Blackpool, Fylde and Wyre Hospitals NHS Trust

"Your Anticipated Journey Through our Healthcare Service"

This Document is Private and Confidential

Visitors and members of the public must not view without the consent of the patient.

Patient Information

- This is a Multidisciplinary Integrated Care Pathway (ICP).
- The pathway will be kept at the foot of your bed as it is a document that all members of staff will refer to whilst providing your care, however if you wish it to be kept at the Nursing station please inform the Nursing staff.
- It contains a record of your planned treatment/management, if you want to know more about your care please follow the pathway.
- If you have any questions please do not hesitate to ask one of the nursing staff or doctors.
- Remember this pathway is a guide to your expected care.
- As an individual your health care requirements may vary from this pathway.
- Do not worry if events do not occur at the exact time stated in the pathway, patients progress at different rates and the team involved in your care will use their professional judgement to adapt your care accordingly.
- Any variation from the pathway will be recorded and explained to you at your request.
- If you would like to know more about how we use your information please ask a member of staff for the leaflet "*How we use your Health Records"*

Blackpool, Fylde and Wyre Hospitals NHS Trust

FOR THE ATTENTION OF ALL STAFF

This Integrated Care Pathway has been developed for use in

Blackpool, Fylde & Wyre Hospitals NHS Trust as a plan of care for patients with: -

Fractured Neck of Femur

It is intended as a guide only, all staff must maintain professional responsibility and accountability when using this pathway.

Decisions regarding an individual patients care remain at the discretion of the professional.

Please read instructions below and sign accountability section before using the pathway.

Instruction and information for staff

- This pathway is to be completed by ALL members of the multidisciplinary team involved in the patients care and will form part of the patients health record
- All sections must be completed
- All professional using this pathway must complete all parts of the accountability section
- It supports decision making but does not constrain your clinical autonomy
- Where available the pathway is evidence-based
- When an activity has been completed sign and record the time. If responsibility for completion of an activity is shared all disciplines must sign
- In exercising professional judgement alteration from the pathway must be noted as a variance and must be recorded on the variance sheet
- Please note variances may be positive or negative
- Put a V in the box next to the activity and then record the variance on the variance sheet
- Record an explanation for the variance on the variance sheet
- Record action taken as a result of the variance on the variance sheet
- A copy of the variance sheet must be forwarded to Marjorie Holden
- There is a multidisciplinary notes/communication section to record e.g. additional care given. These must be signed and dated
- Any additional documentation e.g. blood results must be filed with the ICP in the patients case notes upon discharge
- If you have any queries about using the ICP please contact Ward Managers
- **Care Pathway for review September 2008.**

FILE IN SECTION 4

Integrated Care Pathway for Fractured Neck of Femur

Blackpool, Fylde and Wyre Hospitals NHS Trust

Write patient details or affix Identification label
Hospital Number:
Name:
Address:

Date of Birth:
NHS Number:

ONCE COMPLETED PLEASE FILE INTEGRATED CARE PATHWAY (ICP) IN PATIENTS HOSPITAL CASE NOTES

Abbreviations used in this document to be listed here with the full description:

#NOF -Fracture Neck of Femur
A/E -Accident and Emergency
ADL -Activities or aids of daily living
ARC - Assessment and Rehabilitation Center
Ax - Assessment
DVT -Deep Vein Thrombosis
EWS -Early Warning Score
GA -General Anaesthetic
ICP -Integrated Care Pathway
IM Nail – Intra medullary nail
IVI -Intravenous Infusion
MDT -Multi-Disciplinary Team
MUST -Malnutrition Universal Screening Tool
N/A - Not Applicable
NLU - Nurse Led Unit
O^2 - Oxygen
PCA -Patient Controlled Analgesia
SA Spinal Anaesthetic
SPO^2 -Saturated Percentage Oxygen
OT - Occupational Therapy
U&E's - Urea and Electrolytes

Accountability Section

All Staff must print name in full; sign using the signature/initials to be used throughout the document and then sign the entry with your normal signature.

Printed Name	Designation (E.g. Doctor, Staff Nurse)	Signature/initials to be used	Initials

PHASE OF CARE: Day of Admission ***Milestones/ Outcomes*** *1. Admission to ward 32 / 33 within 2 hrs of arrival to A/E* ☐ *2. Clerked by orthopaedic team* ☐ *3. Admission assessment completed* ☐ *4. Old x-rays obtained* ☐ *5. Medical problems reviewed and relevant referrals considered to* *Anaesthetist* ☐ *Physician* ☐ *Occupational Therapy* ☐ *Hospital Discharge Team* ☐	Write patient details or affix Identification label Hospital Number: Name: Date of Birth: NHS Number:

Date:	***Mark V for variance and record on MDT progress notes***		
Nursing	**Initials**		
	E	**L**	**N**
Safe Admission			
Patient introduced to ward environment			
Information file provided			
Matron's Survey leaflet given			
Full nursing assessment performed using Nursing Assessment Document			
Patient admitted according to policy			
MRSA screen performed			
Plan of care prepared for pre-existing medical conditions ☐ N/A			
Latex allergy check completed Theatres informed if yes and mark as **V** – follow procedure **If YES - e-mail Jean Brown, anaesthetic office with: -Patient name, Hospital number, Allergy Type (1, 11, 111), Consultant, Proposed operative procedure, Date of proposed surgery)**			
Routine investigations available and recorded on fast-track form			
Baseline observation recorded and within normal limits for patient Early Warning Score Less than 3 if No inform SHO and mark as **V**			
Routine Sample Urine (Chart in Admission Document)			
Maintain SPO^2 at 94 % or above. If SPO^2 less than 94%, inform Doctor, mark as **V**, and ensure oxygen prescribed. Administer O^2 at _____l/min as prescribed.			
Pain score one or less. If greater than one give analgesia and chart effectiveness. If remains 2 or more mark as V and inform doctor and Acute Pain Service. Ensure pain score is charted at least 4 hourly.			
Nutrition and Hydration			
If patient nil by mouth for more than 6 hours commence IVI			
Cannula patent and VIP score 1 or less. If score 2 or more remove Cannula and chart as **V.** Reinsert Cannula as per guidelines and ensure Cannula dated Yes ☐ N/A ☐			
Fluid balance chart maintained and urine output > 50ml/hr			
Fluid prescription chart updated with review of electrolytes			
Nutritional status assessed using MUST. If score 1 or more then mark as **V** and document actions			

Seen by anaesthetist. Nil by mouth instructions discussed with patient ☐ Nil by mouth from: Diet _____hrs Fluids_____hrs Clear Fluids_____hrs For Spinal ☐ GA ☐			
Seen by Consultant surgeon. If changes to ICP required-chart as **V** and action			
Patients own medication prescribed Yes ☐ No ☐ N/A ☐			
Pre-medication prescribed Yes ☐ No ☐ N/A ☐			
DVT prophylaxis administered as prescribed at 18:00 **(SIGN56 5.4.2)** Yes ☐ No ☐ N/A ☐			
Elimination	**E**	**L**	**N**
Bowels opened: Yes ☐ No ☐ Last opened Date …….. If more than 72 hours ensure laxatives prescribed If patient on analgesia ensure laxatives prescribed			
Personal Hygiene	**E**	**L**	**N**
Patients personal hygiene needs met and all care to hair, nails and teeth			
Mouthwashes provided if Nil by Mouth N/A ☐			
Manual Handling and Mobility	**E**	**L**	**N**
Patients unaffected leg measured for and antiembolic stocking applied Yes ☐ No ☐ (if No chart as **V** and state why not)			
Pressure Ulcer Risk Assessment monitored today. Risk……. Patient placed on appropriate pressure relieving device for risk. *Specify which:* Static Pressure Redistibution Matress ☐ Primo ☐ Duo ☐ Repose Boots ☐ Foam Gutter Splint ☐			
If pressure ulcers present on admission chart as **V** and commence wound care chart.			
Explain the importance of relieving pressure to patient.			
Use of Monkey pole demonstrated			
Knee function on bed locked out			
Cot sides in situ as per Bed Rails Flowchart in the Nursing Assessment Documentation			
Discharge Planning	**E**	**L**	**N**
Patient referred to Physiotherapist			
Patient referral to Occupational Therapy considered Yes ☐ N/A ☐			
Patient ☐ Relatives ☐ Carers ☐ informed of anticipated surgery time			

Team Nurse signature:		
AM:	**PM:**	**NIGHT:**

Date / time	**Variances Sheet and MDT Progress Notes**	**Signature & profession**

PHASE OF CARE: Peri-operative Day ***Milestones/ Outcomes*** 1. *Operation performed within 24hrs of admission* *Yes ☐ No ☐* ***(if no state reason why in medical notes)*** 2. *Safe preparation for surgery* ***Time to theatre_____***	Write patient details or affix Identification label Hospital Number: Name: Date of Birth: NHS Number:

