University Hospital of North Staffordshire NHS
NHS Trust

Integrated Care Pathway Documentation
(TO BE KEPT IN MEDICAL NOTES)

Fractured Neck of Femur

Unit number	

Referral to Intermediate Care	**County**	**City**	**N/A**

Patient Name (affix label if available); Address: DOB: Patient telephone number……..	Date of admission to A&E……. Time of admission to A&E……. Type of operation: Date of operation…….
Age:	Admitting consultant
Next of kin: Relationship: Contact details:	Operating consultant
	Ward location: Ward…….Date……..Transfer to…….. Ward…….Date……..Transfer to…….. Ward…….Date……..Transfer to……..
Second contact: Telephone number:	
GP details:	Expected date of discharge:
	Actual date of discharge:
Known allergies:	Discharged / transferred to: ……
Marital status:	Removal from pathway: Date removed…….. Variance code…… Comments:
Occupation:	
Religion: Practicing: YES /NO	
Ethnicity: Patients preferred language:	

Coded Variance List

01	Patient not fit for surgery	28	Dizziness / Faints and falls
02	Theatre delay - logistic	29	Leg swelling
03	Patient declined surgery	30	Pressure sores
04	Unplanned transfer	31	Wound dressing needing changing
05	Death – Cause if known……..	32	Reduced urinary output
06	Post op MI and or Cardiac Arrest	33	Urinary incontinence
07	Cerebrovascular accident	34	Bowels not open
08	PE suspected / confirmed	35	Diarrhoea
09	Major allergic reaction	36	Patient confused
10	Cardiac arrhythmias	37	Patient non-compliance/not willing
11	Transfer to ITU/CCU	38	Patient unavailable
12	Unplanned return to theatres	39	Slow to mobilise
13	Dislocation	40	Quick to mobilise
14	Requiring transfusion / low Hb	41	Investigations unavailable/ delay
15	Hypertension / hypotension	42	Pharmacy delay
16	Pyrexia	43	Physiotherapy unavailable
17	MRSA suspected / confirmed	44	Occupational Therapy unavailable
18	Wound infection	45	Delay in transport
19	Chest infection / respiratory depression	46	Delay in Intermediate care team
20	Urinary Tract Infection	47	Equipment/furniture unavailable
21	DVT suspected / confirmed	48	Community services delay
22	Additional O2 therapy required	49	Community bed unavailable
23	Wound oozing	50	Residential home refusing
24	Post op hemorrhage	51	Nursing home bed unavailable
25	Haematoma	52	Patient waiting CCA
26	Pain not controlled	53	Patient refused transfer/discharge
27	Nausea and/or vomiting	54	Discharge goals not met
27a	Venflon blocked or removed	55	Transfer to non-orthopaedic ward
00	Other (specify)	56	Awaiting medical review

Abbreviation List

ADL	Activities of Daily Living	ESR	Erythrocyte Sedimentation Rate	O_2	Oxygen
ANP	Advanced Nurse Practitioner	FBC	Full Blood Count	PALS	Patient Advisory Liaison Service
ASA	Anaesthetic grade	FWB	Full weight Bearing	PE	Pulmonary Embolus
BAEM	British Accident and Emergency Medicine	#NOF	Fractured Neck of Femur	PMH	Past Medical History
BM	Blood Monitoring	GIS	Gastrointestinal system	PWB	Partial Weight Bearing
BMI	Body Mass Index	GP	General Practitioner	Resp	Respiration
BP	Blood Pressure	G&S	Group and Save	R L	Right Left
CCA	Community Care Assessment	GCS	Glasgow Coma Scale	RS	Respiratory System
C&S	Culture & Sensitivity	Hb	Haemaglobin	SHO	Surgical House Officer
CNS	Central Nervous System	HS	Heart Sounds	TED	Thromboembolytic decompression
CVS	Cardiovascular System	INR	International Ratio	TFT	Thyroid Function Test
D.Ped	Dorsalis Pedis	LFT	Liver Function Test	TTO	To Take Out
DVT	Deep Vein Thrombosis	MI	Myocardial Infarction	TTWB	Toe Touch Weight Bearing
ECG	Electrocardiograph	MRSA	Multi Resistant Staphylococcus Aureus	U&E	Urea & Electrolytes
EPR	Electronic Patient Record	MSU	Midstream Urine	WB	Weight Bearing
EPUAP	European Pressure Ulcer Advisory Panel	ODP	Operating Dept Practitioner	WCC	White Cell Count
ESBL	Extended spectrum Beta-Lactamase	OT	Occupational Therapist		

Guidelines for use of pathway

This Care Pathway is a multi-disciplinary document designed for all patients undergoing the standard management for a Fractured Neck of Femur. It is intended to be used as guidance for the care of your patients. All Health Care Professionals will use this document to record their care, although it is intended that clinicians should exercise their clinical judgment to determine if the patient should continue through the pathway.
The care pathway is a confidential record and must remain in the medical notes.
The patient should be encouraged to be involved in their pathway management and comment on any issues on pages 75 and 76

▶ This symbol highlights essential areas of care to be actioned

The patient commences when the Accident and Emergency Department have confirmed the diagnosis of #NOF and the patient has been transferred to the admissions ward.
If a patient is transferred from another ward then the pathway should commence from page 5 – Admission to Ward

The document is colour coded for the various stages of the patient journey:

Green	Pages 1-24	Introduction / Admission and pre-op management
White	Pages 25-30	Consent form
Blue	Pages 31-38	Theatre and recovery
Yellow	Pages 39-72	Post-operative care
White	Pages 73-90	Discharge information and nursing protocols

All clinicians are responsible for completing the appropriate/relevant sections to their specialty. Each section of the documentation is mapped out for the care that is required for an average patient undergoing management for #NOF. However there may be many reasons why the patient does not follow the pathway exactly. These should be noted as variances (in columns labeled with a v) using the variance codes listed on page two and each **new variance summarised on page 73.**
Patients should be removed from the pathway if variances either prevent surgery or the patient is transferred to another speciality for continuation of their care.

▶ All members of the team must sign at the front of the document in the signature section on this page and overleaf. Each section/day, each member of the multi-disciplinary team records a specific activity by initialising the appropriate box. Nursing staff also record at the bottom of each page their signature for each shift.

The version number and review date of this pathway is noted on the back cover

All staff signing for patient care please complete this section.

Print full name	Position and discipline	Full signature	Initials (legible)

All staff signing for patient care please complete this section.

Print full name	Position and discipline	Full signature	Initials (legible)

If you need help in using this care pathway or have any comments please contact:
Surgical division Project Manager **Ext 3102**

Patient name		Unit number	

Admission to Ward…….. **Date……**

ADMISSION PROCEDURE

Information and Education

Sign

Introduce to ward staff / named nurse
Visiting arrangements for family / carer
Time for questions
Expected discharge date discussed:

Specify……

Valuables / Property

Sign

Sensible shoes and clothing available
Valuables: Sent home
In hospital safe
Glasses / contact lenses YES/NO
Hearing aid YES/NO
Dentures YES/NO
Other ……
……

Indemnity statement

I confirm that I do not wish to hand over for safe custody, any property currently held by me. I understand that the Hospital Trust accepts no responsibility for the loss of, or the damage to, personal property of any kind, in whatever way may occur, unless deposited for safe custody.

Signed……

Witness……

Qualification……

Admission check list

Sign

ID band checked

Urine dipstick

Pressure care checked

O_2 saturation…….

Supplementary O_2 required YES/NO

ECG result inserted into investigation section

Blood result sheet inserted into the investigation section of the pathway folder

Xray
Pelvis xray present YES/NO
Chest xray performed and present YES/NO

****Patient information booklet given and discussed with patient and/or carer****

Urine dip stick result

Leucocytes	
Nitrates	
Protein	
pH	
Blood	
Specific gravity	
Ketones	
Glucose	

If blood, protein or nitrates present send MSU

MRSA / ESBL screening

All patients admitted with #NOF are screened on admission for MRSA
All patients are commenced on a decolonization regime with antiseptic washes and mupirocin for 5 days

If swab results –ve, discontinue decolonization
All patients are given prophylaxis at induction that is effective against MRSA

Swab taken YES / NO

Swab result Positive / Negative

Admission procedure completed by

Sign…… …… Sign……

ADMISSION ASSESSMENT Date ……

Complete Nursing assessment card in addition to this assessment

COMMUNICATION	**SAFETY OF PATIENTS WITH MENTAL HEALTH NEEDS**
Speech difficulty YES / NO Interpreter needed YES / NO Language required…… Hearing impaired: left / right Hearing aid: left / right Dentures YES / NO Reading ability…… Visual ability…… …….. **Is visual assessment required** YES / NO if YES – refer as appropriate	Alert / orientated ☐ Confused: day / night ☐ Anxious / distressed ☐ Other…… ☐ **Mental test score** ☐ (complete on purple assessment card) Falls risk assessment score ☐
FOOD AND NUTRITION	**MOBILITY**
Type of menu: Standard ☐ Diabetic ☐ Low fat ☐ Eat well ☐ Cat A ☐ Cat B ☐ Other (please specify)…… …….. Any assistance needed with feeding YES / NO Weight: Actual …… Well Wt …… Estimated…… Nutrition score ☐ Referral to dietitian: YES / NO	Level of mobility / independence: Distance normally able to walk…… Mobile without aids ☐ Mobile with aids ☐ Type of aid…… Side held…… Independent on stairs ☐ Furniture walking ☐ Chairbound ☐ Housebound ☐ Manual Handling Assessment completed ☐ Chiropody referral needed YES / NO
PERSONAL AND ORAL HYGEINE	**PRESSURE AREA CARE**
Has bath / shower at home ☐ Stand up wash ☐ Assistance required ☐ Please specify…… …… Hair care……	Skin intact ☐ Broken areas / ulcers ☐ Specify…… …… Waterlow score ☐ EPUAP stage (guidelines page 85) ☐
CONTINENCE, BLADDER AND BOWEL CARE	**SLEEP**
Regular bowel/bladder habits: Bowels last opened…….. Are any regular laxatives taken YES / NO Constipated ☐ Diarrhea / loose stools ☐ Frequency of micturition ☐ Incontinence: Urine / Faeces ☐ Day / night ☐ Urine – no problems ☐	Normal bedtime…… Normal hours sleep…….. Normal sleep position (pillows)…… Night sedation required…… **PAIN SCORE – Time taken……** 0 = No pain on movement 1 = Mild pain on movement 2 = Moderate pain on movement 3 = Severe pain on movement ☐
Assessment completed by Signed……Date……	**Note:** All of these assessments are supported by the ward essence of care guidelines.

Patient name		Unit number	

Social History Assessment (to be completed on day of admission) Date……

For patients from Nursing Homes and Residential Homes
Has the **Home to Hospital form** arrived with patient YES / NO Date arrived……
If NO, request the form by phone for a faxed copy
******Insert Home to Hospital form into pathway after this page**

Complete this section for patients living in own home

Accommodation

Patient lives: Alone ☐ With Relative ☐ Other……

Property: House ☐ Bungalow ☐ Upstairs flat ☐ Downstairs flat ☐
Residential Home ☐ Nursing Home ☐ Warden controlled ☐

Other ……
Type: Private ☐ Council ☐ Other……..

Support: Family ☐ Friends ☐ Neighbours ☐

Who does the shopping/cleaning?……..
Does the patient have pets at home YES/NO Who will care for them?.....

Property details

Access: Steps into property ☐ how many……. … Lift available…….
Other comments……

Heating: Gas ☐ Electric ☐ Oil ☐ Coal ☐ Other…….

Toilet: Upstairs ☐ Downstairs ☐ Chemical ☐ Commode ☐ Other……....

Bathroom: Bath ☐ Shower ☐ Upstairs ☐ Downstairs ☐

Bed: Double ☐ Single ☐ Upstairs ☐ Downstairs ☐

Community/Social support (enter frequency and contact details if appropriate)

Social Services YES / NO Name of social worker……
District Nurse …….. Health Visitor……
Home Care…….. … Home Help…….. ……
Meals on Wheels……. Day care……
CPN……. Respite care……..
Community Physio…….. Community OT……..
Others……..

