National Office of Clinical Audit | Irish Hip Fracture Database IHFD

IRISH HIP FRACTURE DATABASE

NATIONAL REPORT 2025



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NATIONAL OFFICE OF CLINICAL AUDIT (NOCA)

NOCA was established in 2012 and is funded by the Health Service Executive (HSE), through the office of the Chief Clinical Officer (CCO), Dr Colm Henry, and is managed by HSE Quality and Patient Safety via the HSE National Centre of Clinical Audit (NCCA). Audits are commissioned by the NCCA via the CCO. NOCA is based in and operationally supported by the Royal College of Surgeons in Ireland (RCSI) and is independently governed by a voluntary board.

"Clinical audit is a clinically led quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit specific clinical standards or clinical guidelines and acting to improve care when clinical standards or clinical guidelines are not met. The process involves the selection of aspects of the structure, processes and outcomes of care which are then systematically evaluated against explicit specific clinical standards or clinical guidelines." (Patient Safety (Notifiable Incidents and Open Disclosure) Act, 2023) Following clinical audit, improvements, if required, should be implemented at an individual, team or organisation level and then the care re-evaluated to confirm improvements (Department of Health and Children, 2008).

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IITOS THE IRISH INSTITUTE OF TRAUMA AND ORTHOPAEDIC SURGERY

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Its core purposes are education and research in the study of ageing and promoting a better understanding by the general public of ageing and related issues.

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The Royal College of Surgeons in Ireland (RCSI) provides education and training in the fields of medicine and health sciences at undergraduate and postgraduate level. The RCSI has a strong international presence with schools in Malaysia and Dubai, and a university in Bahrain. The RCSI also provides surgery and emergency medicine training in all recognised specialties and subspecialties.

Trauma Care Ireland

The National Office for Trauma Services manages the implementation and oversight of the Trauma System.

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NOCA National Office of Clinical Audit

Professor Tara Coughlan and Mr Terence Murphy
National Clinical Leads
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2nd October 2026

Dear Professor Coughlan and Mr Murphy,

On behalf of the NOCA Governance Board, I wish to formally acknowledge receipt of the *Irish Hip Fracture Database National Report 2025*.

We extend our sincere congratulations to you and the entire IHFD team, including Audit Managers Dr Mary Walsh and Ursula Kelleher, the Governance Committee and Anne O'Shea Clarke, Patient and Public Interest Representative, for their continued commitment to this important audit.

This thirteenth national report highlights encouraging progress in hip fracture care, with improvements across all seven Irish Hip Fracture Standards and the highest achievement of the Best Practice Tariff since its introduction. With 98% national coverage, the audit continues to provide an important evidence base for benchmarking performance and improving care for older adults across Ireland.

We particularly commend the dedication of hospital audit coordinators and multidisciplinary teams whose ongoing efforts underpin these improvements. We also acknowledge Maureen O'Gorman and her daughter Mary for sharing their experience, highlighting the importance of rehabilitation, independence and person-centred care following hip fracture.

This letter serves as the formal endorsement of the NOCA Governance Board for the Irish Hip Fracture Database National Report 2025. We are confident that its findings will continue to support quality improvement and the delivery of high-quality hip fracture care nationally.

Yours sincerely,



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FOREWORD

It gives me great pleasure to introduce the Irish Hip Fracture Database (IHFD) National Report 2025, the thirteenth national report from this important audit programme. Since its establishment in 2013, the IHFD has become one of Ireland's most successful examples of how clinical audit can drive meaningful improvements in patient care through measurement, collaboration and shared learning. As someone who was fortunate to be involved in the development of the audit from its earliest stages, it is particularly rewarding to reflect on its continued growth and impact.

Hip fracture remains one of the most significant health events affecting older adults. In 2025, all seven Irish Hip Fracture Standards improved compared with the previous year, while achievement of the Best Practice Tariff reached its highest level since introduction. This demonstrates the dedication of clinicians, managers, audit coordinators and multidisciplinary teams working together across Ireland to improve care at every stage of the patient pathway.

As a Consultant Physician in Geriatric Medicine, I am particularly encouraged by the comprehensive review of the orthogeriatric standards undertaken during 2026. Orthogeriatric care has evolved considerably over the lifetime of the IHFD and is now a cornerstone of high-quality hip fracture care. The revised standards, to be implemented from 2027, reflect this progress, with greater emphasis on Comprehensive Geriatric Assessment, delirium, consultant involvement and secondary fracture prevention. These changes reflect the best available evidence while recognising the complexity and individual needs of older adults with hip fracture.

"Since its establishment in 2013, the IHFD has become one of Ireland's most successful examples of how clinical audit can drive meaningful improvements in patient care through measurement, collaboration and shared learning."

A particular highlight of this report is the story of Maureen O'Gorman and her daughter Mary, who generously shared their experience of hip fracture, rehabilitation and recovery. As a fellow Cork woman, Maureen's story has a special resonance for me, while reflecting experiences familiar to older adults and those important to them across Ireland. Their story brings to life the Age-Friendly Health System 4Ms Framework: What Matters, Mind, Mobility and Medication. Maureen's recovery demonstrates how coordinated, multidisciplinary and person-centred care can restore not only mobility, but independence, confidence and quality of life. It reminds us that successful hip fracture care is about seeing the whole person and supporting the outcomes that matter most to them. Thank you to Maureen and Mary for sharing their story.



Finally, I would like to acknowledge the ongoing commitment of the National Office of Clinical Audit, the IHFD Governance Committee, clinical leads, audit coordinators and healthcare teams across the country who continue to support this work. Their dedication has enabled the IHFD to become an internationally recognised audit and an important driver of quality improvement within Irish healthcare.

I commend this report to all those involved in caring for older people and look forward to the next phase of development of the IHFD as we continue to work together to improve outcomes for people who experience hip fracture in Ireland.

Professor Emer Ahern,
Honorary Clinical Professor, University College Cork,
National Clinical Advisor and Group Lead for Older Persons
& Consultant Physician in Geriatric Medicine,
Cork University Hospital

EXECUTIVE SUMMARY

This 2025 report from the Irish Hip Fracture Database (IHFD) represents the largest dataset reported to date, with 4,356 cases included. It is the thirteenth published report of the IHFD. With 98% national coverage across all 16 trauma-receiving hospitals, the IHFD continues to provide a robust platform for benchmarking care against the Irish Hip Fracture Standards (IHFS), supporting hospitals to monitor performance, identify opportunities for improvement and share learning nationally and internationally.

The report opens with a patient story that illustrates the lived experience of hip fracture, rehabilitation and recovery. Through the perspectives of Maureen, a 91-year-old woman who sustained a hip fracture and upper limb fracture, and her daughter Mary, the story highlights the impact of hip fracture on independence, confidence, mobility, nutrition and future living arrangements. Framed around the Age-Friendly Health System 4Ms framework – a blueprint published by the Health Service Executive (HSE) and the Department of Health, intended to transform health and healthcare in older adults – (What Matters, Mind, Mobility and Medication), it demonstrates the contribution of multidisciplinary rehabilitation, person-centred care and coordinated discharge planning in supporting outcomes that matter most to older adults and their families.

In 2025, all seven Irish Hip Fracture Standards improved compared with 2024, continuing the positive trend in care quality observed in recent years. Improvements were evident across the patient pathway, including timely admission, timely surgery, pressure ulcer prevention, orthogeriatric care and early mobilisation.

Performance against the Best Practice Tariff (BPT) also improved. Almost one-in-four patients (24%) received best-practice care, the highest level achieved since the introduction of the BPT in 2018. National BPT payments exceeded €1 million in one year for the first time, reflecting continued improvement in care processes across participating hospitals.

Improvements were also observed in several important aspects of perioperative and multidisciplinary care. Eighty-six per cent of patients received a pre-operative nerve block for pain management; 75% underwent a nutritional risk assessment; and 61% received a delirium assessment on admission. Occupational therapy assessment increased to 70%, reflecting growing multidisciplinary involvement in hip fracture care.

Findings from the third complete year of national surgical site infection (SSI) surveillance through the IHFD are also presented. During 2025–2026, SSI dashboards were developed in collaboration with the Antimicrobial Resistance and Infection Control team (AMRIC), supporting hospitals to monitor infection prevention measures and postoperative outcomes following hip fracture surgery.

Chapter 6 focuses on quality improvement in nutritional care following hip fracture, including collaboration with the Fragility Fracture Network (FFN) and engagement with the IHFD Dietitian Network. This work has strengthened multidisciplinary collaboration and supported local improvement initiatives across participating hospitals.

There are no new recommendations for the health service arising from the 2025 report. Instead, this report focuses on progress made against recommendations from the 2024 IHFD National Report, which are outlined in Chapter 8:

2024 Recommendation 1: Pressure ulcer prevention remained a national focus, with a reduction in the proportion of patients developing pressure ulcers from 4% to 3%.

2024 Recommendation 2: A national review of Orthogeriatric Standards (IHFS 4-6) was completed, and revised standards will be implemented from January 2027. Full details of the review are presented in Chapter 7, Audit Update. The revised standards place greater emphasis on timely comprehensive geriatric assessment, consultant geriatrician involvement, delirium screening and secondary fracture prevention, ensuring continued alignment of the audit with contemporary evidence and practice.

2024 Recommendation 3: Longer-term outcome reporting continued to develop in 2025. Ten hospitals recorded follow-up data, enabling reporting of mobility, quality of life and bone health outcomes from one hospital and one-year survival outcomes from three hospitals.

The IHFD Governance Committee and the National Office of Clinical Audit acknowledge the continued dedication of clinical leads, audit coordinators and multidisciplinary teams across Ireland. Their commitment continues to drive improvements in hip fracture care and outcomes for older adults nationally.

KEY FINDINGS

During 2025, all seven Irish Hip Fracture Standards (IHFS) improved compared with 2024. Improvements were observed across the patient pathway, including timely admission, timely surgery, pressure ulcer prevention, orthogeriatric care and early mobilisation.

The most notable improvements included:

- A three-percentage-point increase in the proportion of patients admitted to an orthopaedic ward or transferred directly to theatre within four hours of presentation (IHFS 1), rising to 39%.
- A two-percentage-point increase in the proportion of patients receiving surgery within 48 hours and during normal working hours (IHFS 2), rising to 79%.
- A reduction in pressure ulcer development from 4% to 3% (IHFS 3).
- Improvements of at least two percentage points across all three orthogeriatric standards (IHFS 4–6), with national achievement rates exceeding 88% for each standard.
- A three-percentage-point increase in early mobilisation (IHFS 7), with 88% of patients mobilised by a physiotherapist on the day of surgery or the day after surgery.

Performance against the Best Practice Tariff (BPT) reached its highest level since its introduction in 2018. Almost one-in-four patients (24%) received best-practice care and national BPT payments exceeded €1 million for the first time.

Improvements were also observed in several important aspects of perioperative and multidisciplinary care. Eighty-six per cent of patients received a pre-operative nerve block for pain management; 75% underwent a nutritional risk assessment; and 61% received a delirium assessment on admission. Occupational therapy assessment increased to 70% nationally.

Data quality and coverage remained strong in 2025. Overall coverage was 98%, with all 16 participating hospitals achieving the threshold required for inclusion in hospital-level reporting for the first time since 2021.

Longer-term outcome collection continued to develop, with 10 hospitals recording follow-up data and four hospitals achieving greater than 70% coverage, enabling more detailed reporting of mobility and mortality outcomes.



KEY HIGHLIGHTS 2025



98%
98% data coverage.

95%
95% of patients were brought straight to the operating hospital.

39%
Irish Hip Fracture Standard (IHFS) 1: 39% of patients were admitted to an orthopaedic ward or went to the operating theatre within 4 hours of presentation

86%
86% of patients received a pre-operative nerve block for pain

61%
61% of patients had a recorded delirium assessment on day 1 of their hospital admission

79%
IHFS 2: 79% of patients received surgery within 48 hours of admission

88%
IHFS 7: 88% of patients were mobilised by a physiotherapist on the day of surgery or the day after surgery

90%
IHFS 6: 90% of patients received a specialist falls assessment

92%
IHFS 5: 92% of patients received a bone health assessment

88%
IHFS 4: 88% of patients were seen by a geriatrician or advanced nurse practitioner

75%
75% of patients received a nutritional risk assessment

3%
IHFS 3: 3% of patients developed a pressure ulcer after admission

79,993
79,993 acute hospital bed days were occupied for patients with a hip fracture

22%
22% of patients were discharged directly home

45%
45% of patients were transferred to an on-site or off-site rehabilitation unit or to early-supported discharge.

24%
Best Practice Tariff: 24%

<1%
Surgical site infection rate: <1%

10
10 of 16 hospitals are actively recording follow-up outcomes, including mobility and mortality.

PATIENT STORY

Through the lens of the Age-Friendly Health System 4Ms (What Matters, Mind, Mobility and Medication) (HSE and Department of Health, 2025), Maureen O'Gorman, a 91-year-old retired primary school teacher, and her daughter Mary reflect on her recovery journey following a hip fracture and the role of multidisciplinary care in supporting rehabilitation and independence.

Maureen: what mattered most

Before the fall, I lived in Rosscarbery. I loved the fresh sea air, the scenery and looking out at Galley Head. I went to an active retirement group where we did exercises and talks. We even established a garden club and grew potatoes. I would meet friends, sit and talk, and always have tea somewhere. Then I would go home happy, watch television, read the Cork Examiner and keep up with what was happening. At the weekend, Mary (my daughter) would come and I would say: 'any news?' She would always bring me something nice. I loved having places to go, people to meet, things to read and something to look forward to. My faith has always been very important to me. It gives me great comfort, and it helps me take each day as it comes.

Mary: independence matters

Looking back, mum had become quite frail and probably wasn't eating or looking after herself as much as she used to. I think she was quite isolated and she thrives on company. The house she was living in was not very suitable, with stairs to the bedroom and bathroom. When she fractured her hip, there was a real worry about what was going to happen next. What she needed was better support, more interaction with people and the opportunity to have some independence again.

Maureen: learning to walk again

I felt the hospital staff in Cork University Hospital (CUH) were looking after me very well. I was in a small ward because I had COVID-19 at the time, but I just took each day as it came. When they decided to move me to the South Infirmary Victoria University Hospital, I thought, 'Grand altogether, I'm moving on from here'. I hoped I would get on well and be able to walk around again.

Firstly, I was given a walker, and I loved feeling that I could stand up straight. Then, I got a rollator and



"The house she was living in was not very suitable, with stairs to the bedroom and bathroom. When she fractured her hip, there was a real worry about what was going to happen next. What she needed was better support, more interaction with people and the opportunity to have some independence again."

thought, 'That's an awful big thing altogether'. But they showed me how to use it and, before long, I was walking everywhere. It meant I could go downstairs, watch television and get out into the garden. The physios were very good to me. I thought I was doing well, but they knew I could do even better.

The occupational therapist took me down to the kitchen to make my own tea. I put the kettle on and got the milk from the fridge. Another day she took me out for coffee. On the way, I said we needed to stop at the red lights and wait for green. It was lovely sitting there with ordinary people around me.

Time flew with all the books I read. People brought me fiction and history books. I loved the evening tea and the dinners in the South Infirmary Victoria University Hospital (SIVUH), especially the soup. Everyone should get a sample of it!

Mary: confidence to recover

While mum was in CUH, I was very focused on her physically. At times, she seemed confused and thought she was somewhere else. It was only later that the delirium was explained to us and we were reassured that it would pass. That information was so important, and I would encourage families not to be afraid to ask, 'Is this normal?'

What struck me when mum came to SIVUH was how positive everybody was. Week by week, they let her do more for herself. They gave her confidence, which was as important as the physical recovery. Rehabilitation gave mum a kind of focus that actually, 'I can get stronger'.

Before the fall, I was always encouraging mum to eat. The team found nutritious foods she enjoyed, even protein-enriched ice-cream. The medication review was another positive. Over the years, mum's medications had accumulated. During her hospital stay, they were carefully reviewed and now she only takes the medications she needs, which is a great outcome.

Maureen: 'I have a much better life now'

I told them if I went home, I had nobody to mind me. Different people came to talk to me and helped me get a place in a retirement village. It is beautiful, full of shrubs and plants. Every morning, I walk two rounds of the houses in the retirement village. I make my own breakfast, read every bit of the newspaper, politics and sport, and I do word searches too. I don't know who invented them but they're very good! I am learning all the time, and that's what keeps my mind active.

When Mary comes at the weekends, we go into Clonakilty and into any shop I like. Recently, I was at the Carbery Show in Skibbereen and I couldn't believe how many people I knew there! I have a much better life now. I am much more in control of myself. Nobody is telling me what to do. My advice to others is to keep going, take up a book and look forward to the day ahead.

Mary: 'we could never have imagined this outcome'

I thought after mum's fracture we were probably looking at nursing home care. Very quickly, the team reassured me that was not necessary. The outcome has been fantastic. She has her own house, but there is a community as well. She has support around her and her independence too. She even gets the Local Link bus to her club, which I never could have imagined before the fall.

Before, she was thin and slow on her feet. Now, I feel she's striding. She is eating better, enjoying her food and looking forward to her Sunday roast. Rehabilitation was a game changer: we were given time, which is critical. She has a whole better life. It goes to show, you can change people's lives, no matter what age they are.

"Firstly, I was given a walker, and I loved feeling that I could stand up straight. Then, I got a rollator and thought, 'That's an awful big thing altogether'. But they showed me how to use it and, before long, I was walking everywhere."

CHAPTER 1
INTRODUCTION



CHAPTER 1: **INTRODUCTION**

CONTEXT



Hip fracture remains one of the most serious and life-changing injuries affecting older adults in Ireland, associated with frailty, loss of independence and increased mortality. Its management requires timely, coordinated care across a complex multidisciplinary pathway, encompassing emergency care, surgery, peri-operative medicine, rehabilitation and access to community supports. As such, hip fracture care is widely recognised as a key marker of how effectively health services meet the needs of older people and deliver safe, high-quality unscheduled care.

Hip fracture places ongoing and significant demand on acute, rehabilitation and community services due to the complexity and frailty of this patient group. National policy emphasises the importance of delivering integrated, age-friendly care, as outlined in *Delivering an Age-Friendly Health System: A Blueprint to Transform Health and Healthcare for Older Adults (2025)*. Central to this approach is the 4Ms framework (What Matters, Medication, Mind and Mobility), which supports a coordinated, person-centred model of care focused on optimising outcomes and maintaining independence for older adults.

Contemporary evidence, including findings from the UK *REDUCE* study (REducing unwarranted variation in the Delivery of high qUality hip fraCture services in England and Wales), demonstrates that variation in hip fracture outcomes is strongly associated with modifiable organisational factors measured through clinical audit. Improvements in audited care processes, such as timely surgery, orthogeriatric care and early mobilisation, are associated with reduced mortality and improved patient outcomes (Patel *et al.,* 2023; Baji *et al.,* 2023).

The Irish Hip Fracture Database (IHFD) reflects this approach through measurement against the Irish Hip Fracture Standards (IHFS). This report presents findings on care delivered across 16 hospitals in 2025 and represents the 13th National IHFD report.

METHODOLOGY



The IHFD is a clinically led, national audit established in 2013 under the governance of the National Office of Clinical Audit (NOCA). The primary aim of the audit is to use clinical data to support and improve the quality of care delivered to people with hip fracture in Ireland. Through continuous measurement, benchmarking and feedback, the IHFD enables hospitals to monitor performance against the Irish Hip Fracture Standards (IHFS) and identify opportunities for quality improvement.

Data are collected through the Hospital In-Patient Enquiry (HIPE) IHFD Portal, which is supported by the Healthcare Pricing Office (HPO). Clinical information entered into the IHFD is combined with routinely collected HIPE data, including demographic and administrative information such as age, sex and admission source. Data collection is completed retrospectively by trained audit coordinators using information documented in patient medical records. See Appendix 2: Hospitals and People That We Work With.

The IHFD collects data on adults aged 18 years and over who sustain a hip fracture; however, the population reported in this national report is restricted to patients aged 60 years and older. In addition to acute admission data, the audit also supports collection of longer-term outcomes through a dedicated follow-up dataset. Where hospitals undertake routine follow-up, information relating to survival, mobility, functional status and other patient outcomes can be recorded on a supplementary IHFD follow-up screen within the HIPE Portal. Surgical site infection details are captured in either dataset, based on whether they occur as an inpatient or after discharge. The admission and follow-up datasets are available in Appendix 4 and Appendix 5.

