NORTHERN ADELAIDE LOCAL HEALTH NETWORK

MR589.1

Please Circle Relevant Hospital

Lyell McEwin HOSPITAL Modbury HOSPITAL

Government of South Australia
SA Health

Suspected Hip Fracture Medical

Emergency Department Assessment

Do not hand write these details, except when adhesive barcode labels are unavailable

UR No.: _____

Surname: _____

First Name: _____

D.O.B. _____ Sex: _____

HIP FRACTURE: TO BE USED FOR ALL SUSPECTED PROXIMAL FEMORAL FRACTURES

Date & Time	PRESENTATION		
	Completed by Name & Designation:	Date & Time:	
	EMERGENCY SCREENING		
	Does the patient demonstrate any life threatening symptoms that require review and/or treatment before addressing the suspected hip fracture? (Check box)		
	☐ **Yes**, address as per local Emergency practice.	☐ **No**, continue with Suspected Hip Fracture Emergency Assessment	
	Initial Presentation:		
	Treatment to Date:		
	PATIENT IDENTIFICATION		
	Person to Contact:		
	Does the patient require a Substitute Decision Maker?	YES / NO	Substitute Decision Maker Details:
	Advance Care Directives copy in medical record	YES / NO	
	Urgent 7 step pathway resuscitation planning required	YES / NO	
	Urgent 7 step pathway resuscitation planning required	YES / NO	Identified as ATSI: YES / NO
	SITUATIONAL ANALYSIS		
	How did the fall occur?		
	Fasting Since:		
	PRE-FRACTURE INFORMATION		
	Residence: ☐ **Home** ☐ **RACF**	Mobility: ☐ **Independent (No aid)** ☐ **Stick** ☐ **4WW/Frame**	
	Function:	Baseline diet and fluids:	

SUSPECTED HIP FRACTURE

MR589.1

September 2018 NALHN 19041629

NORTHERN ADELAIDE LOCAL HEALTH NETWORK

Please Circle Relevant Hospital

Lyell McEwin HOSPITAL

Modbury HOSPITAL

MR589.1

Government of South Australia

SA Health

Suspected Hip Fracture Medical

Emergency Department Assessment

Do not hand write these details, except when adhesive barcode labels are unavailable

UR No.: ____________________

Surname: ____________________

First Name: ____________________

D.O.B. ____________________ Sex: ____________

Date & Time	PAST MEDICAL HISTORY

September 2018 NALHN 19041629

Please Circle Relevant Hospital

Lyell McEwin HOSPITAL | Modbury HOSPITAL

Government of South Australia
SA Health

Suspected Hip Fracture Medical

Emergency Department Assessment

Do not hand write these details, except when adhesive barcode labels are unavailable

UR No.: _____

Surname: _____

First Name: _____

D.O.B. _____ Sex: _____

Date & Time	Medication	Dose and Frequency	Medication	Dose and Frequency
	Allergies: eg. medication/latex		Details including reaction:	

Date & Time	EMERGENCY ASSESSMENT								
	Temp	HR	RR	BP	SaO_2	$Fi0_2$	BSL	PAIN SCORE	GCS
	Neurovascular Observations:		AREA ASSESSED:				PULSE PRESENT:		
			C:		W:		M:		S:
			CAPILLARY REFILL:						

