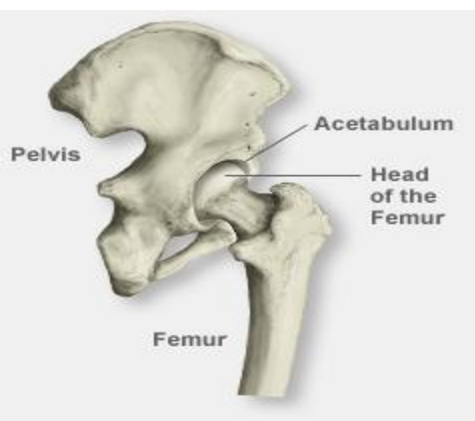
Integrated Care Pathway
For Hip Fracture

Attach patient addressograph here.



The following criteria must be met for this ICP to be appropriate for a patient:

- Definite diagnosis of a proximal femoral fracture
- All members of the multidisciplinary team sign in the care pathway
- Do not leave blank spaces: write N/A if task or information is inappropriate

This ICP was developed by: National ICP Working Group 2015

Insert patient addressograph here

Integrated care pathway for hip fracture

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Colour codes explained	
Nursing	
Emergency Department	
Orthopaedic	
Physiotherapy	
Occupational Therapy	
Orthogeriatrics	
Multidisciplinary team	
Irish Hip Fracture Data Field	

Each discipline is responsible for completing the section relevant to them throughout the pathway. Sign, date and time each entry.

Insert patient addressograph here

Record of staff members signatures

Date	Printed Name As Per Registration	Signature	Initials	Discipline	Registration number

Insert patient addressograph here

Biographical Details

Ward: __________________ Consultant: ______________________________ Age:_______

Date of arrival at first presenting hospital: ___/___/___Time: _______ Hospital:________________

Date of arrival in ED of operating hospital: ___/___/___ Time: _______ Fast track: Yes □ No □

Date of admission to orthopaedic ward: ___/___/___ Time: _______ (Specify other ward________________)

Did patient go direct to theatre from ED: Yes □ No □ ___/___/___Time: _______

Did the patient sustain fracture following an in-patient fall : Yes □ No □

Public Patient □ Private Patient □ Predicted Date2 of Discharge (PDD): ____/____/____

Discussed with patient/family Yes □ No □ Patient Contact No:(H) _______________ (M) ________________

Occupation: _________________ Likes to be called: _______________ Name band applied: Yes□

GP Name: __________________GP Contact No: _________________Religion: _________________

1st Date SOS given: ____/____/____ Initial ____ 2nd SOS ___/___/___Initial ____

3rd SOS ___/___/___Initial ____ 4th SOS ___/___/___Initial ____

Marital/Living Circumstances & Discharge Plan Commencement

Marital Status: Single □ Married □ Widowed □ Separated □ Divorced □ Other □ __________

Living Circumstances: At home Alone □ At Home with Relatives/Carer □

Principal Carer's name:_______________ Relationship:______________ Phone No:______________

Support Given: ____(specify)

In Nursing Home □ ________________________(specify) Other □ ___________________________(specify)

Housing Situation: House □ Two Storey □ Bungalow □ Apartment□ Other □ ________________ Stairs □

Steps □ Other □ _______________ Services in Place: ____

Next of Kin

Name:____ Relationship: ____________________

Address:____

Ph. No.: (H) _______________(M) _________________ To be contacted in an emergency? Yes □ No □

Emergency contact person (if diff. from above) Name:____

Relationship: ____________________ Ph. No.: (H) _____________________(M) ____________________

Patients Property

Patient made aware that they are responsible for their own property: Yes □ Valuables: __________________

Kept by patient □ Sent home □ Sent to Security Office □ _________________________________(specify)

Signature: **Date:** **Time:**

Integrated care pathway for hip fracture

Insert patient addressograph here

Suspected proximal femur (hip) fracture pathway for emergency departments

Triage: Alert stating suspected hip fracture

Rapid senior emergency department doctor review

Fast track through ED

Suitable
Simple isolated fracture following explained fall, medically stable on examination

Focused work-up
Full bloods including (FBC, U&E, INR, group & hold) ECG, CXR, X-ray AP & Lateral Pelvis
Urinalysis, pain assessment and administration of analgesia, consider fascia iliaca block.
Oxygen therapy, Intravenous fluids

Contact orthopaedic team & Contact Bed Manager

Arrange fast track admission to orthopaedic ward

Unsuitable
Complicated presenting complaint and/or medically unstable on examination

Standard work-up in the ED

Standard orthopaedic assessment in the ED

Further specialist assessment and optimisation required in the ED

Admission to appropriate ward

Patient placed on pressure relieving mattress in ward

Orthopaedic review on ward

Integrated care pathway for hip fracture

Insert patient addressograph here

Nurse Assessment Emergency Department

Identity band x 1 applied ☐	Name of nurse: Time:
Known allergies: Allergy band: Yes ☐ No ☐	Verify next of kin details are correct Yes ☐ No ☐

Patient observations recorded Date:___________ Time:_________

HR:_____ BP:_____ Respirations:_____ Saturations:_____ GCS:_____ BM:_____ Temp:_____

MSU result:
Residual volume:______mls
Protein
Blood
Leucocytes
Glucose
CSU sent: Yes ☐ No ☐

Waterlow Score:_____
Pressure areas checked: Yes ☐ No ☐

Skin: Healthy ☐ Dry ☐ Fragile ☐

Areas of: Excoriation ☐ Erythema ☐ Oedema ☐ Maceration ☐ Discolouration ☐ Skin Tear ☐

Details: (Size/Shape etc) _____________

____

____

____

Action:___________________________

____

Pressure relieving devices applied/ ordered ☐ Specify:______________

Pain assessment at rest: Date: Time:
Numerical Rating Scale: 0 1 2 3 4 5 6 7 8 9 10 (Please circle score out of 10)
Analgesia given: Date: Time:

Pain reassessed: Date: Time:
Numerical Rating Scale: 0 1 2 3 4 5 6 7 8 9 10 (Please circle score out of 10)
Analgesia given: Date: Time:

Do not fast patient unless requested by the orthopaedic team
Diet & fluids given: Yes ☐ No ☐

Signature: **Date:** **Time:**

Insert patient addressograph here

Emergency Department Assessment

Date and Time of attendance:	Date and Time of admission:
Date and time of trauma:	Did patient present to another ED first : Yes ☐ No ☐
Date and time of presentation at first ED:	

Mental State Premorbid				**Past Medical History & Medications**
Orientated		**Disorientated**		
Alert		**Drowsy**		
Reason for Admission/ Provisional Diagnosis				

Investigations

ECG: Date:__________ Result:____________________________________

X-rays: Date:________ Chest ☐ Pelvis ☐ AP & Lateral Hip ☐
Type of fracture:____
Oxygen therapy commenced Yes ☐ No ☐ Time:____
Analgesia prescribed: _______________________________________
Fascia Iliaca block given: Yes ☐ No ☐ Time:____
Intravenous cannula inserted and intravenous fluids commenced:
Yes ☐ No ☐ Time:____

Bloods:	**Ordered**	**Time**
FBC	☐	
U&E	☐	
LFT	☐	
Bone profile	☐	
INR	☐	
Group & Save	☐	
Or		
Group & hold	☐	

Other:

Signature:	**MCRN/ Pin Number:**	**Date:**	**Time:**

Insert patient addressograph here

Clinical Notes

Emergency Department Referrals	
Orthopaedic team on-call contacted:	Time:
Other:	Time:
Bed Manager Contacted: Bed booked:	Time:

Insert patient addressograph here

Orthopaedic Admission

Consultant:

Name of admitting doctor:
Date of admission:
Time of admission:

Proximal femur fracture: Right ☐ Left ☐

Type of fracture: Intracapsular- displaced ☐ Inter-trochanteric ☐
Sub-trochanteric ☐ Intracapsular- undisplaced ☐
Other:_______________________________________

Presenting Complaint: **Date/Time of injury:** ___________

Simple mechanical fall ☐ Secondary Fall ☐

Past Medical History

Insert patient addressograph here

Social History

Patient lives:

Alone ☐
With family (who?) ☐
Sheltered housing ☐
Residential Home ☐
Nursing Home/ Long-term care ☐

Walking ability prior to fracture:

Fully independent with no aid ☐
One aid (stick / crutch etc) ☐
Two aids ☐
Frame ☐
Wheelchair / bedbound ☐

New Mobility Score*:
Indoor walking: ___/3 Outdoor walking: ___/ 3 Shopping: ___/ 3
* unable=0; with assistance=1; with an aid=2; independent=3

Cognitive function prior to fracture:

Fully orientated ☐
Disorientated ☐
MMSE *(if known)* ………..……………..

Continence prior to fracture:

Continent ☐
Incontinent Urine ☐
Incontinent Faeces ☐

AMTS	
What is your name?	
Where are we now?	
What day is this?	
What month is this?	
What year is this?	
Remember this address	2 Patrick Street
Do you know who I am?	
Who is the present Taoiseach?	
What date is St.Patricks day?	
Please count backwards from 20	
What is the address I told you?	
Total	**/10**

Vision……………………………………………………………………………………………

Smoking history:……………………………….. **Alcohol (units / week):** ………………………

Insert patient addressograph here

<table>
<tr><th colspan="6">General examination</th></tr>
<tr><td colspan="4">General appearance:</td><td colspan="2">Weight:</td></tr>
<tr><td>BP</td><td>HR</td><td>RR</td><td>SpO2%</td><td>Inhaled O2%</td><td>Temp</td></tr>
<tr><td colspan="6">Cardiovascular</td></tr>
<tr><td colspan="4">Pulse: Regular Irregular</td><td colspan="2" rowspan="5">An echocardiogram is indicated for anyone with a suspicious systolic murmur, dysnoea of unknown cause or worsening CCF(If echo is delayed, surgery should proceed with relevant anaesthetic precautions and monitoring in place)</td></tr>
<tr><td colspan="4">Heart sounds</td></tr>
<tr><td colspan="4">Peripheral Odema</td></tr>
<tr><td colspan="4">Jugular venous pressure</td></tr>
<tr><td colspan="4">Peripheral pulses</td></tr>
<tr><td colspan="3">Respiratory</td><td colspan="3">Gastrointestinal</td></tr>
<tr><td colspan="3"></td><td colspan="3"></td></tr>
<tr><td colspan="6">Musculoskeletal/ Pressure areas</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td colspan="6">Neurological Examination</td></tr>
<tr><td colspan="2">Pain score
Time:</td><td>Movement
/10</td><td colspan="2">Rest
/10</td><td>Stat analgesia if pain score >3/10
+/- fascia iliaca block</td></tr>
<tr><td rowspan="3">Glasgow coma scale</td><td rowspan="3">/15</td><td>Eye /4</td><td rowspan="3">Speech
(eg. Dysphagia/ dysarthria)</td><td colspan="2" rowspan="3"></td></tr>
<tr><td>Motor /5</td></tr>
<tr><td>Voice /6</td></tr>
</table>

Insert patient addressograph here

Medications (on admission): Number of Medications:_____

1.	2.	3.
4.	5.	6.
7.	8.	9.
10.	11.	12.
13.	14.	15.
16.	17.	18.

