# Hip Fracture

## Addendum to the Rehabilitative Care Best Practice Framework in the Context of COVID-19

### INTENT OF THIS ADDENDUM

- Provide additional recommendations on the provision of hip fracture best practice rehabilitative care that complement the existing RCA evidence-based best practice framework while aligning with current pandemic restrictions
- Offer considerations regarding flexible models of care delivery for the provision of hip fracture best practice rehabilitative care in light of the current COVID-19 restrictions

### SECTION 1: CURRENT COVID-19 CONTEXT: THE NEED FOR HIP FRACTURE REHABILITATIVE CARE

On March 15, 2020, Ontario hospitals were directed to ramp down scheduled surgeries and other non-emergent activities to preserve capacity to care effectively for patients with COVID-19. Surgical volumes were significantly reduced, in many cases to only "life and limb" surgical procedures, which included surgical repair of hip fractures. Post-surgically, these patients received rehabilitative care both in acute care and inpatient rehabilitation. However, post-discharge provision of in-home and ambulatory-based services was inconsistent across the province due to the reduction of services, program closures and redeployment of rehabilitative care professionals. During the reopening of these services, it has been noted that COVID-19 infection prevention and control practices contribute to a reduced capacity for rehabilitative care services to provide in-person care. Alternate modes of rehabilitative care options are required, such as virtual care. Guidance specific to rehabilitative care following hip fracture in this context is therefore necessary to meet rehabilitative care best practice recommendations and ensure that best practice care continues to be provided.

### SECTION 2: HIP FRACTURE REHABILITATIVE CARE BEST PRACTICES IN THE CONTEXT OF COVID-19

As part of its efforts to standardize rehabilitative care for individuals with hip fracture, the Rehabilitative Care Alliance (RCA) developed the *Rehabilitative Care Best Practices for Patients with Hip Fracture*, which was last revised in September 2018. This framework provides a basis for informing and improving quality care to support better patient outcomes and increased efficiencies.

However, the COVID-19 pandemic has created an urgent need for best practice guidance, in particular for frail seniors, while meeting infection prevention and control (IPAC) requirements. In response, the RCA released *Frail Seniors: Guidance on Best Practice Rehabilitative Care in the Context of COVID-19* in June 2020. This guidance document provides a brief summary of evidence-based best practice rehabilitative care for seniors living with frailty and offers considerations for the provision of this care in light of restrictions due to the COVID-19 pandemic.

Notwithstanding these resources, there remains a need to define key best practices, considerations and approaches specific to frail seniors who have experienced a hip fracture in light of COVID-19. These are outlined below.

## 1. Hip Fracture Rehabilitative Care is Essential

1.1 Recognize that rehabilitative care resources are an essential aspect of post-surgical care. Post-surgical patient outcomes are dependent on access to best practice rehabilitative care that includes comprehensive geriatric intervention.[1 2 3 4 5]

1.2 Rehabilitative care may be conducted in a hospital inpatient setting, in the community (ambulatory or in-home) or in long term care (LTC) homes.[6] The provision of rehabilitative care post hip fracture should be based on the patient's clinical needs at a duration and intensity that is aligned with best practices and should not be determined by the patient's location.

1.3 Ensure communication with community-based rehabilitative care.[7] There is currently lower capacity due to space and group therapy restrictions, and increased time required per patient due to virtual care and IPAC practices. Therefore planning is required to ensure patients receive necessary rehabilitative care.

