



Joint Approach

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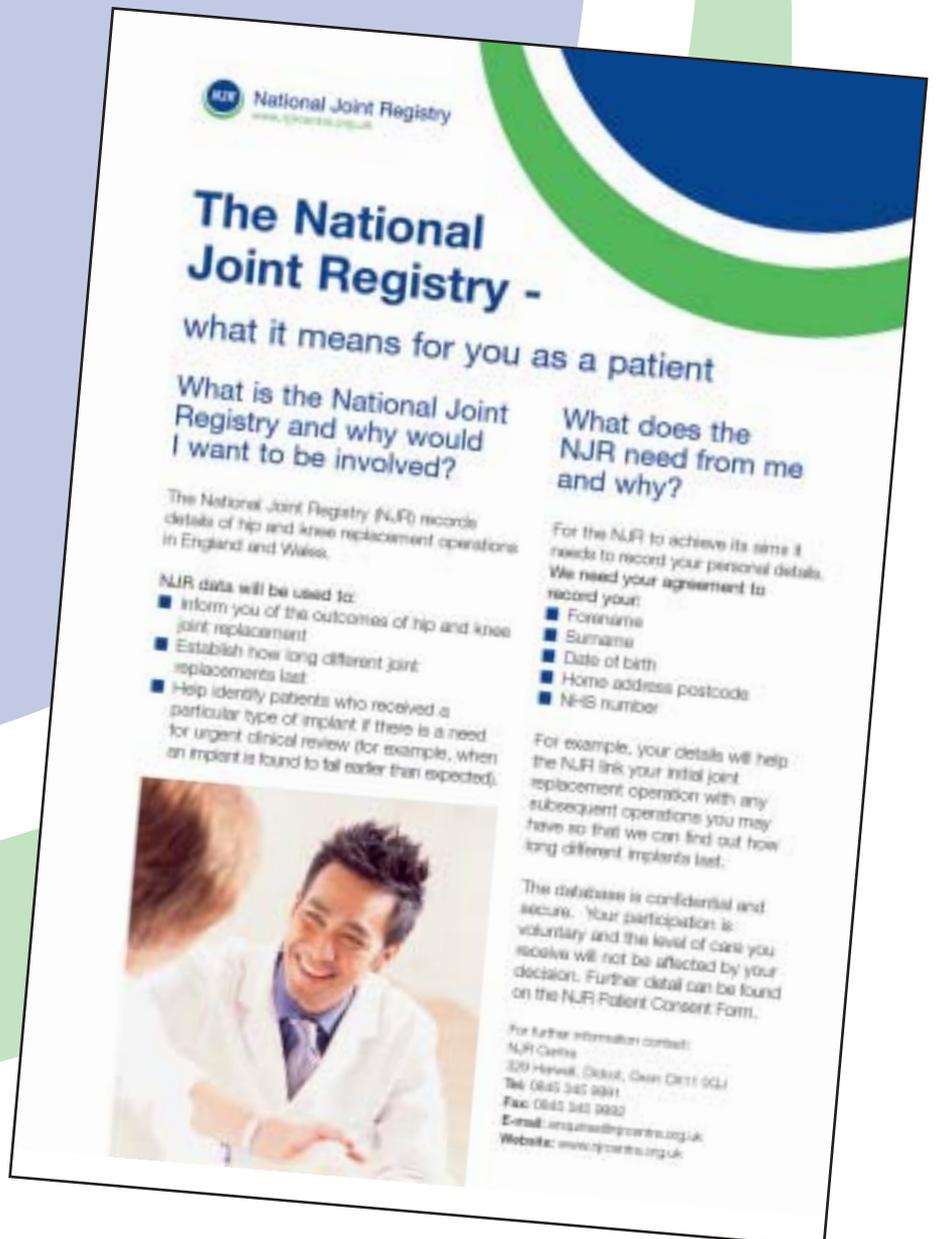
THE NEWSLETTER OF THE
NATIONAL JOINT REGISTRY
WWW.NJRCENTRE.ORG.UK

Updated MDS
proformas

Managing surgeon
default techniques

Improving NJR
consent levels

Hip replacement in
your seventies



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Next newsletter publication: March 2005

If you would like to make a contribution to this Newsletter, please contact the NJR Helpline on 0845 345 9991, or send an email to enquiries@njrcentre.org.uk. Let us know what you would find useful and would like to see in the next issue of the Newsletter.

