Name:.....

NHS No: | | | | | | | | | | |

Hosp No: | | | | | | | | | | |

D.O.B:..... Male Female

Consultant:..... Ward:.....

Worcestershire NHS
Acute Hospitals NHS Trust

FRACTURED NECK OF FEMUR CARE PATHWAY

Inclusion Criteria
The patient commences the pathway once suspected of a Fractured Neck of Femur.

Exclusion Criteria
This care pathway is NOT suitable for patients undergoing a scheduled procedure, admitted with another emergency condition.

This Care Pathway replaces all previous clinical documentation for both nursing, allied health professionals and medical staff involved in the patients care.

Professional Referral *(to be completed below by staff commencing pathway in ED/Ward)*			
	Name of Professional accepting referral	**Time**	**Bleep Number**
Orthopaedic SHO/Registrar			
Orthogeriatrician			
Medical SHO/Registrar			
Trauma Co-ordinator/Practitioner			
Other (please specify)			
To be completed below on admission to ward			
Date of Admission	**Admission Ward**	**Consultant**	
Expected date of Discharge:	**Discharge Date:**		

Other documentation in use for this patients care:

1. **Emergency Department Assessment documentation**
2. **Patients Hospital Notes**
3.

TO BE FILED IN INPATIENT SECTION OF PATIENT CASE NOTES

INDEX

HANDOVER SHEET EMERGENCY DEPARTMENT TO WARD

Patient Name:..... Hosp No: | | | | | | | | | | |

INVESTIGATION	COMPLETED *(Insert tick below)*		Initials
	YES	**NO** (reason for not completed)	
1. Is the patient suitable to **FAST TRACK** to ward?			
2. Is there a bed on Trauma Ward?			
3. Accepted by TO SHO (**or added to overnight list in ED @ WRH)**			
4. Referral to TO Practitioner **(WRH, Mon-Fri 8-4)** or ward			
5. No new medical problems/ other injury			
6. Baseline observations (BP. pulse, 02 sats. temp, BM if required)			
7. Analgesia prescribed and given, documented			
8. ECG completed and reviewed **(In ED or on ward in some instances)**			
9. X-Ray pelvis, lateral Hip **(CXR, other x-rays if clinically indicated)**			
10. Bloods completed • FBC • U&Es • X-match • INR if required • any other bloods required please specify:			
11. IV access / IV fluids commenced			
12. Waterlow score documented • If score above 25 - has ward been • notified for special mattress? (should not delay transfer to ward)			
13. Patient undressed and in a gown			
14. Any lacerations/wounds covered?			
15. Relatives/carers informed of diagnosis, treatment and admission and transfer to ward			
16. **Was there a delay in fast tracking process?** (if so, document reason/) • Emergency Department workload • No available trolley in ED for patient • No bed available • X-ray delayed • TO SHO not accepting patient • Other reasons:	**Comments:**		
Signature of Clinician completing checklist for handover to ward staff:			
Date:	Time:		

GUIDELINES FOR THE COMPLETION OF CARE PATHWAY

1. This is a multidisciplinary document and MUST be completed by all healthcare professionals as the patients care record, therefore documenting all clinical care.
2. Please complete the signature box on page 5 of this pathway. This will aid the identification of persons using the pathway, Initials can then be used.
3. Please place a CODE if indicated or Y-YES, N-NO, N/A, then INITIALS next to the activities that have been address on your shift.
4. **All relevant sections MUST be completed by all members of MDT and initialled.**
5. If there is nothing additional to report then it is acceptable to record 'care delivered, nothing new to report' on MDT sheet.
6. **If an episode of care outlined in the care pathway has not,** for whatever reason been completed, care has changed or patients clinical condition has changed, then this **MUST** be shown as a variance in care.
7. **You must state the variance in care on the MDT sheet at the bottom of each day.**
   - **Document, in what way the patients care will vary**
   - **Give explanation for the variation**
   - **Describe what action you took as a result of the variance in care**
   - **You must sign, date and time all variances/exceptions identified.**
8. All documentation **MUST** be accurate and comprehensive as per Trust policy.
9. You should ensure the patient's name and hospital number are on the top of every sheet.
10. If you have any queries about using the care pathway, contact your Care Pathway Lead Implementers on the Trauma Orthopaedic Ward.
11. **If in your clinical judgement the pathway is not the most appropriate care for the patient, it may be suspended and recorded as to the reason for suspension at any time and other documentation implemented.**

Abbreviations

ABG	Arterial Blood Gases	IVI	Intravenous Infusion
AP	Anterioposterior	IV	Intravenous
AO	Arbeitsgemeinschaft fur osteosunthesesfragen	INR	International Ratio
AM	Austin Moore Hemiarthroplasty	JRI	JRI Hemiarthroplasty
BMI	Body Mass Index	JVP	Jugular Venous Pressure
BP	Blood Pressure	LAT	Lateral
C&S	Culture and Sensitivity	LMP	Last Monthly Period
CCT	Community Care Team	LFT	Liver Function Test
CNS	Central Nervous System	MSU	Mid Stream Specimen of Urine
CRP	C-reactive protein	MRSA	Methicillin Resistant Staphylococcus Aureus
CSU	Catheter Specimen Urine	NBM	Nil by Mouth
DHS	Dynamic Hip Screw	NIDDM	Non Insulin Dependent Diabetes Mellitus
DVT	Deep Vein Thrombosis	NKDA	No Known Drug Allergies
ECG	Electrocardiogram	NOF	Neck of Femur
ESR	Erythrocyte Sedimentation Rate	NSAID	Non Steroidal Anti-inflammatory Drugs
Fx/#	Fracture	O2 Sats	Oxygen Saturation
FBC	Full Blood Count	OT	Occupational Therapist
GCS	Glasgow Coma Score	PE	Pulmonary Embolism
GI	Gastro Intestinal	Physio	Physiotherapy
GP	General Practitioner	PMH	Past Medical History
G&S	Group & Save	POP	Plaster of Paris
Hemi	Hemiarthroplasty	PSA	Prostate Specific Antigen
HR	Heart Rate	PVD	Peripheral Vascular Device
HS	Heart Sounds	RS	Respiratory System
IC	Intermediate Care	TFT	Thyroid Function Test
IMHS	Inter Medullary Hip Screw	TTO's	Tablets to Take Out
IDDM	Insulin Dependent Diabetes Mellitus		

Patient Name:..... Hosp No: | | | | | | | | | | |

NAMES AND SIGNATURE OF STAFF COMPLETING THIS DOCUMENT

All members of staff who are using this care pathway should complete this section. Initials can be used when recording care.

	PRINT NAME	Designation /ID Number	Bleep No/ Ext No	Signature	Initials
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

TRAUMA ADMISSION RECORD

Please attach patient sticker here or record:	Time of Admission	Ward/Unit	Consultant
Name:	...../.....hrs		
Address:	Date of Admission	Admission Type	Medical Notes Req.Urgently
NHS No: ☐☐☐☐☐☐☐☐☐☐		Elective ☐	Yes ☐
Hosp No: ☐☐☐☐☐☐☐☐☐☐		Emergency ☐	No ☐
D.O.B:			
Male Female			

Presenting Complaint

History of Presenting Complaint

Previous Medical and Surgical History

- ☐ Asthma
- ☐ Angina
- ☐ Diabetes
- ☐ DVT/PE
- ☐ Epilepsy
- ☐ Hypertension
- ☐ Jaundice
- ☐ M.I.
- ☐ RF
- ☐ Stroke
- ☐ TB
- ☐ COAD
- ☐ GOR
- ☐ None of the above

PTE Risks

- ☐ > 40 years
- ☐ PHxDVT
- ☐ PHxPE
- ☐ Thrombophilia
- ☐ Obesity
- ☐ Var. Veins
- ☐ C.C.F.
- ☐ Sepsis
- ☐ Recent M.I.
- ☐ Malignancy
- ☐ Immobility
- ☐ O.C.P.
- ☐ U.C/Crohn's
- ☐ Recent op.
- ☐ Major op.

Drug History

Medication	Dose	Freq.

