The Lewisham Hospital **NHS**
NHS Trust

INTEGRATED CARE PATHWAY:

Fractured Neck of Femur

Version 4.0

Patient Label	Consultant: Date of operation: Operation performed: Orthopaedic Surgeon: **Date and time** of arrival to A&E: **Date and time** of arrival on ward: **Date and time** of discharge from ward:

Integrated Care Pathways are multidisciplinary plans for given diagnosis or procedure that identifies best practice to achieve high quality care and patient-focused outcomes. **It is a guide only and is not intended to replace individual clinical judgement.**

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Patient Label

Abbreviations:

E&D	Eating and drinking
EDD	Expected date of discharge
Hb	Haemoglobin
LINC	Home based intermediate care team
MDT	Multidisciplinary team
NH	Nursing home
OT	Occupational therapist
POC	Package of Care
RH	Residential Home
U&E	Urea and electrolytes

Date ________________________ ***Time*** __________________________ ***Signature*** ________________________

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SIGNATURE PAGE
(You must sign and complete this page ONCE if you write in the ICP. This page serves as a medico-legal record of your signature. Please give your extension, bleep/pager No. if applicable).

SIGNATURE	PRINTED NAME	TITLE	INITIALS	BLEEP/ EXT No.

Date _______________________ ***Time*** _________________________ ***Signature*** _______________________

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Patient Label

On Admission – Emergency Department (ED) to Complete *(This does NOT replace the ED-card)*			
Nurse	**Signature**	**Doctor/Nurse** *(tick box)*	**Signature** * Must be signed

Residual volume	ml
MSU Result	
Protein	
Blood	
Leucocytes	
Nitrites	
Glucose	
CSU Sent	Y / N
Pressure Score	
Special mattress requested	Y / N

18G cannula inserted	

Investigations:

Hip X-ray		Chest X-ray	
G&S		Clotting	
FBC		U&Es	
Liver Function tests		Bone profile	
ECG			
Analgesia			
IV fluids to run over 6 hours			

MRSA Screened	Y / N
Date:	

ED Assessment – please comment and sign on investigations: **Name of ED Registrar Assessing Suitability for Direct Admission to Ward**	
Chest x-ray -	*
Hip x-ray –	*
ECG –	*
Urine –	*
Repeat observations – HR BP RR Sats	
GCS BM Temp	
Trigger score (if >2 not for fast-track admission to ward)	*
Fit for transfer to Ward to be seen by orthopaedic F1 Yes / No	*
If not fit for transfer please document reason:	
Orthopaedic Reg (day) / SHO (Out of Hours) informed – Time: Name of Doctor:	*
F1 informed of admission (day-time) - Time: Name of Doctor:	*
Time bed requested:	
Time transferred to ward	
List reasons for delay below	
If bed not available within 40 minutes Orthopaedic team must see patient in ED	
(Please document times of bleeping orthopaedic team)	

Date ________________________ ***Time*** __________________________ ***Signature*** ________________________

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ICP

NOF Flow Chart for Pain

Injury/fall

↓ Ambulance → titrate morphine according to pain and side effects.e.g. 10 mgs morphine in 10 mls. Saline

Give 2mgs IV at 4 min intervals

1mg if BP less than 100mmHg, weight less than 50mgs or over 75 yrs old

A&E/Ward (If pain score 2 and not for theatre within 12hours)

↓

Insert Fascia Iliaca (FIB) 0.25% chirocaine (0.5 ml/ kg to max of 30mls). → If block not possible titrate morphine as above. Plus IV paracetamol

Transfer to theatre → RA (e.g. top up block if in situ./ Psoas 3 in 1 block) +/- GA

↓

Or

Transfer to ward → pre-op use block for pain relief or

↓

Ward

Post -op give regular paracetamol oral /IV - if pain score 1

\+ MST 10 – 20 mgs BD if pain score 2

\+ Oramorphine 20 mgs 3hrly for breakthrough pain if pain score 3

(10 mgs if under 50 kgs or over 75 yrs. old)

Record regular pain scores with observations on back of Trust observation chart

Analgesia can be titrated up as well as down using standard observations including pain scores

Pain Scores recorded on movement

0 No pain

1 Mild pain

2 Moderate pain

3 Severe pain

↓

Discharge Regular paracetamol plus pre injury medication.

Pain Team

Nurses are available for general advice Mon to Fri 9-5 via bleep

Out of hours own medical team.

Problems - contact pain nurses – who can advise

Or direct to appropriate support.

Teaching can be arranged re pain scoring/ medication by pain team nurses

EA/DC/CL/FI June

General principles

1. Use LA where possible
2 Avoid NSAIDS or use one dose only – seek advice
3 Regular oral analgesia plus rescue top up to be prescribed.
4.If opioids prescribed give regular laxatives – see Laxative policy
5.If opioids prescribed give anti-emetics
6.Expect to use higher doses of opioids if on codeine compounds pre op
7 Reduce frequency of opioids not dose if renal/ hepatic impairment.

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

Patient Label

CLERKING

Doctors Name:……………………………………………..………Grade………………

Inform the following:

	Date and Time of notification
Orthopaedic SpR (bleep 2300)	
Anaesthetist (bleep 5100)	
Theatres co-ordinator (bleep 5611)	
Clinical Site Manager (bleep 5705)	

History of presenting complaint:

Additional diagnosis/problems

Walking ability pre fracture (please tick)		
Walking ability indoors	Regularly walked without aids	
	Regularly walked with one aid	
	Regularly walked with 2 aids of ZF	
	Wheelchair or bedbound	
Walking ability outdoors	Regularly walked without aids	
	Regularly walked with one aid	
	Regularly walked with 2 aids of ZF	
	Wheelchair	

Number of falls in past six months?	
Is patient known to UHL Falls Clinic?	Y / N

(Tick relevant box and indicate **when** in the adjoining box)

Syncope	Yes	No	
Previous Fracture	Yes	No	
Dizziness	Yes	No	

Other?……………………………………………………………………………………

……………………………………………………………………………………………

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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Past medical history

Tick relevant box and indicate **when** in the adjoining box)

COPD	Yes	No			Diabetes Mellatus	Yes	No	
Asthma	Yes	No			Hypertension	Yes	No	
MI	Yes	No			Dementia	Yes	No	
Ischemic Heart Disease	Yes	No			Cerebral Vascular Disease	Yes	No	
CCF	Yes	No			Parkinsons Disease	Yes	No	

Other?……………………………………………………………………………………

…………………………………………………………………………………………………

Medications: *(including over the counter medications, herbal and alternative remedies)*
Include dose and frequency.

