International Journal of Orthopaedic and Trauma Nursing (2015) **19**, 24–35

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International Journal of Orthopaedic and Trauma Nursing

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# Improving the experience of hip fracture care: A multidisciplinary collaborative approach to implementing evidence-based, person-centred practice

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**KEYWORDS**
Geriatric Medicine;
Orthopaedics;
Culture;
Communication;
Evidence-based practice

**Abstract** ***Background:*** Hip fracture care is well supported by national guidelines and audit that provide evidence of safe interventions and an improved process. In the drive for organisational efficiency, complications have been reduced and length of stay shortened. Prioritising targets and performance alone can lead to poor multidisciplinary communication that potentially omits the psychosocial needs of older people recovering from hip fracture.

***Aim:*** To explore a multidisciplinary collaborative approach to implementing evidence-based, person-centred hip fracture care.

***Design:*** Collaborative inquiry.

***Methods:*** Sixteen clinical leaders ($n = 16$) from different disciplines, working with older people with hip fracture at different stages of the care pathway participated in eight two-hourly facilitated action meetings. Data collection included strengths and limitations of the present service, values clarification, clinical stories, review of case records and reflections on the stories of three older people and two carers.

***Results:*** Hip fracture care was driven by service pressures, guidelines and audits. The care journey was divided into service delivery units. Professional groups worked

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http://dx.doi.org/10.1016/j.ijotn.2014.03.003

independently resulting in poor communication. Time away from practice enabled collaboration and the sharing of different perspectives.

***Conclusions:*** Working together improved communication and enhanced understanding of the whole care experience.

***Implications for practice:*** Enabling teams to find evidence of safe, effective person-centred cultures requires facilitated time for reflective practice.


**Editor comments**

It has long been recommended that the care of the patient following hip fracture requires well coordinated multidisciplinary effort in order to ensure that it is both effective and patient-centred. Even so, it is often felt that such an approach is not as well executed in practice as it is sold in theory and that true collaboration can be restricted by the professional culture in the care setting. This important study helps practitioners, leaders and managers to begin to understand the drivers and the inhibitors that need to be overcome before real progress can be made in making the intentions of multidisciplinary care a reality for this vulnerable group of patients.

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## Introduction

The national quality strategy provides direction for the delivery of best quality care that is person-centred, safe and effective (Scottish Government [SG], 2010). In hip fracture care there are national standards, evidence-based guidelines and abundant data from a national audit (Clinical Standards Board for Scotland [CSBS], 2002; NHS National Service Scotland [NHS NSS], 2005, 2008; NHS Quality Improvement Scotland [NHS QIS], 2004; Scottish Intercollegiate Guidelines Network [SIGN], 2009) that help demonstrate a measurable impact in terms of reduction in preoperative delay, length of hospital stay and functional ability (Currie and Hutchison, 2005; NHS NSS, 2005). However, despite early surgical fixation, many of the frail older people with hip fracture are unable to regain their pre-injury level of function and independence (Cooper, 1997; Koval et al., 1997; Olssen et al., 2007a; Sirkka and Branholm, 2003) and many are at risk of poor outcomes (Hart et al., 2002; Magaziner et al., 2000).

Recovery following hip fracture has tended to take a restorative approach, providing safe physical recovery through standardised care pathways (British Orthopaedic Association [BOA], 2007; Crotty et al., 2010; Eastwood et al., 2002; Egol et al., 1997; Giaquinto et al., 2000; Koot et al., 2000; Olssen et al., 2007a). At each stage of the care journey, older people meet many different disciplines, specialities and agencies (Askham, 2008; Boockvar et al., 2004; Olssen et al., 2007a; Tierney and Vallis, 1999; Tierney et al., 1998). The presence of an identified leader and caring behaviours of staff were valued and contributed to the experience in a variety of ways (Hallstrom et al., 2000; Hommel and Thorngren, 2003; Huby et al., 2004; Nahm et al., 2010; O'Brien and Fothergill-Bourbonnais, 2004). The older person's perspective of hip fracture has been explored in terms of the individual knowledge and zest for life; the pain; the struggle to move; the need for help with activities of daily living and coming to terms with the decline in physical function (Archibald, 2003; Olssen et al., 2007b; Ziden et al., 2008). However, there is little convincing evidence that guidelines alone improved overall experience of care (Atwal and Caldwell, 2002; Cameron, 2003; O'Connor, 2005).

The culture of hip fracture care can be complex and there can be discrepancies between actual practice and declared protocols at almost every stage of the pathway (Tierney, 1997; Tierney and Vallis, 1999; Tierney et al., 1997). The difference in values between quality improvement processes, evidence-base practice and person-centred practice can tug practitioners in different directions creating stress and confusion in the workplace (Cuthbert and Quallington, 2008; Tutton et al., 2007; Walsh et al., 2011; Woodbridge and Fulford, 2004) potentially hindering the delivery of safe, effective person-centred practice (Christie et al., 2012; Edvardsson et al., 2009; Rycroft-Malone et al., 2002, 2004b; Titchen and Manley, 2006).

Collaboration between multidisciplinary teams in Orthopaedic and Geriatric Medicine can improve quality and reduce cost (Atwal and Caldwell, 2005; Beaupre et al., 2005; Cameron et al., 2000; Christmas