SUSPECTED HIP FRACTURE

Please Circle Relevant Hospital

Lyell McEwin HOSPITAL | Modbury HOSPITAL

Government of South Australia
SA Health

Suspected Hip Fracture Medical

Emergency Department Assessment

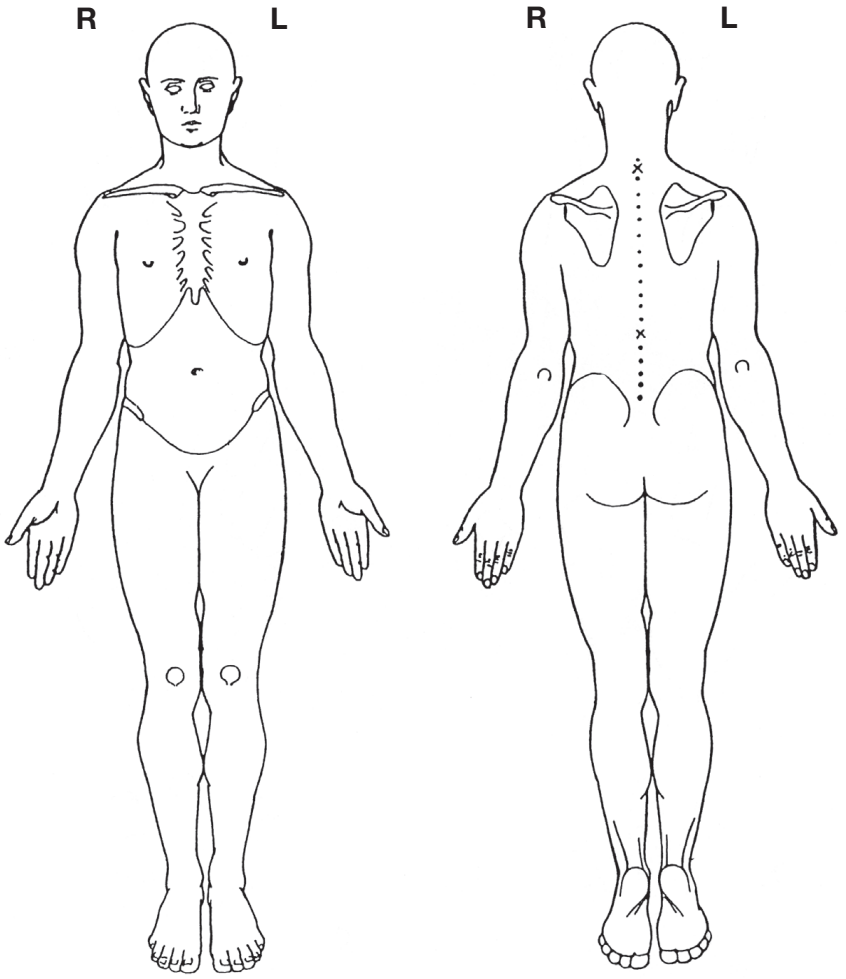
Do not hand write these details, except when adhesive barcode labels are unavailable

UR No.: _____

Surname: _____

First Name: _____

D.O.B. _____ Sex: _____

BRIEF CLINICAL EXAMINATION COMMENTS	
Identify other associated injuries and systems review	

A - Abrasion
B - Burns
C - Contusions
D - Dislocations
F - Fracture
H - Haemorrhage
L - Laceration
N - Numbness
P - Pain
S - Swelling
Pa - Paralysis
U - Ulcer Site
- (stage 1, 2, 3, 4)

Date & Time	BRIEF CLINICAL EXAMINATION COMMENTS
	Working Diagnoses / Problems:
	Patient handed over to: MO Signature:

Please Circle Relevant Hospital

Lyell McEwin HOSPITAL Modbury HOSPITAL

Government of South Australia
SA Health

Suspected Hip Fracture Medical

Emergency Department Assessment

Do not hand write these details, except when adhesive barcode labels are unavailable

UR No.: _____

Surname: _____

First Name: _____

D.O.B. _____ Sex: _____

Date & Time	DIAGNOSTICS (write and sign results)								
	Pathology	FBE		G&H		COAG		MBA20	
	ECG Comment /interpretation								
	Urinalysis / Other								
	Imaging	AP PELVIS		LATERAL OBLIQUE HIP					
	LONG FEMUR VIEWS AP			LONG FEMUR VIEWS LATERAL					
	CHEST			OTHER:					
	MO Signature:		Name (block print):		Time:				
	MANAGEMENT PLAN								
	ANALGESIA								
	Initial Management Plan:								
	Analgesia Review:								
	New Analgesia Administered:								
	Paracetamol	Time:	Comments:						
	Fascia Iliaca Nerve Block	Time:	Comments:						
	Opioids	Time:	Comments:						
	OTHER INJURIES AND TREATMENTS								
	Complete MR720 NALHN Emergency Department Interim Management Plan ☐								
	IDC Insertion YES / NO	Time:	Comment:						
	Other / comment:								

SUSPECTED HIP FRACTURE

Please Circle Relevant Hospital

Lyell McEwin HOSPITAL   Modbury HOSPITAL

Government of South Australia
SA Health

Suspected Hip Fracture Medical

Emergency Department Assessment

Do not hand write these details, except when adhesive barcode labels are unavailable

UR No.: ____________________

Surname: ____________________

First Name: ____________________

D.O.B. ______________ Sex: ______________

	MANAGEMENT PLAN
Date & Time	PROGRESS NOTES (including procedural note). Time and sign each entry please.

