FRACTURED FEMUR CLINICAL PATHWAY

TYPE: ☐ **FRACTURED NECK OF FEMUR**
☐ **SHAFT OF FEMUR**

PHF560350S

Version 10 - Review and Approval 12/06/2014 - National Standards 1.7 & EQuIP National 12.3.1

EXCLUSION CRITERIA: Where Senior Medical or Nursing staff deem guideline inappropriate for a particular patient's care.

PLEASE NOTE: *(last Page For Algorithm)*

- **ALL PREOPERATIVE medical assessments on acutely admitted patients for fractured neck of femur are done by the Pre-operative (Medical) Registrar in hours, and the General Medical Registrar out of hours.**
- **The Ortho-geriatric Service and ACE/Ortho-geriatric Registrar to be involved in assisting the ongoing clinical management of the postoperative patients and support the junior Orthopaedic medical staff with medical management of the patients on a Monday-Friday routine working hour's basis.**

Estimated Length of Stay: (Source - Peninsula Health ONLINE DATA Jan - June 2013)

- (DRG 108A Hip and femur procedures (severe) - Hospital LOS: 10.50 days State Ave LOS: 12.35 days)
- (DRG 108B Hip and femur procedures (non-severe) - Hospital LOS: 8.10 days State Ave LOS: 5.82 days)
- (DRG 178B # Neck of Femur (non-severe) - Hospital LOS: 2 days State Average LOS: 7.68 days)
- (DRG 160Z Femoral Shaft - Hospital LOS: 2.50 days State Average LOS: 7.30 days

Please Note:
- Pre-operative Extended page 13935
- Extension Page Print number 13936 if patient LOS over 7 days
- IV site assessment to be documented on IV Site Assessment Tool - MR 571760

Documentation:

All care outlined within this pathway is a guide only it does not replace your clinical judgement:

- Initial care when attended - this indicates action or care has be given / outcome achieved
- Mark with **X** if not attended or with N/A if not applicable.
- You must record your full name, signature and designation each shift.
- V indicates a variance - **All variances (Change in patient condition or change to the preferred pathway) are to be documented in the Progress Notes at time of occurrence. A Variance is a deviation or change in the clinical path which may alter the patient's anticipated outcome.**
- When documenting a Variance (V) record what the change or issue is, what time it occurred, action taken & the outcome to the intervention.

Adverse Outcomes

1. Transfer to 5GN 8 hours of presentation to ED
2. Medical review greater than 12 hours post presentation to ED
3. Delirium
4. Hospital acquired infection
5. Wound Infection
6. Pressure ulcer
7. Fall

PENINSULA HEALTH

FRACTURED FEMUR CLINICAL PATHWAY

Neck of Femur ☐ Shaft of Femur ☐

UR NUMBER.....

SURNAME.....

GIVEN NAMES.....

DATE OF BIRTH .....
Please fill in if no Patient Label available

 Date: ____/____/____

Time of Presentation to ED: ___:____hrs	Time of Admission to Ward: ____:____hrs	Time of Surgery: Not known ☐ Expected date: ___/___/___ Time: ____:____ hrs.

Pre Operative Assessment — All variances to be written in Progress notes — ND AM PM ND

Please Note: *it is not appropriate to leave a message of notification – the Ward staff must receive verbal confirmation that Orthopaedic HMO & Medical Registrar have received the notification of patient arrival.*

ON ADMISSION **Notification of Admission** **Referrals / Consults**	• **Orthopaedic HMO or Covering HMO** notified of arrival to ward by Nursing staff • **Perioperative (Medical) Registrar** notified on admission **Medical review: Pts. over 60 years (and/or significant co-morbidities)** *see pg. 4 algorithm* ➢ Peri-operative (Medical) Reg (0800 – 1700 hrs Mon- Fri) ☐ ➢ General Medical Reg (after hours) ☐ **Orthopaedic review:** Time: ___: ___hrs - Orthopaedic Registrar Assessment Complete ☐ Consent to Operation complete & signed ☐ Affected Limb marked for surgery ☐ Not yet for Surgery ☐ **Patient scheduled for surgery within 24 hrs of Admission:** ☐ If NOT specify reason for delay: Patient medically unstable ☐ Warfarin related ☐ Clopidogrel ☐ Low Hb ☐ OT Time ☐ Other • **Anaesthetist** has reviewed patient				
Investigations	• **Pathology checked and within normal limits**				
Cognition	**CAM completed in Patient Admission Assessment and Risk screen** - if patient is agitated/ restless - please review analgesia, check bowel and bladder comfort, check temperature. If no improvement from nursing interventions refer / discuss with NUM ☐ / ANUM ☐- Medical review required ☐ Refer Cognition Team☐				
Assessment	Patient Admission Assessment and Risk screen complete • **Observations within normal limits for patient and documented on AOC** ☐ • **Peripheral vascular observations continued** ☐ • BGL (If patient diabetic - as per protocol according to assessment) ☐ IV site observed each shift with no sign of Inflammation and documented on IV cannula assessment Tool				
Medication	**Medications as per Clover** • **Patient has received DVT prophylacti within 12 hours of presentation** - If Not ordered state reason: Warfarin related ☐ Clopidogrel ☐ Other: _____ If delay for surgery greater than 48 hours consider mechanical foot devices and discuss with HMO / ANUM				
Pain Management	**Patient appears comfortable & rates pain < 3 / 10** • **Panadol - oral** ☐ **IV** ☐ **commenced as ordered** ☐ • Other Pain relief administered as ordered on Clover				
RISK	**Risk assessment as per Patient Admission Assessment and Risk Screen** • **strategies implemented as required** - **Falls Risk status is <u>High</u>** • Bed sensor required ☐ Not required ☐ OR Bed sensor in place and switched on ☐				
Hydration & Nutrition	**Time of Theatre Checked with Ortho Reg. prior to giving any food / fluids Yes** ☐ **N/A** ☐ • **If Patient FASTING - IV Therapy commenced as ordered** ☐ Patient last had food at ____:____hrs / fluid at: ____:____hrs • **Fluid Balance chart** maintained on Clover ☐ • **If cancellation of OT and patient to fast longer - referral to Dietitian Ext 7075** • **Fractured Neck of Femur Diet ordered** if required pre operative - Yes ☐ N/A ☐				
Support & Education	**Patient Information Pathway** (13937 # Femur) discussed with and given to Patient/ Carer/Family ☐ **Treatment plan discussed** with patient / family and opportunity offered to ask questions				
Mobility / Self Care	• **Anti embolic stockings fitted and insitu: Yes** ☐ **No** ☐ - if NO consider mechanical foot devices - Pumps insitu Yes ☐ N/A ☐ - Notify NUM or ANUM ☐ • Deep Breathing, Coughing & Foot and Ankle pumps encouraged				
Continence	**Patient Continent** ☐ Incontinent ☐ IDC in-situ ☐ • Reason for IDC insertion -pre morbid ☐ pain ☐ other: _____ Date IDC inserted :_____				
Hygiene & Skin integrity	**Skin integrity intact** - Sacrum and Heels inspected with Interventions implemented • **Traction - skin checked each shift - Weight in bag:** _____ • **Air mattress insitu** ☐ • **Hygiene** attended ☐ **Mouth Care** attended ☐ Independent ☐				

