

# **FRACTURED NECK OF FEMUR**

## **INTEGRATED CARE PATHWAY**

**Patients Name:**

**Hospital No:**

**Ward:**

**Date of Admission:**

**Summary of Guidelines for use:**

1. This protocol is written by the multidisciplinary team to reflect the care for the majority of patients.
2. Protocols can be individualised by writing extra care required in ink on the protocol.
3. The protocol is not cast in stone so please use your professional judgement to decide whether it is appropriate to follow or deviate from it. However if a patient deviates from the protocol please record this as a variance and state the reasons why.
4. If other medical/surgical conditions exist, their assessment and treatment should be documented in usual trust notes.

# **Fractured Neck of Femur/Internal Fixation Integrated Care Pathway**

## **Contents**

1. Abbreviations & List of Variance Codes
2. A&E Fast Track document **Accident and Emergency**  
**Pages 4 & 5**  
**(To be completed by A&E Staff)**
3. Medical Assessment document **Medical Assessment**  
Multidisciplinary Progress Continuation sheets **Pages 6, 7, 8, 9 & 10**  
**(To be completed by Orthopaedic SHO)**
4. Arrival on the ward section **Arrival onto Ward**  
Anticipated Day of Operation/Pre-operative Day  
**(To be completed by Ward Staff)**
5. Day of Operation  
Peri operative Care Plan  
Consent Form **Operative Period**  
Anaesthesia Record/ Operation Case Sheet **(to be completed by Multidisciplinary Team)**  
Post-Operative Observation sheet
6. Post Operation Day 1 section  
Post Operation Day 2 section  
Post Operation Day 3 and 4 section **Post Operative Sections**  
Post Operation Day 5 and 6 section  
Post Operation Days 7-9 section **(to be completed by Multidisciplinary Team)**  
Post Operation Days 10-12 section  
Post Operation Days 13-19 section  
Multidisciplinary Progress Continuation
7. Nursing Records/Standards/Scores **Assessments**  
**(To be included and completed by Nursing Staff)**

Health Records, Nursing Assessment, Clinical Observations Chart and relevant standards to be completed and added on ward

## Abbreviations on Integrated Care Pathway:

Words that can be abbreviated	Allowed abbreviation
Accident and Emergency	A&E
Activities of Living	ADL
Blood Pressure	B/P
Care of	C/O
Charge Nurse	CN-
Check x-ray	QXR
Chronic Obstructive Airways Disease	COAD
Deep Vein Thrombosis	DVT
Department of Medicine for Elderly People	DMEP
Diabetes Mellitus	DM
Dynamic Hip Screw	DHS
Electrocardiogram	ECG
Four times daily medication	QDS
Fractured Neck of Femur	#NOF
Full Blood Count	FBC
Full Weight Bearing	FWB
Glasgow Coma Score	GCS
Haemoglobin	Hb
Health Care Support Work	HCSW
Hemi-Hemiarthroplasty	HA
Hospital at Home	HAH
Intravenous	IV
Liver Function Test	LFT
Microscopy, culture & sensitivity	MC&S
Midstream Urine	MSU
Multidisciplinary Team	MDT
Mini Mental Status (Folstein's Test)	MMS
Multidisciplinary Team Meeting	MDM
Next of Kin	N.O.K
Nil by Mouth	NBM
Non Weight Bearing	NWB
Not Applicable	N/A
Occupational Therapist	OT
Outpatients Appointment	OPA
Partial Weight Bearing	PWB
Patient Controlled Analgesia	PCA
Per oral medication	PO
Post operative day	POD
Pre operative	Pre-op
Pupils equal and reactive to light	PEARL
Registered General Nurse	RGN
Thyroid Function Test	TFT
Senior House Officer	SHO
Seen By	S/B
Senior Sister	SSR
Sister	Sr
Senior Staff Nurse	SSN
Social Worker	S/W
Staff Nurse	SN
Subcutaneous	SC
Take Home Medication	TTA
Three times daily medication	TDS
Urea and Electrolytes	U&E

**Please complete your full details and specimen signature before signing notes completed in this ICP**

[illegible]

## VARIANCE CODES IN ICP

### Accident & Emergency

- A1 Not suitable for Fast Track
- A2 No bed available
- A3 Unable to contact Ortho SHO
- A4 Ortho SHO unable to see