## 2. Care Partners are Essential

2.1 Recognize that care partners are essential to the care of frail older adults and are key in many settings to the provision of care. Care partners are defined by the patient and are often family members or friends. They serve as a liaison between patients and clinicians, and are essential for day-to-day decision-making, care delivery, transition care planning and system navigation.[8 9]

2.2 Care partners should be included in the health care team's communication and care planning. Care partners should also be given access to necessary resources. In the context of the current pandemic, care partners will require protective personal equipment (PPE) with instruction in proper donning and doffing techniques.[8 9]

2.3 Designated care partners should be allowed access to inpatient health care organizations where visits are paramount to the patient's fundamental care needs, mental health and emotional support, and to enable process of care, patient flow and discharge.[8 9] Designated care partners who provide care to maintain the patient's mental and physical health are not simply visitors and are essential to rehabilitation and transition care planning for the hip fracture population.[9]

## 3. Transition Care Planning

3.1 Transition plans should be developed and agreed upon in partnership with the patient, any care partners involved and the care team at each point of transition.[10] A communication liaison should be designated as part of the care team. Care partners provide essential support to coordinate care at major transition times. This is particularly the case during the COVID-19 pandemic, given potential reductions or changes in community-based health service delivery.[8]

3.2 Before transitioning, patients and care partners should be offered education and training to manage health care needs, including guidance on community-based resources, medications and medical equipment.[10]

## 4. Post-Surgical Acute Care & Inpatient Rehabilitation

4.1 As noted above, care partners are essential to the care and recovery of frail seniors. To balance the need to follow organizational and IPAC policies while continuing to engage care partners, organizations should work with the patient to identify a designated care partner(s).

4.2 Health professionals should follow organizational and IPAC policies and designated care partners should be given the necessary resources and instruction.

4.3 Access to inpatient rehabilitation post hip fracture should remain consistent with pre-COVID recommendations.

## 5. Community-based Rehabilitation

5.1 Access to community-based rehabilitation services is a priority as per current best practice and quality-based procedure recommendations. This should include timely assessment and triage.[11]

5.2 Health professionals should follow their professional college, organizational and IPAC policies with respect to the provision of in-person visits.[12]

5.3 Consider virtual care options for rehabilitation, provided that patients' rehabilitative care needs can be met. The patient's preference and/or need for in-person visits should be continually reassessed throughout the course of treatment. [13] [14]

## 6. Virtual Care

Virtual care is defined as "any interaction between patients and/or members of their circle of care, occurring remotely, using any forms of communication or information technologies with the aim of facilitating or maximizing the quality and effectiveness of patient care."[13] Each of the regulated health professional colleges have statements and guidelines regarding the use of virtual care as an alternate mode of service delivery to traditional rehabilitation services. Health professionals must be able to maintain appropriate rehabilitative and regulatory standards of care.

6.1 Organizations should ensure that front line providers have access to the supports required to deliver effective virtual care (e.g., technology, training, etc.).[14]

6.2 Decisions to utilize virtual care must take into consideration both the feasibility of delivering the specific therapy needs, as well as individual patient characteristics (e.g., access to technology, care partner supports, patient preference, etc.).[13]

6.3 Prior to providing virtual care, detailed information regarding what is virtual care and how to access it, the potential privacy/security risks and the scope of care provision should be made available to the patient and/or care partner, and verbal consent to provide care using virtual care electronic communication tools should be obtained and documented in the patient chart.[15]

## SECTION 3: CONSIDERATIONS RE: FLEXIBLE MODELS OF CARE DELIVERY

Flexible models of delivery are needed in response to the COVID-19 pandemic. Virtual care may be considered as a potential strategy to provide hip fracture rehabilitative care.[7] [16] Virtual care can often be utilized for all aspects of patient care, including the patient interview, physical assessment and diagnosis, treatment, maintenance activities, consultation, education and training. However, virtual care is not appropriate for all rehabilitative care needs and should be considered on a case-by-case basis.

