**Name of Journal:** *World Journal of Clinical Cases*

**Manuscript NO:** 71261

**Manuscript Type:** ORIGINAL ARTICLE

***Retrospective Study***

**Evidence-based intervention on postoperative fear, compliance, and self-efficacy in elderly patients with hip fracture**

Fu Y *et al*. Evidence-based intervention in hip fracture

Ying Fu, Li-Juan Zhu, Da-Cheng Li, Jing-Lei Yan, Hai-Ting Zhang, Yu-Hong Xuan, Chun-Ling Meng, Yan-Hong Sun

**Ying Fu, Jing-Lei Yan, Hai-Ting Zhang, Chun-Ling Meng, Yan-Hong Sun,** Joints Osteopathic Department, Chengde Central Hospital, Chengde 067000, Hebei Province, China

**Li-Juan Zhu, Da-Cheng Li,** Traumatic Osteopathic Department, Chengde Central Hospital, Chengde 067000, Hebei Province, China

**Yu-Hong Xuan,** Nursing Department, Chengde Central Hospital, Chengde 067000, Hebei Province, China

**Author contributions:** Fu Y and Zhu LJ contributed equally to this article and should be regarded as co-first authors; Fu Y and Zhu LJ design the experiment; Li DC drafted the work; Yan JL, Zhang HT and Xuan YH collected the data; Meng CL and Sun YH analyzed and interpreted data; Fu Y, Zhu LJ and Li DC wrote the manuscript.

**Corresponding author: Yan-Hong Sun, BM BCh, Chief Nurse,** Joints Osteopathic Department, Chengde Central Hospital, No. 11 Guangren Street, Shuangqiao District, Chengde 067000, Hebei Province, China. syh1858@163.com

**Received:** December 5, 2021

**Revised:** January 7, 2022

**Accepted: February 19, 2022**

**Published online:**

**Abstract**

BACKGROUND

Elderly patients tend to have poor self-efficacy and poor confidence in postoperative rehabilitation for hip fractures, and are prone to negative emotions, which affect treatment compliance.

AIM

To evaluate the effects of evidence-based intervention on postoperative fear, compliance, and self-efficacy in elderly patients with hip fractures.

METHODS

A total of 120 patients with hip fracture surgically treated from June 2018 to June 2020 at the orthopedic department of our hospital were selected and divided into intervention and routine groups (*n* = 60 each) according to different nursing methods. The basic rehabilitation methods of the two groups were consistent, but patients in the intervention group received evidence-based nursing interventions at the same time. Differences between groups in the scores of motion phobia, pain fear, rehabilitation training compliance, self-efficacy, nursing satisfaction, and hip joint function were compared before and after the intervention.

RESULTS

Before the intervention, there were no statistically significant differences in motion phobia and pain fear scores between the groups (all *P* > 0.05). However, motion phobia scores at 1 wk after intervention initiation (*P* < 0.05), and pain fear scores at 1 wk and 2 wk after intervention initiation (all *P* < 0.05), were significantly lower in the intervention group than in the routine group. On the first day of intervention, there was no significant difference in rehabilitation treatment compliance between the groups (*P* > 0.05); however, at 2 wk after intervention initiation, rehabilitation compliance was significantly better in the intervention group than in the routine group (*P* < 0.05). Before the intervention, there were no statistically significant differences in the scores for the two self-efficacy dimensions (overcoming difficulties and rehabilitation exercise self-efficacy) and the total self-efficacy score between the groups (all *P* > 0.05). After 2 wk of intervention, the scores for these two dimensions of self-efficacy and the total self-efficacy score were significantly higher in the intervention group than in the routine group (all *P* < 0.05). At 3 and 6 mo after surgery, hip function as evaluated by the Harris hip score, was significantly better in the intervention group than in the routine group (*P* < 0.05). Additionally, overall nursing satisfaction was significantly higher in the intervention group than in the routine group (*P* < 0.05).

CONCLUSION

Evidence-based nursing intervention can alleviate fear of postoperative rehabilitation in elderly patients who underwent hip fracture surgery, and improve rehabilitation treatment compliance and patient self-efficacy, which promote hip function recovery.