Inclusion criteria

Cases are included in this report if they meet all the following criteria:

- The patient was discharged between 1 January and 31 December 2025 (or between 1 January and 31 December 2024 for analyses of one-year follow-up outcomes).
- The patient had a hip fracture identified through HIPE coding and/or met IHFD diagnostic criteria for an eligible hip fracture, specified as an intracapsular, intertrochanteric or subtrochanteric fracture.
- The patient was aged 60 years or older at the time of admission.

DATA QUALITY

Data quality remains a key priority for the IHFD. Each participating hospital has designated audit coordinators and clinical leads who are responsible for overseeing local data collection and review processes. Hospitals are also encouraged to maintain a multidisciplinary Hip Fracture Committee to support audit engagement and quality improvement activities. Eligible cases are identified through HIPE discharge reports generated within the IHFD Portal, and hospitals can access local reports to monitor performance throughout the year.

In many hospitals, audit data collection is undertaken by healthcare professionals in addition to their clinical duties. To support data quality and consistency, NOCA holds regular engagement sessions with audit coordinators and provides ongoing guidance regarding data definitions, completeness and validation. Overall, improvements in data completeness and accuracy were observed across several variables during 2025. National coverage remained excellent at 98%, with all 16 participating hospitals achieving the minimum coverage threshold required for inclusion in hospital-level reporting.

Further information regarding data quality assurance processes is available within the IHFD Data Quality Statement.

DATA ANALYSIS AND VALIDATION

The final data extract of admission data for the 2025 reporting period was received by NOCA from the Healthcare Pricing Office on 3 May 2026 with follow-up data being received on the 4 June 2026. Following validation and quality assurance checks, the data were analysed by the NOCA Data Analytics Team using the Microsoft Business Intelligence (BI) platform. Results presented in this report reflect the validated data available at the time of analysis.

For analyses relating to Irish Hip Fracture Standards (IHFS) 3, 5 and 6, patients who died during their acute hospital admission were excluded from performance comparisons. These patients are included in all other analyses presented within the report.

DATA COVERAGE

National coverage is calculated by comparing the number of hip fracture cases identified through the HIPE system, with the number of these cases that have IHFD data recorded. In 2025, 4,307 eligible HIPE cases had corresponding IHFD records out of 4,412 identified through HIPE, representing national coverage of 98%. Coverage exceeded 90% in all participating hospitals, demonstrating high level of engagement with the audit and supporting confidence in the national findings presented in this report.

As IHFD cases can be recorded in addition to those identified by HIPE, the overall report includes 4,356 hip fracture cases, which is the highest annual total reported since the audit began.

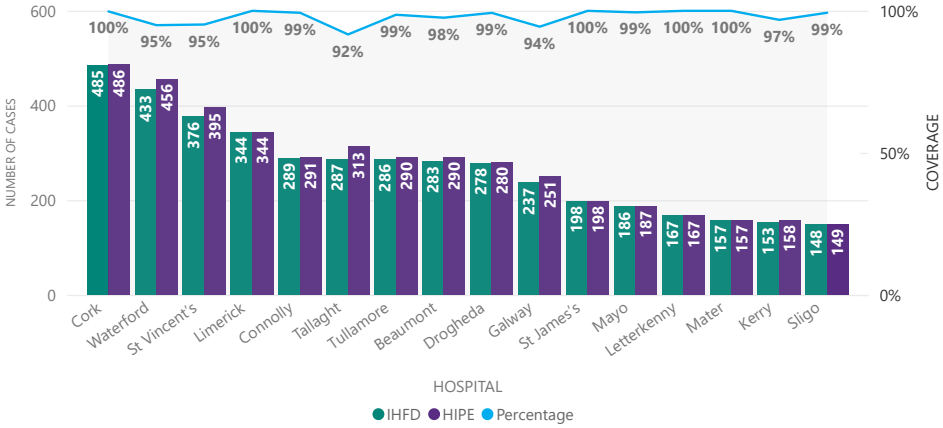
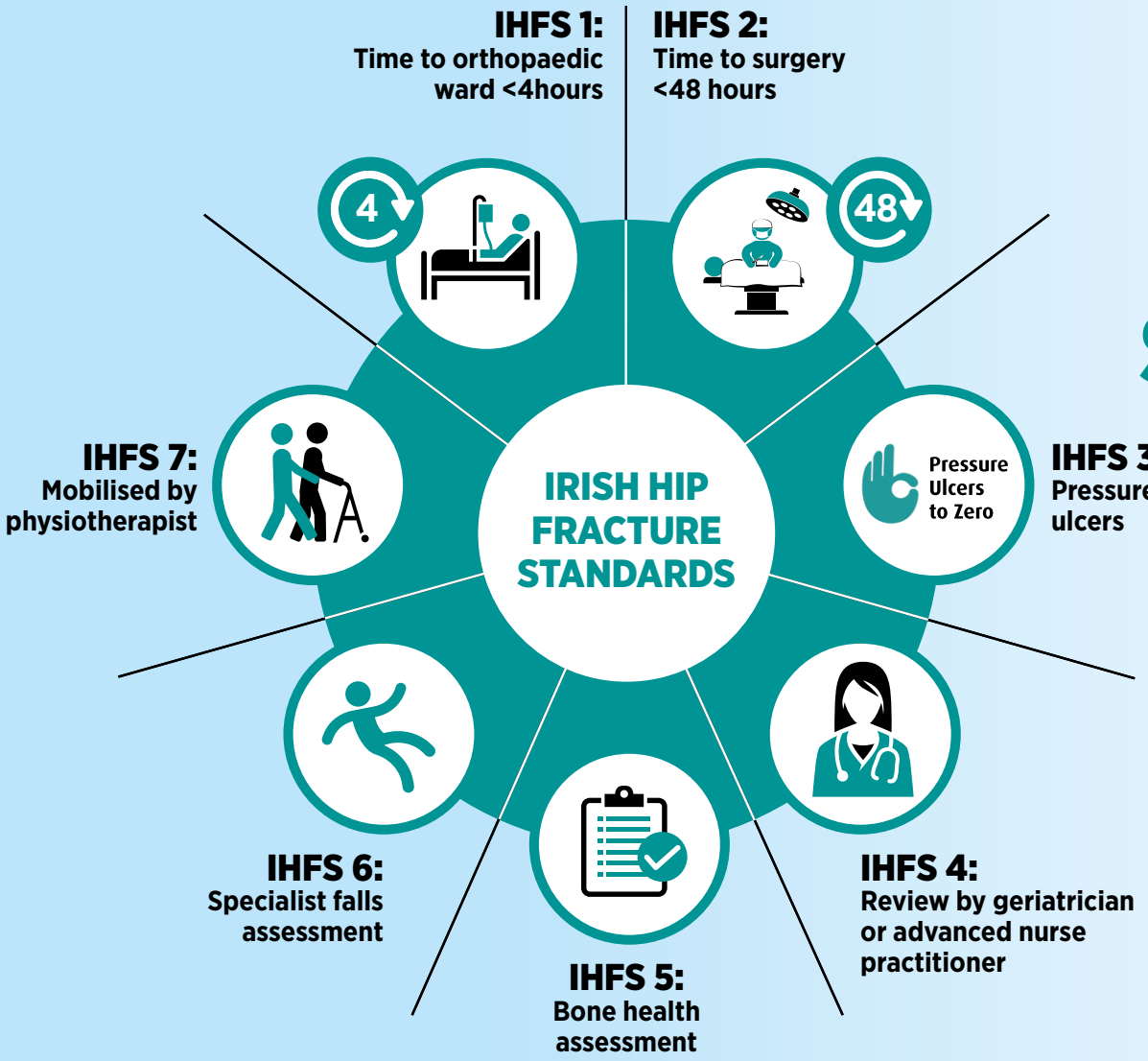


FIGURE 1.1: NUMBER OF HIP FRACTURE CASES PER HOSPITAL RECORDED ON THE HOSPITAL IN-PATIENT ENQUIRY SYSTEM IN 2025 (n=4412) AND HOSPITAL IN-PATIENT ENQUIRY CASES WITH IRISH HIP FRACTURE DATABASE DATA (n=4307), WITH PERCENTAGE COVERAGE[1]

[1] While the report includes 4,356 hip fracture cases in total, only 4,307 of these were HIPE cases included before the deadline for coverage calculation.



CHAPTER 2
IRISH HIP FRACTURE STANDARDS AND BEST PRACTICE TARIFF

CHAPTER 2: **IRISH HIP FRACTURE STANDARDS AND BEST PRACTICE TARIFF**

This chapter focuses on the IHFS and the Best Practice Tariff. The data will be presented at hospital level and national level. This information is intended to allow hospitals to benchmark their individual performance against their previous performance and against other hospitals' performance.

In 2025, all seven of the IHFS improved compared with 2024 (Figure 2.1). Six of the IHFS improved by two to three percentage points, while the proportion of patients developing a pressure ulcer dropped from 4% to 3%.

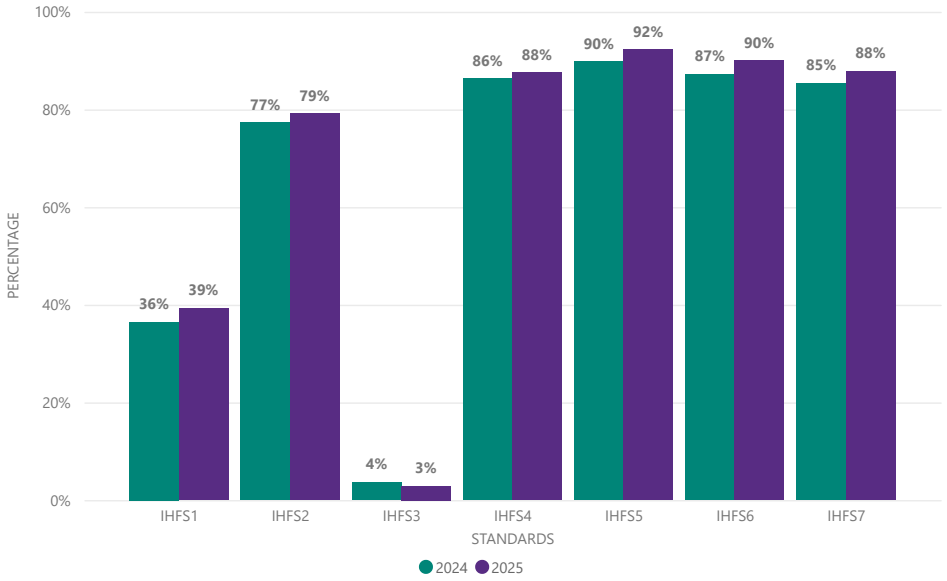


FIGURE 2.1: PERCENTAGE OF PATIENTS NATIONALLY WHO MET EACH IRISH HIP FRACTURE STANDARD, 2024 (n=4294) AND 2025 (n=4356)

IHFS 1

IHFS 1: Percentage of patients admitted to an orthopaedic ward within 4 hours of first presentation or admitted to the operating theatre from the ED within 4 hours of first presentation

In 2025, 39% (n=1,712) of patients with a hip fracture were admitted to an orthopaedic ward or transferred directly from the emergency department (ED) to theatre within four hours of first presentation (Figure 2.2). This represents an improvement of three percentage points compared with 2024 and 18 percentage points since 2022. Hospital-level compliance with IHFS 1 ranged from 4% to 74%. Ten of the 14 hospitals reporting in both years demonstrated improvement since 2024. This sustained progress is notable given the operational challenges associated with patient flow from EDs in acute hospitals.

Of the 2,644 patients who did not meet the four-hour target, a reason for delay was documented in 1,213 cases (46%). The most frequently reported reason was lack of bed availability (n=462; 17% of delayed cases). A further 8% (n=205) were delayed while awaiting orthopaedic assessment or investigation, and 163 patients (6%) were recorded as medically unwell. Additional detail is provided in Appendix 9.

In 367 cases (14%), the reason for delay was recorded as 'other', supported by free-text entries. While these entries provide contextual detail, the lack of standardisation limits their utility for analysis, comparison, and quality improvement.

Review of the free-text entries indicates that most responses cluster into a small number of recurring themes. Outside existing categories, these predominantly relate to delays in imaging (in particular CT brain), inter-hospital transfers, and delays in diagnosis or initiation of the hip fracture pathway. A substantial proportion of these could be captured within structured response categories.

NOCA will continue to work with audit coordinators to improve the completeness and consistency of data collection for this variable. In addition, three new structured response options will be introduced in 2027 to reflect the themes identified in free-text entries.

Improving the structure and usability of these data is essential to support meaningful analysis and to identify targeted opportunities to improve patient flow and timeliness of care.

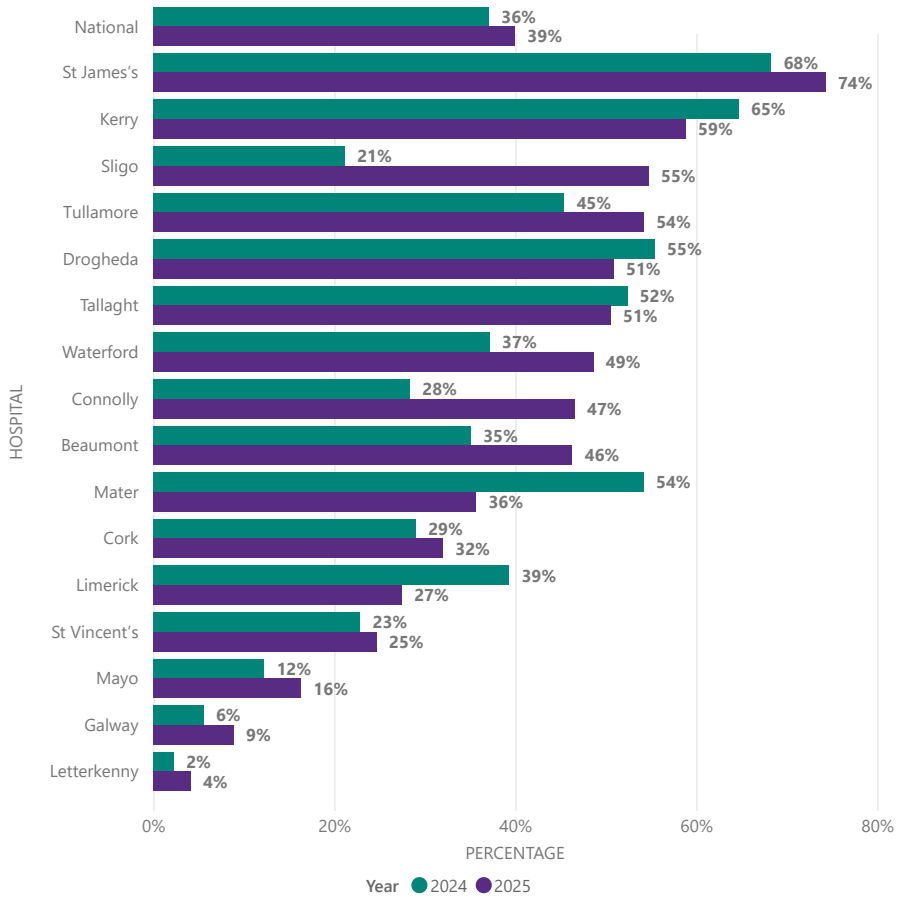


FIGURE 2.2: IRISH HIP FRACTURE STANDARD 1: PERCENTAGE OF PATIENTS ADMITTED TO AN ORTHOPAEDIC WARD WITHIN FOUR HOURS OF FIRST PRESENTATION OR ADMITTED TO THE OPERATING THEATRE FROM THE EMERGENCY DEPARTMENT WITHIN FOUR HOURS OF FIRST PRESENTATION, BY INDIVIDUAL HOSPITAL, 2024 (n=4294) AND 2025 (n=4356)[2]

[2] As coverage for Sligo University Hospital and Mayo University Hospital was less than 80% for 2024, the 2025 results are not comparable.

IHFS 2

IHFS 2: Percentage of patients receiving surgery within 48 hours of first presentation (and within normal working hours)

In 2025, 96% (n=4,181) of patients with a hip fracture underwent surgery. Of these, 79% (n=3,310) received surgery within 48 hours of admission and during working hours (Monday to Sunday, 8.00am–5.59pm) (Figure 2.3), representing an improvement of two percentage points compared with 2024. The national Health Service Executive (HSE) target of 85% reflects allowance for unavoidable delays due to medical complexity, rather than preventable process-related factors (HSE 2025).

Hospital-level compliance with IHFS 2 ranged from 64% to 91% in 2025. Of the 14 hospitals reporting in both years, eight demonstrated improvement since 2024, while two remained unchanged.

In 2025, 57% (n=2,399) of procedures were performed by a consultant orthopaedic surgeon and 33% (n=1,366) by a specialist registrar. A detailed breakdown of operating surgeon grade is provided in Appendix 9.

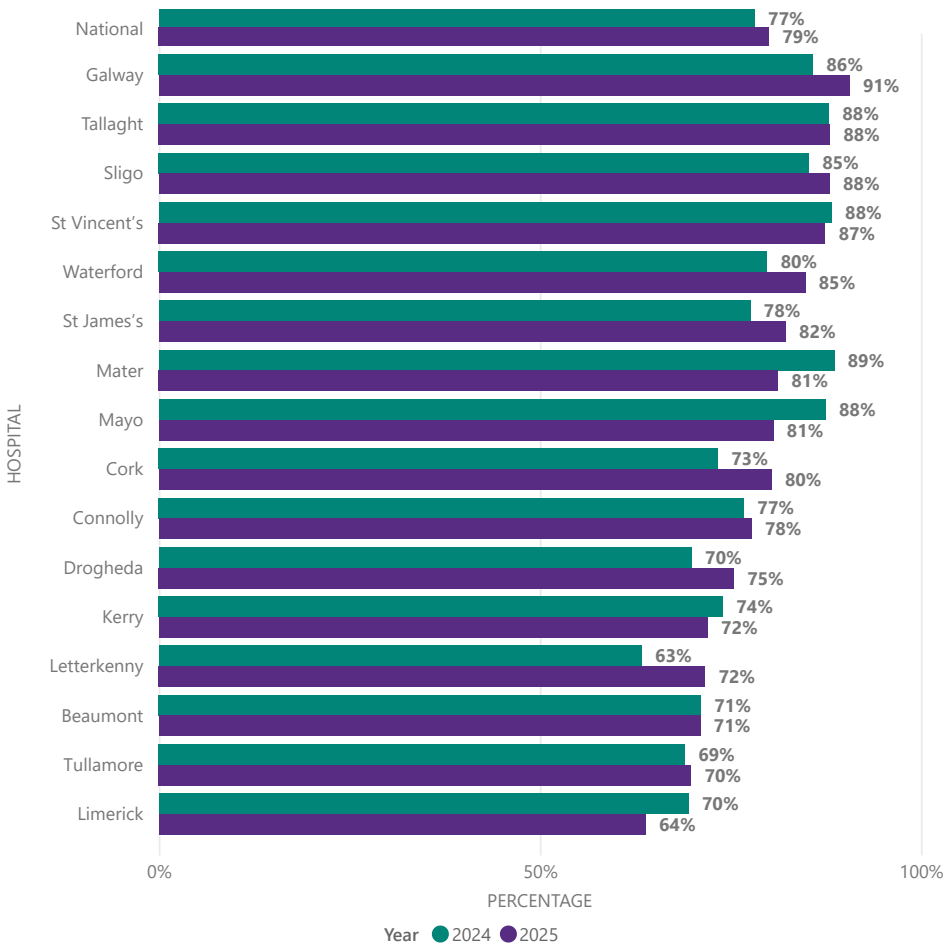


FIGURE 2.3: IRISH HIP FRACTURE STANDARD 2: PERCENTAGE OF PATIENTS RECEIVING SURGERY WITHIN 48 HOURS OF FIRST PRESENTATION (AND WITHIN NORMAL WORKING HOURS), BY INDIVIDUAL HOSPITAL, 2024 (n=4124) AND 2025 (n=4181)[3,4]

[3] Patients who did not have surgery have been excluded.
[4] As coverage for Sligo University Hospital and Mayo University Hospital was less than 80% for 2024, the 2025 results are not comparable.

Of the 871 patients who did not meet IHFS 2, 661 (75%) had a documented reason for a delay. The most frequently reported reasons were: awaiting medical review, investigation, or stabilisation (21%; n=187); issues related to anticoagulation (18%; n=160); and awaiting space on the theatre list (15%; n=133) (see Appendix 9).