Social History

Usual Mobility:

Smoking:

Alcohol:

Family History

Allergies (Drug)

Systematic Enquiry

CVS

Respiratory

GIT

GUS

CNS

LMP

Patient Name:..... Hosp No: | | | | | | | | | | |

Temperature	Weight kg	Height M	B.M.I.	Breasts
	Lymphadenopathy Dehydration Cyanosis		Pallor Jaundice Clubbing	

Respiratory System

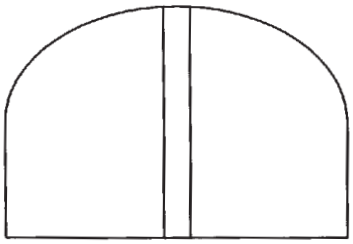
Respiratory Rate

Trachea

Expansion

Percussion

Auscultation



Cardiovascular System

Heart Rate Blood Pressure Oedema

Rhythm

JVP

Heart Sounds

Murmurs

(0 Absent - 1 Diminished - 2 Normal - 3 Bounding - 4 Aneurysmal)

PULSES	Brachial	Aorta	Femoral	Popliteal	DP	PT
R						
L						

Abdomen

Masses

Liver

Spleen/Kidney

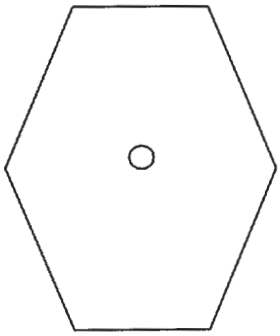
Bowel Sounds

Hernia

Genitalia

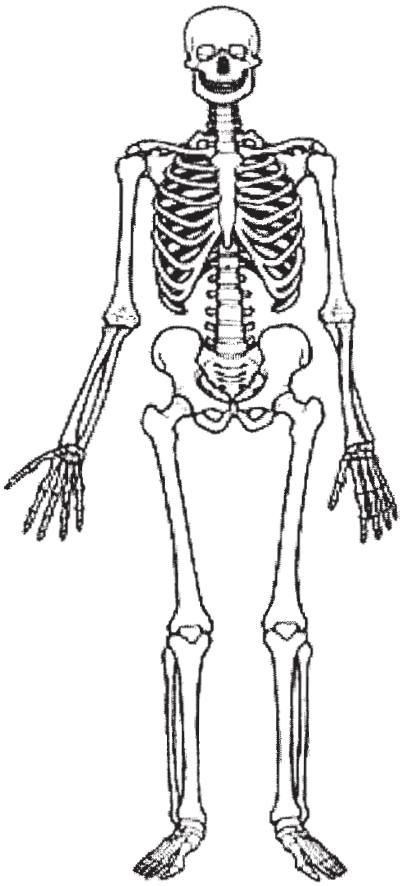
PR

Occult Blood



MUSCULOSKELETAL SYSTEM

R **L**



Patient Name:..... Hosp No: | | | | | | | | | | |

Head Injury Observations			Score	Date Time	
COMA	EYES OPEN	SPONTANEOUSLY	4		
		TO SPEECH	3		
		TO PAIN	2		
		NONE	1		
SCALE	BEST VERBAL RESPONSE	ORIENTATED	5		
		CONFUSED	4		
		INAPPROPRIATE WORDS	3		
		INCOMPREHENSIBLE SOUNDS	2		
		NONE	1		
	BEST MOTOR RESPONSE	OBEY COMMANDS	6		
		LOCALISED PAIN	5		
		WITHDRAWS TO PAIN	4		
		FLEXION TO PAIN	3		
		EXTENSION TO PAIN	2		
		NONE	1		

RADIOLOGY REQUESTED

CXR Required Y ☐ N ☐
Ordered Y ☐ N ☐
SPINE CLEARED Y ☐ N ☐

DATE & TIME .....

CLEARED BY ..... BLEEP NO .....

If Potential Spinal Injury Complete Spinal Proforma overleaf

Monitor Urine Output

Fluid Balance Chart Commenced Y ☐ N ☐

Compartment Syndrome OB's Required Y ☐ N ☐

COMA SCORE

INITIAL INVESTIGATIONS

☐ U & E's

Na .....
K .....
Urea .....
Creatinine .....
Ca .....
ESR .....
CRP .....

☐ LFT's

BiliRubin .....
Alk Phos .....
ALT .....
GT .....
Albumin .....

☐ Glucose

☐ Blood Cultures

☐ FBC

Hb.....
WCC .....
Platelets .....

☐ Coagulation

INR .....
APTK .....

☐ Blood Gases

pH .....
H+ .....
PO2 .....
pCO2 .....
HCO3 .....
Base Excess .....

G&S ☐ Xmatch ☐ No. Units ☐

Referrals	Needed	Done
Anaesthetic	☐	☐
Medical	☐	☐
Gen. Surgery	☐	☐
Vascular	☐	☐
Other	☐	☐

DIAGNOSIS & TREATMENT PLAN

Nurse Name:..... Signature.....

Doctor's Name: ..... Signature: .....

Grade: ..... Bleep No: .....

PRE OP CHECK LIST

Cannula	☐	TEDS	☐
Analgesia	☐	Thomas Splint	☐
Fluids	☐	Trough	☐
Site Marked	☐	Brauns Frame	☐
Consent	☐	Bradford Sling	☐
Clexane	☐	Xrays/Scans	☐
(not Spinal injury)	☐	ECG	☐

NBM from .....

Patient Name:..... Hosp No: | | | | | | | | | | |

SPINAL INJURY CHECKLIST

Local Exam

Tenderness . . . . . .

Swelling /bruising. . . . . .

. . . . . .

Bp: . . . . . Pulse . . . . . .

	Sensation R	Sensation L	Power R	Power L	Reflex R	Reflex L
C4						
5					Bi	
6						
7					Tri	
8						
T1					Brachioradialis	
2						
3					ABDO	
4						
5						
6						
7						
8						
9						
10					KT	
11						
12						
L1					AT	
2						
3					PL	
4						
5						
S1						

Perianal Sensation P ☐ A ☐ R ☐	Tone P ☐ A ☐ R ☐	SLR R Y ☐ N ☐ L Y ☐ N ☐
BLADDER PALPABLE Yes ☐ No ☐	**No catheter to be passed without PR being performed immediately before and documented in notes**	

Patient Name:..... Hosp No: | | | | | | | | | | |

MEDICAL ASSESSMENT CONTINUATION SHEET

Patient Name:..... Hosp No: | | | | | | | | | | |

MEDICAL ASSESSMENT CONTINUATION SHEET

Patient Name:..... Hosp No: | | | | | | | | | | |

MEDICAL ASSESSMENT CONTINUATION SHEET

Patient Name:..... Hosp No: | | | | | | | | | | |

Assessment for Secondary Prevention of Fracture

1. Social History:

Patient lives: Rest Home / Nursing Home / Own home / Alone or not / Stairs or not

Normal Mobility:

Carer(s) or Not:

2. Falls History:

Indoor / Outdoor / While walking / While turning

Witnessed / Syncopal / Unexplained / Preceding symptoms / Trip hazards / Other:

Previous falls: How many? Over what period? Details:

3. Acute / Chronic Medical Problems

Diagnosis of musculoskeletal / nervous / cardiovascular systems:

Cognitive impairment:

Medical on admission: (*in conjunction with Emergency Department - Orthopaedic Assessments)*

Medication changes:

Patient Name:..... Hosp No: | | | | | | | | | | |

Assessment for Secondary Prevention of Fracture

Bone Health: FRAX tool: Age:

BMI <22 kg/m

Height: Weight: Sex

History of parental hip fracture Current smoker?

Secondary Osteoporosis Alcohol =/>3 units/day

Previous Fragility Fracture Oral Steroids (>3m ever)

RA

DXA Femoral Neck

Examination of Mental State:

Address / Time	DOB:	Age:
Place orientation	WWI commenced	2 person
Year	20-1	Monarch

Recall (of previously stated 42 West Street)

Score out of above 10 questions =

Mental State:

Lying BP: **Standing BP:**

Current Mobility:

SUMMARY:

Premorbid condition:

Falls risk:

Bone Health:

Prognosis:

Advice:

Re: current medication situation

Re: Falls risk

Re: bone health

Re: discuss with patient and family, where likely to be discharged to and expected Date of Discharge

Action:

Tests:

Referrals:

Other:

Patient Name:..... Hosp No: | | | | | | | | | | |

Patient Profile: *(to be completed on admission by Nursing Staff or AHP)*	
Surname: N/W/Div/Single	Name Nurse:
Forenames:	Reason for Admission:
Address: Post Code	Medical diagnosis:
Date of Birth: Age: Tel No: Religion	Operation
Likes to be know as	Removal of clips/sutures due:
Consultant Date of admission	Family aware of diagnosis: YES / NO
Date of discharge Source GP Address Tel No	Relevant Medical History
Next of kin Address Tel No	Medication HRT / Contraceptives
Next of kin Address Tel No	Smokes Alcohol Allergies
Dependants	Type of accommodation
Occupation	Stairs/steps Toilet/bathroom
Personal property on admission: Dentures: Upper . . . . . Lower . . . . . . Hearing Aid Spectacles Pension Book Other	Relevant information
Description of valuables and where Valuables listed below given to: . . . . . . Disclaimer form signed:	On admission Temp: Pulse: BP: Resps: Weight: Urinalysis: Waterlow score: Nutritional score:

Patient Name:..... Hosp No: ☐☐☐☐☐☐☐☐☐☐

Activities of Daily Living

Maintaining a Safe Environment
Fully orientated: ☐
Confused/disorientated: ☐

In pain: YES ☐ NO ☐
Details:

Accommodation
Flat ☐ House ☐ Bungalow ☐ Caravan ☐
Phone ☐ Alarm ☐

Social
Lives alone ☐ spouse ☐ family ☐
Children ☐ pets ☐

Support services

Social Services

Home care

Meals on Wheels

Communication
Difficulties with:
Speech ☐ Hearing ☐ Sight ☐
Details:

Eating and Drinking
Appetite: Good ☐ Poor ☐
Special diet:

Eliminating
Urine:
Continent ☐ Incontinent ☐

Management at home:
Pads: Type Frequency of use ☐
Catheter: Type ☐

Who manages continence at home?
Patient ☐ Carer ☐ Community Nurse ☐
Continence Nurse Specialist ☐

Bowels:
last opened:
Frequency of opening bowels:
Aperients used:

Personal Hygiene
Self caring ☐
Requires help: washing ☐ bathing ☐
shaving ☐ dressing ☐
Skin condition:

Maintaining body temperature
Self caring ☐
Heating ☐
Needs assistance ☐

Mobility
Fully mobile ☐
Walks distances easily ☐
Difficulty ☐
Needs help getting ☐
Walking ☐
Bed / chair bound ☐
Problems: ☐

Resting and Sleeping
Sleep pattern: Good ☐ Poor ☐
Sedation:

Anxieties about procedure/diagnosis

Signature: Print Name: Date:

Patient Name:..... Hosp No: | | | | | | | | | | |

Patient Profile: *(to be completed on admission by Nursing Staff or AHP)*

Does the patient have a SAP folder?	**YES**	☐	**NO**	☐
If YES, have they brought it into hospital with them?	YES	☐	NO	☐
If NO, can relatives/carers bring folder in?	YES	☐	NO	☐
If not initiate SAP Referral:	YES	☐	NO	☐

Contact Residential / Nursing Home for more information on patient and discharge planning arrangements: **YES** ☐ **NO** ☐

Date/time contacted home:

Contact Name of Manager of Home:

date/Time of assessment by home:

Issues highlighted by home for transfer:

Discuss with relatives/carers regarding Discharge Planning issues:

1.	Do patient/relative/staff anticipate any problems on discharge?	YES	☐	NO	☐
2.	Ensure patient/family aware of likely discharge destination for patient	YES	☐	NO	☐
3.	Ensure patient/family is aware of expected date of discharge	YES	☐	NO	☐

Comments:

If yes, refer to relevant services: (fill in referral box page 18)

Patient Name:..... Hosp No: | | | | | | | | | | |

Referral to other members of MDT / Agencies

REFERRAL	Referral Date (& referred by whom)	Name (of assessor)	Contact No / Bleep No	Actions / Date
Orthogeriatrician				
Occupational Therapy				
Social Worker				Services required:
Physiotherapist				
Discharge Liaison Team				Rehab/Discharge goal:
Dietitian				
Pharmacist				Medication review date: Osteoporosis drugs prescribed Date: TTO/s prescribed date: Medicines Management:

Patient Name:..... Hosp No: | | | | | | | | | | |

ADMISSION TO TRAUMA WARDS **Date:** **Time:**						
Insert code Y/N/NA and initial on each shift relevant care carried out. Record any exceptions to care with actions on MDT sheets.	**E**	**CODE**	**L**	**CODE**	**ND**	**CODE**
Ward environment and routines explained to patient/relatives						
Contact details of ward and senior staff given to patient and relatives						
Admission pack completed and details checked						
TPR and PARS score completed on observation chart						
Neuro-vascular status assessed						
Reassess pain score and action						
Waterlow risk assessment completed (pressure areas checked)						
Waterlow Score						
Any broken skin / pressure ulcers observed						
Patient nursed on pressure mattress						
Manual handling risk assessment completed						
Falls Risk Assessment and Care Plan completed						
Nutritional assessment completed						
PVD assessment record completed						
Medications/Intravenous Fluid Rota prescribed and actioned						
MRSA screen completed on admission to ward NASAL: Date: GROIN: Date: AXILLA: Date: Other: Date:						
Octenisan wash completed till swab results confirmed						
Stool chart commenced						
Bowels opened						
Bowels NOT opened for .....days - problem actioned (input no of days)						
Preoperative checklist commenced						
Assessed by Orthopaedic doctor on admission						
Referred to Orthogeriatrician for Medical & Falls assessments						
Surgical Assessment						
Patient consented to operation - risks and benefits explained						
E-Consent patient information given to patient						
Patient has been marked for surgery						
Check drug chart completed						
Anaesthetic Assessment completed						
Patient to be Nil by Mouth from (insert time in code box)						
DVT Prophylaxis *Please indicate which DVT Prophylaxis is to be used*						
Compression stockings						
Pharmacological - *please specify*						

Patient Name:..... Hosp No: | | | | | | | | | | |

MDT COMMUNICATION SHEET (Admission)

Patient Name:..... Hosp No: | | | | | | | | | | |

DAY OF SURGERY/DELAY IN SURGERY - DAY 1

DATE: **TIME:**

Reason for delayed operation:

Patient/relatives informed of delayed surgery: YES NO

ACTION: Insert code Y/N/NA and initial on each shift relevant care carried out. Record any exceptions to care with actions on MDT sheets.	E	CODE	L	CODE	ND	CODE
Observations and PARS score recorded						
Pain score assessed adequate analgesia given						
Normal diet and fluids						
Nil by Mouth (I.V. fluids prescribed and given as per rota)						
Maintain fluid balance chart						
Pressure areas assessed and documented						
Pressure mattress provided						
Monitor adequate urine output: Catheterised? YES NO						
Bowels opened						
Blood results available						
All Risk Assessments reviewed and updated						
Patient / family / career informed impending surgery						
Hygiene needs met						
Seen by Orthopaedic Team for pre-operative review						
Check for signs of chest infection or DVT/P.E						
Complete Pre-operative checklist						
Seen by Orthogeriatrician/medical team for pre-operative review-refer						
Seen by anaesthetist for pre-operative review						

PLAN OF ACTION

Patient Name:..... Hosp No: | | | | | | | | | | |

DAY OF SURGERY/DELAY IN SURGERY - DAY 2

DATE: **TIME:**

Reason for delayed operation:

Patient/relatives informed of delayed surgery: YES NO

ACTION: Insert code Y/N/NA and initial on each shift relevant care carried out. Record any exceptions to care with actions on MDT sheets.	E	CODE	L	CODE	ND	CODE
Observations and PARS score recorded						
Pain score assessed adequate analgesia given						
Normal diet and fluids						
Nil by Mouth (I.V. fluids prescribed and given as per rota)						
Maintain fluid balance chart						
Pressure areas assessed and documented						
Pressure mattress provided						
Monitor adequate urine output: Catheterised? YES NO						
Bowels opened						
Blood results available						
All Risk Assessments reviewed and updated						
Patient / family / career informed impending surgery						
Hygiene needs met						
Seen by Orthopaedic Team for pre-operative review						
Check for signs of chest infection or DVT/P.E						
Provisional date of planned surgery						
Complete Pre-operative checklist						
Seen by Orthogeriatrician/medical team for pre-operative review-refer						
Seen by anaesthetist for pre-operative review						

PLAN OF ACTION

Patient Name:..... Hosp No: | | | | | | | | | | |

DAY OF SURGERY/DELAY IN SURGERY - DAY 3

DATE: **TIME:**

Reason for delayed operation:

Patient/relatives informed of delayed surgery: YES NO

ACTION: Insert code Y/N/NA and initial on each shift relevant care carried out. Record any exceptions to care with actions on MDT sheets.	**E**	**CODE**	**L**	**CODE**	**ND**	**CODE**
Observations and PARS score recorded						
Pain score assessed adequate analgesia given						
Normal diet and fluids						
Nil by Mouth (I.V. fluids prescribed and given as per rota)						
Maintain fluid balance chart						
Pressure areas assessed and documented						
Pressure mattress provided						
Monitor adequate urine output: Catheterised? YES NO						
Bowels opened						
Blood results available						
All Risk Assessments reviewed and updated						
Patient / family / career informed impending surgery						
Hygiene needs met						
Seen by Orthopaedic Team for pre-operative review						
Check for signs of chest infection or DVT/P.E						
Provisional date of planned surgery						
Complete Pre-operative checklist						
Seen by Orthogeriatrician/medical team for pre-operative review-refer						
Seen by anaesthetist for pre-operative review						

PLAN OF ACTION

Patient Name:..... Hosp No: | | | | | | | | | | |

RETURN FROM THEATRE DATE: TIME:						
ACTION: Insert code Y/N/NA and initial on each shift relevant care carried out. Record any exceptions to care with actions on MDT sheets.	**E**	**CODE**	**L**	**CODE**	**ND**	**CODE**
Read Post operative notes						
Baseline observations and PARS score						
Observations recorded and within normal limits: ¼hrly ½ hrly, 1hrly, 2hrly						
Observations recorded and **NOT within normal limits**						
Oxygen therapy: litres per min/duration of therapy						
Neurovascular status intact: (check hourly for six hours)						
Check surgical wound hourly: **N-Nil M-Minimal oozing**						
Patient is not confused: (if confused nurse in high observation area)						
Administer anti thrombolitic treatment as per consultant protocol						
Manual Handling assessment updated						
Fluid balance management						
Has passed urine:						
Catheterised: Size:						
Catheter label insert here:						
MSU sent at time of catheterisation:						
Complete fluid balance chart:						
Commence oral diet and fluids as tolerated:						
Dentures in place:						
IV Therapy						
I.V. fluids given as prescribed						
PVD form completed (phlebitis score documented)						
Antibiotic therapy - post op due:						
Analgesia						
P-PCA E-Epidural I-Injection O-Oral R-Rectal RB-Regional block						
Pain score documented and analgesia effectiveness monitored						
Refer to Pain Nurse if issues with pain relief						
Pressure area assessment						
Pressure areas/skin integrity checked: record on charts						
Waterlow score reassessed: Update Waterlow Score						
If hemiarthroplasty/DHS check trough insitu in situ						
If hemi arthroplasty, check for evidence of dislocation						
Post operative wash and changed into clean gown/own nightclothes						