### Pre-op Period

- P1 No space on theatre list
- P2 Run out of theatre time
- P3 Patient medically unfit
- P4 Patient not put on operating list
- P5 Patient waiting to be seen by medics
- P6 Patient waiting to be seen by surgeons
- P7 Patient waiting to be seen by other specialist team
- P8 Patient refusing operation
- P9 Low blood pressure
- P10 High blood pressure
- P11 Blood transfusion required
- P12 Stroke
- P13 Cardiac problems/condition
- P14 Diabetes (uncontrolled)
- P15 Pyrexia
- P16 Urinary Tract Infection
- P17 Chest Infection
- P18 Clostridium difficile
- P19 DVT suspected
- P20 DVT confirmed
- P21 PE suspected
- P22 PE confirmed
- P23 INR not within range
- P24 Skin not suitable for TED stockings
- P25 Pressure Sores
- P26 Allergy
- P27 Urinary Incontinence
- P28 Retention of Urine
- P29 Blood results not available

### Post-op Period

- PO1 Nausea/Vomiting
- PO2 Fainting episode
- PO3 Waiting for QXR
- PO4 QXR not reviewed
- PO5 No instructions documented
- PO6 Wound oozing
- PO7 Wound infected
- PO8 Confusion/disorientation post op
- PO9 Inadequate pain control

### Post op (cont'd)

- PO10 Physio equipment availability
- PO11 IVI continued
- PO12 Respiratory difficulties
- PO13 Urinary tract infection
- PO14 Physio's decision
- PO15 OT's decision
- PO16 Dr's decision
- PO17 Nurse's decision
- PO18 Check bloods not taken/  
results not available

### Discharge

- D1 No ambulance available
- D2 OT equipment availability
- D3 Residential Home
- D4 Nursing Home
- D5 Patient awaiting social service  
package
- D6 Patient awaiting funding
- D7 Patient awaiting rehab bed
- D8 Incomplete discharge plan  
(please specify)
- D9 Porter not available
- D10 TTAs not prescribed
- D11 TTAs not ready

## ACCIDENT AND EMERGENCY DEPARTMENT

Patient Name \_\_\_\_\_

Day/Date \_\_\_\_\_

Please record the **Triage time:** \_\_\_\_.

Admitted to ward within **4 hours** of Triage time

**MILESTONES MET ?**      MET /Not Met

If NO please give variance code

### Fast Track Criteria

	Initial	Time
• The patient is 60+ years of age?	<input type="text"/>	
• If younger, Orthopaedic SHO should carry out further investigations into cause of injury.	<input type="text"/>	
• The patient has not fallen from > 2 metres.	<input type="text"/>	
• Observations are within the following ranges:		
Temperature: 35-37.5	<input type="text"/>	
Pulse: 50-100bpm	<input type="text"/>	
Resps: 12-16 rpm	<input type="text"/>	
B.P: Systolic > 100	<input type="text"/>	
Blood Glucose <b>3.5 – 6.1 mmols/l</b>	<input type="text"/>	
• Normal ECG for age group	<input type="text"/>	
• The patient does not fall within criteria for Trauma Call Team.	<input type="text"/>	
• The patient has no other condition requiring intervention apart from those that can be carried out by a Nurse Practitioner/RN	<input type="text"/>	
• Bed available on Orthopaedic Ward	<input type="text"/>	
• Waterlow score	<input type="text"/>	

**Is patient suitable for fast-track?**

**YES/NO**

**If yes work through following investigation list.**

**If no please refer to casualty dr.**

**Signature:** \_\_\_\_\_

**Status:** \_\_\_\_\_

**Time seen by Casualty Officer: .....**

**PLEASE REFER TO CASUALTY CARD FOR FURTHER INFO**

## ACCIDENT & EMERGENCY DEPARTMENT

Patients Name \_\_\_\_\_ Date \_\_\_\_\_

### INVESTIGATIONS:

Investigation	Date requested	Results
*Full blood count		Hb:_____ WCC:_____ Platelets:_____
Cross match or group and save		
U&Es and Creatanine		Na:___ K:___ Urea:___ Creat:___
Chest X-ray		
Hip X-ray		
ECG		
Sickle Cell if appropriate		
Random Glucose		
*TFT's		TSH: T3: T4: Free T4:
*LFTS		Bil: ALKP: ALT: Albumin:
*Bone Profile		Ca: Adj Ca: CRP: Phosphate: Albumin: Alk Phosphatase:

\*Needed for every patient to exclude secondary causes of Osteoporosis

I.V Cannula in situ

I.V.FLUIDS Yes / No

Analgesia

Pain Assessment Score \_\_\_\_\_

Analgesia given: IV /IM /PO Time:\_\_\_\_\_

Please circle

**Please record any reasons for delay in fast-tracking your patient and approximate time**

Reason Time

**Time referred to Ortho SHO: .....**

**TO BE COMPLETED BY ORTHOPAEDIC SHO**

**Patients name** \_\_\_\_\_ **Date** \_\_\_\_\_ **Time Seen/Assessed** \_\_\_\_\_

**CLINICAL ASSESSMENT**

Presenting Complaint:

History of Presenting Complaint:

**PAST MEDICAL & SURGICAL HISTORY**

	Yes	No
Ischaemic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
DM	<input type="checkbox"/>	<input type="checkbox"/>
Soft Tissue Injury	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

**ALLERGIES:**

**SOCIAL HISTORY:**

Where does the patient live (tick one box)

Own home

Relatives Home

Other (specify below)

☐☐☐

Bungalow

House with stairs

Residential Home

Nursing Home

Sheltered Accommodation

**High Risk MRSA** (specify reasons why)

**Low Risk MRSA** (See Criteria on page ??)

(Please circle as appropriate)

Who does patient live with?