All NJR information and documents are available on the NJR website (www.njrcentre.org.uk). If you do not have access to the web, contact the NJR Centre to receive a copy of future newsletters by email or post.

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Latest NJR news - at a glance

New MDS proformas (v2.1, October 2004)

The paper proformas used to collect NJR data have been updated and all hospitals need to use version 2.1 (October 2004) in place of all previous versions. This applies to all four proformas, H1, H2, K1 and K2.

The revised proformas have been updated to incorporate user feedback and reflect the Data Entry System more closely. But the most important change is the addition of a new MDS v2 data field - patient procedure. This data field will become mandatory on 31 January 2005, hence the importance of introducing the updated MDS v2 proformas into your hospital processes now. See page 3 for further details.

Patient consent

The NJR Centre provides several tools to assist hospitals to gather and record NJR consent. These include:

- an NJR patient consent form (which includes explanatory details to help the patient make an informed decision)
- a revised NJR patient consent poster
- guidance on how to implement the NJR consent form.

Coming soon! A Good Practice Guide to NJR patient consent. See page 6 for further details.

Bulk upload

The control files (XML schema and instance files) have now been released and are available on the NJR website. This will enable interested parties to generate the file that is required to use the bulk upload facility. A test version of the system will be made available so that the facility can be tested in full. It will also allow interested parties to test their systems and create the required bulk upload XML file.

Bar code reading

The structure of the bar coding standards used by suppliers has been analysed along with the product data. This is an extensive project, but necessary to ensure that the highest possible number of products are available on the bar coding system. Testing of the data is on-going, and will continue throughout the development process and final integration of the system into the main NJR application.

Events Diary

The NJR will be at the following event:

British Hip Society Annual Meeting
3 - 4 March 2005
Wrightington Hospital

Feedback on the NJR 1st Annual Report

Readers are invited to complete the feedback form available in Appendix 8 of the Annual Report. Alternatively, you can complete the online version available on the NJR website. Feedback will help with the preparation of future reports.

Updated MDS proformas

The paper proformas used to collect NJR data have been updated to incorporate user feedback and reflect the Data Entry System more closely.

All hospitals should now use the updated forms (version 2.1, October 2004) in place of all previous versions.

One of the most important changes is the addition of a new MDS v2 data field - patient procedure. This data field will become mandatory on 31 January 2005, hence the importance of introducing the updated MDS v2 proformas now. The proformas have been released well ahead of January so that hospitals have time to incorporate them in their systems.

The main changes to the proformas are:

- 1. Patient procedure** - this is the new MDS v2 data field and has been added to all four proformas, H1, H2, K1 and K2. The data field has already been added to the Data Entry System, but will not become a mandatory field until 31 January 2005.
- 2. Selection listings** - user feedback highlighted that these were not always presented in the same order as on the

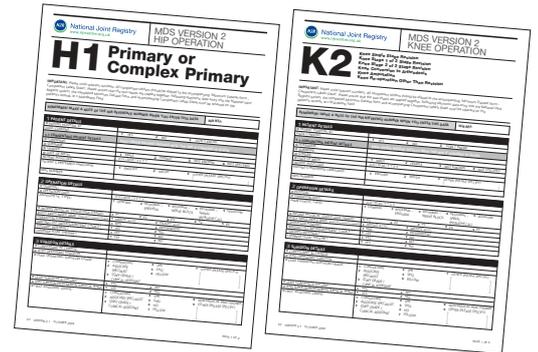
Data Entry System; they have now been synchronised.

- 3. Choosing the option 'other'** - whenever the option 'other' is selected, the details need to be specified. The text 'Please specify' has now been added where this option is offered.
- 4. Explanatory notes** - supporting information has been provided in specific areas of the proformas to aid clarity, for example:
 - a) If the surgeon default technique is selected on a proforma, the surgeon must have previously completed the relevant data fields online within the Data Entry System - currently, this can only be done via the surgeon's NJR user account (see pages 4 and 5 for new developments). Data entry staff will not necessarily know what the surgeon's actual default technique includes. If the surgeon has not completed the default technique, then the relevant data must be forwarded to data entry staff to allow them to complete the NJR electronic record.