Patient Name:..... Hosp No: | | | | | | | | | | |

MDT COMMUNICATION SHEET (Admission)

Patient Name:..... Hosp No: | | | | | | | | | | |

POST OPERATIVE: DAY 1 DATE: TIME:						
ACTION: Insert code Y/N/NA and initial on each shift relevant care carried out. Record any exceptions to care with actions on MDT sheets.	**E**	**CODE**	**L**	**CODE**	**ND**	**CODE**
Baseline observations/investigations						
6 hourly observations and PARS score						
Oxygen therapy required for: **Document no of hours/rate**						
No signs of chest infection : (productive cough/green sputum/ temperature/low 02 sats/confusion/sweating/tachcardia/rapid breathing)						
Check for signs of PE : LOC/SOB/chest pain/discomfort/low 02 sats)						
Check for signs for DVT: (swollen warm tender calf/oedema/temperature)						
Continue any thrombolitic treatment						
Patient is not confused: (if confused nurse in high observation area)						
Post op x-ray required: Yes No X-ray form completed and sent: Yes No						
Blood check: full blood count/urea & electrolytes						
PVD check (see form)						
Fluid balance management / Nutrition						
Fluid balance reviewed						
Adequate urine output						
Catheterised: Yes No						
Intravenous therapy: **C-Continuing D-Discontinued**						
Oral diet and fluids tolerated: **NBM-Nil by Mouth LD-Light Diet P-Pureed Diet S-Soft Diet**						
Assistance required: **I-Independent M-Minimal Assistance F-Full Assistance**						
Red tray required:						
Family would like to assist at mealtimes						
Commenced food chart						
Drink supplements prescribed for 10.00 and 14:00						
IV antibiotics completed						
Nutritional assessment (see form)						
Would Management						
Would Review: **D-Dressing change I-intact**						
Analgesia						
P-PCA E-Epidural I-Injection O-Oral R-Rectal RB-Regional block						
Pain score documented and analgesia effectiveness monitored						
Refer to Pain Nurse if issues with pain relief						
Hygiene						
Hygiene needs: **I-Independent M-Minimal Assistance F-Full Assistance**						
Dentures available-cleaned						
Check bowels (check aperients prescribed on drug chart) Last opened: (date)						
Pressure areas/skin integrity checked: record on charts						

Patient Name:..... Hosp No: | | | | | | | | | | |

Physiotherapy: ***(To be completed by Physiotherapist / SEE GOAL SHEET)***
Check weight bearing status: FWB PWB NWB
Bed exercises completed:
Transfers bed to chair using
Mobilising using
Comments

Occupational Therapy (refer to O.T section as well)						
Discharge Planning (refer to initial assessment, referrals, MDT meetings)						
Review of Expect date of discharge						
Ensure all relevant members of MDT aware of any potential discharge issues - document on MDT sheet and actions taken						

MDT Communication Sheet - Day 1

Patient Name:..... Hosp No: | | | | | | | | | | |

MDT Communication Sheet - Day 1

Patient Name:..... Hosp No: | | | | | | | | | | |

POST OPERATIVE: DAY 2 DATE: TIME:						
ACTION: Insert code Y/N/NA and initial on each shift relevant care carried out. Record any exceptions to care with actions on MDT sheets.	**E**	**CODE**	**L**	**CODE**	**ND**	**CODE**
Baseline observations/investigations						
6 hourly observations and PARS score						
No signs of chest infection : (productive cough/green sputum/ temperature/low 02 sats/confusion/sweating/tachcardia/rapid breathing)						
Check for signs of PE : LOC/SOB/chest pain/discomfort/low 02 sats)						
Check for signs for DVT: (swollen warm tender calf/oedema/temperature)						
Continue any thrombolitic treatment						
Patient is not confused: (if confused nurse in high observation area)						
Check Post operative x-ray completed and reviewed						
Blood check: full blood count/urea & electrolytes						
PVD check (see form)						
Transfer to rehabilitation ward/hospital						
Is patient medically fit for rehabilitation? liaise with doctors						
Has patient been reviewed by Orthogeriatrician? if not why not?						
Identify with MDT where rehabilitation will take place & refer to appropriate clinicians/ward/community hospital for transfer **Document reasons for delay in transfer**						
Fluid balance management / Nutrition						
Fluid balance reviewed						
Adequate urine output						
Catheterised: Yes No						
Intravenous therapy: **C-Continuing D-Discontinued**						
Oral diet and fluids tolerated: **NBM-Nil by Mouth LD-Light Diet P-Pureed Diet S-Soft Diet**						
Assistance required: **I-Independent M-Minimal Assistance F-Full Assistance** Red tray required: Family would like to assist at mealtimes Commenced food chart Drink supplements prescribed for 10.00 and 14:00						
IV antibiotics completed						
Nutritional assessment (see form)						
Wound Management						
Wound Review: **D-Dressing change I-intact**						
Analgesia						
P-PCA E-Epidural I-Injection O-Oral R-Rectal RB-Regional block						
Pain score documented and analgesia effectiveness monitored						
Refer to Pain Nurse if issues with pain relief						
Hygiene						
Hygiene needs: **I-Independent M-Minimal Assistance F-Full Assistance**						
Dentures available-cleaned						
Check bowels (check aperients prescribed on drug chart) Last opened: (date)						
Pressure areas/skin integrity checked: record on charts						

Patient Name:..... Hosp No: | | | | | | | | | | |

Physiotherapy: ***(To be completed by Physiotherapist / SEE GOAL SHEET)***						
Check weight bearing status: FWB PWB NWB						
Bed exercises completed:						
Transfers bed to chair using						
Mobilising using						
Comments						
Occupational Therapy (refer to O.T section as well)						
Ensure OT assessments completed, if not, ensure OT referral initiated						
Discharge Planning (refer to initial assessment, referrals, MDT meetings)						
Review of Expected date of discharge and change date-update white boards on ward with information of Discharge Planning						
Ensure all relevant members of MDT aware of any potential discharge issues - document on MDT sheet and actions taken						
Document reasons for potential delay in discharge and actions taken						
Does the patient require assessment for Continuing Health & Social care? Refer to Discharge Liaison Nurses for assessments						
Identify discharge residence: **P-Place of residence C-Community Hospital I-Intermediate Care**						
Ensure referred to: **R-Rehabilitation Ward C-Community Hospital**						
Discharge review to be actioned to include the following:						
Discuss rehabilitation/discharge planning with patient						
Discuss or arrange to discuss with relatives rehabilitation/discharge goals						
Discuss wound management for discharge						
Information pharmacist of potential discharge/transfer date						
Discuss transport arrangements - book transport if required-document						
Commence discharge section of Care Pathway						

Patient Name:..... Hosp No: | | | | | | | | | | |

MDT Communication Sheet - Day 2

Patient Name:..... Hosp No: | | | | | | | | | | |

POST OPERATIVE: DAY 3 DATE: TIME:						
ACTION: Insert code Y/N/NA and initial on each shift relevant care carried out. Record any exceptions to care with actions on MDT sheets.	**E**	**CODE**	**L**	**CODE**	**ND**	**CODE**
Baseline observations/investigations						
6 hourly observations and PARS score						
No signs of chest infection : (productive cough/green sputum/ temperature/low 02 sats/confusion/sweating/tachcardia/rapid breathing)						
Check for signs of PE : LOC/SOB/chest pain/discomfort/low 02 sats)						
Check for signs for DVT: (swollen warm tender calf/oedema/temperature)						
Continue any thrombolitic treatment						
PVD check (see form)						
Patient is not confused: (if confused nurse in high observation area)						
Transfer to rehabilitation ward/hospital						
Is patient medically fit for rehabilitation? liaise with doctors						
Has patient been reviewed by Orthogeriatrician? if not why not?						
Identify with MDT where rehabilitation will take place & refer to appropriate clinicians/ward/community hospital for transfer **Document reasons for delay in transfer**						
Fluid balance management / Nutrition						
Fluid balance reviewed Adequate urine output						
Catheterised: Yes No						
Intravenous therapy: **C-Continuing D-Discontinued**						
Oral diet and fluids tolerated: **NBM-Nil by Mouth LD-Light Diet P-Pureed Diet S-Soft Diet** Assistance required: **I-Independent M-Minimal Assistance F-Full Assistance** Red tray required: Family would like to assist at mealtimes						
Commenced food chart						
Drink supplements prescribed for 10.00 and 14:00						
IV antibiotics completed						
Nutritional assessment (see form)						
Wound Management						
Wound Review: **D-Dressing change I-intact**						
Analgesia						
P-PCA E-Epidural I-Injection O-Oral R-Rectal RB-Regional block						
Pain score documented and analgesia effectiveness monitored						
Refer to Pain Nurse if issues with pain relief						
Hygiene						
Hygiene needs: **I-Independent M-Minimal Assistance F-Full Assistance**						
Dentures available-cleaned						
Check bowels (check aperients prescribed on drug chart) Last opened: (date)						
Pressure areas/skin integrity checked: record on charts						