Allergies and drug reactions:

Alcohol / **smoking history:**

Medicines Checklist

Analgesia prescribed according to protocol
Thromboprophylaxis prescribed:

- Enoxaparin 40mg s/c at 18.00 hours for 28 days **OR**
- Heparin 5000 units s/c BD at 18.00 hours for 28 days if Cr/Cl <30mls/min or Cr >200µmol/L
  Dose omitted at LEAST 12 hours before surgery

Teicoplanin 400mg IV stat dose prescribed with instructions ‘For induction in theatres’

OMIT the following medicines pre-operatively, where applicable:

Warfarin till INR less than 1.5
Withold antiplatelets (aspirin, clopidrogrel, dipyridamole)
Angiotension converting enzyme (ACE) inhibitors e.g. ramipril
Angiotension II receptor antagonists (AIIRA) e.g. candersartan
Omit oral hypoglycaemics e.g. metformin, sulphonylureas, according to guidance in ‘Guys, St Thomas’ and Lewisham Hospital formulary: Peri-operative Management of Diabetes Mellitus’. Prescribe sliding scale insulin

CONTINUE all beta blockers e.g. atenolol, bisoprolol pre-operatively
CONTINUE all other medicines pre-operatively unless instructed otherwise. Seek advise from pharmacist.

Whilst ‘Nil by Mouth’ medicines may be taken with a small amount of water (approximately 20mls) of water

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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Patient Label

Pharmacist:

Date	Medication	Started	Dose changed	Discontinued	Withheld	Restart date	Reason	Patient/relative informed (Initials/ Date)

Drug History verified: Initials:______________ Date:__________________

Patients own drugs: Yes/ No
Checked by pharmacist: Yes/ No
Patients own supply at home: Yes/ No

Medication dosing system? Yes/ No

Name of community pharmacist: Tel No:_________________

Fax No: ________________

Is the patient/relatives able to obtain a continued supply of medicines after discharge, during period of immobility? Yes/No

Can the community pharmacist deliver? Yes/ No

Does the care package need to include collection of medicines by carers? Yes/No

Number of days notice required in advance to prepare dosette box: [ ]

Signature:______________________ Date:_________________

Date ________________________ ***Time*** __________________________ ***Signature*** ________________________

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ICP

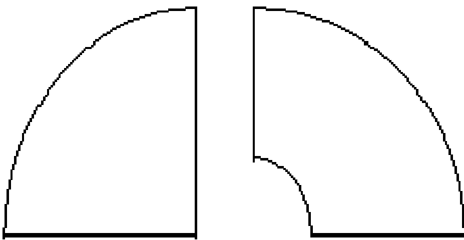
Examination findings

General appearance: (e.g. cyanosis, anaema, jaundice)

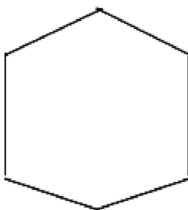
Observations:

CVS:

Resp system:



GIT:



CNS/PNS:

Musculoskeletal:
(Examination of joints)

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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Patient Label

Urinary:

Indwelling catheter long term?	Y / N
Urinary incontinent?	Y / N

Breasts:

Visual acuity: R eye ☐/6 L eye ☐/6

Hearing:

Mental test score:

Age	1	
DOB	1	
Time (nearest hour)	1	
Address to recall	1	
Year	1	
Name of hospital	1	
Two people	1	
Year WW1 began	1	
Monarch	1	
Count back from 20	1	
SCORE		/10

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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Osteoporosis Risk Assessment Tool			
Information leaflet on Osteoporosis given?	Y / N	Presence of medical condition associated with increase bone mass, e.g.	
If 65 – 75 DEXA?	Y / N	Inflammatory bowel disease	Y / N
Age > 75years	Y / N	Cushings	Y / N
Parental history of hip#	Y / N	DM (Type I)	Y / N
BMI <22	Y / N	Thyroid Disease	Y / N
Alcohol >= 4 units /day	Y / N	Coeliac disease	Y / N
Premature Menopause	Y / N	Rheumatoid Arthritis	Y / N
		Ankylosing Spondylitis	Y / N
Previous DEXA	Y / N	Anorexia	Y / N
Previous Fractures	Y / N	COPD	Y / N
		Prolonged Immobility	Y / N
Treatment:			
Calcium and vitamin D	Y / N		
Biophosphorate	Y / N		
Osteoporosis treatment continued from pre-admission	Y / N		
Other drugs i.e.			
Strontium	Y / N		
Raboxifene	Y / N		

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

Patient Label

Summary:		
Fall due to:		
Impressions:	Tick	Give details
Mechanical		
Syncope/Cardiological		
Neurological		
Other		

Problem List:	
1.	4.
2.	5.
3.	6.

Plan:	

Information given to patient and other relevant information

Written information given ❑ Information discussed with patient ❑

(*Patients understanding of condition and any anxieties/ concerns discussed)*

Date…………………..…Time……………………..Doctor Signature:…………………..……………………

Property Disclaimer

I understand that the Lewisham Hospital NHS Trust does not accept responsibility for the loss of or damage to any personal property unless it is locked in an official hospital safe. Any property or money which is not locked up is not the responsibility of the Trust regardless of how any loss or damage may occur.

Patient name: …………………………………… Patient signature: ……………………………….