Date:	***Mark V for variance and record on MDT progress notes***		
Nursing	**Initials**		
	E	**L**	**N**
Pre-operative Phase			
Theatre checklist completed			
Consent for operation obtained			
Plan of care prepared for pre-existing medical conditions ☐ N/A Mark as **V** and actions			
Baseline observation recorded and within normal limits for patient Early Warning Score Less than 3 if No inform SHO and mark as **V** and monitor observations ½ hourly			
Affected limb marked and elevated on a gutter splint with the heel elevated off the bed			
Maintain SPO^2 at 94 % or above. If SPO^2 less than 94%, inform Doctor, mark as **V** , and ensure oxygen prescribed. Administer O^2 at _____l/min as prescribed.			
Pain score one or less. If greater than one give analgesia and chart effectiveness. If remains 2 or more mark as **V** and inform doctor and Acute Pain Service. Ensure pain score is charted at least 4 hourly.			
Premedication given as prescribed N/A ☐			
Nutrition and Hydration			
If patient nil by mouth for more than 6 hours commence IVI			
Cannula patent and VIP score 1 or less. If score 2 or more remove Cannula and chart as **V.** Reinsert Cannula as per guidelines and ensure Cannula dated Yes ☐ N/A ☐			
Fluid balance chart maintained and urine output > 50ml/hr hour if no chart as **V** and inform Doctor			
Fluid prescription chart updated with review of electrolytes			
Nutritional status assessed using MUST. If score 1 or more then mark as **V** and document actions			
Seen by anaesthetist. Nil by mouth instructions discussed with patient ☐ Nil by mouth from: Diet _____hrs Fluids_____hrs Clear Fluids_____hrs			
Elimination	**E**	**L**	**N**
Bowels opened: Yes ☐ No ☐ Last opened Date …….. If more than 72 hours ensure laxatives prescribed If patient on analgesia ensure laxatives prescribed			
Personal Hygiene			
Patients personal hygiene needs met and all care to hair, nails and teeth			

Mouthwashes provided if Nil by Mouth N/A ☐			
Manual Handling and Mobility			
Pressure Ulcer Risk Assessment monitored today. Risk……. Patient placed on appropriate pressure relieving device for risk. *Specify which:* Static Pressure Redistibution Matress ☐ Primo ☐ Duo ☐ Repose Boots ☐ Foam Gutter Splint ☐			
If pressure ulcers present on admission chart as **V** and commence wound care chart.			
Explain the importance of relieving pressure to patient.			
Use of Monkey pole demonstrated			
Knee function on bed locked out			
Cot sides in situ as per Bed Rails Flowchart in the Nursing Assessment Documentation			
Patients unaffected leg measured for and antiembolic stocking applied Yes ☐ No ☐ (if No chart as **V** and state why not)			
Referred to physiotherapist			
Seen by physiotherapist if not record as **V** and document reason why			
Chest physiotherapy given Yes ☐ No ☐ N/A ☐			
Discharge Planning	**E**	**L**	**N**
Patient referred to Hospital Discharge Team			
Patient referred to Occupational Therapy ☐ N/A ☐			
Patient☐ Relatives☐ Carers☐ informed of anticipated surgery time			
Patient information			
Patient ☐ Relatives ☐ Carers ☐ informed of anticipated surgery time			
Post operative management discussed and any anxieties allayed			

Team Nurse signature:		
AM:	**PM:**	**NIGHT:**

Date / time	Variances Sheet and MDT Progress Notes	Signature & profession

PHASE OF CARE: Post-Operative Time transferred back from Theatre: _____hrs	Write patient details or affix Identification label Hospital Number: Name: Date of Birth: NHS Number:
Date:	

Milestones / Outcomes

1. **Surgery performed within 24hrs trauma**
2. **Check x-ray performed**
3. **Oxygen administered for minimum 6hrs**
4. **Safe recovery from anaesthetic**
5. **Pain and Nausea well controlled**

Mark V for variance and record on MDT progress notes	**Initials**		
	E	**L**	**N**
Observations recorded and within normal limits for patient Early Warning Score Less than 3 if No inform SHO and mark as **V** and monitor observations ½ hourly			
Pain score one or less. If greater than one give analgesia and chart effectiveness. If remains 2 or more mark as **V** and inform doctor and Acute Pain Service. Ensure pain score is charted at least 4 hourly.			
PCA maintained as per protocol N/A ☐			
Maintain SPO^2 at 94 % or above. If SPO^2 less than 94%, inform Doctor, mark as **V**, and ensure oxygen prescribed. Administer O^2 at _____l/min as prescribed. **(Continue for at least six hours post-op) (SIGN 56 8.2)**			
Wound checked hourly and wound care chart completed accordingly			
Wound drainage charted ½ hourly Drain 1 _____ Drain 2 _____			
IVI fluids prescribed with review of electrolytes Yes ☐ IVI Discontinued as tolerating oral fluids ☐			
Cannula patent and VIP score 1 or less. If score 2 or more remove Cannula and chart as **V.** Reinsert Cannula as per guidelines and ensure Cannula dated Yes ☐ N/A ☐			
Autologous blood collection/ transfusion in situ N/A ☐			
Fluid balance chart recorded and urine output > 50mls hour if no chart as **V** and inform Doctor			
DVT prophylaxis administered as prescribed and prescribed at 18:00			
Urine output monitored and above 50ml per hour Urethral Catheter **Care of catheter as per guideline** ☐ N/A			
Oral fluids commenced and tolerated when the patient is awake when the anaesthetic wars off. If sedation score 2 or more inform anaesthetist and mark as a **V.** Document medical advice.			
Patient reassured and any anxieties allayed			
Elimination	**E**	**L**	**N**
Bowels opened: Yes ☐ No ☐ Last opened Date…….. If more than 72 hours ensure laxatives prescribed If patient on analgesia ensure laxatives prescribed			

Personal Hygiene	**E**	**L**	**N**
Patients personal hygiene needs met and all care to hair, nails and teeth			
Mouthwashes provided if Nil by Mouth N/A ☐			
Manual Handling and Mobility	**E**	**L**	**N**
Pressure Ulcer Risk Assessment monitored today. Risk……. Patient placed on appropriate pressure relieving device for risk. *Specify which:* Static Pressure Redistibution Matress ☐ Primo ☐ Duo ☐ Repose Boots ☐ Foam Gutter Splint ☐			
If pressure ulcers present chart as **V** and complete wound care chart. If new then complete clinical incident form			
Explain the importance of relieving pressure to patient.			
Charnley Wedge in situ (for Thompson's Prosthesis) N/A ☐ Gutter Splint in situ (for Dynamic hip screws) N/A ☐			
Use of Monkey pole demonstrated			
Knee function on bed locked out			
Patients unaffected leg measured for and antiembolic stocking applied Yes ☐ No ☐ (if No chart as **V** and state why not)			
Patients heels observed Yes ☐ No ☐ Heels intact and healthy Yes ☐ No ☐			
Cot sides in situ as per Bed Rails Flowchart in the Nursing Assessment Documentation			
Referred to physiotherapist			
Chest physiotherapy given Yes ☐ No ☐ N/A ☐			
Discharge Planning	**E**	**L**	**N**
Patient referred to Hospital Discharge Team			
Patient referred to Occupational Therapy ☐ N/A ☐			
Patient☐ Relatives☐ Carers☐ informed of return to ward			
Team Nurse signature:			
AM:	**PM:**	**NIGHT:**	

Date / time	**Variances Sheet and MDT Progress Notes**	**Signature & profession**

PHASE OF CARE: Post-Op Day 1	Write patient details or affix Identification label Hospital Number: Name: Date of Birth: NHS Number:
Date:	

Milestones / Outcomes

1. **Pain well controlled**
2. **No signs of Hypoxaemia**
3. **Oxygen administered at night for 48hr**
4. **No urinary retention**
5. **Fluid & electrolytes monitored**
6. **Hb monitored**
7. **Mobilisation commenced within 24hrs surgery**

