ACI Hip Fracture Project: Challenges of Implementation

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Background
Port Macquarie Base Hospital

- 180 bed hospital
- New 9 theatre complex
- New Orthopaedic ward
- New 20 bed ICU/HDU
- New Emergency Dept
- New Cardiology Dept
- Revamp all old wards and units
- No Neuro/Cardiac thoracic surgery
- Major Trauma Centre
Out with the old and......
In with the new!
NSW Health has long recognised the issues for hip fracture patients.

- 2008 – PMBH established continuous FIB for #NOF’s
- 2010– ACI released the Orthogeriatric Model of Care
- 2011 – CEC report on Fractured Hip identified areas to improve patient management and reduce 30-day mortality.
- 2014 – ACI developed the Minimum Standards for the management of hip fractures
- Standards were introduced to 35 sites in NSW
ACI Standards

- Orthogeriatric clinical management of each pt
- Optimal pain management
- Surgery within 48 hrs and in hours (regardless of inter hospital transfers)
- Surgery is not cancelled
- Commencement of mobilisation within 24hrs of surgery
- Refracture prevention
- Local ownership of data systems
Gap Analysis – self assessment

- Delayed time to Theatre
  - No dedicated trauma theatre
  - No dedicated Orthopaedic ward
- Regular cancellations – 37%
- Delayed mobilisation
Benefits of an ACI project

- Evidenced based research
- Multi institutional – benchmark
- Support for Up skilling
  - transfer of knowledge
- Definite focus on specific speciality
- Definitive time line
- Ongoing support through transition stages
- Evaluation of the project
- Feedback
Advantages of a Rural Hospital

- Smaller/fewer Network hospitals
- Practitioner expertise – embrace change
  - Previous interaction with ACI
    - Proven track record
  - Smaller hospital
    - Knowledge of staff
    - Key stakeholders
    - Respected rapport with Peers
  - Support from Administration
  - Proven record with implementation of change
  - Open to change management
Challenges

- Engagement of clinicians
- Time constraints
- Meetings
- Perception “of more work”
- Hybrid system–Paperless ED
- Unskilled staff
- Engagement of Patients
- Hospital move
- Introduction of pumps hospital wide
- End of the year
- Time line – momentum
Added Bonus.....

- Opportunistic – Refocus on #NOF’s
  - Vulnerable
  - Elderly
  - Dementia
  - Fasted unnecessarily
  - Malnourished
PMBH Standard 8

- Commence high carbohydrate drinks in ED
- Mandatory 1700hrs cut off time to theatre
- Delirium screen within 24hrs – TNP
- Malnutrition screen within 24hrs – dietician
- Prophylactic bowel management in ED

- Starving clock – no more than 8 hrs fasting
TIME of Operation BOOKED by Orthopaedic Team

8 hours later OR at 1700hrs

Ward staff to ring Duty Anaesthetist

- Theatre Time verified
- Patient able to eat (meal organised)

Keep Pt NBM
Downside

- Hard to backfill in specialist areas
- Rural area – travel
- No benchmarking data system
- No follow up from evaluation meeting
  - How did we go?
  - What improvements
  - No recognition
Would we do it all again???

Definitely!!!

- I believe it is one of the most positive change of practices that I have seen in my nursing career.
- This very vulnerable group of patients now have a voice, a better journey and the chance of improved outcomes.
- This pathway is now considered the default practice within our organisation.