In 106 cases (12%), the reason for delay was recorded as 'other', supported by free-text entries. Review of these entries demonstrated that delays categorised as 'other' were often multifactorial, commonly involving a combination of diagnostic uncertainty, specialist surgical review, medical optimisation, patient-related factors, and operational constraints. This reflects the complexity of a small subset of delays that are not fully captured within existing categories.

Free-text information is also collected to provide additional detail on delays attributed to medical review, investigation, or stabilisation. Review of these entries identified cardiac assessment and optimisation, respiratory illness, anticoagulation management, neurological review and critical care requirements as the most common themes, highlighting the clinical complexity underlying many surgical delays.

New fields were introduced to the IHFD dataset in 2026 to capture pre-operative anticoagulant and antiplatelet medication for all patients, recognising the potential impact of antithrombotic therapy on the timing of surgery and anaesthetic decision-making (ESAIC/ESRA, 2022; Griffiths *et al*., 2021). Data from these fields will be available for analysis in the 2026 report and will provide additional insight into the relationship between antithrombotic medication use and surgical timeliness.

IHFS 3

IHFS 3: Percentage of patients developing a pressure ulcer following admission

Of the 4,171 patients discharged alive in 2025, 3% (n=120) developed a new pressure ulcer during their admission (Figure 2.4). This represents a 1-percentage-point reduction compared with 2024. This standard includes pressure ulcers of grade 2 or higher that developed after admission and within 120 days of admission.

At hospital level, the proportion of patients who developed a pressure ulcer ranged from 0% to 7% in 2025.

In 2024, the national rate remained at 4% for a second consecutive year, with five of 14 hospitals reporting rates above 4%. In response, the 2024 report included detailed analysis of this cohort, which indicated that patients who developed pressure ulcers were more likely to have higher levels of illness on admission and to experience prolonged periods of immobility during their hospital stay. The 2024 report also recommended a renewed focus on pressure ulcer prevention education for staff at national and local level, in line with updated HSE resources.

While the reduction to 3% in 2025 reflects a return to levels observed between 2017 and 2022 (NOCA, 2022b; 2023), caution is required in interpretation given the severity of pressure ulcers and their association with poor patient outcomes (Song *et al.*, 2019). Individual cases should be reviewed at hospital level to identify local patterns and inform targeted quality improvement initiatives.

The variation observed between hospitals, including sites reporting very low rates, highlights the importance of continued review of pressure ulcer prevention practices, case ascertainment and data recording processes. During 2027, NOCA will work with audit coordinators to better understand variation in performance and facilitate shared learning across participating hospitals where appropriate.

Throughout 2026, NOCA has raised awareness of, and signposted to, the National Improvement Programme for Wound Management Clinical Resource Pack: Pressure Ulcers (HSE, 2025), a national initiative designed to support prevention and management. NOCA will continue to promote awareness of this resource in 2027.

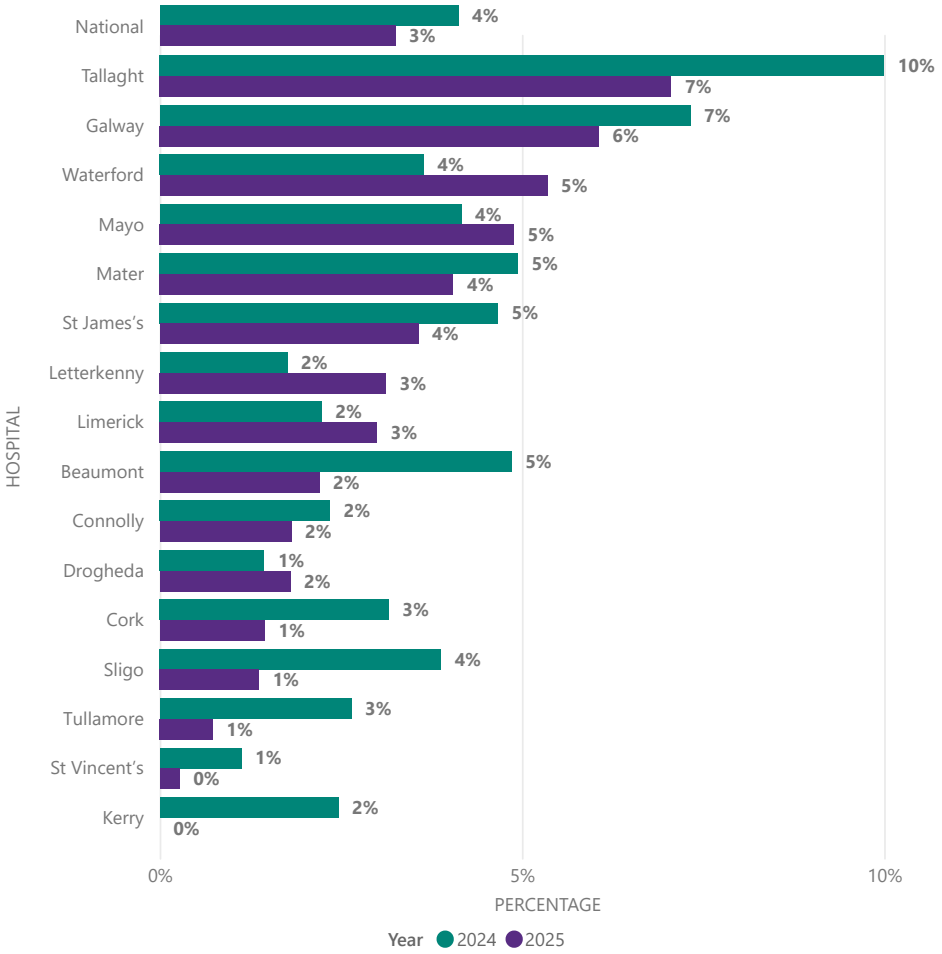


FIGURE 2.4: IRISH HIP FRACTURE STANDARD 3: PERCENTAGE OF PATIENTS WHO DEVELOPED PRESSURE ULCERS FOLLOWING ADMISSION, BY INDIVIDUAL HOSPITAL, 2024 (n=4112) AND 2025 (n=4171)[5,6]

[5] Patients who died have been excluded.
[6] As coverage for Sligo University Hospital and Mayo University Hospital was less than 80% for 2024, the 2025 results are not comparable.

IHFS 4

IHFS 4: Percentage of patients reviewed by a geriatrician or ANP at any point during admission

Figure 2.5 shows that, in 2025, 88% of patients (n=3,815) received a review by a geriatrician or advanced nurse practitioner (ANP) during their acute hospital stay, representing a 2-percentage-point increase compared with 2024. Although variation in hospital-level performance for IHFS 4 remains, the range narrowed in 2025. In both 2023 and 2024, one hospital reported compliance of only 30%. In 2025, the lowest hospital-level compliance increased to 59%.

Of the patients who met IHFS 4 (n=3,815), 63% (n=2,410) were reviewed by a consultant geriatrician and 23% were reviewed by an SPR/ Registrar (n=873). Overall, 28% (n=1,063) were reviewed by an ANP or candidate advanced nurse practitioner (cANP) during their admission, with over half of these (n=580) receiving a review from both an ANP and geriatrician. These proportions were broadly consistent with those reported in 2024. In terms of timeliness, 61% (n=2,327) of patients who met IHFS 4 received their first geriatric assessment within three days of hospital presentation. A further 23% (n=869) were assessed after three days, while the date of first geriatric assessment was unknown for 16% of patients.

The 2024 report recommended that NOCA explore whether IHFS 4–6 could be combined to provide a more comprehensive measure of best-practice orthogeriatric care. This recommendation was based on the consistent improvement observed across all three standards since 2017, together with the close relationship between the processes of care they measure. During 2026, a national review of Orthogeriatric Standards 4–6 concluded that future measurement should focus on timely initiation of Comprehensive Geriatric Assessment, Consultant Geriatrician involvement, delirium screening and integrated secondary fracture prevention. Revised standards will be introduced from January 2027 and are described in Chapter 7, Audit Update.

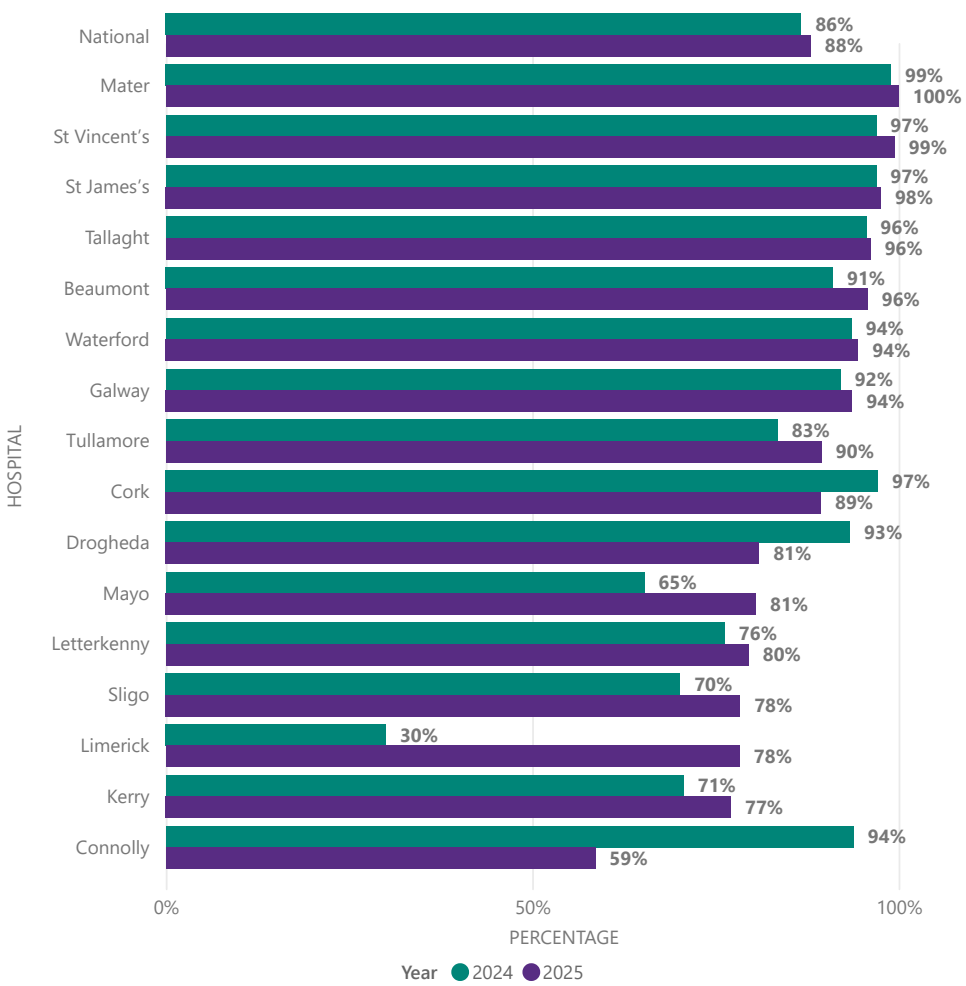


FIGURE 2.5: IRISH HIP FRACTURE STANDARD 4: PERCENTAGE OF PATIENTS SEEN BY A GERIATRICIAN OR ADVANCED NURSE PRACTITIONER AT ANY POINT DURING ADMISSION, BY INDIVIDUAL HOSPITAL, 2024 (n=4294) AND 2025 (n=4356)[7]

[7] As coverage for Sligo University Hospital and Mayo University Hospital was less than 80% for 2024, the 2025 results are not comparable.

IHFS 5

IHFS 5: Percentage of patients receiving a bone health assessment

Figure 2.6 shows that 92% (n=3,850) of patients received a bone health assessment in 2025, representing a 2-percentage-point increase compared with 2024. In 2025, 13 of 16 hospitals achieved at least 90% compliance with IHFS 5. While variation in performance remained between hospitals, the lowest hospital-level compliance improved substantially, increasing from 35% in 2024 to 75% in 2025.

Of the patients who achieved IHFS 5, 58% (n=2,240) were commenced on bone health medication during their admission, while 17% (n=654) continued medication that had been prescribed prior to admission.

A total of 25% (n=956) of patients who achieved IHFS 5 were not receiving bone health medication at discharge. Of patients that met IHFS 5, 8% (n=300) were awaiting a dual-energy X-ray absorptiometry (DXA) scan; 8% (n=295) were awaiting outpatient assessment; and, for 9% (n=361), bone health medication was recorded as not required or not appropriate. There was variation between hospitals in the proportion of patients discharged without bone health medication. The interpretation of these findings, and their relationship to the measurement of orthogeriatric care, formed part of the review of IHFS 4–6 and is discussed further in Chapter 7, Audit Update.

At present, the specific bone health medication prescribed or continued is recorded in a free-text field. This information is completed in more than two-thirds of relevant cases. Review of the free-text entries indicates that zoledronic acid and denosumab are the medications most frequently recorded; however, the free-text format limits detailed analysis and interpretation. A structured drop-down list will be introduced in 2027 to improve data quality and facilitate more consistent reporting.

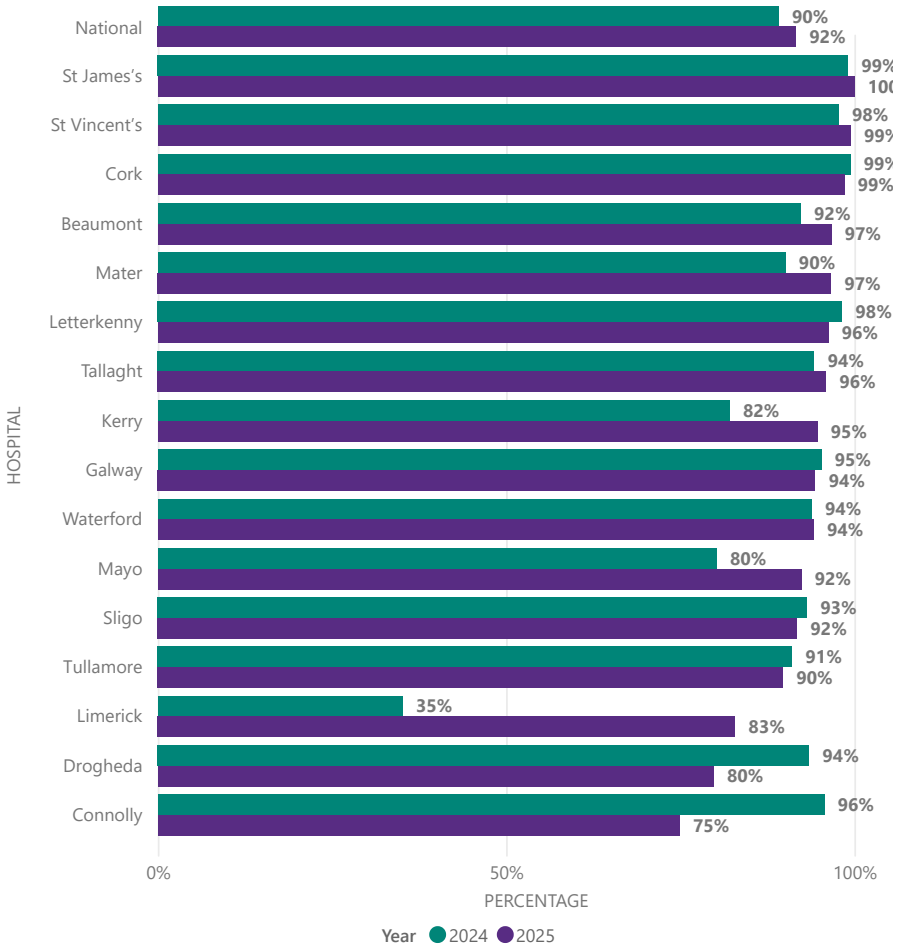


FIGURE 2.6: IRISH HIP FRACTURE STANDARD 5: PERCENTAGE OF PATIENTS RECEIVING A BONE HEALTH ASSESSMENT, BY INDIVIDUAL HOSPITAL, 2024 (n=4112) AND 2025 (n=4171) [8,9]

[8] Patients who died have been excluded.
[9] As coverage for Sligo University Hospital and Mayo University Hospital was less than 80% for 2024, the 2025 results are not comparable.

IHFS 6

IHFS 6: Percentage of patients receiving a specialist falls assessment

In 2025, 90% of patients with a hip fracture (n=3,755) received a specialist falls assessment during their admission, a 3-percentage-point increase compared with 2024 (Figure 2.7). Hospital-level performance also improved, with the lowest compliance increasing from 28% in 2024 to 72% in 2025. In addition, 13 hospitals achieved compliance of at least 90%.

For the purposes of this standard, a specialist falls assessment is defined as a systematic assessment undertaken by a suitably trained healthcare professional, such as a geriatrician or specialist nurse, which includes: evaluation of falls history; the cause of the index fall; risk factors for future falls and injury; and medication review. The assessment should inform a documented plan to reduce the risk of future falls.

Findings from the Irish Hip Fracture Database 2024 Organisational Survey indicate that specialist falls assessments are primarily delivered by orthogeriatric services and, typically, include a multifactorial assessment incorporating falls history, medication review, cardiovascular assessment, and investigation of potential causes of syncope where clinically indicated. While there is some variation in local service configuration, the core components of assessment have been reported as broadly consistent across hospitals.

The overlap in performance observed across IHFS 5 and IHFS 6, particularly in 2024 and 2025, formed an important component of the review of IHFS 4–6. The findings of this review are presented in Chapter 7, Audit Update, supporting development of a combined secondary fracture prevention standard from 2027.

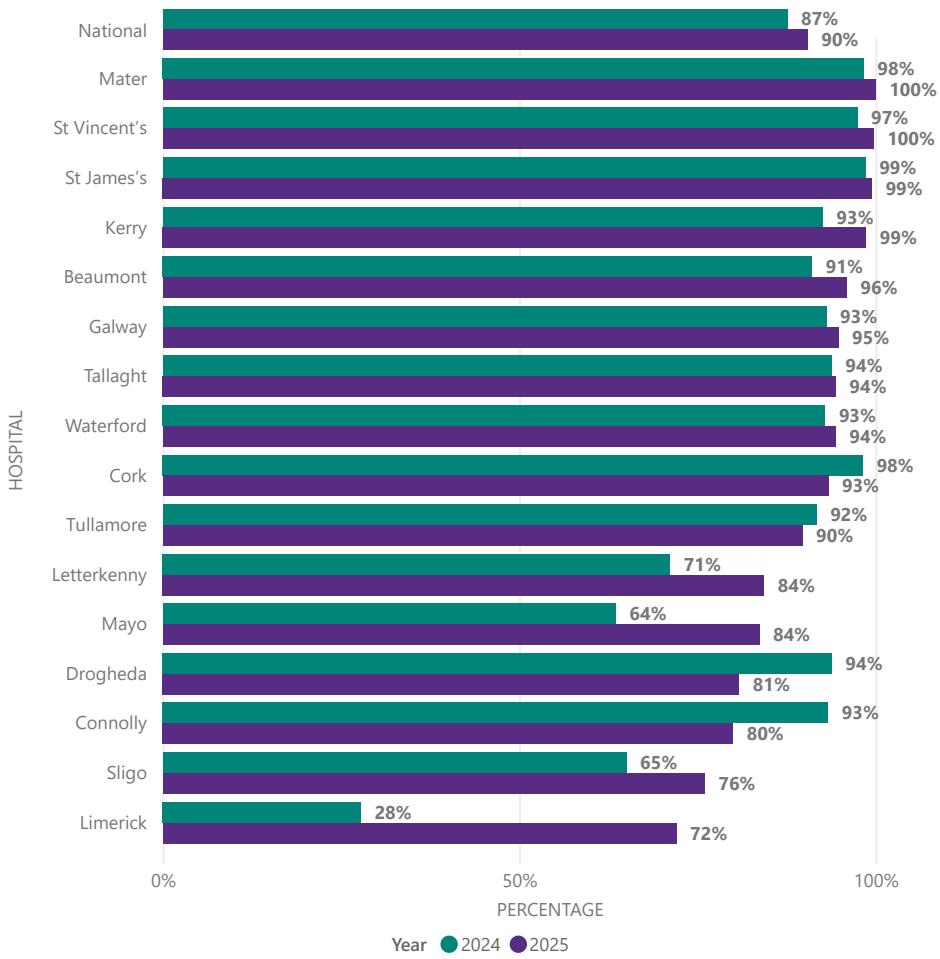


FIGURE 2.7: IRISH HIP FRACTURE STANDARD 6: PERCENTAGE OF PATIENTS RECEIVING A SPECIALIST FALLS ASSESSMENT, BY INDIVIDUAL HOSPITAL, 2024 (n=4112) AND 2025 (n=4171) [10,11]

[10] Patients who died have been excluded.
[11] As coverage for Sligo University Hospital and Mayo University Hospital was less than 80% for 2024, the 2025 results are not comparable.