Document generic name of each drug clearly, the dose and frequency above

ALLERGIES:

ANTICOAGULANTS/ ANTI- PLATELET DRUGS:

Names : Last dose taken on (time/date):

1.

2.

IF PATIENT IS ON ANTI-COAGULANTS PLEASE ADHERE TO LOCAL PROTOCOL AND STATE ACTION TAKEN BELOW:_______________________________________

____

INVESTIGATIONS AND CONSULTATIONS	DATE	RESULT
ECG		
Echocardiography		
Coronary Angio +/- Stenting		
Cardiac Stress test		
CXR (If Newly Diagnosed Heart Failure or Pneumonia, or if clinically indicated)		
Cardiology Review (For patients with Implantable Cardiac Devices)		
Other Consults (Including reason for request)		

Insert patient addressograph here

Lab Results	**Date**	**Result**	***Tick appropriate box below***
Hb			If Hb < 9.0g/dL or 9.0-9.9g/dL with IHD consider transfusion **Cross match ordered** □
Platelets			If Hb 10.0-12.0 g/dL, **Crossmatch ordered** □
WCC			Otherwise **Group & save ordered** □
INR			If INR ≥1.5 and reversal for urgent surgery required consider 2.5mg-5mg Vitamin K oral or intravenous. **Recheck after 6 hours.** **Re-dose as appropriate.** **Vitamin K given** □
PT			
APTT			
APTR			
Fibrinogen			
Sodium			
Potassium			
Creatinine			
Urea			
Random glucose			
Fasting glucose			
Other tests ordered			

Potential Delays to Surgery	**Prevention/ Management of delay**
Patient incapable of consenting	
Atrial fibrillation >100/min	
Un-investigated systolic murmur	
Haemostatic impairment/ Anticoagulants/ Low platelet count	
Abnormal lab results	
HDU/ PACU Bed needed	
Resuscitation Status	
Discussed □ Inappropriate □ Not discussed □	Decision:

Insert patient addressograph here

Other relevant information:

____

____

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____

Admission checklist (Please initial when completed)	
Orthopaedic admission completed	
Bloods: FBC, U&E, Group & Hold +/- cross match completed	
Hip X-ray AP & Lateral completed	
CXR completed	
Pain relief regular and PRN & regular medication and IV Fluids charted	
ECG completed	
Consent obtained and limb marked correctly	
Pre-op fast times 6 hours for solids and 2 hours for clear fluids	
Does patient need pre-op investigations Pacemaker check (if not within the last year) □ If clinical indication for ECHO d/w anaesthetist first □	
VTE Prophylaxis (evening dosing of LMWH)	
Add patients details to Operating Theatre trauma list	
Consultations (if any) required preoperatively: Team+ Doctor consulted:___________________ Date/Time consulted:_______	
On call anaesthetist informed (Anaesthetist Name __________________________) of the patients whereabouts, relevant medical history and current medical condition	

Signature & printed name of admitting doctor:_______________________________

MRCN no.:________________ Bleep no.:__________________________________

Integrated care pathway for hip fracture

Insert patient addressograph here

Nursing Admission

1.MAINTAINING A SAFE ENVIRONMENT

Can Maintain own safety **Yes** ☐ **No** ☐ *Baseline (if diff)*___________________________________

Orientate patient to the ward:

Call bell ☐ Bathroom ☐ Visiting ☐ Hospital information leaflet given **Yes** ☐ **No** ☐

Level of Consciousness Is the patient confused? **Yes** ☐ **No** ☐ *(? care plan)*

Fully alert ☐ Altered ☐ Unconscious ☐ *(?care plan)* **Glasgow Coma Score** *(if applicable)*

2. BREATHING

Any specific complaint? **Yes** ☐ **No** ☐ *(care plan)* List: ______________________________________

Baseline (if diff) ____

Patient is on **Home Oxygen** **Yes** ☐ **No** ☐ Patient on **Home Nebuliser** **Yes** ☐ **No** ☐

Patient on **Home BiPAP** **Yes** ☐ **No** ☐ Patient on **Home CPAP** **Yes** ☐ **No** ☐

Patient has a **Tracheostomy** **Yes** ☐ **No** ☐

Patient is a **Smoker** **Yes** ☐ **No** ☐ Brief **Smoking Cessation Advise/Information** given **Yes** ☐ **No** ☐

Comment____

3. COMMUNICATION

Hearing: Normal ☐ Impaired ☐ *Baseline (if diff)*_____________________________________

Hearing Aid: Left ☐ Right ☐ Both ☐ **With patient** **Yes** ☐ **No** ☐

Vision: Normal ☐ Impaired ☐ *Baseline (if diff)*_____________________________________

Glasses: with patient on admission **Yes** ☐ **No** ☐

Speech: Normal ☐ Impaired ☐ *Baseline (if diff)*_____________________________________

Language: English ☐ Other ☐ Specify ______________________ Interpreter required **Yes** ☐ **No** ☐

Emotional Status: Relaxed ☐ Anxious ☐ Distressed ☐ Comment __________________________

Pain: Yes ☐ No ☐ Acute ☐ Chronic ☐ Location: _____________________________

Initial pain assessment: No pain 1- 2- 3-4- 5-6-7- 8-9-10 **Worst pain imaginable** ***(Please circle score)***

4. ELIMINATION

Independent with toileting **Yes** ☐ **No** ☐

Urinary Elimination: Continent ☐ Urgency ☐ Incontinent ☐ Nocturia ☐ Ileal Conduit ☐

Comment ____

Catheter in situ? **Yes** ☐ **No** ☐ **If Yes** Type: ____________ Size: _______Insertion date:__________

Bowel Elimination: *Baseline Bowel pattern* ___________ **Last bowel motion: Date:**_______________

Indicate if patient: Constipated ☐ Diarrhoea ☐ Malaena ☐ Colostomy ☐ Ileostomy ☐ *(? Care Plan)*

Laxatives? **Yes** ☐ **No** ☐ Incontinent aids: **Yes** ☐ **No** ☐ Comment: _________________________

Insert patient addressograph here

5. MOBILISING

Baseline mobility: Freely mobile without aids ☐
Mobilises outdoors with 1 aid ☐
Mobilises outdoors with 2 aids/ frame ☐
Some indoor mobility but never mobilises outside ☐
No functional mobility using lower limb ☐ Requires assistance: **Yes** ☐ **No** ☐

Current mobility____

6. PERSONAL CLEANING AND DRESSING

Personal Hygiene/Dressing: Self Caring ☐ Assisted ☐ Dependant ☐ *(?care plan)*

Baseline (if diff) ____

Oral Hygiene: Self Caring ☐ Assisted ☐ Dependant ☐ Oral Assessment Tool: **Yes** ☐ **No** ☐

Wears **Dentures: Yes** ☐ **No** ☐ With Patient **Yes** ☐ **No** ☐ **Specify:** Full Set ☐ Top only ☐ Bottom only ☐

7. SLEEPING

Usual sleeping pattern____

Night sedation **Yes** ☐ **No** ☐ Specify: ____

8. EATING AND DRINKING

Special Diet (specify)________________________________ TPN ☐ PEG ☐ NG ☐ Nil PO ☐

Assistance required: **Yes** ☐ **No** ☐ Comment: ______________________________________

Is swallowing identified as a problem **Yes** ☐ **No** ☐ *(? Care Plan)*

Alcohol units consumed per week: *(1 unit = ½ pint beer, 1 single spirit, small glass wine)*

Alcohol Withdrawal Care Plan required **Yes** ☐ **No** ☐

9. DYING/SPIRITUAL NEEDS

Has patient specified any cultural/religious needs **Yes** ☐ **No** ☐

Comment: ____

10. EXPRESSING SEXUALITY

Patient has concerns **Yes** ☐ **No** ☐ Comment: ______________________________________

Body image concerns **Yes** ☐ **No** ☐ Comment: ______________________________________

11. SOCIAL HISTORY

Patient lives: Alone ☐ With family (who?) ☐ ______________________________
Supported housing ☐ Nursing Home/ ☐
Homehelp Yes ☐ No ☐ How often____
Carer Yes ☐ No ☐ How often____
Other:

Insert patient addressograph here

Integrated care pathway for hip fracture

Falls Risk Assessment Tool: FRAT

- **Complete on All patients**
- **Reassess once weekly or more regularly if there is a change in the patients status**

Sex	**Score A**	**Score B**	**Score C**	**Score D**	**Medication**	**Score A**	**Score B**	**Score C**	**Score D**
Male	1	1	1	1	Hypnotics	1	1	1	1
					Tranquilisers	1	1	1	1
Female	2	2	2	2	Anti Hypertensive's	1	1	1	1
Age	**Score**	**Score**	**Score**	**Score**	**Medical History**	**Score**	**Score**	**Score**	**Score**
60-70	1	1	1	1	Diabetes	1	1	1	1
71-80	2	2	2	2	Organic Brain disease/Confusion	1	1	1	1
80+	1	1	1	1	Fits	1	1	1	1
Gait	**Score**	**Score**	**Score**	**Score**	**Mobility**	**Score**	**Score**	**Score**	**Score**
Steady	0	0	0	0	Full	1	1	1	1
Hesitant	1	1	1	1	Uses Aid	2	2	2	2
Poor transfer	3	3	3	3	Restricted	3	3	3	3
Unsteady	3	3	3	3	Bed bound	1	1	1	1
Sensory Deficit	**Score**	**Score**	**Score**	**Score**	**Falls History**	**Score**	**Score**	**Score**	**Score**
					None	0	0	0	0
Sight	2	2	2	2	At home	2	2	2	2
Hearing	1	1	1	1	In wards	1	1	1	1
Balance	2	2	2	2	Both	3	3	3	3