**Key Words:** Evidence-based nursing; Gerontism; Hip fracture; Rehabilitation; Fear; Compliance; Self-efficacy

Fu Y, Zhu LJ, Li DC, Yan JL, Zhang HT, Xuan YH, Meng CL, Sun YH. Evidence-based intervention on postoperative fear, compliance, and self-efficacy in elderly patients with hip fracture. *World J Clin Cases* 2022; In press

**Core Tip:** This study shows that evidence-based nursing intervention can alleviate the fear of postoperative rehabilitation in elderly patients who undergo hip fracture surgery, improve rehabilitation treatment compliance, and improve the self-efficacy of patients, consequently promoting the recovery of hip function in patients.

**INTRODUCTION**

The occurrence of hip fractures in the elderly population is related to decreased strain force and activity, osteoporosis, and other factors, and can cause severe pain, activity disorders, and long-term bed rest, thus leading to lower extremity deep vein thrombosis, pulmonary infections, urinary tract infections, and other complications, which hinder recovery[1-4]. Therefore, elderly patients with hip fractures should undergo surgery as soon as possible to correct joint dysfunction, restore joint function, and reduce the rate of disability. Although surgery is the first choice for the treatment of hip fractures, rehabilitation training is needed to help recover hip function[5].

Currently, there are many clinical intervention measures for postoperative rehabilitation in elderly patients who undergo hip fracture surgery. However, due to a lack of knowledge, memory, and understanding of post-fracture rehabilitation, elderly patients have poor self-efficacy and poor confidence in rehabilitation, and are prone to negative emotions, which affect treatment compliance[6]. Evidence-based nursing is a new nursing model that takes clinical nursing problems as the starting point and solves problems in an evidence-based manner[7]. This study aimed to evaluate the effects of evidence-based intervention on postoperative fear, compliance, and self-efficacy in elderly patients with hip fractures.

**MATERIALS AND METHODS**

***Patient selection***

A total of 120 patients with hip fractures surgically treated from June 2018 to June 2020 at the orthopedic department of our hospital were selected and divided according to different nursing methods into two groups of 60 patients each: the intervention group and routine group. The inclusion criteria were as follows: (1) received closed reduction and intramedullary nailing at the department of orthopedics of our hospital due to a hip fracture; (2) underwent rehabilitation training in our hospital after the surgery; (3) aged 65–85 years; (4) underwent unilateral hip surgery; and (5) was able to understand, read, listen, and converse. The exclusion criteria were as follows: (1) fracture or cancer caused by a malignant tumor; (2) previous nerve and muscle diseases of the lower limbs leading to lower limb dysfunction; (3) artificial hip replacement or re-repair; (4) previous ankle and knee surgery; (5) coagulation disease; and (6) accompanied by large tissue defects of the lower limbs, large blood vessels, and nerve damage. The study protocol was approved by the Ethics Committee.

***Basic rehabilitation intervention***

All patients were treated with basic rehabilitation. The patients were visited by nurses prior to surgery, and instructed to perform effective coughing and lip-constricted breathing after the surgery. They were also instructed to practice inhalation through the nose and exhalation with the lips parted, similar to whistling. Postoperatively, the patients received help in maintaining proper posture, and were instructed to maintain gentle movements once placed into position. Soft pads were used to protect the patient's bone carina and prevent pressure sores. Additionally, the patients in both groups were instructed to perform ankle pump movements in bed, as well as plantar flexion, lower toe, back extension, and hook toe exercises, 20 min/time, 2 times/d.

***Evidence-based nursing interventions***

The intervention group received evidence-based nursing. First, an evidence-based nursing team, composed of head nurses and responsible nurses, was established. Before the study, the group members were trained on the common complications, emotional problems, and self-management problems in elderly patients after hip fracture surgery. The group members’ grasp of the training content was enhanced by centralized on-site training, teaching videos, and online learning platforms, *etc.* Based on clinical nursing experience, evidence-based issues were put forward, the relevant literature was consulted, and individualized nursing plans were formulated. Patients were evaluated preoperatively, and evidence-based interventions were performed to address possible problems.