Patient Name:..... Hosp No: | | | | | | | | | | |

Physiotherapy: ***(To be completed by Physiotherapist / SEE GOAL SHEET)***
Check weight bearing status: FWB PWB NWB
Bed exercises completed:
Transfers bed to chair using
Mobilising using
Comments

Occupational Therapy (refer to O.T section as well) **Discharge Planning** (refer to initial assessment, referrals, MDT meetings)						
Review of Expected date of discharge and change date-update white boards on ward with information of Discharge Planning						
Ensure all relevant members of MDT aware of any potential discharge issues - document on MDT sheet and actions taken						
Document reasons for potential delay in discharge and actions taken						
Does the patient require assessment for Continuing Health & Social care? Refer to Discharge Liaison Nurses for assessments						
Identify discharge residence: **P-Place of residence C-Community Hospital I-Intermediate Care**						
Ensure referred to: **R-Rehabilitation Ward C-Community Hospital**						
Discharge review to be actioned to include the following:						
Discuss rehabilitation/discharge planning with patient						
Discuss or arrange to discuss with relatives rehabilitation/discharge goals						
Discuss wound management for discharge						
Inform pharmacist of potential discharge/transfer date/order TTOs						
Discuss transport arrangements - book transport if required-document						
Commence discharge section of Care Pathway						

Patient Name:..... Hosp No: | | | | | | | | | | |

MDT Communication Sheet - Day 3

Patient Name:..... Hosp No: | | | | | | | | | | |

POST OPERATIVE: DAY 4 DATE: TIME:						
ACTION: Insert code Y/N/NA and initial on each shift relevant care carried out. Record any exceptions to care with actions on MDT sheets.	**E**	**CODE**	**L**	**CODE**	**ND**	**CODE**
Baseline observations/investigations						
6 hourly observations and PARS score						
No signs of chest infection : (productive cough/green sputum/ temperature/low 02 sats/confusion/sweating/tachcardia/rapid breathing)						
Check for signs of PE : LOC/SOB/chest pain/discomfort/low 02 sats)						
Check for signs for DVT: (swollen warm tender calf/oedema/temperature)						
Continue any thrombolitic treatment						
PVD check (see form)						
Patient is not confused: (if confused nurse in high observation area)						
Transfer to rehabilitation ward/hospital						
Is patient medically fit for rehabilitation? liaise with doctors						
Has patient been reviewed by Orthogeriatrician? if not why not?						
Identify with MDT where rehabilitation will take place & refer to appropriate clinicians/ward/community hospital for transfer **Document reasons for delay in transfer**						
Ensure Falls/Bone health assessments have been completed by Orthogeriatrician-if not action and document why not?						
Fluid balance management / Nutrition						
Fluid balance reviewed						
Adequate urine output Catheterised: Yes No						
Intravenous therapy: **C-Continuing D-Discontinued**						
Oral diet and fluids tolerated: **NBM-Nil by Mouth LD-Light Diet P-Pureed Diet S-Soft Diet** Assistance required: **I-Independent M-Minimal Assistance F-Full Assistance** Red tray required: Family would like to assist at mealtimes						
Continue food chart if required						
Drink supplements prescribed for 10.00 and 14:00						
Nutritional assessment (see form)						
Wound Management						
Wound Review: **D-Dressing change I-intact**						
Analgesia						
Oral Analgesia						
Pain score documented and analgesia effectiveness monitored						
Refer to Pain Nurse if issues with pain relief						
Hygiene						
Hygiene needs: **I-Independent M-Minimal Assistance F-Full Assistance**						
Dentures available-cleaned						
Dressed in own clothes						
Check bowels (check aperients prescribed on drug chart) Last opened: (date)						
Pressure areas/skin integrity checked: record on charts						

Patient Name:..... Hosp No: | | | | | | | | | | |

Physiotherapy: ***(To be completed by Physiotherapist / SEE GOAL SHEET)***
Check weight bearing status: FWB PWB NWB
Bed exercises completed:
Transfers bed to chair using
Mobilising using
Comments

Occupational Therapy (refer to O.T section as well) **Discharge Planning** (refer to initial assessment, referrals, MDT meetings)						
Review of Expected date of discharge and change date-update white boards on ward with information of Discharge Planning						
Ensure all relevant members of MDT aware of any potential discharge issues - document on MDT sheet and actions taken						
Document reasons for potential delay in discharge and actions taken						
Does the patient require assessment for Continuing Health & Social care? Refer to Discharge Liaison Nurses for assessments						
Identify discharge residence: **P-Place of residence C-Community Hospital I-Intermediate Care**						
Ensure referred to: **R-Rehabilitation Ward C-Community Hospital**						
Discharge review to be actioned to include the following:						
Discuss rehabilitation/discharge planning with patient						
Discuss or arrange to discuss with relatives rehabilitation/discharge goals						
Discuss wound management for discharge						
Inform pharmacist of potential discharge/transfer date/order TTOs						
Discuss transport arrangements - book transport if required-document						
Commence discharge section of Care Pathway						

Patient Name:..... Hosp No: | | | | | | | | | | |

MDT Communication Sheet - Day 4

Patient Name:..... Hosp No: | | | | | | | | | | |

POST OPERATIVE: DAY 5 DATE: TIME:						
ACTION: Insert code Y/N/NA and initial on each shift relevant care carried out. Record any exceptions to care with actions on MDT sheets.	**E**	**CODE**	**L**	**CODE**	**ND**	**CODE**
Baseline observations/investigations						
6 hourly observations and PARS score						
No signs of chest infection : (productive cough/green sputum/ temperature/low 02 sats/confusion/sweating/tachcardia/rapid breathing)						
Check for signs of PE : LOC/SOB/chest pain/discomfort/low 02 sats)						
Check for signs for DVT: (swollen warm tender calf/oedema/temperature)						
Continue any thrombolitic treatment						
PVD check (see form)						
Patient is not confused: (if confused nurse in high observation area)						
Transfer to rehabilitation ward/hospital						
Is patient medically fit for rehabilitation? liaise with doctors						
Has patient been reviewed by Orthogeriatrician? if not why not?						
Identify with MDT where rehabilitation will take place & refer to appropriate clinicians/ward/community hospital for transfer **Document reasons for delay in transfer**						
Ensure Falls/Bone health assessments have been completed by Orthogeriatrician-if not action and document why not?						
Fluid balance management / Nutrition						
Fluid balance reviewed						
Adequate urine output Catheterised: Yes No						
Intravenous therapy: **C-Continuing D-Discontinued**						
Oral diet and fluids tolerated: **NBM-Nil by Mouth LD-Light Diet P-Pureed Diet S-Soft Diet** Assistance required: **I-Independent M-Minimal Assistance F-Full Assistance** Red tray required: Family would like to assist at mealtimes						
Continue food chart if required						
Drink supplements prescribed for 10.00 and 14:00						
Nutritional assessment (see form)						
Wound Management						
Wound Review: **D-Dressing change I-intact**						
Analgesia						
Oral Analgesia						
Pain score documented and analgesia effectiveness monitored						
Refer to Pain Nurse if issues with pain relief						
Hygiene						
Hygiene needs: **I-Independent M-Minimal Assistance F-Full Assistance**						
Dentures available-cleaned						
Dressed in own clothes						
Check bowels (check aperients prescribed on drug chart) Last opened: (date)						
Pressure areas/skin integrity checked: record on charts						

Patient Name:..... Hosp No: | | | | | | | | | | |

Physiotherapy: ***(To be completed by Physiotherapist / SEE GOAL SHEET)***
Check weight bearing status: FWB PWB NWB
Bed exercises completed:
Transfers bed to chair using
Mobilising using
Comments

Occupational Therapy (refer to O.T section as well) **Discharge Planning** (refer to initial assessment, referrals, MDT meetings)						
Review of Expected date of discharge and change date-update white boards on ward with information of Discharge Planning						
Ensure all relevant members of MDT aware of any potential discharge issues - document on MDT sheet and actions taken						
Document reasons for potential delay in discharge and actions taken						
Does the patient require assessment for Continuing Health & Social care? Refer to Discharge Liaison Nurses for assessments						
Identify discharge residence: **P-Place of residence C-Community Hospital I-Intermediate Care**						
Ensure referred to: **R-Rehabilitation Ward C-Community Hospital**						
Discharge review to be actioned to include the following:						
Discuss rehabilitation/discharge planning with patient						
Discuss or arrange to discuss with relatives rehabilitation/discharge goals						
Discuss wound management for discharge						
Inform pharmacist of potential discharge/transfer date/order TTOs						
Discuss transport arrangements - book transport if required-document						
Commence discharge section of Care Pathway						