Score	**Risk**
3 to 8	Low risk
9 to 12	Medium risk ***(commence care plan)***
13 +	High risk ***(commence care plan)***

Score A (Initial)________ Date: _______________ Signature: __________________________
Score B: _________ Date: _______________ Signature: __________________________
Score C: _________ Date: _______________ Signature: __________________________
Score D: _________ Date: _______________ Signature: __________________________

RGN Signature:________________ **Std.N. Signature:_________________**

Integrated care pathway for hip fracture

Insert patient addressograph here

Bed Rail Assessment Scale (All Adults)

Score on Admission: Date: Signature: ______________________

Patient/Family Choice			Reassessment		
			Date	Score	Signature
Patient/Family want bed rails up	☐	Please tick			
Patient/Family do not wish bed rails up	☐	Please tick			

Is there a risk of entrapment with use of Bed Rails – if yes consider alternatives

Age	Score	Mobility	Score	Fall History	Score
Greater than 75 years of age	2	Patient can safely and independently get in and out of bed	0	No previous falls	0
		Patient is comatosed	0	History of near misses or falls during previous admission	2
Sensory Status		Patient needs assistance to transfer to and from bed	2	Has attempted to or has come over bed rails during this admission	4
Patient has no sensory problems	0	**OR**			
Patient has sensory problems	1	Patient can transfer without assistance but is unsteady	2		
Elimination		**Cognitive Status**		**Sleep/Rest Pattern**	
Patient is independent with elimination needs	0	Patient is unresponsive	0	No problem in sleeping pattern	0
Needs assistance with toileting (may be incontinent)	1	Patient can use call bell appropriately	0	Problems sleeping at night	2
Patient cannot move and requires total nursing care	0	Patient does not always remember to use call bell prior to getting up (if assistance is warranted)	3	Restless and agitated in afternoon/early evening	2
Drug Therapy		Patient can lower bed rail or have it lowered by another	0		
Patient is not on sedatives, psychotrophics, laxatives or diuretics	0	Patient cannot lower device	1		
Patient is on sedatives, psychotrophics, laxatives or diuretics	2	Bed rails act as an enabler to the patient (aid in turning, environment cue, or assisting mobility in bed)	1		

BED RAIL ASSESSMENT SCORE RATING

Score 1 - 3
Low risk of falling from bed or around bed area.
Patients do not need bed rails unless this is a personal/family preference

Score 4-9
Moderate risk of falling from or around bed area.
Patients may have the ability to get out of bed independently.
Bed rails to be used with caution.

Score 10+
High risk of falling from or around bed area.
Bed rails may prove to be hazard.
Refer to alternatives to bed rail use.

Option 1: Physical Intervention
Assess the patient's mental and physical condition Remove patient from the situation / Increase staff observation Toilet regime as per patients schedule (check for altered elimination patterns) Offer snacks and beverages / Pain relief / Repositioning Ensure good body temperature / Monitor laboratory values and vital signs Do a Falls Risk Assessment Provide rest periods (consider if patient has disturbed rest/sleep pattern) Provide opportunity to exercise / comfortable clothing
Option 2: Environmental Changes
Room change / lower bed / close proximity to Nurses Station / reduce noise level Reduce light level during rest periods / Bedside commode / Call bell within easy reach / familiar comforting belongings / reality links (clock etc)
Option 3: Emotional Support
Encourage families/friends to sit with the patient / Orientate patient / Deal with patients complaints immediately / Staff to stay with patient if warranted / Explanation to be given to patient before all therapeutic interventions / respect personal space / reassurance
Option 4: Medication
Monitor all drug side effects and have a multidisciplinary evaluation of medication regime

Insert patient addressograph here

Integrated care pathway for hip fracture

- **Complete on Admission**
- Reassess once weekly and more frequently if there is a change in the patient's condition
- Don't forget to complete Malnutrition Screening Tool (MST) on all Patients

Waterlow & MST Screening Tool

Key: Add totals to obtain risk score. More than 1 score per category can be used.

Has the patient had a previous pressure ulcer? Please circle **Yes** *or* **No**

Build/ Weight for Height				**Major Surgery Trauma**			
Average BMI(20-24.9)	0	0	0	Orthopaedic / Spinal	5	5	5
Above Average (25-29.9)	1	1	1	On table >2hr #	5	5	5
Obese (>30)	2	2	2	On table >6hr #	8	8	8
Below Average (>20)	3	3	3				
Continence				**Medications Max of 4**			
Complete /Catheterised	0	0	0	Cytotoxic, long term/high dose steroids Anti-Inflammatory	4	4	4
Urinary Incontinence	1	1	1				
Faecal Incontinence	2	2	2				
Urinary and Faecal Incontinence	3	3	3				
Skin Type /Visual Risk Areas				**Special Risks** **Tissue Malnutrition**			
Healthy	0	0	0	Terminal Cachexia	8	8	8
Tissue Paper	1	1	1	Multiple Organ Failure	8	8	8
Dry	1	1	1	Single Organ Failure (Respiratory, Renal, Cardiac)	5	5	5
Oedematous	1	1	1	Peripheral Vascular Disease	5	5	5
Discoloured – Stage 1	2	2	2	Anaemia (Hb<B)	2	2	2
Pressure Ulcer Stage 2-4	3	3	3	Smoking	1	1	1
Gender / Age							
Male	1	1	1				
Female	2	2	2				
14-49	1	1	1				
50-64	2	2	2	**Neurological Deficit**			
65-74	3	3	3	Diabetes, MS,CVA 4 - 6			
75-80	4	4	4	Motor / Sensory 4 - 6			
81+	5	5	5	Paraplegia 4 - 6			
Mobility							
Fully	0	0	0				
Restless/Fidgety	1	1	1				
Apathetic	2	2	2				
Restricted	3	3	3				
Bed bound eg traction	4	4	4				
Chair bound eg wheelchair	5	5	5				

Score on Admission / Reassessment		
Date	**Score**	**Signature**

10+ At Risk - initiate care plan
15+ High Risk - initiate care plan
20+ Very High Risk - initiate care plan

Score	**Support Surfaces**
1-15	Hospital pressure reducing viscoelastic foam mattress.
15-20	Patient to remain on foam mattress until condition warrants change to alternating pressure relieving mattress.
20+	Alternating pressure relieving mattress.

Note:

The benefits of a pressure redistributing device should not be undermined by prolonged chair sitting.

Pressure ulcer prevention strategies require a 24 hour approach and should include all surfaces used by the patient.

Malnutrition Screening Tool (MST)

(Nutrition, Vol. 15, No 6 1999 – Australia)

A. Has patient lost weight recently?

Yes – go to B
No – Go to C
Unsure – go to C and Score 2

B. Weight Loss Score

0.5 - 5 kg	= 1
5 - 10 kg	= 2
10 - 15 kg	= 3
>15 kg	= 4
Unsure	= 2

C. Patient eating poorly or Lack of Appetite

"No"	= 0
"Yes" Score	= 1

Nutrition Score on Adm.

If > 2 initiate Malnutrition Care Plan

Date	**Score**	**Signature**

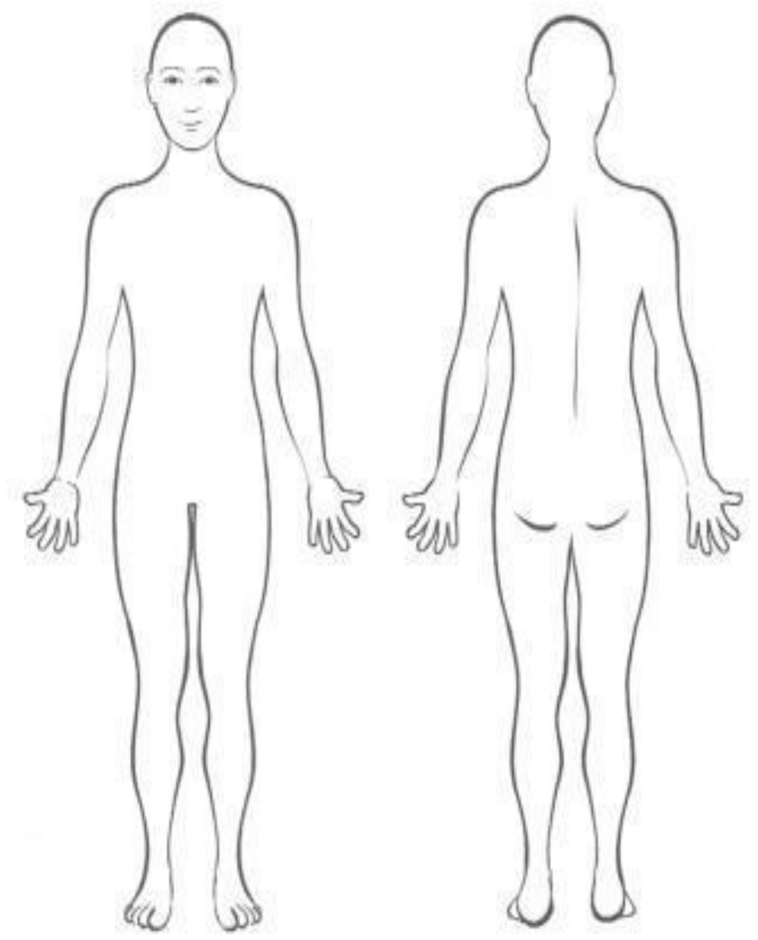
Integrated care pathway for hip fracture

Attach patient addressograph here

Initial Skin Assessment

Complete on all patients on admission and repeat on T/F to other units

Mark area of concern ***with a number & a shape*** on the diagrams below and ***describe in the 'Details Box'***



Details Box

Skin: Healthy ☐ Dry ☐ Fragile ☐

Areas of: Excoriation ☐ Erythema ☐ Oedema ☐ Maceration ☐ Discoloration ☐ Skin Tear ☐

Details: (Size/Shape etc) ________________

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Action Taken: __________________________

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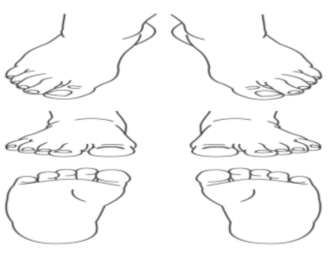
Signature: _______________ ***Date:***__________