Mark V for variance and record on MDT progress notes	**Initials**		
	E	**L**	**N**
Observations recorded and within normal limits for patient Early Warning Score Less than 3 if No inform SHO and mark as **V and** monitor observations ½ hourly			
Pain score one or less. If greater than one give analgesia and chart effectiveness. If remains 2 or more mark as **V** and inform doctor and Acute Pain Service. Ensure pain score is charted at least 4 hourly.			
PCA maintained as per protocol N/A ☐			
Maintain SPO^2 at 94 % or above. If SPO^2 less than 94%, inform Doctor, mark as **V**, and ensure oxygen prescribed. Administer O^2 at _____l/min as prescribed.			
Oxygen to be administered at night Prescribed at_____l/min **(Continue for at least 48 hours post-op)**			
Wound checked and wound care chart completed accordingly			
Wound drainage charted Wound drains removed Yes ☐ if No Mark as **V** and document reason why Drain 1 _____ Drain 2 _____			
Cannula patent and VIP score 1 or less. If score 2 or more remove Cannula and chart as **V.**			
Fluid balance chart recorded and urine output > 50mls hour if no chart as **V** and inform Doctor			
Urine output monitored and above 50ml per hour Urethral Catheter **Care of catheter as per guideline** ☐ N/A			
DVT prophylaxis administered as prescribed and prescribed at 18:00			
Hygiene needs met and all care to hair, nails and teeth			
Oral diet and fluids tolerated			
Nutritional status assessed using MUST. If score 1 or more then mark as **V** and document actions			
Patient reassured and any anxieties allayed			
Normal sleep pattern achieved and patient well rested			
Elimination	**E**	**L**	**N**
Bowels opened: Yes ☐ No ☐ Last opened Date …….. If more than 72 hours ensure laxatives prescribed If patient on analgesia ensure laxatives prescribed			

Personal Hygiene	**E**	**L**	**N**
Patients personal hygiene needs met and all care to hair, nails and teeth			
Manual Handling and Mobility			
Pressure Ulcer Risk Assessment monitored today. Risk……. Patient placed on appropriate pressure relieving device for risk. *Specify which:* Static Pressure Redistibution Matress ☐ Primo ☐ Duo ☐ Repose Boots ☐ Foam Gutter Splint ☐			
If pressure ulcers present chart as **V** and complete wound care chart. If new then complete clinical incident form			
Explain the importance of relieving pressure to patient.			
Charnley Wedge in situ whilst in bed (for Thompson's/Monks Prosthesis) N/A ☐ Gutter Splint in situ whilst in bed (for Dynamic Hip Screws) N/A ☐			
Use of Monkey pole demonstrated			
Knee function on bed locked out			
Patients affected leg measured for and antiembolic stocking applied Yes ☐ No ☐ (if No chart as **V** and state why not)			
Cot sides in situ as per Bed Rails Flowchart in the Nursing Assessment Documentation			
Check x-ray reviewed prior to sitting out in chair (for Thompson's/Monks Prosthesis only) N/A ☐			
Sat out in chair if not record as **V** and document reason why MUST be a HIGH chair for Thompson's/Monks Prosthesis only			
☐Thompson's/Monks Prosthesis - mobilized with Zimmer frame – fully weight bearing, if not record as **V** and document reason why ☐DHS - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why ☐Gamma/IM Nail - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why			
Chest physiotherapy given Yes ☐ No ☐ N/A ☐			
Discharge Planning	**E**	**L**	**N**
Patient seen by Hospital Discharge Team			
Patient seen by Occupational Therapy Yes ☐ No ☐ N/A ☐			
Patient☐ Relatives☐ Carers☐ informed of anticipated discharge date			

Team Nurse signature:		
AM:	**PM:**	**NIGHT:**

Date / time	**Variances Sheet and MDT Progress Notes**	**Signature & profession**

PHASE OF CARE: Post-Op Day 2	Write patient details or affix Identification label Hospital Number: Name: Date of Birth: NHS Number:
Date:	

Milestones / Outcomes

1. **Pain well controlled**
2. **No signs of Hypoxaemia**
3. **Oxygen administered at night for 48hrs**
4. **Mobilisation commenced within 24hrs surgery**

Mark V for variance and record on MDT progress notes	**Initials**		
	E	**L**	**N**
Observations recorded and within normal limits for patient Early Warning Score Less than 3 if No inform SHO and mark as **V and** monitor observations ½ hourly			
Pain score one or less. If greater than one give analgesia and chart effectiveness. If remains 2 or more mark as **V** and inform doctor and Acute Pain Service. Ensure pain score is charted at least 4 hourly.			
PCA discontinued If not chart as **V** and document reason why. N/A ☐			
Maintain SPO^2 at 94 % or above. If SPO^2 less than 94%, inform Doctor, mark as **V**, and ensure oxygen prescribed. Administer O^2 at _____l/min as prescribed.			
Oxygen to be administered at night Prescribed at_____l/min **(Continue for at least 48 hours post-op)**			
Wound checked and wound care chart completed accordingly			
Remove Cannula. Document VIP score. If not removed chart as **V** and document reason why.			
Fluid balance chart recorded and urine output > 50mls hour if no chart as **V** and inform Doctor			
Urine output monitored and above 50ml per hour If Urethral Catheter consider removal **Care of catheter as per guideline** ☐ N/A			
DVT prophylaxis administered as prescribed and prescribed at 18:00			
Hygiene needs met and all care to hair, nails and teeth			
Oral diet and fluids tolerated			
Nutritional status assessed using MUST. If score 1 or more then mark as **V** and document actions			
Patient reassured and any anxieties allayed			
Normal sleep pattern achieved and patient well rested			
Elimination	**E**	**L**	**N**
Bowels opened: Yes ☐ No ☐ Last opened Date …….. If more than 72 hours ensure laxatives prescribed If patient on analgesia ensure laxatives prescribed			
Personal Hygiene	**E**	**L**	**N**
Patients personal hygiene needs met and all care to hair, nails and teeth			

Manual Handling and Mobility	E	L	N
Pressure Ulcer Risk Assessment monitored today. Risk……. Patient placed on appropriate pressure relieving device for risk. *Specify which:* Static Pressure Redistibution Matress ☐ Primo ☐ Duo ☐ Repose Boots ☐ Foam Gutter Splint ☐			
If pressure ulcers present chart as **V** and complete wound care chart. If new then complete clinical incident form			
Explain the importance of relieving pressure to patient.			
Charnley Wedge in situ whilst in bed (for Thompson's/Monks Prosthesis) N/A ☐ Gutter Splint in situ whilst in bed (for Dynamic Hip Screws) N/A ☐			
Use of Monkey pole demonstrated			
Knee function on bed locked out			
Antiembolic stocking removed to check heels. Both heels healthy Yes ☐ No ☐ N/A ☐ (if No chart as **V** complete wound care chart)			
Cot sides in situ as per Bed Rails Flowchart in the Nursing Assessment Documentation			
Check x-ray reviewed prior to sitting out in chair (for Thompson's/Monks Prosthesis only) N/A ☐			
Sat out in chair if not record as **V** and document reason why MUST be a HIGH chair for Thompson's/Monks Prosthesis only			
☐Thompson's/Monks Prosthesis - mobilized with Zimmer frame – fully weight bearing, if not record as **V** and document reason why ☐DHS - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why ☐Gamma/IM Nail - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why			
Chest physiotherapy given Yes ☐ No ☐ N/A ☐			
Discharge Planning	**E**	**L**	**N**
Patient seen by Hospital Discharge Team			
Patient seen by Occupational Therapy Yes ☐ No ☐ N/A ☐			
Patient☐ Relatives☐ Carers☐ informed of anticipated discharge date			

Team Nurse signature:		
AM:	**PM:**	**NIGHT:**

Date / time	Variances Sheet and MDT Progress Notes	Signature & profession

PHASE OF CARE: Post-Op Day 3	Write patient details or affix Identification label Hospital Number: Name: Date of Birth: NHS Number:
Date:	

Milestones / Outcomes

1. **Early mobilisation achieved**
2. **Prevention of constipation**
3. **Fluid and electrolyte balance maintained**

Mark V for variance and record on MDT progress notes	**Initials**		
	E	**L**	**N**
Observations recorded and within normal limits for patient Early Warning Score Less than 3 if No inform SHO and mark as **V and** monitor observations ½ hourly			
Pain score one or less. If greater than one give analgesia and chart effectiveness. If remains 2 or more mark as **V** and inform doctor and Acute Pain Service. Ensure pain score is charted at least 4 hourly.			
Maintain SPO^2 at 94 % or above. If SPO^2 less than 94%, inform Doctor, mark as **V**, and ensure oxygen prescribed. Administer O^2 at _____l/min as prescribed.			
Wound checked and wound care chart completed accordingly			
Remove Cannula. Document VIP score. If not removed chart as **V** and document reason why. If been in situ for 72 hours change Cannula as per procedure Yes ☐ No ☐			
Discontinue fluid balance chart If no chart as **V** and document reason why			
DVT prophylaxis administered as prescribed and prescribed at 18:00			
Oral diet and fluids tolerated			
Nutritional status assessed using MUST. If score 1 or more then mark as **V** and document actions			
Patient reassured and any anxieties allayed			
Normal sleep pattern achieved and patient well rested			
Elimination	**E**	**L**	**N**
Bowels opened: Yes ☐ No ☐ Last opened Date ……. If more than 72 hours ensure laxatives prescribed If patient on analgesia ensure laxatives prescribed			
Personal Hygiene	**E**	**L**	**N**
Patients personal hygiene needs met and all care to hair, nails and teeth			
Manual Handling and Mobility	**E**	**L**	**N**
Pressure Ulcer Risk Assessment monitored today. Risk……. Patient placed on appropriate pressure relieving device for risk. *Specify which:* Static Pressure Redistibution Matress ☐ Primo ☐ Duo ☐ Repose Boots ☐ Foam Gutter Splint ☐			
If pressure ulcers present chart as **V** and complete wound care chart. If new then complete clinical incident form			
Explain the importance of relieving pressure to patient.			
Charnley Wedge in situ whilst in bed (for Thompson's/Monks Prosthesis) N/A ☐ Gutter Splint in situ whilst in bed (for Dynamic Hip Screws) N/A ☐			