Patient Name:..... Hosp No: | | | | | | | | | | |

MDT Communication Sheet - Day 5

Patient Name:..... Hosp No: | | | | | | | | | | |

POST OPERATIVE: DAY 6 DATE: TIME:						
ACTION: Insert code Y/N/NA and initial on each shift relevant care carried out. Record any exceptions to care with actions on MDT sheets.	**E**	**CODE**	**L**	**CODE**	**ND**	**CODE**
Baseline observations/investigations						
6 hourly observations and PARS score						
No signs of chest infection : (productive cough/green sputum/ temperature/low 02 sats/confusion/sweating/tachcardia/rapid breathing)						
Check for signs of PE : LOC/SOB/chest pain/discomfort/low 02 sats)						
Check for signs for DVT: (swollen warm tender calf/oedema/temperature)						
Continue any thrombolitic treatment						
PVD check (see form)						
Patient is not confused: (if confused nurse in high observation area)						
Transfer to rehabilitation ward/hospital						
Is patient medically fit for rehabilitation? liaise with doctors						
Has patient been reviewed by Orthogeriatrician? if not why not?						
Identify with MDT where rehabilitation will take place & refer to appropriate clinicians/ward/community hospital for transfer **Document reasons for delay in transfer**						
Ensure Falls/Bone health assessments have been completed by Orthogeriatrician-if not action and document why not?						
Fluid balance management / Nutrition						
Fluid balance reviewed						
Adequate urine output Catheterised: Yes No						
Intravenous therapy: **C-Continuing D-Discontinued**						
Oral diet and fluids tolerated: **NBM-Nil by Mouth LD-Light Diet P-Pureed Diet S-Soft Diet** Assistance required: **I-Independent M-Minimal Assistance F-Full Assistance** Red tray required: Family would like to assist at mealtimes						
Continue food chart if required						
Drink supplements prescribed for 10.00 and 14:00						
Nutritional assessment (see form)						
Wound Management						
Wound Review: **D-Dressing change I-intact**						
Analgesia						
Oral Analgesia						
Pain score documented and analgesia effectiveness monitored						
Refer to Pain Nurse if issues with pain relief						
Hygiene						
Hygiene needs: **I-Independent M-Minimal Assistance F-Full Assistance**						
Dentures available-cleaned						
Dressed in own clothes						
Check bowels (check aperients prescribed on drug chart) Last opened: (date)						
Pressure areas/skin integrity checked: record on charts						

Patient Name:..... Hosp No: | | | | | | | | | | |

Physiotherapy: ***(To be completed by Physiotherapist / SEE GOAL SHEET)***
Check weight bearing status: FWB PWB NWB
Bed exercises completed:
Transfers bed to chair using
Mobilising using
Comments

Occupational Therapy (refer to O.T section as well)						
Discharge Planning (refer to initial assessment, referrals, MDT meetings)						
Review of Expected date of discharge and change date-update white boards on ward with information of Discharge Planning						
Ensure all relevant members of MDT aware of any potential discharge issues - document on MDT sheet and actions taken						
Document reasons for potential delay in discharge and actions taken						
Does the patient require assessment for Continuing Health & Social care? Refer to Discharge Liaison Nurses for assessments						
Identify discharge residence: **P-Place of residence C-Community Hospital I-Intermediate Care**						
Ensure referred to: **R-Rehabilitation Ward C-Community Hospital**						
Discharge review to be actioned to include the following:						
Discuss rehabilitation/discharge planning with patient						
Discuss or arrange to discuss with relatives rehabilitation/discharge goals						
Discuss wound management for discharge						
Inform pharmacist of potential discharge/transfer date/order TTOs						
Discuss transport arrangements - book transport if required-document						
Commence discharge section of Care Pathway						

Patient Name:..... Hosp No: | | | | | | | | | | |

MDT Communication Sheet - Day 6

Patient Name:..... Hosp No: | | | | | | | | | | |

POST OPERATIVE: DAY 7 DATE: TIME:						
ACTION: Insert code Y/N/NA and initial on each shift relevant care carried out. Record any exceptions to care with actions on MDT sheets.	**E**	**CODE**	**L**	**CODE**	**ND**	**CODE**
Baseline observations/investigations						
6 hourly observations and PARS score						
No signs of chest infection : (productive cough/green sputum/ temperature/low 02 sats/confusion/sweating/tachcardia/rapid breathing)						
Check for signs of PE : LOC/SOB/chest pain/discomfort/low 02 sats)						
Check for signs for DVT: (swollen warm tender calf/oedema/temperature)						
Continue any thrombolitic treatment						
Transfer to rehabilitation ward/hospital						
Is patient medically fit for rehabilitation? liaise with doctors						
Has patient been reviewed by Orthogeriatrician? if not why not?						
Identify with MDT where rehabilitation will take place & refer to appropriate clinicians/ward/community hospital for transfer **Document reasons for delay in transfer**						
Ensure Falls/Bone health assessments have been completed by Orthogeriatrician-if not action and document why not?						
Fluid balance management / Nutrition						
Fluid balance reviewed						
Adequate urine output Catheterised: Yes No						
Intravenous therapy: **C-Continuing D-Discontinued**						
Oral diet and fluids tolerated: **NBM-Nil by Mouth LD-Light Diet P-Pureed Diet S-Soft Diet** Assistance required: **I-Independent M-Minimal Assistance F-Full Assistance** Red tray required: Family would like to assist at mealtimes						
Continue food chart if required						
Drink supplements prescribed for 10.00 and 14:00						
Nutritional assessment (see form)						
Wound Management						
Wound Review: **D-Dressing change I-intact**						
Analgesia						
Oral Analgesia						
Pain score documented and analgesia effectiveness monitored						
Refer to Pain Nurse if issues with pain relief						
Hygiene						
Hygiene needs: **I-Independent M-Minimal Assistance F-Full Assistance**						
Dentures available-cleaned						
Dressed in own clothes						
Check bowels (check aperients prescribed on drug chart) Last opened: (date)						
Pressure areas/skin integrity checked: record on charts						

Patient Name:..... Hosp No: | | | | | | | | | | |

Physiotherapy: ***(To be completed by Physiotherapist / SEE GOAL SHEET)***
Check weight bearing status: FWB PWB NWB
Bed exercises completed:
Transfers bed to chair using
Mobilising using
Comments

Occupational Therapy (refer to O.T section as well)						
Discharge Planning (refer to initial assessment, referrals, MDT meetings)						
Review of Expected date of discharge and change date-update white boards on ward with information of Discharge Planning						
Ensure all relevant members of MDT aware of any potential discharge issues - document on MDT sheet and actions taken						
Document reasons for potential delay in discharge and actions taken						
Does the patient require assessment for Continuing Health & Social care? Refer to Discharge Liaison Nurses for assessments						
Identify discharge residence: **P-Place of residence C-Community Hospital I-Intermediate Care**						
Ensure referred to: **R-Rehabilitation Ward C-Community Hospital**						
Discharge review to be actioned to include the following:						
Discuss rehabilitation/discharge planning with patient						
Discuss or arrange to discuss with relatives rehabilitation/discharge goals						
Discuss wound management for discharge						
Inform pharmacist of potential discharge/transfer date/order TTOs						
Discuss transport arrangements - book transport if required-document						
Commence discharge section of Care Pathway						

Patient Name:..... Hosp No: | | | | | | | | | | |

MDT Communication Sheet - Day 7

Patient Name:..... Hosp No: | | | | | | | | | | |

POST OPERATIVE: DAY 8 DATE: TIME:						
ACTION: Insert code Y/N/NA and initial on each shift relevant care carried out. Record any exceptions to care with actions on MDT sheets.	**E**	**CODE**	**L**	**CODE**	**ND**	**CODE**
Baseline observations/investigations						
6 hourly observations and PARS score						
No signs of chest infection : (productive cough/green sputum/ temperature/low 02 sats/confusion/sweating/tachcardia/rapid breathing)						
Check for signs of PE : LOC/SOB/chest pain/discomfort/low 02 sats)						
Check for signs for DVT: (swollen warm tender calf/oedema/temperature)						
Continue any thrombolitic treatment						
Transfer to rehabilitation ward/hospital						
Is patient medically fit for rehabilitation? liaise with doctors						
Has patient been reviewed by Orthogeriatrician? if not why not?						
Identify with MDT where rehabilitation will take place & refer to appropriate clinicians/ward/community hospital for transfer **Document reasons for delay in transfer**						
Ensure Falls/Bone health assessments have been completed by Orthogeriatrician-if not action and document why not?						
Fluid balance management / Nutrition						
Fluid balance reviewed						
Adequate urine output Catheterised: Yes No						
Intravenous therapy: **C-Continuing D-Discontinued**						
Oral diet and fluids tolerated: **NBM-Nil by Mouth LD-Light Diet P-Pureed Diet S-Soft Diet** Assistance required: **I-Independent M-Minimal Assistance F-Full Assistance** Red tray required: Family would like to assist at mealtimes						
Continue food chart if required						
Drink supplements prescribed for 10.00 and 14:00						
Nutritional assessment (see form)						
Wound Management						
Wound Review: **D-Dressing change I-intact**						
Analgesia						
Oral Analgesia						
Pain score documented and analgesia effectiveness monitored						
Refer to Pain Nurse if issues with pain relief						
Hygiene						
Hygiene needs: **I-Independent M-Minimal Assistance F-Full Assistance**						
Dentures available-cleaned						
Dressed in own clothes						
Check bowels (check aperients prescribed on drug chart) Last opened: (date)						
Pressure areas/skin integrity checked: record on charts						