Signs to look for:	***Signs to feel for:***
Purplish/Bluish Areas Persistent red areas /erythema Non-blanching erythema Areas of discomfort or pain Pressure due to medical devices Cracks, Calluses & Corns Localised oedema Blisters Shiny areas Dry patches	Hard Areas (induration) Warm areas Localised Coolness if tissue death occurs Swollen skin over bony points



Attach patient addressograph here

Infection Prevention & Control Assessment

Please refer to Infection Prevention & Control Policy (Yellow Folder)	Yes	No
History of MRSA?	☐	☐
History of VRE?	☐	☐
Risk/History of CRE?	☐	☐
Has the patient diarrhoea and/or vomiting?	☐	☐
Has the patient any transmissible infection? *(List of communicable infection in Infection prevention & control policy)* If so please state:____	☐	☐
Does the patient meet any of the following screening requirements for MRSA as follows? 1. Previous history of MRSA (including those who have had 3 consecutive negative screens in the past) 2. Has been transferred form another healthcare facility including Nursing Homes. 3. Patient is being admitted to ICU or high risk area. 4. Has a history of multiple previous hospital admissions. 5. For elective surgery who may require ICU admission. 6. Has an infected non-intact skin and /or leg ulcers or pressure ulcers. 7. Is a health care worker who requires hospitalisation for anticipated surgery. 8. Is attending a pre op assessment clinic. 9. Is being transferred from low to high and moderate risk areas. *(See table 1, Pg..11 of Infection Control Manual)* 10. During an Outbreak of infection as determined by the Infection Prevention & Control Team. 11. All associated patients of newly diagnosed MRSA positive patients in moderate & high risk clinical areas. *(See table 1. Pg. 11 of Infection Control Manual)* **If Yes** to the above question**, please circle** which **number or numbers** are relevant	☐	☐
Does the patient require isolation? *(Refer to isolation methods for communicable disease in the Inf. prevention and control policy)*	☐	☐
If Yes, has the patient been isolated? **Date** ____/____/____	☐	☐
Has Bed management informed?	☐	☐
Has Inf. Prevention and Control CNS been informed?	☐	☐
Patient given verbal information?	☐	☐
Patient given written information?_______________________________(specify)	☐	☐
Family/ significant other given information?	☐	☐

KEY
√ = Swab Taken
+ = Result of Swab MRSA Positive
- = Result of Swab MRSA Negative

ture

MRSA Colonisation Ward-Based Surveillance Tool

Patient ID label

Date of Swabs															
		√	Result	√	Result	√	Result	√	Result	√	Result	√	Result	√	Result
Nasal *(same swab for both nostrils)*															
Perineum or Groin															
Sputum *(if available)*															
Urine *(if catheterised or previously positive)*															
Surgical Wound Sites															
Surgical Wounds Inc. PEG Site Tracheostomy Site etc	**Site:**														
	Site:														
	Site:														
Non-Surgical Wound Sites															
e.g. Ulcer Skin lesions etc	**Site:**														
	Site:														
	Site:														
	Site:														
Blood															
Intravascular Lines															
Blood Culture															
Other Site:															
(specify)															
Initials															
Comments															

1st Treatment Commenced Date: ..…/…..../…... **Treatment Discontinued: ..…/…..../…...** **Rescreen Date: ..…/…..../…..**

2nd Treatment Commenced Date: ..…/..…./…... **Treatment Discontinued: ..…/…..../…...** **Rescreen Date: ..…/…..../…..**

Integrated care pathway for hip fracture

Attach patient addressograph here

DAY OF ADMISSION (DAY 0)

Multidisciplinary Care Plan

Date

Nursing	**Please initial each box accordingly**					
Shift (if patient does not go to theatre within 24 hours use column two)	**AM**	**PM**	**ND**	**AM**	**PM**	**ND**
0. Ward Orientation Give patient/ family hip fracture information leaflet □						
1. Hygiene: Assist patient with hygiene needs						
2. Nutrition: Complete MST screening tool page □ Score:____						
3. Mobility: Document baseline & current mobility in admission						
4. Continence Assessment Yes □ No □						
5. NEWS Observation & Neurovascular assessment Yes □ No □ Ward urinalysis taken/ MSU if required Yes □ No □ Delirium screen Yes □ No □						
6. Tissue Viability: Waterlow completed Yes □ No □Score:__ __ Pressure areas checked regularly Yes □ No □ Pressure ulcer location:__________________________________N/A □ Pressure relieving devices used:________________________						
7. Infection Control Prevention MRSA screen taken if required. Yes □ No □ N/A □						
8. Medication Administer prophylactic anti-coagulant if theatre is delayed. Administer medication pre-operatively as per local protocol						
9. Falls prevention & Maintaining a safe environment Complete FRAT assessment Yes □ No □ Score:____						
10. Rest & Sleep Adequate night sleep received by patient Yes □No □						
11. Pain Control Administer analgesia regularly& record pain score___/10 Use pain score to guide appropriate analgesia.						
12. Days since last bowel motion? ___Laxatives given Yes □ No □						
13. Prevent Thromboembolism Ensure prophylactic anti-coagulant is given 12 hours prior to surgery						
14. Discharge Planning: PDD documented Discuss discharge plan with patient/ family Contact discharge coordinator GP or PHN if necessary						

Medical	**Signature & MRCN:**
Patient listed for theatre on trauma list Yes □ No □ Theatre, anaesthetist on-call and ward notified Yes □ No □ Patient fully worked up for theatre Yes □ No □	

Physiotherapist	**Signature:**
Introduced to patient Yes □ No □ Chest exercises Yes □ No □ Bed exercises Yes □ No □ Other:____	

Attach patient addressograph here

ADMISSION/ PREOPERATIVE DAY(S)

Multidisciplinary Notes Page

Date: **Record time and signature below**

Attach patient addressograph here

ADMISSION/ PREOPERATIVE DAY(S)

Multidisciplinary Notes Page

Date: **Record time and signature below**

Attach patient addressograph here

Please insert

1) Consent form

2) Anaesthetic form

3) Theatre booklet

4) Surgical site safety form here

Attach patient addressograph here

POST-OPERATIVE INSTRUCTIONS

Antibiotics:____

Removal of sutures:____

Drains:____

Dressings:____

Is check x-ray required prior to mobilisation? Yes ☐ No ☐ _______________________

Weight bearing status:
- Full weight bearing ☐
- Partial weight bearing ☐
- Weight bearing as tolerated ☐
- Non weight bearing ☐

Is patient candidate for accelerated rehab? (ie. mobilisation on day of surgery) __________

____

Notes:

Clinical Judgement must be used at all times when using this document. Please use black pen only.

Attach patient addressograph here

POST-OPERATIVE RETURN TO WARD
Multidisciplinary Care Plan
Date:

Nursing	**Please initial each box**		
Shift	**AM**	**PM**	**ND**
1. Hygiene: Assist patient with hygiene needs			
2. Nutrition: Reintroduce diet & encourage fluids			
3. Mobility: Assist with ADL's			
4. Continence Assessment Perform catheter care if relevant Yes □ No □			
5. NEWS Observation & Neurovascular assessment Yes □ No □ Continue oxygen therapy as appropriate Record intake and output strictly Yes □ No □ Delirium screen Yes □ No □			
6. Tissue Viability Observe wound regularly Yes □ No □ Pressure areas checked regularly Yes □ No □			
7. Infection Control Prevention			
8. Medication Administer post-operative antibiotics Yes □ No □ Perform IV access care Yes □ No □			
9. Falls prevention &maintaining a safe environment Consider appropriate placement of patient on the ward in the post-operative period for close observation.			
10. Prevent & control nausea			
11. Pain Control Administer analgesia regularly & record pain score___/10 Use pain score to guide appropriate analgesia.			
12. Days since last bowel motion? __ Laxatives given Yes □ No □			
13. Prevent Thromboembolism Ensure prophylactic anti-coagulant is prescribed □ Anti-embolism stockings □			
14. Rest & Sleep			

Medical	**Signature & MRCN No. below**
Clinically examine patient & document findings in multidisciplinary notes section Assess pain score and review analgesia Yes □ No □ Pain score: ___/10	

Physiotherapist	**Signature, date and time below**
Patient reviewed Yes □ No □ Continue chest and bed exercises Yes □ No □ Other:____	

Discharge Planning (Multidisciplinary team)
Discharge plan discussed with patient and/ or family Yes □No □ Specify: Updated predicted discharge date: _____ Referral to occupational therapist: Yes □ No □ Signature:

Attach patient addressograph here

POST OPERATIVE

Multidisciplinary Notes Page

Date: **Record time and signature below**

Attach patient addressograph here

DAY 1 POST OPERATIVE
Multidisciplinary Care Plan
Date:

Nursing	**Please initial each box**		
Shift	**AM**	**PM**	**ND**
1. Hygiene Assist patient with hygiene needs			
2. Nutrition: Encourage normal diet and fluid intake			
3. Mobility: Sit patient out for mealtimes. If patient had a HEMI or THR please refer to occupational therapist Yes □ No □			
4. Continence Assessment Perform catheter care if relevant & consider removal Yes □ No □N/A□			
5. NEWS Observation& Neurovascular assessment Yes □ No □ Record intake & output strictly Yes □ No □ Delirium screen Yes □ No □			
6. Tissue Viability: Pressure areas checked regularly Yes □ No □ Remove drain today Yes □ No □ N/A □ Observe wound Yes □ No □			
7. Infection Control Prevention			
8. Medication Administer IV fluids for 24 hours Yes □ No □ Perform IV access care Yes □ No □			
9. Falls prevention & maintaining a safe environment Consider appropriate placement of patient & reassess FRAT following surgery Score:			
10. Pain Control Administer analgesia regularly & record pain score___/10 Use pain score to guide appropriate analgesia			
11. Days since last bowel motion? ___Laxatives given Yes □No □			
12. Prevent Thromboembolism Ensure prophylactic anti-coagulant is prescribed & given Yes □No □			
13. Rest & Sleep			

Medical	**Signature & MRCN No.**
Clinically examine patient & document findings in the multidisciplinary disciplinary notes section Document updated predicted discharge date below Yes □ No □ Ensure blood forms are done for tomorrow: FBC, U&E, Bone profile, Other:________________Yes □ No □ Orthogeriatric Referral Yes □ No □ Other:____ ____ ____ ____ ____ ____ ____ ____	

Attach patient addressograph here

Physiotherapist Assessment

*PMH and baseline history are documented on page ____ Surgery: ___________________________

Post-Op Instructions: WBAT □ FWB □ PWB □ NWB □ TTWB □ Other □ __________

Hip Precautions : Yes □ No □

Subjective:____

Objective: ____

Treatment:

Read post –operative note	Yes	No	Other
Complete baseline/falls history on page ?9	Yes	No	Other
Exercises Day 1 (see below)	Yes	No	Other
Exercise Leaflet Given	Yes	No	Other
If patient has Hip Precautions:			
Patient transferred out of bed on operated side	Yes	No	N/A
Educated re hip precautions	Yes	No	N/A
Mobility Status:			
Mobility aid: Full hoist□ Standing hoist□ Gutter frame□ Zimmer frame □ Cru			
Mobility assistance: Independent□ Supervision□ Assistance x 1□ 2 □ 3□			

Cumulated Ambulatory Score*
Bed Mobility ____/2
STS ____/2
Mobility ____/2
Total ___ /6
*Unable=0;
Assistance 1-2 people = 1;
Independent = 2.