September 2018 NALHN 19041629

Please Circle Relevant Hospital

Lyell McEwin HOSPITAL Modbury HOSPITAL

Government of South Australia
SA Health

Suspected Hip Fracture Medical

Emergency Department Assessment

Do not hand write these details, except when adhesive barcode labels are unavailable

UR No.: _____

Surname: _____

First Name: _____

D.O.B. _____ Sex: _____

Date & Time	CONFIRMED HIP FRACTURE DIAGNOSIS		
	Diagnosis including imaging result:		
	Diagnosing Doctor:	Time:	
	Contacted: Orthopaedic ☐ Orthogeriatrics ☐ Other / Comment:		
Date & Time	**UP-TRANSFER – Complete ☐ MR012 Request for Non-Elective Admission**		
	Up Transfer Required	YES / NO	Allocated Hip Fracture Centre:
	Transfer Booked with:		
	Time patient transferred:	Imaging films included in transfer: YES / NO	
Date & Time	**TRANSFER TO WARD - Complete ☐ MR012 Request for Non-Elective Admission**		
	Patient provided with appropriate pressure area care mattress: YES / NO		
	Ward:	Time of Transfer:	
Date & Time	**ADDITIONAL COMMENTS or PROGRESS NOTES (Time and sign each entry please):**		
	ED Consultant Note:	Name:	Time:
	Patient handed over to:	**MO Signature:**	

SUSPECTED HIP FRACTURE

MR589.1

Please Circle Relevant Hospital

Lyell McEwin HOSPITAL | Modbury HOSPITAL

Government of South Australia
SA Health

Hip Fracture Medical Pre-Op Checklist

Do not hand write these details, except when adhesive barcode labels are unavailable

UR No.: _____

Surname: _____

First Name: _____

D.O.B. _____ Sex: _____

TO BE COMPLETED BY ORTHOPAEDIC/ORTHOGERIATRIC RMO OR AFTER HOURS ADMITTING SURGICAL MEDICAL STAFF

COMPLETED BY: Name (block print): _____

Designation (block print): _____ Date: _____ Time: _____

PRE-OPERATIVE INVESTIGATIONS:

☐ ECG: _____	☐ CXR: _____	☐ X-Rays

BLOOD / FLUID / ELECTROLYTES CHECKED:

☐ Na: _____	☐ K: _____	☐ Urea: _____
☐ Hb: _____	☐ Platelets: _____	☐ Creatinine: _____
☐ Vitamin D + Calcium/Thyroid function test/LFTs Ordered		☐ Urinalysis checked
☐ Fluid balance reviewed and intravenous therapy prescribed		☐ Indwelling catheter
☐ Group and hold ordered		

REVIEW OF MEDICATIONS:

☐ Hold anti-hypertensives except beta-blocker

☐ Antiplatelet: ☐ Indication:

☐ Dual antiplatelet:

_____

Consult Orthogeriatrican and cardiology

☐ Hold direct oral anticoagulant

☐ Apixaban /rivaroxaban drug level (include dose and time of last dose): Indication _____

Dabigatran:
Indication _____ ☐ Thrombin clotting time

☐ Warfarin INR: _____ ☐ Indication: _____

- Hold warfarin
- Give IV Vitamin K 5mg, check INR @6hr
- If repeat INR >1.5, give IV Vitamin K 3 mg and repeat INR in 6 hours

Contact on call Geriatrician to discuss management of medically unstable patient. Liaise with medical sub-specialty registrar for medical review for medically unstable patient. Interim Plan:

MO Name: **Signature:** **Designation:**

September 2018 NALHN 19041629

Please Circle Relevant Hospital

Lyell McEwin HOSPITAL Modbury HOSPITAL

Government of South Australia
SA Health

Neck of Femur Orthopaedic Admission

Do not hand write these details, except when adhesive barcode labels are unavailable