IHFS 7

IHFS 7: Percentage of patients mobilised by a physiotherapist on the day of surgery or the day after surgery

In 2025, 88% of patients (n=3,672) achieved IHFS 7 (Figure 2.8). This represents an improvement of 3 percentage points compared with 2024 and 1 percentage point compared with 2023.

Physiotherapy assessment on the day of or the day following surgery was achieved for 97% of patients (n=4,045), while fewer than 1% (n=7) were mobilised, but not by a physiotherapist. For the purposes of IHFS 7, mobilisation is defined as the patient standing out of bed as a minimum.

Table 2.1 outlines the reasons provided for 493 patients not mobilising on the day of or the day following surgery. The most frequently reported reason was medical unfitness (47%; n=231). This reflects the clinical complexity of the hip fracture population and highlights that 100% compliance with IHFS 7 is neither expected nor appropriate. A further 87 patients (18%) were unable to mobilise because of confusion, agitation, or delirium. This highlights the impact of cognitive impairment on post-operative recovery and reinforces the importance of delirium prevention, screening, and early recognition throughout the patient pathway. By contrast, only 11 patients were not mobilised because of low baseline functional status, supporting the applicability of this standard to the vast majority of patients with hip fracture.

The national achievement of IHFS 7 remains high by international standards. For example, the National Hip Fracture Database in England and Wales reported that 82% of patients were mobilised out of bed (either standing or hoisted) by the day after surgery in 2025 (National Falls and Fragility Fracture Audit, n.d.).

Fifty-three per cent of patients with a hip fracture (n=2,218) had a Cumulated Ambulation Score (CAS) recorded after surgery and at discharge. The CAS is a validated measure of basic mobility that assesses a patient's ability to get in and out of bed, rise from a chair, and walk. While IHFS 7 records whether a patient has achieved early mobilisation, CAS provides a measure of the patient's level of functional mobility and independence. Recording CAS both after surgery and at discharge can demonstrate changes in mobility during the hospital stay, providing additional information on rehabilitation progress and recovery following hip fracture.

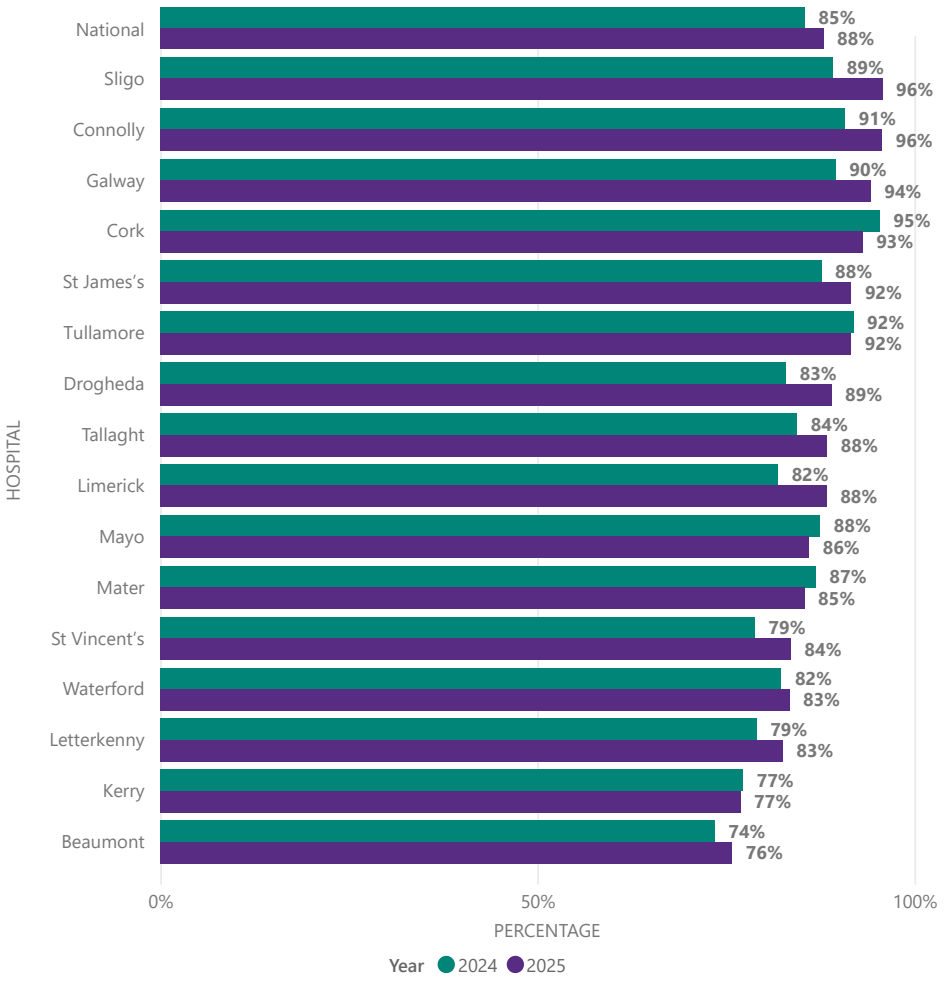


FIGURE 2.8: IRISH HIP FRACTURE STANDARD 7: PERCENTAGE OF PATIENTS MOBILISED BY A PHYSIOTHERAPIST ON THE DAY OF SURGERY OR THE DAY AFTER SURGERY, BY INDIVIDUAL HOSPITAL, 2024 (N=4124) AND 2025 (N=4181) [12,13]

[12] Patients who did not have surgery have been excluded.
[13] As coverage for Sligo University Hospital and Mayo University Hospital was less than 80% for 2024, the 2025 results are not comparable.

TABLE 2.1: REASONS FOR NOT MOBILISING IN 2025

Reasons	n	%
Medically not fit	231	47%
Confusion/agitation/delirium	87	18%
Other	41	8%
Pain	34	7%
Patient declined	34	7%
Staffing issues	31	6%
Not mobile pre-fracture	11	2%
Not documented	24	5%
Total	**493**	**100%**

BEST PRACTICE TARIFF

Since 2018, the IHFD has supported the Best Practice Tariff (BPT), which financially incentivises best practice hip fracture care as defined by the Irish Hip Fracture Standards. Further background and information about this are available on the NOCA website.

Overall, 24% of patients with a hip fracture received best practice care in 2025, representing an improvement of 3 percentage points compared with 2024. This is the highest level of achievement since the Best Practice Tariff (BPT) was introduced in 2018. Consequently, national BPT payments exceeded €1 million for the first time in 2025 (Figure 2.9).



FIGURE 2.9: IRISH HIP FRACTURE DATABASE TOTAL BEST PRACTICE TARIFF (BPT) PAYMENTS AND PERCENTAGE OF PATIENTS ACHIEVING THE STANDARD EACH YEAR FROM 2018 TO 2025

BPT PAYMENTS BY HOSPITAL

All hospitals participating in the IHFD received a BPT payment in 2025, although the value varied considerably between hospitals, ranging from €3,000 to €153,000 (Figure 2.10). Table 2.2 presents hospital-level BPT achievement in 2024 and 2025. Thirteen of the 16 hospitals improved their performance compared with 2024. Sligo University Hospital demonstrated the largest increase, with BPT achievement rising from 3% in 2024 to 32% in 2025. University Hospital Waterford also demonstrated notable sustained improvement, increasing from 18% in 2023 to 25% in 2024 to 35% in 2025. St James's Hospital achieved the highest rate nationally, with 57% of patients meeting the BPT criteria, and will receive the Golden Hip Award for the third consecutive year. Teams from all three hospitals have contributed case studies describing the quality improvement initiatives that supported these achievements, with potential learning for other hospitals seeking to improve performance.

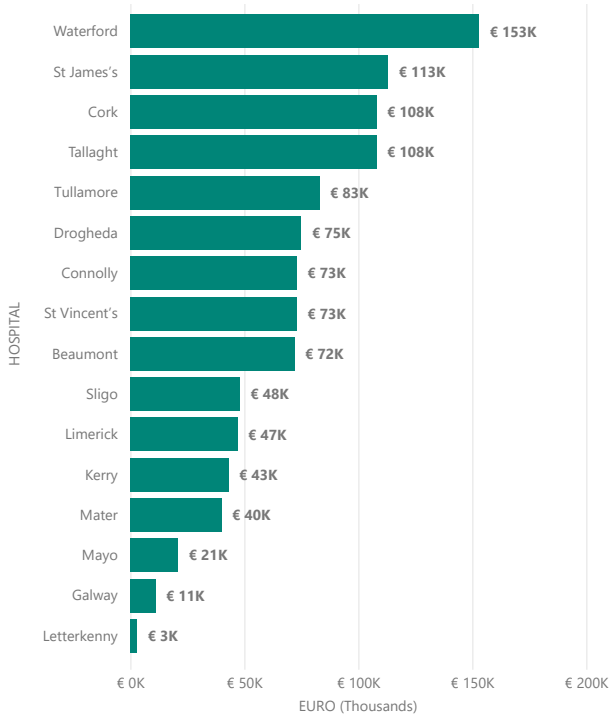


FIGURE 2.10: TOTAL BEST PRACTICE TARIFF PAYMENTS, BY INDIVIDUAL HOSPITAL, 2025

TABLE 2.2: BEST PRACTICE TARIFF ACHIEVEMENT BY INDIVIDUAL HOSPITAL, 2023–2025

Hospital	2023	2024	2025
Beaumont Hospital	5%	18%	25%
Connolly Hospital	10%	18%	25%
Cork University Hospital	24%	22%	22%
Our Lady of Lourdes Hospital Drogheda	13%	30%	27%
University Hospital Galway	1%	3%	5%
University Hospital Kerry	16%	27%	28%
Letterkenny University Hospital	2%	1%	2%
University Hospital Limerick	4%	7%	14%
Mater Misericordiae University Hospital	39%	39%	25%
Mayo University Hospital	3%	1%	11%
Sligo University Hospital	2%	3%	32%
St James's Hospital	49%	51%	57%
St Vincent's University Hospital	8%	17%	19%
Tallaght University Hospital	14%	37%	38%
Midland Regional Hospital Tullamore	21%	22%	29%
University Hospital Waterford	18%	25%	35%
National	**15%**	**21%**	**24%**

GOLDEN HIP AWARD 2025 : ST JAMES'S HOSPITAL

FROM ACHIEVEMENT TO OPPORTUNITY: RIGHT PATIENT, RIGHT PLACE, RIGHT TIME

We are delighted that St James's Hospital has been awarded the Golden Hip Award for the third consecutive year. The award recognises the hospital's performance across the seven Irish Hip Fracture Standards and achievement of the Best Practice Tariff, reflecting the CodeHip Team's continued commitment to high-quality hip fracture care.

Our experience of working together to achieve and sustain these standards has demonstrated what can be achieved through a focused, multidisciplinary approach. We continue to build on this experience by using our data to identify opportunities for improvement across the wider hip fracture pathway. Here, we share one such project focused on rehabilitation and recovery.

THE OPPORTUNITY FOR IMPROVEMENT

In 2024, our median length of stay for patients with hip fracture exceeded the national median. We recognised an opportunity to improve access to rehabilitation, make referral pathways clearer and support patients to move to the rehabilitation setting best suited to their needs. Working within the St James's



Hospital Rehabilitation and Recovery Programme, we set out to develop a more transparent, measurable approach to rehabilitation and recovery.

TURNING DATA INTO ACTION

Central to this work was embedding the Rehabilitation Complexity Scale-Extended (RCS-E) as an objective measure of rehabilitation need. Alongside the Clinical Frailty Scale, these data informed the development of a rehabilitation access matrix and decision tree to guide referral to the most appropriate post-operative rehabilitation setting.

Strong multidisciplinary collaboration was fundamental. Executive sponsorship through the Rehabilitation and Recovery Programme, supported by SCOPe leadership, helped drive the work, while monthly CodeHip meetings provided a forum to review data and build consensus. Embedding the RCS-E at day five required a significant workflow change. Developing the assessment within the Electronic Patient Record, with clear guidance for clinicians, helped integrate it into routine practice.

IMPROVING THE REHABILITATION JOURNEY

For patients and families, the rehabilitation and recovery pathway is now clearer. Staff have greater confidence discussing rehabilitation options, patients are better informed about their recovery pathway, and a more consistent referral process supports timely access to appropriate rehabilitation. The RCS-E is now embedded as standard practice, and median length of stay showed a sustained reduction from quarter two of 2025, reaching an estimated nine days by quarter two of 2026.

WHAT WE LEARNED

Objective measures provide valuable information, but improvement comes from how teams use that information together. Multidisciplinary collaboration, regular review and clear processes have helped us support the right patient to access the right rehabilitation pathway at the right time.

Receiving the Golden Hip Award for a third consecutive year is a source of great pride for our CodeHip Team, but also reminds us of the importance of continuing to look critically at where we can improve. Sustaining high-quality hip fracture care requires strong leadership, engaged multidisciplinary teams and a willingness to use our data to identify new opportunities for improvement. We are delighted to accept this award on behalf of everyone across St James's Hospital whose collective efforts make this achievement possible.

MOST IMPROVED AWARD 2025: SLIGO UNIVERSITY HOSPITAL

GETTING TO THE WARD SOONER: PRACTICAL CHANGES DRIVING IMPROVEMENT

We are immensely proud that Sligo University Hospital has received the IHFD Most Improved Award for 2025. Our improvement was seen across several Irish Hip Fracture Standards, contributing to an increase in Best Practice Tariff achievement from 3% in 2024 to 32% in 2025. This recognition reflects the dedication and collaboration of everyone involved in the care of patients with hip fracture and what can be achieved when teams across the patient pathway come together around a shared goal.

One of our clearest priorities was Irish Hip Fracture Standard 1 (IHFS 1), which measures timely admission to an orthopaedic ward or theatre. Achievement was 17% in 2023 and 21% in 2024. We wanted to reduce unnecessary delays in the Emergency Department (ED) and get patients to the orthopaedic ward as quickly and safely as possible.

A SHARED FOCUS ON REDUCING DELAYS

In January 2025, a committee was established under the leadership of the Hospital Manager, bringing together Orthopaedics, Emergency Medicine, Orthogeriatrics, nursing, perioperative services and the hip fracture audit team. Having the right people around the table created strong buy-in and a shared vision for improving the patient journey.

Together, we developed a clear ED-to-ward pathway, beginning with a National Ambulance Service pre-alert and incorporating early investigations and fascia iliaca block, fast-track transfer where appropriate, and structured ISBAR handover to the orthopaedic ward. The pathway includes clear contact details and is displayed prominently in the ED. Education is repeated at each non-consultant hospital doctor changeover.



PRACTICAL CHANGES THAT MADE A DIFFERENCE

Some of the changes were simple but made a real difference. Best Practice Tariff funding enabled us to purchase a dedicated hip fracture trolley, stored on the orthopaedic ward so it is always available, and a dedicated block trolley for the ED. A whiteboard alerts the ED porter to collect the hip fracture trolley when a pre-alert is received. Early communication with the orthopaedic ward means a bed and pressure-relieving mattress can be prepared before the patient arrives, while agreed criteria help identify patients requiring medical review in the ED.

For patients, reducing these delays matters. One patient described spending three hours in the busy ED following her hip fracture and finding it difficult to get comfortable. Reaching the ward made a real difference: she was comfortable in bed and reassured that preparations were already underway for theatre the following morning.

SEEING THE IMPACT

Our IHFS 1 achievement increased from 21% in 2024 to an average of 55% in 2025, reaching 72% in quarter two. Regular review of Irish Hip Fracture Database results at governance and orthopaedic specialty meetings, alongside visible feedback of results in the ED and ward, has helped maintain momentum.

Receiving the Most Improved Award is an important recognition of how far our team has come. Our experience has shown us the value of getting the right people around the table, keeping the pathway clear and looking closely at practical barriers to patient flow. With leadership, teamwork, education and continued communication, small, achievable changes can add up to significant improvement. We are proud of the progress made and committed to building on it for every patient with hip fracture.

SUSTAINED IMPROVEMENT 2025: UNIVERSITY HOSPITAL WATERFORD

NO BONES ABOUT IT: EVERY STEP IS SUNNIER IN UHW

We are delighted that University Hospital Waterford has been recognised for Sustained Improvement in hip fracture care. Our Best Practice Tariff achievement increased steadily from 18% in 2023 to 25% in 2024 and 35% in 2025, reflecting sustained progress across our service.

Hip fracture can be a distressing and uncertain time, from injury through to discharge. Our highly engaged multidisciplinary team is committed to incrementally improving each stage of the patient journey through seamless coordination, clear communication, timely surgery, excellent peri-operative and age-friendly care, and early rehabilitation.

BUILDING AN INTEGRATED PATHWAY

Our overarching goal was to streamline high-quality, patient-centred care from pre-admission to discharge. Staff awareness, ongoing training and education have been central to this work. Our team developed an integrated care pathway incorporating an Emergency Department (ED) care bundle, multidisciplinary admission booklet, theatre pathway and hip fracture nursing care booklet. Recognising the importance of early mobilisation and nutrition, we introduced seven-day priority physiotherapy, a 'SipTilSend' approach to minimise fasting, and proactive prescription of oral nutritional supplements.

Ensuring consistent high-quality care across multiple services and disciplines is challenging. Our integrated care pathway is triggered by National Ambulance Service pre-alerts to the ED, with simultaneous activation of the ED care bundle and our dedicated emergency hip fracture alert, notifying the orthopaedic senior house officer and Surgical Bed Manager. This supports timely imaging, early fascia iliaca block, orthopaedic assessment and bed allocation, as well as coordinated orthogeriatric care.







INVESTING IN SUSTAINED IMPROVEMENT

University Hospital Waterford has consistently performed well across several Irish Hip Fracture Standards, particularly early mobilisation (IHFS 7). Best Practice Tariff funding has supported investment in equipment, telemetry and environmental improvements across our orthopaedic wards and other services. Working with hospital management, we have also developed an off-site orthogeriatric acute reablement unit. Since its introduction, we have observed shorter hospital stays and a greater proportion of patients returning directly home. Feedback from patients and relatives has been very positive, particularly in relation to our ward environment and multidisciplinary care pathway across both the hospital and reablement unit.

BUILDING ON PROGRESS YEAR ON YEAR

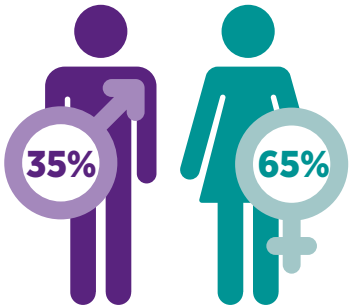
Over time, and with the involvement of hospital management and our multidisciplinary teams, we have made consistent improvements across the patient journey, building on them year on year. Quality improvement has its ups and downs, but through teamwork, persistence, a positive outlook and identifying key priorities each year, meaningful change can blossom over time. Teamwork and persistence really can make the dream work!