- b) A reminder of implant components that are not recorded by the NJR has been added to the 'component label sheet' - these include wire, mesh, cables, plates, screws, surgical tools, endoprotheses and bipolar heads. Cement, however, **MUST** be recorded on the NJR database.

- 5. Section headings and numbers** - these have been reviewed and updated so that the proformas and Data Entry System correspond more closely, thereby aiding transfer of data from a proforma to the database.

Your feedback and suggestions are always welcome and we aim to incorporate them wherever feasible to provide improvement.



Trauma surgery and the NJR

It has always been the intention of the NJR that total hip and total knee replacements undertaken as a result of fresh traumatic injury to the joint should be entered into the database.

To clarify the requirements related to trauma, the following statement is issued as the definitive opinion of the NJR Steering Committee.

“All total hip and total knee replacements undertaken as a result of traumatic injury are within the scope of the NJR. This is the case whether or not such a procedure is performed immediately after the injury or as a result of the failure of more conservative treatments aimed at restoring normal joint function.”

The H1 proforma (for primary hip procedures) has been amended to reflect such cases. For example, the list of indications for implantation now includes:

- failed hemiarthroplasty
- failed internal fixation
- fractured acetabulum
- fractured neck of femur
- other hip trauma.

It is recognised that such procedures often include implantation of other related products such as bone plates, screws, circlage wires and metallic meshes. Such products are not included within the scope

of the NJR and, therefore, should not be entered onto the system.

Finally, all NJR users are reminded that conventional methods of treating femoral neck fractures, such as the use of endoprotheses, bipolar heads and compression hip screws, are not classed as total hip replacement procedures. Such products and procedures are, therefore, not considered to be within the scope of the NJR.

If you require any further clarification on this issue, please contact the NJR Helpline on **0845 345 9991**.

Managing surgeon default techniques

Why the NJR records surgeon default techniques

The NJR Data Entry System has a facility for creating a default technique for each surgeon. This facility was developed specifically to help limit repetitive data entry. Prerecording the surgeon default technique on the NJR enables certain data fields to be populated at the data entry stage when creating a record for a new procedure. The relevant data fields are populated when a specific lead surgeon is selected and where that surgeon indicated they used their default technique.

Enabling NJR Hospital Data Managers to help surgeons

The MDS proformas (H1, H2, K1 and K2) are used to capture the details of an individual procedure and allow the surgeon to indicate whether their default technique was used. However, these forms do not capture the details of the surgeon's default technique; these need to be entered into the Data Entry System separately for each individual surgeon.

Until recently the NJR Data Entry System only allowed surgeons to create their default techniques via their own NJR user accounts. However, not all surgeons have completed their default technique online, which has in the past led to some confusion at the data entry stage and resulted in incomplete records which could not be submitted to the NJR. To help remedy this situation, the ability to create the surgeon's default technique online has been opened up to Hospital Data Managers (providing they have the surgeon's permission).

A Hospital Data Manager (HDM) can now enter the surgeons' default techniques on behalf of those surgeons associated with their hospital via their own HDM account.

Maintaining the ownership of a surgeon's default technique

An HDM can use the forms to agree with a surgeon which data fields represent their surgical default technique, and then enter

New forms for recording a surgeon default technique

The NJR Centre has developed a form which can be used as an initial record of the surgeon default technique details. The HDM can then use this to enter the details into the Data Entry System.

There are separate forms for a default hip technique and a default knee technique. With the introduction of MDS v2 the data fields for the default techniques were modified, hence there are also separate forms for the default technique to be stored in MDS v1 and MDS v2 on the Data Entry System. The forms available to use are:

***HD1** - Hip default technique for MDS v1

***KD1** - Knee default technique for MDS v1

HD2 - Hip default technique for MDS v2

KD2 - Knee default technique for MDS v2

The forms are available from the NJR website at www.njrcentre.org.uk (from the Healthcare Providers area follow the links to **surgeon default technique**). They can also be accessed directly from the surgeon default technique screen in the Data Entry System.

*Note: All new procedures recorded by the NJR must use MDS v2. The only reason why a form has been made available to capture MDS v1 default techniques is to enable the submission of data currently held on MDS v1 proformas and where a surgeon has indicated they used their default technique but has not recorded their details on the Data Entry System.

these data into the NJR. Once the data have been submitted to the NJR, there is a facility to print a copy of the saved default technique - this copy should be signed and dated by the surgeon to provide an accurate and up-to-date record.