Given the likelihood of high-risk factors that cause postoperative complications, such as deep venous thrombosis of the lower limbs, bedsores, precipitate pneumonia, and urinary tract infections, the health education provided to patients was strengthened, so as to ensure that the patient understood that postoperative self-management is important to the prognosis. As part of basic rehabilitation, the patients were instructed to perform effective coughing, lip-constricting breathing, and ankle pump movement, using the same methods as those in the routine group. Additionally, the patients were helped in turning over regularly, the back was patted, and soft pads to protect the patient's bone carinal area were used to prevent pressure sores. The patients were guided to appropriately raise the affected limb and perform ankle pump movements after surgery, and were encouraged to get out of bed as early as possible, follow the doctor's advice to undergo lower limb function training, strengthen the quadriceps muscle contraction with training, assist with proper massage, and hot compress the affected limb. If lower extremity swelling and venous thrombosis were found, massage was stopped, and the patient was reported to the doctor for thrombolysis treatment in a timely manner.

For elderly patients who easily produce negative emotions, the nurses adhered to a gentle, cordial attitude and communicated with the patient regarding issues caused by negative emotions in nursing work, and provided the corresponding psychological counseling. Patients were guided to listen to the radio and watch videos, as a form of distraction to relieve negative emotions.

Given the characteristics of impaired vision, hearing, and comprehension in elderly patients, the communication between nurses and patients was strengthened, using masterful communication skills at an appropriately increased volume. The influence of postoperative rehabilitation exercise on the recovery of lower limb function was repeatedly emphasized to the patients, and they were instructed to overcome their pain and fear and actively cooperate with rehabilitation training. Nurses praised the progress made by patients in a timely manner, and guided the patients to carry out self-care without tiredness.

***Evaluation indexes***

Differences in the scores of motion phobia, pain fear, rehabilitation training compliance, self-efficacy, nursing satisfaction, and hip joint function between the two groups were evaluated before and after the intervention.

The Tamp Scale (TSK) was used to evaluate motion phobia[8]. The TSK comprises 17 items, each of which is scored on a 4-point Likert scale. The total score ranges 17-68 points, with higher scores indicating greater motion phobia severity. A total score > 37 was considered to indicate that the patient had symptoms of motion phobia[8].

The pain fear questionnaire comprises 30 items, each of which is scored from 1 to 5 points; accordingly, the total score ranges 30-150 points. A higher score indicates more severe pain fear[9].

An early rehabilitation training compliance evaluation table was used to evaluate rehabilitation training compliance, and the compliance standards were divided into three levels as follows: (1) full compliance: the patient can actively complete the daily rehabilitation training plan, with good quality and quantity, according to the guidance of nurses, and the rehabilitation effect is good; (2) partial compliance: the patient competes the daily rehabilitation training plan only when supervised by a nurse, or only occasionally, sometimes due to a lack of action, sometimes due to a lack of time, and the rehabilitation effect is fair; and (3) noncompliance: the patient does not follow instructions and refuses to carry out early rehabilitation training according to the guidance of nurses, and the rehabilitation effect is poor.

The self-efficacy for rehabilitation scale (SER) was used to assess self-efficacy[10]. The SER is used to evaluate self-efficacy in patients undergoing postoperative knee or hip rehabilitation, and has a total of 12 items for two dimensions of self-efficacy: rehabilitation exercise self-efficacy and self-efficacy in overcoming difficulties. The highest total score is 120 points, and scores are proportional to the patient’s self-efficacy[10].

Hip joint function was evaluated using the Harris hip scale, which includes items on pain, lower limb deformity, hip joint function, and hip joint range of motion[11]. The highest total score is 100 points, and higher scores indicate better hip joint function[11].

Nursing satisfaction was evaluated using a 100-point scale, completed by patients and their families at discharge. The sum of the two scores was averaged as the nursing satisfaction score, with scores ≥ 90 indicating very satisfied; 80-89, relatively satisfied; 70-79, fair; and < 79, not satisfied.

***Statistical analyses***

Age, various scale scores, and other measurement indicators used in this study were evaluated for normal distribution by pp and qq diagrams, which indicated approximately normal or normal distributions. Accordingly, these data are expressed as mean ± SD, and the independent-sample *t*-test was used to evaluate differences between the two groups. Sex, affected side, combined diseases, and other count data are expressed as percentages, and differences between groups were evaluated using the *χ*2 test for non-grade count data and the Whitney-*U* test for grade count data. Significance was set at *P* = 0.05.

**RESULTS**

***Comparisons in baseline characteristics***

There were no statistically significant differences in age, height, weight, and interval between the fracture and surgery between the two groups (all *P* > 0.05) (Table 1).