Nurses/Witness signature: …………………………… Date: ………………………………………..

Date _______________________ ***Time*** _________________________ ***Signature*** _______________________

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Anaesthetic Plan for ASA III and IV for Fractured neck of femur

Please note the anaesthetic consensus on the following particular issues:

- *Clopidogrel should not be a reason for delaying surgery. It is left to the individual anaesthetist to decide on the method of anaesthesia.*
- *Low Na+ levels do not preclude surgery. However Dextrose/Saline as maintenance fluid should be avoided.*
- *Low K+ should not delay surgery. IV replacement should be prescribed in the maintenance fluid.*
- *Echocardiogram: the indication is left to the individual anaesthetist as long as the operation is **NOT delayed***
- Elderly >80 or medically unwell patients require 2 units cross match.

Date:

Anaesthetist:
Grade:
Contact no/bleep:

Date/ time of next available slot on trauma list:

Problems:

Investigation required	Requested	Result expected at

Date ______________________ *Time* ________________________ *Signature* ______________________

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Patient Label

Plan:

Anaesthetic technique

Post op overnight HDU bed needed?	Yes	No
Necessary and bed booked	Yes	No
Not necessary ward aware of monitoring needed	Yes	No

Plan discussed with either the consultant on call or the anaesthetist in charge of the list?
Yes No

Date/time of operation:

Anaesthetist aware:	Yes	No
Surgeon aware:	Yes	No

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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Day of Procedure					
		Y	N	N/A	Signature
Date	**Time**				
Seen by operating surgeon					
Operation explained					
Seen by anesthetist					
Pre-operative assessment by physiotherapist					
Consent obtained					
Blood results available where appropriate					
Investigations performed if needed					
All TTO's and / or medication prescribed					
Baseline observations performed + recorded					
Pre-operative Checklist					
Identity band correct					
Notes / Drug Chart / X-Rays / Scans					
Dentures removed					
Make up / nail vanish / hair grips / jewellery / piercings removed					
Nil by mouth since: ______________________________					
Additional Information:					

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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Patient Label

Operation Notes

Date		Patient Details (Affix patient label where available)
Start Time	Finish Time	
Surgeon(s)		Anaesthetist(s)

Theatre Personnel

Scrub: **Circulating:** **Anaesthetic:**

Operation Performed

Type of fracture (tick box)					
LEFT □ or RIGHT □					
Intracapsular - displaced		Intertrochanteric		Basal/basicervical	
Intracapsular - undisplaced		Subtrochanteric			

Details of operation performed

Date ________________________ *Time* __________________________ *Signature* ________________________

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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**

☐ **Non weight bearing**

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

Yes ☐ **No** ☐

Notes:

Date ______________________ *Time* ________________________ *Signature* ______________________

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Patient Label

Intra-operative Care Plan					
Position					
	Heel supports	Arms Protected	Flowtron Boots	Other	
Diathermy		Monopolar		Bipolar	
Site					
Tourniquet	Total Time……………………………		Pressure………………………………		
Skin Preparation	Povidine □ Yes □ No	Chlorhexadine & Cetrimide □ Yes □ No	Chlorhexadine Gluconate 70% □ Yes □ No		
Skin Closure	State type……………………………………………………………...			**Absorbable** □ Yes □ No	
Dressing	State Type ……………………………………………………………..			**Change Date** …………………	
Specimen	□ Yes □ No	Histology number……………………………………………………... Microbiology number……………………………………………………. Cytology number…………………………………………………………			
Drains	□ Yes □ No	Type …………………..	Size ………………	Batch ………………...	Vacuum □ Yes □ No
Urinary Catheter	□ Yes □ No	Type …………………..	Size ………………	Batch ………………...	Balloon size ………… ….

Date ________________________ ***Time*** __________________________ ***Signature*** ________________________

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Additional Information

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Patient Label

Recovery Care Record				
Recovery Staff				
Patient received at:				
Airway Support	ET Tube	BLM	Guedal	None
Time removed:				
Oxygen therapy	□ Yes □ No	Litres/min		
IV Fluids Administered □ Yes □ No				
Analgesia Administer □ Yes □ No				
Anti-emetic Administered □ Yes □ No				
Additional Comments				

Transfer to Ward				
Pain	Severe	Moderate	Mild	No pain
Nausea	Vomiting	Severe	Moderate	None
Conscious level	Unconscious / difficult to wake	Mostly sleeping	Dozing	Awake
Additional Comments				
Name…………………………………………………………...			**Designation**………………………	
Signature………………………………………………………			**Transfer time**…………………….	

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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<table>
<tr><th>Post-op Day One:
Nurse / Doctor (F1)</th><th>M</th><th>E</th><th>N</th><th>Nurse</th><th>M</th><th>E</th><th>N</th></tr>
<tr><td rowspan="3">Accurate fluid balance recorded.
Urinary catheter removed with gentamicin cover.
No indications of dislocation.
Limb colour, sensation and warmth satisfactory.
Drain removed if drainage is <50ml/24 hrs.
No evidence of DVT/PE.

Other medical conditions stable.</td><td rowspan="3"></td><td rowspan="3"></td><td rowspan="3"></td><td>Cannula sites patent and clean.
Wound dressing dry & intact.
Personnel………………………
Equipment………………………
Manual handling carried out as Planned.</td><td></td><td></td><td></td></tr>
<tr><td>Physiotherapy</td><td colspan="3">Initial & time</td></tr>
<tr><td>Mobilisation commenced
<table><tr><td>1st day post-op exercises Taught</td><td>Y / N</td></tr><tr><td>Mobilisation commenced</td><td>Y / N</td></tr></table></td><td colspan="3"></td></tr>
</table>

Day 1 post op	Y/N	Done by (Name)	Signature	Date and Time
Removal of catheter				
Drain removed if <50ml/24h				
On regular medications except warfarin				
Check U&Es				
On Clexane or Heparin				
Any signs of pneumonia				
Sat out of bed				
Seen by physiotherapist				
Referred to OT				
Referred to social services				
EDD				
Check x-ray seen by Reg.				