It is the responsibility of the surgeon to ensure the correct default technique is recorded on the NJR database. A printed and signed copy of the saved default technique should be kept as part of the surgeon's records. It is suggested that the HDM also keeps a copy for their records.

Some surgeons and HDMs may find it more convenient to sit together and select the data fields on the Data Entry System directly. Clearly, in this situation the default technique template forms do not need to be used. However, it is important that the saved default technique is printed and

a copy signed by both parties for their own records.

Setting-up a surgeon default technique

A quick outline of how to set up a surgeon default technique within the Data Entry System is provided here, but for detailed step-by-step instructions please refer to section 6.3 of the NJR Reference Manual (available from the NJR website).

As an NJR Hospital Data Manager

1. From the main menu select **System Functions** and then **Manage Surgeons**.
2. Select the appropriate surgeon and then select **MDS1 Technique** or **MDS2 Technique** as appropriate, see Figure 1.
3. Select **knee technique** or **hip technique** from the tab options across the top of the screen, see Figure 2.

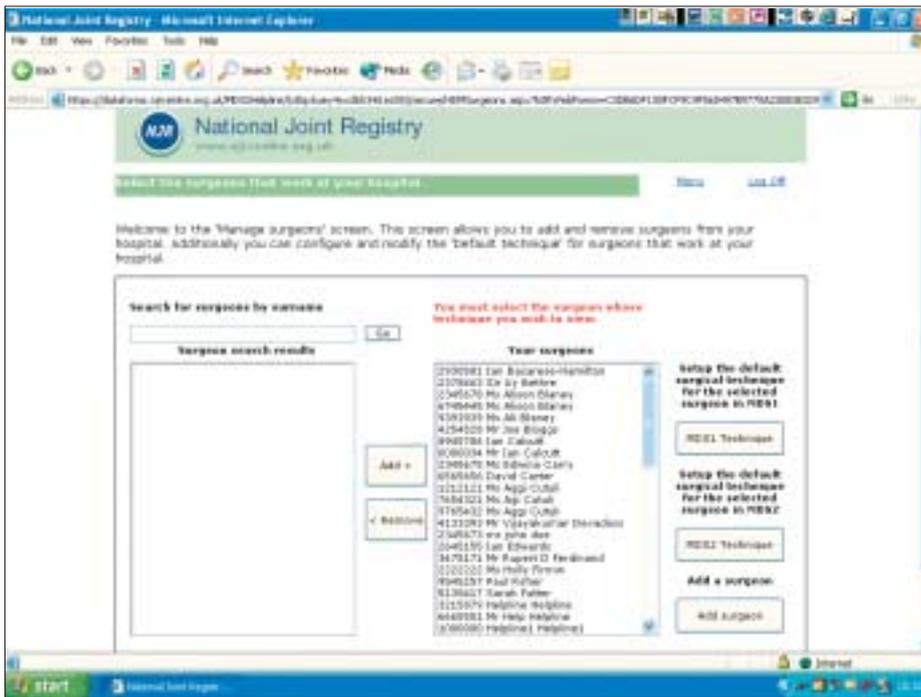


Figure 1 - Manage Surgeons screen

4. Complete all data fields listed. Fields marked with an asterisk are mandatory.
5. To save your default technique click on the save button.
6. Click on [View a printable version of the saved default technique for this surgeon](#). Print a copy of the saved default technique and obtain the signature of the surgeon as confirmation that the technique is complete and accurate. Retain a copy for your reference files.

As a surgeon

1. From the main menu select **System Functions** and then **Modify Surgeon Profile**.
2. Select **knee technique** or **hip technique** from the tab options across the top of the screen.
3. Complete all data fields listed. Fields marked with an asterisk are mandatory.
4. To save your default technique click on the save button.
5. Click on [View a printable version of the saved default technique](#). Print a copy of the saved default technique, sign and date. Retain a copy for your reference files.