***Comparison in motion phobia scores before and after the intervention***

Before the intervention, there was no statistically significant difference in motion phobia scores between the two groups (*P* > 0.05). At 1 wk after intervention initiation, motion phobia scores were significantly lower in the intervention group than in the routine group (*P* < 0.05) (Table 2).

***Comparison in pain fear scores before and after the intervention***

Before the intervention, there was no statistically significant difference in pain fear scores between the two groups (*P* > 0.05). At 1 wk and 2 wk after intervention initiation, pain fear scores were significantly lower in the intervention group than in the routine group (*P* < 0.05) (Table 3).

***Comparison in rehabilitation treatment compliance***

On the first day of the intervention, rehabilitation treatment compliance was evaluated, and there was no significant difference between the two groups (*P* > 0.05). At 2 wk after the intervention, the rehabilitation treatment compliance was significantly better in the intervention group than in the routine group (*P* < 0.05) (Table 4).

***Comparison in self-efficacy scores before and after the intervention***

Before the intervention, there were no statistically significant differences in the scores for the two self-efficacy dimensions (overcoming difficulties and rehabilitation exercise self-efficacy), and the total score, between the two groups (all *P* > 0.05). At 2 wk after intervention initiation, scores on the two self-efficacy dimensions and the total score were significantly higher in the intervention group than in the conventional group (all *P* < 0.05) (Table 5).

***Comparison in Harris hip scores before and after intervention***

At 3 and 6 mo after surgery, hip function was evaluated. At both timepoints, the Harris hip score was significantly higher in the intervention group than in the routine group (all *P* < 0.05) (Table 6).

***Comparison in nursing satisfaction***

The overall nursing satisfaction was significantly higher in the intervention group than in the routine group (*P* < 0.05) (Table 7).

**DISCUSSION**

In the elderly population, physiological degeneration occurs in various organs, and immunity is relatively low. Once a hip fracture occurs, it is more difficult for elderly patients to recover than young and middle-aged patients. Because the elderly tend to have osteoporosis, a long postoperative bed rest will further aggravate bone loss, rendering the degree of osteoporosis more serious[12]. Therefore, elderly patients with hip fracture should pay close attention to rehabilitation training. However, due to declines in cognitive ability, including comprehension, in elderly patients, the degree of rehabilitation training acceptance and ability for self-management are not high; thus, elderly patient often cannot cooperate with rehabilitation training[13]. In view of this problem, it is very important to strengthen the intensity of nursing interventions. However, the intervention effect of routine rehabilitation nursing is often not ideal, resulting in a fair hip fracture rehabilitation effect in elderly patients[14].

Evidence-based nursing emphasizes clinical nursing experience and the patient’s actual needs, and is mainly objectively based, using literature reviews and evidence-based practice as a guide. Evidence-based nursing combines theory and practice to provide patients with more targeted, detailed nursing interventions. This nursing mode can avoid blindness in nursing work and improve work efficiency[15]. Evidence-based nursing intervention has been applied in every clinical area, and shows a good application effect in enhancing patients' self-management ability, improving their emotional state, and reducing complications and unsafe events[5,16-18]. In the present study, evidence-based nursing interventions were applied to the postoperative treatment of elderly patients with hip fractures. It was found that after 1 wk of intervention, motion phobia scores were lower, and rehabilitation treatment compliance was better, in patients who received evidence-based nursing intervention than in patients who received routine intervention alone. Similarly, after 1 wk and 2 wk of intervention, pain fear scores were lower in patients who received evidence-based nursing intervention than in patients who received routine intervention alone. These results suggest that evidence-based nursing intervention can reduce the fear of postoperative rehabilitation in elderly patients who undergo hip fracture surgery and improve rehabilitation treatment compliance. Under the mode of evidence-based nursing intervention, nursing group members put forward the common problems of postoperative elderly patients with hip fracture according to their own clinical nursing practice, and conducted targeted intervention in accordance with literature reviews and clinical experience. Through on-site training, lecture videos, online learning platforms, and other channels, team members can better grasp the key points and issues requiring attention in the care of elderly patients with hip fractures. Furthermore, through repeated and detailed health education, patients can better understand the risk of postoperative complications and the significance of postoperative self-management and combined treatment for the prognosis; patients should be encouraged in a timely manner when they make progress, so that they can overcome their own thoughts on the fear of pain and better coordinate with the treatment plan[6,11,19].