Treatment continued ____

Analysis -tick main problems:	**Goals:**
Pain □ Anxiety / Fear of falling □ Cognition □ Delirium □ Reduced power □ Reduced ROM □ Decreased fitness □ Decreased mobility □ Other:	

Treatment plan:____

____Signature:_________________________

Clinical Judgement must be used at all times when using this document. Please use black pen only.

Attach patient addressograph here

Occupational Therapist Assessment

Care Pathway LOS= 10 DAYS

Date of admission: …………Date of Surgery: …………. Date of referral: …………….

Plan Pick –up and initiation of OT intervention *2 Days S/P surgery, max Moderate Assistance, Medically stable

Phase 1: Day 1 – 2 OT input

1. **Full Initial Assessment: (see page 66)** ☐
   (inclusive of PADL/ transfers/ mobility)

2. **Discharge Planning**:

- Discharge destination identified ☐
- Assess for appropriate equipment needs ☐
- Information sought on home supports ☐
- Information sought on environmental issues /issued with heights form ☐

Occupational Performance : Functional Status:

- Performs transfers with moderate Assistance:
  Bed ☐
  Chair ☐
  Toilet ☐
- Performs lower body dressing with mod A with assistive devices. ☐
- Issued with OT information booklet re hip precautions ☐

Prepare OTA flowsheet

Signature:____

Date: Time:

Notes:

Clinical Judgement must be used at all times when using this document. Please use black pen only.

Attach patient addressograph here

DAY 1 POST-OPERATIVE

Multidisciplinary Notes Page

Date: **Record time and signature below**

Discharge Planning (Multidisciplinary team)

Discuss discharge plan with patient and/ or family Yes □No □

Specify:____

Update Predicted date of discharge: ________________

Clinical Judgement must be used at all times when using this document. Please use black pen only.

Attach patient addressograph here

DAY 2 POST OPERATIVE
Multidisciplinary Care Plan
Date:

Nursing	**Please initial each box**		
Shift	**AM**	**PM**	**ND**
1. Hygiene Encourage and support patient to self care with ADL's			
2. Nutrition: Encourage fluids and diet intake			
3. Mobility Sit patient out for mealtimes and encourage mobility			
4. Continence Assessment Perform catheter care if relevant: consider removal today. Yes □ No □ N/A□			
5. NEWS Observation & Neurovascular assessment Yes □ No □ Record intake & output Yes □No □ Delirium screen Yes □ No □			
6. Tissue Viability: Pressure areas checked regularly Yes □ No □ Observe wound Yes □ No □			
7. Infection Control Prevention			
8. Medication Discontinue IV Fluids and encourage oral intake Perform IV access care or remove if no longer in use Yes □ No □			
9. Falls prevention & maintaining a safe environment			
10. Prevent Thromboembolism Ensure prophylactic anti-coagulant is prescribed & given Yes □ No □			
11. Pain Control Administer analgesia regularly Record pain score /10			
12. Days since last bowel motion? ___ Laxatives given Yes □ No □			
13. Rest & Sleep			

Medical	**Signature & MRCN No.**
Clinically examine patient & document on multidisciplinary page FBC, U&E and bone profile reviewed Yes □ No □ Liaise with MDT regarding progress and discharge plan & Assess pain and review medications. Pain score ___/10	

Physiotherapist

Subjective: ____

Objective: ____

Cumulated Ambulatory Score* Bed Mobility ____/2 STS ____/2 Mobility ____/2 **Total ___ /6** *Unable=0; Assistance 1-2 people = 1; Independent = 2
Mobility Status: Mobility aid: Full hoist □Standing hoist□ Gutter frame□ Zimmer frame □Crutches□ Sticks□ Other □ ___________
Mobility assistance: Independent□ Supervision□ Assistance x 1□ 2 □ 3□ people Other □ _________________
Outcome measures:

Treatment:____

____

Analysis- tick main problems:	**Treatment plans/ Goals:**
Pain □ Anxiety / Fear of falling □ Cognition □ Delirium □ Reduced power □ Reduced ROM □ Decreased fitness □ Decreased mobility □ Other:	

Signature: Date:

Integrated Care Pathway for Hip Fracture

Attach patient addressograph here

DAY 2 POST-OPERATIVE

Multidisciplinary Notes Page

Date: **Record time and signature below**

Discharge Planning (Multidisciplinary team)

Refer patient to geriatrician Yes □ No □

Liaise with discharge coordinator Yes □ No □ Discuss discharge plan with patient and/ or family

Yes □ No □ Specify:____

Update Predicted date of discharge: ________________

Signature:

Integrated Care Pathway for Hip Fracture

Attach patient addressograph here

DAY 3 POST-OPERATIVE
Multidisciplinary Care Plan
Date:

Nursing	**Please initial each box**		
Shift	**AM**	**PM**	**ND**
1. Hygiene Encourage and support patient to self care with ADL's			
2. Nutrition Encourage fluids and diet intake			
3. Mobility Sit patient out for mealtimes & encourage mobility			
4. Continence Assessment Remove catheter today Yes □No□			
5. NEWS Observation & Neurovascular assessment Yes □ No□ Delirium screen Yes □ No □			
6. Tissue Viability: Assess wound and pressure areas Yes □ No □			
7. Infection Control Prevention			
8. Medication			
9. Falls prevention & Safe Environment			
10. Rest & Sleep			
11. Pain Control Administer analgesia regularly Record pain score /10			
12. Days since last bowel motion? ____Laxatives given Yes □ No □			
13. Prevent Thromboembolism Ensure prophylactic anti-coagulant is prescribed & given Yes □ No □			

Medical	**Signature & MRCN No.**
Clinically examine patient & document outcomes Tests ordered:____ Assess pain and review medication. Pain score ___/10	

Physiotherapist

Subjective:

____

Objective:

____

Cumulated Ambulatory Score* Bed Mobility ____/2 STS ____/2 Mobility ____/2
Total ___ **/6** *Unable=0; Assistance 1-2 people = 1; Independent = 2

Mobility Status: Mobility aid: Full hoist □Standing hoist□ Gutter frame□ Zimmer frame □Crutches□ Sticks□ Other □ __________

Mobility assistance: Independent□ Supervision□ Assistance x 1□ 2 □ 3□ people Other □ _________________

Outcome measures:

Treatment:____

____

Analysis- tick main problems: Pain □ Anxiety / Fear of falling □ Cognition □ Delirium □ Reduced power □ Reduced ROM □ Decreased fitness □ Decreased mobility □ Other:	**Treatment plans/ Goals:**

Signature: Date:

Attach patient addressograph here

DAY 3 POST-OPERATIVE

Multidisciplinary Notes Page

Date: **Record time and signature below**

Discharge Planning (Multidisciplinary team)

Liaise with discharge coordinator Yes □ No □

Discuss discharge plan with patient and/ or family Yes □No □ Specify:___________________________

Update Predicted date of discharge: ________________Signature:

Attach patient addressograph here

DAY 4 POST-OPERATIVE
Multidisciplinary Care Plan
Date:

Nursing	**Please initial each box**		
Shift	**AM**	**PM**	**ND**
1. Hygiene Encourage and support patient to self care with ADL's			
2. Nutrition Encourage fluids and diet intake			
3. Mobility Sit patient out for mealtimes & encourage mobility			
4. Continence Assessment			
5. NEWS Observation & Neurovascular assessment Yes □ No □			
6. Tissue Viability Observe wound, dressing changed Yes □No □ N/A□			
7. Infection Control Prevention			
8. Medication			
9. Falls prevention & maintaining a safe environment			
10.Pain Control Administer analgesia regularly Record pain score. /10			
11. Days since last bowel motion? __ Laxatives given Yes □No □			
12. Prevent Thromboembolism Ensure prophylactic anti-coagulant is prescribed & given Yes □No □			
14. Rest & Sleep			

Medical	**Signature & MRCN No.**
Clinically examine patient & document outcomes Tests ordered:_______________________________________ Assess pain and review medication. Pain score: ___/10	

Physiotherapist

Subjective:

____

Objective:

____

Cumulated Ambulatory Score* Bed Mobility ____/2 STS ____/2 Mobility ____/2 **Total** ___ **/6** *Unable=0; Assistance 1-2 people = 1; Independent = 2
Mobility Status: Mobility aid: Full hoist □Standing hoist□ Gutter frame□ Zimmer frame □Crutches□ Sticks□ Other □ ___________
Mobility assistance: Independent□ Supervision□ Assistance x 1□ 2 □ 3□ people Other □ __________________
Outcome measures:

Treatment:____

____

____

Analysis- tick main problems: Pain □ Anxiety / Fear of falling □ Cognition □ Delirium □ Reduced power □ Reduced ROM □ Decreased fitness □ Decreased mobility □ Other:	**Treatment plans/ Goals:**

Signature: Date:

Clinical Judgement must be used at all times when using this document. Please use black pen only.