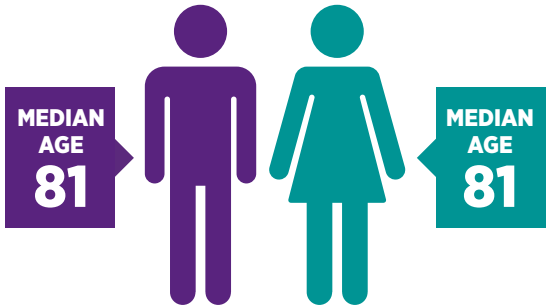


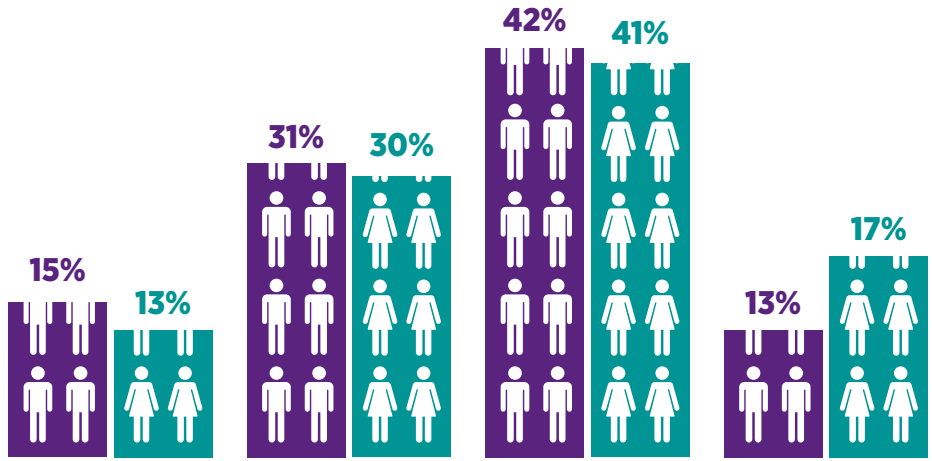
CHAPTER 3
CASE MIX FOR 2025

CHAPTER 3: **CASE MIX FOR 2025**

SEX & AGE GROUP







AGED 60-69 **13%**

AGED 70-79 **30%**

AGED 80-89 **41%**

AGED 90+ **15%**

SOURCE OF ADMISSION



Admitted from home



Other



Transfer from nursing or other long-stay facility



Transfer from hospital included in HIPE listing

[14] Percentages may not add to 100% due to rounding

AMERICAN SOCIETY OF ANESTHESIOLOGISTS (ASA) PHYSICAL STATUS CLASSIFICATION (DRIPPS, 1963)[15]

GRADE 1 — 1%
Healthy person

GRADE 2 — 31%
Mild systemic disease

GRADE 3 — 59%
Severe systemic disease

GRADE 4 — 8%
Severe systemic disease that is a constant threat to life

GRADE 5 — 0%
A moribund person who is not expected to survive without the operation

CLINICAL FRAILITY SCALE (CFS) RECORDED

CFS 1	CFS 2	CFS 3	CFS 4	CFS 5
2%	7%	10%	10%	11%

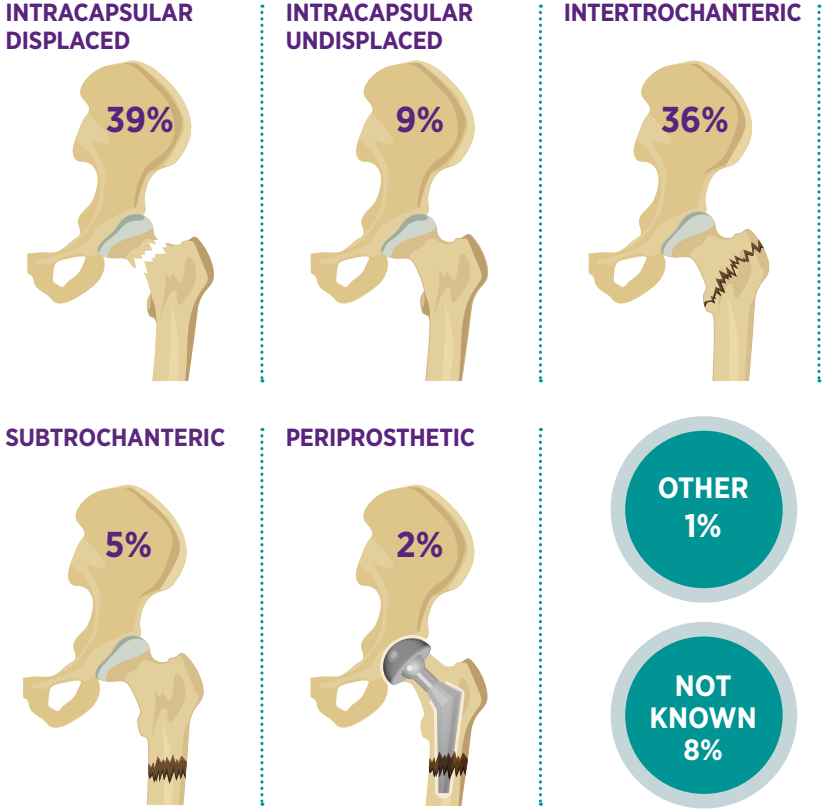
CFS 6	CFS 7	CFS 8+	UNKNOWN
12%	8%	1%	39%

PRE-FRACTURE MOBILITY, NEW MOBILITY SCORE (NMS)[16]

0-6 LOW FUNCTIONAL ABILITY — 50%

7-9 HIGH FUNCTIONAL ABILITY — 50%

FRACTURE TYPE



[15] A total of 369 patients did not have an ASA grade recorded and have been excluded from the analysis.
[16] Only patients with scores for all three types of mobility are included in this analysis; 341 patients did not have an NMS recorded for any of the following: indoor walking, outdoor walking or shopping.



CHAPTER 4
PATIENT PATHWAY

CHAPTER 4: **PATIENT PATHWAY**

This chapter describes the journey patients take from the time of their injury and through the hospital system.

PLACE OF INJURY

Overall, the most common place for hip fracture injury to occur was in the home (n=2,863; 66%), representing two-thirds of the cohort. A further 14% each took place in public areas (n=627) and institutions (n=627). See Appendix 9: Additional Information. In line with these findings, NOCA will continue to promote materials on home safety and falls, which are available on the NOCA website in the form of infographics, and a checklist and video.

In 2025, a total of 72 hip fractures occurred within the hospital, representing less than 2% of all hip fractures. This is unchanged compared to the five-year period 2020–2024, as presented in the 2024 report.

ADMISSION PATHWAY

In 2025, 95% of patients with a hip fracture (n=4,131) were brought directly to the operating hospital. Five per cent of patients (n=201) were assessed by the orthopaedic team during their hospital stay, either following admission through another service, such as a clinic or under a different specialty, or after experiencing an inpatient fall. This is unchanged from 2024.

CUMULATIVE TIME TO SURGERY

In 2025, 46% of patients with a hip fracture (n=1,944) received their surgery within 24 hours, 64% (n=2,663) received their surgery within 36 hours and 80% (n=3,344) received their surgery within 48 hours (Figure 4.1). There has been improvement in all three time points by 2–3 percentage points since 2024.

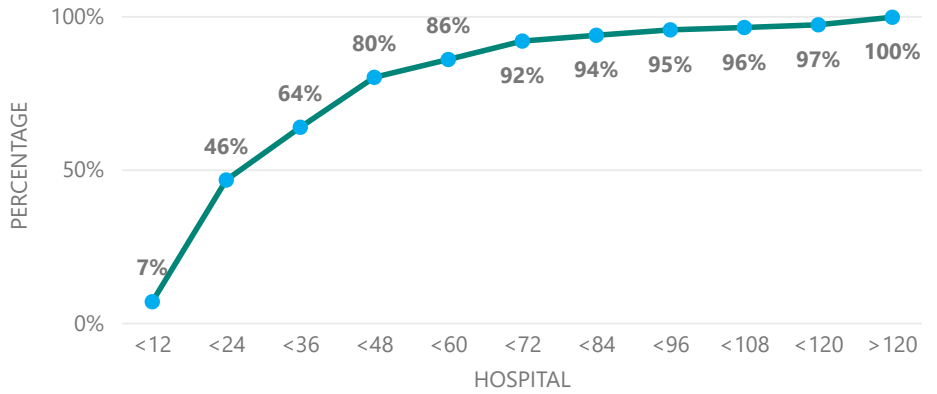


FIGURE 4.1: CUMULATIVE TIME TO SURGERY, 2025 (n=4181)

TYPE OF ANAESTHESIA

Spinal anaesthetic (SA) continues to be the predominant type of anaesthesia used (70%; n=2,924); this includes SA on its own and a combination of SA and sedation or SA and a nerve block. It is also used in combination with general anaesthetic (GA) (2%; n=78). Twenty-eight per cent (n=1,153) of patients with a hip fracture received GA in 2025, a 3% increase from 2024 and a 6% increase from 2023. There continues to be variation across individual hospitals in terms of the type of anaesthesia used.

PERCENTAGE RECEIVING A NERVE BLOCK

Eighty-six per cent (n=3,605) of patients received a nerve block pre-operatively in 2025 (Figure 4.2), which represents an increase of 2 percentage points since 2024 and 4 percentage points since 2023. Data from the Irish Hip Fracture Database 2024 Organisational Survey indicate that pre-operative nerve blocks are primarily provided by Emergency Department physicians, either independently or in collaboration with anaesthetic teams, highlighting variation in local models of care. The widespread use of pre-operative nerve blocks is in keeping with contemporary European Society of Regional Anaesthesia (ESRA) Procedure Specific Postoperative Pain Management (PROSPECT) recommendations for pain management following hip fracture surgery, which emphasise regional anaesthetic techniques as part of a multimodal analgesic approach that may reduce reliance on opioid analgesia (Pissens *et al*., 2024).

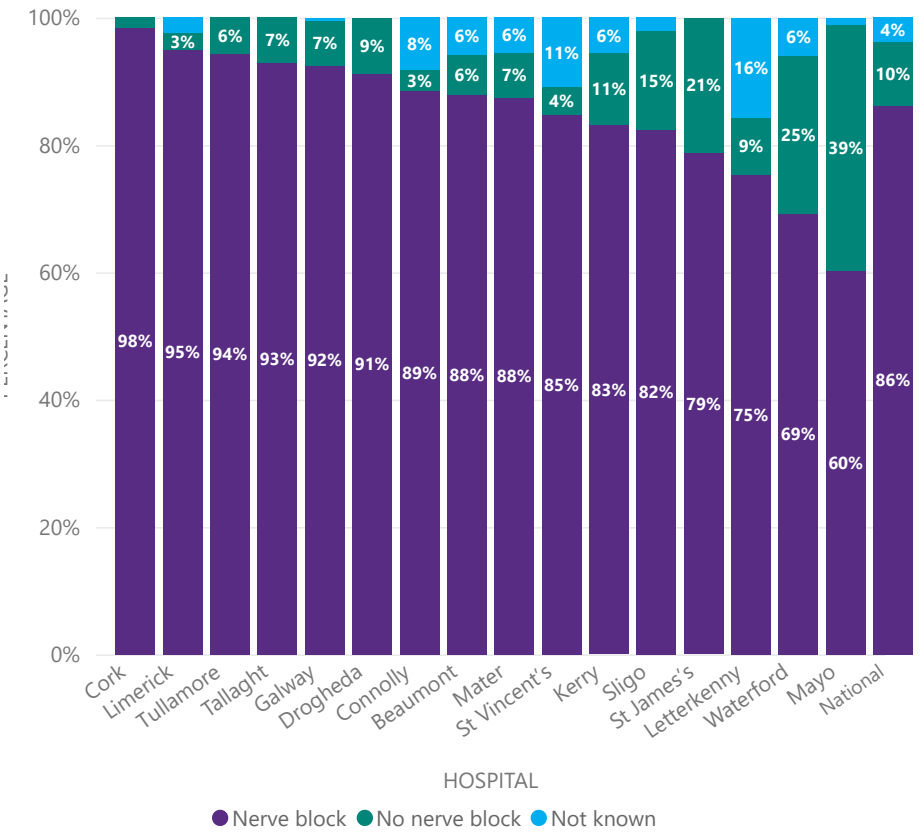


FIGURE 4.2: PERCENTAGE OF PATIENTS WHO RECEIVED A NERVE BLOCK PRE-OPERATIVELY, BY INDIVIDUAL HOSPITAL, 2025 (n=4181)[17]

[17] Patients who did not have surgery have been excluded.

NUTRITIONAL RISK ASSESSMENT

Figure 4.3 shows that 75% of patients (n=3,255) received a nutritional risk assessment during their admission in 2025, representing an improvement of 4 percentage points compared with 2024. Of those assessed, 2% (n=79) were identified as malnourished, 17% (n=558) were identified as being at risk of malnutrition, and 80% (n=2,618) were classified as having normal nutritional status. There was substantial variation between hospitals in the proportion of patients receiving a nutritional risk assessment and also in the proportion identified as 'at risk' when assessed.

The relatively low proportion of patients identified as malnourished contrasts with the international literature, which consistently reports a high prevalence of malnutrition (15–40%) and nutrition-related conditions among older adults admitted with hip fracture (Meermans and van Egmond, 2025). Malnutrition, undernutrition, sarcopenia, and frailty frequently coexist in this population and are associated with poorer clinical outcomes, including increased complications, reduced functional recovery, and higher mortality. Traditional nutritional screening tools may not fully capture the complexity of nutritional deficits in older adults with hip fracture, many of whom have experienced gradual loss of muscle mass, weight, and physiological reserve prior to their injury (Inoue *et al.,* 2020; Chiavarini *et al.,* 2024).

Nutrition remains an important area for quality improvement within hip fracture care. Building on the national collaboration event held in March 2025, NOCA has continued to support the development of the IHFD Dietitian Network and strengthen links with international initiatives. Chapter 6 describes how collaboration with the Fragility Fracture Network (FFN), informed, in part, by the SIMPLER Nutrition Pathway (Bell *et al*., 2025), has supported shared learning, multidisciplinary engagement and local quality improvement activity across participating hospitals.

National Clinical Guideline No. 22 recommends that all adults admitted to an acute hospital setting should undergo nutritional screening and receive appropriate nutritional support where indicated (Department of Health, 2020). To strengthen measurement of nutrition care within the IHFD, a new variable will be introduced in 2027 to record the prescription of oral nutritional supplements. Further work will continue to determine whether a nutrition-related IHFS can be developed that is clinically meaningful, evidence-based, and feasible to implement consistently across hospitals.

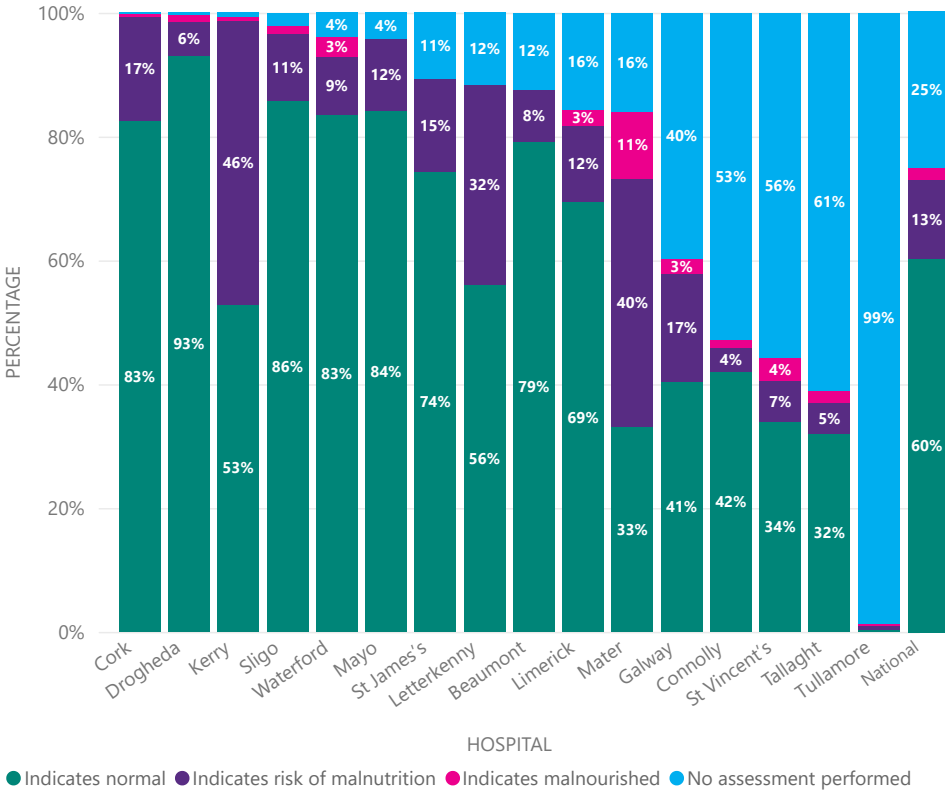


FIGURE 4.3: PERCENTAGE OF PATIENTS BY NUTRITIONAL RISK ASSESSMENT RESULTS, BY INDIVIDUAL HOSPITAL, 2025 (n=4356)

DELIRIUM SCREENING

Delirium is an acute neuropsychiatric syndrome characterised by a disturbance in attention, awareness and cognition that develops over a short period of time. It is common among older adults who sustain a hip fracture and is associated with poorer patient outcomes, including prolonged hospital stay, increased risk of re-admission and higher mortality. The 4AT screening tool (MacLullich, 2011) is widely used nationally and internationally to identify patients with possible delirium, enabling prompt investigation of underlying causes and early intervention to prevent further deterioration (www.the4AT.com).

Delirium screening is widely incorporated into international hip fracture audits. A HipCog scoping review found that: 14 of 22 audits recorded delirium screening; eight used the 4AT tool; and five included delirium screening within their standards of care (Merriman *et al*., 2025). UK data have also demonstrated an association between delirium assessment and improved quality of life following hip fracture (Griffin *et al*., 2021).

Figure 4.4 demonstrates that 61% (n=2,661) of patients underwent 4AT screening on the day of admission, representing an improvement of seven percentage points since 2024 and 12 percentage points since 2023.

Figure 4.5 shows that 47% (n=2,058) of patients underwent 4AT screening on day 3 of admission, representing an improvement of five percentage points compared with 2024.

Figure 4.6 demonstrates that 47% (n=2,026) of patients underwent 4AT screening at another point during their admission, representing an improvement of six percentage points compared with 2024.

Despite these improvements, marked differences in screening practice remain between hospitals. Completion rates for 4AT screening on admission ranged from 4% to 99%, while rates on day 3 of admission ranged from 3% to 81%. Screening completion at any other point during admission ranged from 16% to 84%.

Figure 4.7 presents the proportion of patients who screened positive for delirium using the 4AT. Of those assessed, 13% (n=352) screened positive on the day of admission, 21% (n=435) screened positive on day 3 of admission, and 19% (n=385) screened positive at another point during their hospital stay.

Delirium assessment is not currently included within the IHFS, despite national guidance recommending routine 4AT screening for older adults presenting to the ED or AMAU (HSE, 2019). All patients admitted with a hip fracture should undergo delirium screening on admission and receive appropriate prevention and management throughout their hospital stay.

A review of Orthogeriatric Standards 4–6, undertaken following a recommendation in the 2024 IHFD Report, considered the introduction of a delirium care standard. Given that delirium screening is a standardised and measurable process that is routinely collected internationally, a new delirium standard will be introduced to the IHFS from 2027 (see Chapter 7: Audit Update). The introduction of this standard represents one of the most significant developments arising from the 2026 review of orthogeriatric standards. It reflects growing national and international recognition of the importance of delirium identification and management in improving outcomes following hip fracture.