UR No.: _____

Surname: _____

First Name: _____

D.O.B. _____ Sex: _____

COMPLETED BY: Name (block print): _____

Designation (block print): _____ Date: _____ Time: _____

Profile:	**Presenting Complaint:**

Past Medical History:

Physical Examination	BP:	HR:	SaO_2:
RR:	Temp:	BGL:	Pain:

Assessment:

Plan:

☐ Liaise with Anaesthetics ☐ Liaise with Orthogeriatrics	☐ Discuss 7-step pathway with patient and family	Outcome (circle): Delay surgery / Proceed to theatre / Not for surgery

☐ Consent obtained with patient / substitute decision maker. Request interpreter if necessary	☐ Non-operable management: consider and discuss end of life pathway with orthogeriatrics

☐ Patient added to emergency theatre list. Advise theatres of the following:

- Name and URN • Surgeon • Procedure
- Location (Hip / Left or Right / Proximal or Distal)
- ORMIS Clinical Priority Code OR Expected Operation Date (if> 24/24)
- If company equipment required – If Yes, Loan or Consignment, Company name and if company rep required

MO Name:	**Signature:**	**Designation:**

SUSPECTED HIP FRACTURE

September 2018 NALHN 19041629

MR589.1

NORTHERN ADELAIDE LOCAL HEALTH NETWORK

MR589.1

Please Circle Relevant Hospital

Lyell McEwin HOSPITAL   Modbury HOSPITAL

Government of South Australia
SA Health

Orthopaedics Admission Medical

Do not hand write these details, <u>except when</u> adhesive barcode labels are unavailable

UR No.: ____________________

Surname: ____________________

First Name: ____________________

D.O.B. ____________ Sex: ____________

	MANAGEMENT PLAN
Date & Time	**PROGRESS NOTES (including procedural note). Time and sign each entry please.**

September 2018 NALHN 19041629

Please Circle Relevant Hospital

Lyell McEwin HOSPITAL Modbury HOSPITAL

Government of South Australia
SA Health

Orthogeriatric Admission Medical

Do not hand write these details, except when adhesive barcode labels are unavailable

UR No.: _____

Surname: _____

First Name: _____

D.O.B. _____ Sex: _____

COMPLETED BY: Name (block print): _____

Designation (block print): _____ Date: _____ Time: _____

Presenting Complaint and History of falls:	**Falls Risk factors:**
	☐ Previous falls/#
	☐ Polypharmacy: regular ≥5 meds
	☐ Visual impairment
	☐ Urinary/faecal incontinence
	☐ Hearing impairment
	☐ Postural dizziness
	☐ Cognition: delirium/cognitive impairment/dementia

Past Medical/Surgical History

Medication: Generic Name/Form/Strength/ Route of administration (write drug names in full)	**Dose**	**Frequency**	**Indication**

Allergies: Eg.: Medication/Latex	**Types of reaction**

SUSPECTED HIP FRACTURE

Please Circle Relevant Hospital

Lyell McEwin HOSPITAL Modbury HOSPITAL

Government of South Australia
SA Health

Neck of Femur Orthogeriatric Admission Medical

Do not hand write these details, except when adhesive barcode labels are unavailable

UR No.: _____

Surname: _____

First Name: _____

D.O.B. _____ Sex: _____

Smoking:				**Alcohol:**			
Residence: ☐ **Home** ☐ **RACF** ☐ **Home care service (circle)** (shower / cleaning / medications / bladder / bowel care)							
Living situation (e.g. alone, with family etc):							
Social history:							
Mobility: ☐ **Independent (no aid),** ☐ **stick,** ☐ **4WW/frame,** ☐ **other:**							
Baseline diet and fluids:				**Pressure Area:**			
Physical Examination	BP:	HR:	SaO_2:	Temp:	RR:	BGL:	Pain:

4AT: Screening for patient ≥65 years old, known history of dementia or cognitive impairment or assessment raises concerns of delirium

