**Hip protectors and compliance**

Following our feature on hip protectors in the May issue of *Nursing Older People*, Sue Witchard considers compliance – from a project nurse’s experience and perspective

As a project nurse for hip protection on wards for older people at King’s College Hospital, London, I gained unique insights into a number of issues surrounding compliance with hip protectors. I had two main questions regarding compliance:

- Why are people often reluctant to wear their hip protectors?
- Why are compliance rates low, particularly at night?

I interviewed patients and recorded the reasons why they did not wear their protectors during their stay in hospital and the information I gained fell broadly into the following categories:

- the design of the protectors – fabric, comfort and toileting
- the patient’s perception of the seriousness of the fall
- psychological issues and general wellbeing of the patient; for example, mood, personality and motivation
- institutional factors such as laundry facilities.

Probably the most common issue to affect compliance is the design, which is close-fitting. The male version has a fly opening, which is usually quite small so that the discs or padding stay over the greater trochanter and remain in place after a fall. For some patients this can cause problems. Some of our patients, especially men, had not been wearing any underwear since arriving in hospital, tending to wear pyjama trousers instead which generally enabled them to use a bottle or commode. Hip protectors slowed this process down. For example, the fly opening was difficult to manage for male patients who had poor manual dexterity. Frequency or urge incontinence compounded the problem; women found it difficult to pull the pants down quickly.

The fabric of the garments also affected compliance. The heavy cotton could feel too warm in the summer months and some patients complained of feeling too hot. On the other hand, when the weather was cold, patients often said they were glad of the extra layer.

A further design aspect was the discomfort of the hip protector shell. The products we were using at the time were cotton pants into which the hip protector shell was incorporated. Many patients felt that these were too uncomfortable to lie down in. Consequently, hip protectors were often not worn in bed even though patients were advised that many falls occur when getting out of bed.

The second main issue was the patient’s perception of how traumatic a previous fall had been. If it had resulted in a fracture patients were keener to use hip protectors. If the fall had happened recently, or was one of several falls, many patients were prepared to try anything that might get them home quicker or protect their hips if they were to fall again. This was countered, however, by memories of falls and the passage of time. As time passed on the ward many patients forgot to put on their protectors; others were initially keen but that enthusiasm often waned.

Psychological issues and the general wellbeing of the patient appeared to challenge commitment to wearing hip protectors. Depression affected motivation, and worries over discharge arrangements and paying bills affected compliance. Some patients said that they could not cope with hip protectors at the present time; the hospital episode had overwhelmed them and they could not take on the extra decisions and information. Personality appeared to be a factor: some people expressed a more positive outlook, or were more willing to ‘give it a try’. I found that reluctant patients would need a day or two to try out a hip protector and to make up their minds.

Often, if they were going to give up wearing the hip protectors, they did so within 48 hours of being fitted. Development of further health problems or complications which caused them to feel unwell made them reluctant to continue with hip protectors.

The final factor to affect compliance is unique to the acute hospital environment. The size of the hospital made it difficult to keep track of the protectors. Many patients had no visitors to do their laundry so the protectors had to be washed and returned to the patient by staff on the ward, using the ward washing machine. Some staff were reluctant to take on this additional task. If the hip protectors were accidentally put into the main hospital laundry system, they were never seen again.

Although there was an on-site laundry system for patients’ clothing, this proved inadequate as there were often delays in hip protectors being returned. This resulted in hip protectors not being worn for days at a time. A further problem was that staff sometimes did not communicate information about the hip protectors effectively. This meant that staff were not aware that their patient might need prompting or assistance to put them on.

Although I have listed the reasons why patients did not wear their hip protectors, many of them put up with these ‘annoyances’ because the benefits outweighed the disadvantages. Many also felt their confidence was increased when wearing their hip protectors. I observed that compliance was improved when patients had the opportunity to encourage each other. One successful idea was to hold a coffee morning for the hip protector patients. There is every reason to believe that compliance can be improved and many of the problems overcome. Manufacturers need to improve the design of hip protectors and nurses need to work with patients and colleagues to find ways of resolving the practical issues. The future for hip protection is a bright one.

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