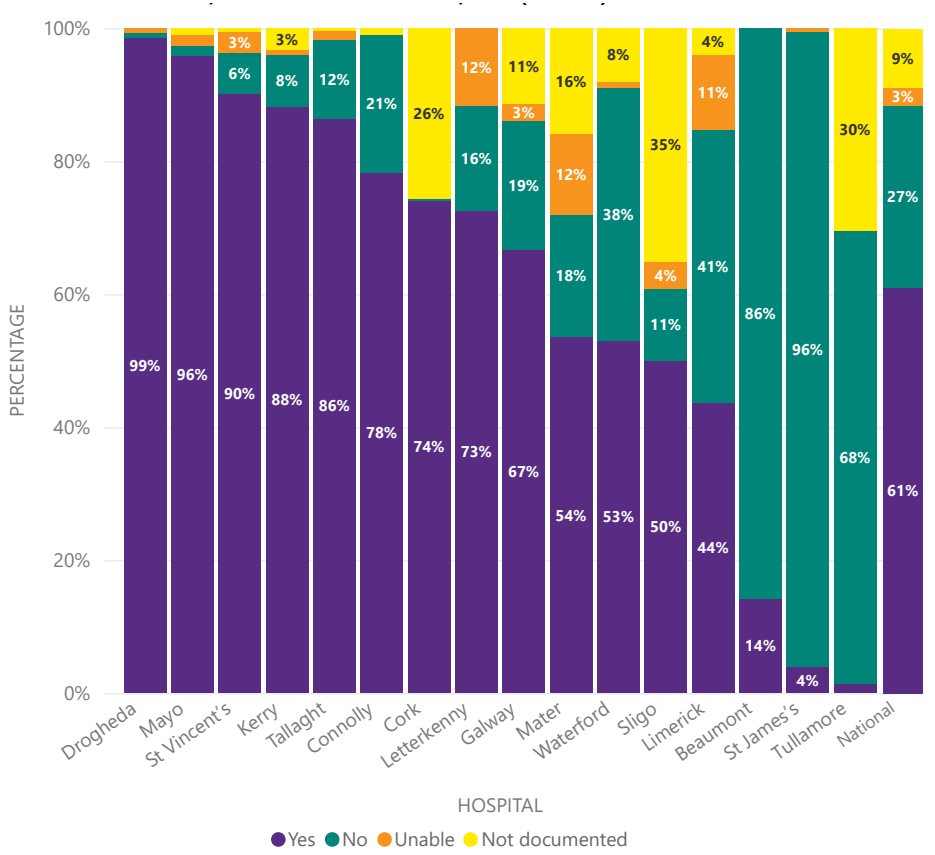


FIGURE 4.4: PERCENTAGE OF PATIENTS RECORDED AS HAVING A 4AT DELIRIUM ASSESSMENT ON DAY 1 OF ADMISSION, BY INDIVIDUAL HOSPITAL, 2025 (N=4356)

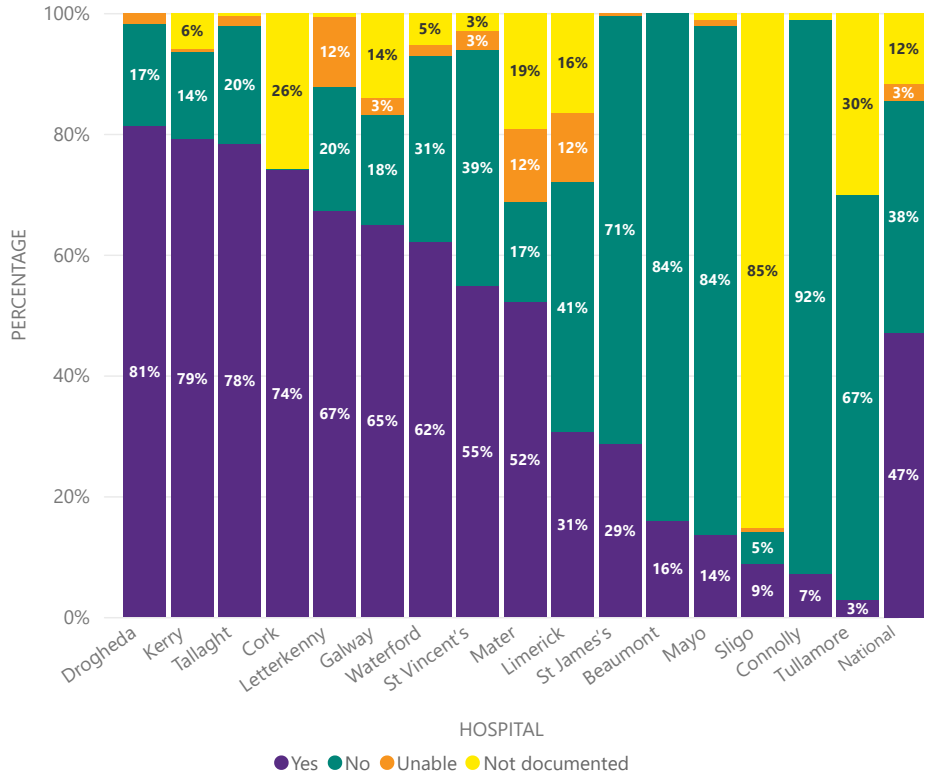


FIGURE 4.5: PERCENTAGE OF PATIENTS RECORDED AS HAVING A 4AT DELIRIUM ASSESSMENT ON DAY 3 OF ADMISSION, BY INDIVIDUAL HOSPITAL, 2025 (N=4356)

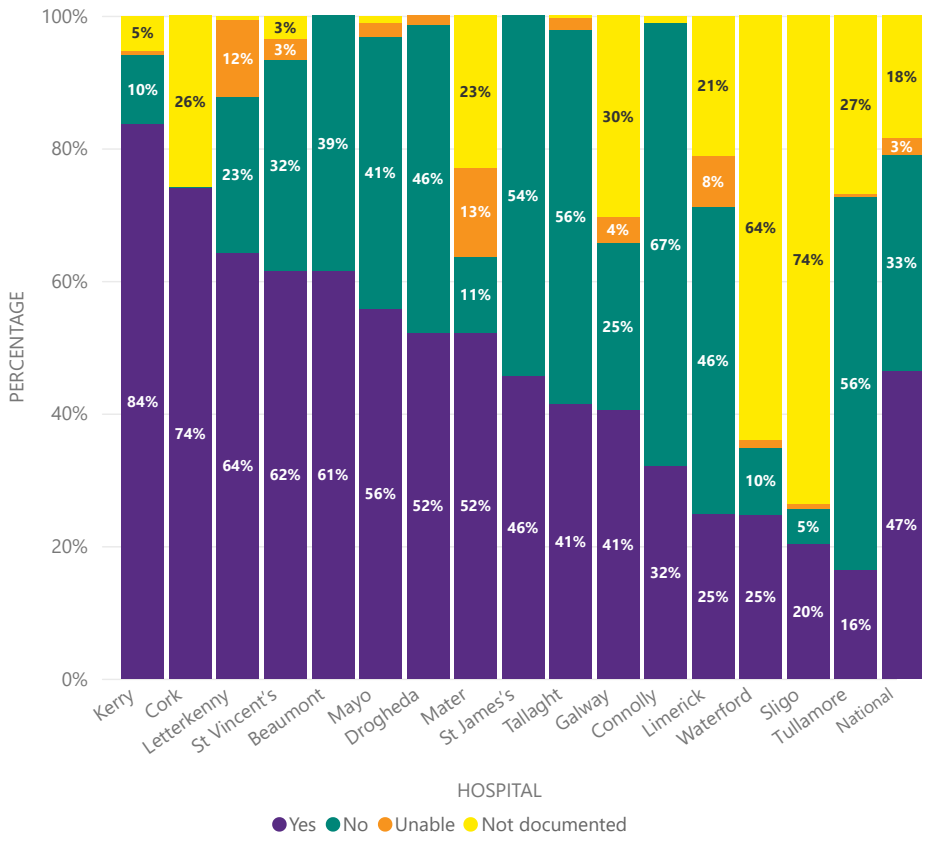


FIGURE 4.6: PERCENTAGE OF PATIENTS RECORDED AS HAVING A 4AT DELIRIUM ASSESSMENT AT ANY OTHER TIME POINT DURING ADMISSION, BY INDIVIDUAL HOSPITAL 2025 (N=4356)

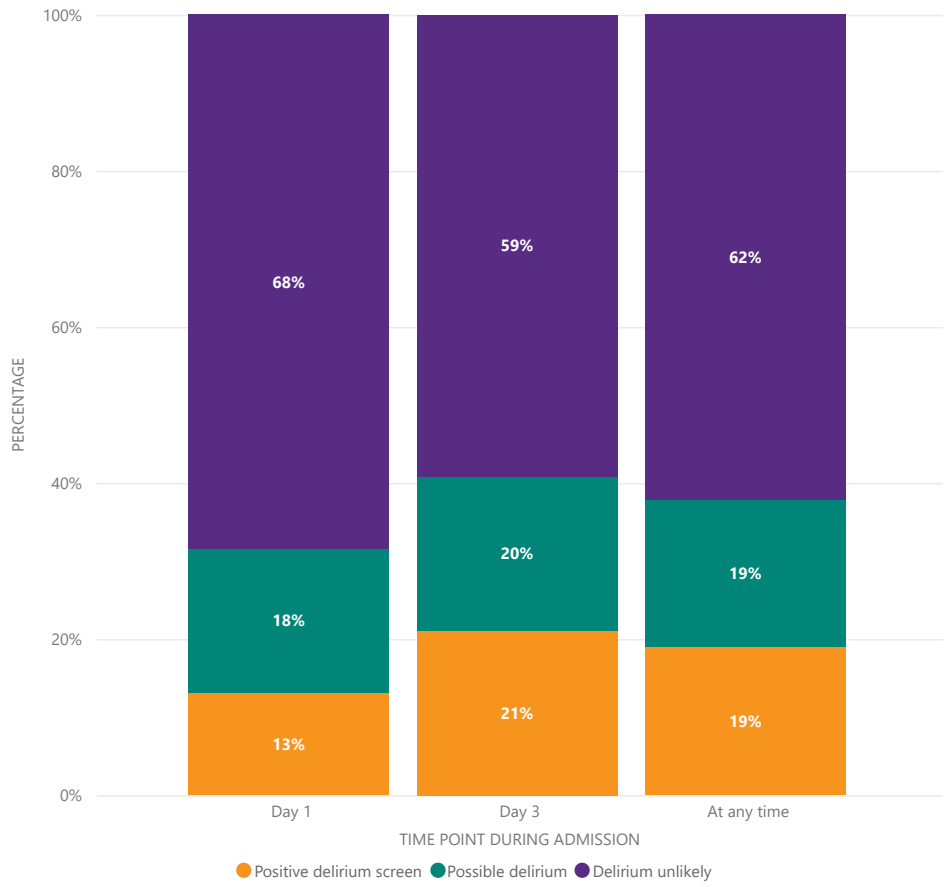


FIGURE 4.7: PERCENTAGE OF PATIENTS GROUPED BY 4AT SCORE ON DAY 1 OF ADMISSION (n=2681), DAY 3 OF ADMISSION (n=2068) AND AT ANY OTHER TIME DURING ADMISSION (n=2024), 2025[18]

[18] Minor differences between the number of patients recorded as having received a 4AT assessment and the denominator used for 4AT score distributions reflect data-recording variations. In a small number of cases, a 4AT score was recorded where the corresponding screening field was incomplete or recorded differently.

TYPE OF SURGERY

Figure 4.8 shows the distribution of procedure types in 2025, which has remained broadly stable since 2022. Considerable variation in implant selection persists between hospitals, including variation in the use of total hip replacement and cemented arthroplasty (Figure 4.9).

There remains ongoing debate regarding the optimal choice of implant for the management of hip fracture. Recent evidence suggests that outcomes may vary according to factors such as cemented stem design, surface coating of uncemented arthroplasties, and intramedullary nail length (Anusitviwat *et al*., 2025). As evidence continues to evolve, greater granularity in implant-level data is required to support future national analysis. To facilitate this, a number of enhancements were introduced to the IHFD dataset in 2026. These changes were informed by a national survey of implant usage across participating hospitals in 2025 and a two-year pilot of an expanded implant dataset conducted at three hospitals between 2024 and 2025.

The revised dataset, which will be reported on in the 2026 IHFD report:

- classifies cemented arthroplasties (hemiarthroplasty and total hip replacement) as either polished or matt stem designs
- subdivides short IM nails into devices measuring less than 200 mm and 200–240 mm
- classifies coated uncemented arthroplasties as partially or fully coated
- removes implant options that were not used nationally, in line with international practice, reducing the risk of misclassification.

NOCA will work with audit coordinators throughout 2026 to support the introduction of these new variables and to ensure high-quality data collection. These enhancements will enable more detailed analysis of implant choice and outcomes in future reports.

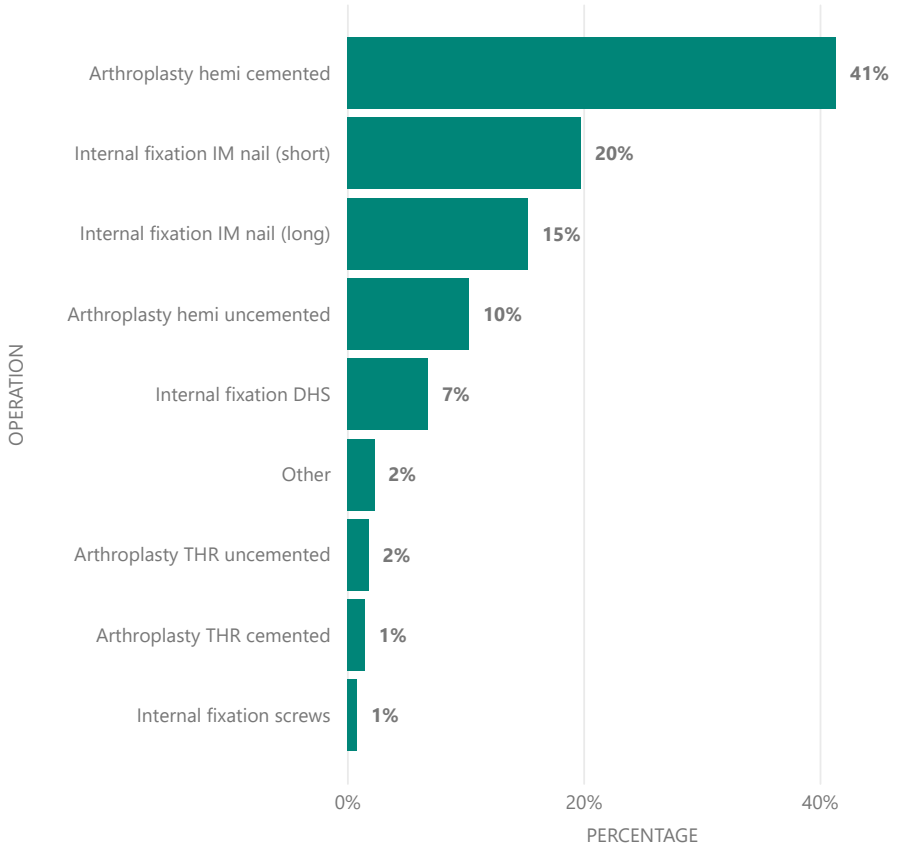


FIGURE 4.8: TYPE OF SURGERY, 2025 (n=4181)[19]

[19] Patients who did not have surgery have been excluded.

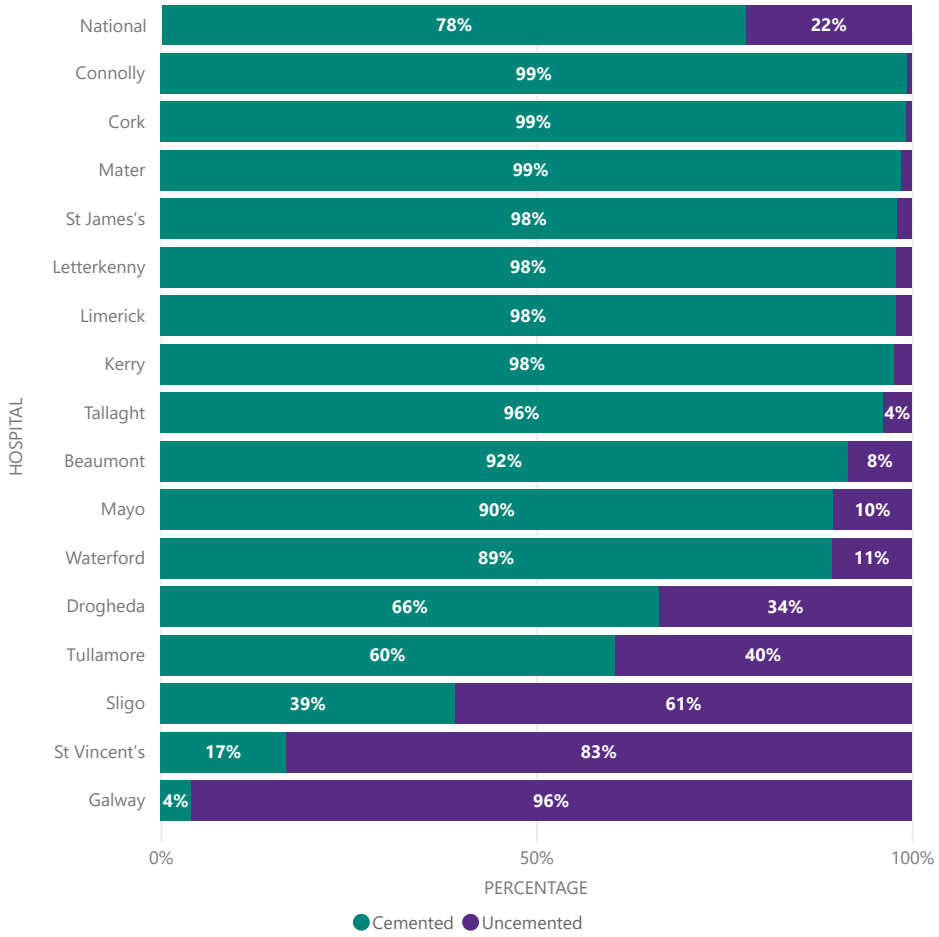


FIGURE 4.9: PERCENTAGE OF PATIENTS WITH A HIP FRACTURE WITH CEMENTED AND UNCEMENTED ARTHROPLASTIES, BY INDIVIDUAL HOSPITAL, 2025 (n=2299)

OCCUPATIONAL THERAPY

Since 2024, the IHFD has collected data on occupational therapy assessment during the acute hospital admission. Occupational therapists play an important role in hip fracture care, supporting rehabilitation, functional recovery, activities of daily living, and discharge planning (Dyer *et al.*, 2021).

In 2025, 70% (n=3,057) of patients with a hip fracture received an occupational therapy assessment during their admission, representing an increase of 2 percentage points compared with 2024. However, performance differed considerably between hospitals. The proportion of patients assessed ranged from 22% to 98% (Figure 4.10).

During 2026, NOCA increased its engagement with occupational therapy professionals. The inaugural meeting of the IHFD occupational therapy network was held in March 2026 and included representatives from 11 acute hospitals participating in the IHFD, together with three rehabilitation hospitals. Occupational therapy representation on the IHFD Governance Committee was also established through the HSE National Health and Social Care Professions Office in 2026.

In 2027, NOCA will continue to work with the occupational therapy network and Governance Committee representative to ensure that occupational therapy perspectives are reflected in the ongoing development of the IHFD and to support quality improvement initiatives in this area.

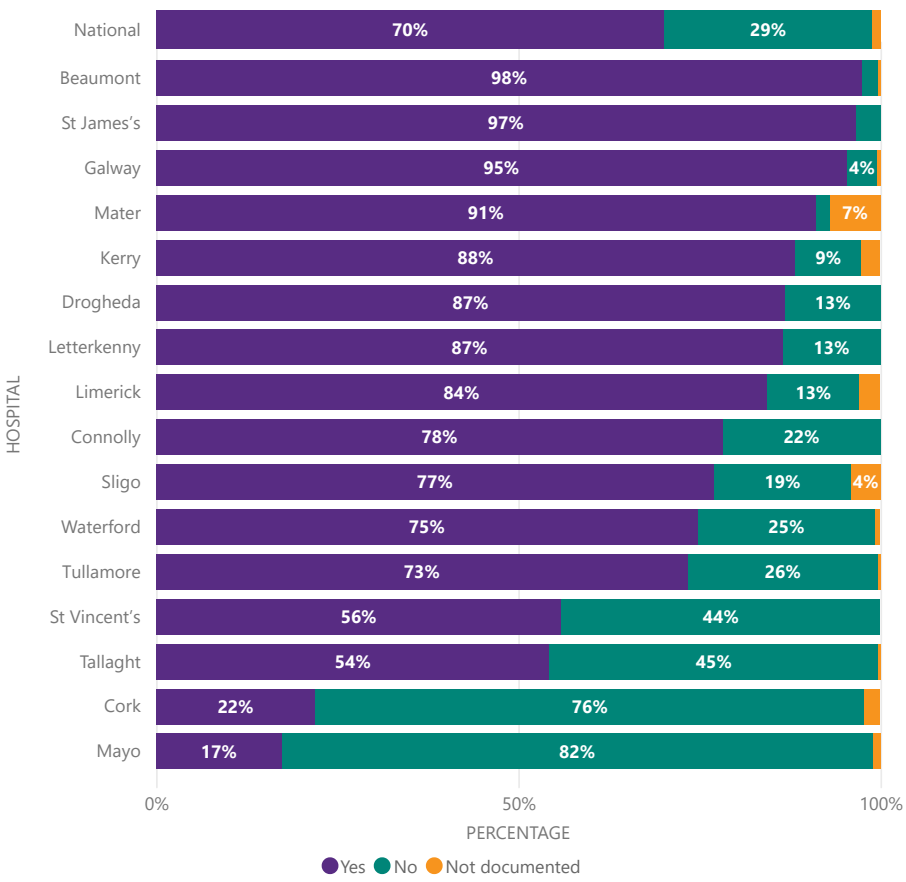


FIGURE 4.10: PERCENTAGE OF PATIENTS WITH A HIP FRACTURE WHO RECEIVED OCCUPATIONAL THERAPY ASSESSMENT, BY HOSPITAL, 2025 (n=4356)



CHAPTER 5
OUTCOMES

CHAPTER 5: **OUTCOMES**



Twenty-seven per cent (n=523) of patients with a hip fracture who had a CAS recorded achieved independent mobility on the day of discharge.



The median length of stay for patients with a hip fracture was 12 days (IQR: 7–21 days).



A total of 79,993 acute hospital bed days were occupied for patients with a hip fracture.