Use of Monkey pole demonstrated			
Knee function on bed locked out			
Antiembolic stocking removed to check heels. Both heels healthy Yes ☐ No ☐ N/A ☐ (if No chart as **V** complete wound care chart)			
Cot sides in situ as per Bed Rails Flowchart in the Nursing Assessment Documentation			
Sat out in chair if not record as **V** and document reason why MUST be a HIGH chair for Thompson's/Monks Prosthesis only			
☐Thompson's/Monks Prosthesis - mobilized with Zimmer frame – fully weight bearing, if not record as **V** and document reason why ☐DHS - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why ☐Gamma/IM Nail - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why			
Chest physiotherapy given Yes ☐ No ☐ N/A ☐			
Discharge Planning	**E**	**L**	**N**
Patient seen by Hospital Discharge Team			
Consider referral to Clifton Hospital N/A ☐ or to rehab services ie *ARC, *NLU, *intermediate care services N/A ☐ ***circle as appropriate**			
Patient seen by Occupational Therapy Yes ☐ No ☐ N/A ☐			
Patient☐ Relatives☐ Carers☐ informed of anticipated discharge date			

Team Nurse signature:		
AM:	**PM:**	**NIGHT:**

Date / time	**Variances Sheet and MDT Progress Notes**	**Signature & profession**

PHASE OF CARE: Post-Op Day 4	Write patient details or affix Identification label Hospital Number: Name: Date of Birth: NHS Number:
Date:	

Milestones / Outcomes

1. **Early mobilisation achieved**
2. **Prevention of constipation**
3. **Fluid and electrolyte balance maintained**

Mark V for variance and record on MDT progress notes	**Initials**		
	E	**L**	**N**
Observations recorded and within normal limits for patient Early Warning Score Less than 3 if No inform SHO and mark as **V and** monitor observations ½ hourly			
Pain score one or less. If greater than one give analgesia and chart effectiveness. If remains 2 or more mark as **V** and inform doctor and Acute Pain Service. Ensure pain score is charted at least 4 hourly.			
Maintain SPO^2 at 94 % or above. If SPO^2 less than 94%, inform Doctor, mark as **V**, and ensure oxygen prescribed. Administer O^2 at _____l/min as prescribed.			
Wound checked and wound care chart completed accordingly			
Remove Cannula. Document VIP score. If not removed chart as **V** and document reason why. If been in situ for 72 hours change Cannula as per procedure Yes ☐ No ☐			
Discontinue fluid balance chart If no chart as **V** and document reason why			
DVT prophylaxis administered as prescribed and prescribed at 18:00			
Oral diet and fluids tolerated			
Nutritional status assessed using MUST. If score 1 or more then mark as **V** and document actions			
Patient reassured and any anxieties allayed			
Normal sleep pattern achieved and patient well rested			
Elimination	**E**	**L**	**N**
Bowels opened: Yes ☐ No ☐ Last opened Date ……. If more than 72 hours ensure laxatives prescribed If patient on analgesia ensure laxatives prescribed			
Personal Hygiene	**E**	**L**	**N**
Patients personal hygiene needs met and all care to hair, nails and teeth			
Manual Handling and Mobility	**E**	**L**	**N**
Pressure Ulcer Risk Assessment monitored today. Risk……. Patient placed on appropriate pressure relieving device for risk. *Specify which:* Static Pressure Redistibution Matress ☐ Primo ☐ Duo ☐ Repose Boots ☐ Foam Gutter Splint ☐			
If pressure ulcers present chart as **V** and complete wound care chart. If new then complete clinical incident form			
Explain the importance of relieving pressure to patient.			
Charnley Wedge in situ whilst in bed (for Thompson's/Monks Prosthesis) N/A ☐ Gutter Splint in situ whilst in bed (for Dynamic Hip Screws) N/A ☐			

Use of Monkey pole demonstrated			
Knee function on bed locked out			
Antiembolic stocking removed to check heels. Both heels healthy Yes ☐ No ☐ N/A ☐ (if No chart as **V** complete wound care chart)			
Cot sides in situ as per Bed Rails Flowchart in the Nursing Assessment Documentation			
Sat out in chair if not record as **V** and document reason why MUST be a HIGH chair for Thompson's/Monks Prosthesis only			
☐Thompson's/Monks Prosthesis - mobilized with Zimmer frame – fully weight bearing, if not record as **V** and document reason why ☐DHS - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why ☐Gamma/IM Nail - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why			
Chest physiotherapy given Yes ☐ No ☐ N/A ☐			
Discharge Planning	**E**	**L**	**N**
Patient seen by Hospital Discharge Team			
Consider referral to Clifton Hospital N/A ☐			
Patient seen by Occupational Therapy Yes ☐ No ☐ N/A ☐			
Patient☐ Relatives☐ Carers☐ informed of anticipated discharge date			

Team Nurse signature:		
AM:	**PM:**	**NIGHT:**

Date / time	Variances Sheet and MDT Progress Notes	Signature & profession

PHASE OF CARE: Post-Op Day 5	Write patient details or affix Identification label Hospital Number: Name: Date of Birth: NHS Number:
Date:	

Milestones / Outcomes

1. **Early mobilisation achieved**
2. **Prevention of constipation**
3. **Fluid and electrolyte balance maintained**

Mark V for variance and record on MDT progress notes	**Initials**		
	E	**L**	**N**
Observations recorded and within normal limits for patient Early Warning Score Less than 3 if No inform SHO and mark as **V and** monitor observations ½ hourly			
Pain score one or less. If greater than one give analgesia and chart effectiveness. If remains 2 or more mark as **V** and inform doctor and Acute Pain Service. Ensure pain score is charted at least 4 hourly.			
Maintain SPO^2 at 94 % or above. If SPO^2 less than 94%, inform Doctor, mark as **V**, and ensure oxygen prescribed. Administer O^2 at _____l/min as prescribed.			
Wound checked and wound care chart completed accordingly			
DVT prophylaxis administered as prescribed and prescribed at 18:00			
Oral diet and fluids tolerated			
Nutritional status assessed using MUST. If score 1 or more then mark as **V** and document actions			
Patient reassured and any anxieties allayed			
Normal sleep pattern achieved and patient well rested			
Elimination	**E**	**L**	**N**
Bowels opened: Yes ☐ No ☐ Last opened Date ……. If more than 72 hours ensure laxatives prescribed If patient on analgesia ensure laxatives prescribed			
Personal Hygiene	**E**	**L**	**N**
Patients personal hygiene needs met and all care to hair, nails and teeth			
Manual Handling and Mobility	**E**	**L**	**N**
Pressure Ulcer Risk Assessment monitored today. Risk……. Patient placed on appropriate pressure relieving device for risk. *Specify which:* Static Pressure Redistibution Matress ☐ Primo ☐ Duo ☐ Repose Boots ☐ Foam Gutter Splint ☐			
If pressure ulcers present chart as **V** and complete wound care chart. If new then complete clinical incident form			
Explain the importance of relieving pressure to patient.			
Charnley Wedge in situ whilst in bed (for Thompson's/Monks Prosthesis) N/A ☐ Gutter Splint in situ whilst in bed (for Dynamic Hip Screws) N/A ☐			
Use of Monkey pole demonstrated			
Knee function on bed locked out			
Antiembolic stocking removed to check heels. Both heels healthy Yes ☐ No ☐ N/A ☐ (if No chart as **V** complete wound care chart)			