RN : AM	
RN : PM	
RN : ND	

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PENINSULA HEALTH

FRACTURED FEMUR CLINICAL PATHWAY

Neck of Femur ☐ Shaft of Femur ☐

Date: _____/_____/_____

UR NUMBER.....

SURNAME.....

GIVEN NAMES.....

DATE OF BIRTH .....

Please fill in if no Patient Label available

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Time of Admission to 5GN Ward: _____:_____hrs

Time of Surgery: Not known ☐
Expected date: ____/____/____ Time: ____:_____ hrs.

Day 2 Pre Operative

All variances to be written in Progress notes

		AM	PM	ND
C/Handover	ISBAR guided Bedside Clinical Handover received as per policy (patient included) as required			
Referral/ Consults	• Orthogeriatric Service review ☐ Orthopaedic Unit review ☐ Anaesthetist review ☐ • Orthopaedic Registrar Assessment Completed ☐ • **Consent to Operation complete & signed** ☐ OR To be completed in OR ☐ • Affected Limb marked for surgery (if assessed for surgery) Yes ☐ Not for surgery today ☐			
Investigations	• **Pathology reviewed and HMO aware of any abnormalities**			
Assessment	**Observations within normal limits** - monitored according to the patient's individulal monitoring plan on the Adult Observation Chart. • **Periheral neurovascular observations continued** ☐ • BGL within normal limits if patient has diabetes ☐ IV site observed each shift with no sign of Inflammation and documented on IV cannula assessment Tool -(MR 571760)			
Medication	• **Usual medication given as per Clover** • **Prophylactic IV antibiotics if ordered (i.e. Vancomycin if MRSA positive)** • **DVT prophylactixis commenced** Yes ☐ NO ☐ - If Not ordered state reason: Warfarin related ☐ Clopidogrel ☐ Other: _____ **If delay for surgery greater than 48 hours consider mechanical foot devices & discuss with HMO / ANUM**			
Pain Management	• **Panadol Oral ☐ IV ☐ given as per Clover** • **Other Pain relief administered as required** **Pain management assessed & effective as Patient appears comfortable & rates pain< 3 / 10**			
Cognition	**If patient is agitated/restless**- please review analgesia, check bowel and bladder comfort, check temperature. If no improvement from nursing interventions refer / discuss with NUM ☐ / ANUM ☐ - Medical review required ☐ Cognition Team referral ☐			
FALLS RISK	• **FRAT maintained with required Risk Strategies and interventions implemented** • **If Patient impulsive - Bed sensor checked each shift - switched ON and active**			
Support & Education	• **Patient/family have discussed Patient Information Pathway** • **Patient and family are involved in preliminary discharge plan- anticipated discharge destination known . Opportunity offered to patient and family to ask questions**			
Mobility, Self Care,& Vigour	• **Deep Breathing, Coughing & Foot & Ankle pumps encouraged** • **Anti embolic stockings insitu on both legs: Yes ☐ No ☐** - if Not NUM or ANUM are aware ☐ - if NO consider mechanical foot pumps - Pumps insitu Yes ☐ N/A ☐			
Hydration & Nutrition	• **Fractured Neck of Femur Diet ordered if required pre operative** • **If patient fasting IV Therapy maintained as ordered** • Patient last had food and fluid at: ____:____hours - Fluid Balance chart maintained • **Discussion held with Ortho Registrar re Theatre time prior to giving any food / fluids** • **If patient fasted for 2nd time due to cancellation of OT Alert sent to Ext 7075 (dietitian)**			
Continence	• **Adequate urinary output for patient (> 30 mls hourly, urine not concentrated)** **Patient Continent** ☐ Incontinent ☐ IDC in-situ ☐ Reason for IDC insertion -pre morbid ☐ pain ☐ other: _____ Date IDC inserted :_____ • Voided prior to theatre if no IDC insitu (recorded on Theatre Checklist) ☐ **Bowels open within last 48 hours and recorded on Clover:** Yes ☐ No ☐			
Hygiene & Skin integrity	**Skin integrity intact** - Sacrum and Heels inspected with Interventions implemented /PRAT maintained • **Traction - skin checked each shift - Weight in bag:** _____ • **Patient nursed on Air mattress** **Hygiene maintained:** Sponge in bed ☐ **Mouth Care** attended (with assistance)			
Support	**Patient/family offered opportunity to ask questions & discuss plan of care** ☐			

RN : AM	
RN : PM	
RN : ND	

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Date: ____/____/____ All variances to be written in Progress notes Initial / V