Sixty-seven patients (2%) underwent reoperation within 30 days.[20]



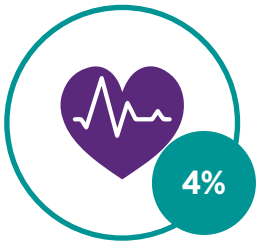
Twenty-two per cent of patients with a hip fracture (n=942) were discharged directly home.



Forty-five per cent of patients with a hip fracture (n=1,805) were transferred to a rehabilitation service: 36% to an off-site inpatient unit, 7% to an on-site inpatient unit and 2% to Early Supported Discharge (ESD)



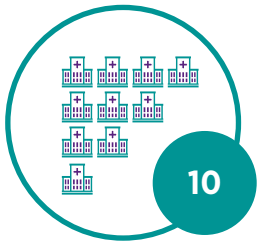
Thirteen per cent of patients with a hip fracture (n=552) were discharged to 'convalescence care' or to a Model 2/3 hospital.



Four percent of patients with a hip fracture (n=185) died as inpatients.



Less than 1% of patients had a surgical site infection (SSI).



Out of 16 hospitals, 10 reported longer-term outcomes from 2024 or 2025 with varying coverage and levels of completeness.



Three hospitals reported 1-year mortality: 5% at 30 days, 11% at 120 days and 18% at 1 year.

[20] Excluding patients who did not have surgery.

LONGER-TERM OUTCOMES

Longer-term outcomes (including survival, function and quality of life) enable us to better understand how patients with a hip fracture recover and how this relates to the care they receive. Since 2022, the IHFD has included additional fields to record seven outcomes: survival, residential status, reoperation, readmission, bone protection status, New Mobility Score (NMS), and quality of life as per the EuroQol 5-Dimension 5–level (EQ-5D-5L) questionnaire. Participation and coverage across follow-up fields increased steadily from 2022 to 2024.

In the 2024 IHFD Report, NOCA recommended that hospital managers support their staff to continue or to begin to record follow-up data after hip fracture as part of routine care processes. It was recommended that hospitals should continue to collect follow-up data in a manner that is feasible for their service. Functional outcomes should be recorded at a single medium-term time point (30–120 days), and one-year mortality can be captured retrospectively. Recording the exact date of assessment is important in order to inform future guidance and standardisation of the recommended follow-up time point.

This report includes long-term outcomes from 10 hospitals. Medium-term outcomes (30–120 days) were reported across seven hospitals for patients discharged in 2025. One-year outcomes were reported across five hospitals for patients discharged in 2024. Table 5.1 shows the proportion of patients with medium-term and one-year outcomes reported at each hospital.

TABLE 5.1: OUTCOMES REPORTED ACROSS 10 HOSPITALS FOR PATIENTS DISCHARGED IN 2025 (30–120 DAYS) AND 2024 (ONE-YEAR OUTCOMES)

Hospital	Medium-term outcomes (30–120 days)			One-year outcomes	
	% followed up	Outcome measures recorded (n)	median days	% followed up at 1 year	Outcome measures recorded (n)
St James's	72%	7	29	0%	N/A
Waterford	38%	7	120	0%	N/A
Tallaght	36%	7	188	25%	7
Letterkenny	31%	7	61	95%	2
Connolly	24%	7	45.5	0%	N/A
Mayo	23%	4	44	0%	N/A
Limerick	19%	7	49	0%	N/A
St Vincent's	0%	N/A	N/A	42%	7
Beaumont	0%	N/A	N/A	100%	1
Drogheda	0%	N/A	N/A	100%	1

Four hospitals achieved greater than 70% coverage at one time-point, enabling more detailed reporting of mobility and mortality outcomes. Table 5.2 and Figure 5.1 show detailed medium-term outcome results from St James's hospital which followed greater than 70% of their patients with hip fracture in 2025. Three hospitals reported survival data, including a date of death where applicable for over 85% of their patients. This was for a total of 722 patients discharged in 2024 from Beaumont, Letterkenny and Drogheda hospitals. Based on both inpatient and follow-up dates of death available for patients followed, mortality rates were 5% (n=37) at 30 days, 11% (n=76) at 120 days and 18% (n=128) at one year.

TABLE 5.2: OUTCOME RESULTS AT 30 DAYS AFTER PRESENTATION FROM ST JAMES'S HOSPITAL (n=148)[21]

	n	%
Residence		
Home	54	36%
Rehabilitation (on or off-site)	54	36%
Nursing Home	11	8%
Inpatient	16	11%
Other (including Convalescence)	10	7%
Mobility		
Low mobility level	139	94%
High mobility level	<5	<6%
Bone protection		
Yes	112	76%
No	30	20%

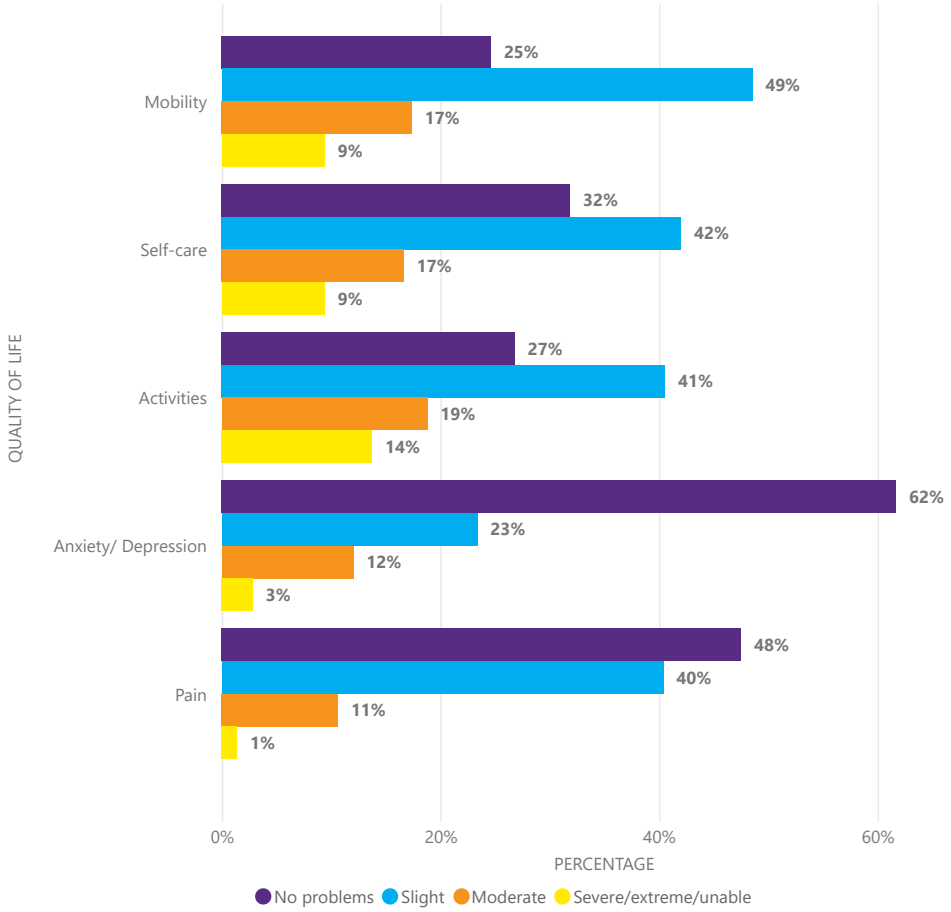


FIGURE 5.1: EQ-5D-5L RESULTS AT 30 DAYS POST-HIP FRACTURE, BY REPORTED SEVERITY LEVEL ACROSS THE FIVE DIMENSIONS (ST JAMES'S HOSPITAL) (n=141)[22]

[21] The denominator for all measures is n=148; percentages do not sum to 100% due to deaths and missing data. HIPE identified a further six patients who remained acute inpatients and eight who died in hospital within 30 days; these are excluded from the denominator. Reoperation, readmission and reported deaths are not shown as each involved fewer than five cases.
[22] Denominator does not include reported deaths.

SURGICAL SITE INFECTION

Surgical site infection (SSI) is an important patient safety outcome following hip fracture surgery. Although uncommon following hip fracture surgery, with previous IHFD reports reporting a rate of <1% SSI recorded out of 3,602 cases in 2024 (NOCA, 2024; Masters *et al*, 2025), SSI can result in prolonged hospital stay, delayed recovery, additional surgical procedures and increased healthcare costs (Codyre *et al,* 2026; ECDC,2025). In collaboration with Antimicrobial Resistance and Infection Control (AMRIC), the IHFD has developed a national surveillance process to support the collection and reporting of SSI data following hip fracture surgery. National data on SSI surveillance capacity suggest that surveillance programmes remain variable across Irish hospitals, highlighting the importance of a coordinated national approach to monitoring infection prevention measures and outcomes following surgery (Glynn, 2026).

SSI surveillance within the IHFD is aligned with the *Framework for HSE National Programme for Surgical Site Infection Surveillance – Pilot through the Irish Hip Fracture Database (IHFD)* (HSE National Programme for Surgical Site Infection Surveillance, 2023) and uses definitions consistent with the European Centre for Disease Prevention and Control (ECDC) (ECDC,2025). Data can be recorded during the acute admission and through the IHFD follow-up dataset *(*Appendix 4 and Appendix 5*),* supporting the identification of infections diagnosed after hospital discharge[23]. The year 2025 represents the third complete year of SSI data collection within the IHFD.

A major development during 2025 was the introduction of national SSI interactive dashboards (Power BI) and six SSI indicators developed collaboratively by IHFD and AMRIC. Additional information on indicator definitions can be found here. The infographic below displays the 2025 national indicators, excluding CUH (Figure 5.2 shows an example of what the dashboard looks like to users). The dashboards are refreshed quarterly and provide participating hospitals with graphical benchmarking against national performance. Hospitals can also review more detailed information on types of SSI diagnosed, skin preparation agents and methods of surgical wound closure using an additional "detail" tab on the dashboard, supporting local quality improvement initiatives aimed at reducing SSI risk.



FIGURE 5.2: IHFD SURGICAL SITE INFECTION DASHBOARD EXAMPLE

[23] In line with European Centre for Disease Prevention and Control (ECDC) definitions: superficial SSIs are recorded up to 30 days following surgery, while deep and organ/space infections are recorded up to 30 days after the operation if no implant is left in place and up to 90 days following surgery where an implant remains *in situ*, as is the case for most patients with hip fracture who require arthroplasty (ECDC, 2025).

In 2025, 4,356 patients with hip fracture were recorded in the IHFD, of whom 4,181 (96%) underwent surgery. Fifteen of the 16 participating hospitals submitted SSI data in 2025. Cork University Hospital was excluded from SSI analyses because no SSI data were submitted for the reporting period. The analyses presented below are, therefore, based on 3,686 surgical patients across 15 hospitals.

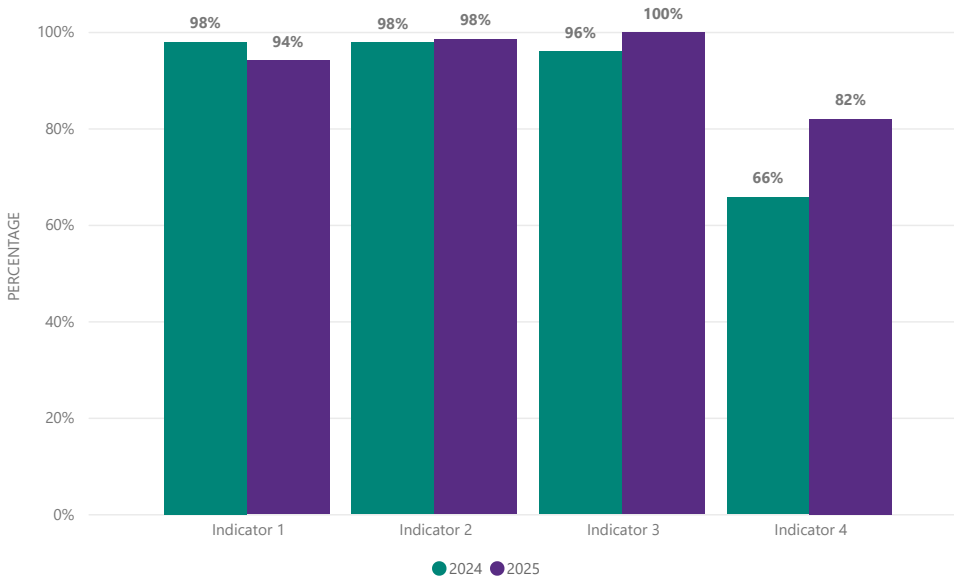


FIGURE 5.3: PERCENTAGE OF PATIENTS NATIONALLY WHO MET IHFD SURGICAL SITE INFECTION INDICATORS 1 TO 4 IN 2024 (n=3602) AND 2025 (n=3686)[24,25,26]

Figure 5.3 shows four of the six IHFD SSI indicators in 2025 compared with 2024 in patients who received surgery across 15 hospitals.

- In 2025, 94% (n=3,465) of patients had their operative site prepared using an alcohol-containing antiseptic solution, compared to 98% (n=3,526) in 2024.
- In 2025, 98% (n=3,629) received surgical prophylactic antibiotics prior to surgery, unchanged from 2024.
- In 2025, almost 100% (n=3,682) had a post-operative dressing applied to minimise contamination of the surgical wound, compared to 96% (n=3,452) in 2024.
- In 2025 82% (n=3,020) underwent surgery lasting less than two hours, compared to 66% (n=2,367) in 2024.

In 2025, a total of 21 patients (0.6%) were recorded as having a clinician-diagnosed SSI during the surveillance period (Indicator 5). Almost half of these infections (n=10) were classified as superficial, with the remainder classified as deep or organ/space infections. All SSIs received a classification in 2025, an improvement on 2024 where 10% of SSIs were unclassified. Among patients diagnosed with an SSI, normothermia was documented as maintained in 15 of 21 cases (71%) (Indicator 6).

In 2025, the most commonly used skin preparation agent was chlorhexidine/alcohol, (75%; n=2,786) while staples were the most frequently documented method of skin closure (57% n=2,103). Further details of skin preparation and skin closure types recorded are available in Appendix 9: Additional Information.

Overall, high levels of compliance were observed for several SSI prevention measures, including administration of surgical prophylactic antibiotics within 60 minutes of incision and application of post-operative wound dressings. The low number of clinician-diagnosed SSIs recorded nationally should, however, be interpreted in the context of the ongoing development of SSI reporting processes and variation in case identification across participating hospitals.

SSI surveillance following hip fracture surgery continues to develop nationally. While participation and data completeness have improved since the introduction of the dataset, post-discharge surveillance is not yet consistently available across all participating hospitals.

[24] Excludes patients that did not receive surgery
[25] Excludes Cork University Hospital for both years as they are not entering data
[26] Indicators 5 and 6 are presented in the narrative as they involve small numbers.

As a result, some SSIs diagnosed after discharge may not be identified or recorded. In addition, the clinician-diagnosed SSI indicator represents only one component of SSI detection and reporting. Differences in local surveillance, follow-up and reporting processes should be considered when interpreting variation in SSI rates between hospitals (Glynn, 2026). As SSI monitoring and reporting processes become more established, increases in reported SSI rates may reflect improved recognition and case ascertainment rather than a true increase in infection occurrence.

During 2025-2026, ongoing education and support were provided to audit coordinators and clinical leads regarding SSI definitions, surveillance requirements and data collection processes. As SSI data continue to accumulate, plans are underway to incorporate the National Healthcare Safety Network (NHSN) Risk Index to support future risk-adjusted analyses and benchmarking. This will enhance the interpretation of SSI rates, support meaningful comparisons over time and between hospitals, and facilitate potential future submission of SSI data to the European Centre for Disease Prevention and Control (ECDC) for international benchmarking against European SSI surveillance data. In addition, the time of administration of surgical antibiotic prophylaxis (SAP) was added to the 2026 dataset. This will enable assessment of whether SAP is administered within 60 minutes prior to incision, in line with the joint position statement on SAP duration developed by AMRIC, the HSE Antimicrobial Stewardship Advisory Group and the National Clinical Programme for Surgery (HSE, 2021).

The IHFD will continue to collaborate with AMRIC, audit coordinators and participating hospitals to strengthen SSI surveillance, support post-discharge data collection and facilitate quality improvement initiatives aimed at reducing SSI following hip fracture surgery.



CHAPTER 6
QUALITY IMPROVEMENT

CHAPTER 6: **QUALITY IMPROVEMENT**

Nutrition quality improvement through collaboration and shared learning

This chapter describes how the Irish Hip Fracture Database (IHFD) is supporting quality improvement in nutritional care following hip fracture through education, multidisciplinary collaboration and engagement with the international Fragility Fracture Network (FFN).



Nutrition is increasingly recognised as an important component of recovery following hip fracture. Older adults with hip fracture are at high risk of malnutrition, sarcopenia and poor functional outcomes (Inoue *et al.*, 2020; Chiavarini *et al.,* 2024). To support evidence-informed care, IHFD has strengthened engagement with clinical dietitians nationally and with international colleagues through the FFN. This work has focused on sharing learning, identifying opportunities for improvement and supporting greater consistency in nutritional care across the patient journey. Discussions were informed by recognised quality improvement approaches, including the FFN SIMPLER Nutrition Pathway (Bell *et al.*, 2025).

Between May 20-28 2026, Dr Jack Bell (Advanced Dietitian, Adjunct Professor at the University of Iceland and FFN Education Committee Chair-Elect) visited nine hospitals across Ireland, including acute and rehabilitation settings: St Vincent's University Hospital, Clontarf Hospital, Connolly Hospital Blanchardstown, Mater Misericordiae University Hospital, University Hospital Waterford, University Hospital Kerry, Mayo University Hospital, Sligo University Hospital and Our Lady of Lourdes Hospital, Drogheda.

In advance of the visits, NOCA convened the IHFD Dietitian Network, providing an opportunity for dietitians working across hip fracture services to discuss current practice, share local initiatives and identify priorities for improvement. Dietitians from St James's Hospital and Tallaght University Hospital also participated in network discussions before and after the visits.

The visits highlighted strong multidisciplinary engagement and demonstrated that many aspects of evidence-based nutritional care were already embedded in practice. Areas of particular strength included fasting minimisation, increasing adoption of 'Sip Til Send' approaches and use of oral nutritional supplements (ONS). There was also widespread recognition that people with hip fracture should be considered nutritionally vulnerable, regardless of formal nutrition screening scores.

Opportunities for improvement were also identified, including: strengthening patient education regarding nutrition and recovery; expanding access to high-protein food and drink options; and improving continuity of nutritional care after discharge. Dietitians highlighted the complexity of the hip fracture population, including frailty, multimorbidity, cognitive impairment and nutritional risk. Discussions reinforced that effective nutritional care requires specialist dietetic leadership, multidisciplinary support and alignment with National Clinical Guideline No. 22 (Department of Health, 2020).



Examples of quality improvement initiatives shared included:

- Nutritional care pathways for patients with hip fracture.
- Addition of nutrition and ONS prompts to admission and orthogeriatric documentation.
- Introduction of patient nutrition information leaflets.
- Increased multidisciplinary education on nutrition and recovery.
- Review of fasting practices and implementation of 'Sip Til Send'.
- Greater integration of nutrition into rehabilitation pathways.

Following the site visits, NOCA hosted a second meeting of the IHFD Dietitian Network in June 2026. Dr Bell joined the meeting to reflect on the findings, discuss implementation challenges, and identify priorities for national improvement activity.

In parallel, Dr Bell presented to the IHFD Governance Committee in May 2026. The Committee reviewed findings from the site visits and discussed emerging evidence and international perspectives on nutritional care following hip fracture. Dr Bell noted that all participating sites had implemented at least two components of the FFN SIMPLER Nutrition Pathway, which compares favourably with his international experience. He also highlighted the strong enthusiasm and multidisciplinary engagement observed across sites. Dr Bell presented evidence from a recent Cochrane systematic review showing that oral nutritional supplements (ONS) were associated with lower mortality in hospitalised older people at nutritional risk (Kiesswetter *et al*., 2026). Following discussion, it was agreed that a new variable, capturing prescription of ONS, will be added to the IHFD dataset from 2027.

The IHFD Governance Committee also agreed to explore the development of a nutrition-related standard within the IHFS. However, it was recognised that additional evidence and national audit data are required before a specific standard can be defined.

The site visits and network meetings strengthened collaboration between hospitals, dietitians and multidisciplinary teams while raising the profile of nutrition within hip fracture care, nationally. They highlighted the value of audit, shared learning, clinical leadership and international collaboration in supporting quality improvement and provide a strong foundation for future work to strengthen nutritional care throughout the patient journey.