Patient Name:..... Hosp No: | | | | | | | | | | |

Physiotherapy: ***(To be completed by Physiotherapist / SEE GOAL SHEET)***
Check weight bearing status: FWB PWB NWB
Bed exercises completed:
Transfers bed to chair using
Mobilising using
Comments

Occupational Therapy (refer to O.T section as well)						
Discharge Planning (refer to initial assessment, referrals, MDT meetings)						
Review of Expected date of discharge and change date-update white boards on ward with information of Discharge Planning						
Ensure all relevant members of MDT aware of any potential discharge issues - document on MDT sheet and actions taken						
Document reasons for potential delay in discharge and actions taken						
Does the patient require assessment for Continuing Health & Social care? Refer to Discharge Liaison Nurses for assessments						
Identify discharge residence: **P-Place of residence C-Community Hospital I-Intermediate Care**						
Ensure referred to: **R-Rehabilitation Ward C-Community Hospital**						
Discharge review to be actioned to include the following:						
Discuss rehabilitation/discharge planning with patient						
Discuss or arrange to discuss with relatives rehabilitation/discharge goals						
Discuss wound management for discharge						
Inform pharmacist of potential discharge/transfer date/order TTOs						
Discuss transport arrangements - book transport if required-document						
Commence discharge section of Care Pathway						

Patient Name:..... Hosp No: | | | | | | | | | | |

MDT Communication Sheet - Day 8

Patient Name:..... Hosp No: | | | | | | | | | | |

POST OPERATIVE: DAY 9 DATE: TIME:						
ACTION: Insert code Y/N/NA and initial on each shift relevant care carried out. Record any exceptions to care with actions on MDT sheets.	**E**	**CODE**	**L**	**CODE**	**ND**	**CODE**
Baseline observations/investigations						
6 hourly observations and PARS score						
No signs of chest infection : (productive cough/green sputum/ temperature/low 02 sats/confusion/sweating/tachcardia/rapid breathing)						
Check for signs of PE : LOC/SOB/chest pain/discomfort/low 02 sats)						
Check for signs for DVT: (swollen warm tender calf/oedema/temperature)						
Continue any thrombolitic treatment						
Transfer to rehabilitation ward/hospital						
Is patient medically fit for rehabilitation? liaise with doctors						
Has patient been reviewed by Orthogeriatrician? if not why not?						
Identify with MDT where rehabilitation will take place & refer to appropriate clinicians/ward/community hospital for transfer **Document reasons for delay in transfer**						
Ensure Falls/Bone health assessments have been completed by Orthogeriatrician-if not action and document why not?						
Fluid balance management / Nutrition						
Fluid balance reviewed						
Adequate urine output Catheterised: Yes No						
Oral diet and fluids tolerated: **NBM-Nil by Mouth LD-Light Diet P-Pureed Diet S-Soft Diet** Assistance required: **I-Independent M-Minimal Assistance F-Full Assistance** Red tray required: Family would like to assist at mealtimes						
Continue food chart if required						
Drink supplements prescribed for 10.00 and 14:00						
Nutritional assessment (see form)						
Wound Management						
Wound Review: **D-Dressing change I-intact**						
Analgesia						
Oral Analgesia						
Pain score documented and analgesia effectiveness monitored						
Refer to Pain Nurse if issues with pain relief						
Hygiene						
Hygiene needs: **I-Independent M-Minimal Assistance F-Full Assistance**						
Dentures available-cleaned						
Dressed in own clothes						
Check bowels (check aperients prescribed on drug chart) Last opened: (date)						
Pressure areas/skin integrity checked: record on charts						

Patient Name:..... Hosp No: | | | | | | | | | | |

Physiotherapy: ***(To be completed by Physiotherapist / SEE GOAL SHEET)***
Check weight bearing status: FWB PWB NWB
Bed exercises completed:
Transfers bed to chair using
Mobilising using
Comments

Occupational Therapy (refer to O.T section as well)						
Discharge Planning (refer to initial assessment, referrals, MDT meetings)						
Review of Expected date of discharge and change date-update white boards on ward with information of Discharge Planning						
Ensure all relevant members of MDT aware of any potential discharge issues - document on MDT sheet and actions taken						
Document reasons for potential delay in discharge and actions taken						
Does the patient require assessment for Continuing Health & Social care? Refer to Discharge Liaison Nurses for assessments						
Identify discharge residence: **P-Place of residence C-Community Hospital I-Intermediate Care**						
Ensure referred to: **R-Rehabilitation Ward C-Community Hospital**						
Discharge review to be actioned to include the following:						
Discuss rehabilitation/discharge planning with patient						
Discuss or arrange to discuss with relatives rehabilitation/discharge goals						
Discuss wound management for discharge						
Inform pharmacist of potential discharge/transfer date/order TTOs						
Discuss transport arrangements - book transport if required-document						
Commence discharge section of Care Pathway						

Patient Name:..... Hosp No: | | | | | | | | | | |

MDT Communication Sheet - Day 9 continued

Patient Name:..... Hosp No: | | | | | | | | | | |

POST OPERATIVE: DAY 10 DATE: TIME:						
ACTION: Insert code Y/N/NA and initial on each shift relevant care carried out. Record any exceptions to care with actions on MDT sheets.	**E**	**CODE**	**L**	**CODE**	**ND**	**CODE**
Baseline observations/investigations						
6 hourly observations and PARS score						
No signs of chest infection : (productive cough/green sputum/ temperature/low 02 sats/confusion/sweating/tachcardia/rapid breathing)						
Check for signs of PE : LOC/SOB/chest pain/discomfort/low 02 sats)						
Check for signs for DVT: (swollen warm tender calf/oedema/temperature)						
Continue any thrombolitic treatment						
Transfer to rehabilitation ward/hospital						
Is patient medically fit for rehabilitation? liaise with doctors						
Has patient been reviewed by Orthogeriatrician? if not why not?						
Identify with MDT where rehabilitation will take place & refer to appropriate clinicians/ward/community hospital for transfer **Document reasons for delay in transfer**						
Ensure Falls/Bone health assessments have been completed by Orthogeriatrician-if not action and document why not?						
Fluid balance management / Nutrition						
Fluid balance reviewed						
Adequate urine output Catheterised: Yes No						
Oral diet and fluids tolerated: **NBM-Nil by Mouth LD-Light Diet P-Pureed Diet S-Soft Diet** Assistance required: **I-Independent M-Minimal Assistance F-Full Assistance** Red tray required: Family would like to assist at mealtimes						
Continue food chart if required						
Drink supplements prescribed for 10.00 and 14:00						
Nutritional assessment (see form)						
Wound Management						
Wound Review: **D-Dressing change I-intact**						
Analgesia						
Oral Analgesia						
Pain score documented and analgesia effectiveness monitored						
Refer to Pain Nurse if issues with pain relief						
Hygiene						
Hygiene needs: **I-Independent M-Minimal Assistance F-Full Assistance**						
Dentures available-cleaned						
Dressed in own clothes						
Check bowels (check aperients prescribed on drug chart) Last opened: (date)						
Pressure areas/skin integrity checked: record on charts						

Patient Name:..... Hosp No: | | | | | | | | | | |

Physiotherapy: ***(To be completed by Physiotherapist / SEE GOAL SHEET)***
Check weight bearing status: FWB PWB NWB
Bed exercises completed:
Transfers bed to chair using
Mobilising using
Comments

Occupational Therapy (refer to O.T section as well)						
Discharge Planning (refer to initial assessment, referrals, MDT meetings)						
Review of Expected date of discharge and change date-update white boards on ward with information of Discharge Planning						
Ensure all relevant members of MDT aware of any potential discharge issues - document on MDT sheet and actions taken						
Document reasons for potential delay in discharge and actions taken						
Does the patient require assessment for Continuing Health & Social care? Refer to Discharge Liaison Nurses for assessments						
Identify discharge residence: **P-Place of residence C-Community Hospital I-Intermediate Care**						
Ensure referred to: **R-Rehabilitation Ward C-Community Hospital**						
Discharge review to be actioned to include the following:						
Discuss rehabilitation/discharge planning with patient						
Discuss or arrange to discuss with relatives rehabilitation/discharge goals						
Discuss wound management for discharge						
Inform pharmacist of potential discharge/transfer date/order TTOs						
Discuss transport arrangements - book transport if required-document						
Commence discharge section of Care Pathway						

Patient Name:..... Hosp No: | | | | | | | | | | |

MDT Communication Sheet - Day 10 continued

Patient Name:..... Hosp No: | | | | | | | | | | |

DISCHARGE/TRANSFER TO REHABILITATION / PLACE OF RESIDENCE

(Nurses & AHP to commence on admission and completed at least 24-48 hours prior to discharge/transfer)

Expected date of discharge: **Transfer:**

To be commenced on Admission	Met Initials	Comments	Date
Identify expected date of discharge/transfer (enter above)			
Social Services agree expected discharge/transfer date			
Physiotherapy agrees expected discharge/transfer date			
OT agrees expected discharge/transfer date			
Discharge Team involved in discharge/transfer date			
Is the patient returning to their normal place of residence?		If NO, order temporary GP letter	
Care package arranged			
Equipment ordered			
TTO's written up and Pharmacist to discuss with patient, medicine management.			