Daily review	Y/N	Performed by (Surname)	Signature	Date and Time
Any evidence of DVT/PE: do Doppler/VQ/CTPA				
Any evidence of pneumonia				
Check wound				
Check limb colour/warmth/sensation				
Check Hb, U&Es daily for 1st 3 days				
Is patient eating and drinking?				

Notes / Variances	Signature & Time
Use Redivac drainage fluid chart	
Is patient candidate for accelerated rehab?	

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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Patient Label

Date ________________________ ***Time*** __________________________ ***Signature*** ________________________

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Post-operative Physiotherapy Assessment – First visit	**Date: ______________**
Assessment	**Details**
Operation – type and date:	
Surgical approach:	
Findings:	
Post –op instructions/Weight Baring status:	
Check X-ray required prior to mobilisation?	
Subjective:	
Hand over from nursing staff	
Consent	
Patients mental state	
Vision	
Hearing	
Cognition	
Pain score (0-10)	
Cough/ sputum	

Objective:			
Observations:		Time taken:	
BP:	TPR:	SaO_2:	FiO_2:
Patient position:		Catheter:	Drains:
TEDS:		Abduction wedge in situ?	

Chest auscultation	
Breath sounds	
Added sounds	
Chest expansion	
Ability to do exercises/ huff/cough	

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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Patient Label

Post-Operative Physiotherapy Assessment – First visit		
Objective Assessment:		
Observation: Leg length, swelling, bruising		
Upper limbs		
Neuro Sensation		
Active range of movement		
Hip flexion	Left:	Right:
Hip abduction	Left:	Right:
Knee flexion	Left:	Right:
Knee extension	Left:	Right:
Ankle dorsi-flexion	Left:	Right:
Ankle plantar-flexion	Left:	Right:
Passive range of movement		
Hip flexion	Left:	Right:
Hip abduction	Left:	Right:
Knee flexion	Left:	Right:
Knee extension	Left:	Right:
Ankle dorsi-flexion	Left:	Right:
Ankle plantar-flexion	Left:	Right:
Muscle power		
Static Gluts	Left:	Right:
Static Quads	Left:	Right:
Transfers		
Lie to Sit		
Sit to Stand		
Gait		
Treatment:		

Date ________________________ ***Time*** __________________________ ***Signature*** ________________________

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Physiotherapy *(Date & sign ONLY when indicated)*		
Date	**PROBLEMS**	**Signature**
	1.At risk of post-op complications due to immobility a) Respiratory b) Circulatory c) Unaffected limbs	
	2. Increased pain in operative hip	
	3. Increased swelling in operative hip	
	4. Decreased range of movement in operative hip	
	5. Decreased power in operative hip	
	6. Decreased mobility and transfer ability	
Date	PLAN	Signature
	1.a. Assess chest post-operatively and instruct on breathing exercises. b. Teach circulatory exercises. c. Encourage normal use of unaffected limbs.	
	2 Liaise with MDT re appropriate analgesia and treat post analgesia when possible.	
	3. a. Elevation b. Ice therapy	
	4.a. Passive hip flexion / abduction. b. Active assisted hip flexion/abduction. c. Active hip flexion/abduction. d. Hip flexion/abduction/extension in standing.	
	5. a. SQ b. SG c. IRQ d. Bridging	
	6. a. Lying ↔ sitting b. Sitting↔standing c. Mobilisation commenced with zf/ rf d. Mobilisation commenced with ec/sticks e. Stair assessment	

Date: Time:

Physiotherapist signature:

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Patient Label

Date	Goals	Goal Time	Date achieved	Signature
	1.a. Able to maintain chest function and clear any secretions independently. b. Complete circulatory exercises independently c. Able to maintain normal movement of unaffected limbs			
	2. Maintain good pain relief during treatment			
	3. Minimise operated limb swelling			
	4 & 5. a. Attain hip extension to 10° Attain hip abduction to 30° Attain hip flexion to 90° b Patient performing HEP independently by discharge.			
	6. a. Independent with transfers and mobility. Safe with an appropriate walking aid.			

Social History		
Accommodation:	House / Flat / Residential Home / Nursing Home / Sheltered Accommodation	
Steps / Stairs to access property:	Yes / No	How many
Rails:	Yes / No	Left / Right side ascending
Internal steps / stairs:	Yes / No	How many
Rails:	Yes / No	Left / Right side ascending
Mobility: Independent / Walking frame / Walking stick(s) / Wheelchair / Elbow crutches / Bed bound		
Outdoor Mobility:	Independent / with walking aid / wheelchair	

Date: Time:

Physiotherapist signature:

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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Day 2 post op	Y/N	Done by (Name)	Signature	Date and Time
If not E&D refer to dietician, and continue IV fluids				
Is patient mobilising				
OT Intervention started				
Has patient been seen by social worker				
Has EDD been set				
Has MDT decision been acted on, i.e. referral to LINC/bed based ICT/banding form for RH/NH				

Daily review	Y/N	Performed by (Surname)	Signature	Date and Time
Any evidence of DVT/PE: do Doppler/VQ/CTPA				
Any evidence of pneumonia				
Check wound				
Check limb colour/warmth/sensation				
Check Hb, U&Es daily for 1st 3 days				
Is patient eating and drinking?				

Notes / Variances	Signature & Time

Date ____________________ ***Time*** ____________________ ***Signature*** ____________________

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Patient Label

Day 3 post op	Y/N	Done by (Name)	Signature	Date and Time
Is patient mobilising				
Continuing OT assessment				
Has social worker seen patient				

Daily review	Y/N	Performed by (Surname)	Signature	Date and Time
Any evidence of DVT/PE: do Doppler/VQ/CTPA				
Any evidence of pneumonia				
Check wound				
Check limb colour/warmth/sensation				
Check Hb, U&Es daily for 1st 3 days				
Is patient eating and drinking? If not by day 3 consider AXR to r/o ileus.				

