Background / Aim
The Scottish Hip Fracture Audit is a world-leading nationwide audit assessing adherence to 11 standards of care relating to the whole hip fracture patient journey. Adherence to these standards has been demonstrated to lead to better patient outcomes such as lower mortality, shorter length of inpatient stay and greater independence at discharge.

In order to improve patient outcomes and experience, we decided to use the Hip Fracture Audit Standards as a focus to drive improvements in care through a Quality Improvement approach.

Methods
We set up a multiprofessional group from all departments involved in the hip fracture journey (Emergency Department, Trauma Orthopaedic Ward, Theatres, Geriatric Medicine and Anaesthetics). This group meets on a regular basis. Using each Audit Standard as a focus, we develop ideas for change and implement them using the Model for Improvement.

Initially we had support from a part-time Quality Improvement Advisor, and subsequently the Orthogeriatric Medical Support Nurses developed experience and skills in Quality Improvement methodology.

Hip fracture audit information was collected regularly by our dedicated Audit Nurse and used as a basis for measuring improvement and identifying further areas to change. We display this data prominently on a ‘Hip Fracture Board’ to highlight areas of improvement.

We conducted regular multidisciplinary teaching regarding the importance of the different aspects of hip fracture care. All disciplines and grades were engaged to develop ideas for improvement.

We visited other units and departments to generate more ideas for change in our own ward. The information box contains examples of tests of change that we have implemented.

We gathered patient experience feedback in a structured manner and illustrated these in cartoons.

We gathered feedback from staff regarding the effect of these changes.

Results
Audit data shows progressive and sustained improvement across a wide range of standards of care (see Figures 2 and 3 as examples) Qualitative feedback showed that staff on the ward valued this approach, were more aware of the challenges faced by older people with hip fractures, and felt they had more ownership of the quality of care provided on the ward.

Team members have gained a better understanding of the Hip Fracture Standards, which has helped improve knowledge and motivation on the Unit. The learning gained has been used to improve care for all patients on the ward, not just those with Hip Fracture. Patient experience feedback has been very positive.

Conclusion
A multi-disciplinary, multi-department, Quality Improvement approach, using the Scottish Hip Fracture Audit standards as a focus has led to improvements in quality of care, patient experience and staff satisfaction and engagement.

Information Box: Examples of changes that we implemented
- Redesign of Hip Fracture clerking.
- Redesign of Emergency Department Hip Fracture protocol.
- Revised analgesia protocol.
- Improved communication around fasting times.
- Development of Orthogeriatric Review process.
- Daily MDT Huddle to improve communication.
- Implementation of Discharge Pause to improve discharge safety and experience.
- Development of Hip Fracture Patient Passport.
- Introduction of Getting to Know Me document.
- Development of tools to improve recognition and management of delirium.

References
1. The Scottish Hip Fracture Audit. www.shfa.scot.nhs.uk
3. Institute for Healthcare Improvement. www.ihi.org/resources/Pages/HowtoImprove/default.aspx

Acknowledgements
David Boddie Trauma Clinical Lead, Carol Carnegie Research Nurse, Angela Pettie Audit nurse, Denise Johnson, Quality Improvement Advisor, Jill Forbrache Quality Improvement Advisor, John Lee ED Consultant, Kathleen Ferguson Consultant Anaesthetist, Marion Slater Consultant Geriatrician, Caroline Mutch and Angela Brown Senior Charge Nurses, Physio and Occupational therapist teams, Trauma theatre team