Cot sides in situ as per Bed Rails Flowchart in the Nursing Assessment Documentation			
Sat out in chair if not record as **V** and document reason why MUST be a HIGH chair for Thompson's/Monks Prosthesis only			
☐Thompson's/Monks Prosthesis - mobilized with Zimmer frame – fully weight bearing, if not record as **V** and document reason why ☐DHS - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why ☐Gamma/IM Nail - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why			
Chest physiotherapy given Yes ☐ No ☐ N/A ☐			
Discharge Planning	**E**	**L**	**N**
Patient seen by Hospital Discharge Team			
Consider referral to Clifton Hospital N/A ☐			
Patient seen by Occupational Therapy Yes ☐ No ☐ N/A ☐			
Patient☐ Relatives☐ Carers☐ informed of anticipated discharge date			

Team Nurse signature:		
AM:	**PM:**	**NIGHT:**

Date / time	Variances Sheet and MDT Progress Notes	Signature & profession

PHASE OF CARE: Post-Op Day 6	Write patient details or affix Identification label Hospital Number: Name: Date of Birth: NHS Number:
Date:	

Milestones / Outcomes

1. **Early mobilisation achieved**
2. **Prevention of constipation**
3. **Fluid and electrolyte balance maintained**

Mark V for variance and record on MDT progress notes	**Initials**		
	E	**L**	**N**
Observations recorded and within normal limits for patient Early Warning Score Less than 3 if No inform SHO and mark as **V and** monitor observations ½ hourly			
Pain score one or less. If greater than one give analgesia and chart effectiveness. If remains 2 or more mark as **V** and inform doctor and Acute Pain Service. Ensure pain score is charted at least 4 hourly.			
Maintain SPO^2 at 94 % or above. If SPO^2 less than 94%, inform Doctor, mark as **V**, and ensure oxygen prescribed. Administer O^2 at _____l/min as prescribed.			
Wound checked and wound care chart completed accordingly			
DVT prophylaxis administered as prescribed and prescribed at 18:00			
Oral diet and fluids tolerated			
Nutritional status assessed using MUST. If score 1 or more then mark as **V** and document actions			
Patient reassured and any anxieties allayed			
Normal sleep pattern achieved and patient well rested			
Elimination	**E**	**L**	**N**
Bowels opened: Yes ☐ No ☐ Last opened Date ……. If more than 72 hours ensure laxatives prescribed If patient on analgesia ensure laxatives prescribed			
Personal Hygiene	**E**	**L**	**N**
Patients personal hygiene needs met and all care to hair, nails and teeth			
Manual Handling and Mobility	**E**	**L**	**N**
Pressure Ulcer Risk Assessment monitored today. Risk……. Patient placed on appropriate pressure relieving device for risk. *Specify which:* Static Pressure Redistibution Matress ☐ Primo ☐ Duo ☐ Repose Boots ☐ Foam Gutter Splint ☐			
If pressure ulcers present chart as **V** and complete wound care chart. If new then complete clinical incident form			
Explain the importance of relieving pressure to patient.			
Charnley Wedge in situ whilst in bed (for Thompson's/Monks Prosthesis) N/A ☐ Gutter Splint in situ whilst in bed (for Dynamic Hip Screws) N/A ☐			
Use of Monkey pole demonstrated			
Knee function on bed locked out			

Antiembolic stocking removed to check heels. Both heels healthy Yes ☐ No ☐ N/A ☐ (if No chart as **V** complete wound care chart)			
Cot sides in situ as per Bed Rails Flowchart in the Nursing Assessment Documentation			
Seen by physiotherapist if not record as **V** and document reason why			
Sat out in chair if not record as **V** and document reason why <u>MUST</u> be a <u>HIGH</u> chair for Thompson's/Monks Prosthesis only			
☐<u>Thompson's/Monks Prosthesis</u> - mobilized with Zimmer frame – fully weight bearing, if not record as **V** and document reason why ☐<u>DHS</u> - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why ☐<u>Gamma/IM Nail</u> - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why			
Chest physiotherapy given Yes ☐ No ☐ N/A ☐			
Discharge Planning	**E**	**L**	**N**
Consider referral to Nurse Led Unit N/A ☐ Consider referral to Clifton Hospital N/A ☐			
Patient seen by Hospital Discharge Team			
Patient seen by Occupational Therapy Yes ☐ No ☐ N/A ☐			
Patient☐ Relatives☐ Carers☐ informed of anticipated discharge date			
Team Nurse signature:			

AM:	**PM:**	**NIGHT:**

Date / time	Variances Sheet and MDT Progress Notes	Signature & profession

PHASE OF CARE: Post-Op Day 7	Write patient details or affix Identification label Hospital Number: Name: Date of Birth: NHS Number:
Date:	

Milestones / Outcomes

1. **Early mobilisation achieved**
2. **Prevention of constipation**
3. **Fluid and electrolyte balance maintained**

Mark V for variance and record on MDT progress notes	**Initials**		
	E	**L**	**N**
Observations recorded and within normal limits for patient Early Warning Score Less than 3 if No inform SHO and mark as **V and** monitor observations ½ hourly			
Pain score one or less. If greater than one give analgesia and chart effectiveness. If remains 2 or more mark as **V** and inform doctor and Acute Pain Service. Ensure pain score is charted at least 4 hourly.			
Maintain SPO^2 at 94 % or above. If SPO^2 less than 94%, inform Doctor, mark as **V**, and ensure oxygen prescribed. Administer O^2 at _____l/min as prescribed.			
Wound checked and wound care chart completed accordingly			
DVT prophylaxis administered as prescribed and prescribed at 18:00			
Oral diet and fluids tolerated			
Nutritional status assessed using MUST. If score 1 or more then mark as **V** and document actions			
Patient reassured and any anxieties allayed			
Normal sleep pattern achieved and patient well rested			
Elimination	**E**	**L**	**N**
Bowels opened: Yes ☐ No ☐ Last opened Date ……. If more than 72 hours ensure laxatives prescribed If patient on analgesia ensure laxatives prescribed			
Personal Hygiene	**E**	**L**	**N**
Patients personal hygiene needs met and all care to hair, nails and teeth			
Manual Handling and Mobility	**E**	**L**	**N**
Pressure Ulcer Risk Assessment monitored today. Risk……. Patient placed on appropriate pressure relieving device for risk. *Specify which:* Static Pressure Redistibution Matress ☐ Primo ☐ Duo ☐ Repose Boots ☐ Foam Gutter Splint ☐			
If pressure ulcers present chart as **V** and complete wound care chart. If new then complete clinical incident form			
Explain the importance of relieving pressure to patient.			
Charnley Wedge in situ whilst in bed (for Thompson's/Monks Prosthesis) N/A ☐ Gutter Splint in situ whilst in bed (for Dynamic Hip Screws) N/A ☐			
Use of Monkey pole demonstrated			
Knee function on bed locked out			

Antiembolic stocking removed to check heels. Both heels healthy Yes ☐ No ☐ N/A ☐ (if No chart as **V** complete wound care chart)			
Cot sides in situ as per Bed Rails Flowchart in the Nursing Assessment Documentation			
Sat out in chair if not record as **V** and document reason why MUST be a HIGH chair for Thompson's/Monks Prosthesis only			
☐Thompson's/Monks Prosthesis - mobilized with Zimmer frame – fully weight bearing, if not record as **V** and document reason why ☐DHS - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why ☐Gamma/IM Nail - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why			
Chest physiotherapy given Yes ☐ No ☐ N/A ☐			
Discharge Planning	**E**	**L**	**N**
Consider referral to Nurse Led Unit N/A ☐ Consider referral to Clifton Hospital N/A ☐			
Patient seen by Hospital Discharge Team			
Patient seen by Occupational Therapy Yes ☐ No ☐ N/A ☐			
Patient☐ Relatives☐ Carers☐ informed of anticipated discharge date			

Team Nurse signature:

AM:	**PM:**	**NIGHT:**

Date / time	**Variances Sheet and MDT Progress Notes**	**Signature & profession**

PHASE OF CARE: Post-Op Day 8	Write patient details or affix Identification label Hospital Number: Name: Date of Birth: NHS Number:
Date:	

Milestones / Outcomes

4. **Early mobilisation achieved**
5. **Prevention of constipation**
6. **Fluid and electrolyte balance maintained**