Notes / Variances	Signature & Time

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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ICP

Day 4 post op	Y/N	Done by (Name)	Signature	Date and Time
Is patient mobilising				
Has POC been set up for EDD				
Has patient been referred to ICT if needed				
Has OT Access Visit been arranged (if appropriate)				
Has plan for ongoing Clexane been considered?				

Daily review	Y/N	Performed by (Surname)	Signature	Date and Time
Any evidence of DVT/PE: do Doppler/VQ/CTPA				
Any evidence of pneumonia				
Check wound				
Check limb colour/warmth/sensation				
Check Hb, U&Es daily for 1st 3 days				
Is patient eating and drinking?				

Notes / Variances	Signature & Time

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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Patient Label

Day 5 post op	Y/N	Done by (Name	Signature	Date and Time
Has any necessary equipment been put in place for discharge				
Is patient mobilising independently or with aids				
Have TTOs been done				

Daily review	Y/N	Performed by (Surname)	Signature	Date and Time
Any evidence of DVT/PE: do Doppler/VQ/CTPA				
Any evidence of pneumonia				
Check wound				
Check limb colour/warmth/sensation				
Check Hb, U&Es daily for 1st 3 days				
Is patient eating and drinking?				

Notes / Variances	Signature & Time

Date ________________________ ***Time*** __________________________ ***Signature*** ________________________

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Day 6 post op:

If not ready for discharge give reason:

On discharge	Y/N	Done by (Name)	Signature	Date and Time
Has OT intervention been completed				
Has the administration of enoxaparin in the community been organised?				
Patient independently mobile and safe on stairs				
Does patient require follow-up physiotherapy Specify:				
NH/RH informed:				
District nurse organised?				

Daily review	Y/N	Performed by (Surname)	Signature	Date and Time
Any evidence of DVT/PE: do Doppler/VQ/CTPA				
Any evidence of pneumonia				
Check wound				
Check limb colour/warmth/sensation				
Check Hb, U&Es daily for 1st 3 days				
Is patient eating and drinking?				

Notes / Variances	Signature & Time

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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Patient Label

Multidisciplinary Team Meeting

To be completed by any member of the multidisciplinary team
ANY potential social problems MUST be discussed at this meeting

Attended by: ***(give names and titles).***	

To include:
Expected Date of Discharge: ______________________(*guide: 1 week from procedure*)

Key outcomes and actions from meeting:

Name of person completing this form: ________________ Today's Date: ________________

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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Multidisciplinary Team Meeting

To be completed by any member of the multidisciplinary team
ANY potential social problems MUST be discussed at this meeting

Attended by: ***(give names and titles).***	

To include:
Expected Date of Discharge: ______________________ (*guide: 1 week from procedure*)

Key outcomes and actions from meeting:

Name of person completing this form: __________________ Today's Date: _________________

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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ICP

Patient Label

Discharge Checklist (To be completed by any member of the Multidisciplinary team)

Planned Discharge Date: ________________

Service & Action taken	Not required	Date arranged See discharge Summary comments	Print Name	Sign	Profession*
Patient consulted					
Relatives informed					
Transport booked					
TTO's ordered					
Patient medication Brought from home	Please tick	YES	NO		
Outpatients appointment					
Door keys					
Property & valuables					
Clothes					
Restart Social services					
New social services					
District nurse Phone referral					
District nurse Written referral					
Blue Folder With patient	Please tick	YES	NO		
Dressings etc. supplied					
Home manager Informed					
Home manager Written referral					
Walking aid / wheelchair					
Special equipment					
Nursing report sent					
Medical report sent					
S.A.L.T.					
Ongoing Physio Referral					
Dietetics GP letter For supplements					
Home Entral feeding Organised					
Other					

***Codes for profession**
N= Nursing M=Medical OT= Occupational therapist PT=Physiotherapist SALT=Speech therapist D=Dietetics Ph=Pharmacy SW=Social worker WC=Ward clerk LT=Liaison team

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

OT Discharge Summary of ADL				
Date:	**Independent**	**Independent with supervision**	**Independent with Aids/Equipment**	**Dependent**
Washing / Dressing				
Mobility				
Transfers: Bed Armchair Toilet/commode				
Kitchen activities: Hot drink Snack Meal				
Equipment issued:				
Other comments: Date……………………………Signature…………………………………………………				

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Patient Label

BARTHEL ADL FUNCTIONAL ASSESSMENT SCALE

Bowels 0 = Incontinent (or needs to be given enemas) 1 = Occasional accident (once/week) 2 = Continent	**Mobility** 0 = Immobile 1 = Wheel chair independent including corners etc 2 = Walks with help of one person (verbal or physical) 3 = Independent (may use stick etc)
Bladder 0 = Incontinent, or catheterised 1 = Occasional accident (max once per 24 hrs) 2 = Continent (over 7 days)	**Transfer** 0 = Unable - no sitting balance 1 = Major help (one/two people) can sit 2 = Minor help (verbal or physical) 3 = Independent
Grooming 0 = Needs help with personal care 1 = Independent face/hair/teeth/shaving (implements provided)	**Dressing** 0 = Dependent 1 = Needs help, can do half unaided 2 = Independent (including buttons, zips, laces, etc)
Toilet Use 0 = Dependent 1 = Needs some help, can do something alone 2 = Independent (on and off, dressing/wiping)	**Stairs** 0 = Unable 1 = Needs help (verbal/physical) 2 = Independent
Feeding 0 = Unable 1 = Needs help cutting, etc 2 = Independent (food in reach)	**Bathing** 0 = Dependent 1 = Independent

Date ________________________ ***Time*** __________________________ ***Signature*** ________________________

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Date ______________________ **Time** ________________________ **Signature** ______________________

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Patient Label

WATERLOW PRESSURE AREA SCORE/PREVENTION SCORE

Name		Hospital Number	
Ward		Date of Admission	

Please ensure a Waterlow Score is calculated within 6 hours of admission.
The patient's Waterlow Score must be re-calculated weekly or sooner if the patient's condition dictates e.g. Post surgery
Do not ring the numbers on the form as the score may change.