Benefits arrangements checked……..
Which agencies have been informed of the patients admission……
……

Comments / Action plan

Source of this information (please circle)

Patient Carer Other If "other" state name……

Signed Nursing staff……..

Single assessment process summary

(to be completed pre-operatively and ongoing through the pathway)

Name **Address** **Unit number**	**Preferred name**

Assessment category	**Comments – summary of issues** **(include assessment scores if appropriate)**	**Initial**
Health promotion issues Nutrition, sleep, personal care, Smoking, alcohol, weight		
Safety assessment Falls, environment (Note if 2 or more falls in last 6/12)		
Medication issues Difficulties in taking, understanding		
Personal care and domestic needs ADL – washing, dressing, housework		
Mobility issues Transfers, access		
Sensory needs Sight, hearing		
Emotional well being Mental health, orientation, depression, concentration, distress		
Environmental needs / resources Accommodation, security, finance, Allowances, disability access		
Relationship / carer support Support needed, carer involvement		

Patients own description of main problems / issues (what would you like to get help with**)**

Further assessments needed

Services / agencies / professionals that need to be involved

Source of this information (please circle)

Patient Carer Other If "other" state name……

Agreement to share information

I understand that the relevant information from my assessment may be shared with other agencies involved in my care. I agree for this information to be shared YES / NO

Signed…….. Patient / Carer Date…….

Completed by	**Signed**	**Initial**

Photocopy this page for patient and send copy to main agency (s) involved

Pre-operative care

PRE – OP CARE DAY 1 Date……..

Goals / pre-op management:	Early/am		Late/pm		Night	
To promote / maintain optimal medical health	Sign	V	Sign	V	Sign	V
Observations: 4 hourly Venflon site checked **Blood test review:** Monitor heamatological / biochemical status as required **Nutrition/Hydration:** Assess nutritional status – Nutrition assessment complete Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Passes urine am……. pm……. night……. Bowels opened: am……. pm……. night……. Action required…… **Continue anti-thrombotic treatment** – check for DVT **Skin / Pressure area review:** Checked and intact YES/NO Comments…… Mattress……. Cushion…… **Waterlow assessment completed**						
Pain management						
Subjective pain assessment (0-3): am……. pm……. night……. Pain controlled to a suitable level: YES / NO Medication reviewed Assess vital signs, nausea and sedation: YES / NO						
Understand management						
Patient alert and orientated Patient able to express fears and anxieties Daily plan explained Management discussed with family/carer YES / NO						
Respiration						
Observe for respiratory depression Breathing/circulation exercises explained and practiced Check optimal position for respiration Administer prescribed O_2 Referral for Respiratory Physiotherapy YES / NO						
Independence						
Hygiene Encouraged patient to do as much as possible						
Social						
Social issues discussed Comments…… ……						
▶ **Surgical / Medical / Anaesthetic review**						
Assessed fit for surgery YES / NO ASA grade……. Identified place on theatre list YES / NO Fasting for surgery commenced YES / NO If YES – commence iv infusion If not fit – medical problems listed and actioned YES / NO Reason for delayed surgery…… …… ……						
Named nurse	Early……Late……Night……..					

Patient name		Unit number	

PRE-OP CARE DAY 1 Date …………………

(Page to be removed if transferred to theatre)

Multi-disciplinary progress notes **If mental capacity is affected, document assessment and decision taken**		
Time	Comments	Signature

If further documentation needed for this day please add extra green continuation sheets

PRE – OP CARE DAY 2 Date…….

Goals / pre-op management:	Early/am		Late/pm		Night	
To promote / maintain optimal medical health	Sign	V	Sign	V	Sign	V
Observations: 4 hourly Venflon site checked **Blood test review:** Monitor heamatological / biochemical status as required **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Passes urine am……. pm……. night……. Bowels opened: am……. pm……. night……. Action required…….. **Moving/handling review** **Continue anti-thrombotic treatment** – check for DVT **Skin / Pressure area review:** Checked and intact YES/NO Comments…… Mattress……. Cushion…….. **Waterlow assessment completed**						
Pain management						
Subjective pain assessment (0-3): am……. pm……. night……. Pain controlled to a suitable level: YES / NO Medication reviewed Assess vital signs, nausea and sedation: YES / NO						
Understand management						
Patient alert and orientated YES / NO Patient able to express fears and anxieties Daily plan explained Management discussed with family/carer YES / NO						
Respiration						
Observe for respiratory depression Breathing/circulation exercises explained and practiced Check optimal position for respiration Administer prescribed O_2 Referral for Respiratory Physiotherapy YES / NO						
Independence						
Hygiene Encouraged patient to do as much as possible						
Social						
Social issues discussed Comments…… ……						
▶ **Surgical / Medical / Anaesthetic review**						
Assessed fit for surgery YES / NO ASA grade……. Identified place on theatre list YES / NO Fasting for surgery commenced YES / NO If not fit – medical problems listed and actioned YES / NO If YES – commence IV infusion Reason for delayed surgery…… …… …… ……						
Named nurse	Early……Late……Night……..					

Patient name		Unit number	

PRE-OP CARE DAY 2 Date …………

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Multi-disciplinary progress notes **If mental capacity is affected, document assessment and decision taken**		
Time	Comments	Signature

If further documentation needed for this day please add extra green continuation sheets

PRE – OP CARE DAY 3 Date…….

Goals / pre-op management:	Early/am		Late/pm		Night	
To promote / maintain optimal medical health	Sign	V	Sign	V	Sign	V
Observations: 4 hourly Venflon site checked **Blood test review:** Monitor heamatological / biochemical status as required **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Passes urine am……. pm……. night……. Bowels opened: am……. pm……. night……. Action required…….. **Moving/handling review** **Continue anti-thrombotic treatment** – check for DVT **Skin / Pressure area review:** Checked and intact YES/NO Comments…… Mattress……. Cushion…….. **Waterlow assessment completed**						
Pain management						
Subjective pain assessment (0-3): am……. pm……. night……. Pain controlled to a suitable level: YES / NO Medication reviewed Assess vital signs, nausea and sedation: YES / NO						
Understand management						
Patient alert and orientated YES / NO Patient able to express fears and anxieties Daily plan explained Management discussed with family/carer YES / NO						
Respiration						
Observe for respiratory depression Breathing/circulation exercises explained and practiced Check optimal position for respiration Administer prescribed O_2 Referral for Respiratory Physiotherapy YES / NO						
Independence						
Hygiene Encouraged patient to do as much as possible						
Social						
Social issues discussed Comments…… ……						
▶ **Surgical / Medical / Anaesthetic review**						
Assessed fit for surgery YES / NO ASA grade……. Identified place on theatre list YES / NO Fasting for surgery commenced YES / NO If not fit – medical problems listed and actioned YES / NO If YES – commence IV infusion Reason for delayed surgery…… …… …… ……						
Named nurse	Early……Late……Night……..					

Patient name		Unit number	

PRE-OP CARE DAY 3 Date …………

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Multi-disciplinary progress notes **If mental capacity is affected, document assessment and decision taken**		
Time	Comments	Signature

If further documentation needed for this day please add extra green continuation sheets

PRE – OP CARE DAY 4 Date…….

Goals / pre-op management:	Early/am		Late/pm		Night	
To promote / maintain optimal medical health	Sign	V	Sign	V	Sign	V
Observations: 4 hourly Venflon site checked **Blood test review:** Monitor heamatological / biochemical status as required **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Passes urine am……. pm……. night……. Bowels opened: am……. pm……. night……. Action required…… **Continue anti-thrombotic treatment** – check for DVT **Skin / Pressure area review:** Checked and intact YES/NO Comments…… Mattress……. Cushion…… **Waterlow assessment completed**						
Pain management						
Subjective pain assessment (0-3): am……. pm……. night……. Pain controlled to a suitable level: YES / NO Medication reviewed Assess vital signs, nausea and sedation: YES / NO						
Understand management						
Patient alert and orientated YES / NO Patient able to express fears and anxieties Daily plan explained Management discussed with family/carer YES / NO						
Respiration						
Observe for respiratory depression Breathing/circulation exercises explained and practiced Check optimal position for respiration Administer prescribed O_2 Referral for Respiratory Physiotherapy YES / NO						
Independence						
Hygiene Encouraged patient to do as much as possible						
Social						
Social issues discussed Comments…… ……						
▶ **Surgical / Medical / Anaesthetic review**						
Assessed fit for surgery YES / NO ASA grade……. Identified place on theatre list YES / NO Fasting for surgery commenced YES / NO If not fit – medical problems listed and actioned YES / NO If YES – commence IV infusion Reason for delayed surgery…… …… …… ……						
Named nurse	Early……Late……Night……..					

Patient name		Unit number	

PRE-OP CARE DAY 4 Date …………

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Multi-disciplinary progress notes **If mental capacity is affected, document assessment and decision taken**		
Time	Comments	Signature

If further documentation needed for this day please add extra green continuation sheets

PRE – OP CARE DAY 5 Date…….

Goals / pre-op management:	Early/am		Late/pm		Night	
To promote / maintain optimal medical health	Sign	V	Sign	V	Sign	V
Observations: 4 hourly Venflon site checked **Blood test review:** Monitor heamatological / biochemical status as required **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Passes urine am……. pm……. night……. Bowels opened: am……. pm……. night……. Action required…… **Continue anti-thrombotic treatment** – check for DVT **Skin / Pressure area review:** Checked and intact YES/NO Comments…… Mattress……. Cushion…… **Waterlow assessment completed**						
Pain management						
Subjective pain assessment (0-3): am……. pm……. night……. Pain controlled to a suitable level: YES / NO Medication reviewed Assess vital signs, nausea and sedation: YES / NO						
Understand management						
Patient alert and orientated YES / NO Patient able to express fears and anxieties Daily plan explained Management discussed with family/carer YES / NO						
Respiration						
Observe for respiratory depression Breathing/circulation exercises explained and practiced Check optimal position for respiration Administer prescribed O_2 Referral for Respiratory Physiotherapy YES / NO						
Independence						
Hygiene Encouraged patient to do as much as possible						
Social						
Social issues discussed Comments…… ……						
▶ **Surgical / Medical / Anaesthetic review**						
Assessed fit for surgery YES / NO ASA grade……. Identified place on theatre list YES / NO Fasting for surgery commenced YES / NO If not fit – medical problems listed and actioned YES / NO If YES – commence IV infusion Reason for delayed surgery…… …… …… ……						
Named nurse	Early……Late……Night……..					

Patient name		Unit number	

PRE-OP CARE DAY 5 Date ……….

(Page to be removed if transferred to theatre)

Multi-disciplinary progress notes **If mental capacity is affected, document assessment and decision taken**		
Time	Comments	Signature

If further documentation needed for this day please add extra green continuation sheets

PRE – OP CARE DAY 6 Date…….

Goals / pre-op management:	Early/am		Late/pm		Night	
To promote / maintain optimal medical health	Sign	V	Sign	V	Sign	V
Observations: 4 hourly Venflon site checked **Blood test review:** Monitor heamatological / biochemical status as required **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Passes urine am……. pm……. night……. Bowels opened: am……. pm……. night……. Action required…… **Continue anti-thrombotic treatment** – check for DVT **Skin / Pressure area review:** Checked and intact YES/NO Comments…… Mattress……. Cushion…… **Waterlow assessment completed**						
Pain management						
Subjective pain assessment (0-3): am……. pm……. night……. Pain controlled to a suitable level: YES / NO Medication reviewed Assess vital signs, nausea and sedation: YES / NO						
Understand management						
Patient alert and orientated YES / NO Patient able to express fears and anxieties Daily plan explained Management discussed with family/carer YES / NO						
Respiration						
Observe for respiratory depression Breathing/circulation exercises explained and practiced Check optimal position for respiration Administer prescribed O_2 Referral for Respiratory Physiotherapy YES / NO						
Independence						
Hygiene Encouraged patient to do as much as possible						
Social						
Social issues discussed Comments…… ……						
▶ **Surgical / Medical / Anaesthetic review**						
Assessed fit for surgery YES / NO ASA grade……. Identified place on theatre list YES / NO Fasting for surgery commenced YES / NO If not fit – medical problems listed and actioned YES / NO If YES – commence IV infusion Reason for delayed surgery…… …… …… ……						
Named nurse	Early……Late……Night……..					