Self-efficacy refers to a person’s subjective judgment about whether they can successfully complete a certain behavior, and is consistent with self-competence, self-confidence, and other categories. Self-efficacy plays a very important role in the medical field, and is directly related to a patient’s emotional state, treatment compliance, and treatment effect. Therefore, clinical practice has gradually focused on improving patients' self-efficacy to help them overcome the disease[19]. The present study found that evidence-based nursing intervention can better improve two dimensions of self-efficacy, overcoming difficulties and rehabilitation exercise self-efficacy, as well as the total self-efficacy score. Accordingly, the patients’ confidence in rehabilitation was enhanced and they were better able to cooperate with the rehabilitation therapy, which is also one of the important reasons for their good prognosis. For elderly patients who tend toward negative emotions, non-acceptance, and poor understanding, evidence-based nursing interventions focus on the ways and methods of communication in nursing work, *via* observation and inquiry, to identify the reason for the patient’s decreased confidence, so as to provide the corresponding psychological counseling and alleviate negative emotions through a variety of means. The importance of postoperative rehabilitation therapy was repeatedly emphasized so that the patients could better cooperate with the treatment. Patients were praised in a timely manner for their progress, and were tirelessly guided on self-care. Under this model, the patient's hip function can be improved, and their confidence in recovery can be increased significantly.

This study also evaluated hip function at 3 and 6 mo of intervention, and found that evidence-based nursing intervention can help improve the patients’ hip function and their overall nursing satisfaction. Based on the above-mentioned results, this is likely due to reduced fear of postoperative rehabilitation and improved rehabilitation treatment compliance and self-efficacy. Furthermore, the patients’ self-efficacy was improved in multiple domains and by several methods (*e.g.*, physical and psychological interventions), rendering the patients more proactive, with better cooperation during postoperative rehabilitation training, leading to improvements in hip function. Good recovery of the hip joint was the main reason for the higher patient satisfaction in the evidence-based intervention group than in the routine intervention group. In addition, during nurse-patient communication, the patients felt kindness and care from the nursing staff, which was also one of the reasons for the improvement in patient satisfaction.

**CONCLUSION**

In conclusion, evidence-based nursing intervention can alleviate fear of postoperative rehabilitation in elderly patients who undergo hip fracture surgery, improve rehabilitation treatment compliance, and improve the self-efficacy of patients, so as to promote the recovery of hip function in patients. This method has a high requirement for preliminary work by the nursing staff, including disease condition assessment, the discovery of nursing problems, literature reviews, statistical summaries, and professional training, which leads to an increase in the workload of the nursing staff to a certain extent. However, this method can improve the patients' self-efficacy and treatment compliance, and make follow-up nursing work easier (double the result with half the effort), so it has certain advantages.

**ARTICLE HIGHLIGHTS**

***Research background***

Elderly patients tend to have poor self-efficacy and confidence in postoperative rehabilitation of hip fractures, which are prone to negative emotions and affect treatment compliance.

***Research motivation***

Provide guidance for postoperative treatment of elderly patients with hip fractures.

***Research objectives***

This study aimed to evaluate the effect of evidence-based intervention on postoperative fear, compliance, and self-efficacy in elderly patients with hip fractures.

***Research methods***

A total of 120 patients with hip fracture surgically treated from June 2018 to June 2020 were selected and divided into intervention and routine groups (*n* = 60 each) according to different nursing methods.

***Research results***

Before the intervention, there was no statistically significant difference in motor phobia and pain fear scores between the groups. However, the motor phobia scores one week after the intervention and the pain fear scores one and two weeks after the intervention were significantly lower in the intervention group than in the conventional group. After 2 wk of intervention, the scores of the two dimensions of self-efficacy and the total score of self-efficacy of the intervention group were significantly higher than those of the conventional group.

***Research conclusions***

Evidence-based nursing intervention can alleviate fear of postoperative rehabilitation in elderly patients who underwent hip fracture surgery, and improve rehabilitation treatment compliance and patient self-efficacy, which promote hip function recovery.

***Research perspectives***

Evidence-based nursing intervention can be more widely used in the postoperative treatment of elderly patients undergoing hip fracture surgery.