Post Operative **Time patient returned to 5GN** : __:__hrs AM PM ND

C/Handover	• **ISBAR guided Bedside Clinical Handover received as per policy (patient included)** • **Oxygen and Suction Checked**			
Referrals	Seen by: Physio ☐ Speech ☐ OT ☐ SW ☐ DT ☐ Diabetic ☐ PENDAP ☐ Pharmacist ☐ Other: _____ • Emotional/Spiritual referral: Pastoral Carer ☐ Family Support ☐			
Cognition	**If** patient is agitated/restless - please review analgesia, check bowel and bladder comfort, check temperature. If no improvement from nursing interventions refer / discuss with NUM ☐ / ANUM ☐ - Medical review required ☐ Cognition Team ☐			
Investigations	P**ost op x-ray (as per Drs orders)** ☐ Not required ☐			
Assessment	**Observations within normal limits** - and monitored according to the patient's individulal monitoring plan on the Adult Observation Chart. • **Peripheral neurovascular observations of affected leg attended each shift** • BGL attended and stable (if indicated/diabetes) Note frequency_____ **IV site observed each shift with no sign of Inflammation and documented on IV cannula assessment Tool -(MR 571760)**			
Medication & Pain Management	• **Panadol Oral ☐ IV ☐ given as ordered on Clover** • Other Pain relief administered as required ☐ Specify_____ **Pain management assessed & effective. Patient appears comfortable & rates pain < 3 / 10** • Medications given as per MR /13 ☐ IV Antibiotics as ordered ☐ • DVT phrophlaxis givwen as ordered: ☐ HMO does not require ans NUM aware ☐			
Wound, DT/ Procedures	• **Dressing dry & intact** **On Return to ward** - No Unexpected ooze ☐ OR Dressing required reinforcement ☐ • Dressing reinforced if necessary as per Drs preference (note as variance)			
Hydration & Nutrition	• **Fluids tolerated with FBC maintained on Clover** • **IV therapy in situ & maintained as ordered** • Food tolerated - Food chart maintained (if required) ☐ N/A ☐ • Fractured Neck of Femur Diet ordered: Yes ☐ If no, state reason:_____ Mealtime requirements attended Independent ☐ Set Up ☐ Assist ☐ Aids ☐ Supervision ☐			
Continence	• **Adequate urinary output for patient (> 30 mls hourly, urine not concentrated)** • Patient continent ☐ Incontinent ☐ IDC in-situ: Yes ☐ No ☐ Note datye of insertion *Reason for use in P/notes* • Bowel sounds present: Yes ☐ No ☐ Bowels open Yes ☐ No ☐ If no to either note as variance with outcome			
Hygiene & Skin integrity	**Skin integrity intact** - Sacrum and Heels inspected with PRAT maintained & strategies implemented • **Patient nursed on Air mattress** **Hygiene maintained:** Sponge in bed ☐ Shower ☐ **Mouth Care** attended (with assistance)			
FALLS RISK	**Falls Risk status is HIGH - FRAT maintained and Strategies/ interventions implemented** • **If Patient impulsive - Bed sensor checked each shift - switched ON and active**			
Mobility, Vigour & Self Care	• Deep Breathing/ Coughing/Foot & Ankle pumps encouraged • Anti embolic stockings in-situ (if required) - Yes ☐ No ☐ - Calf Pumps ☐ Yes - if NO NUM or ANUM aware ☐ • Charnley insitu (if required): Yes ☐ Not required ☐			
Psycho/social Support & Education	• **Education reinforced with patient:** Information re procedure / analgesia ☐ Hip precautions education ☐ • **Patient / carer offered opportunity to ask questions** ☐			
Discharge Requirements	• Allied Health Referrals considered			

RN : AM	
RN :PM	
RN :ND	

PENINSULA HEALTH

FRACTURED FEMUR CLINICAL PATHWAY

UR NUMBER.....

SURNAME.....

GIVEN NAMES.....

DATE OF BIRTH .....

Please fill in if no Patient Label available

Day 1 **Date:** _____/_____/_____ All variances to be written in Progress notes		Initial / V		
		AM	PM	ND
C/Handover	• **ISBAR guided Bedside Clinical Handover received as per policy (patient included)** • **Oxygen and Suction Checked**			
Referrals	**Review by:** Orthopaedic team ☐ **Ortho**geriatric Service ☐ **Seen by:** Physio ☐ Sp ☐ OT ☐ SW ☐ DT ☐ Diabetic ☐ PENDAP ☐ Pharmacist ☐ Other: _____ • EmotionalWellbeing referral: Pastoral Carer ☐ Family Support ☐			
Communication Dementia, Delirium	**If** patient is agitated/restless - please review analgesia, check bowel and bladder comfort, check temperature. If no improvement from nursing interventions refer / discuss with NUM ☐ / ANUM ☐ - Medical review required ☐ Cognition Team ☐			
Investigations	Hb taken: Yes ☐ Below 7mmol ☐ < 8mmol (with patient symptomatic or with ongoing bleeding) • Transfusion required Yes ☐ No ☐ If NO & HB <9 Medical management ordered Yes ☐ N/Req • Hip X-Ray as per Drs preference ☐			
Assessment	**Observations within normal limits** - monitored according to the patient's individulal monitoring plan on the Adult Observation Chart. • **Peripheral neurovascular observations of effected leg attended each shift** • BGL attended and stable (if indicated/diabetes) - Note frequency_____ **IV site observed each shift with no sign of Inflammation and documented on IV cannula assessment Tool -(MR 571760)**			
Medication & Pain Management	• **Panadol Oral ☐ IV ☐ given as ordered on Clover** • Specify other analgesia given _____ **Pain management assessed & effective. Patient appears comfortable & rates pain < 3 / 10** • Medications given as per MR /13 ☐ IV Antibiotics as ordered ☐ • DVT phrophlaxis given as ordered: ☐ HMO does not require ans NUM aware ☐			
Wound, Procedures	• Dressing dry and intact - *Changed as per Doctors preferences* _____ Dressing removed No Unexpected ooze			
Hydration & Nutrition	• **Fluids tolerated with FBC maintained on Clover** • **IV therapy in situ & maintained as ordered** • Food tolerated - if decreased nutritional intake Dietitian referral initiated: Yes☐ N/A☐ Food chart maintained i(f required) - ☐ N/A☐ • Fractured Neck of Femur Diet ordered - Yes ☐ If no, state reason:_____ Mealtime requirements attended Independent ☐ Set Up ☐ Assist ☐ Aids ☐ Supervision ☐			
Continence	**Adequate urinary output for patient (> 30 mls hourly, urine not concentrated)** Patient continent ☐ Incontinent ☐ **Elevated toilet seat available** ☐ IDC in-situ: Yes ☐ No ☐ Reason for use: _____ Date inserted :_____Review date: _____ • Bowels open within last 48 hours and recorded on Clover - consider Aperiant as ordered			
Hygiene & Skin integrity	**Skin integrity intact** - Sacrum and Heels inspected with PRAT maintained & strategies implemented • **Patient nursed on Air mattress** • If Pre existing break in skin integrity - Wound chart maintained **Hygiene maintained:** Sponge in bed ☐ Shower ☐ **Mouth Care** attended (with assistance) **PADL's:** Independent ☐ Assisted ☐ Full dependency ☐ Aid _____			
FALLS RISK	**Falls Risk status is _____ - FRAT maintained and required interventions implemented** • **If Patient impulsive - Bed sensor checked each shift - switched ON**			
Mobility, Vigour & Self Care	**WB status:** WBAT ☐ PWB ☐ TWB ☐ NWB ☐ Delay in mobilisation: No ☐ if yes due to: Pain ☐ Low Hb ☐ Sedation ☐ Other: _____ • **Initial physiotherapy assessment with 24 hours: Yes ☐ No ☐** Ambulant with Physio only ☐ **Transfers:** Independent ☐ Supervision ☐ Assist X 1 ☐ Assist X 2 ☐ Aid _____ **Mobility:** Independent ☐ Supervision ☐ Assist X 1 ☐ Assist X 2 ☐ Aid _____ **Sit Out of Bed:** Independent ☐ Supervision ☐ Assist X 1 ☐ Assist X 2 ☐ Aid _____ • Deep Breathing/ Coughing/Foot & Ankle pumps encouraged • Anti embolic stockings in-situ (if required) - Yes ☐ No ☐ - Calf Pumps ☐ Yes - if NO NUM or ANUM aware ☐			
Support & Education	**Patient / carer offered opportunity to ask questions & Education reinforced re:** **Surgical procedure ☐ Analgesia ☐ Hip precautions if applicable ☐ Cough & limb exercises ☐**			
Discharge	**Discharge destination prediction: Return Home ☐ Sub Acute ☐ Residential ☐** • **Allied Health referrals considered**			
RN : AM				
RN : PM				
RN : ND				