Patient name		Unit number	

PRE-OP CARE DAY 6 Date ……….

(Page to be removed if transferred to theatre)

Multi-disciplinary progress notes **If mental capacity is affected, document assessment and decision taken**		
Time	Comments	Signature

If further documentation needed for this day please add extra green continuation sheets

PRE – OP CARE DAY 7 Date…….

Goals / pre-op management:	Early/am		Late/pm		Night	
To promote / maintain optimal medical health	Sign	V	Sign	V	Sign	V
Observations: 4 hourly Venflon site checked **Blood test review:** Monitor heamatological / biochemical status as required **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Passes urine am……. pm……. night……. Bowels opened: am……. pm……. night……. Action required…….. **Continue anti-thrombotic treatment** – check for DVT **Skin / Pressure area review:** Checked and intact YES/NO Comments…… Mattress……. Cushion……. **Waterlow assessment completed**						
Pain management						
Subjective pain assessment (0-3): am……. pm……. night……. Pain controlled to a suitable level: YES / NO Medication reviewed Assess vital signs, nausea and sedation: YES / NO						
Understand management						
Patient alert and orientated YES / NO Patient able to express fears and anxieties Daily plan explained Management discussed with family/carer YES / NO						
Respiration						
Observe for respiratory depression Breathing/circulation exercises explained and practiced Check optimal position for respiration Administer prescribed O_2 Referral for Respiratory Physiotherapy YES / NO						
Independence						
Hygiene Encouraged patient to do as much as possible						
Social						
Social issues discussed Comments…… ……						
▶ **Surgical / Medical / Anaesthetic review**						
Assessed fit for surgery YES / NO ASA grade…… Identified place on theatre list YES / NO Fasting for surgery commenced YES / NO If not fit – medical problems listed and actioned YES / NO If YES – commence IV infusion Reason for delayed surgery…… …… …… ……						
Named nurse	Early…….Late……..Night……..					

Patient name		Unit number	

PRE-OP CARE DAY 7 Date ……….

(Page to be removed if transferred to theatre)

Multi-disciplinary progress notes **If mental capacity is affected, document assessment and decision taken**		
Time	Comments	Signature

If further documentation needed for this day please add extra green continuation sheets

PRE – OP CARE DAY 8 Date…….

(Add additional pages as needed)

Goals / pre-op management:	Early/am		Late/pm		Night	
To promote / maintain optimal medical health	Sign	V	Sign	V	Sign	V
Observations: 4 hourly Venflon site checked **Blood test review:** Monitor heamatological / biochemical status as required **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Passes urine am……. pm……. night……. Bowels opened: am……. pm……. night……. Action required…….. **Continue anti-thrombotic treatment** – check for DVT **Skin / Pressure area review:** Checked and intact YES/NO Comments…… Mattress……. Cushion…… **Waterlow assessment completed**						
Pain management						
Subjective pain assessment (0-3): am……. pm…….. night……. Pain controlled to a suitable level: YES / NO Medication reviewed Assess vital signs, nausea and sedation: YES / NO						
Understand management						
Patient alert and orientated YES / NO Patient able to express fears and anxieties Daily plan explained Management discussed with family/carer YES / NO						
Respiration						
Observe for respiratory depression Breathing/circulation exercises explained and practiced Check optimal position for respiration Administer prescribed O_2 Referral for Respiratory Physiotherapy YES / NO						
Independence						
Hygiene Encouraged patient to do as much as possible						
Social						
Social issues discussed Comments…… ……						
▶ **Surgical / Medical / Anaesthetic review**						
Assessed fit for surgery YES / NO ASA grade…… Identified place on theatre list YES / NO Fasting for surgery commenced YES / NO If not fit – medical problems listed and actioned YES / NO If YES – commence IV infusion Reason for delayed surgery…… …… …… ……						

Named nurse	Early……Late……Night……..

- **If patient unable to consent themselves remove Consent form 1 and replace with Consent form 4 – affix into pathway**

University Hospital of North Staffordshire NHS
NHS Trust

Consent Form 1

Patient agreement to investigation or treatment

Patient details (or pre-printed label)

Patients surname/family name……

Patient's first names……..

Date of birth……

Responsible health profession……

Job title……

NHS number (or other identifier……

☐ Male ☐ Female

Special requirements……
(e.g. other language/other communication method)

Guidance to health professionals (to be read in conjunction with consent policy)

What is consent for?

This form documents the patient's agreement to go ahead with the investigation or treatment you have proposed. It is not a legal waiver – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients are also entitled to change their mind after signing the form, if they retain the capacity to do sop. The form should act as an *aide-memoire* to health professionals and patients, by providing a check list of the kind of information patients should be offered, and enabling the patient to have a written record of the main points discussed. In no way, however, should the written information provided for the patient be regarded as a substitute for face-to face discussion with the patient.

The law on consent

See the Department of \health's Reference guide to consent for examination or treatment for a comprehensive summary on the law of consent (also available at www.doh.gov.uk/consent).

Who can give consent?

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what has been proposed", than he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally "competent" younger children, may therefore sign this form themselves, but may like a parent to countersign as well. If the child is not able to give consent for himself or herself, someone with parental responsibility may do so on their behalf and a separate form is available for this purpose. Even where a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If a parent is mentally competent to give consent, but is unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally

When not to use this form

If the patient is 18 or over and is not legally competent to give consent, you should use form 4, (form for adults who are unable to give consent to investigation or treatment), instead of this form. A patient will not be legally competent to give consent if:
They are unable to comprehend and retail information material to the decision and/or
They are unable to weigh and use this information in coming to a decision

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds. The courts have stated that patients should be told about "significant risks which would affect the judgment of a reasonable patient". "Significant" has not been legally defined, but he GMC requires doctors to tell patients about "serious or frequently occurring risks". In addition, if patients make clear that they have particular concerns about certain kinds of risks, you should make sure that they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where the information is refused, you should document this in the patient's notes.

University Hospital of North Staffordshire NHS
NHS Trust

Patient name Unit number (affix patient label)

Consent Form

Name of proposed procedure or course of treatment (include brief explanation if medical term not clear)……
……
……

Statement of health professional (to be filled in by a health professional with appropriate knowledge of proposed procedure, as specified by consent policy)
I have explained the procedure to the patients. In particular I have explained:
The intended benefits……
……
……
Serious or frequently occurring risks……
……
……

Any extra procedures which may become necessary during the procedure:
☐ Blood transfusion……

☐ Other procedure (please specify)……..
……..

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.
☐ The following leaflet/tape has been provided……..

This procedure will involve:
☐ General and/or regional anaesthesia ☐ local anaesthesia ☐ sedation

Signed …… Date……..
Name (PRINT)…….. Job Title……

Contact details (if patient wishes to discuss options later)……..

Statement of interpreter (where appropriate)
I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.
Signed …… Date……
Name (PRINT)……

Top copy accepted by patient: Yes / No (please ring)

Deliberately left blank

Consent form - Statement of Patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of the form which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment on this form

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however have the appropriate experience.

I understand that I will have the opportunity to discuss the details on anaesthesia with an Anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having a general or regional anesthesia)

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion

……
……
……

Patient's signature…… Date……
Name (PRINT)……

A witness should sign below if the patient is unable to sign, but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes).

Signature …….. Date……
Name (PRINT)……

Confirmation of consent (to be completed by a health professional when the patient is admitted for procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confinrmed with the patient that s/he has no further questions and wishes the procedure to go ahead

Signature ……Date……
Name (PRINT)…… Job Title……

Important notes: (tick if applicable)

☐ See also advance directive/living will (eg Jehovah's Witness form)
☐ Patient has withdrawn consent (ask patient to sign/date here)……

PATIENT CORRECT SITE MARKING AND PRE-OPERATIVE CHECK LIST

Date of procedure		**Name of procedure**	
Baseline observations:	**Weight:**		**Patient Demographic label:**
Temperature:		**Pulse**	
Blood Pressure		**Last food eaten at:**	
Urine:		**Last fluids taken at:**	
If diabetic – Blood glucose:		**Pre-medication of:**	
		Given at:	

*The surgeon should be the consultant in charge of the patient's care or their nominated surgical team representative who will be in theatre

	Ward Nurse Yes or No	Theatre Staff Yes or No	Comments	Surgeon signature*
Confirm patient identity and that an identity band is in place?				***Prior to pre-op marking**
Written consent obtained?				***
Operation site marked pre-operatively **Cross checked by surgeon with the supporting information.**	**Cross checked with operation list**			***Final check in anaesthetic room**
Any allergies? **If yes, list in comments.**				
Dentures removed?				
Any loose teeth, caps or crowns? **If yes, identify in comments.**				
All jewellery, make-up and nail varnish removed? **If no, state what is left in comments**				
Relevant notes, prescription chart, x-rays and scans with patient. Imaging relevant to the surgery available prior to surgery?				***Final check prior to start of surgery**
Hygiene cares undertaken ie bath, shower, shave if yes identify in comments				
DVT prophylaxis? **State what measures in comments.**				
Antibiotic prophylaxis?				
The availability of the correct prosthesis/implant				***Final check prior to start of surgery**
Verbal confirmation by the theatre team prior to commencement of surgery. ➢ **Correct patient in theatre** ➢ **Marking of the correct site** ➢ **Procedure confirmed**				***
Ward nurse: Date:…… **Signature: ……**			**Theatre nurse/ODP: Date:……** **Signature:……..**	

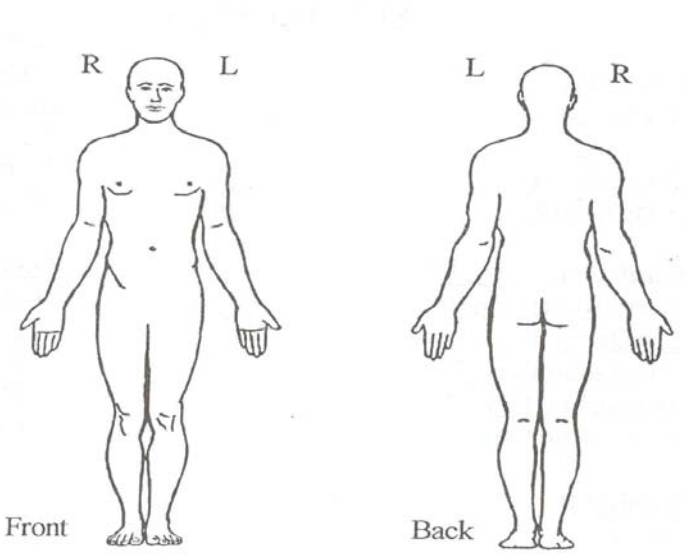
Further surgical/anaesthetic instructions must be clearly documented in the clinical records.

- **If failure of any pre-operative checks occurs, the surgeon in charge should assess the situation and either return the patient to the ward/day care area or note and sign a decision to proceed at risk.**
- **If either a decision to return the patient to the ward/day care area or a clinical decision to proceed at risk is agreed, an adverse incident form should be generated in accordance with UHNS policy RM07 Policy and Procedures for Reporting of Adverse Incidents.**
- **When a patient has been returned to the ward/day care area, a senior member of staff should offer an explanation and apology.**
- **If surgery is carried out at the incorrect site, an adverse incident form should be generated in accordance with UHNS policy RM07 Policy and Procedure for Reporting of Adverse Incidents.**

Patient name		Unit number	

Theatre: Pre-operative **Date……**

E	ECG	
BP	Blood pressure cuff	
P	Pulse oximeter	
X	Temperature probe	
A	Arterial lines	
EP	Epidural	
S	Spinal	
Q	Combined Epi/Spinal	
V	Peripheral lines	
D	Diathermy plate	
TQ	Tourniquet	
VP	Eye protection ……..	
Other……		



Transfer: bed to table	
Assisted – pat slide	
Assisted – Other	
Number of staff	

Patient position	
Supine	
Left lateral	
Right lateral	
Other	

Arms	
At side	
Across chest	
Arm supports	
Secured	

Skin Preparation	
Aqueous Chlor-hexadine	
Alcohol Chlor-hexadine	
Aqueous Betadine	
Alcohol Betadine	
Other	

Pressure relieving aids	
Gel mats	
Heel bars	
Pillows	
SCD	
Other	

Other positioning aids	
Post (padded) traction boots (DHS) Other relevant padding	
Sand bags	
Pelvic / back support	
Safety straps	
Other	

Diathermy	
Monopolar	
Bipolar	
Prosthesis check	

Urinary catheter	
In situ on arrival	
Inserted in theatre	
Inserted by……	

Theatre: Peri-operative

Surgeon 1	Surgeon 2
Surgeon 3	Surgeon 4
Anaesthetist 1	Anaesthetist 2
Anaesthetist ODP 1	Anaesthetist ODP 2
Scrub Nurse 1	Scrub Nurse 2
Circulating Person 1	Circulating Person 2

Temperature control		
Warm air blanket:	Disposable	Non-disposable
Fluid warming:	Level 1	Other

Equipment Check					
Swab count	**Total**	**Sharps**	**Total**	**Tourniquet**	
Small		Suture needles		Type	
Medium		Hypodermic needles		Pressure	
Abdominal		Blades		Time on	
Red strings		Other		Time off	
Other					

Instruments correct: YES / NO

Washout: Solution…….....
Total……..