Add scores, several scores per category may be used

Build/Weight for Height	*	Skin Type Visual Risk Areas	*	Sex Age	*	Special Risks	*
Average Above Average Obese Below Average	0 1 2 3	Healthy Tissue Paper Dry Oedematous Clammy (temp) Discoloured Broken spot	0 1 1 1 1 2 3	Male Female 14 - 49 50 - 64 65 - 74 75 - 80 81+	1 2 1 2 3 4 5	**TISSUE MALNUTRITION** e.g. Terminal Cachexia Cardiac Failure Peripheral vascular Anaemia Smoking	* 8 5 5 2 1
CONTINENCE	*	**MOBILITY**		**APPETITE**	*	**NEUROLOGICAL DEFICIT**	*
Complete/ Catheterised Occasionally Incontinent Cath/incont of faeces Doubly incontinent	0 1 2 3	Fully Restless/fidgety Apathetic Restricted Inert/Traction Chairbound	0 1 2 3 4 5	Average Poor N.G. tube/Fluids only NBM/Anorexic	0 1 2 3	e.g. Diabetes M.S. CVA motor senor paraplegia **MAJOR SURGERY/TRAUMA** Orthopaedic - below waist, spinal On table >2 hours **MEDICATION** Steroids Cytotoxics High Dose	4-6 * 5 5 * 4

10+ AT RISK	15+ HIGH RISK	20+ VERY HIGH RISK

Date					
Score					
Signature					
Designation					

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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Date ______________________ Time ________________________ Signature ______________________

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Patient Label

HOSPITAL NUTRITION SCREENING TOOL

Patient ________________________ Admission date ______________________

COMPLETE THIS FORM FOR ALL PATIENTS WITHIN 48 HOURS OF HOSPITAL ADMISSION

Date of assessment					
Has the patient unintentionally lost weight in the last 6 months or since the last assessment?					
NO	**0**	**0**	**0**	**0**	**0**
YES	**2**	**2**	**2**	**2**	**2**
Has the patient unintentionally been eating less in the last 6 months or since the last assessment?					
NO	**0**	**0**	**0**	**0**	**0**
YES	**2**	**2**	**2**	**2**	**2**
NBM/unable to eat for ≥ 5 days	**3**	**3**	**3**	**3**	**3**
TOTAL SCORE					
Usual weight (kg): **Recalled height (m):** / **Actual weight (kg)**					
Is the Body Mass Index (BMI) in the pale blue category (less than 18.5kg/m^2)? Please circle appropriate response.	**YES/ NO**	**YES/ NO**	**YES/ NO**	**YES/ NO**	**YES/ NO**
NURSE'S SIGNATURE					
Date patient referred to dietitian:					

ACTION PLAN

Score 0 – 2 Re-assess patient weekly throughout hospital stay
Score 3 – 5 **or** **BMI in pale blue category (less than 18.5kg/m^2)** **or** **patient on tube feed (NG/PEG/jejunostomy) or parenteral nutritiion** **or** **patient has Grade 3-4 pressure sore**

Discuss with multi-disciplinary team & refer to dietitian within 24 hours

Produced by Guy's & St Thomas NHS Trust

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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Patient Label

University Hospital Lewisham
Pressure Ulcer Prevention Care Plan

Patient Name…………………………………..Hospital No…………………………

Consultant……………………………………...Ward………………………………..

Problem:

………………………………….. is at risk of developing pressure ulcers.

Aim:

To minimise or alleviate the risk factors that cause pressure ulcers. To detect and prevent tissue damage.

Nursing Actions:

- Qualified Nurse to calculate Waterlow score and perform skin assessment within 6 hours of admission. Reassess weekly or more frequently if condition dictates.
- Previous pressure ulceration **yes** / **no**
  If yes, location(s)……………………………………………………………….
- Assess the need for pressure relieving/reducing equipment according to patient choice, equipment flowchart, clinical judgement and risk assessment.

Equipment (Document when equipment is in place)

Mattress Type…………………………………………Date & Time………………

Cushion…………………………………………………Date & Time………………

- Ensure patient comfort is regularly assessed and monitored.
- Repositioning regime (turning chart) required: **yes** / **no**
- Inspect patient's skin when repositioning, or as skin condition dictates, and ensure any changes are documented.
- Avoid prolonged seating, max 2 hours as recommended by NICE (2003).
- NICE (2003) information booklet given to patient/carer: **yes** / **no**
- Plan of care discussed and agreed with patient/carer: **yes** / **no**
- Complete Trust Manual Handling Risk Assessment if patient requires assistance to move. Provide relevant equipment, to ensure that shear and friction are minimised.
- Ensure that Trust Nutritional Screening Tool is completed.
  Referral to Dietitian: **yes** / **no**
- Ensure that the multidisciplinary team is consulted, and aware of, plan of care.
- Ensure appropriate use of incontinence products.
- Promote skin integrity by the regular use of emollients.
- Ensure the maintenance of patient privacy and dignity at all times, respecting individual's spiritual and cultural beliefs.
- Refer patient to appropriate members of the multidisciplinary team as necessary.

Review of Plan:

Care plan must be reviewed on a weekly basis, or more frequently if patient condition changes.

Date Commenced:……………..Name & Signature…………………………………

Date Reviewed…………………Name & Signature…………………………………

Date Reviewed…………………Name & Signature…………………………………

Date Reviewed…………………Name & Signature………………………………….