**REFERENCES**

1 **de Miguel Artal M**, Roca Chacón O, Martínez-Alonso M, Serrano Godoy M, Mas Atance J, García Gutiérrez R. [Hip fracture in the elderly patient: Prognostic factors for mortality and functional recovery at one year]. *Rev Esp Geriatr Gerontol* 2018; **53**: 247-254 [PMID: 29929867 DOI: 10.1016/j.regg.2018.04.447]

2 **Khoujah D**, Cimino-Fiallos N. The geriatric emergency literature 2020: COVID and beyond. *Am J Emerg Med* 2021; **44**: 177-183 [PMID: 33905980 DOI: 10.1016/j.ajem.2021.04.034]

3 **Groenendijk I**, Kramer CS, den Boeft LM, Hobbelen HSM, van der Putten GJ, de Groot LCPGM. Hip Fracture Patients in Geriatric Rehabilitation Show Poor Nutritional Status, Dietary Intake and Muscle Health. *Nutrients* 2020; **12** [PMID: 32825439 DOI: 10.3390/nu12092528]

4 **Gumustas S**, Tosun HB, Isyar M, Serbest S, Oznam K, Bulut G. Femur neck fracture in young adults, is it really an urgent surgery indication: retrospective clinical study. *Pan Afr Med J* 2018; **30**: 112 [PMID: 30364439 DOI: 10.11604/pamj.2018.30.112.13643]

5 **Alexiou KI**, Roushias A, Varitimidis SE, Malizos KN. Quality of life and psychological consequences in elderly patients after a hip fracture: a review. *Clin Interv Aging* 2018; **13**: 143-150 [PMID: 29416322 DOI: 10.2147/CIA.S150067]

6 **Haj-Mirzaian A**, Eng J, Khorasani R, Raja AS, Levin AS, Smith SE, Johnson PT, Demehri S. Use of Advanced Imaging for Radiographically Occult Hip Fracture in Elderly Patients: A Systematic Review and Meta-Analysis. *Radiology* 2020; **296**: 521-531 [PMID: 32633673 DOI: 10.1148/radiol.2020192167]

7 **Harrington CC**. Evidence-Based Practice Guideline: Assessing Heart Failure in Long-Term Care Facilities. *J Gerontol Nurs* 2019; **45**: 18-24 [PMID: 30985905 DOI: 10.3928/00989134-20190409-01]

8 **Tkachuk GA**, Harris CA. Psychometric properties of the Tampa Scale for Kinesiophobia-11 (TSK-11). *J Pain* 2012; **13**: 970-977 [PMID: 23031396 DOI: 10.1016/j.jpain.2012.07.001]

9 **Waddell G**, Newton M, Henderson I, Somerville D, Main CJ. A Fear-Avoidance Beliefs Questionnaire (FABQ) and the role of fear-avoidance beliefs in chronic low back pain and disability. *Pain* 1993; **52**: 157-168 [PMID: 8455963 DOI: 10.1016/0304-3959 (93)90127-B]

10 **Picha KJ**, Lester M, Heebner NR, Abt JP, Usher EL, Capilouto G, Uhl TL. The Self-Efficacy for Home Exercise Programs Scale: Development and Psychometric Properties. *J Orthop Sports Phys Ther* 2019; **49**: 647-655 [PMID: 31291552 DOI: 10.2519/jospt.2019.8779]

11 **Miller HR**, Streiner DL. The Harris-Lingoes subscales: fact or fiction? *J Clin Psychol* 1985; **41**: 45-51 [PMID: 3973039 DOI: 10.1002/1097-4679 (198501)41:1<45::aid-jclp2270410109>3.0.co;2-s]

12 **Nilsen P**, Wallerstedt B, Behm L, Ahlström G. Towards evidence-based palliative care in nursing homes in Sweden: a qualitative study informed by the organizational readiness to change theory. *Implement Sci* 2018; **13**: 1 [PMID: 29301543 DOI: 10.1186/s13012-017-0699-0]

13 **James S**. Implementing Evidence-Based Practice in Residential Care - How Far Have We Come? *Resid Treat Child Youth* 2017; **34**: 155-175 [PMID: 31080313 DOI: 10.1080/0886571X.2017.1332330]

14 **Robbins JM**, Dillon J. Evidence-Based Approach to Advanced Wound Care Products. *J Am Podiatr Med Assoc* 2015; **105**: 456-467 [PMID: 26429618 DOI: 10.7547/14-089]

