

Results: 50 patients met the inclusion criteria for this review. Bone grafting with internal fixation was more successful than procedures without added fixation (80.5% vs. 75%). Internal fixation with compression screws was more successful than using Kirschner Wires (87% vs. 72%). Ultimately, eleven patients (22%) developed persistent non-union with three requiring revision procedures.

Conclusions: Scaphoid non-union is a complex condition with significant socio-economic implications. There is increasing evidence to support the use of early MRI scans for clinically apparent fractures which are radiographically negative. Severe forms of the deformity are more likely to fail following non-vascularised bone grafting and vascular grafts should therefore be considered for proximal pole non-unions. Further research is required to investigate the functional outcome following treatment.

0790: PREVENTING A SECOND HIP FRACTURE: A PROSPECTIVE AUDIT

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Neck of femur fragility fracture sufferers are at high risk of developing a second hip fracture. Guidelines for bone protection following hip fractures are widely available.

Aim: To assess compliance to NICE guidelines which state that patients who obtain a fragility hip fracture when less than 75y.o. should have a DEXA scan organised before discharge to identify osteoporosis. Those who obtain a fragility hip fracture when 75y.o. or older, should be commenced on an appropriate bone protective agent with no investigations necessary beforehand.

Methods: 93 patients who were admitted to Tunbridge Wells Hospital with neck of femur fractures between May and July 2012 were selected. Patients who died within 28 days (8), suffered pathological fractures (1) or high-energy fractures (0) had been excluded.

Results: We found that of the 16 patients less than 75y.o. only 4 (25%) had a DEXA scan performed or organised. 88.3% of hip fracture survivors older than 75y.o. had appropriate bone protection prescribed on discharge from hospital.

Conclusions: The data suggests that greater compliance of the guidelines, particularly with hip fracture survivors less than 75y.o. is required. The hip fracture admissions proforma has been reformed and orthopaedic doctors receive compulsory training to improve their compliance.

0792: PRESCRIBING VENOUS-THROMBOEMBOLISM PROPHYLAXIS IN HIP FRACTURE PATIENTS: A CLOSED AUDIT CYCLE

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Patients sustaining a neck of femur (NOF) fracture are at high risk of developing fatal postoperative pulmonary embolism. Guidelines to prevent venous thromboembolism (VTE) in hip fractures are widely available.

Aim: To assess compliance to the National Institute of Clinical Excellence (NICE) guidelines which state that patients should receive between 28-35 days of chemical thromboprophylaxis following their hip fracture.

Methods: We performed a retrospective audit of 63 patients, admitted to Tunbridge Wells Hospital with a hip fracture, in a three-month period from May 2012. A re-audit of 36 patients admitted in September 2012 was performed after introducing compulsory VTE training and encouraging the use of pre-entered Dalteparin on the electronic discharge system. Patients who died within 28 days of their fracture, on long-term warfarin and in-patients for >28 days had been excluded.

Results: Patient demographics were comparable in both audits. The authors found that there was a significant increase in appropriate chemical thromboprophylaxis prescribing from 30.2% to 91.7% following the implementation of these changes.

Conclusions: Simple actions such as compulsory VTE training to orthopaedic junior doctors, and the pre-entering of Dalteparin on the discharge notification to remind doctors, can improve the compliance to NICE VTE guidelines.

0794: 2011 NICE GUIDELINES AND DOUBLING THE NUMBER OF TOTAL HIP REPLACEMENTS FOR A FRACTURED NECK OF FEMUR IN HIGH DEMAND PATIENTS

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The management of patients with displaced intra-capsular hip fractures is usually a Hip Hemiarthroplasty procedure. NICE guideline 124 published in 2011 (1) suggested that Total Hip Replacement (THR) surgery should be considered in a sub group of patients with no cognitive impairment, who walk independently and are medically fit for a major surgical procedure.

The Royal Devon and Exeter Hospital manages approximately 600 patients every year who have sustained a fracture of neck of femur, of which approximately 90 patients fit the above criteria. Prior to the guideline less than 20% of this sub-group were treated with a THR whereas after the guideline over 40% of patients are treated with THR, with all THRs performed by sub-specialist Hip surgeons. This poster describes the changes implemented within the Trauma and Orthopaedic Department to achieve this, including changes to elective lists, 'Firebreak' lists and a positive working culture to utilise theatre time and list flexibility.

This practice is financially viable in terms of costs incurred and Tariff received. Complete follow up data at 120 days post op supports the claim that this change will enable patients to return to independent living and walk with less aids.

0818: PREOPERATIVE PATIENT EDUCATION AS TOOL TO IMPROVING POST-OPERATIVE PATIENT RECOVERY

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Total knee replacement (TKR) is one of the most common orthopaedic operations performed, national guidelines and standards for postoperative recovery are available from the British Orthopaedic Association and the Physiotherapy Association. This study reviews whether preoperative patient education improves postoperative recovery.

Method: Patient postoperative recovery after TKR was audited retrospectively over 2 years. In the first year patients received no preoperative education while in the second year patients were educated on knee anatomy, the operation, the expected physiotherapy, recovery time and day of discharge. Patients with significant co-morbidities were excluded. Primary outcome measures were postoperative days in hospital, to standing, walking, and climbing stairs. Subjectively postoperative patient confidence was assessed and a cost analysis performed.

Results: Over a 2-year period 76 TKR patients were studied, 39 received no preoperative education and 37 did. There was a significant reduction in hospital stay (5.41 to 4.46 days, $p = 0.047$), resulting in overall cost savings for the trust. A non-significant improvement in days to walking and climbing stairs was observed. There was no improvement in days to standing. Subjectively, educated patients reported to be more confident during physiotherapy.

Conclusions: Preoperative patient education can improve postoperative patient recovery and reduce cost.

0859: RADIOGRAPHIC OUTCOMES OF DISTAL RADIUS FRACTURES TREATED BY ORIF – SINGLE CENTRE REVIEW OF 218 CASES

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Aim: A recent publication by Ng and McQueen attempts to define the radiological parameters that correlate with a satisfactory clinical outcome in active patients undergoing open reduction internal fixation (ORIF) of distal radius (DR) fractures. We believe these parameters should be aimed for in all patients undergoing DR ORIF. We aim to identify if these parameters are being achieved in our centre.

Method: Post-operative radiographs were assessed for Ng and McQueen's parameters: positive ulna variance <2mm; radial dorsal tilt <0 degrees; no carpal malalignment; articular gap or step <2mm. Fracture classification and type of plate used were recorded.

Results: 218 cases performed over 27 months were reviewed. 63% (n=138) were satisfactory in all parameters. 25% (n=54) were unacceptable in 1 parameter, 5.5% (n=12) in 2 and in 3 parameters and 1% (n=2) in 4 parameters. All fractures with 3 or 4 unacceptable parameters were comminuted or intra-articular.

Conclusions: Implants for internal fixation of DR fractures are often marketed as "easy to use". Complacency must however be avoided and strict adherence to the principles of operative fracture management must be maintained to achieve satisfactory outcomes. Radiographic outcomes