Attach patient addressograph here

DAY 4 POST-OPERATIVE

Multidisciplinary Notes Page

Date: **Record time and signature below**

Discharge Planning (Multidisciplinary team)	
Liaise with discharge coordinator Yes □ No □	
Discuss discharge plan with patient and/ or family Yes □No □	
Update Predicted date of discharge: ________________	
Specify:____	Signature:

Attach patient addressograph here

DAY 5 POST-OPERATIVE
Multidisciplinary Care Plan
Date:

Nursing	**Please initial each box**		
Shift	**AM**	**PM**	**ND**
1. Hygiene Encourage and support patient to self care with ADL's			
2. Nutrition Encourage fluids and diet intake			
3. Mobility Encourage patient to sit out and mobilise			
4. Continence Assessment			
5. NEWS Observation & Neurovascular assessment Yes □ No□			
6. Tissue Viability Observe wound, dressing changed Yes □No □ N/A□			
7. Infection Control Prevention			
8. Medication			
9. Falls prevention &maintaining a safe environment			
10. Rest & Sleep			
11.Pain Control Administer analgesia regularly, record pain score. /10			
12. Days since last bowel motion? __Laxatives given Yes □ No□			
13. Prevent Thromboembolism Ensure prophylactic anti-coagulant is prescribed & given Yes □ No □			

Medical	**Signature & MRCN No.**
Clinically examine patient & document outcomes Tests ordered:______________________________ Review wound and liaise with physiotherapist and occupational therapist re progress and confirm discharge plan Yes □ No□	

Physiotherapist

Subjective:

____

Objective:

____

Cumulated Ambulatory Score* Bed Mobility ____/2 STS ____/2 Mobility ____/2
Total ___ **/6** *Unable=0; Assistance 1-2 people = 1; Independent = 2

Mobility Status: Mobility aid: Full hoist □Standing hoist□ Gutter frame□ Zimmer frame □Crutches□ Sticks□ Other □ ___________

Mobility assistance: Independent□ Supervision□ Assistance x 1□ 2 □ 3□ people Other □ _________________

Outcome measures:

Treatment:____

____

Analysis- tick main problems:	**Treatment plans/ Goals:**
Pain □ Anxiety / Fear of falling □ Cognition □ Delirium □ Reduced power □ Reduced ROM □ Decreased fitness □ Decreased mobility □ Other:	

Signature: Date:

Occupational Therapist- Care Pathway Phase 3 (Phase 3: Day 5-6)

Occupational Performance: Functional status

- Performs transfers with supervision: ☐ Bed ☐ Chair ☐ Toilet ☐
- Completes lower body dressing with supervision with appropriate aides. ☐
- Rehab referral : appropriate forms completed ☐

Attach patient addressograph here

DAY 5 POST-OPERATIVE

Multidisciplinary Notes Page

Date: **Record time and signature below**

Discharge Planning (Multidisciplinary team)

Discuss discharge plan with patient and/ or family Yes □No □

Initiate any referrals required: Rehab □ Convalescence □ Home care package □ Other:_______________

Update Predicted date of discharge: ________________

Liaise with discharge coordinator Yes □ No □ Signature:

Attach patient addressograph here

DAY 6 POST-OPERATIVE
Multidisciplinary Care Plan
Date:

Nursing	**Please initial each box**		
Shift	**AM**	**PM**	**ND**
1. Hygiene Encourage and support patient to self care with ADL's			
2. Nutrition Encourage fluids and diet intake			
3. Mobility Encourage patient to sit out and mobilise			
4. Continence Assessment			
5. NEWS Observation & Neurovascular assessment			
6. Tissue Viability Observe wound, dressing changed Yes □No □ N/A□			
7. Infection Control Prevention			
8. Medication			
9. Falls prevention &maintaining a safe environment			
10. Prevent Thromboembolism Ensure prophylactic anti-coagulant is prescribed & given Yes □ No □			
11. Pain Control Administer analgesia regularly Record pain score /10			
12. Days since last bowel motion ___ Laxatives given Yes □ No□			
13. Rest & Sleep			

Medical	**Signature & MRCN no.**
Clinically examine patient & document outcomes Tests ordered:____	

Physiotherapist

Subjective:

____

Objective:

____

Cumulated Ambulatory Score* Bed Mobility ____/2 STS ____/2 Mobility ____/2
Total ___ **/6** *Unable=0; Assistance 1-2 people = 1; Independent = 2

Mobility Status: Mobility aid: Full hoist □Standing hoist□ Gutter frame□ Zimmer frame □Crutches□ Sticks□ Other □ ___________

Mobility assistance: Independent□ Supervision□ Assistance x 1□ 2 □ 3□ people Other □ _________________

Outcome measures:

Treatment:____

____

____

____

Analysis- tick main problems:	**Treatment plans/ Goals:**
Pain □ Anxiety / Fear of falling □ Cognition □ Delirium □ Reduced power □ Reduced ROM □ Decreased fitness □ Decreased mobility □ Other:	

Signature: Date:

Attach patient addressograph here

DAY 6 POST-OPERATIVE

Multidisciplinary Notes Page

Date: **Record time and signature below**

Discharge Planning (Multidisciplinary team)
Discuss discharge plan with patient and/ or family Yes □No □
Liaise with discharge coordinator Yes □ No □
Update Predicted date of discharge: ________________
Signature:

Attach patient addressograph here

DAY 7 POST-OPERATIVE
Multidisciplinary Care Plan
Date:

Nursing	**Please initial each box**		
Shift	**AM**	**PM**	**ND**
1. Hygiene Encourage and support patient to self care with ADL's			
2. Nutrition Encourage fluids and diet intake			
3. Mobility Encourage patient to sit out and mobilise			
4. Continence Assessment			
5. NEWS Observation & Neurovascular assessment Yes □ No □			
6. Tissue Viability Observe wound, dressing changed Yes □ No □ N/A□			
7. Infection Control Prevention			
8. Medication			
9. Falls prevention &maintaining a safe environment Reassess FRAT Score:			
10. Prevent Thromboembolism Ensure prophylactic anti-coagulant is prescribed & given Yes □ No □			
11. Pain Control Record pain score /10			
12. Days since last bowel motion? ___			
13. Rest & Sleep			

Medical	**Signature & MRCN No.**
Clinically examine patient & document outcomes Tests ordered:_______________________ Consider treatment for osteoporosis Yes □ No □ Reassess AMTS: /10	

Physiotherapist

Subjective:

____

Objective:

____

Cumulated Ambulatory Score* Bed Mobility ____/2 STS ____/2 Mobility ____/2
Total ___ **/6** *Unable=0; Assistance 1-2 people = 1; Independent = 2

Mobility Status: Mobility aid: Full hoist □Standing hoist□ Gutter frame□ Zimmer frame □Crutches□ Sticks□ Other □ __________

Mobility assistance: Independent□ Supervision□ Assistance x 1□ 2 □ 3□ people Other □ ________________

Outcome measures:

Treatment:____

____

Analysis- tick main problems:	**Treatment plans/ Goals:**
Pain □ Anxiety / Fear of falling □ Cognition □ Delirium □ Reduced power □ Reduced ROM □ Decreased fitness □ Decreased mobility □ Other:	

Signature: Date:

Occupational Therapist- Care Pathway Phase ? (Day 6- 7) Plan Discharge home.

Occupational Performance: Functional status

Completes light domestic tasks with environmental set up and supervision □

Performs transfers independently (with necessary equipment.)

Bed □ Chair □ Toilet □

Completes lower body dressing independently with appropriate aides □

Attach patient addressograph here

DAY 7 POST-OPERATIVE

Multidisciplinary Notes Page

Date: **Record time and signature below**

Discharge Planning (Interdisciplinary team)

Discuss discharge plan with patient and/ or family Yes □No □

Liaise with discharge coordinator Yes □ No □

Update Predicted date of discharge: ________________

OT: Necessary supports/equipment in place/organised Yes □No □ ________________________________

____

Signature:

Attach patient addressograph here

DAY 8 POST-OPERATIVE
Multidisciplinary Care Plan
Date:

Nursing	**Please initial each box**		
Shift	**AM**	**PM**	**ND**
1. Hygiene Encourage and support patient to self care with ADL's			
2. Nutrition Encourage fluids and diet intake			
3. Mobility Encourage patient to sit out and mobilise			
4. Continence Assessment			
5. NEWS Observation/Neurovascular assessment			
6. Tissue Viability			
7. Infection Control Prevention			
8. Medication			
9. Falls prevention &maintaining a safe environment			
10. Pain Control Record pain score /10			
11. Days since last bowel motion? __ Laxatives given Yes □ No □			
12. Prevent Thromboembolism Ensure prophylactic anti-coagulant is prescribed & given Yes □ No □			

Medical	**Signature & MRCN No.**
Clinically examine patient & document outcomes Tests ordered:____	

Physiotherapist

Subjective:

____

Objective:

____

Cumulated Ambulatory Score* Bed Mobility ____/2 STS ____/2 Mobility ____/2
Total ___ **/6** *Unable=0; Assistance 1-2 people = 1; Independent = 2

Mobility Status: Mobility aid: Full hoist □Standing hoist□ Gutter frame□ Zimmer frame □Crutches□ Sticks□ Other □ ___________

Mobility assistance: Independent□ Supervision□ Assistance x 1□ 2 □ 3□ people Other □ _________________

Outcome measures:

Treatment:____

____

____

____

____

Analysis- tick main problems: Pain □ Anxiety / Fear of falling □ Cognition □ Delirium □ Reduced power □ Reduced ROM □ Decreased fitness □ Decreased mobility □ Other:	**Treatment plans/ Goals:**

Signature: Date:

Attach patient addressogram here

DAY 8 POST-OPERATIVE

Multidisciplinary Notes Page

Date: **Record time and signature below**

Discharge Planning (Multidisciplinary team)

Discuss discharge plan with patient and/ or family Yes □No □

Update Predicted date of discharge: ________________

Liaise with discharge coordinator Yes □ No □

Updated Predicted discharge date: _______________ Signature:

Attach patient addressograph here

DAY 9 POST-OPERATIVE
Multidisciplinary Care Plan
Date:

Nursing	**Please initial each box**		
Shift	**AM**	**PM**	**ND**
1. Hygiene Encourage and support patient to self care with ADL's			
2. Nutrition Encourage fluids and diet intake			
3. Mobility Encourage patient to sit out and mobilise			
4. Continence Assessment			
5. NEWS Observation/Neurovascular assessment			
6. Tissue Viability			
7. Infection Control Prevention			
8. Medication			
9. Falls prevention &maintaining a safe environment			
10.Prevent Thromboembolism Ensure prophylactic anti-coagulant is prescribed & given Yes □ No □			
11. Pain Control Record pain score /10			
12. Days since last bowel motion? ___ Laxatives given Yes □ No □			
13. Rest & Sleep			

Medical	**Signature & MRCN No.**
Clinically examine patient & document outcomes Tests ordered:____	

Physiotherapist

Subjective:

____

Objective:

____

Cumulated Ambulatory Score* Bed Mobility ____/2 STS ____/2 Mobility ____/2
Total ___ **/6** *Unable=0; Assistance 1-2 people = 1; Independent = 2

Mobility Status: Mobility aid: Full hoist □Standing hoist□ Gutter frame□ Zimmer frame □Crutches□ Sticks□ Other □ ___________

Mobility assistance: Independent□ Supervision□ Assistance x 1□ 2 □ 3□ people Other □ _________________

Outcome measures:

Treatment:____

____

____

____

Analysis- tick main problems: Pain □ Anxiety / Fear of falling □ Cognition □ Delirium □ Reduced power □ Reduced ROM □ Decreased fitness □ Decreased mobility □ Other:	**Treatment plans/ Goals:**

Signature: Date:

Clinical Judgement must be used at all times when using this document.
Please use black pen only.

