly had iv morphine in ambulance
- Possible #NOF: call #NOF Keyworker
- X-ray
- # confirmed then default analgesia regime
  - Fascia iliaca block (FIB)
  - 1g iv paracetamol – avoid morphine
  - Avoid oral analgesia – slow gastric transit after trauma
- Fast track = 2 hours
- Trauma list / trauma coordinator
- NBM 0500 following day unless time to fit in the same day. If pm op then clear fluids until 1100.
- Consider Preload night before/day of op (experience in PERP has reduced renal failure)
Analgesia in A&E

- **Fascia Iliaca Block:**
  - started August 2011
  - Safe
  - 30ml chirocaine
  - ‘two-pop’ technique
  - effective analgesia up to 24 hrs
  - can be repeated
  - does not require anaesthetist or doctor (Luton & Dunstable: nurse practitioners)
  - 92% of JPUH patients got FIB in 2013 (this is > 76% of patients since August 2011)
  - is INR significant?
Analgesia in A&E

- Intravenous paracetamol
  - effective
  - relatively safe with few side effects
  - iv route bypasses absorption problems
  - avoid morphine: increases confusion and risk of delirium
  - avoid oral analgesia due to slower gastric transit
  - oral paracetamol given on site is not only ineffective but then excludes use of paracetamol in A&E: have to resort to morphine
#NOF Keyworker

- To provide information and education specifically designed for patients with #NOF
- To follow the patients progress from admission in A&E, through treatment, rehabilitation, discharge and beyond…..
- To liaise with family members/carers re: treatment, progress and discharge planning.
- To provide information, support and advice to patients, carers and members of the MDT
#NOF Keyworker

- To enhance relationships between MDT members at each stage of the patients’ pathway
- To facilitate the consultant orthogeriatrician ward rounds
- To ensure a high standard of care is maintained in accordance with patient expectation, NICE guidelines, Best Practice Tariff.
Orthogeriatrician

- 9 hours a week paid for by orthopaedic dept for assessments to comply with BOA/NICE standards for hip fracture patients
- 3 rounds per week – Mon pm – new patients only, Tues am, Fri am (full rounds)
- Assessment of all patients admitted with #NOF for medical, falls and osteoporosis assessment
- Teaching round with ortho SHO as no formal orthogeriatric team for the ward
Orthogeriatrician

- Manages ongoing medical concerns for specific referrals of all orthopaedic pts (not just hip fracture pts)
- Limited availability due to staffing levels and multi team obligations
- Recruitment into F/T post/dedicated middle grade has been unsuccessful
Integrated Care Pathway

- Structured assessments – the right things are done in the right order at the right time
- Best practice
- Stops things being forgotten
Procedures

- Hemiarthroplasty – all S&N: either CPCS or uncemented polar

- THR for the younger fitter patients: do not compare outcomes to elective THRs. Should we do more of these?

- DHS

- PF nail

- FN plate
Post-op analgesia regime

- peri-op ropivacaine infiltration (copied from elective pathway)
- post-op ropivacaine infusion via catheter and pump (the same) – later abandoned in elective & #NOF surgery – no evidence to support continued use
- consistent oral analgesia regime
  - paracetamol 1g qds
  - targinact 10mg bd up to day 5 (targinact is oxycodone & naloxone)
  - oramorph 10-20mg 2hrly prn. If has targinact and oramorph >20mg/24 hours refer to Pain team
- if < 20mg oramorph then stop targinact and start:
  - tramadol MR 100-200mg bd – can still have oramorph 10-20mg prn
- avoid codeine – constipation & confusion
Length of stay

- Not the only reason for NOFERP: better journey for the patient
- 1000 patients since May 2011
- April 2010-March 2011 (pre-NOFERP)
  - Mean LOS 15.22 days
- Overall since May 2011
  - Mean LOS 13.03 days (70% out by day 15)
- March 2014
  - Mean LOS 12.25 days (58% out by day 12)
Background to discharges

- Population covered by JPUH > 200,000 with proportionally larger older population aged 65 and over in eastern Norfolk & Suffolk compared to England as a whole
  - East Norfolk 21%
  - Waveney District Council 24%
  - England 16% (2011 census)
- much of this older population lives alone without close family support, surviving on a knife edge
- lack of community beds, aggravated by recent loss of 24 beds. This in comparison to other areas:
  - Kent with 12 units (18% 65+)
  - Leicestershire with 10 units, most of them being new builds! (17% 65+)
Discharges

- due to lack of step-down facilities, many patients have to stay on ortho ward to be fit enough to go home: this extends LOS

- discharges supported by
  - Admission Prevention Service
  - Reablement
  - Falls Service
  - these all have limited capacity and are not Early Supported Discharge Team or Hospital at Home

- delayed discharge often has little to do with the patients’ medical or orthopaedic conditions

- unrealistic aspirations of patients and relatives
Discharges

- Residential Homes
  - Early return of residents as protected environment: aim 3-5 days
  - new residential care placement
    - protracted process
    - continuing care assessments
    - funding panels
    - relatives looking for residential accommodation
    - all of this occurs while an inpatient on an acute ortho ward at £360/day compared to £800/week in residential care
  - this extends LOS beyond orthopaedic needs and inflates LOS: distorting statistics
Questions?