# Hip Pain (suspected #NOF)

**Aim:**
- Early initiation of treatment / clinical care and symptom management within benchmark time.

## Assessment Criteria:
On assessment the patient should have one or more of the following signs / symptoms:

- Hip pain post mechanical fall
- Rotation of the leg on the injured side
- Shortening of the leg on the injured side
- Decreased mobility

## Escalation Criteria:
Immediate life-threatening presentations that require escalation and referral to a Senior Medical Officer (SMO):

- Suspected Shaft of Femur fracture
- Syncope / Collapse
- Anticoagulant therapy
- Multiple system injuries

## Primary Survey:
- Airway: patency
- Circulation: perfusion, BP, heart rate, temperature
- Respiration: RR, SpO2
- Disability: GCS, pupils, limb strength

## Notify CNUM and SMO if any of the following red flags is identified from Primary Survey and Between the Flags criteria:

- **Airway – at risk**
  - Partial / full obstruction
  - Disability – decreased LOC

- **Breathing – respiratory distress**
  - RR < 5 or >30 /min
  - SpO2 < 90%

- **Exposure**
  - Temperature <35.5°C or >38.5°C
  - BGL < 3mmol/L or > 20mmol/L

- **Circulation – shock / altered perfusion**
  - HR < 40bpm or > 140bpm
  - BP < 90mmHg or > 200 mmHg

- **Postural drop > 20mmHg**
- **Capillary return > 2 sec**

## History:
- Presenting complaint
- Allergies
- Medications: Anticoagulant Therapy, Anti-hypertensives, Diabetic meds, Analgesics, Inhalers, Chemotherapy, Non-prescription meds, and any recent change to medications
- Past medical past surgical history relevant
- Last ate / drank & last menstrual period (LMP)
- Events and environment leading to presentation
- Pain Assessment / Score: PQRST (Palliating/ provoking factors, Quality, Region/radiation, Severity, Time onset)
- Associated signs / symptoms: hip / pelvic pain, nature of pain / radiation,
- History: history of falls, collapse or cardiac arrhythmias

## Systems Assessment:
Focused hip and lower limb assessment:
- Inspection: Bruises, scars, lacerations, deformities, swelling, symmetry of the pelvis and lower limb (rotation, shortening). If patient is freely mobilising, assess patient stance, gait and walk for symmetry and heal-strike. Observe for C-sign.
- Palpate: Palpate for crepitus, pulses and assess for neurovascular compromise
- Range of movement (stop if pain occurs): straight leg raise and flexion/extension.

**Explore mechanism of injury and events leading up to injury to guide further patient assessments.**

## Notify CNUM and Senior Medical Officer (SMO) if any of following red flags is identified from History or Systems Assessment:

- Asymmetrical pelvis
- Unrelieved pain post analgesia
- Elderly > 65 years
- Hypotension
- Urinary retention
- Acute confusion / agitation
- Neurovascular compromise
- Dislocation of hip
- Sepsis (CEC Sepsis Pathway) **Note:**

## Investigations / Diagnostics:

**Bedside:**
- BGL: If < 3 or >20mmol/L notify SMO
- ECG: [as indicated] look for Arrhythmia, AMI
- Urinalysis / MSU: if urinary symptoms present

**Laboratory / Radiology:**
- **Pathology:** Refer to local nurse initiated STOP
  - FBC, UEC, Coags (if anticoagulant therapy)
  - Group and Hold (if bleeding suspected or for OT)
  - Blood Cultures (if Temp ≤35 or ≥38.5°C)
- **Radiology:** AP Hip / Pelvis X-ray (CXR if fracture confirmed)
Nursing Interventions / Management Plan:

**Resuscitation / Stabilisation:**
- Oxygen therapy & cardiac monitor [as indicated]
- IV Cannulation (consider large bore i.e. 16-18gauge)
- IV Fluids: Sodium Chloride 0.9% 1 litre stat (discuss with SMO)

**Symptomatic Treatment:**
- **Antiemic:** as per district standing order
- **Analgesia:** as per district standing order
- **IV Fluids:** as per district standing order

**Supportive Treatment:**
- Nil By Mouth (NBM)
- Monitor vital signs as clinically indicated (BP, HR, T, RR, SpO2)
- Monitor neurological status GCS as clinically indicated
- Monitor pain assessment / score

- Fluid Balance Chart (FBC)
- Consider IDC for Female with confirmed fractured NOF or males with confirmed fractured NOF and signs of urinary retention
- Monitor neurovascular assessment as clinically indicated (minimum hourly assessments)

**Practice Tips / Hints:**
- Regular re-assessment of the patient’s pain, vital signs and neurovascular assessment (minimum standards hourly). Escalate any abnormalities immediately and document the variance, who you escalated to and the treatment plan.
- Position the patient to ensure comfort. Consider ordering a pressure relieving mattress once the patient is admitted.
- Where a fracture is confirmed, consider escalation to a SMO for a Fascio Iliaca Block (FIB) to provide adequate pain relief.
- The patient must remain NBM until otherwise advised by a SMO. NBM patient will require maintenance fluids while NBM.
- Any patient who presents with decreased mobility must have a mobility assessment completed and documented prior to discharge home. Consider the patient’s situation and home arrangements are suitable for discharge.
- Ensure admitted or discharge patients have appropriate pain management prior to leaving the ED.

**Further Reading / References:**


**Acknowledgements:** SESLHD Adult Emergency Nurse Protocols were developed & adapted with permission from:
- Murphy, M (2007) Emergency Department Toolkits. Westmead Hospital, SWAHS
- Hodge, A (2011) Emergency Department, Clinical Pathways. Prince of Wales Hospital SESLHD.

**Revision & Approval History**

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