PENINSULA HEALTH

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CLINICAL PATHWAY

UR NUMBER.....

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Day 2 **Date:** _____/_____/_____ All variances to be written in Progress notes Initial / V

		AM	PM	ND
Clinical Handover	• **ISBAR guided Bedside Clinical Handover received as per policy (patient included)** • **Oxygen and Suction Checked**			
Referrals	**Review by:** Orthopaedic team ☐ Orthogeriatric Service ☐ **Seen by:** Physio ☐ Sp ☐ OT ☐ SW ☐ DT ☐ Diabetic ☐ PENDAP ☐ Pharmacist ☐ Other: _____ • EmotionalWellbeing referral: Pastoral Carer ☐ Family Support ☐			
Cognition	**If** patient is agitated/restless - please review analgesia, check bowel and bladder comfort, check temperature. If no improvement from nursing interventions refer / discuss with NUM ☐ / ANUM ☐ - Medical review required ☐ Cognition Team ☐			
Investigations				
Assessment	**Observations within normal limits** - monitored according to the patient's individulal monitoring plan on the Adult Observation Chart. • Peripheral neurovascular observations of affected leg attended each shif • BGL attended and stable (if indicated) - Note frequency_____ **IV site observed each shift with no sign of Inflammation and documented on IV cannula assessment Tool -(MR 571760)**			
Medication & Pain Management	• **Panadol Oral ☐ IV ☐ given as ordered** • Other Pain relief administered as required ☐ (Specify effectiveness & frequency) **Pain management assessed & effective. Patient appears comfortable & rates pain < 3 / 10** • Medications given as per Clover ☐ • IV Antibiotics as ordered on Clover ☐ • DVT phrophlaxis givwen as ordered: ☐ HMO does not require ans NUM aware ☐			
Procedure	**Wound clean and dry with no redness or inflammation** • Dressing dry and intact as per Drs prefences with no unexpected ooze			
Hydration & Nutrition	• **Fluids tolerated with FBC maintained on Clover** • **IV therapy in situ & maintained as ordered** • Food tolerated - if decreased nutritional intake Dietitian referral initiated: Yes☐ N/A☐ Food chart maintained i(f required) - ☐ N/A ☐ • Fractured Neck of Femur Diet ordered ☐ If no, state reason:_____ Mealtime requirements attended Independent ☐ Set Up ☐ Assist ☐ Aids ☐ Supervision ☐			
Continence	**Adequate urinary output for patient (> 30 mls hourly, urine not concentrated)** Patient continent ☐ Incontinent ☐ • **Elevated toilet seat available** ☐ IDC in-situ: Yes ☐ No ☐ Reason for use: _____ Date inserted :_____Review date: _____ • Bowels open within last 48 hours and recorded on Clover			
Hygiene & Skin integrity	**Skin integrity intact** - Sacrum & Heels inspected with PRAT maintained & strategies implemented • **Patient nursed on Air mattress** **Hygiene maintained:** Sponge in bed ☐ Shower ☐ **Mouth Care** attended (with assistance if required) **PADL's:** Independent ☐ Assisted ☐ Full dependency ☐ Aid _____			
FALLS RISK	**Falls Risk status is _____ - FRAT maintained and required interventions implemented** • **Bed sensor checked each shift - switched ON and active**			
Mobility, Vigour & Self Care	**WB status:** WBAT ☐ PWB ☐ TWB ☐ NWB ☐ Delay in mobilisation: No ☐ if yes due to: Pain ☐ Low Hb ☐ Sedation ☐ Other: _____ **Transfers:** Independent ☐ Supervision ☐ Assist X 1 ☐ Assist X 2 ☐ Aid_____ **Mobility:** Independent ☐ Supervision ☐ Assist X 1 ☐ Assist X 2 ☐ Aid _____ **Sit Out of Bed:** Independent ☐ Supervision ☐ Assist X 1 ☐ Assist X 2 ☐ Aid _____ • Deep Breathing/ Coughing/Foot & Ankle pumps encouraged • Anti embolic stockings in-situ (if required) - Yes ☐ No ☐ - Calf Pumps ☐ Yes - if NO NUM or ANUM aware ☐			
Support & Education	**Patient /carer offered opportunity to ask questions with Education reinforced re:** **Surgical procedure ☐ Analgesia ☐ Hip precautions if applicable ☐ Discharge Planning ☐**			
Discharge Requirements	**Discharge destination prediction:** Return Home ☐ Sub Acute ☐ Residential ☐ • Allied Health referral considered			

RN : AM	
RN : PM	
RN : ND	

PENINSULA HEALTH

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Please fill in if no Patient Label available