To be commenced on Admission	Met Initials	Date
Patient consents to nurse/AHP led discharge		
Patient and carer aware of expected date & time of discharge or transfer		
Patient/carer has arranged for patient to be collected on discharge		
Ensure patient has clothes for discharge - including coat and shoes		
Patient has keys/access to home		
Is there food at home?		
Is the heating on at home?		
Patient/relatives aware patient will be transferred to Discharge Lounge if meets criteria, to be collected from there.		

CLINICAL GOALS (All must be met on day of discharge)	Met Initials	Date
Post op notes or instructions written and followed		
Apyrexial for 24 hours, BP and pulse within own baseline limits		
Urine output satisfactory, bowels opened within last 24 hours or patient's normal pattern		
Wound checked - not oozing, signs of infection		
Pain score <1 after analgesia		
Eating and drinking normally		
Free of chest / calf pain		
Investigations completed and acted on		
No nausea or vomiting		
Physiotherapist and OT have documented that agree discharge		
Social worker, if involved aware of discharge		
Discharge Teams aware of discharge and agreed		

Patient Name:..... Hosp No: ☐☐☐☐☐☐☐☐☐☐

DISCHARGE CHECKLIST - Day of Discharge

	Goal Met	Comments
Patient clinically fit as per standard - ***all clinical goals met***		
Venflon removed		
Has the Patient's valuables/property been returned?		
Discharge advice sheets given and explained to patient - **operation, falls prevent, OT, Physio etc.**		
Anti-embolic stockings given plus spare pair to wash Medications given and explained by pharmacist/nursing staff		
Anti-coagulant appointment given and booklet - ***has GP agreed to takeover if required?***		
Medical Certificate given		
If nursing / residential home, transfer form completed		
TTO sheet sent to GP		
Discharge Letter: Sent to GP ☐ given to patient ☐ Faxed ☐ emailed ☐		
Have the discharge arrangements been confirmed with the service providers? Complete Referral box below		
Equipment - has the patient received and been education in the use of any aids/equipment?		
Transfer to Discharge Lounge 1. Is the patient being discharged after 11.00am? State time 2. If YES, is the patient being transferred to the Discharge Lounge? 3. Has the Discharge Lounge been contacted and transfer arranged?		
Transport booked for discharge if required: Own/Carer/Relative ☐ Taxi ☐ Hospital Transport ☐ Other ☐		
OPD appointments arranged: Given to patient ☐ Posted ☐		
Falls Clinic OPD on discharge: Given to patient ☐ Posted ☐		
Information put in patients SAP folder is applicable		
Has the carer/care home been notified the patient has left the ward?		

Referral	Date/Time	Name	Date Seen	Comments
District Nurse Liaison				
Intermediate Care Team				
Community Therapy Services				
Falls Clinic				
Community Hospital				
Social Services				
GP				
Other:				

Date Discharge:..... Time:.....

Signature of Nurse/AHP authorising discharge:.....

If DATE of discharge different from expected date, give reason (and document date on front of ICP).....

Patient Name:..... Hosp No: | | | | | | | | | | |

INTEGRATED DISCHARGE TEAM MANAGEMENT PLAN

Patient Name:..... Hosp No: | | | | | | | | | | |

INTEGRATED DISCHARGE TEAM MANAGEMENT PLAN

Patient Name:..... Hosp No: | | | | | | | | | | |

INTEGRATED DISCHARGE TEAM MANAGEMENT PLAN

Patient Name:..... Hosp No: | | | | | | | | | | |

PHYSIOTHERAPY PROBLEM LIST AND GOALS

PHYSIOTHERAPIST: Signature..... Print Name:.....

Date set & sign	Problem No.	Problem	Action to be taken	Short term goals	Time Scale	Outcome date & sign

Patient Name:..... Hosp No: ☐☐☐☐☐☐☐☐☐☐

OCCUPATIONAL THERAPY PATIENT SCREENING

KEY: ▲ Problem ☒ Impaired/Problem

△ No Problem ☐ No problem

1. ACCOMMODATION △

Type: Flat / House / Bungalow / Caravan

Ownership: Private / Council / Rented / owned / Hous. assoc.

Amenities: phone / alarm / heating / power / hot-water / shops

Access: External

Internal

Rails: L / R / Both / None / NA

Bathroom: Up / down Shower / Bath / Over bath shower

Toilet: Up / down / in / out Bed: Up / down

2. SOCIAL △

Patient lives: Alone / with family / spouse / children / friend / pets

Support Services / Social Contact / Carer - specify whom & duration

3. MOBILITY △

Walking	☐	Falls	☐	Car/Public Transport	☐
W/Chair	☐	Stairs	☐	On/Off floor	☐
Bed	☐	Chair	☐	Toilet	☐
Bath/Shower	☐	Hoist	☐		

4. PADL △

Dress UL	☐	Feeding	☐	Medication	☐
Dress LL	☐	Wash	☐	Night-time	☐
Undress	☐	Grooming	☐	Personal Relationships	☐
Footwear	☐	Continence	☐		

5. DADL △

Hot drink	☐	Meals	☐	Housework	☐
Snack	☐	Laundry/Ironing	☐	Shopping	☐

6. SENSORY/MOTOR △

R.O.M.	☐	Tone	☐	Joint	☐
Strength	☐	Co-ordination	☐	Soft Tissue	☐
Sensation	☐	Proprioception	☐	Balance	☐

7. COGNITION △

☐ Perception, Concentration, Planning, Orientation

☐ Insight, Motivation, Confusion, Mood Acceptance

8. WORK / LEISURE / COMMUNICATION △

☐ Reading/writing/telepone	☐ Language/Speech
☐ Employed/Unemployed/Retired	☐ Leisure
☐ School/College	☐ Holidays

9. MEDICAL △

☐ Visual/Auditory

☐ Pressure / S.O.B / Diabetes / Pain / Inflammation

Patient Name:..... Hosp No: | | | | | | | | | | |

OCCUPATIONAL THERAPY PATIENT SCREENING

Date of Surgery . . . . / . . . / . . . . . = Day 0

Prob	Anticipated Outcome	Action	Outcome Code	Outcome/Variance	Sig/Date
	Patient to have initial screening carried out within 2 working days of receipt of referral	Initial screen Issue height measurement Establish cause of fall			
**	Patient understand and is aware of the hip precautions	Explain hip precautions and issue Hemiarthroplasty book			
2	Upon discharge appropriate statutory/voluntary care will be arranged	Discuss services with MDT patient, and family e.g. Home Care Meals on Wheels Red Cross Pendant Alarm			
2	Upon discharge appropriate action will be taken to decrease risk of future falls	Referral to falls group Advice about falls prevention/home access visit			
3	Patient will demonstrate the ability to safely mobilise with the appropriate walking aid by discharge.	Observe mobility during functional assessment. Check with physio re stairs			
3	Patient will be able to safely and independently transfer on/off bed, chair and toilet and use bath/shower if appropriate (with or without equipment) by discharge.	Complete transfer assessment. Provide equipment if required and advice re techniques			
4	Patient will demonstrate the ability to wash and dress lower body safely and independently by discharge.	Assess/advise on personal care tasks. Provide long handled dressing equipment and teach dressing techniques.			
5	If appropirate, the patient will be able to safely and independently make hot beverage and snack by discharge. Patient/carer will receive verbal and written safety instructions for all adjustable items of loan equipment.	Assess/advise on kitchen and domestic tasks. Provide equipment if required. Verbal instructions given and safety leaflet issued.			

** Applies to patients with hemi-arthroplasty only

N = Not achieved U = Unachievable

A = Achieved E = Exceeded

P = Partially achieved N/A = Not applicable

OT Treatment completed: . . . . . / . . . . ./ . . . . . Name: . . . . . Signature: . . . . . .

Patient Name:... Hosp No: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

OCCUPATIONAL THERAPY CONTINUATION SHEET

Date	Time	No.	SOAP	Notes	Signature

Patient Name:.. Hosp No:

OCCUPATIONAL THERAPY CONTINUATION SHEET

Date	Time	No.	SOAP	Notes	Signature

Patient Name:.. Hosp No: | | | | | | | | | | |

OCCUPATIONAL THERAPY CONTINUATION SHEET

Date	Time	No.	SOAP	Notes	Signature