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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Patient Label

Falls Risk Assessment (Stratify)

Patient Name: ____________________ Date of Birth: ____________

Hospital Number: ____________________ Ward: ____________

	Date:	ADMISSION SCORE	1	2	3	4
1	Is the patient in hospital primarily due to a fall or has he/she fallen since admission? Yes = 1 No = 0					
2	**Do you think that the patient is agitated?** Yes = 1 No = 0					
3	Does the patient have any visual difficulties that are affecting their everyday lifestyle? Yes = 1 No = 0					
4	Does the patient need to visit the toilet more than every four hours? Yes = 1 No = 0					
5	Is the patient: a) Able to mobilise independently and safely with or without a walking aid? Yes = 0 b) Able to mobilise independently with some assistance but is nevertheless unsteady? Yes = 1 c) Unable to walk / stand without a lot of help or prompting? Yes = 0					
	Total Score:					
	If the total score is 2 or more or if the patient falls then the patient is at higher risk of falling and an appropriate falls prevention action plan will be required in the long term care setting. PRACTITIONER NAME: DESIGNATION: SIGNATURE: DATE:					

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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Date ________________________ ***Time*** __________________________ ***Signature*** ________________________

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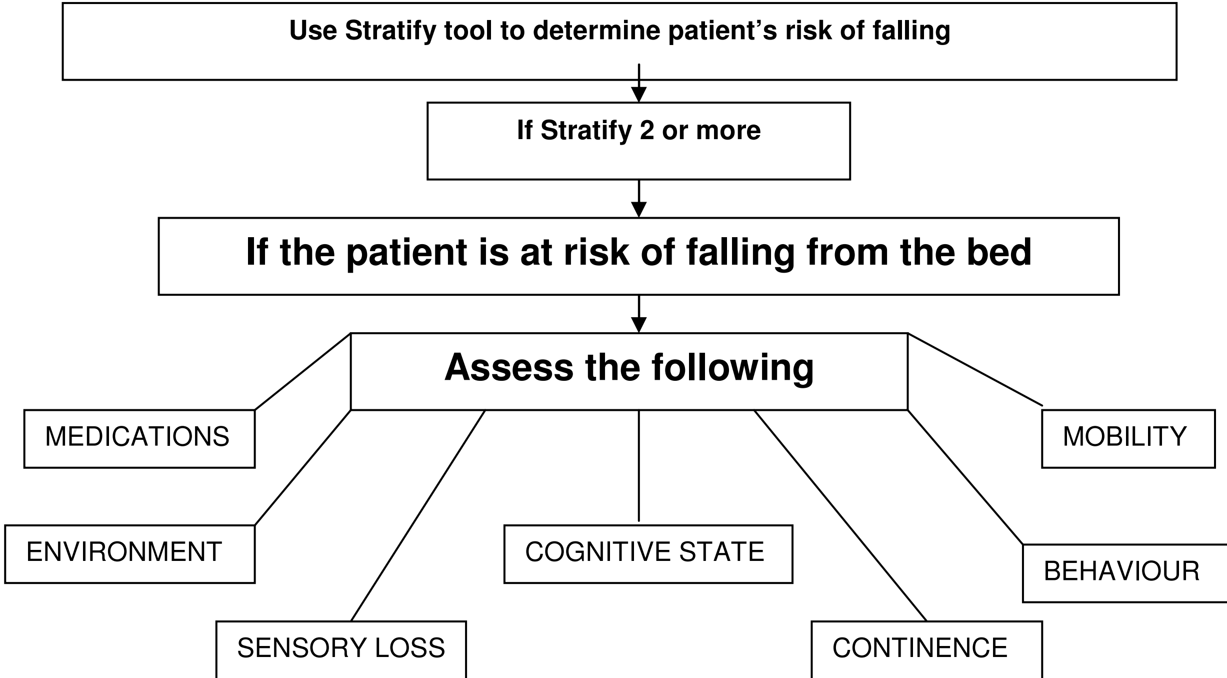
Patient Label

Bedrails Assessment
(see next page for guidance on areas to be assessed)



Is the use of Bedrails indicated? **Yes / No**

If yes, why? ____________________

If no, why not? ____________________

Discussed with MDT? **Yes / No** **Date:**____________

(Ward doctor, physio, OT, consultant)____________

Discussed with patient / relatives? **Yes / No**

Signature of trained nurse ____________

Print name ____________

Review Date	Signature	Discussed with patient / family	Please record any falls whilst the patient is on the ward	
			Date of fall	Signature of nurse

Date ____________ ***Time*** ____________ ***Signature*** ____________

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Medications: Do any of the patient's medications have side effects such as dizziness, confusion, postural hypertension?

Environment: If they are at risk of falling from the bed, is the patient nursed on the ward where they can be easily observed from the nurses station? Is their locker / bedside table within easy reach?

Sensory loss: Does the patient have any visual disturbances or wear glasses? Are they hard of hearing? Does the patient have any difficulties with touch sensation and awareness of immediate surroundings?

Cognitive state: What is the patient's mental test score? Is the patient alert and orientated? If the patient is confused is it acute or chronic?

Continence: What are the patient's toileting needs? Has a continence assessment been done?

Behaviour: Is the patient restless or agitated?

Mobility: Is the patient independently mobile or do they need assistance with transferring? Do they use a walking aid?

Date _____________________ ***Time*** _______________________ ***Signature*** _____________________

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Patient Label

Name:	Main ID:	Completed by:

Background information & Contact assessment

Confidential

Basic personal details						
Family name:				Given name(s):		
Prefers to be known as:						Title:
NHS No *(enter n/k if not known)*:				Social care ID*(enter n/k if not known)*:		
Local health system ID *(state system)*:				Local Social Services system ID*(state system)*:		
Gender *(tick)*	Female		Male		Date of birth	
Present address/location: Post code: Tel number(s):				Permanent address (if different): Post code: Tel number(s):		
Marital status:				Resident of:		
Preferred language				Interpreter required?	Yes		No