Day 3 Date: ____/____/____ All variances to be written in Progress notes Initial / V

		AM	PM	ND
C/Handover	• **ISBAR guided Bedside Clinical Handover received as per policy (patient included)** • **Oxygen and Suction Checked**			
Referrals	**Review by:** Orthopaedic team ☐ Orthogeriatric Service ☐ **Seen by:** Physio ☐ Sp ☐ OT ☐ SW ☐ DT ☐ Diabetic ☐ PENDAP ☐ Pharmacist ☐ Other: _____ • EmotionalWellbeing referral: Pastoral Carer ☐ Family Support ☐			
Cognition	**If** patient is agitated/restless - please review analgesia, check bowel and bladder comfort, check temperature. If no improvement from nursing interventions refer / discuss with NUM ☐ / ANUM ☐ - Medical review required ☐ Cognition Team ☐			
Investigations	**Hb checked post transfusion in applicable** Yes ☐ No ☐ N/A ☐			
Assessment	**Observations within normal limits** -and monitored according to the patient's individulal monitoring plan on the Adult Observation Chart. • Peripheral neurovascular observations of affected leg attended each shif • BGL attended and stable (if indicated) - Note frequency_____ **IV site observed each shift with no sign of Inflammation and documented on IV cannula assessment Tool -(MR 571760)**			
Medication & Pain Management	**Pain level assessed (verbal scale 0-10)** & Patient appears comfortable & rates pain <3/10 • Regular oral analgesia administered as per Clover • Anticoagulant Therapy given as per Clover ☐ HMO does not require ☐ • Medications given as per Clover ☐ including Antibiotics ☐ Antiemetics ☐			
Procedure	**Wound clean and dry with no redness or inflammation** • Dressing dry and intact as per Drs prefences with no unexpected ooze			
Hydration & Nutrition	**Fluids tolerated with FBC maintained on Clover** • IV therapy in situ Yes ☐ No ☐ Maintained per orders ☐ Bunged ☐ Ceased ☐ • Food tolerated - if decreased nutritional intake Dietitian referral initiated: Yes☐ N/A☐ • Food chart maintained i(f required) - ☐ N/A ☐ • Patient receiving Fractured Neck of Femur Diet ☐ • Mealtime requirements attended Independent ☐ Set Up ☐ Assist ☐ Aids ☐ Supervision ☐			
Continence	**Adequate urinary output for patien**t (> 30 mls hourly, urine not concentrated) Yes ☐ No ☐ • Continent ☐ Incontinence ☐ Elevated toilet seat insitu ☐ • IDC in-situ: Yes ☐ No ☐ Does IDC need review? **BOWELS:** Normal function ☐ Constipation ☐ other: _____ • Bowels open within last 48 hrs and recorded on Clover ☐ No ☐ If no, Aperient given ☐			
Hygiene & Skin integrity	**Skin integrity intact** - Sacrum & Heels inspected with PRAT maintained & strategies implemented • **Hygiene maintained:** Sponge in bed ☐ Shower ☐ **Mouth Care** attended (with assistance if required) **PADL's:** Independent ☐ Assisted ☐ Full dependency ☐ Aid _____			
FALLS RISK	**Falls Risk status is _____ - FRAT maintained and required interventions implemented** • **Bed sensor checked each shift - switched ON and active**			
Mobility, Vigour & Self Care	**WB status:** WBAT ☐ PWB ☐ TWB ☐ NWB ☐ Delay in mobilisation: No ☐ if yes due to: Pain ☐ Low Hb ☐ Sedation ☐ Other: _____ **Transfers:** Independent ☐ Supervision ☐ Assist X 1 ☐ Assist X 2 ☐ Aid _____ **Mobility:** Independent ☐ Supervision ☐ Assist X 1 ☐ Assist X 2 ☐ Aid _____ **Sit Out of Bed:** Independent ☐ Supervision ☐ Assist X 1 ☐ Assist X 2 ☐ Aid _____ • Deep Breathing/ Coughing/Foot & Ankle pumps encouraged • Anti embolic stockings in-situ (if required) - Yes ☐ No ☐ - Calf Pumps ☐ Yes - if NO NUM or ANUM aware ☐			
Psychosocial & Education	**Patient / carer offered opportunity to ask questions** with Education reinforced re: Surgical procedure ☐ Analgesia ☐ Hip precautions if applicable ☐ Coughing and limb exercises ☐			
Discharge Requirements	**Discharge destination prediction:** Return Home ☐ Sub Acute ☐ Residential ☐ AH referral considered **If Nursing Home Patient:** Physio has prepared letter for discharge Yes ☐ No ☐ N/A ☐			

RN : AM	
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Day 4 **Date:** _____/_____/_____