Mobility Status: (Circle)

ALONE

STICK

FRAME

FRAME + 1

IMMOBILE

Able to manage stairs

YES/NO

Able to transfer independently

YES/NO

If NO how transfers

Smoker

YES/NO

Alcohol

.....UNITS/WEEK

TO BE COMPLETED BY ORTHOPAEDIC SHO

Patients name \_\_\_\_\_ Date \_\_\_\_\_

**MEDICATIONS:**

**OSTEOPOROSIS REFERRAL TO FRACTURE LIASON SERVICE**  
**FORM COMPLETED AND FAXED TO 0208 529 9919**

**REVIEW OF SYSTEMS:**

CVS	Chest Pain/Palpitations/Orthopnoea/PND/Skin Ulceration
Respiratory	SOB on exertion (time in minutes)
Abdomen	Pain/Nausea/Vomiting/Diarrhoea/Constipation/Continence
CNS	Fits/Faints/Falls/Dizzy Spells
GU	Continence

**EXAMINATION**

General examination:

Conscious & Orientated: YES/NO

GCS: /15

MMS: /10

Jaundice, Anaemia, Clubbing, Cyanosis, Lymphadenopathy

Temperature:

**Respiratory system:**

Respiratory Rate:

Supplemental % O2:

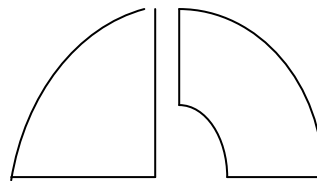
Oxygen Saturations:

Trachea:

Inspection:

Palpation:

Auscultation



**Cardiovascular system:**

Pulse:

BP:

JVP:

HS:

Peripheral Pulses:

Femoral

Popliteal

Posterior Tibial

Dorsalis Pedis

R

L

TO BE COMPLETED BY ORTHOPAEDIC SHO

Patients Name \_\_\_\_\_

Date \_\_\_\_\_

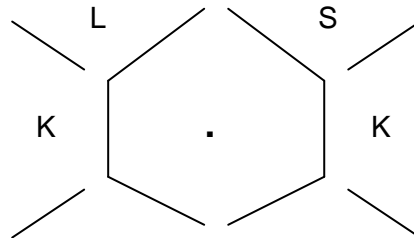
**EXAMINATION (continued)**

**G.I. system:** Grossly intact, not formally assessed ☐

Inspection:

Palpation:

Auscultation



**Musculoskeletal system:**

Look:

Feel:

Move:

Any other injury:

**CNS:** Grossly Intact, not formally assessed ☐

PERL:

CN:

**LUL**

**RUL**

**LLL**

**RLL**

Tone:

Power:

Sensation:

Reflexes: **B** **I** **S** **K** **A** **Plantars**

(R)

(L)

Speech:

Co-ordination:

**Metabolic System**  
**Diabetes**

**Renal**

**Hepatic**

**Other**

**TO BE COMPLETED BY ORTHOPAEDIC SHO**

**Patients Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Tissue Health**    Ischaemia    Necrosis    ulceration

**Immune System**

Existing infection

Inflammatory conditions

Suspected infection

**If yes inform GP of blood results**

Yes                  No

**X-ray findings:**

**Imp:**

**Plan:**

Date \_\_\_\_\_

Time of examination \_\_\_\_\_

Signature \_\_\_\_\_

Bleep number \_\_\_\_\_

Name (printed) \_\_\_\_\_

**INTRODUCTION OF PATHWAY TO PATIENT**  
***(To be completed by Nurse admitting to ward)***

**A key aspect of our Integrated Care Pathway is involving our patients, where possible, in all areas of their care. It is an opportunity to establish an active dialogue with our patients and/or carers or relatives where appropriate.**

**ON ARRIVAL TO \_\_\_\_\_ WARD**

Date \_\_\_\_\_ Time of Arrival \_\_\_\_\_ Patient Name:

Patient admitted to ward from: A&E ☐ other hospital/ward ☐ \_\_\_\_\_ (name)