Attach patient addressograph here

DAY 9 POST-OPERATIVE

Multidisciplinary Notes Page

Date: **Record time and signature below**

Discharge Planning (Multidisciplinary team)

Discuss discharge plan with patient and/ or family Yes □No □

Liaise with discharge coordinator Yes □ No □

Update Predicted date of discharge: ________________

If patient is going directly home contact PHN Yes □ No □ Signature:

Attach patient addressograph here

DAY 10 POST-OPERATIVE
Multidisciplinary Care Plan
Date:

Nursing	**Please initial each box**		
Shift	**AM**	**PM**	**ND**
1. Hygiene Encourage and support patient to self care with ADL's			
2. Nutrition Encourage fluids and diet intake			
3. Mobility Encourage patient to sit out and mobilise			
4. Continence Assessment			
5. NEWS Observation/Neurovascular assessment			
6. Tissue Viability: Remove clips/ sutures today Yes □ No □			
7. Infection Control Prevention			
8. Medication			
9. Falls prevention &maintaining a safe environment			
10.Prevent Thromboembolism Ensure prophylactic anti-coagulant is prescribed & given Yes □ No □			
11. Pain Control Record pain score /10			
12. Days since last bowel motion? ____ Laxatives given Yes □ No □			
13. Rest & Sleep			
14. Discharge Planning Discuss discharge plan with patient/ family Yes □ No □ Contact discharge coordinator Yes □ No □ Contact PHN/GP Yes □ No □			
Medical	**Signature &MRCN No.**		
Clinically examine patient & document outcomes Assess wound before removal of clips/ sutures Tests ordered:____			

Physiotherapist

Subjective:
____

Objective:
____

Cumulated Ambulatory Score* Bed Mobility ____/2 STS ____/2 Mobility ____/2
Total ___ **/6** *Unable=0; Assistance 1-2 people = 1; Independent = 2

Mobility Status: Mobility aid: Full hoist □Standing hoist□ Gutter frame□ Zimmer frame □Crutches□ Sticks□ Other □ ___________

Mobility assistance: Independent□ Supervision□ Assistance x 1□ 2 □ 3□ people Other □ _________________

Outcome measures:

Treatment:____
____

Analysis- tick main problems:	**Treatment plans/ Goals:**
Pain □ Anxiety / Fear of falling □ Cognition □ Delirium □ Reduced power □ Reduced ROM □ Decreased fitness □ Decreased mobility □ Other:	

Signature: Date:

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Attach patient addressograph here

DAY 10 POST-OPERATIVE

Multidisciplinary Notes Page

Date: **Record time and signature below**

Discharge Planning Multidisciplinary team)

Discuss discharge plan with patient and/ or family Yes □No □

Update Predicted date of discharge: ________________

Liaise with discharge coordinator Yes □ No □ Discharge letters completed: ____________________

Signature:

Attach patient addressograph here

Orthogeriatric assessment

Date: **Record time and signature below**

Patient summary:

____

____

____

____

____

____

Falls risk assessment	**Fracture risk factors**
No. of falls in past 12 months:___________ Explained falls: ______________________ Unexplained falls:______________________ ____ ____ Investigations ordered: ____ ____ ____	Previous fracture Yes □ No □ Parent fractured hip Yes □ No □ Current smoking Yes □ No □ Alcohol 3 or more units/day Yes □ No □ Rheumatoid arthritis Yes □ No □ Glucocorticoids within 3/12 Yes □ No □ Secondary causes: Yes □ No □

Bone health assessment

Calcium_____ Phosphorus______ Alkaline Phosphatase_____ ionised calcium_____ 25OHD_____ PTH_____

eGFR:_____

Is patient already on treatment: Yes □ No □

Treatment plan: ____

Discharge plan**:**____

Other recommendations:

____

____

____

____

In

KEY

For All Indicators - Put √ in box if care is given
- Put X in box if care is not given
Initial bottom of relevant column
NB * Input the relevant abbreviation each shift for Hygiene, Nutrition, Mobility & Continence Assessment,

- **Independent - I √ Assisted * 1 - A1√**
- **Assisted * 2 - A2√ Hoist - H√**

Core Care Record
Nursing

Patient ID label

Day 10 – Day 17

Date																					
Day	**Day 11**			**Day 12**			**Day 13**			**Day 14**			**Day 15**			**Day 16**			**Day 17**		
PDD																					
Shift	**AM**	**PM**	**ND**	**AM**	**PM**	**ND**	**AM**	**PM**	**ND**	**AM**	**PM**	**ND**	**AM**	**PM**	**ND**	**AM**	**PM**	**ND**	**AM**	**PM**	**ND**
1. Hygiene																					
2. Nutrition																					
3. Mobility																					
4.Continence Assessment																					
5. NEWS Observations																					
6. Tissue Viability																					
7. Inf.Control Prevention																					
8. Medication																					
9. Safe Environment																					
10.Rest/ Sleep																					
Initials																					

NB. Day Staff If working a **long day** – it is sufficient to write in **AM** column only (unless changes occur)

Attach patient addressogaph here

Multidisciplinary Notes Page

Date: **Record time and signature below**

Clinical Judgement must be used at all times when using this document.
Please use black pen only

Attach patient addressograph here

Multidisciplinary Notes Page

Date: **Record time and signature below**

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Attach patient addressograph here

Multidisciplinary Notes Page

Date: **Record time and signature below**

Attach patient addressograph here

Multidisciplinary Notes Page

Date: **Record time and signature below**

Attach patient addressograph here

Multidisciplinary Notes Page

Date: **Record time and signature below**

Attach patient addressograph here

Physiotherapy Discharge / Transfer Summary:

History of presenting complaint:	**Past Medical History:**

Operation Details and Date:
Postoperative instructions: WBAT □ PWB □ NWB □ TTWB □ Other □ ___
Hip Precautions: Yes □ No □

Social History	**Falls History:**	**Baseline Mobility:**
		Walking Aid: Frame□ Crutches □ Stick □ Other □ ________

New Mobility Score (NMS)*:

Indoor Walking	___/3
Outdoor Walking	___/3
Shopping	___/3
Total NMS	___/9

*Unable:0 With assistance:1 With an aid:2 Independent:3

Signature: **Date:** **Contact number:**

Mobility Status:

Bed Mobility	___/2
STS	___/2
Mobility	___/2
Total CAS	___/6

Cumulated Ambulatory Score (CAS)
Unable:0
Assistance of one/two people:1
Independent: 2

Outcome Measures:

EQ-15
Under each heading, please tick the ONE box that best describes your health TODAY.

Mobility
I have no problems in walking about q
I have slight problems in walking about q
I have moderate problems in walking about q
I have severe problems in walking about q
I am unable to walk about q

Self-Care
I have no problems washing or dressing myself q
I have slight problems washing or dressing myself q
I have moderate problems washing or dressing myself q
I have severe problems washing or dressing myself q
I am unable to wash or dress myself q

USUAL ACTIVITIES *(e.g. work, study, housework, family or leisure activities)*
I have no problems doing my usual activities q
I have slight problems doing my usual activities q
I have moderate problems doing my usual activities q
I have severe problems doing my usual activities q
I am unable to do my usual activities q

PAIN / DISCOMFORT
I have no pain or discomfort q
I have slight pain or discomfort q
I have moderate pain or discomfort q
I have severe pain or discomfort q
I have extreme pain or discomfortq

ANXIETY / DEPRESSION
I am not anxious or depressed q
I am slightly anxious or depressed q
I am moderately anxious or depressed q
I am severely anxious or depressed q
I am extremely anxious or depressed q

Other information:

Follow-up physiotherapy arranged:

No Yes Location
____

Integrated care pathway for hip fracture

Attach patient addressograph here

Nursing Discharge Tracking Form & Checklist

	General Check for All Discharges	**Yes**	**No**	**N/A**	**Initials**
1	Has a Nursing Assessment been made of the Patient's Discharge needs?				
2	Has the PDD been documented?				
3	Has PDD been discussed with Patient ☐ NOK ☐ Carer ☐ PCC ☐ Other ☐ _ _ _ _ _ _ _ *(specify)*				
4	Has Time of Discharge been agreed with *(home by 11.00hrs)* Patient ☐ NOK ☐ Carer ☐ PCC ☐ Other ☐ _ _ _ _ _ _ _ *(specify)* Name of Person Collecting Patient _ _ _ _ _ _ _ _ _ Ph._ _ _ _ _ _ _ _ _ Ambulance Booking No. _ _ _ _ _ _ _ _ _ Date of Booking _ _ /_ _ /_ _ Time of Booking: _ _ _ _ _ _				
5	Discharged by 11.00hrs				
6	Cannula/e removed				
7	Wound & Dressings checked				
8	Pain Control Satisfactory				
9	Prescription given ☐ Medication Education Given ☐				
10	Patients own medications returned				
11	OPD appointment given ☐ App. To follow ☐ GP Follow up ☐				
12	Patients valuables returned				
13	Patient Education Given?_ *(Specify)*				
14	Communication about any transmissible infection status given _ *(Specify)*				
15	Did the Discharge Date match the PDD **If No. state why**?_ _				
	Discharge Home/To Family	**Yes**	**No**	**N/A**	**Initials**
1	PHN contacted: Spoke with ☐ Message Left ☐				
2	PHN Letter Faxed ☐ PHN Letter Posted ☐				
	Discharge to Nursing Home/Other Hospital	**Yes**	**No**	**N/A**	**Initials**
1	Nursing Transfer letter completed & sent				
2	Doctor's Transfer Letter completed & sent				

Clinical Judgement must be used at all times when using this document.
Please use black pen only.