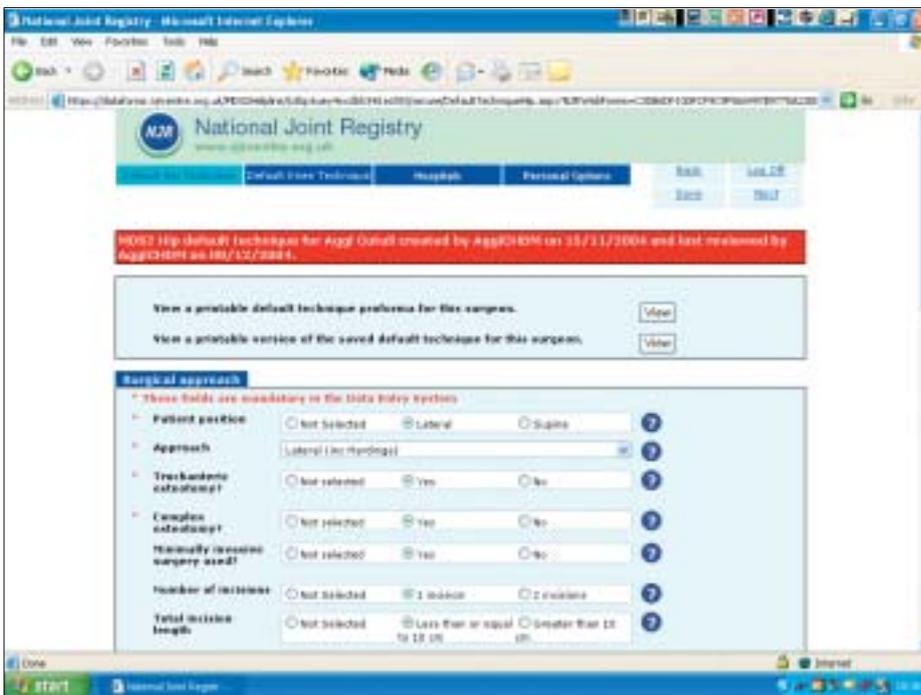


Figure 2 - Default Technique screen (hip)

Ensuring the surgeon default techniques are kept up-to-date

It is important that a surgeon's default techniques are kept up-to-date. If a surgeon changes their preferred technique, the Data Entry System must be updated to reflect any relevant changes. We strongly recommend that surgeons review their default details at least annually. Surgeons may choose to work closely with their NJR HDMs to ensure these records are reviewed on a regular basis.

Advice and training available

The NJR Centre is committed to providing training and support to all NJR users. If you need further advice or want specific training on how to set up the surgeon default technique on the Data Entry System, your local Regional Audit Co-ordinator will be able to help.

Alternatively, you can contact the NJR Helpline on **0845 345 9991**.

Involving patients will help improve NJR consent levels

For the NJR to be effective, it needs to collect as many records as possible with patient consent. Patient consent allows personal details (forename, surname, date of birth, postcode and NHS number) to be recorded.

Recording personal details allows the NJR to:

- identify patients who have received a specific prosthesis that is later found to be faulty
- link a patient's primary and any subsequent revision procedures, so that the survivability of particular implants can be determined (the link being via the NHS number)
- invite patients to participate in any subsequent feedback process.

NJR patient consent rates

The NJR 1st Annual Report highlights the importance of having records submitted with personal details. In the reporting period (1 April to 31 December 2003), 46,497 patients were recorded as having received a joint replacement, of which 62.8% were recorded as having given their consent.

Whilst it is encouraging that more than half of the hospitals submitting data achieved patient consent levels of more than 80%, a quarter obtained consent rates of less than 40%, and there were 27 (8.1%) participating hospitals that returned a zero consent rate.

Where consent has not been obtained, this can be due to:

- patients withholding their consent
- patients never having been asked for their consent
- the data entry person not having proof available that consent was obtained.

High consent levels are achievable: 68 hospitals obtained consent rates of 100%.

Giving the patient a choice

The patient's permission must be obtained for their personal details to be recorded by the NJR. Patients should be given the opportunity to sign an NJR patient consent form. Patients must not be coerced, but be reassured that the level of care they receive will not be affected should they choose not to participate.

Missing NHS numbers

For the first nine-month NJR reporting period, only 65.1% of NHS numbers were available for patients who gave consent. However, more than a quarter of hospitals recorded NHS numbers for 80% or more of consenting patients. Of these hospitals, 23 had an NHS number for all patients, demonstrating that it is possible to achieve high levels of completeness.

