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Caring for Patients with Fragile Hip Fracture: Seamless Transition of Care from an Acute Care Hospital to the Community

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Introduction

Hip fracture is a major cause of functional decline in the elderly with many suffering from reduced morbidity, and/or became semi or fully dependent after the fracture. In Changi General Hospital, acute care is directed by an interdisciplinary team through the use of a clinical pathway to expedite functional recovery of patients. However post discharge follow up and seamless care transition is of paramount importance to ensure quality and safe care for patients as they continue their rehabilitation and recovery in the community.

Aim

The study aimed to evaluate the seamless transition of care in patients with hip fractures beyond acute setting.

Methodology

A prospective study of all hip fracture patients admitted from Jan 2016 to Dec 2016 in Changi General Hospital (CGH).

Data includes outpatient case manager review of all hip fracture patients:

1. Discharged to Saint Andrew's Community Hospital (SACH) within 24 to 48 hours post-transfer, in view of its' proximity to CGH
2. Age 60 years and above discharged with 3rd, 6th and 12th months post-surgery follow-up at CGH Orthopaedic Specialist Outpatient Clinic

Role of Outpatient Case Manager

Discharge to SACH

ST. ANDREW'S COMMUNITY HOSPITAL

- Bridge communication gaps and care concern during transfer and handover pertaining to patient's:
  - Family dynamic
  - Wound care
  - Outpatient appointments
- Provide support and reassurance to patients and family members

Orthopedics Outpatient Review

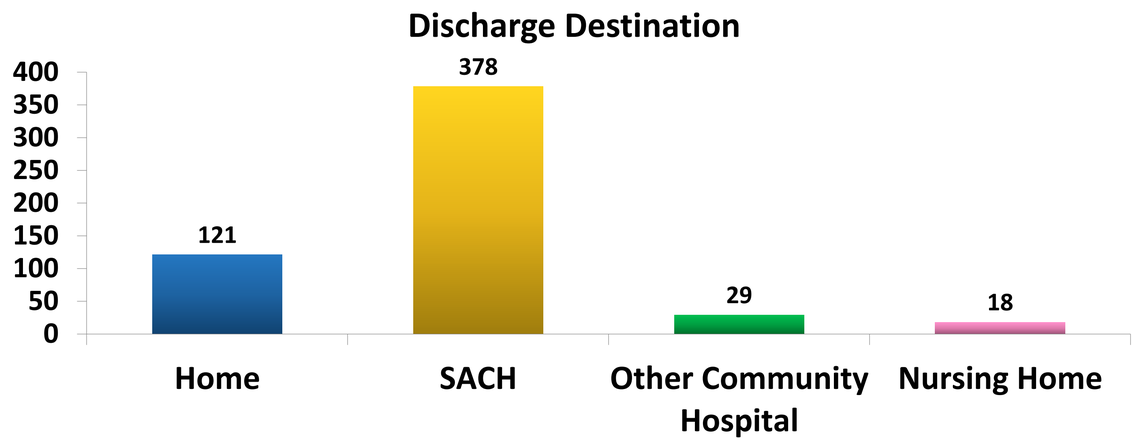
Changi General Hospital

- Conduct post-op functional assessment of patient at 3rd, 6th and 12th month
- Identify and initiate referral for continuous rehab
- Provide education and reinforcement on fall precautions, osteoporosis treatment and compliance to follow-up

Results

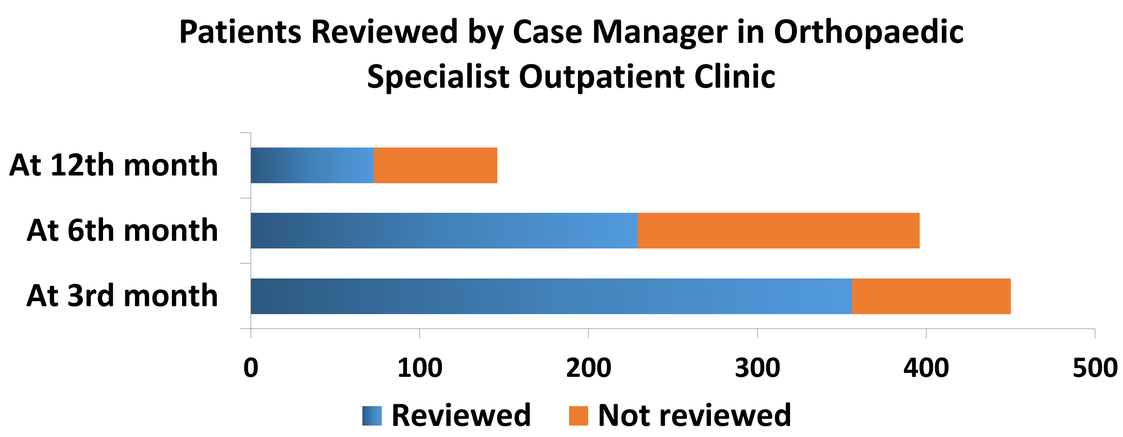
A total of 571 hip fracture patients were admitted during the study period. The mean age is 80 years, with 30% (n=172) males and 70% (n=399) females.

Patient's Demographic		Number	Percentage
Gender	Male	172	30%
	Female	399	70%
Age	< 60 years	31	5%
	≥ 60 years	540	95%



Of the 378 patients discharged to SACH, 95% (n=359) of patients were reviewed by the Case Manager. The Case Manager was able to clarify issues regarding:

1. Wound management (4.2%)
2. Weight bearing status and/or compliance to analgesia affecting rehabilitation (1.1%)
3. Missing information during handoff (1.1%)
4. Appointment and discharge plan (0.6%)



450 patients were discharged with an Orthopaedic outpatient appointment. Of the patients due for 3rd, 6th and 12th months post-op follow up, the Case Manager had reviewed 79% (n=356), 58% (n=229) and 50% (n=73) patients respectively.

In the reviews, the case manager identified issues related to caregiver stress, functional decline, frequent falls, and medicine / appointments compliance. This allows the case manager to close the gaps by providing appropriate referral to medical social service for caregiver support, continue rehab, falls clinic and reinforced education.

Conclusion

Seamless transition and follow up has added value and addressed gaps. It has also ensured continuum of care beyond just the acute hospitalization.