Mark V for variance and record on MDT progress notes	**Initials**		
	E	**L**	**N**
Observations recorded and within normal limits for patient Early Warning Score Less than 3 if No inform SHO and mark as **V and** monitor observations ½ hourly			
Pain score one or less. If greater than one give analgesia and chart effectiveness. If remains 2 or more mark as **V** and inform doctor and Acute Pain Service. Ensure pain score is charted at least 4 hourly.			
Maintain SPO^2 at 94 % or above. If SPO^2 less than 94%, inform Doctor, mark as **V**, and ensure oxygen prescribed. Administer O^2 at _____l/min as prescribed.			
Wound checked and wound care chart completed accordingly			
DVT prophylaxis administered as prescribed and prescribed at 18:00			
Oral diet and fluids tolerated			
Nutritional status assessed using MUST. If score 1 or more then mark as **V** and document actions			
Patient reassured and any anxieties allayed			
Normal sleep pattern achieved and patient well rested			
Elimination	**E**	**L**	**N**
Bowels opened: Yes ☐ No ☐ Last opened Date ……. If more than 72 hours ensure laxatives prescribed If patient on analgesia ensure laxatives prescribed			
Personal Hygiene	**E**	**L**	**N**
Patients personal hygiene needs met and all care to hair, nails and teeth			
Manual Handling and Mobility	**E**	**L**	**N**
Pressure Ulcer Risk Assessment monitored today. Risk……. Patient placed on appropriate pressure relieving device for risk. *Specify which:* Static Pressure Redistibution Matress ☐ Primo ☐ Duo ☐ Repose Boots ☐ Foam Gutter Splint ☐			
If pressure ulcers present chart as **V** and complete wound care chart. If new then complete clinical incident form			
Explain the importance of relieving pressure to patient.			
Charnley Wedge in situ whilst in bed (for Thompson's/Monks Prosthesis) N/A ☐ Gutter Splint in situ whilst in bed (for Dynamic Hip Screws) N/A ☐			
Use of Monkey pole demonstrated			
Knee function on bed locked out			
Antiembolic stocking removed to check heels. Both heels healthy Yes ☐ No ☐ N/A ☐ (if No chart as **V** complete wound care chart)			

Cot sides in situ as per Bed Rails Flowchart in the Nursing Assessment Documentation			
Sat out in chair if not record as **V** and document reason why MUST be a HIGH chair for Thompson's/Monks Prosthesis only			
☐Thompson's/Monks Prosthesis - mobilized with Zimmer frame – fully weight bearing, if not record as **V** and document reason why ☐DHS - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why ☐Gamma/IM Nail - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why			
Chest physiotherapy given Yes ☐ No ☐ N/A ☐			
Discharge Planning	**E**	**L**	**N**
Consider referral to Nurse Led Unit N/A ☐ Consider referral to Clifton Hospital N/A ☐			
Patient seen by Hospital Discharge Team			
Patient seen by Occupational Therapy Yes ☐ No ☐ N/A ☐			
Patient☐ Relatives☐ Carers☐ informed of anticipated discharge date			

Team Nurse signature:		
AM:	**PM:**	**NIGHT:**

Date / time	Variances Sheet and MDT Progress Notes	Signature & profession

PHASE OF CARE: Post-Op Day 9	Write patient details or affix Identification label Hospital Number: Name: Date of Birth: NHS Number:
Date:	

Milestones / Outcomes

1. **Early mobilisation achieved**
2. **Prevention of constipation**
3. **Fluid and electrolyte balance maintained**

Mark V for variance and record on MDT progress notes	**Initials**		
	E	**L**	**N**
Observations recorded and within normal limits for patient Early Warning Score Less than 3 if No inform SHO and mark as **V and** monitor observations ½ hourly			
Pain score one or less. If greater than one give analgesia and chart effectiveness. If remains 2 or more mark as **V** and inform doctor and Acute Pain Service. Ensure pain score is charted at least 4 hourly.			
Maintain SPO^2 at 94 % or above. If SPO^2 less than 94%, inform Doctor, mark as **V**, and ensure oxygen prescribed. Administer O^2 at _____l/min as prescribed.			
Wound checked and wound care chart completed accordingly			
DVT prophylaxis administered as prescribed and prescribed at 18:00 Self administration techniques commenced Yes ☐ No ☐ N/A ☐			
Oral diet and fluids tolerated			
Nutritional status assessed using MUST. If score 1 or more then mark as **V** and document actions			
Patient reassured and any anxieties allayed			
Normal sleep pattern achieved and patient well rested			
Elimination	**E**	**L**	**N**
Bowels opened: Yes ☐ No ☐ Last opened Date ……. If more than 72 hours ensure laxatives prescribed If patient on analgesia ensure laxatives prescribed			
Personal Hygiene	**E**	**L**	**N**
Patients personal hygiene needs met and all care to hair, nails and teeth			
Manual Handling and Mobility	**E**	**L**	**N**
Pressure Ulcer Risk Assessment monitored today. Risk……. Patient placed on appropriate pressure relieving device for risk. *Specify which:* Static Pressure Redistibution Matress ☐ Primo ☐ Duo ☐ Repose Boots ☐ Foam Gutter Splint ☐			
If pressure ulcers present chart as **V** and complete wound care chart. If new then complete clinical incident form			
Explain the importance of relieving pressure to patient.			
Charnley Wedge in situ whilst in bed (for Thompson's/Monks Prosthesis) N/A ☐ Gutter Splint in situ whilst in bed (for Dynamic Hip Screws) N/A ☐			
Use of Monkey pole demonstrated			
Knee function on bed locked out			

Antiembolic stocking removed to check heels. Both heels healthy Yes ☐ No ☐ N/A ☐ (if No chart as **V** complete wound care chart)			
Cot sides in situ as per Bed Rails Flowchart in the Nursing Assessment Documentation			
Sat out in chair if not record as **V** and document reason why MUST be a HIGH chair for Thompson's/Monks Prosthesis only			
☐Thompson's/Monks Prosthesis - mobilized with Zimmer frame – fully weight bearing, if not record as **V** and document reason why ☐DHS - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why ☐Gamma/IM Nail - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why			
Chest physiotherapy given Yes ☐ No ☐ N/A ☐			
Discharge Planning	**E**	**L**	**N**
Consider referral to Nurse Led Unit N/A ☐ Consider referral to Clifton Hospital N/A ☐			
Patient seen by Hospital Discharge Team			
Patient seen by Occupational Therapy Yes ☐ No ☐ N/A ☐			
Patient☐ Relatives☐ Carers☐ informed of anticipated discharge date			

Team Nurse signature:

AM:	**PM:**	**NIGHT:**

Date / time	**Variances Sheet and MDT Progress Notes**	**Signature & profession**

PHASE OF CARE: Post-Op Day 10	Write patient details or affix Identification label Hospital Number: Name: Date of Birth: NHS Number:
Date:	

Milestones / Outcomes

1. **Early mobilisation achieved**
2. **Prevention of constipation**
3. **Fluid and electrolyte balance maintained**

Mark V for variance and record on MDT progress notes	**Initials**		
	E	**L**	**N**
Observations recorded and within normal limits for patient Early Warning Score Less than 3 if No inform SHO and mark as **V and** monitor observations ½ hourly			
Pain score one or less. If greater than one give analgesia and chart effectiveness. If remains 2 or more mark as **V** and inform doctor and Acute Pain Service. Ensure pain score is charted at least 4 hourly.			
Maintain SPO^2 at 94 % or above. If SPO^2 less than 94%, inform Doctor, mark as **V**, and ensure oxygen prescribed. Administer O^2 at _____l/min as prescribed.			
Wound checked and wound care chart completed accordingly			
Sutures/clips removed and wound care chart completed accordingly if not record as V and document reason why			
DVT prophylaxis administered as prescribed and prescribed at 18:00 Self administration techniques commenced Yes ☐ No ☐ N/A ☐			
Oral diet and fluids tolerated			
Nutritional status assessed using MUST. If score 1 or more then mark as **V** and document actions			
Patient reassured and any anxieties allayed			
Normal sleep pattern achieved and patient well rested			
Elimination	**E**	**L**	**N**
Bowels opened: Yes ☐ No ☐ Last opened Date ……. If more than 72 hours ensure laxatives prescribed If patient on analgesia ensure laxatives prescribed			
Personal Hygiene	**E**	**L**	**N**
Patients personal hygiene needs met and all care to hair, nails and teeth			
Manual Handling and Mobility	**E**	**L**	**N**
Pressure Ulcer Risk Assessment monitored today. Risk……. Patient placed on appropriate pressure relieving device for risk. *Specify which:* Static Pressure Redistibution Matress ☐ Primo ☐ Duo ☐ Repose Boots ☐ Foam Gutter Splint ☐			
If pressure ulcers present chart as **V** and complete wound care chart. If new then complete clinical incident form			
Explain the importance of relieving pressure to patient.			
Charnley Wedge in situ whilst in bed (for Thompson's/Monks Prosthesis) N/A ☐ Gutter Splint in situ whilst in bed (for Dynamic Hip Screws) N/A ☐			
Use of Monkey pole demonstrated			
Knee function on bed locked out			