		Initial / V		
		AM	PM	ND
C/Handover	• **ISBAR guided Bedside Clinical Handover received as per policy (patient included)** • **Oxygen and Suction Checked**			
Referrals	**Review by:** Orthopaedic team ☐ Orthogeriatric Service ☐ **Seen by:** Physio ☐ Sp ☐ OT ☐ SW ☐ DT ☐ Diabetic ☐ PENDAP ☐ Pharmacist ☐ Other: _____			
Cognition	**If** patient is agitated/restless - please review analgesia, check bowel and bladder comfort, check temperature. If no improvement from nursing interventions refer / discuss with NUM ☐ / ANUM ☐ - Medical review required ☐ Cognition Team ☐			
Investigations	**Hb checked post transfusion in applicable** Yes ☐ No ☐ N/A ☐			
Assessment	**Observations within normal limits** -and monitored according to the patient's individulal monitoring plan on the Adult Observation Chart. • Peripheral neurovascular observations of affected leg attended each shif • BGL attended and stable (if indicated) - Note frequency_____ **IV site observed each shift with no sign of Inflammation and documented on IV cannula assessment Tool -(MR 571760)**			
Medication & Pain Management	**Pain level assessed (verbal scale 0-10)** & Patient appears comfortable & rates pain <3/10 • Regular oral analgesia administered as per Clover • Anticoagulant Therapy given as MR/13 as ordered: Yes ☐ HMO does not require ☐ • Medications given as per MR /13 ☐ including Antibiotics ☐ Antiemetics ☐			
Procedure	**Wound clean and dry with no redness or inflammation** • Dressing dry and intact as per Drs prefences with no unexpected ooze			
Hydration & Nutrition	• **Fluids tolerated with FBC maintained** • IV therapy in situ Yes ☐ No ☐ Maintained per orders ☐ Bunged ☐ Ceased ☐ • Food tolerated - if decreased nutritional intake Dietitian referral initiated: Yes☐ N/A☐ • Patient receiving Fractured Neck of Femur Diet ☐ • Mealtime requirements attended Independent ☐ Set Up ☐ Assist ☐ Aids ☐ Supervision ☐			
Continence	**Adequate urinary output for patien**t (> 30 mls hourly, urine not concentrated) Yes ☐ No ☐ • Continent ☐ Incontinence ☐ • Elevated toilet seat insitu ☐ • IDC in-situ: Yes ☐ No ☐ Does IDC need review? **BOWELS:** Normal function ☐ Constipation ☐ Stoma ☐ Incontinent of faeces ☐ Bowel Chart ☐ • Bowels open within last 48 hrs ☐ No ☐ If no, Aperient given ☐			
Hygiene & Skin integrity	**Skin integrity intact** - Sacrum & Heels inspected with PRAT maintained & strategies implemented • **Patient nursed on Air mattress** **Hygiene maintained:** Sponge in bed ☐ Shower ☐ **Mouth Care** attended (with assistance if required) **PADL's:** Independent ☐ Assisted ☐ Full dependency ☐ Aid _____			
FALLS RISK	**Falls Risk status is _____ - FRAT maintained and required interventions implemented** • **Bed sensor checked each shift - switched ON and active**			
Mobility, Vigour & Self Care	**WB status:** WBAT ☐ PWB ☐ TWB ☐ NWB ☐ Delay in mobilisation: No ☐ if yes due to: Pain ☐ Low Hb ☐ Sedation ☐ Other: _____ **Transfers:** Independent ☐ Supervision ☐ Assist X 1 ☐ Assist X 2 ☐ Aid _____ **Mobility:** Independent ☐ Supervision ☐ Assist X 1 ☐ Assist X 2 ☐ Aid _____ **Sit Out of Bed:** Independent ☐ Supervision ☐ Assist X 1 ☐ Assist X 2 ☐ Aid _____ • Deep Breathing/ Coughing/Foot & Ankle pumps encouraged • Anti embolic stockings in-situ (if required) - Yes ☐ No ☐ - Calf Pumps ☐ Yes - if NO NUM or ANUM aware ☐			
Support & Education	**Patient /carer offered opportunity to ask questions** with Education reinforced re: Surgical procedure ☐ Analgesia ☐ Hip precautions if applicable ☐ Discharge Planning ☐			
Discharge Requirements	• Allied Health referrals considered. **Discharge needs:** PenPac ☐ Home Help ☐ Other: _____ **Discussion re Plan of care taken place between Surgeon /Team / patient / Family** • Discharge summary written ☐ 6/52 appointment arranges with Surgeon ☐ 6/52 X-Ray appointment ☐			

RN : AM	
RN : PM	
RN : ND	

PENINSULA HEALTH

FRACTURED FEMUR
CLINICAL PATHWAY

UR NUMBER.....

SURNAME.....

GIVEN NAMES.....

DATE OF BIRTH .....
Please fill in if no Patient Label available

Day 5 **Date:** _____/_____/_____ All variances to be written in Progress notes		Initial/V AM	PM	ND
C/Handover	• **ISBAR guided Bedside Clinical Handover received as per policy (patient included)** • **Oxygen and Suction Checked**			
Referrals	**Review by:** Orthopaedic team ☐ Orthogeriatric Service ☐ **Seen by:** Physio ☐ Sp ☐ OT ☐ SW ☐ DT ☐ Diabetic ☐ PENDAP ☐ Pharmacist ☐ Other: _____ • EmotionalWellbeing referral: Pastoral Carer ☐ Family Support ☐			
Cognition	**If** patient is agitated/restless- please review analgesia, check bowel and bladder comfort, check temperature. If no improvement from nursing interventions refer / discuss with NUM ☐ / ANUM ☐ - Medical review required ☐ Cognition Team ☐			
Investigations				
Assessment	**Observations within normal limits** - the 6 core physiological signs have been monitored according to the patient's individulal monitoring plan on the Adult Observation Chart. • Peripheral neurovascular observations of affected leg attended each shif • BGL attended and stable (if indicated) - Note frequency_____ **IV site observed each shift with no sign of Inflammation and documented on IV cannula assessment Tool -(MR 571760)**			
Medication & Pain Management	**Pain level assessed (verbal scale 0-10)** & Patient appears comfortable & rates pain <3/10 • Regular oral analgesia administered • Anticoagulant Therapy given as per Clove Yes ☐ HMO does not require ☐ • Medications given as perClover ☐ including Antibiotics ☐ Antiemetics ☐			
Procedure	**Wound clean and dry with no redness or inflammation** • Dressing dry and intact as per Drs prefences with no unexpected ooze			
Hydration & Nutrition	• **Fluids tolerated with FBC maintained** • IV therapy in situ Yes ☐ No ☐ Maintained per orders ☐ Bunged ☐ Ceased ☐ • Patient receiving Fractured Neck of Femur Diet ☐ • Mealtime requirements attended Independent ☐ Set Up ☐ Assist ☐ Aids ☐ Supervision ☐			
Continence	**Adequate urinary output for patien**t (> 30 mls hourly, urine not concentrated) Yes ☐ No ☐ • Continent ☐ Incontinence ☐ • Elevated toilet seat insitu ☐ • IDC in-situ: Yes ☐ No ☐ Does IDC need review? **BOWELS:** Normal function ☐ Constipation ☐ Other: _____ • Bowels open within last 48 hrs and recorded on Clover ☐ No ☐ If no, Aperient given ☐			
Hygiene & Skin integrity	**Skin integrity intact** - Sacrum & Heels inspected with PRAT maintained & strategies implemented • **Patient nursed on Air mattress** **Hygiene maintained:** Sponge in bed ☐ Shower ☐ **Mouth Care** attended (with assistance if required) **PADL's:** Independent ☐ Assisted ☐ Full dependency ☐ Aid _____			
FALLS RISK	**Falls Risk status is _____ - FRAT maintained and required interventions implemented** • **Bed sensor checked each shift - switched ON and active**			
Mobility, Vigour & Self Care	**WB status:** WBAT ☐ PWB ☐ TWB ☐ NWB ☐ Delay in mobilisation: No ☐ if yes due to: Pain ☐ Low Hb ☐ Sedation ☐ Other: _____ **Transfers:** Independent ☐ Supervision ☐ Assist X 1 ☐ Assist X 2 ☐ Aid _____ **Mobility:** Independent ☐ Supervision ☐ Assist X 1 ☐ Assist X 2 ☐ Aid _____ **Sit Out of Bed:** Independent ☐ Supervision ☐ Assist X 1 ☐ Assist X 2 ☐ Aid _____ • Deep Breathing/ Coughing/Foot & Ankle pumps encouraged • Anti embolic stockings in-situ (if required) - Yes ☐ No ☐ - Calf Pumps ☐ Yes - if NO NUM or ANUM aware ☐			
Support & Education	**Patient /carer offered opportunity to ask questions** with Education reinforced re: Surgical procedure ☐ Analgesia ☐ Hip precautions if applicable ☐ Discharge Planning ☐			
Discharge Requirements	• Allied Health referrals considered. **Discharge needs:** PenPac ☐ Home Help ☐ Other: _____ **Discussion re Plan of care taken place between Surgeon /Team / patient / Family** • Discharge summary written ☐ 6/52 appointment arranges with Surgeon ☐ 6/52 X-Ray appointment ☐			