Theatre Post –operative information

Skin Closure	
Sub-cuticular	
Interrupted	
Clips	
Other	

Local infiltrations	
Amount	
Type	
Site	

Dressings	
Opsite	
Mepore	
Pressure	
Other	

Drainage	
Estimated blood loss	
Suction drain	
Other	

Packs	
Wound	
Other	
Diathermy site checked: Comments……	

Specimens	
Histology	
Cytology	
C&S	
Biochemistry	
Haematology	
X-match	
Other	

Patient name		Unit number	

Theatre: Peri-operative continued Date……

Transfer: table to bed: Assisted - Pat slide Assisted - Other Number of staff…….

Instrument / Prosthesis Bar Codes All bar code stickers to be placed in this box

Signed Scrub Nurse……	Signed Circ. Person……

Theatre: Operation Notes
Length of Operation: Hours……. Mins…….. Date…….

Indications Trauma

Other - details

Type of fracture

Bone sent for histology YES / NO

Operated side …….. (written in full)

Approach Anterolateral ☐ Direct lateral ☐ Other……

Other - details

Prosthesis type - details

Image intensifier used YES / NO

Intra-operative variance details:

Comments:

Routine post-op protocol **YES / NO**

Intra-operative antibiotics - 1 dose Cefuroxine ☐ 1 dose of Gentamyacin ☐

Aspirin, TED's, drains out 24hrs, FWB, Mobilising Day 1 if comfortable
Check X-ray Day 2 if hemi-arthroplasty prosthesis used.
(Follow thrombo-prophylaxis guidelines page 88-9)

Variance in post – op protocol PWB TTWB Heel WB NWB

Instructions:

Surgeons signature……. Dictated **YES / NO**

(please sign signature sheet on pages3/4)

Patient name		Unit number	

Recovery care plan: Admission assessment

Date……. **Stand Number…….**

Airway	
Laryngeal mask	
Endotracheal tube	
Tracheostomy	
Other	
Nasal	

Positioning	
Supine	
Left lateral	
Right lateral	
Sitting up	
Other	

Breathing	
Spontaneous	
Ventilated	
Oxygen therapy	
Endobronchial	

Drainage	
Catheter in situ	
Bladder irrigation	
Tenchkoff	
Wound drain	
Chest drain	
Nausea/ Vomiting	
Ryles tube	
Colostomy/ileostomy	
Pervagina	
Other	

Intravenous lines	
Butterfly cannula	
Venflon	
Central	
Arterial	
Epidural	
Intravenous infusion	
Syringe drivers	

Observations	
Oxygen saturation	
Heart rate	
Cardiac monitoring	
Non-invasive BP	
Arterial blood pressure	
Central venous blood pressure	
Respiration	
Temperature	
Blood glucose	
Neurological observations	
Urine output	
Colour, movement, sensation	
AV fistula	
Arterial blood pressure	
Cardiac output studies	
Other	

Wound observations	
Dressing intact	
Wound packs	
POP	
Traction	
External fixator	
Other	

Condition on discharge from recovery

Responding to command	Yes / No	Anaesthetist approved transfer	Yes / No
Head lifting	Yes / No	BP/Pulse satisfactory	Yes / No
Comments:			

Patient destination:		Transferred to another hospital……							
Return to admitting ward - number		ICU / HDU		SSCU		MIU			
Transfer to another ward - number		Patient died Yes / No							
Signed Recovery Nurse ……		Signed Ward Nurse ……..							

Landscape obs chart

Recovery assessment continued Date…………

Post-operative evaluation continued

Time	Comments	Sign

POST – OP Day of surgery Time returned from theatre……Date……..

Goals / post op management:	Early/am		Late/pm		Night	
Successful operative recovery	Sign	V	Sign	V	Sign	V
Observations $^1/_2$ hourly for an hour, then hourly until stable and awake, then 4 hourly Venflon site checked……. **Nutrition/Hydration:** Assess nutritional status – Nutrition score:☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Intravenous Infusion required YES / NO Passes urine am……. pm……. night……. Catheter in situ YES / NO Bowels opened: am……. pm……. night……. If not opened – action taken **Moving/handling review** **Continue anti-thrombotic treatment** – check for DVT TED stockings in situ **Wound / Skin / Pressure area review:** Wound drainage recorded Dressing checked Comments……. ……. Pressure areas checked and intact YES/NO Mattress……. Cushion……. **Waterlow / EPUAP assessment completed**						
Pain management						
Subjective pain assessment (0-3): am……. pm…….. night……. Pain controlled to a suitable level: YES / NO Medication reviewed Assess vital signs, nausea and sedation: YES / NO						
Understand management						
Patient alert and orientated Patient able to express fears and anxieties Daily plan explained Management discussed with family/carer YES / NO						
Respiration						
Observe for respiratory depression Breathing/circulation exercises explained and practiced Check optimal position for respiration Administer prescribed O_2 Referral for Respiratory Physiotherapy YES / NO. Comments…….						
Mobility						
Leg exercises practiced						
Independence						
Hygiene Encouraged patient to do as much as possible						
Discharge planning						
▶ Intermediate care team informed patient returned from surgery						
Named nurse	Early……Late……..…Night……..					

Patient name		Unit number	

POST – OP Day of surgery **Date…………….**

Multi-disciplinary Progress Notes **If mental capacity is affected, document assessment and decision taken**		
Time	Comments	Signature

If further documentation needed for this day please add extra yellow continuation sheets

POST – OP DAY 1 Date……..

Goals / post op management:	Early/am		Late/pm		Night	
Successful operative recovery	Sign	V	Sign	V	Sign	V
Observations: 4 hourly Venflon site checked **Blood test review:** Check FBC / ESR sent YES / NO Check U&E's sent YES / NO Check TFT / Bone profile sent YES / NO **MRSA check – appropriate management commenced** **Abbreviated Mental test score** ☐ (Complete on purple nursing assessment card) **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Intravenous Infusion required YES / NO Passes urine am……. pm……. night……. Catheter in situ YES / NO **Bowels opened:** am……. pm……. night……. Days not opened……. If not opened – action taken **Moving/handling review** **Continue anti-thrombotic treatment** – check for DVT TED stockings in situ **Wound / Skin / Pressure area review:** Wound / dressing checked Comments…… …… Wound drainage recorded Drains removed after 24 hours Skin checked and intact **Waterlow / EPUAP assessment completed**						
Pain management						
Subjective pain assessment (0-3): am……. pm…….. night…… Pain controlled to a suitable level: YES / NO Medication reviewed – started Oral analgesia YES / NO Assess vital signs, nausea and sedation: YES / NO						
Understand management						
Patient able to express fears and anxieties Daily plan explained						
Respiration						
Breathing/circulation exercises explained and practiced Check optimal position for respiration Administer / prescribed O_2 Referral to Respiratory Physiotherapy team YES / NO						
Mobility and safety						
Exercises: Leg exercises demonstrated and practiced ▶ **Patient mobilises if able:** Transfer from bed and stand with frame: Assistance needed…….. Sit out in chair if able YES / NO Distance mobilized…… ……						
Independence						
Encourage ADL independence						
Named nurse	Early……Late……..……Night……..					

Patient name		Unit number	

POST – OP DAY 1 Date…………..…

Multi-disciplinary Progress Notes

If mental capacity is affected, document assessment and decision taken

Time	Comments	Signature

If further documentation needed for this day please add extra yellow continuation sheets

POST – OP DAY 2 Date…….

Goals / post op management:	Early/am		Late/pm		Night	
Successful operative recovery	Sign	V	Sign	V	Sign	V
Observations: 4 hourly ▶ **Blood test review:** Results accessed and entered onto blue blood results sheet **If abnormal – contact SHO / ANP for review **Xray requested** (Hemiarthroplasty procedure) Reviewed by doctor Venflon site checked Coments……. **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Intravenous Infusion required YES / NO Passes urine am……. pm……. night……. ▶ Catheter removed **Bowels opened:** am……. pm……. night……. Days not opened……. If not opened – action taken **Continue anti-thrombotic treatment** – check for DVT TED stockings in situ **Wound / Skin / Pressure area review:** Wound / dressing checked Comments……. ……. ▶ Drains removed after 24/48 hours Skin checked and intact **Waterlow / EPUAP assessment completed**						
Pain management						
Subjective pain assessment (0-3): am……. pm…….. night…… Pain controlled to a suitable level: YES / NO Started Oral analgesia YES / NO						
Understand management						
Patient able to express fears and anxieties Daily plan explained						
Respiration						
Breathing exercises explained and practiced Check optimal position for respiration Respiratory physiotherapy required……						
Mobility and safety						
Exercises: Leg exercises demonstrated and practiced **Patient mobilises:** Transfer from bed and stand with frame: Assistance needed…….. Sit out in chair if able YES / NO Distanced mobilised…… …… ……						
▶ **Independence**						
Encourage ADL independence						

Named nurse	Early……Late……..…Night……..

Patient name		Unit number	

POST – OP DAY 2 **Date…………**

Multi-disciplinary Progress Notes

If mental capacity is affected, document assessment and decision taken

Time	Comments	Signature

If further documentation needed for this day please add extra yellow continuation sheets

Deliberately left blank

Patient name		Unit number	

OSTEOPOROSIS ASSESSMENT SHEET FOR #NOF PATIENTS

(see osteoporosis guidelines page 86-87)

1. Risk factors
   - BMI 19 or less YES/NO
   - Alcohol intake of 21 units or more for males YES/NO
     14 units of more for females YES/NO
   - Smoker YES/NO
   - Takes minimal weight bearing exercise YES/NO
   - Corticosteroid therapy YES/NO
   - Previous history of fragility fracture e.g. wrist or vertebra YES/NO
     Details……..
   - Early menopause YES/NO
   - Maternal history of osteoporosis YES/NO

2. DEXA done in the past YES/NO
   Check date & T score if possible, insert here……..

3. On any treatment for osteoporosis on admission YES/NO
   Is this to continue? YES/NO

4. Prescribed Calcium and Vitamin D this admission YES/NO

5. Prescribed Alendronate YES/NO
   If not, why not

6. Rationale for new treatment prescribed explained to patient YES/NO

   Explanation given regarding osteonecrosis of the jaw YES/NO
   Written or verbal, state which

7. DEXA scan required YES/NO

   If no, why not

   If yes, insert date requested

8. Written information given to the patient on falls and bone health YES/NO

   If no, has it been given to a relative instead YES/NO

9. Any advice given re how to reduce risk factors YES/NO

10. Any other comments

Date **……/……/……..**
Signature **……...**
Grade **……**

POST – OP DAY 3 Date……

Goals / post op management:	Early/am		Late/pm		Night	
Successful operative recovery	Sign	V	Sign	V	Sign	V
Observations: 4 hourly Venflon site checked Comments……. **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Passes urine am……. pm……. night……. ▶ Catheter removed **Bowels opened:** am……. pm……. night……. Days not opened……. If not opened – action taken **Continue anti-thrombotic treatment** – check for DVT TED stockings in situ **Wound / Skin / Pressure area review:** Wound / Dressing checked Checked and intact YES/NO Comments……. **Waterlow / EPUAP assessment completed** **Respiration:** checked and optimised						
Pain management						
Subjective pain assessment (0-3): am……. pm……. night…… Pain controlled to a suitable level: YES / NO Educate patient to use pain relief effectively						
Understand management						
Complete mental test score on purple assessment card Patient able to express fears and anxieties Patient / relative agreement for discharge YES / NO Explain daily plan / Reinforce knowledge						
Mobility and safety						
Patient increases mobility: Independent with transfers – bed and chair YES/NO Independent with frame YES/NO Distanced mobilised…… …… ……						
Independence						
OT initial assessment complete (page81) Comments …… …… …… ……						
▶ **Discharge to safe environment**						
Medically stable: Nurse YES / NO **Medical review:** Doctor YES / NO Medical problems actioned YES / NO Informed discharge coordinator to initiate discharge planning YES / NO **Social services input required** YES / NO Discharge discussed with Intermediate Care team YES / NO						

Named nurse	Early……Late……..…Night……..