Antiembolic stocking removed to check heels. Both heels healthy Yes ☐ No ☐ N/A ☐ (if No chart as **V** complete wound care chart)			
Cot sides in situ as per Bed Rails Flowchart in the Nursing Assessment Documentation			
Sat out in chair if not record as **V** and document reason why MUST be a HIGH chair for Thompson's/Monks Prosthesis only			
☐Thompson's/Monks Prosthesis - mobilized with Zimmer frame – fully weight bearing, if not record as **V** and document reason why ☐DHS - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why ☐Gamma/IM Nail - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why			
Chest physiotherapy given Yes ☐ No ☐ N/A ☐			
Discharge Planning	**E**	**L**	**N**
Consider referral to Nurse Led Unit N/A ☐ Consider referral to Clifton Hospital N/A ☐			
Patient seen by Hospital Discharge Team			
Patient seen by Occupational Therapy Yes ☐ No ☐ N/A ☐			
Patient☐ Relatives☐ Carers☐ informed of anticipated discharge date			

Team Nurse signature:

AM:	**PM:**	**NIGHT:**

Date / time	**Variances Sheet and MDT Progress Notes**	**Signature & profession**

PHASE OF CARE: Post-Op Day 11	Write patient details or affix Identification label Hospital Number: Name: Date of Birth: NHS Number:
Date:	

Milestones / Outcomes

1. **Early mobilisation achieved**
2. **Prevention of constipation**
3. **Fluid and electrolyte balance maintained**

Mark V for variance and record on MDT progress notes	**Initials**		
	E	**L**	**N**
Observations recorded and within normal limits for patient Early Warning Score Less than 3 if No inform SHO and mark as **V and** monitor observations ½ hourly			
Pain score one or less. If greater than one give analgesia and chart effectiveness. If remains 2 or more mark as **V** and inform doctor and Acute Pain Service. Ensure pain score is charted at least 4 hourly.			
Maintain SPO^2 at 94 % or above. If SPO^2 less than 94%, inform Doctor, mark as **V**, and ensure oxygen prescribed. Administer O^2 at _____l/min as prescribed.			
Wound checked and wound care chart completed accordingly			
DVT prophylaxis administered as prescribed and prescribed at 18:00 Self administration techniques commenced Yes ☐ No ☐ N/A ☐			
Oral diet and fluids tolerated			
Nutritional status assessed using MUST. If score 1 or more then mark as **V** and document actions			
Patient reassured and any anxieties allayed			
Normal sleep pattern achieved and patient well rested			
Elimination			
Bowels opened: Yes ☐ No ☐ Last opened Date ……. If more than 72 hours ensure laxatives prescribed If patient on analgesia ensure laxatives prescribed			
Personal Hygiene			
Patients personal hygiene needs met and all care to hair, nails and teeth			
Manual Handling and Mobility			
Pressure Ulcer Risk Assessment monitored today. Risk……. Patient placed on appropriate pressure relieving device for risk. *Specify which:* Static Pressure Redistibution Matress ☐ Primo ☐ Duo ☐ Repose Boots ☐ Foam Gutter Splint ☐			
If pressure ulcers present chart as **V** and complete wound care chart. If new then complete clinical incident form			
Explain the importance of relieving pressure to patient.			
Charnley Wedge in situ whilst in bed (for Thompson's/Monks Prosthesis) N/A ☐ Gutter Splint in situ whilst in bed (for Dynamic Hip Screws) N/A ☐			
Use of Monkey pole demonstrated			
Knee function on bed locked out			

Antiembolic stocking removed to check heels. Both heels healthy Yes ☐ No ☐ N/A ☐ (if No chart as **V** complete wound care chart)			
Cot sides in situ as per Bed Rails Flowchart in the Nursing Assessment Documentation			
Sat out in chair if not record as **V** and document reason why <u>MUST</u> be a <u>HIGH</u> chair for Thompson's/Monks Prosthesis only			
☐<u>Thompson's/Monks Prosthesis</u> - mobilized with Zimmer frame – fully weight bearing, if not record as **V** and document reason why ☐<u>DHS</u> - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why ☐<u>Gamma/IM Nail</u> - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why			
Chest physiotherapy given Yes ☐ No ☐ N/A ☐			
Discharge Planning	**E**	**L**	**N**
Consider referral to Nurse Led Unit N/A ☐ Consider referral to Clifton Hospital N/A ☐			
Patient seen by Hospital Discharge Team			
Patient seen by Occupational Therapy Yes ☐ No ☐ N/A ☐			
Patient☐ Relatives☐ Carers☐ informed of anticipated discharge date			

Team Nurse signature:

AM:	**PM:**	**NIGHT:**

Date / time	**Variances Sheet and MDT Progress Notes**	**Signature & profession**

PHASE OF CARE: Post-Op Day 12	Write patient details or affix Identification label Hospital Number: Name: Date of Birth: NHS Number:
Date:	

Milestones / Outcomes

1. **Early mobilisation achieved**
2. **Prevention of constipation**
3. **Fluid and electrolyte balance maintained**

Mark V for variance and record on MDT progress notes	**Initials**		
	E	**L**	**N**
Observations recorded and within normal limits for patient Early Warning Score Less than 3 if No inform SHO and mark as **V and** monitor observations ½ hourly			
Pain score one or less. If greater than one give analgesia and chart effectiveness. If remains 2 or more mark as **V** and inform doctor and Acute Pain Service. Ensure pain score is charted at least 4 hourly.			
Maintain SPO^2 at 94 % or above. If SPO^2 less than 94%, inform Doctor, mark as **V**, and ensure oxygen prescribed. Administer O^2 at _____l/min as prescribed.			
DVT prophylaxis administered as prescribed and prescribed at 18:00 Self administration techniques commenced Yes ☐ No ☐ N/A ☐			
Oral diet and fluids tolerated			
Nutritional status assessed using MUST. If score 1 or more then mark as **V** and document actions			
Patient reassured and any anxieties allayed			
Normal sleep pattern achieved and patient well rested			
Elimination			
Bowels opened: Yes ☐ No ☐ Last opened Date ……. If more than 72 hours ensure laxatives prescribed If patient on analgesia ensure laxatives prescribed			
Personal Hygiene			
Patients personal hygiene needs met and all care to hair, nails and teeth			
Manual Handling and Mobility			
Pressure Ulcer Risk Assessment monitored today. Risk……. Patient placed on appropriate pressure relieving device for risk. *Specify which:* Static Pressure Redistibution Matress ☐ Primo ☐ Duo ☐ Repose Boots ☐ Foam Gutter Splint ☐			
If pressure ulcers present chart as **V** and complete wound care chart. If new then complete clinical incident form			
Explain the importance of relieving pressure to patient.			
Charnley Wedge in situ whilst in bed (for Thompson's/Monks Prosthesis) N/A ☐ Gutter Splint in situ whilst in bed (for Dynamic Hip Screws) N/A ☐			
Use of Monkey pole demonstrated			
Knee function on bed locked out			
Antiembolic stocking removed to check heels. Both heels healthy Yes ☐ No ☐ N/A ☐ (if No chart as **V** complete wound care chart)			

Cot sides in situ as per Bed Rails Flowchart in the Nursing Assessment Documentation			
Sat out in chair if not record as **V** and document reason why MUST be a HIGH chair for Thompson's/Monks Prosthesis only			
☐Thompson's/Monks Prosthesis - mobilized with Zimmer frame – fully weight bearing, if not record as **V** and document reason why ☐DHS - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why ☐Gamma/IM Nail - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why			
Chest physiotherapy given Yes ☐ No ☐ N/A ☐			
Discharge Planning	**E**	**L**	**N**
Consider referral to Nurse Led Unit N/A ☐ Consider referral to Clifton Hospital N/A ☐			
Patient seen by Hospital Discharge Team			
Patient seen by Occupational Therapy Yes ☐ No ☐ N/A ☐			
Patient☐ Relatives☐ Carers☐ informed of anticipated discharge date			

Team Nurse signature:		
AM:	**PM:**	**NIGHT:**

Date / time	**Variances Sheet and MDT Progress Notes**	**Signature & profession**

PHASE OF CARE: Post-Op Day 13	Write patient details or affix Identification label Hospital Number: Name: Date of Birth: NHS Number:
Date:	

Milestones / Outcomes

4. **Early mobilisation achieved**
5. **Prevention of constipation**
6. **Fluid and electrolyte balance maintained**