Accompanied (please circle) YES/NO by whom \_\_\_\_\_

Anticipated length of stay: **11 DAYS** Estimated date of discharge: \_\_\_\_\_

Orientated to Ward/Patient Information folder supplied to patient? YES/NO

If NO please state reason why

Sign: \_\_\_\_\_

Information leaflet given to patient re:  
specific fracture type and operation

**Yes /No**

Sign: \_\_\_\_\_

Ward Phone Number given to Carer/Relatives:

**Yes /No**

Sign: \_\_\_\_\_

Visiting times given to carer/relatives:

**Yes /No**

Sign: \_\_\_\_\_

Information leaflet given to patient/relatives re:  
surgery times and reasons for cancellation

**Yes /No**

Sign: \_\_\_\_\_

MRSA Risk Status Identified & explained to patient/carers  
Please circle as appropriate

**HIGH/LOW**

Sign: \_\_\_\_\_

If High Risk MRSA Screen taken?  
If NO please state reason

**Yes /No**

Sign: \_\_\_\_\_

MRSA Eradication Protocol commenced?  
If NO please state reason

**Yes /No**

Sign: \_\_\_\_\_

Appropriate Antibiotic Prophylaxis Regime prescribed?

**Yes /No**

If NO please state action taken

NURSE COMPLETING TO SIGN PLEASE \_\_\_\_\_

### ADMISSION TO WARD

Patients Name: \_\_\_\_\_ Inpatient day Number: \_\_\_\_ Date: \_\_\_\_\_

#### NURSING

#### INITIAL

a) Nursing Assessment completed

**Yes /No**

\_\_\_\_\_

b) Clinical Observations Recorded

**Yes /No**

\_\_\_\_\_

c) Complete **Care Standard for Skin Integrity, Mattress and Chair Cushion Provision**

Including: \*Pressure Ulcer Risk Factor screen, \*Ongoing Skin Inspection Record, **Yes /No**

\*Ongoing Repositioning Schedule.

**Yes /No**

\_\_\_\_\_

\*Order Primo or Duo pressure therapy mattress.

**Yes /No**

\_\_\_\_\_

\*Order Primo or Duo cushion for Post-op use.

**Yes /No**

\_\_\_\_\_

• Complete moving and Handling assessment

**Yes /No**

\_\_\_\_\_

• Complete Wound care Standard for each wound.

**Yes /No**

\_\_\_\_\_

d) Are prescribed IV fluids in progress

**Yes / No**

\_\_\_\_\_

e) Commence regular pain assessment: Score \_\_\_\_\_

<b>DOCTOR</b>		<b>INITIAL</b>
a) Medical assessment completed	Yes /No	_____
b) Procedure explained including risks & Consent Form signed	Yes /No	_____
c) Limb marked	Yes /No	_____
d) Blood results in <b>ICP</b>	Yes /No	_____
e) If raised MCV discuss with haematologist (check B12 folate)	Yes /No	_____
f) Cross match 2 unit	Yes /No	_____
g) Antibiotics prescribed preoperatively as per protocol: <div style="text-align: center;"> <b>High Risk Patients:</b> Teicoplanin 400mgs IV <b>AND</b>              Gentamicin 160mgs IV at induction           </div>		
h) Analgesia prescribed: Consider CoCodamol OR Tramadol & Paracetamol dependant on individual patient. Oral analgesia to be prescribed in regular section PRN IM analgesia prescribed		
	Yes /No	_____
i) Calcichew D3 Forte prescribed	Yes /No	_____
j) Regular medications prescribed	Yes /No	_____
k) <b>Laxatives prescribed: Senna and Docusate</b>	Yes /No	_____
l) IVI prescribed	Yes /No	_____
m) Clexane 20/40 mgs sc once daily for 10 days post-op prescribed	Yes /No	_____
n) TED Stockings prescribed if not contraindication	Yes /No	_____
o) Referred to Medics/DMEP or other Specialist team if required	Yes /No	_____
If yes please specify		
<b><u>MANAGEMENT</u></b> a) Skin traction applied if prescribed (discuss with Dr) <span style="float: right;">Weight_____</span> b) Identify operation date _____ Time _____ c) To be NBM from _____ d) Additional Nursing Care Plan identified if appropriate <span style="float: right;">Yes /No _____</span>		

Patients Name:

Inpatient Day No:

Hospital No:

## MULTI-DISCIPLINARY COMMUNICATION RECORD

Date/ Time	Content	Signature/ Status
Nursing care given as per protocol and nursing care plan, unless otherwise documented		
Care Leader:	AM PM Night	

[illegible]

Milestones Met	YES/NO (Circle as appropriate)
----------------	--------------------------------

If NO please record Variance code here

## Milestone

### Variance Code

## Action

## Sign

Will need additional multi-disciplinary sheets to be added in for patients who do not go to theatre within 24 hours

## Add in MRSA High and Low Risk Assessment Details

**Add in all the wound care / pressure care paperwork**