15 **Desarno J**, Sandate I, Green K, Chavez P. When in Doubt, Pull the Catheter Out: Implementation of an Evidence-Based Protocol in the Prevention and Management of Peripheral Intravenous Infiltration/Extravasation in Neonates. *Neonatal Netw* 2018; **37**: 372-377 [PMID: 30567887 DOI: 10.1891/0730-0832.37.6.372]

16 **Gillette J**, Balevi B. Simple Approaches for Establishing an Evidence-Based Dental Practice. *Dent Clin North Am* 2019; **63**: 1-16 [PMID: 30447786 DOI: 10.1016/j.cden.2018.08.002]

17 **Muckart DJJ**, Malbrain MLNG. The future of evidence-based medicine: is the frog still boiling? *Anaesthesiol Intensive Ther* 2017; **49**: 329-335 [PMID: 29150997 DOI: 10.5603/AIT.a2017.0059]

18 **Paez A**. The "architect analogy" of evidence-based practice: Reconsidering the role of clinical expertise and clinician experience in evidence-based health care. *J Evid Based Med* 2018; **11**: 219-226 [PMID: 30444073 DOI: 10.1111/jebm.12321]

19 **Erickson KLB**. Innovations in Care of the Elderly Hip Fracture Patient; a Nightmare No More. *Nurs Clin North Am* 2020; **55**: 149-161 [PMID: 32389250 DOI: 10.1016/j.cnur.2020.02.010]

**Footnotes**

**Institutional review board statement:** The study was approved by Chengde Central Hospital Ethics Committee.

**Informed consent statement:** Patients were not required to provide informed consent to participate in the study because the analysis used anonymous clinical data that were obtained after each patient agreed to treatment by written consent.

**Conflict-of-interest statement:** The authors have declared no conflict of interest.

**Data sharing statement:** No additional data are available.

**Open-Access:** This article is an open-access article that was selected by an in-house editor and fully peer-reviewed by external reviewers. It is distributed in accordance with the Creative Commons Attribution NonCommercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: https://creativecommons.org/Licenses/by-nc/4.0/

**Provenance and peer review:** Unsolicited article; Externally peer reviewed.

**Peer-review model:** Single blind

**Peer-review started:** December 5, 2021

**First decision:** December 27, 2021

**Article in press:**

**Specialty type:** Orthopedics

**Country/Territory of origin:** China

**Peer-review report’s scientific quality classification**

Grade A (Excellent): 0

Grade B (Very good): B, B

Grade C (Good): C

Grade D (Fair): 0

Grade E (Poor): 0

**P-Reviewer:** Abdelwahed M, Kapur BP, Taheri S **S-Editor:** Wang JL **L-Editor: P-Editor:**

**Table 1 Comparisons in baseline characteristics between the two groups, *n* (%)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Baseline data** | **The intervention group (*n* = 60)** | **The routine group (*n* = 60)** | **t/χ2 value** | ***P* value** |
| Age (yr) | 71.4 ± 6.1 | 70.9 ± 5.2 | 0.483 | 0.630 |
| Height (cm) | 166.8 ± 4.1 | 165.5 ± 5.0 | 1.557 | 0.122 |
| Weight (kg) | 64.9 ± 5.8 | 66.3 ± 5.2 | -1.392 | 0.167 |
| Interval between fracture and operation (d) | 3.1 ± 1.3 | 3.3 ± 1.1 | -0.910 | 0.365 |
| Gender |  |  | 0.556 | 0.456 |
| Male | 34 (56.67) | 38 (63.33) |  |  |
| Female | 26 (43.33) | 22 (36.67) |  |  |
| Affected side distribution |  |  | 0.536 | 0.464 |
| Left side | 30 (50.00) | 34 (56.67) |  |  |
| Right side | 30 (50.00) | 26 (43.33) |  |  |
| Hypertension |  |  | 2.596  | 0.107  |
| Yes | 11 (18.33) | 5 (8.33) |  |  |
| No | 49 (81.67) | 55 (91.67) |  |  |
| Diabetes |  |  | 0.536 | 0.464 |
| Yes | 3 (5.00) | 5 (8.33) |  |  |
| No | 57 (95.00) | 55 (91.67) |  |  |
| Reason of fracture |  |  | 2.004 | 0.157 |
| Traffic accident | 14 (23.33) | 8 (13.33) |  |  |
| Self fall injury | 46 (76.67) | 52 (86.67) |  |  |