Mark V for variance and record on MDT progress notes	**Initials**		
	E	**L**	**N**
Observations recorded and within normal limits for patient Early Warning Score Less than 3 if No inform SHO and mark as **V and** monitor observations ½ hourly			
Pain score one or less. If greater than one give analgesia and chart effectiveness. If remains 2 or more mark as **V** and inform doctor and Acute Pain Service. Ensure pain score is charted at least 4 hourly.			
Maintain SPO^2 at 94 % or above. If SPO^2 less than 94%, inform Doctor, mark as **V**, and ensure oxygen prescribed. Administer O^2 at _____l/min as prescribed.			
DVT prophylaxis administered as prescribed and prescribed at 18:00 Self administration techniques commenced Yes ☐ No ☐ N/A ☐			
Oral diet and fluids tolerated			
Nutritional status assessed using MUST. If score 1 or more then mark as **V** and document actions			
Patient reassured and any anxieties allayed			
Normal sleep pattern achieved and patient well rested			
Elimination	**E**	**L**	**N**
Bowels opened: Yes ☐ No ☐ Last opened Date ……. If more than 72 hours ensure laxatives prescribed If patient on analgesia ensure laxatives prescribed			
Personal Hygiene	**E**	**L**	**N**
Patients personal hygiene needs met and all care to hair, nails and teeth			
Manual Handling and Mobility	**E**	**L**	**N**
Pressure Ulcer Risk Assessment monitored today. Risk……. Patient placed on appropriate pressure relieving device for risk. *Specify which:* Static Pressure Redistibution Matress ☐ Primo ☐ Duo ☐ Repose Boots ☐ Foam Gutter Splint ☐			
If pressure ulcers present chart as **V** and complete wound care chart. If new then complete clinical incident form			
Explain the importance of relieving pressure to patient.			
Charnley Wedge in situ whilst in bed (for Thompson's/Monks Prosthesis) N/A ☐ Gutter Splint in situ whilst in bed (for Dynamic Hip Screws) N/A ☐			
Use of Monkey pole demonstrated			
Knee function on bed locked out			
Antiembolic stocking removed to check heels. Both heels healthy Yes ☐ No ☐ N/A ☐ (if No chart as **V** complete wound care chart)			

Cot sides in situ as per Bed Rails Flowchart in the Nursing Assessment Documentation			
Sat out in chair if not record as **V** and document reason why MUST be a HIGH chair for Thompson's/Monks Prosthesis only			
☐Thompson's/Monks Prosthesis - mobilized with Zimmer frame – fully weight bearing, if not record as **V** and document reason why ☐DHS - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why ☐Gamma/IM Nail - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why			
Chest physiotherapy given Yes ☐ No ☐ N/A ☐			
Discharge Planning	**E**	**L**	**N**
Consider referral to Nurse Led Unit N/A ☐ Consider referral to Clifton Hospital N/A ☐			
Patient seen by Hospital Discharge Team			
Patient seen by Occupational Therapy Yes ☐ No ☐ N/A ☐			
Patient☐ Relatives☐ Carers☐ informed of anticipated discharge date			

Team Nurse signature:		
AM:	**PM:**	**NIGHT:**

Date / time	**Variances Sheet and MDT Progress Notes**	**Signature & profession**

PHASE OF CARE: Post-Op Day 14	Write patient details or affix Identification label Hospital Number: Name: Date of Birth: NHS Number:
Date:	

Milestones / Outcomes

7. **Early mobilisation achieved**
8. **Prevention of constipation**
9. **Fluid and electrolyte balance maintained**

Mark V for variance and record on MDT progress notes	**Initials**		
	E	**L**	**N**
Observations recorded and within normal limits for patient Early Warning Score Less than 3 if No inform SHO and mark as **V and** monitor observations ½ hourly			
Pain score one or less. If greater than one give analgesia and chart effectiveness. If remains 2 or more mark as **V** and inform doctor and Acute Pain Service. Ensure pain score is charted at least 4 hourly.			
Maintain SPO^2 at 94 % or above. If SPO^2 less than 94%, inform Doctor, mark as **V**, and ensure oxygen prescribed. Administer O^2 at _____l/min as prescribed.			
DVT prophylaxis administered as prescribed and prescribed at 18:00 Self administration techniques commenced Yes ☐ No ☐ N/A ☐			
Oral diet and fluids tolerated			
Nutritional status assessed using MUST. If score 1 or more then mark as **V** and document actions			
Patient reassured and any anxieties allayed			
Normal sleep pattern achieved and patient well rested			
Elimination			
Bowels opened: Yes ☐ No ☐ Last opened Date ……. If more than 72 hours ensure laxatives prescribed If patient on analgesia ensure laxatives prescribed			
Personal Hygiene			
Patients personal hygiene needs met and all care to hair, nails and teeth			
Manual Handling and Mobility			
Pressure Ulcer Risk Assessment monitored today. Risk……. Patient placed on appropriate pressure relieving device for risk. *Specify which:* Static Pressure Redistibution Matress ☐ Primo ☐ Duo ☐ Repose Boots ☐ Foam Gutter Splint ☐			
If pressure ulcers present chart as **V** and complete wound care chart. If new then complete clinical incident form			
Explain the importance of relieving pressure to patient.			
Charnley Wedge in situ whilst in bed (for Thompson's/Monks Prosthesis) N/A ☐ Gutter Splint in situ whilst in bed (for Dynamic Hip Screws) N/A ☐			
Use of Monkey pole demonstrated			
Knee function on bed locked out			
Antiembolic stocking removed to check heels. Both heels healthy Yes ☐ No ☐ N/A ☐ (if No chart as **V** complete wound care chart)			

Cot sides in situ as per Bed Rails Flowchart in the Nursing Assessment Documentation			
Sat out in chair if not record as **V** and document reason why MUST be a HIGH chair for Thompson's/Monks Prosthesis only			
☐Thompson's/Monks Prosthesis - mobilized with Zimmer frame – fully weight bearing, if not record as **V** and document reason why ☐DHS - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why ☐Gamma/IM Nail - mobilized with Zimmer frame – partially weight bearing, if not record as **V** and document reason why			
Chest physiotherapy given Yes ☐ No ☐ N/A ☐			
Discharge Planning	**E**	**L**	**N**
Consider referral to Nurse Led Unit N/A ☐ Consider referral to Clifton Hospital N/A ☐			
Patient seen by Hospital Discharge Team			
Patient seen by Occupational Therapy Yes ☐ No ☐ N/A ☐			
Patient☐ Relatives☐ Carers☐ informed of anticipated discharge date			

Team Nurse signature:

AM:	**PM:**	**NIGHT:**

Date / time	**Variances Sheet and MDT Progress Notes**	**Signature & profession**

OCCUPATIONAL THERAPY

COMPREHENSIVE ASSESSMENT FORMS HELD BY NAMED Occupational Therapist

Initial Assessment:

	Initialled	Dated
a) Social Situation Lives Alone Yes ☐ No ☐ …… Type of Housing: Flat … … … … .. ☐ House … … … … … ☐ Bungalow … … … ☐ Other … … … … … ☐ b) Previous functional ability Mobility …… … … … … … … … … … ……. … … … … .. … Personal ADL … … … … … … … … … … … … ……..… ……..… … … Meal preparation … … … … … … … … … … … … ……..… … … ……. Domestic ADL … … … … … … … … … … … … …… …….. Agencies Involved/support available: …… … … ……..… …… … …… … … ……..… Mental State … … … … … … … … … … … … … … …… … … …… Other Considerations …… … … …… … … ……		

Education/Advice:

Precautions discussed/booklet issued : Yes ☐ No ☐ N/A ☐ Height chart issued : Yes ☐ Return date …… .. No ☐……N/A ☐ Falls advice given : Yes ☐ No ☐:……..……	

Functional Assessment/ Treatment Outcomes:

	Recommendations	Treatment completed
Personal ADL…… …… …		
Transfers: Bed…… Chair…… Toilet…….. Other(please specify)……..		
Kitchen Assessment……. …… …… ……		
Other Assessments conducted ……. …… …… ……		

Discharge Planning:

Equipment ordered: Yes ☐ No ☐…….. Is the equipment essential for discharge? : Yes ☐ No ☐…….. Equipment fitted: Yes ☐ No ☐…….. Other comments……..…….. …….	

Discharge Arrangements/ Plan:			
	Yes	**N/A**	**Initials/ signature/date and time**
Physiotherapy intervention for discharge completed?			
Physio Outpatient appointment made?			
Occupational therapy intervention for discharge completed?			
Seen by HDT and all relevant support arrangements completed?			
GP letter written?			
GP Letter given to patient			
Medications given to patient* relatives* /ambulance crew* with written and verbal instructions (*Circle appropriate)			
Own medications returned to patient			
Outpatient appointment made?			
Written and verbal discharge advice given			
District nurse referral faxed?			
DS 53 completed for Tinzaparin			
Access to accommodation Key with Patient* /Key with relatives*/other access secured* (*Circle appropriate)			
Cannula removed			
Ycan removed			
Next of kin informed. Whom……			
Locker checked for belongings			
Bedspace checked for belongings			
Transport organized Whom……. Time……			
Person accompanying patient on discharge …….			
Date and time of Discharge			