## 1.00 Dataset Item Summary Notes

**FFN** Fragility Fracture Network
*of the Bone and Joint Decade*

FFN Hip Fracture Audit database

Minimum Common Dataset (MCD) Version 1.5

June 2014

The following pages are extracted from the system help pages and provides a little background to each dataset item.

Please refer to the MCD specification for specific details of each field definition.

## 1.01 Patient Consent

Has the patient given 'informed consent', in accordance with your hospitals Information Governance, to take part in this audit?

Without this consent the patient information can only be used if you have some other form of legal basis, or consent is not required in your country.

How you obtain 'consent' is up to you and your local regulations.

You may be able to give the patient a leaflet and display a poster to provide information about the audit or you may require to discuss the audit with each patient individually, you may require a signature from each patient if your local law demands it.

(This is a key field - You must choose "Yes" to save this record)

## 1.02 Audit Number

This is the number you will use to identify the patient for updating the record or for follow up.

It is a pseudo anonymised reference number (or code) so that the patient is only identifiable at a local level for updating purposes.

It should NOT be: your 'official' Patient ID, Hospital number or organisation number.

*You will need to use an 'Audit Number' when importing records.*

## 1.03 Gender

Please choose the patients gender.

(This is a key field - You must choose a value to save this record)

## 1.04 Age on admission to hospital with a hip fracture

Please insert the age of the patient at the time of admission
(either admission to the hospital or the time referred to the trauma team if the fracture occurred in hospital).

(This field is 'mandatory' - A valid value is needed)

## 2.01 Pre Fracture Residence

Pre-fracture residence
This is the usual place of residence for the patient prior to hip fracture
-        If the patient is on holiday then use their home residence
-        If the patient falls and fractures whilst in respite care then use their usual home residence
-        If the patient falls and fractures whilst an in-patient in hospital then use acute care
-        If the patient lives in a care home, long term hospital or other institution then use institution

## 2.02 Pre-fracture mobility

Use the description that fits closest to the patients' mobility prior to the hip fracture occurring .

(This field is 'mandatory' - A valid value is needed)

## 2.03 Pre-Op AMTS - Abbreviated Mental Test Score

The AMTS is a mental capacity test to assess the patients current mental condition . The patient is asked 10 questions prior to surgery and each correct answer is given 1 point.

This is a list of sample questions :

1. How old is are yout?
2. What time is it? (to nearest hour)
3. An address - for example 42 West Street (NB. to be repeated by the patient at the end of the test)
4. What ear is it?
5. Name of hospital, residential institution or home address (depending on where the patient is situated)
6. Recognition of two persons - eg. doctor, nurse, home help etc.
7. Date of birth
8. Year Second World War started (or other local monumental date)
9. Name of present monarch or prime minister (or other significant important person)
10. Count backwards from 20 to 1

(EACH QUESTION SCORES ONE POINT)
Total score.  A score of less than SEVEN suggests dementia and an appropriate referral should be made

Reference:
Hodkinson HM. Evaluation of a mental test score for assessment of mental impairment in the elderly . Age Ageing. 1972 Nov;1(4):233-8.

(This field is 'mandatory' - A valid value is needed)

## 2.04 ASA Grade (Physical Status Classification System)

This only becomes mandatory if surgery is actually carried out . However, it should be recorded in all cases, even if the patient does not have surgery as it will influence analysis of mortality figures
- missing it out may affect your unit's performance.