**Table 2 Comparisons in motion phobia scores before and after intervention initiation between the two groups (mean ± SD, scores)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Groups** | ***n*** | **Before intervention** | **1 wk after intervention** | **2 wk after intervention** |
| Intervention group | 60 | 57.3 ± 6.2 | 43.8 ± 5.6 | 28.6 ± 4.0 |
| Routine group | 60 | 58.5 ± 5.8 | 46.4 ± 5.5 | 30.0 ± 4.8 |
| *t* value |  | -1.095 | -2.566 | -1.736 |
| *P* value |  | 0.276 | 0.012 | 0.085 |

**Table 3 Comparisons in pain fear scores before and after intervention initiation between the two groups (mean ± SD, scores)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Groups** | ***n*** | **Before intervention** | **1 wk after intervention** | **2 wk after intervention** |
| Intervention group | 60 | 127.4 ± 12.9 | 95.8 ± 10.2 | 58.1 ± 8.3 |
| Routine group | 60 | 125.0 ± 14.1 | 101.3 ± 12.4 | 62.7 ± 9.6 |
| *t* value |  | 0.973 | -2.653 | -2.808 |
| *P* value |  | 0.333 | 0.009 | 0.006 |

**Table 4 Comparisons in rehabilitation treatment compliance between the two groups, *n* (%)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Groups** | **Complete compliance** | **Partial compliance** | **Noncompliance**  |
| 1 d of intervention |
| the intervention group (*n* = 60) | 22 (36.67) | 32 (53.33) | 6 (10.00) |
| the routine group (*n* = 60) | 24 (40.00) | 29 (48.33) | 7 (11.67) |
| *Z* value | -0.204 |
| *P* value | 0.838 |
| 2 wk after intervention |
| the intervention group (*n* = 60) | 47 (78.33) | 13 (21.67) | 0 (0.00) |
| the routine group (*n* = 60) | 36 (60.00) | 22 (36.67) | 2 (3.33) |
| *Z* value | -2.243 |
| *P* value | 0.025 |

**Table 5 Comparisons in self-efficacy scores before and after intervention initiation between the two groups (mean ± SD, scores)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Groups** | ***n*** |  **Self-efficacy of overcoming difficulties** | **Self-efficacy of rehabilitation exercise** | **Total score of self-efficacy** |
| **Before intervention** | **2 wk after intervention** | **Before intervention** | **2 wk after intervention** | **Before intervention** | **2 wk after intervention** |
| Intervention group | 60 | 37.5 ± 8.7 | 49.6 ± 9.0 | 34.3 ± 7.2 | 50.3 ± 8.5 | 71.8 ± 6.6 | 99.9 ± 10.5 |
| Routine group | 60 | 35.8 ± 8.2 | 45.3 ± 8.8 | 36.8 ± 8.0 | 46.5 ± 8.1 | 72.6 ± 8.0 | 91.8 ± 8.8 |
| *t* value |  | 1.101 | 2.646 | -1.799 | 2.507 | -0.598 | 4.580 |
| *P* value |  | 0.273 | 0.009 | 0.075 | 0.014 | 0.551 | 0.000 |

**Table 6 Comparisons in Harris scores before and after intervention initiation between the two groups (mean ± SD, scores)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Groups** | ***n*** | **3 mo after operation** | **6 mo after operation** |
| Intervention group | 60 | 64.8 ± 8.1 | 88.4 ± 7.4 |
| Routine group | 60 | 60.3 ± 7.6 | 84.8 ± 7.1 |
| *t* value |  | 3.138 | 2.719 |
| *P* value |  | 0.002 | 0.008 |

**Table 7 Comparisons in the patients’ satisfaction with nursing between the two groups, *n* (%)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Groups** | ***n*** | **Satisfied** | **Fairly satisfied** | **Normal** | **Unsatisfied** |
| Intervention group | 60 | 41 (68.33) | 13 (21.67) | 6 (10.00) | 0 (0.00) |
| Routine group | 60 | 30 (50.00) | 18 (30.00) | 9 (15.00) | 3 (5.00) |
| *Z* value |  | -2.166  |
| *P* value |  | 0.030  |