Patient name		Unit number	

POST – OP DAY 3 **Date…………..**

Multi-disciplinary Progress Notes

If mental capacity is affected, document assessment and decision taken

Time	Comments	Signature

If further documentation needed for this day please add extra yellow continuation sheets

POST – OP DAY 4 Date……

Goals / post op management:	Early/am		Late/pm		Night	
Successful operative recovery	Sign	V	Sign	V	Sign	V
Observations: Daily - if wound clean and dry (unless suspected infection, then continue 4 hourly) Venflon site checked Comments…… **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Passes urine am……. pm……. night……. **Bowels opened:** am……. pm……. night……. Days not opened……. If not opened – action taken **Continue anti-thrombotic treatment** – check for DVT TED stockings in situ **Manual handling review** ▶ **Falls risk assessment score** ☐ **Wound / Skin / Pressure area review:** Wound / Dressing checked Comments…… **Waterlow / EPUAP assessment completed** **Respiration:** checked and optimised						
Pain management						
Pain controlled to a suitable level: YES / NO Monitor effect of oral analgesia						
Understand management						
Patient able to express fears and anxieties Daily plan explained Agreement for discharge YES / NO						
Mobility and safety						
Patient mobilises: Independent with frame YES/NO Progression of walking aid…….. Distanced mobilised…….. …… ▶ **Stairs:** step / stairs practiced (if applicable) YES / NO (medical fitness and obs checked before stair assessment completed)						
Independence						
OT assessment complete + action plan YES / NO Transfer assessment (Ax): Bed …… Chair…….. Toilet…….. Comments……						
☐Discharge to safe environment						
Safe for discharge: **Physio** YES / NO / With input **Intervention completed:** **OT** YES / NO / With input **Medically stable:** **Nurse** YES / NO **Medical review/medication review:** **Doctor** YES / NO Medical problems actioned YES / NO Informed discharge coordinator YES / NO Discharge discussed with Intermediate Care team YES / NO						
Named nurse	Early……Late……..Night……..					

Patient name		Unit number	

Multi-disciplinary Progress Notes

If mental capacity is affected, document assessment and decision taken

Time	Comments	Signature

If further documentation needed for this day please add extra yellow continuation sheets

POST – OP DAY 5 Date……

Goals / post op management:	Early/am		Late/pm		Night	
Successful operative recovery	Sign	V	Sign	V	Sign	V
Observations: Daily Venflon site checked/removed Comments……. **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Passes urine am……. pm……. night……. **Bowels opened**: am……. pm……. night……. Days not opened……. If not opened – action taken **Continue anti-thrombotic treatment – check for DVT** TED stockings in situ **Wound / Skin / Pressure area review:** Wound / Dressing checked Comments …… **Waterlow / EPUAP assessment completed** **Respiration:** checked and optimised						
Pain management						
Pain controlled to a suitable level: YES / NO Monitor effect of oral analgesia						
Understand management						
Complete mental test score on purple assessment card Patient able to express fears and anxieties Daily plan explained Agreement for discharge from care YES / NO						
Mobility and safety						
Patient mobilises: Walking aid used……..Independent YES/NO Progression of walking aid…….. Mobility practice…… …… …… ▶ **Stairs:** step / stairs practiced (if applicable) YES / NO (medical fitness and obs checked before stair assessment completed)						
Independence						
OT assessment complete + action plan YES / NO **Transfer assessment (Ax):** Bed …… Chair…….. Toilet…….. **Equipment**…… Access visit……						
Discharge to safe environment						
Safe for discharge: Physio YES / NO / With input **Intervention completed**: OT YES / NO / With input **Medically stable:** Nurse YES / NO ▶ If No - Medical review completed and actioned YES / NO **Medication review:** YES / NO **Suitable to transfer to other service**…… If fit for discharge: Discharge paperwork completed Transport arrangements confirmed TTO's prescribed Discharge/transfer destination……						
Named nurse	Early……Late……Night……..					

Patient name		Unit number	

POST – OP DAY 5 **Date…………..**

Multi-disciplinary Progress Notes

If mental capacity is affected, document assessment and decision taken

Time	Comments	Signature

If further documentation needed for this day please add extra yellow continuation sheets

POST – OP DAY 6 Date……

Goals / post op management:	Early/am		Late/pm		Night	
Successful operative recovery	Sign	V	Sign	V	Sign	V
Observations: Daily Venflon site checked/removed Comments…….. **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Passes urine am……. pm……. night……. **Bowels opened:** am……. pm……. night……. Days not opened……. If not opened – action taken **Continue anti-thrombotic treatment** – check for DVT TED stockings in situ **Wound / Skin / Pressure area review:** Wound / Dressing checked Skin checked and intact YES/NO Comments…….. **Waterlow / EPUAP assessment completed** **Respiration:** checked and optimised						
Pain management						
Pain controlled to a suitable level: YES / NO Monitor effect of oral analgesia						
Understand management						
Patient able to express fears and anxieties Daily plan explained Agreement for discharge from care YES / NO						
Mobility and safety						
Patient mobilises: Walking aid used……..Independent YES/NO Mobility practice…… …… …… ▶ **Stairs:** step / stairs practiced (if applicable) YES / NO (medical fitness and obs checked before stair assessment completed)						
Independence						
OT assessment complete + action plan YES / NO **Independent with transfers YES / NO** OT review…… …… ……						
Discharge to safe environment						
Safe for discharge: Physio YES / NO / With input **Intervention completed**: OT YES / NO / With input **Medically stable:** Nurse YES / NO ▶ If No - Medical review completed YES / NO **Medication review:** YES / NO **Discharge requirements reassessed**…… …… **Suitable to transfer to other service**…… If fit for discharge: Discharge paperwork completed Transport arrangements confirmed TTO's prescribed Discharge/transfer destination……						

Named nurse	Early……Late……..Night……..

Patient name		Unit number	

POST – OP DAY 6 **Date…………….**

Multi-disciplinary Progress Notes

If mental capacity is affected, document assessment and decision taken

Time	Comments	Signature

If further documentation needed for this day please add extra yellow continuation sheets

POST – OP DAY 7 Date……

Goals / post op management:	Early/am		Late/pm		Night	
Successful operative recovery	Sign	V	Sign	V	Sign	V
Observations: Daily Venflon site checked/removed Comments…… **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Passes urine am……. pm……. night……. **Bowels opened:** am……. pm……. night……. Days not opened……. If not opened – action taken **Continue anti-thrombotic treatment** – check for DVT TED stockings in situ **Wound / Skin / Pressure area review:** Wound / Dressing checked Skin checked and intact YES/NO Comments…… **Waterlow / EPUAP assessment completed** **Respiration:** checked and optimised						
Pain management						
Pain controlled to a suitable level: YES / NO Monitor effect of oral analgesia						
Understand management						
Patient able to express fears and anxieties Daily plan explained Agreement for discharge from care YES / NO						
Mobility and safety						
Patient mobilises: Walking aid used……..Independent YES/NO Mobility practice…… …… …… …… ▶ **Stairs:** step / stairs practiced (if applicable) YES / NO (medical fitness and obs checked before stair assessment completed)						
Independence						
Maintain independence OT review…… …… …… ……						
Discharge to safe environment						
Safe for discharge: Physio YES / NO / With input **Intervention completed**: OT YES / NO / With input **Medically stable:** Nurse YES / NO ▶ If No - Medical review completed YES / NO **Medication review:** YES / NO **Discharge requirements reassessed**…… …… ▶ **Reason for no discharge**…… If fit for discharge: Discharge paperwork completed Transport arrangements confirmed TTO's prescribed Discharge/transfer destination……						
Named nurse	Early……Late……..Night……..					

Patient name		Unit number	

POST – OP DAY 7 Date…………

Multi-disciplinary Progress Notes

If mental capacity is affected, document assessment and decision taken

Time	Comments	Signature

If further documentation needed for this day please add extra yellow continuation sheets

POST – OP DAY 8 Date……

Goals / post op management:	Early/am		Late/pm		Night	
Successful operative recovery	Sign	V	Sign	V	Sign	V
Observations: Daily Venflon site checked/removed Comments…… **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Passes urine am……. pm……. night……. **Bowels opened:** am……. pm……. night……. Days not opened……. If not opened – action taken **Continue anti-thrombotic treatment** – check for DVT TED stockings in situ **Wound / Skin / Pressure area review:** Dressing checked Skin checked and intact YES/NO Comments…… **Waterlow / EPUAP assessment completed** **Respiration:** checked and optimized						
Pain management						
Controlled with oral analgesia						
Understand management						
Complete mental test score on purple assessment card Management discussed / agreed with patient						
Mobility and safety						
Patient mobilises: Walking aid used……..Independent YES/NO Mobility practice…… …… …… …… ▶ **Stairs:** step / stairs practiced (if applicable) YES / NO (medical fitness and obs checked before stair assessment completed)						
Independence						
Maintain ADL independence Comments…… …… ……						
Discharge to safe environment						
Safe for discharge: Physio YES / NO / With input **Intervention completed**: OT YES / NO / With input **Medically stable:** Nurse YES / NO ▶ If No - Medical review completed YES / NO **Medication review:** YES / NO **Discharge requirements reassessed / comments**…… …… …… …… ▶ **Reason for no discharge**…… …… <u>If fit for discharge</u>: Discharge paperwork completed Transport arrangements confirmed TTO's prescribed Discharge/transfer destination……						
Named nurse	Early……Late……..…Night……..					

Patient name		Unit number	

POST – OP DAY 8 **Date…………**

Multi-disciplinary Progress Notes

If mental capacity is affected, document assessment and decision taken

Time	Comments	Signature

If further documentation needed for this day please add extra yellow continuation sheets

POST – OP DAY 9 Date……

Goals / post op management:	Early/am		Late/pm		Night	
Successful operative recovery	Sign	V	Sign	V	Sign	V
Observations: Daily Venflon site checked Comments…… **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Passes urine am……. pm……. night……. **Bowels opened:** am……. pm……. night……. Days not opened……. If not opened – action taken **Continue anti-thrombotic treatment** – check for DVT TED stockings in situ **Wound / Skin / Pressure area review:** Dressing checked Skin checked and intact YES/NO Comments…… **Waterlow / EPUAP assessment completed** **Respiration:** checked and optimized						
Pain management						
Controlled with oral analgesia Reassessment of pain medication needed YES / NO						
Understand management						
Management discussed / agreed with patient						
Mobility and safety						
Patient mobilises: Walking aid used……..Independent YES/NO Mobility practice…… …… …… …… ▶ **Stairs:** step / stairs practiced (if applicable) YES / NO (medical fitness and obs checked before stair assessment completed)						
Independence						
Maintain ADL independence Comments…… …… ……						
Discharge to safe environment						
Safe for discharge: Physio YES / NO / With input **Intervention completed**: OT YES / NO / With input **Medically stable:** Nurse YES / NO ▶ If No - Medical review completed YES / NO **Medication review: YES / NO** **Discharge requirements reassessed / comments……** **……** **……** **……** ▶ **Reason for no discharge……** **……** **If fit for discharge: Discharge paperwork completed** **Transport arrangements confirmed** **TTO's prescribed** **Discharge/transfer destination……**						
Named nurse	**Early……Late……Night……..**					

Patient name		Unit number	

POST – OP DAY 9 Date…………….