ASA Physical Status 1 - A normal healthy patient
ASA Physical Status 2 - A patient with mild systemic disease
ASA Physical Status 3 - A patient with severe systemic disease
ASA Physical Status 4 - A patient with severe systemic disease that is a constant threat to life
ASA Physical Status 5 - A moribund patient who is not expected to survive without the operation

**ASA Physical Status Classification System**

**ASA Physical Status 1** - A normal healthy patient
Without any clinically important co-morbidity and without a clinically significant past/present medical history

**ASA Physical Status 2** - A patient with mild systemic disease -
Patients with angina symptoms less than once a week
High blood pressure treated with a single type of medicine
Well controlled diabetes (annual checks but not under a diabetic clinic)
Asthma controlled by inhalers

**ASA Physical Status 3** - A patient with severe systemic disease -
Angina symptoms more than once a week
Taking more than one blood pressure tablet
Having complications of diabetes such as kidney failure or poor circulation
Asthma requiring frequent hospital admissions
Respiratory disease [COPD / COAD] causing breathlessness climbing a single flight of stairs
Someone with a raised creatinine of less than 200 micro mol/L, without dehydration

**ASA Physical Status 4** - A patient with severe systemic disease that is a constant threat to life -
A patient that their doctor would not be surprised to hear had died, due to the degree of their medical problems.
Patients with advanced cirrhosis requiring dietary restrictions and medication would also be this grade.

**ASA Physical Status 5** - A moribund patient who is not expected to survive with or without an operation
It is questionable whether patients of this grade should be having hip fracture surgery, but they should still be included in the database.

http://www.asahq.org/For-Members/Clinical-Information/ASA-Physical-Status-Classification-System.aspx

(This field is 'mandatory' - A valid value is needed)

## 2.05 Side of fracture

Choose either left or right – if both hips fracture at the same time make two records – one for each side.

(This is a 'key field' - you must enter a value to save this record)

## 2.06 Pathological

Select 'Malignancy' only if primary or secondary malignancy is present at the fracture site.

Select 'Atypical' only if this is a transverse femoral fracture, with an unusual cortical spike medially, that occurred in the subtrochanteric and shaft regions (you should only enter subtrochanteric ones to the database).

They follow low trauma injuries and are associated with bisphosphonates, glucocorticoids or proton pump inhibitor use.
Patients may report pre injury pain.

For more information go to: http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON120213

## 2.07 Fracture type

**Atypical Fracture**
Atypical fractures are transverse femoral fractures, with an unusual cortical spike medially, that occur in the subtrochanteric and shaft regions.
you should only enter subtrochanteric ones to the database.
They follow low trauma injuries and are associated with bisphosphonates, glucocorticoids or proton pump inhibitor use.
Patients may report pre injury pain.
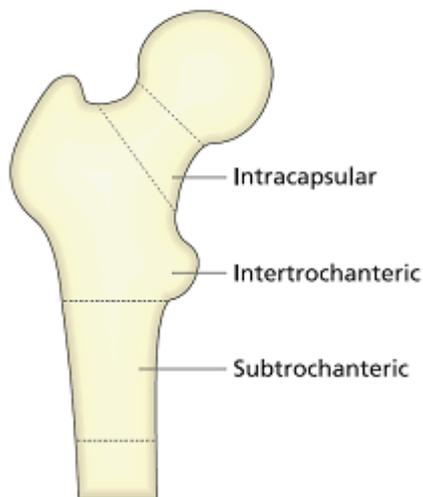


(This field is 'mandatory' - A valid value is needed)

## 2.08 Pre-Fracture bone protection medication

| Bisphosphonates | Oral or IV |
|---|---|
| Other bone protection medication | This does not include Calcium and Vitamin D |

(This field is 'mandatory' - A valid value is needed)

## 3.01 Date & time of admission to orthopaedic care

Please enter the date and time admitted to orthopaedic care using the drop down boxes provided.

Note the time value should be entered between: 00:00 to 23:59
Please only use 24 hour clock, enter leading zeros and use a colon character (**:**) between hours and minutes.

(This field is 'mandatory' - A valid value is needed)

## 3.02 Operation Performed

Complete this field using the drop down box provided

 – if the patient is treated conservatively use no operation performed.

(This field is 'mandatory' - A valid value is needed)

## 3.03 Date & time of primary surgery

Please enter the date and time of primary surgery using the drop down boxes provided

(time of primary surgery is taken from the time of induction of anaesthesia) – if no surgery performed leave these fields blank.