RN : AM	
RN : PM	
RN : ND	

PENINSULA HEALTH

FRACTURED FEMUR
CLINICAL PATHWAY

UR NUMBER.....

SURNAME.....

GIVEN NAMES.....

DATE OF BIRTH .....

Please fill in if no Patient Label available

Day 6 **Date:** _____/_____/_____ All variances to be written in Progress notes Initial / V

		AM	PM	ND
C/Handover	• **ISBAR guided Bedside Clinical Handover received as per policy (patient included)** • **Oxygen and Suction Checked**			
Referrals	**Review by:** Orthopaedic team ☐ Orthogeriatric Service ☐ **Seen by:** Physio ☐ Sp ☐ OT ☐ SW ☐ DT ☐ Diabetic ☐ PENDAP ☐ Pharmacist ☐ Other: _____ • EmotionalWellbeing referral: Pastoral Carer ☐ Family Support ☐			
Cognition	**If** patient is agitated/restless- please review analgesia, check bowel and bladder comfort, check temperature. If no improvement from nursing interventions refer / discuss with NUM ☐ / ANUM ☐ - Medical review required ☐ Cognition Team ☐			
Investigations				
Assessment	**Observations within normal limits** - monitored according to the patient's individulal monitoring plan on the Adult Observation Chart. • Peripheral neurovascular observations of affected leg attended each shif • BGL attended and stable (if indicated) - Note frequency_____ **IV site observed each shift with no sign of Inflammation and documented on IV cannula assessment Tool -(MR 571760)**			
Medication & Pain Management	**Pain level assessed (verbal scale 0-10)** & Patient appears comfortable & rates pain <3/10 • Regular oral analgesia administered • Anticoagulant Therapy given as per Clove Yes ☐ HMO does not require ☐ • Medications given as perClover ☐ including Antibiotics ☐ Antiemetics ☐			
Procedure	**Wound clean and dry with no redness or inflammation** • Dressing dry and intact as per Drs prefences with no unexpected ooze			
Hydration & Nutrition	• **Fluids tolerated with FBC maintained** • IV therapy in situ Yes ☐ No ☐ Maintained per orders ☐ Bunged ☐ Ceased ☐ • Patient receiving Fractured Neck of Femur Diet ☐ • Mealtime requirements attended Independent ☐ Set Up ☐ Assist ☐ Aids ☐ Supervision ☐			
Continence	**Adequate urinary output for patien**t (> 30 mls hourly, urine not concentrated) Yes ☐ No ☐ • Continent ☐ Incontinence ☐ Elevated toilet seat insitu ☐ • IDC in-situ: Yes ☐ No ☐ Does IDC need review? **BOWELS:** Normal function ☐ Constipation ☐ Other: _____ • Bowels open within last 48 hrs and recorded on Clover ☐ No ☐ If no, Aperient given ☐			
Hygiene & Skin integrity	**Skin integrity intact** - Sacrum & Heels inspected with PRAT maintained & strategies implemented • **Patient nursed on Air mattress** **Hygiene maintained:** Sponge in bed ☐ Shower ☐ **Mouth Care** attended (with assistance if required) **PADL's:** Independent ☐ Assisted ☐ Full dependency ☐ Aid _____			
FALLS RISK	**Falls Risk status is _____ - FRAT maintained and required interventions implemented** • **Bed sensor checked each shift - switched ON and active**			
Mobility, Vigour & Self Care	**WB status:** WBAT ☐ PWB ☐ TWB ☐ NWB ☐ Delay in mobilisation: No ☐ if yes due to: Pain ☐ Low Hb ☐ Sedation ☐ Other: _____ **Transfers:** Independent ☐ Supervision ☐ Assist X 1 ☐ Assist X 2 ☐ Aid _____ **Mobility:** Independent ☐ Supervision ☐ Assist X 1 ☐ Assist X 2 ☐ Aid _____ **Sit Out of Bed:** Independent ☐ Supervision ☐ Assist X 1 ☐ Assist X 2 ☐ Aid _____ • Deep Breathing/ Coughing/Foot & Ankle pumps encouraged • Anti embolic stockings in-situ (if required) - Yes ☐ No ☐ - Calf Pumps ☐ Yes - if NO NUM or ANUM aware ☐			
Support & Education	**Patient /carer offered opportunity to ask questions** with Education reinforced re: Surgical procedure ☐ Analgesia ☐ Hip precautions if applicable ☐ Discharge Planning ☐			
Discharge Requirements	• Allied Health referrals considered. **Discharge needs:** PenPac ☐ Home Help ☐ Other: _____ **Discussion re Plan of care taken place between Surgeon /Team / patient / Family** • Discharge summary written ☐ 6/52 appointment arranges with Surgeon ☐ 6/52 X-Ray appointment ☐			

RN : AM	
RN : PM	
RN : ND	

Suspected Fractured Neck of Femur

Presentation to ED resulting in confirmed **radiological diagnosis**

Commence Clinical Pathway

Referral to Orthopaedic Registrar who will accept patient directly or review in ED

Does Patient meet these medical criteria?