Multi-disciplinary Progress Notes

If mental capacity is affected, document assessment and decision taken

Time	Comments	Signature

If further documentation needed for this day please add extra yellow continuation sheets

POST – OP DAY 10 Date……

Goals / post op management:	Early/am		Late/pm		Night	
Successful operative recovery	Sign	V	Sign	V	Sign	V
Observations: Daily Venflon site checked Comments…… **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Passes urine am……. pm……. night……. **Bowels opened: am……. pm……. night…….** Days not opened……. If not opened – action taken **Continue anti-thrombotic treatment – check for DVT** TED stockings in situ **Wound / Skin / Pressure area review:** Dressing checked Skin checked and intact YES/NO Comments…… **Waterlow / EPUAP assessment completed** **Respiration:** checked and optimized						
Pain management						
Controlled with oral analgesia Reassessment of pain medication needed YES / NO						
Understand management						
Management discussed / agreed with patient						
Mobility and safety						
Patient mobilises: Walking aid used……..Independent YES/NO Mobility practice…… …… …… …… ▶ **Stairs:** step / stairs practiced (if applicable) YES / NO (medical fitness and obs checked before stair assessment completed)						
Independence						
Maintain ADL independence Comments…… …… ……						
Discharge to safe environment						
Safe for discharge: Physio YES / NO / With input **Intervention completed**: OT YES / NO / With input **Medically stable:** Nurse YES / NO ▶ If No - Medical review completed YES / NO **Medication review:** YES / NO **Discharge requirements reassessed / comments**…… …… …… …… ▶ **This patient should be discharged. What is the reason for no discharge?**…… If fit for discharge: Discharge paperwork completed Transport arrangements confirmed TTO's prescribed Discharge/transfer destination……						

Named nurse	Early……Late……..….Night……

Patient name		Unit number	

POST – OP DAY 10 Date…………

Multi-disciplinary Progress Notes If mental capacity is affected, document assessment and decision taken		
Time	Comments	Signature

If further documentation needed for this day please add extra yellow continuation sheets

POST – OP DAY 11 Date……

Goals / post op management:	Early/am		Late/pm		Night	
Successful operative recovery	Sign	V	Sign	V	Sign	V
Observations: Daily Venflon site checked Comments…… **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Passes urine am……. pm……. night……. **Bowels opened:** am……. pm……. night……. Days not opened……. If not opened – action taken **Continue anti-thrombotic treatment** – check for DVT TED stockings in situ **Wound / Skin / Pressure area review:** Dressing checked Skin checked and intact YES/NO Comments…… **Waterlow / EPUAP assessment completed** **Respiration:** checked and optimized						
Pain management						
Controlled with oral analgesia Reassessment of pain medication needed YES / NO						
Understand management						
Management discussed / agreed with patient						
Mobility and safety						
Patient mobilises: Walking aid used……..Independent YES/NO Mobility practice…… …… …… …… ▶ **Stairs:** step / stairs practiced (if applicable) YES / NO (medical fitness and obs checked before stair assessment completed)						
Independence						
Maintain ADL independence Comments…… …… ……						
Discharge to safe environment						
Safe for discharge: Physio YES / NO / With input **Intervention completed**: OT YES / NO / With input **Medically stable:** Nurse YES / NO ▶ If No - Medical review completed YES / NO **Medication review:** YES / NO **Discharge requirements reassessed / comments**…… …… …… …… ▶ **Reason for no discharge**…… …… <u>If fit for discharge</u>: Discharge paperwork completed Transport arrangements confirmed TTO's prescribed Discharge/transfer destination……						
Named nurse	Early……Late……..…Night……					

Patient name		Unit number	

POST – OP DAY 11 Date…………

Multi-disciplinary Progress Notes

If mental capacity is affected, document assessment and decision taken

Time	Comments	Signature

If further documentation needed for this day please add extra yellow continuation sheets

POST – OP DAY 12 Date……

Goals / post op management:	Early/am		Late/pm		Night	
Successful operative recovery	Sign	V	Sign	V	Sign	V
Observations: Daily Venflon site checked Comments…… **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Passes urine am……. pm……. night……. **Bowels opened:** am……. pm……. night……. Days not opened……. If not opened – action taken **Continue anti-thrombotic treatment** – check for DVT TED stockings in situ **Wound / Skin / Pressure area review:** Dressing checked Skin checked and intact YES/NO Comments…….. **Waterlow / EPUAP assessment completed** **Respiration:** checked and optimized						
Pain management						
Controlled with oral analgesia Reassessment of pain medication needed YES / NO						
Understand management						
Management discussed / agreed with patient						
Mobility and safety						
Patient mobilises: Walking aid used……..Independent YES/NO Mobility practice…… …… …… …… ▶ **Stairs:** step / stairs practiced (if applicable) YES / NO (medical fitness and obs checked before stair assessment completed)						
Independence						
Maintain ADL independence Comments…… …… ……						
Discharge to safe environment						
Safe for discharge: Physio YES / NO / With input **Intervention completed**: OT YES / NO / With input **Medically stable:** Nurse YES / NO ▶ If No - Medical review completed YES / NO **Medication review:** YES / NO **Discharge requirements reassessed / comments**…… …… …… …… ▶ **Reason for no discharge**…… …… <u>If fit for discharge</u>: Discharge paperwork completed Transport arrangements confirmed TTO's prescribed Discharge/transfer destination……						
Named nurse	Early……Late……..…Night……..					

Patient name		Unit number	

POST – OP DAY 12 **Date…………**

Multi-disciplinary Progress Notes

If mental capacity is affected, document assessment and decision taken

Time	Comments	Signature

If further documentation needed for this day please add extra yellow continuation sheets

POST – OP DAY 13 Date……

Goals / post op management:	Early/am		Late/pm		Night	
Successful operative recovery	Sign	V	Sign	V	Sign	V
Observations: Daily Venflon site checked Comments…… **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Passes urine am……. pm……. night……. **Bowels opened:** am……. pm……. night……. Days not opened……. If not opened – action taken **Continue anti-thrombotic treatment** – check for DVT TED stockings in situ **Wound / Skin / Pressure area review:** Dressing checked Skin checked and intact YES/NO Comments…… **Waterlow / EPUAP assessment completed** **Respiration:** checked and optimized						
Pain management						
Controlled with oral analgesia Re-assessment of pain medication needed YES / NO						
Understand management						
Management discussed / agreed with patient						
Mobility and safety						
Patient mobilises: Walking aid used……..Independent YES/NO Mobility practice…… …… …… …… ▶ **Stairs:** step / stairs practiced (if applicable) YES / NO (medical fitness and obs checked before stair assessment completed)						
Independence						
Maintain ADL independence Comments…… …… ……						
Discharge to safe environment						
Safe for discharge: Physio YES / NO / With input **Intervention completed**: OT YES / NO / With input **Medically stable:** Nurse YES / NO ▶ If No - Medical review completed YES / NO **Medication review:** YES / NO **Discharge requirements reassessed / comments**…… …… …… …… ▶ **Reason for no discharge**…… …… <u>If fit for discharge</u>: Discharge paperwork completed Transport arrangements confirmed TTO's prescribed Discharge/transfer destination……						
Named nurse	Early……Late……Night……					

Patient name		Unit number	

POST – OP DAY 13 **Date…………**

Multi-disciplinary Progress Notes

If mental capacity is affected, document assessment and decision taken

Time	Comments	Signature

If further documentation needed for this day please add extra yellow continuation sheets

POST – OP DAY 14 Date……

Goals / post op management:	Early/am		Late/pm		Night	
Successful operative recovery	Sign	V	Sign	V	Sign	V
Observations: Daily Venflon site checked Comments…… **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Passes urine am……. pm……. night……. **Bowels opened:** am……. pm……. night……. Days not opened……. If not opened – action taken **Continue anti-thrombotic treatment** – check for DVT TED stockings in situ **Wound / Skin / Pressure area review:** Dressing checked Skin checked and intact YES/NO Comments…… **Waterlow / EPUAP assessment completed** **Respiration:** checked and optimized						
Pain management						
Controlled with oral analgesia Reassessment of pain medication needed YES / NO						
Understand management						
Management discussed / agreed with patient						
Mobility and safety						
Patient mobilises: Walking aid used……..Independent YES/NO Mobility practice…… …… …… …… ▶ **Stairs:** step / stairs practiced (if applicable) YES / NO (medical fitness and obs checked before stair assessment completed)						
Independence						
Maintain ADL independence Comments…… …… ……						
Discharge to safe environment						
Safe for discharge: Physio YES / NO / With input **Intervention completed**: OT YES / NO / With input **Medically stable:** Nurse YES / NO ▶ If No - Medical review completed YES / NO **Medication review:** YES / NO **Discharge requirements reassessed / comments**…… …… …… …… ▶ **Reason for no discharge**…… …… <u>If fit for discharge</u>: Discharge paperwork completed Transport arrangements confirmed TTO's prescribed Discharge/transfer destination……						
Named nurse	Early……Late……Night……					

Patient name		Unit number	

POST – OP DAY 14 Date…………

Multi-disciplinary Progress Notes **If mental capacity is affected, document assessment and decision taken**		
Time	Comments	Signature

If further documentation needed for this day please add extra yellow continuation sheets

POST – OP DAY 15 Date……

Goals / post op management:	Early/am		Late/pm		Night	
Successful operative recovery	Sign	V	Sign	V	Sign	V
Observations: Daily Venflon site checked Comments…… **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Passes urine am……. pm……. night……. **Bowels opened:** am……. pm……. night……. Days not opened……. If not opened – action taken **Continue anti-thrombotic treatment** – check for DVT TED stockings in situ **Wound / Skin / Pressure area review:** Dressing checked Skin checked and intact YES/NO Comments…… **Waterlow / EPUAP assessment completed** **Respiration:** checked and optimized						
Pain management						
Controlled with oral analgesia Reassessment of pain medication needed YES / NO						
Understand management						
Management discussed / agreed with patient						
Mobility and safety						
Patient mobilises: Walking aid used……..Independent YES/NO Mobility practice…… …… …… …… ▶ **Stairs:** step / stairs practiced (if applicable) YES / NO (medical fitness and obs checked before stair assessment completed)						
Independence						
Maintain ADL independence Comments…… …… ……						
Discharge to safe environment						
Safe for discharge: Physio YES / NO / With input **Intervention completed**: OT YES / NO / With input **Medically stable:** Nurse YES / NO ▶ If No - Medical review completed YES / NO **Medication review:** YES / NO **Discharge requirements reassessed / comments**…… …… …… …… ▶ **Reason for no discharge**…… …… <u>If fit for discharge</u>: Discharge paperwork completed Transport arrangements confirmed TTO's prescribed Discharge/transfer destination……						
Named nurse	Early……Late……Night……					

Patient name		Unit number	

POST – OP DAY 15 Date…………

Multi-disciplinary Progress Notes

If mental capacity is affected, document assessment and decision taken

Time	Comments	Signature

If further documentation needed for this day please add extra yellow continuation sheets

POST - OP DAY …… Date……

(Affix extra post op rehab sheets if care continues after day 15)

Goals / post op management:	Early/am		Late/pm		Night	
Successful operative recovery	Sign	V	Sign	V	Sign	V
Observations: Daily Venflon site checked **Nutrition/Hydration:** Assess nutritional status – Nutrition score: ☐ Actions implemented Ensure fluid / dietary requirements are adhered to Record input hourly on fluid balance chart Passes urine am……. pm……. night……. **Bowels opened:** am……. pm……. night……. Days not opened……. If not opened – action taken **Continue anti-thrombotic treatment** – check for DVT TED stockings in situ **Wound / Skin / Pressure area review:** Dressing checked Skin checked and intact YES/NO Comments…….. **Waterlow / EPUAP assessment completed** **Respiration:** checked and optimized						
Pain management						
Controlled with oral analgesia						
Understand management						
Management discussed / agreed with patient						
Mobility and safety						
Maintain mobility with walking aid of choice …… …… **Stairs:** step / stairs practiced (if applicable) YES / NO (medical fitness and obs checked before stair assessment completed)						
Independence						
Maintain ADL independence Comments …… ……						
Discharge to safe environment						
Safe for discharge: Physio YES / NO / With input **Intervention completed**: OT YES / NO / With input **Medically stable:** Nurse YES / NO ▶ If No - Medical review completed YES / NO **Medication review:** YES / NO **Discharge requirements reassessed / comments**…… …… …… …… ▶ **Reason for no discharge**…… …… If fit for discharge: Discharge paperwork completed Transport arrangements confirmed TTO's prescribed Discharge/transfer destination……						
Named nurse	Early……Late……..….Night……..					