The NHS Strategic Tracing Service (NSTS) helped to locate some of the missing NHS numbers by using the patients' name, date of birth and postcode. Not every missing NHS number was located, partly due to incorrect, incomplete or missing postcodes. Hence, extra effort is needed to ensure the patient's postcode is entered if the NHS number is unknown at the time of gaining consent.

Helping you to record NJR patient consent

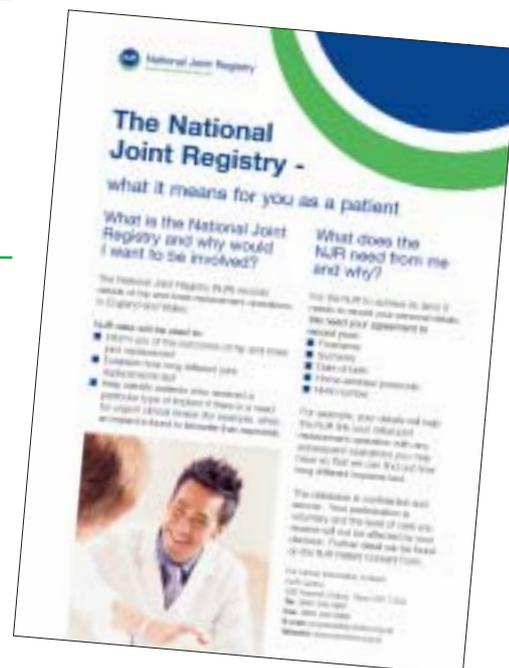
The NJR Centre provides several tools to assist hospitals to gather and record NJR consent. These include:

- An NJR patient consent form

The current version (1.4, February 2004) can be downloaded from the NJR website (www.njrcentre.org.uk). The consent form is available in Welsh and as large print.

- A revised NJR patient consent poster

This is designed to communicate directly to the patient; you may find it useful to display it in patient waiting areas such as the



pre-operative assessment clinic. The poster introduces the NJR, its benefits and why the patient is being asked for their consent.

A colour A3 poster is now available on request. Ask your Regional Audit Co-ordinator, or call the NJR Helpline on 0845 345 9991. Alternatively, an A4 poster can be downloaded from the NJR website.

- Guidance on how to implement the NJR consent form

This is available from the NJR website. It provides some background to NJR patient consent and why it is important. It also includes a checklist to help prompt hospitals to consider how the patient consent form will be used at a local level.

- Coming soon! A Good Practice Guide - NJR patient consent

This guide will provide advice and some useful tips on how to collect patient consent. Also included are examples of hospitals that obtain high levels of patient consent and how they have gone about achieving this. The guide will be made available from the NJR website.

For further information or advice, talk to your Regional Audit Co-ordinator, or call the NJR Helpline on **0845 345 9991**.

Australian Orthopaedic Association National Joint Replacement Registry - an update

In October 2004, the Australian Orthopaedic Association National Joint Replacement Registry (AOANJRR) released its 5th Annual Report. The information presented involved the analysis of 74,063 hip and 76,049 knee procedures carried out between September 1999 and December 2003.

With each report, the Registry has increasingly focused on presenting data that compare different classes of prostheses, as well as determining the performance of individual prosthesis types. The results are obtained by examining subsequent revisions of primary procedures recorded by the Registry. As a consequence of its staged, state-by-state introduction, the Registry has only collected full national data since mid-2002. Therefore, almost 80% of revisions have been undertaken within 12 months of the original primary procedure.

The report highlights differences in the early outcome of Austin Moore prostheses compared to Thompson prostheses when used for the management of displaced subcapital fractures of the neck of the femur. The Austin Moore is revised almost

three times more frequently and is also associated with an increase in mortality.

Early results for total hip replacements have been recorded, including conventional total hips and resurfacing procedures. Cemented hips have a significantly lower revision rate compared to hybrid and cementless hips. These revisions are independent of both age and gender. Resurfacing hips have a significantly higher early revision rate than conventional hips, when patients aged over 55 are compared. The most common reason is fracture of the femoral neck, accounting for 66% of the revisions. Revision for fracture following resurfacing occurs almost twice as often as revision for dislocation following conventional primary total hip replacement. Individual prostheses identified as having higher than anticipated early revision rates include the SPH Blind acetabular component and the Margron femoral stem.