Attach patient addressograph here

Integrated Discharge Plan

Ward : Consultant: Admission Date: ____/____/____

Predicted Day of Discharge (PDD) ____/____/____

PDD discussed with Pt. **Yes** ☐ **No** ☐ PDD discussed with NOK **Yes** ☐ **No** ☐ _______________(*specify*)

1st Revised PDD ___/___/___ Discussed with NOK **Yes** ☐ **No** ☐ ________________________________(*specify*)

Reason : ____

2nd Revised PDD ___/___/___ Discussed with NOK **Yes** ☐ **No** ☐ ________________________________(*specify*)

Reason : ____

Housing Situation

House ☐ Two Storey ☐ Bungalow ☐ Apartment ☐ Other ☐ ______________________ *(specify)*

Stairs ☐ Steps ☐ Other ☐ ____ *(specify)*

Principal Carer

Name: Relationship: Phone No.
Support Given:

Services in Place

Home Help ☐_______________
Home Care Att. ☐_______________
Family Support ☐_______________
Private Carer ☐_______________
Meals Supply ☐_______________
Laundry ☐_______________
Day Care ☐_______________
Day Hospital ☐_______________
PHN ☐_______________
CMHN ☐_______________
Pendant Alarm ☐_______________
Other ☐_______________
Comment: ___________________

Referrals

Inpatient	***Date***	***Signature***	***Community***	***Date***	***Signature***
O.T.			O.T.		
Physio			Physio		
SLT			SLT		
Dietician			Dietician		
Comm. Liaison Nurse			PHN *Name*		
Older Care PHN					
D/C Planner			*Number*		
Home Care Team					
Social Worker			Other		
Other					

Options of Ongoing Care discussed with the Patient and his/her Preferred Option

Older Care Discharge Planning

Refer to older care team: ☐ Date: _____/______/_______ CSAR completed ☐
Fair Deal App. Form given to family ________________________(specify) Date: ____/_____/_____
Referred to Rehab ☐ Date: _____/______/______ Location: _________________________________
Referred for Convalescence ☐ Date: _____/______/______ Location:_________________________

Care Services Required

Signature:___________________________________ **Date of Discharge:** _____/______/______

Attach patient addressograph here

ABBREVIATIONS

ADL's: Activities of Daily Living	N.E.W.S. National Early Warning Score
AMTS: Abbreviated Mental Test Score	MCRN: Medical Council Registration Number
BP: Blood Pressure	MDT: Multidisciplinary Team
BNO: Bowels Not Open	MMSE: Mini-Mental State Examination
CNM: Clinical Nurse Manager	MSU: Midstream Specimen of Urine
CXR: Chest x-ray	NOK: Next of kin
ED: Emergency Department	NRS: Numerical Rating Scale
ECG: Electrocardiogram	NWB: Non Weight Bearing
FBC: Full Blood Count	O.P.D: Out Patient Department
FWB: Full Weight Bearing	PDD: Predicted Date of Discharge
GA: General Anaesthetic	P.O: Per Oral
GCS: Glasgow Coma Ccale	P.H.N: Public Health Nurse
GP: General Practitioner	PWB: Partial Weight Bearing
HEMI: Hemiarthroplasty	PPE: Personal Protective Equipment
HR: Heart Rate	SAO2: Oxygen saturations
ICP: Integrated Care Pathway	SOS: Sacrement of the sick
IM Nail: Intra-medullary Nail	TEDs: Thrombo-Embolic Deterrent Stockings
IV: Intravenous	THR: Total Hip Replacement
KDP: Kidney Disease Profile	TVN: Tissue Viability Nurse
LFTs: Liver Function Tests	U&E: Urea & Electrolytes
L.T.C: Long Term Care	VTE: Venothromboembolism
LMWH: Low Molecular Weight Heparin	

Occupational Therapy Assessment

Patient Name: ________________________ Episode No: ____________ Date: _______________

Consent obtained for assessment**:** Yes ☐ No ☐

Performance Components	
Affect	Alert ☐ Lethargic ☐ Anxious ☐
Cognition Orientation	Day ☐ Date ☐ Month ☐ Year ☐ Place ☐ Person ☐
Insight into Deficits	Yes ☐ No ☐
Ability to Follow Commands	2 Step☐ 1 Step☐ Gestures ☐ Unable/Inconsistent ☐
Safety Awareness	Intact ☐ Impaired ☐
Perception	Intact ☐ Impaired ☐ Requires further assessment ☐
Sitting balance Static Dynamic	 Intact ☐ / Impaired ☐ Intact ☐ / Impaired ☐
Seating	Recommended Chair:
Standing Balance Static Dynamic	 Intact ☐ / Impaired ☐ Intact ☐ / Impaired ☐
Upper Limb Fx	Within Normal Limits ☐ Requires Further Assessment ☐ Deficits Noted :

Occupational Performance	
Functional Mobility	
Falls Risk	High ☐ Low ☐ Decreased Safety Awareness ☐ Decreased Static/Dynamic Standing Balance ☐

Bed Mobility	Ind.	Ass	Device/Modification/FIM Score*/Comment
Rolling			
Bridging			
Scooting			
Supine to Sit			
Sit to Supine			

Transfers	Ind.	Ass	Device/Modification/FIM Score*/Comment
Sit to stand			
Bed to chair			
Toilet			
Shower			

Personal care	Ind.	Ass	Device/Modification/FIM Score*/Comment
Feeding			
Grooming			
Washing			
Dressing Upper Body			
Lower Body			
Toileting			

Pressure Care	Waterlow Score: Cushion in place?
	Continence : Urine Y/N Catheter Y/N Faeces Y/N

Analysis/ Deficits identified	See Occupational Therapy note ______________ for detailed analysis.
Goals	____ ____ ____ ____ ____
Plan	1. Discharge from OT as patient at preadmission baseline □ 2. Further Ax: Kitchen Ax □ Cognitive Ax □ Other ____________________ 3. Rehabilitation □ 4. Provide equipment essential for discharge: ____ 5. Refer to Community OT □ ________________________ 6. Other ____ ____ ____ ____

* Functional Independence Measure (FIM) (score 1-7)

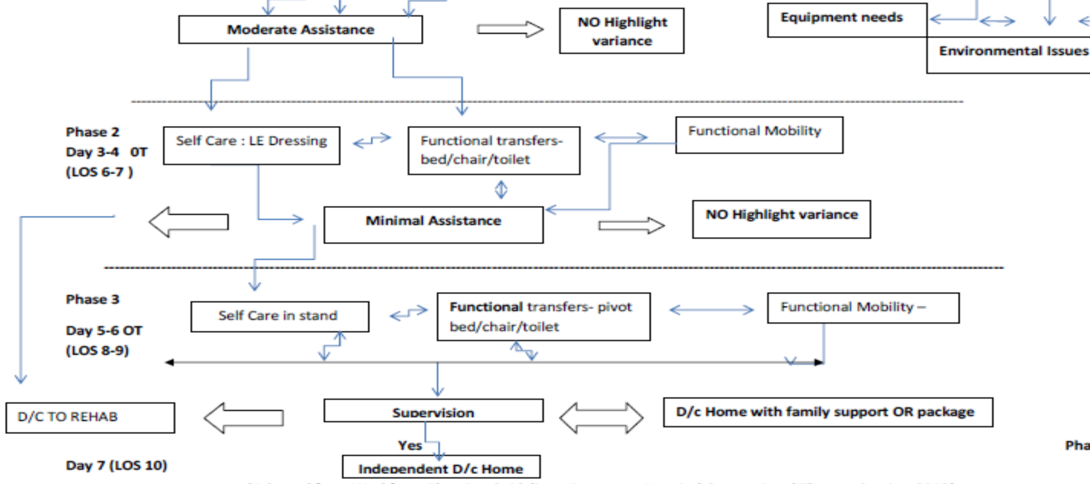
Independent	7	Minimal assistance / contact	4
Modified independent	6	Moderate assistance	3
Supervision or set up	5	Maximal assistance	2
		Total assistance / two people	1

Discharge Destination:

Home _______ LTC _______ Sheltered Housing _______ Other________

Occupational Therapist: ____________________ Dect No: _________ Date: ______

Occupational TherapyAlgorithm



'Adopted from Workforce Planning Guidelines, Beaumont Hospital Occupational Therapy Service, 2013'.

HIP FRACTURE PATHWAY

EMT/GP: Suspect a hip fracture if: the patient has had a fall, is unable to weightbear and the leg is shortened and externally rotated

Triage: Senior ED doctor review: pain relief given, x-ray taken AP & lateral of hip to confirm hip fracture

Work-up for theatre: full bloods, x-match, ECG, CXR, IV fluids & O2

Stable: Admit straight to trauma ward for admission by orthopaedic team: Consent & prepared for theatre, pressure relieving mattress

Unstable: Admit in ED, for review by orthopaedic team in ED work-up medically to make stable

Trauma Ward

Anaesthetic review

Theatre

Post-operative: Monitor vital signs regularly, monitor neurovascular status regularly, monitor intake and output strictly for 48 hours, continue IV fluids until drinking sufficiently, O2 as required, pressure area care, regular pain assessment and analgesia.

Day 1: Sit patient out for short while, encourage fluids and diet and regular analgesia, monitor vital signs regularly and neurovascular assessment. Discuss discharge plan with patient and family, refer to geriatrician and occupational therapist as appropriate.

Day 2: Encourage patient to stand several times and take some steps with physiotherapist. Sit out for mealtimes. Consider discontinuing IV fluids and remove all indwelling devices such as catheters and IV cannulas.

Day 3, 4, 5: Encourage mobility as much as possible, mobilise patient to bathroom to use toilet. Sit patient out for mealtimes. Ensure bowels are working. Check wound.

Day 6: Continue to encourage mobility and allow patient to undertake as much personal care as able. Geriatric assessment for falls/ bone health/ polypharmacy/ medical status and discharge plan. Determine need for rehabilitation or if patient could potentially be discharged directly home.

Day 7, 8, 9: Allow patient to mobilise with supervision and undertake all personal care in the bathroom/ shower. Reinforce discharge plan and preparations. Ask discharge coordinator to liaise with patient and family.

Day 10: Remove sutures/ clips from wound. Give patient discharge advice and follow-up care plan. Letters to be completed: prescription, GP letter, nursing discharge plan, physiotherapy & occupational therapy discharge letter and doctor's letter if being referred to rehabilitation.

Home/ Rehabilitation/ LTC
Details inputted into the Irish Hip Fracture Database

Follow-up in outpatients at 6/52 following DHS/ nailing/cannulated screws or 3/12 following HEMI/THR. Discharge all patients at 3/12

Pre-operative
Post-operative