The following factors should be taken into account when considering virtual care delivery of rehabilitation interventions:

- Access to technology and internet and other practical limitations (e.g., communication abilities).[17]

- Potential safety issues. Engage and train care partners to provide assistance for both the safety of tasks during intervention and/or technical support.[17] [18]
- Difficulty with hearing, vision or language barriers and the impact this will have on their ability to participate.[17]
- Cognitive ability and how it may impact their safety, ability to complete a self-directed program and the carry-over advice that is provided. [17]
- Confidentiality issues. Patients may be at home with many other people or in a virtual group therapy session, which can impact confidentiality. Additional sessions may be required for sensitive issues, e.g., phone call or private in-person visits. Clients may need to sign consents and/or paperwork where originals are required. Additional time for mailing may be needed.[15]
- Need for flexible hours to accommodate the needs of patients and their care partners. Allow for extra time to build rapport and trust and for potential technical issues. [17]
- Virtual care is more than video or phone visits. It includes digital supports for self-care, online education and self-management tools, provider-to-provider and provider-to-patient supports via messaging, email, text, apps, etc. and remote sensor monitoring.[13]

When the above considerations for virtual care cannot be met, patients and their care partners will need in-person assessment and intervention, i.e., ambulatory or in-home rehabilitation. Hybrid models which include both in-person and virtual care may also be considered (e.g., virtual assessment with in-person follow up, if required). In this case, health care providers will require the necessary equipment and must maintain physical distancing as per recommendations from public health. The following tables list interventions and clinical activities to consider when delivering rehab virtually versus in-person.

**Table 1: List of hip fracture interventions and clinical activities to consider delivering in a virtual capacity**

| Interventions and Clinical Activities |
|---|
| • Intake/history assessment<br>• Goal-setting with the patient and care partner to maximize function and develop a specific plan of care. Discuss the patient and care partners' expectations during this episode of care. Identify and address patient/care partner concerns.[3] [6]<br>• Review of educational materials, including benefits of a healthy active lifestyle, fall prevention, osteoporosis management, nutrition, safe activity level and precautions.<br>• Observation of home setting, including home equipment and safety check[19]<br>• Multifactorial fall risk assessment based on patient & care partner report and observation<br>• Osteoporosis management and fracture prevention interventions related to rehabilitation and exercise according to the Clinical Practice Guidelines for the Diagnosis and Management of Osteoporosis in Canada. Patients with fragility hip fractures are at high risk for future fractures. Emphasize to the patient and the care partners the importance of drug treatment in reducing future fractures. A bone mineral density test is not required at this point.[20] [21]<br>• Observation and provision of feedback for functional tasks, exercises and range of motion[19]<br>• Provision of rehabilitative care programs with regulated rehabilitative care professional supervision that is matched to the patient's needs[19]<br>• Administration of outcome measures, assessment and screening tools.<br>  ○ Cognitive Assessment (copy of the tool to be sent to the patient before the assessment)[22] |

- Considerations for choosing an appropriate tool can be found here: Choosing a Cognitive Screening Tool
- Depression Screening examples[23] [24]
  - Geriatric Depression Scale (GDS)
  - SelfCARE(D) self-rating scale
  - Patient Health Questionnaire – 9 (PHQ-9)
- Performance Outcome Measure examples:
  - 30 Second Chair Stand Test[25]
  - Timed Up and Go
- Patient Reported Outcome Measures examples:
  - EQ-5D-5L™
  - Pain Visual Analogue Scale (VAS)/Numeric Pain Rating Scale (NPRS)

**Table 2: List of hip fracture clinical needs or interventions requiring in-person assessment and/or treatment**

| Clinical Needs or Interventions |
|---|
| • Hands-on therapy, as required<br>• Assessment and intervention for skin integrity, mobility, balance and falls where patient safety is a concern<br>• Hands-on care partner or family teaching where required to support rehabilitation goals<br>• Cognitive, perceptual or emotional difficulties that limit independence and/or there is no care partner/family available to assist[17]<br>• Change in status requiring in-person visits to assess and treat[17] |


## ACKNOWLEDGEMENTS

This document reflects the work of a large number of individuals across the province. The RCA would like to acknowledge the contributions of the patients and care partners who kindly provided input via focus groups, the RCA Hip Fracture Best Practices Task Group and the RCA Frail Seniors Advisory Group.


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