Note the time value should be entered between: 00:00 to 23:59
Please only use 24 hour clock, enter leading zeros and use a colon character (:) between hours and minutes.

(If no surgery performed 3.02, this field is disabled)

## 3.04 Type of Anaesthesia

GA=General,

SA=Spinal,

If a spinal anaesthetic is attempted and proceeds to a general anaesthetic then choose GA

If no operation performed then leave this field blank

## 3.05 Pressure Ulcers

This should be answered as 'yes' only if the patient has developed a grade 2 pressure ulcer or above during their acute orthopaedic admission.

| Grade | Short Description | Definition |
|---|---|---|
| Grade 1 | Non-blanchable erythema of intact skin | Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin. |
| Grade 2 | Blister | Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister. |
| Grade 3 | Superficial ulcer | Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. |
| Grade 4 | Deep ulcer | Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss. |

http://www.epuap.org/guidelines

(This field is 'mandatory' - A valid value is needed)

## 3.06 Physician / Geriatrician involvement

Indicate if a physician or geriatrician was involved in the care of the patient during the acute phase (up to 72 hours post admission).

(This field is 'mandatory' - A valid value is needed)

## 3.07 Life Status / Mortality

Please complete if the patient dies in hospital.

Alive - Patient has completed surgery and has been placed on a recovery ward.
(Surgery fields do apply)

Died pre-surgery - Patient has died prior to any surgical procedure.
(Surgery fields do not apply)

Died post-surgery - Patient has died during or following surgery.
(Surgery fields do apply, but no discharge or followup details requird)

(This field is 'mandatory' - A valid value is needed)

## 3.08 First day mobilisation

A patient would be described as 'mobilised' if they are able to sit or stand out of bed.

Choose 'Yes' if:
- on the day of their return from operation, or
- on the following day

Otherwise, 'No' if they were immobile or 'No operation performed'

(This field is 'mandatory' - A valid value is needed)

## 4.01 Date of discharge from orthopaedic care

Enter the date and time discharged from orthopaedic care (as an in-patient and not including any follow up appointments) using the drop down boxes provided.

Note the time value should be entered between: 00:00 to 23:59
Please only use 24 hour clock, enter leading zeros and use a colon character (:) between hours and minutes.

(This field is disabled if patient is deceased at 3.07)

## 4.02 Discharge destination

If the patient is discharged to a relative's home prior to going to their own home use Home

Only use unknown if the discharge destination is not documented in the notes.

(This field is disabled if patient is deceased at 3.07)

## 4.03 Bone protection medication

Enter bone protection medication prescription in relation to admission bone protection medication.

(This field is disabled if patient deceased at 3.07)

## 5.01 Hip related readmission

Has the patient been re-admitted within 30 days of the primary hip surgery with a hip related issue (including infection and dislocation of prosthesis?)

(This field is disabled if the patient is deceased at either 3.07 or 4.02)

## 5.02 Re-operation within 30 days of admission to orthopaedics

Re-operation on the affected hip only.

Choose 'None' if no reoperation required.

Choose other and enter a basic description in the field provided - Note: this field is not part of the official MCD dataset.

(This field is disabled if the patient is deceased at either 3.07 or 4.02)

## 5.03 Alive at 30 Days

Is the patient still alive at 30 days post admission – either still in hospital or discharged?

(This field is disabled if the patient is deceased at either 3.07 or 4.02)

## 5.04 Mobility at 30 days

What is the patients' mobility at 30 days post admission?

(This field is disabled if the patient is deceased at either 3.07 or 4.02 or 5.03)

## 5.05 Residence at 30 days

If the patient is staying at a relative's home prior to going to their own home use Home.

(This field is disabled if the patient is deceased at either 3.07 or 4.02 or 5.03)

## 5.06 Bone protection medication

Is the patient taking bone protection medication at 30 days post admission?

(This field is disabled if the patient is deceased at either 3.07 or 4.02 or 5.03)