If further documentation is required add extra pink continuation sheets

Patient name

Unit number

(affix patient label)

Actual Complications / Variance Summary

Date	Complication / Variance	Action	Initial

Deliberately left blank

Significant Patient events / patient comments
Conversations with patients / relatives (state names involved)

Date/Time	Comments

Significant Patient events / Patient comments
Conversations with patients / relatives (state names involved)

Date/Time	Comments

Add additional sheets if required

Discharge / Transfer Plan Date……

(Adapted from Trust policy for discharge for adult patients – C05)

Action	Tick	Comments	Initial
Patient pronounced ready for discharge by Doctor, or by authorised nurse in accordance with consultant's written instructions and discharge decision recorded in medical notes.			
Patient and carer ready and willing for discharge on planned date			
Patient / carer's learning and care needs have been met and relevant information supplied			
All actions planned have been implemented and successful outcome obtained			
Discharge care plan explained Other agencies / services involved (list in comments section)			
Patient / carer advised concerning activity, driving and return to work, and any necessary certificates have been supplied			
Patient / carer given opportunity to ask questions to clinician team			
Medicines to take home prescribed and given to patient / carer with appropriate verbal and written instructions. Own medications returned			
Dressings and any necessary appliances Given to patient / carer with appropriate verbal and written instructions			
Details of any out-patient appointments made given to patient / carer			
EPR discharge section completed			
Patient's copy of Continuing Care Request Form given to patient / carer to give to Community Nurse on first visit			
Valuables returned to patient / carer Clothes available for discharge			
Transport arrangements completed Access to home arranged			
Patient / carer told who to contact if any queries or anxiety following discharge			
PALS feedback form offered / made available and completed			
Discharge summary passed to Intermediate care team or transfer service and GP (pg79)			
Patient information leaflets given ▪ Fractured Neck of Femur ▪ Falls and bone health ▪ Reducing blood clots ▪ Discharge medication			
Variance summary sheet completed			

Deliberately left blank

University Hospital of North Staffordshire NHS
NHS Trust

Discharge / Transfer Summary

Patient name
Unit number
(affix patient label)

Top copy to be sent to Intermediate Care team / transfer service
Second copy sent to GP as medical summary sheet with KMR

Date……

Consultant :	**Date of Admission:** **Ward:**
Primary diagnosis/presenting problem:	**PMH:**

Operation title:

Date of procedure:

Post-operative management / Complications / Variances from pathway:

Physio summary: Previous level of mobility……..
WB status = Continue WB status for…….days / weeks

Further intervention needed YES / NO

OT summary:

Further intervention needed YES / NO

D/C advice and information	**Medications started this admission**	**Medications stopped**
Outstanding investigations		
Removal of suture date:	**Follow up clinic date:……..** **Transport arranged YES / NO**	

Last two blood results

Dates			**Dates**			**Dates**		
Hb			Urea			Glucose		
WCC			Creatinine			INR		
Platelets			Sodium			ESR		
			Potassium					

Final observations - Date…….			
BP		Resps	
Pulse		O_2 sat	
Temp			

MRSA / ESBL status:

This summary was Completed by:	Name in capitals……	Signature ……

Deliberately left blank

University Hospital of North Staffordshire NHS
NHS Trust

Patient name Unit number (affix patient label)

OT SCREENING ASSESSMENT
(Carbonated for removal by OT team)

Accommodation		**Support**
Type	Heating	Family/ Friends / Neighbours
Occupants		
Internal steps / stairs		Social services
External access		

Functional Ability	**Pre admission**	**Present**		**Pre admission**	**Present**
Mobility			Cooking / Drinks		
Transfers – chair					
Transfers – bed			Cleaning /Laundry		
Transfers– toilet			Shopping		
Transfers – bath			Work / Leisure		
Dressing			Equipment in situ		
Feeding					
Other information:					

Problem list / Actions

Problem /Need	Action	Inactive	Sign

Signed OT…….Date completed…….

Deliberately left blank

Falls risk Assessment recommended guidelines

Low risk intervention

- Assess and advise patient/relative on suitability of foot wear
- If walking aid used, is it within reach? Is it appropriate? If not refer to a physiotherapist
- Orientate patients to ward/department layout
- Ensure manual handling risk assessment is completed and updated, ensure necessary equipment is available
- Ensure call bell is working and within reach
- Ensure brakes on beds, chairs and commodes are in working order
- Where appropriate, check hearing aid for correct fir and that batteries are working
- Where appropriate ensure glasses are clean, within reach and that they are the most current pair
- Where appropriate (e.g. if a patient is dysphagic) provide patient with prompt card
- Ensure that environment is clutter free
- Where appropriate check that urinalysis has been performed
- Ensure bed is in lowest position
- Discuss review of medication with medic staff

Medium risk interventions

(all low risk interventions apply in addition to the following)

- Refer patient to the physiotherapist for assessment
- Educate patient, family and carers where appropriate re: risks of falling and associated risk factors
- Discuss review of medication with medical staff
- Consider daily observation and record of standing and lying blood pressure
- Where appropriate teach patient how to get up from floor correctly
- Consider use of cot sides following guidelines (refer to Trust bed rail application handbook)

High risk interventions

(all low and medium risk interventions apply in addition to the following)

- Refer patient to the Occupational therapist for assessment
- Ensure that bed is easily observable
- Inform medical staff of identified risk of falling
- Involve family, explain risks and consider extending visiting hours
- Prior to discharge give information leaflet regarding fall prevention
- Consider multidisciplinary assessment

Nutrition Screening Tool

7 – 10	11 – 18	19 – 24
Minimal risk Review patient **weekly** by weighing and rescoring Document as part of nursing process	**Moderate risk** Eat well menu and regular snacks Provide meal replacement for unfinished meals (eg sandwich, Yoghurt, cheese and biscuits) Food intake charts Give Build-ups between meals (unless on special diet or contraindicated) Review patient **weekly** by weighing and rescoring. If no improvement discuss with dietitian Document as part of nursing process	**High risk** Inform medical staff and refer to Dietitian Eat well menu and regular snacks Food intake charts Give Build-ups between meals (unless on special diet or contraindicated) Medical staff to prescribe supplements (Fortsip) Review diet daily. If needed contact the dietitian for further advice Review patient **twice-weekly** by weighing and rescoring Document as part of nursing process

North Staffordshire Flow chart for selecting Mattresses

Steve to add in

WATERLOW PRESSURE ULCER PREVENTION/TREATMENT POLICY

RING SCORES IN TABLE, ADD TOTAL. MORE THAN 1 SCORE/CATEGORY CAN BE USED

BUILD/WEIGHT FOR HEIGHT		SKIN TYPE VISUAL RISK AREAS		SEX AGE	
AVERAGE		HEALTHY	0	MALE	1
BMI = 20-24.9	0	TISSUE PAPER	1	FEMALE	2
ABOVE AVERAGE		DRY	1	14 - 49	1
BMI = 25-29.9	1	OEDEMATOUS	1	50 - 64	2
OBESE		CLAMMY, PYREXIA	1	65 - 74	3
BMI > 30	2	DISCOLOURED GRADE 1	2	75 - 80	4
BELOW AVERAGE		BROKEN/SPOTS GRADE 2-4	3	81 +	5
BMI < 20	3				
BMI=Wt(Kg)/Ht (M)^2					

MALNUTRITION SCREENING TOOL (MST) (Nutrition Vol.15, No.6 1999 - Australia

A - HAS PATIENT LOST WEIGHT RECENTLY
YES - GO TO B
NO - GO TO C
UNSURE - GO TO C AND SCORE 2

B - WEIGHT LOSS SCORE
0.5 - 5kg = 1
5 - 10kg = 2
10 - 15kg = 3
> 15kg = 4
unsure = 2

C - PATIENT EATING POORLY OR LACK OF APPETITE
'NO' = 0; 'YES' SCORE = 1

NUTRITION SCORE
If > 2 refer for nutrition assessment / intervention

CONTINENCE		MOBILITY	
COMPLETE/ CATHETERISED	0	FULLY	0
URINE INCONT.	1	RESTLESS/FIDGETY	1
FAECAL INCONT.	2	APATHETIC	2
URINARY + FAECAL INCONTINENCE	3	RESTRICTED	3
		BEDBOUND e.g. TRACTION	4
		CHAIRBOUND e.g. WHEELCHAIR	5

SCORE

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

SPECIAL RISKS

TISSUE MALNUTRITION		NEUROLOGICAL DEFICIT	
TERMINAL CACHEXIA	8	DIABETES, MS, CVA	4-6
MULTIPLE ORGAN FAILURE	8	MOTOR/SENSORY	4-6
SINGLE ORGAN FAILURE (RESP, RENAL, CARDIAC,)	5	PARAPLEGIA (MAX OF 6)	4-6
PERIPHERAL VASCULAR DISEASE	5	**MAJOR SURGERY or TRAUMA**	
ANAEMIA (Hb < 8)	2	ORTHOPAEDIC/SPINAL	5
SMOKING	1	ON TABLE > 2 HR#	5
		ON TABLE > 6 HR#	8

MEDICATION - CYTOTOXICS, LONG TERM/HIGH DOSE STEROIDS, ANTI-INFLAMMATORY MAX OF 4

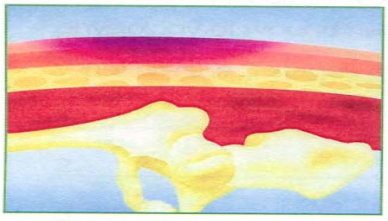
Scores can be discounted after 48 hours provided patient is recovering normally

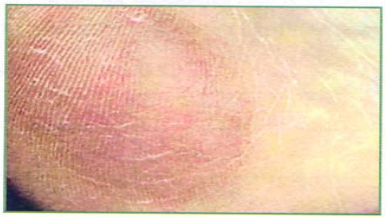
* The 2005 revision incorporates the research undertaken by Queensland Health.

www.judy-waterlow.co.uk

European Pressure Ulcer Advisory Panel (EPUAP)
Pressure ulcer grading

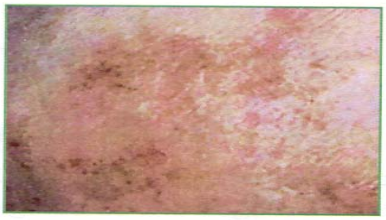
Stage 1





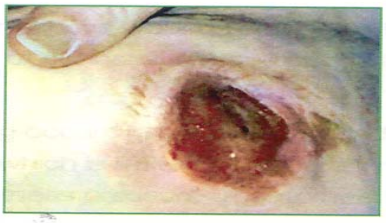
A stage 1 pressure ulcer is characterised by observable pressure related alteration of intact skin. These may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red or blue hues.