Criteria for Medical Referral:
- Hb < 70
- Na+ <130 05 >150
- K+ < 3.0 or > 5.5
- Creatinine > 200
- SaO2 < 90%
- Tachycardia HR > 110
- Hypotensive Systolic BP < 100
- Hypertensive Systolic BP > 180
- New confusion or delirium
- Acute Medical problem (e.g. AMI, Stroke, Pneumonia)

No

Yes

Transfer to Orthopaedic Ward

Medical stabilisation

Medical stabilisation:
- Perioperative (Medical) registrar on behalf of the Orthogeriatric Service - for NOFs aged over 60 years (and/or significant co-morbidities) in hours (0800 hr - 1700 hrs Mon – Fri)
- Admitting General Medicine Registrar delegate out of hours

Yes

Is patient over 60 years and/or significant co-morbidities

Yes

Yes

No

Refer to Orthogeriatric Service

Yes

Is patient suitable for surgery

No

Ward staff to inform Orthopaedic HMO or Ward covering HMO and obtain verbal confirmation that notification has been received.

HMO to admit patient within 6 hours of admission to Ward

Outcome for patient admitted requiring Orthopaedic Management:
Stabilisation of fracture with surgical management.

Outcome for patient requiring Medical Management:
Admission to Medical Ward for management

Perioperative (Medical) Registrar review (in hours)
and
General Medicine Registrar (out of hours) for all patients over 60 years (and/or significant co-morbidities) within 6 hours of admission to ward or more urgently for patients as clinically indicated.

Key performance Indicators:

- ☐ Admission to ward accepted by Ortho Reg within 6 hours of notification of confirmed diagnosis.
- ☐ All NOF patients older than 60 years (and/or significant co-morbidities) to be reviewed by the Perioperative (Medical) Registrar (or GMR delegate) within 6 hours of admission to the orthopaedic ward.
- ☐ Transfer to Orthopaedic Ward within 6 hours of presentation.

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PENINSULA HEALTH

MUST BE COMPLETED PRIOR TO DISCHARGE

UR NUMBER.....

SURNAME.....

GIVEN NAMES.....

DATE OF BIRTH ..... Sex: M F
Please fill in if no Patient Label available

DISCHARGE CHECKLIST

DISCHARGE CONFIRMED BY CONSULTANT REGISTRAR ☐ Yes ☐ No
If NO please specify reason: _____

DISCHARGE SUMMARY FOR GP COMPLETE ☐ Yes ☐ No
If NO please specify reason: _____

- Discharge Summary given to and explained to patient ☐ Yes ☐ No
- Medical Certificate written and given to patient ☐ Yes ☐ No
- Documentation complete on discharge including Pathways and progress Notes ☐

CANNULA REMOVED ☐ Yes ☐ No ☐ N/A If no state reason: _____

NOTIFICATION OF DISCHARGE ARRANGEMENTS COMPLETE: ☐ Yes ☐ No ☐ N/A

- Specify who has been notified - ☐ Family ☐ Carer ☐ Nursing Home ☐ Hostel ☐ Sub Acute
  Other: _____
  Date of notification: Date: ____/____/____ Time of notification: _____ : _____ hrs.
- Name of person collecting patient on discharge if for discharge home:
  Other details: _____

MODE OF TRANSPORT CONFIRMED:
☐ Private ☐ Hospital Car ☐ Ambulance(Order no:_____) ☐ Taxi (Order no:_____)

HITH Services required and activated: ☐ Yes ☐ No N/A☐
- Paper Medication Chart generated: ☐ Yes ☐ Not required

CONTINUING CARE SERVICES

- **Home Services have been reactivated:** ☐ Yes ☐ No N/A☐
  Specify services: ☐ Home Help ☐ MOW ☐ PCA ☐ MEPACS ☐ Home Respite ☐ Other _____
- **Community Based Services activated:** ☐ Yes ☐ No ☐ N/A
  Specify services: ☐ PENPAC ☐ RDNS ☐ CRP ☐ EOPP ☐ Other_____

AIDS FOR DISCHARGE

- Progressive Wound Care Chart & Dressing Management faxed to ☐ PENPAC ☐ RDNS ☐ N/A
  Other:_____

1. Aids / Appliances (OT/Physio): ☐ Supplied ☐ Education complete ☐ N/A
2. Dressings supplied (three days dressings to be supplied) ☐ Yes ☐ No ☐ N/A
3. Leg Bag supplies ☐ Yes ☐ No ☐ N/A

RETURNED / GIVEN TO PATIENT

- **Own medications returned** ☐ Yes ☐ No ☐ N/A **X -Rays/Scans** ☐ Yes ☐ No ☐ N/A
- **Valuable** ☐ Yes ☐ No ☐ N/A **Continence aids** ☐ Yes ☐ No ☐ N/A
- **Medications supplied:** ☐ Yes ☐ No ☐ N/A **Script supplied** ☐ Yes ☐ No ☐ N/A
- **Transfer letter supplied:** ☐ Yes ☐ No ☐ N/A
- **Consumer Feedback Survey given to and completed by patient /carer** ☐ Yes ☐ No

FOLLOW-UP APPOINTMENTS CONFIRMED WITH ☐ patient ☐ family ☐ carer

- **Outpatients / Specialist Appointments made:** ☐ Yes ☐ No ☐ Not required
- **GP Appointment made** ☐ Yes ☐ No ☐ Not required
- **Patient to make own GP Appointment post discharge:** ☐ Yes ☐ Not required

PATIENT/FAMILY/CARER

1. HAVE BEEN GIVEN THE DISCHARGE INFORMATION SHEET WITH ALL APPOINTMENTS DOCUMENTED ON IT ☐
2. PATIENT/FAMILY/CARER DEMONSTRATE UNDERSTANDING OF ALL DISCHARGE ARRANGEMENTS AS WELL AS SIGNS AND SYMPTOMS OF DETERIORATION THAT REQUIRE MEDICAL REVIEW ☐

OTHER: _____

SIGNATURE OF RN/S DISCHARGING PATIENT FROM WARD

Signature:_____Print Name_____Designation: **Date**___/___/____ **. Time:**____:____

Signature:_____Print Name_____Designation: **Date**___/___/____ **. Time:**____:____

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