	White		Mixed		Asian or Asian British	
Ethnicity	White British		White and Black Caribbean		Indian	
	White Irish		White and Black African		Pakistani	
	Any other white background		White and Asian		Bangladeshi	
	Black or Black British		Any other mixed		Any other Asian	
	Caribbean		Other groups		Not stated	
	African		Chinese		*Details of 'other' selections (enter category/code):*	
	Any other Black background		Any other group *(specify)*			
Religion	None		Buddhist		Jewish	
	Christian		Hindu		Muslim	
	Sikh		Any other religion		*Details:*	

Current/previous occupation	

Primary client category						
	Physical disability, frailty or sensory impairment		Physical disability/frailty		Hearing impairment	
			Visual impairment		Dual sensory loss	
	Mental health		Dementia		Learning disability	
	Substance misuse		Other vulnerable person		*Details:*	

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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Date ________________________ Time __________________________ Signature ________________________

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Patient Label

Home details								
Type of permanent accommodation	House		Flat/bedsit		Bed and breakfast		Supported housing	
	Bungalow		Nursing care		Residential care		Other (specify)	
Tenure of permanent accommodation	Council		Home owner		Private rented		With family	
	Housing association				Other *(specify)*		*Details:*	

Does the home have a working smoke alarm?	Don't Know		Yes		No	

Household details *(who lives with person)*	Number of people in household	

Does the person live alone? *(if no complete household details below)*	Yes		No	
Details of household:				
Does the person have any caring roles? *(detail below, including primary carer)*	Yes		No	
Is the person being cared for? *(detail below, including primary carer)*	Yes		No	
Does the household contain a dependent child? *(detail below, including primary carer)*	Yes		No	
Does the household contain a person over 18 being cared for? *(detail, inc. primary carer)*	Yes		No	
Does the household contain any pets? *(detail below, including primary carer)*	Yes		No	

Visit information *(access, when available, dog etc)*	Safety issues when visiting?	Yes		No	
Key safe available?		Yes		No	

Key holder name *(if any)*		Tel No	

Risk				
Known risk(s) to self? *(e.g. falls, self-harm, if yes describe below)*	Yes		No	
Known risk(s) to others? *(e.g. aggression, if yes describe below)*	Yes		No	

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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Patient Label

Current care				
Services currently being received *(If Yes detail below, provide contact details over)*	Yes		No	
Referral details				
Reason for referral				
Source of referral *(specify)*:				

Type									
Type	Self-referral		Primary health		Secondary health		Family/friend/ neighbour		LA Housing Dept/ Housing Association	
Type	Internal		Other departments of own or other LA				Legal agency		Other	

Recent medical history/admission relevant to referral *(if yes detail below)*	Yes		No	

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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Date ________________________ ***Time*** __________________________ ***Signature*** ________________________

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Patient Label

Key contacts	
Person most close to person *(e.g. carer/next of kin)*	**Emergency contact** *(if different)*
Family name:	Family name:
Forenames:	Forenames:
Preferred name:	Preferred name:
Relationship to person:	Relationship to person:
Address:	Address:
Post-code:	Post-code:
Phone number(s):	Phone number(s):
E-mail:	E-mail:
Availability:	Availability:
Referrer's details	**GP**
Name:	Name:
Role:	Practice:
Organisation:	Address:
Address:	
Post-code:	Post-code:
Phone number(s):	Phone number(s):
Fax number:	Fax number:
E-mail:	E-mail:
Care co-ordinator	**Hospital consultant**
Name:	Name:
Role:	Ward/specialty:
Organisation:	Organisation:
Phone number(s):	Phone number(s):
Fax number:	Fax number:
E-mail:	E-mail:

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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Patient Label

Other professional/person involved	Other professional/person involved
Name:	Name:
Role:	Role:
Organisation:	Organisation:
Address:	Address:
Post-code:	Post-code:
Phone number(s):	Phone number(s):
Fax number:	Fax number:
E-mail:	E-mail:

Name:	Main ID:	Completed by:

Contact assessment				
Presenting problem, difficulty or concern *(person's own words/views)*				
Communication issues *(including sensory loss, indicate need for Communication assessment)*	Yes		No	
Perceived impact on person's life				
Relevant recent life events or changes in the person's life?	Yes		No	
What does the person think might help? *(inc. preferred outcome of contact)*				
Family member(s) or carer's perception of problem, difficulty or concern				

Date ______________________ ***Time*** ________________________ ***Signature*** ______________________

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Patient Label

Other needs/difficulties experienced by the person						
Further actions	None		Provide information		Overview assessment	
	Other assessment		Referral		Intervention	
	Liaise with		Tests/investigations		Other action	

Details:

Copies of other documents attached? *(e.g. medical/social work/financial/reimbursement)*	Yes		No	

Was consent given for information to be shared as needed? (*detail requested limitations below)*	Yes		Yes, with limitations		No	

Signature of person:	**Date**
Assessment completed by:	**Job title**
Signature:	**Date**

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Patient Label

Pre-operative marking verification checklist

Check	Responsibility	Signature to confirm check completed
Check 1 • Check the patient's identity • Check reliable documentation and/or images to ascertain intended surgical site • Mark the intended site with an arrow using an indelible pen	The operating surgeon, or nominated deputy who will be present in the theatre at the time of the patient's procedure	**Signed** **Print Name**
Check 2 • Prior to leaving ward/day care area the mark is inspected and confirmed against the patient's supporting documents • Relevant imaging studies accompany patient or are available in operating theatre or suite	Ward or day care nursing staff	**Signed** **Print Name**
Check 3 • In the anaesthetic room and prior to anaesthesia, the mark is inspected and checked against the patient's supporting documentation • Re-check imaging studies accompany patient or are available in operating theatre or suite • The availability of the correct implant (if applicable)	Operating surgeon or a senior member of the team	**Signed** **Print Name**
Check 4 The surgical, anaesthetic and theatre ream involved in the intended operative procedure prior to commencement of surgery should pause for verbal briefing to confirm • Presence of correct patient • Marking of the correct site • Procedure to be performed	Theatre staff directly involved in the intended operative procedure	**Signed** **Print Name**

Extracted from:

Surgical Booklet / Draft 7 / KH / July 2007

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