Stage 2



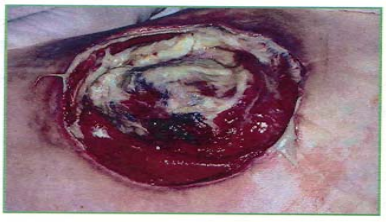
A stage 2 pressure ulcer is characterised by partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

Stage 3



A stage 3 pressure ulcer has full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

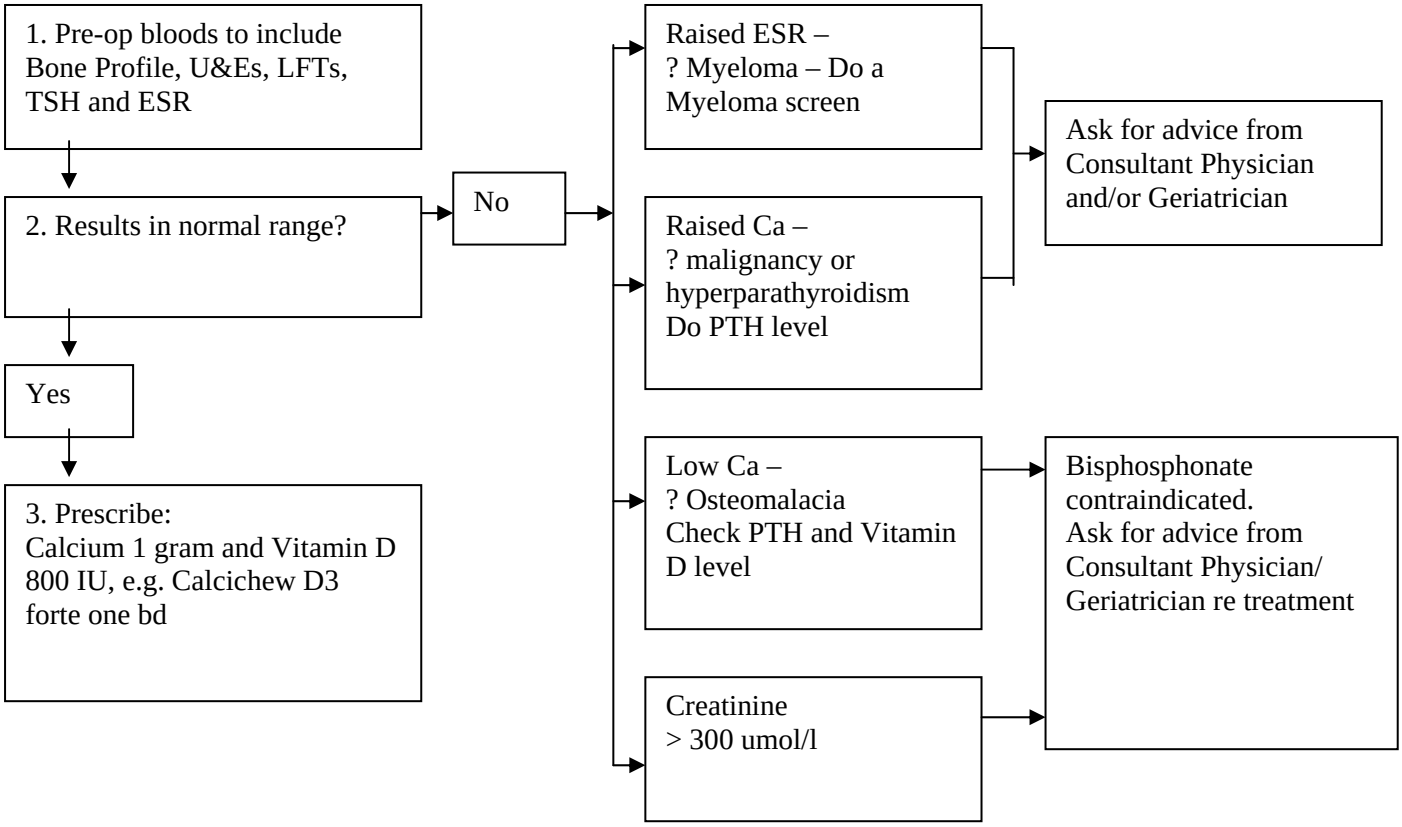
Stage 4



Stage 4 pressure ulcers are characterised by full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures (tendon or joint capsule). Undermining and sinus tracts may also be associated with a Stage 4 ulcer.

OSTEOPOROSIS ASSESSMENT CHART FOR PATIENTS WITH FRACTURED NECK OF FEMUR

1. CALCIUM AND VITAMIN D should be prescribed FOR ALL PATIENTS unless contraindicated. Follow flow diagram below:



2. Bisphosphonates should be <u>considered</u> for all patients. Follow appropriate flow diagram below to determine treatment and need for DEXA.

<u>a: Females 75 or over</u>

These patients do not require a DEXA scan, as they are more than likely to have osteoporosis

Unless there are:
1) Contraindications to Bisphosphonates*
2) Abnormal blood results or
3) Unable to comply

Prescribe Alendronate 70 mgs weekly**
DEXA not required

<u>b: Females up to and including age 74 and all males</u>

These patients require a DEXA to clarify whether Bisphosphonates are needed

Ensure a full osteoporosis assessment has been done, as per check list, and correctable factors dealt with

Refer patient for a DEXA, unless unable to co-operate.
Do not refer if patient has severe OA of lumbar spine and metalwork in both hips

** Please note Alendronate must be swallowed whole with a full glass of water on an empty stomach 30 minutes before breakfast (and any other oral medication). The patient must sit upright for 30 minutes after taking it. It must not be taken at bedtime or before rising.

3. ALTERNATIVE TREATMENT for osteoporosis may be appropriate e.g. Raloxifene, intravenous Pamidronate or Teriparatide, in a few patients who have been unable to take/tolerate Bisphosphonates* or who have fractured despite taking Bisphosphonates* correctly for at least 1 year.

If you think alternative treatment may be indicated please ask for advice from Consultant Physician and/or Geriatrician and do a referral to Haywood for a DEXA scan
Female patients >75 years can be referred to the Haywood for advice but do not request DEXA scans for these patients

<u>* CONTRA-INDICATIONS TO BISPHOSPHONATES</u>

1. Hypocalcaemia
2. Severe renal impairment
3. Use with caution in patients who are unable to follow the instructions re timing of taking Bisphosphonates
4. Intolerance of Bisphosphonates is defined as oesophageal ulceration, erosion or stricture or symptoms of oesophageal irritation (e.g. worsening heartburn), which have warranted discontinuation of Bisphosphonate treatment

<u>CAUTIONS WITH BISPHOSPHONATES</u>

Osteoporosis of the jaw is a rare complication of treatment with oral Bisphosphonates. Patients should be encouraged to maintain good dental hygiene. Remedial dental work should be carried out <u>before</u> starting Bisphosphonates.

<u>References</u>

NICE guidelines, “Final Appraisal Determination – July 2004; Bisphosphonates, Selective Oestrogen Receptor Modulators and PTH for secondary prevention of Osteoporotic Fragility Fractures”.

THROMBO-PROPHYLAXIS FOR PATIENTS WITH FRACTURED NECK OF FEMUR

- The majority of these patients are in the high risk category for DVT/PE. For patients aged 60 or over please follow **these** guidelines in preference to the SURGICAL GUIDELINES.

- For patients under the age of 60, please assess their risk as per Surgical Guidelines; some will require low molecular weight Heparin, others will not. We currently use Dalteparin.

1. PRESCRIBE DALTEPARIN 5000 u s/c at 5.00 pm daily from the day of admission, unless there is a contraindication to Heparin such as:

- Haemorrhagic disorder
- Past history of Heparin allergy or Heparin induced thrombocytopenia

Dalteparin is **NOT** normally administered on the day of operation.

2. Use TED socks or stockings on both legs also.

3. As per NICE Guidelines 2007, continue Dalteparin, if possible, until day 28.

This should be possible;

1. for all patients who remain in hospital up to day 28
2. for those returning or being discharged to nursing homes
3. for those who can be taught to self administer Heparin or who have a carer who has been taught how to do this

4. If a patient or carer is going to self administer, ensure patient has been taught how to do this and that it is documented in their notes that this instruction has been given.

5. For those who are returning home and cannot self administer, try to clarify whether DISTRICT NURSES can administer Dalteparin or not. For patients on Dalteparin check Potassium on day 7 and Platelet Count on day 6 and 10.

6. Where Dalteparin for 28 days is not feasible, Aspirin can provide some reduction in the risk of PE/DVT, once Dalteparin has been stopped on discharge. Dosage required = 150 mgs to be stopped on day 35 post op.

7. If patient is already on Aspirin 75 mgs increase dose to 150 mgs up to day 35 and then reduce to 75 mgs on day 35.

GP and patient to be notified regarding this temporary dosage change on discharge summary.

ASPIRIN THERAPY

CONTRAINDICATIONS	CAUTIONS
• Uncorrected bleeding disorders - haemophilias - oral anticoagulants - platelet count <70x10^{o}/L • Bleeding or potentially bleeding lesions - oesophageal varices - active peptic ulcer - recent (3 months) GI or intracranial bleed - intracranial aneurysm or angioma • Allergy • Heparin-associated thrombocytopenia or Thrombosis (LMW heparin)	• Aspirin-induced asthma • Severe liver impairment, alcoholism • Severe kidney impairment • Major trauma or surgery to brain, eye or spinal cord (within three months) • Spinal or epidural block • Anaemia (Hb <10 g/dL)

8. Ensure that the patient is given the patient information leaflet titled 'Reducing the risk of a blood clot from surgery' (NICE Guidelines) and document that this has been given.

#NOF PATIENTS TAKING WARFARIN FOR ATRIAL FIBRILLATION, WHO REQUIRE SURGERY

It is vital that these patients have their operation as soon as possible. Surgery can proceed with an INR of 1.7, but preferably the INR should be down to 1.5 or less.

PRE OP

1. Check INR.
2. Stop Warfarin, DO NOT give therapeutic Dalteparin as it is not indicated.
3. If INR >2, give Vitamin K 1 mg IV – recheck INR 6 hours later.
4. If INR still >2 and surgery can be done within next 24 hours given a further 1 mg Vitamin K IV and then repeat INR, six hours later.

POST OP

1. Rx Dalteparin 5000 s/c
2. Repeat INR
3. Restart Warfarin, unless wound has oozed significantly. Do not start with a loading dose, but restart Warfarin according to patient's usual dose regime.
   Please remember that INR may be slow to reach the therapeutic range, as the effect of Vitamin K can take several days to wear off.
4. Ensure arrangements are made for INR checks to be done 3-4 days after discharge.
5. If patient is still in hospital, stop Dalteparin once INR is in the therapeutic range.

OTHER POINTS TO NOTE RE WARFARIN, ASPIRIN AND CLOPIDOGREL IN PATIENTS WITH FRACTURED NECK OF FEMUR

1. If patients are admitted taking ASPIRIN or CLOPIDOGREL, DO NOT stop these drugs (they may have been prescribed for angina, PH MI, CVA, TIA)

2. If patients are admitted taking WARFARIN, please refer to SURGICAL GUIDELINES 2004 Page 55-57 for clear guidelines as to what to do.

For patients with prosthetic heart valves discussion with Anaesthetist re timing of surgery is crucial, as these patients require anticoagulation to be continued for up to 6 hours pre op.

3. For patients who require resumption of Warfarin therapy follow the advice re time to restart contained in the Surgical Guidelines. Refer to section titled – Patients Taking Warfarin.

For patients in atrial fibrillation it is safer to restart them on their usual maintenance dose; daily INR checks will be required.

4. For patients starting Warfarin de novo for PE/DVT please note that in frailer older patients who may have underlying sepsis or are on antibiotics a starting dose of 5 mgs on day 1 is recommended.

Please note the WARFARIN NOMOGRAM is not to be used if starting dose = 5 mgs.

5. For all patients being discharged on Warfarin please ensure that arrangements have been made to monitor INR on discharge. All patients MUST be given a yellow Warfarin book. Patients who have been on Warfarin prior to admission must be asked to return to the clinic/GP surgery etc where INR was previously monitored.

REFERENCES

1. Scottish Intercollegiate Guidelines 62 – Prophylaxis of venous thrombo-embolism (www.sign.ac.uk/guidelines/fulltext/62/index.html).

2. Prevention of pulmonary embolism and deep vein thrombosis with low dose aspirin (PEP) trial. Lancet 2000; 355: 1295-1302.

3. Surgical Guidelines. West Mercia 2004.

4. NICE Guidelines. 46 Venous Thrombo-embolism April 2007.

University Hospital of North Staffordshire NHS

NHS Trust

This care pathway document was designed in collaboration with all members of the multidisciplinary team and patient involvement, and is the property of the Locomotor Division, North Staffordshire Hospital NHS Trust.

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