CHAPTER 7
AUDIT UPDATE

CHAPTER 7: **AUDIT UPDATE**

The Irish Hip Fracture Database (IHFD) continued to evolve during 2025-2026 through a combination of audit development, data quality improvement, multidisciplinary collaboration, and quality improvement activity. Several significant developments were completed during the year, alongside the continued delivery of routine national audit functions.

Key achievements during 2025-2026 included:

- Completion of a national review of IHFS 4-6, resulting in revised orthogeriatric standards and associated dataset changes, which will be implemented from January 2027.
- Introduction of new dataset variables relating to pre-operative anticoagulant and antiplatelet medication, surgical antimicrobial prophylaxis timing, and enhanced implant-level information. Education and guidance were provided nationally to support implementation of these variables.
- Completion of targeted data quality reviews of selected free-text variables identified opportunities to improve structured data collection and informed planned refinements to the dataset from 2027.
- Development of the IHFD Dietitian Network, collaboration with the Fragility Fracture Network and site visits to nine hospitals led by Dr Jack Bell. This work supported national quality improvement activity relating to nutrition and informed the introduction of a new oral nutritional supplement variable from 2027.
- Development of the IHFD Occupational Therapy (OT) network with new OT representation on the IHFD Governance Committee.
- Continued collaboration and research involvement including the HipCog Study and doctoral work being completed by NOCA Head of Audit Management, Louise Brent.

Alongside these developments, core audit activities continued throughout the year, including monthly audit coordinator meetings, quarterly reporting, promoting educational materials and engagement with public and patient representatives. National audit coverage remained high at 98%, with all 16 participating hospitals achieving the threshold required for inclusion in hospital-level reporting.

The sections that follow describe these developments in greater detail, beginning with the review and revision of the orthogeriatric standards. Key development priorities for 2027 are summarised at the end of this chapter.

REVIEW OF ORTHOGERIATRIC STANDARDS



The IHFD National Report 2024 recommended a review of IHFS 4–6, which relate to orthogeriatric assessment, bone health assessment, and specialist falls assessment. This recommendation was based on sustained high levels of national achievement across all three standards, together with evidence that the standards measure closely related aspects of orthogeriatric care.

A review was undertaken during 2026 to determine whether the standards continued to reflect contemporary evidence and clinical practice, and to identify opportunities to strengthen their value as drivers of quality improvement.

Review process

The review involved several stages:

- An international review of hip fracture standards and orthogeriatric models of care in February 2026.
- A national survey of orthogeriatric clinicians and IHFD Hospital Clinical Leads in March-April 2026.
- A multidisciplinary consensus workshop in May 2026.
- Discussions between orthogeriatric leads, IHFD clinical leads, and the NOCA team.
- A consultation with audit coordinators regarding feasibility, data collection, and interpretation of existing variables.
- A review of 2025 IHFD data to assess current performance and variation.

The national survey received 21 responses from clinicians across 11 hospitals, including consultant geriatricians, advanced nurse practitioners (ANPs), orthopaedic surgeons, researchers, and audit personnel. Respondents were asked to consider the relevance, clarity, feasibility, and future direction of IHFS 4–6, rating agreement out of 5 points with specific topics under each standard in addition to nutrition and delirium care.

A multidisciplinary workshop subsequently took place in May 2026 to review survey findings, examine international practice, and build consensus on proposed revisions. A series of live polls were conducted to rate support for different options.

Key findings



There was broad agreement that the existing standards have supported significant improvements in orthogeriatric care nationally. However, stakeholders considered that the standards should evolve to place greater emphasis on meaningful clinical assessment, documented management plans, and patient-centred outcomes rather than completion of individual processes in isolation.

Several key themes emerged:

- Support for early orthogeriatric assessment by a dedicated orthogeriatric team.
- Recognition that bone health and falls assessment form part of a wider secondary prevention pathway.
- Strong support for introducing a dedicated delirium standard
- Support for recording frailty as part of the comprehensive geriatric assessment.
- Recognition that nutritional assessment requires further development before consideration as a future standard.

Analysis of 2025 IHFD data demonstrated substantial overlap between achievement of the bone health and specialist falls assessment standards, supporting consideration of a combined secondary prevention measure.

REVISED STANDARDS FOR 2027



Following review and consultation, it was agreed that the orthogeriatric standards will be revised for patients discharged from 1 January 2027.

IHFS 4: Acute orthogeriatric assessment

The revised standard will require:

- Commencement of a Comprehensive Geriatric Assessment (CGA) by a member of the orthogeriatric team within three days of presentation.
- Clinical review by a Consultant Geriatrician during the acute admission.

To support implementation of this standard, the existing geriatric assessment fields will be revised to focus on commencement of a CGA rather than review by an individual clinician. Additional data collection will record whether the patient was reviewed by a Consultant Geriatrician during admission. The profession and grade of the healthcare professional who initiated the CGA will also be captured, reflecting the multidisciplinary nature of orthogeriatric care.

Although there was strong support for incorporating the Clinical Frailty Scale (CFS) into the standard, stakeholders agreed that CFS recording should continue to be encouraged during 2027, with consideration of its incorporation into the IHFS definition from 2028. The CFS may be completed by any appropriately trained team member and should reflect the patient's baseline status prior to the hip fracture.

IHFS 5: Delirium Screening

A new delirium standard will be introduced.

The revised standard will require:

- Completion of a 4AT assessment on admission, pre-operatively.
- Completion of a second 4AT assessment in the days following surgery.

The revised standard has been designed to reflect delirium assessment across the patient pathway rather than a single point in time. Compliance will require documentation of both assessments, recognising that delirium may be present on admission or may develop following surgery.

The Governance Committee recognised that delirium screening is only one component of high-quality delirium care and that effective management is equally important. At present, however, there is no agreed feasible and auditable measure of delirium management that can be collected consistently across participating hospitals. For this reason, the 2027 standard focuses on delirium screening at key points in the patient pathway. The IHFD will continue to

work with stakeholders to develop and evaluate potential measures of delirium management with a view to evolving the standard in future years.

Feedback from audit coordinators identified variation in how existing delirium fields are interpreted and recorded. Revised guidance and data definitions will, therefore, accompany implementation of the new standard to improve consistency of recording, interpretation and reporting across participating hospitals.

IHFS 6: Secondary prevention

The existing bone health assessment and specialist falls assessment standards will be combined into a single secondary prevention standard.

Patients will be required to receive:
- A documented specialist falls assessment.
- A documented bone health assessment.

Updated guidance will define the minimum components of a specialist falls assessment. These will include assessment of previous falls, circumstances surrounding the index fall, falls risk factors, medication review and cardiovascular assessment.

A revised bone health assessment variable will record whether a comprehensive bone health assessment has been completed during the admission. This assessment should include consideration of osteoporosis risk, previous fragility fractures, current and previous anti-osteoporosis treatments, requirements for further investigation, calcium and vitamin D requirements, and a documented decision regarding bone protection therapy.

Additional changes will include the introduction of a structured medication list for bone protection therapy, replacing the current free-text field.

Supporting dataset changes

Implementation of the revised standards will be accompanied by a number of dataset enhancements from 2027, including:
- New variables relating to commencement of Comprehensive Geriatric Assessment.
- Recording of Consultant Geriatrician involvement.
- A revised bone health assessment variable.
- Structured recording of bone protection therapies.
- A new variable to record prescription of oral nutritional supplements.

These changes are intended to improve consistency of data collection, reduce reliance on free-text entries and support future quality improvement initiatives.

Conclusion

The review concluded that the existing standards have been successful in improving orthogeriatric care nationally and should be retained in an updated form rather than replaced. The revised standards place greater emphasis on early initiation of CGA, delirium care and secondary fracture prevention, while remaining measurable within the existing audit infrastructure.

The revised standards and associated dataset changes will be implemented from January 2027. Data collected during 2027 will form the basis of reporting in future IHFD National Reports.

PRESENTATIONS

The IHFD was represented through talks and poster presentations at several events since publication of the 2024 IHFD Report:

- National Rehabilitation Conference, 5 December 2025
- Age & Anaesthesia Conference, 26–27 March 2026
- Galway Orthopaedic Nursing Conference: 23 April 2026
- Irish Gerontological Society Conference: 1–3 October 2026
- Scottish Hip Fracture Audit - Hip Fracture Conference, Edinburgh: 7 October 2026
- Fragility Fracture Network European Congress, Edinburgh: 8-10 October 2026.
- National Orthopaedic Nurses Conference, National Orthopaedic Hospital Cappagh, 17 October 2026

PUBLICATIONS

Recent publications from the IHFD include:

- Brent, L., Ojeda-Thies, C., Fitzpatrick, F., Merriman, N. and Byrne, E., 2025. Protocol for a scoping review to explore governance for national hip fracture clinical audits [version 2; peer review: 1 approved, 1 approved with reservations].
- Brent, L., Thies, C.O., Fitzpatrick, F., Merriman, N.A. and Byrne, E., 2025. Understanding governance for a national hip fracture clinical audit: a scoping review. *Injury*, 56 (8), p.112572
- Brent, L., Ahern, E., Murphy, T., Hurson, C., Coughlan, T., Hickey, P., Lodola, C., Walsh, M.E., Byrne, E. and Fitzpatrick, F., 2026. The development and evolution of the Irish Hip Fracture Database: a quality care initiative 2013–2024. *Archives of Osteoporosis*, 21 (1), p. 96.
- Brent L, Hickey P, Walsh M et al. Understanding how a national clinical audit is established, maintained and sustained using the Irish Hip Fracture Database as an exemplar: a realist evaluation protocol [version 2; peer review: 2 approved]. HRB Open Res 2026, 9:53 (https://doi.org/10.12688/hrbopenres.14451.2)
- Geary E, Turner H, Brent L, Walsh ME, Hurson C. Service-level factors associated with total arthroplasty rate and time to arthroplasty surgery after hip fracture in Ireland: Analysis of the national Irish Hip Fracture Database 2017-2020. *The Journal of The Surgeon.* 2026 Apr;24 (2):76-81. doi: 10.1016/j.surge.2025.12.009.
- Merriman, N.A., Walsh, M.E., Ferris, H. *et al*. Diagnostic test accuracy of screening tools for the detection of neurocognitive disorders in older adults post-trauma in acute care settings: a systematic review. *European Geriatric Medicine*. 17, 525–535 (2026). https://doi.org/10.1007/s41999-025-01287-9

COLLABORATIONS

The HipCog study

NOCA continues to collaborate with the HipCog Study, a Health Research Board-funded programme led by Dr Niamh Merriman (Dublin City University), which aims to improve understanding of cognitive impairment and delirium in older adults following trauma and hip fracture.

Findings emerging from the study are helping to strengthen the evidence base for hip fracture care and have informed discussions regarding cognitive assessment, delirium screening and rehabilitation pathways within the IHFD. The study is also generating new knowledge regarding rehabilitation interventions for older adults with hip fracture and cognitive impairment, with a particular focus on understanding which approaches are most effective and under what circumstances.

The extension of the study to 2028 provides further opportunities to use linked national data, including IHFD data, to improve understanding of the impact of cognitive impairment on patient outcomes, quality of care and longer-term recovery following hip fracture. The findings will continue to support the development of evidence-based audit measures, standards and quality improvement initiatives.



Research to support the development of hip fracture audit

Louise Brent, Head of Audit Management at NOCA and former IHFD Audit Manager, is currently undertaking doctoral research examining the factors that have contributed to the establishment, sustainability and impact of the Irish Hip Fracture Database.

This programme of research uses the IHFD as an exemplar to identify lessons that may support the development and sustainability of national clinical audits both within Ireland and internationally. The work has explored governance, stakeholder engagement, quality improvement and the use of audit data to drive change in clinical practice and service delivery.

Current research is focused on understanding how and why the IHFD has achieved sustained engagement and improvement over more than a decade and identifying the key factors that contribute to successful audit implementation and impact. The findings will support ongoing development of the IHFD and provide valuable insights for the wider clinical audit community.



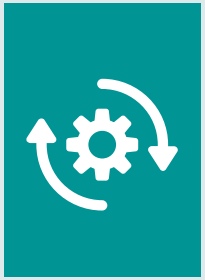
Older adults health and wellbeing profile

The IHFD has contributed data to the HSE Ageing Well in Later Life: Older Adults Health and Wellbeing Profile, developed initially for Dublin South and Wicklow to support planning and improvement of services for older adults (Health Service Executive, 2026). IHFD data were used within the Profile to report an indicator on bone protection medication use before admission among people aged 65 years and over admitted with hip fracture. Collaboration is continuing as the Profile expands across Integrated Health Areas, HSE Health Regions and nationally, extending the contribution of IHFD data to understanding older people's health and healthcare needs.



KEY DEVELOPMENT PRIORITIES FOR 2027

The IHFD will continue to support participating hospitals to improve the quality of care provided to patients following hip fracture. Building on work completed during 2025–2026, the following areas have been identified as priorities for 2027.



Implementation of revised orthogeriatric standards

A major priority for 2027 will be the implementation of the revised Irish Hip Fracture Standards (IHFS) 4–6. These revised standards, informed by a comprehensive national review, place greater emphasis on Comprehensive Geriatric Assessment, delirium assessment and management, and secondary fracture prevention. Supporting dataset changes, education resources and guidance will be provided to facilitate consistent implementation across participating hospitals.

The IHFD will continue to promote recording of the Clinical Frailty Scale (CFS) during 2027, with experience from implementation informing consideration of its inclusion within the national standard from 2028. The audit will also continue to work with stakeholders to explore feasible and auditable measures of delirium management to support future development of the standards.



Dataset development and data quality enhancement

Further developments to the IHFD dataset will be introduced during 2027. These include new variables relating to bone protection therapy and oral nutritional supplement use following hip fracture. In addition, data collection relating to delays in admission will be refined through the introduction of enhanced structured response options informed by recent data quality reviews.



Nutrition quality improvement

Building on the work of the IHFD Dietitian Network and collaboration with the Fragility Fracture Network, the audit will support quality improvement initiatives relating to nutritional assessment and nutritional support following hip fracture. This work will seek to improve the visibility and measurement of nutrition-related care processes and outcomes.



Rehabilitation and longer-term outcomes

The IHFD will continue to explore opportunities to strengthen measurement of rehabilitation and longer-term outcomes following hip fracture. This work will be informed by NOCA's national rehabilitation audit feasibility study and ongoing collaboration with rehabilitation services, health and social care professional networks and national stakeholders.



Supporting national collaboration and quality improvement

The IHFD will continue to support multidisciplinary collaboration through the orthogeriatric, physiotherapy, dietitian and occupational therapy networks and through ongoing engagement with national and international partners.



CHAPTER 8
RECOMMENDATIONS

CHAPTER 8: **RECOMMENDATIONS**

This chapter provides an update on recommendations made in the IHFD National Report 2024 and summarises progress achieved during 2025–2026. There are no new recommendations for the healthcare system arising from this report. The key development priorities arising from this report are described in Chapter 7: Audit Update, including implementation of the revised orthogeriatric standards, dataset enhancements and ongoing work relating to nutrition, rehabilitation and quality improvement. This work will be carried out by NOCA.

UPDATE ON AUDIT RECOMMENDATIONS FROM 2024

2024 RECOMMENDATION 1

PRESSURE ULCERS Status: Ongoing

Update

The 2024 IHFD National Report highlighted the need for continued focus on pressure ulcer prevention following an increase in pressure ulcer incidence observed nationally. In response, NOCA provided targeted education to audit coordinators during 2026 relating to pressure ulcer definitions and data collection and promoted the HSE Clinical Resource Pack: Pressure Ulcers.

These activities coincided with an improvement in national performance, with the proportion of patients developing a pressure ulcer following admission reducing from 4% in 2024 to 3% in 2025. Pressure ulcer incidence has remained a focus of quarterly reporting and will continue to be monitored through routine audit processes.

REGIONAL PROGRESS

All responding regions reported ongoing staff education and quality improvement initiatives relating to pressure ulcer prevention.

Regional actions included implementation of aSSKINg bundles, audit of prevention measures, tissue viability nurse education programmes and governance review of incidents.

2024 RECOMMENDATION 2

REVIEW AND REVISION OF ORTHOGERIATRIC STANDARDS (IHFS 4–6) Status: Complete

Update

The 2024 IHFD National Report recommended a review of Irish Hip Fracture Standards (IHFS) 4–6 to determine whether the standards continued to reflect contemporary orthogeriatric practice and to explore opportunities to strengthen measurement of care associated with improved patient outcomes.

A comprehensive review was undertaken during 2026. This process has been described in detail in Chapter 7: Audit Update.

The review concluded that the existing standards have been highly successful in supporting improvements in orthogeriatric care nationally, with more than 88% of patients achieving each standard in 2025. However, it also identified opportunities to better align the standards with contemporary evidence and clinical practice.

As a result, revised orthogeriatric standards and associated dataset changes will be introduced for patients discharged from 1 January 2027.

KEY CHANGES INCLUDE:

IHFS 4: ACUTE ORTHOGERIATRIC ASSESSMENT

- Commencement of a Comprehensive Geriatric Assessment by a member of the orthogeriatric team within three days of presentation.
- Clinical review by a Consultant Geriatrician during the acute admission.

IHFS 5: DELIRIUM SCREENING

- Completion of a 4AT assessment on admission, pre-operatively.
- Completion of a second post-operative 4AT assessment.

IHFS 6: SECONDARY PREVENTION

- Completion of a documented specialist falls assessment.
- Completion of a documented bone health assessment.

Implementation of the revised standards will be supported through updated guidance documents, dataset changes, education sessions and ongoing engagement with participating hospitals. Compliance with the revised standards will be monitored through routine IHFD reporting during 2027 and will inform future discussions regarding Best Practice Tariff criteria from 2028.

2024 RECOMMENDATION 3

LONGER-TERM OUTCOME COLLECTION Status: Ongoing

Update

The 2024 report recommended that hospitals continue to develop longer-term outcome collection as part of routine care processes following hip fracture.

Progress was made in 2025, with 10 hospitals actively collecting follow-up data and several hospitals achieving coverage sufficient to support reporting of mobility and mortality outcomes. Long-term outcome collection continued to be promoted through audit coordinator engagement and HipFORESST (Hip Fracture Outcome Recording – Empowering, Supporting and Sustaining Teams) educational resources. Long-term outcome collection training developed through HipFORGE (Hip Fracture Outcome Recording and Geographic Equality) was completed by an additional three hospitals in 2026.

REGIONAL PROGRESS

Follow-up data collection continues to expand nationally, with a number of hospitals embedding six-week review processes into routine outpatient care.

Challenges remain in some regions because of workforce and resource limitations, including lack of dedicated trauma CNS support and reduced access to rehabilitation follow-up pathways.



CHAPTER 9
CONCLUSION

CHAPTER 9: **CONCLUSION**

The Irish Hip Fracture Database National Report 2025 demonstrates continued improvement in the quality of hip fracture care delivered across Ireland. Performance improved across all seven Irish Hip Fracture Standards when compared with 2024, reflecting the sustained commitment of multidisciplinary teams to delivering high-quality care for patients with hip fracture.

The report highlights progress across the patient pathway, including timely surgery, orthogeriatric care, pressure ulcer prevention, early mobilisation and increasing achievement of the Best Practice Tariff. It also highlights the growing focus on areas such as rehabilitation, nutritional care and delirium assessment, while expanding understanding of patient experience and longer-term outcomes following hip fracture.

During 2026, the IHFD completed a comprehensive review of the orthogeriatric standards. The resulting revised standards, to be introduced from January 2027, will better reflect contemporary evidence and practice through an increased focus on comprehensive geriatric assessment, delirium care and secondary fracture prevention. These developments will ensure that the audit continues to drive meaningful quality improvement and remains responsive to the changing needs of older adults with hip fracture.

The report highlights progress across the patient pathway, including timely surgery, orthogeriatric care, pressure ulcer prevention, early mobilisation and increasing achievement of the Best Practice Tariff.

Finally, Maureen and Mary's story reminds us that behind every audit measure is a person, a family and a recovery journey. While a hip fracture can be a life-changing event, the right combination of specialist care, rehabilitation, support and person-centred decision-making can help patients regain confidence, maintain independence and achieve outcomes that matter most to them.

The IHFD will continue to work with patients, clinicians, researchers and participating hospitals to support high-quality care, reduce variation and improve outcomes for people who experience a hip fracture in Ireland.



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ACCESSING REPORT APPENDICES

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