Also reported are significant differences in revision rates depending on the class of knee replacement. This includes a two-fold increase in revision of unicompartmental knee replacements compared to total knee

replacements when adjusted for age and sex in patients having surgery for osteoarthritis. The Registry previously reported a high revision rate for Allegretto Unis and this continues to be the situation. The 2004 report also highlights a higher than anticipated revision rate for the recently released Preservation Uni, approaching 7% at 18 months. This was for both fixed and sliding tibial inserts, with tibial component loosening being the principal cause of failure.

Early results of total knee replacement are not related to the intrinsic stability of the prostheses (i.e. minimally compared to posterior stabilised), or if the tibial insert is fixed or mobile. A number of prostheses were identified as having a higher than anticipated failure rate, including the Profix and Genesis II mobile bearing knees. The reason for revision was femoral component loosening and relates to an oxinium macro-textured cementless femoral component, which has been withdrawn from the market.

Professor Stephen Graves
Director, AOA National Joint Replacement Registry

NJR 1st Annual Report published

The NJR 1st Annual Report can be accessed from the NJR website (www.njrcentre.org.uk) - follow the links from the Healthcare Providers page. A 16-page summary report is also available.

The report's findings are based on data from operations that took place between 1 April and 31 December 2003 in participating hospitals. The data were submitted to the NJR by 31 March 2004.

Launching the report

The report was launched by Lord Hunt in September at the British Orthopaedic Association Annual Congress 2004. Bill Darling (chair of the NJR Steering Committee) introduced some key aspects of the NJR. Following on, Lord Hunt (chair of the National Patient Safety Agency and a strong advocate of the NJR) discussed the conception and development of the NJR, and its importance from the patient's perspective.

Finally, Paul Gregg (vice-chair of the NJR Steering Committee) gave an overview of the Annual Report's results.

Since then, the NJR Centre has distributed printed copies of the full report and summary report to all NJR registered hospitals.



Hip replacement in your seventies

Carrying on regardless

At 75 years old, Muriel thought that she was suffering from sciatica in her hip. She had had sciatica before and thought it would pass, so she carried on living life as normal - well, as normal as it can be when experiencing constant pain. Beautiful walks in the country became increasingly more difficult, but she had hoped the pain would pass. It was a friend from the WI who noticed her intense discomfort and expressed her concern, "Muriel, I don't like seeing you in pain, you need to do something about it." This was the nudge she'd needed and after discussing it with her husband, Muriel made a visit to her local GP to find out what the problem was.

The diagnosis

Her GP was extremely helpful and told her that she needed to have an X-ray. Muriel was sent to her local hospital, and the X-ray showed that the cartilage in her hip joint had degenerated. This was the cause of her discomfort for the previous year; without the cartilage, the bones were rubbing together. Her consultant explained that she needed a total hip replacement. Although Muriel is a strong believer in the NHS, she decided to fund her own operation to reduce her waiting time and curtail her suffering.

Positive thinking

For many people, an episode in hospital is quite daunting, but a solution had been identified for Muriel and she was positive that her pain would be a thing of the past. She began to look forward to long walks in the country, sleep-filled nights and pain-free holidays abroad. In fact, she couldn't wait to have the operation.

Hospital support and information

Muriel is full of praise for all the staff that cared for her in hospital, and she said her consultant had been 'super'. He explained in great detail what hip replacement surgery entailed and reassured her that the success rate of this type of surgery was high, with around 80% of operations being successful. He drew diagrams to explain the technicalities, leaving her feeling totally at ease about the procedure she was about to undergo.

Muriel spent a total of nine days in hospital after her hip replacement. The surgeon visited her every morning and evening to check on progress. On the second day, she suffered from delayed post-operative shock but she recovered quickly with the help and care of the nursing staff.

Muriel's time in hospital following her operation was a very positive experience, giving her the time she needed to relax and recuperate. She said, "The nursing staff and the physiotherapists were fantastic." During her stay, she was able to carry on with some work for the WI and even had time for some long-awaited knitting, before going home.

Home sweet home

Muriel described the six weeks of sleeping on her back as the worst thing about her experience, but now, a year on, she is sleeping well.

Muriel still has a slight limp, but this is slowly improving through the exercises she was given to help build up the muscles in her hip and leg. Through the excellent care and support from the hospital and her husband, Muriel is fit and well, and is enjoying her active and pain-free life once again.