[1] ALERTNESS	**Score**	**[2] AMT 4: Age, date of birth, place (name of hospital), current year**	**Score**
Normal (fully alert, but not agitated throughout assessment)	**0**	No mistakes	**0**
Mild sleepiness for < 10 seconds after waking, then normal	**0**	1 mistake	**1**
Clearly abnormal	**4**	2 or more mistakes/untestable	**2**
[3] ATTENTION Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted. Months of the year backwards:	**Score**	**[4] ACUTE CHANGE OR FLUCTUATING COURSE** Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. Paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs	**Score**
Achieves 7 months or more correctly	**0**	No	**0**
Starts but scores < 7 months/refuses to start	**1**	Yes	**4**
Untestable (cannot start because unwell, drowsy, inattentive)	**2**	**4AT SCORE: IF ≥4, REQUIRES FURTHER COGNITIVE ASSESSMENT.**	**TOTAL** _____

Please Circle Relevant Hospital

Lyell McEwin HOSPITAL | Modbury HOSPITAL

Government of South Australia
SA Health

Neck of Femur Orthogeriatric Admission Medical

Do not hand write these details, except when adhesive barcode labels are unavailable

UR No.: _____

Surname: _____

First Name: _____

D.O.B. _____ Sex: _____

Investigations: Refer to pre-operative ward checklist for results	
Impression and Plan (Record observations and plan as needed. Complete pre-operative ward checklist if not done already.)	
Active Issues	**Plan**
#NOF secondary to fall	
Analgesia	
Cardiovascular	
Respiratory	**Sit patient up as tolerated** **Monitor for signs of HAP**
Renal	**Fluids**
Cognition: **Document history of MCI/neurodegenerative history/ delirium**	**4AT, SMMSE, Clock face** **Interventions to prevent and treat delirium:** • **For patients: given informant form and delirium info sheet** • **Regular orientation** • **Ensure patient has sensory aids** • **Medication review** • **Correction of dehydration, malnutrition and constipation** • **Avoid hypoxia** • **Pain assessment and management** • **Promote sleep and avoid sleep disturbance** • **Nursing: alert nursing staff regarding delirium management protocol** **If 4AT ≥4: require further medical assessment and exclude reversible causes of delirium**
Medication review	
Endocrine Is patient on oral hypoglycaemic/insulin? If yes, please refer to preoperative diabetes guidelines SSI01210 on NALHN PPG	

SUSPECTED HIP FRACTURE

Please Circle Relevant Hospital

Lyell McEwin HOSPITAL Modbury HOSPITAL

Government of South Australia
SA Health

Neck of Femur Orthogeriatric Admission Medical

Do not hand write these details, except when adhesive barcode labels are unavailable

UR No.: _____

Surname: _____

First Name: _____

D.O.B. _____ Sex: _____

Active Issues	Plan
GIT and Genitourinary (including constipation)	**Regular aperients** **IDC removal when sitting upright and commenced mobilisation (within 24 hours)**
VTE prophylaxis ☐ YES ☐ NO **Management of anticoagulation**	**If not, document reasons why:**
Nutrition	**Wt: Ht: BMI: e-MUST score:** e-MUST score = 0 or 1, order HEP diet e-MUST score = 2+, order HEP diet and referral to Dietetics indicated Pre-morbid dysphagia requiring modified consistency diet and/or fluids – referral to Speech Pathology indicated New swallowing concerns during admission – referral to Speech Pathology indicated **Minimise fasting (NOF supplement to be given up to 2 hours prior to scheduled surgery if not contraindicated)**
Skin integrity: pressure area	**Dynamic pressure relieving mattress**
Fall	**Osteoporosis**
Plan: (including additional investigations requested)	☐ **Discussed with Orthogeriatrician** **Name:**
Is patient medically stable to proceed to surgery within 24 hours? **YES/ NO**	**If NO, outline issues**
☐ **Discussed with duty Anaesthetist** **Time: Name:**	☐ **Discussed with Orthopaedic registrar/RMO** **Time: Name:**
Outcome after discussion: **Delay surgery/ Proceed to theatre/ Not for surgery**	☐ **Hip fracture registry: patient information statement given and explained to patient/ family**
MO Name:	**Designation:**

September 2018 NALHN 19041629

NORTHERN ADELAIDE LOCAL HEALTH NETWORK

MR589.1

Please Circle Relevant Hospital

Lyell McEwin HOSPITAL   Modbury HOSPITAL

Government of South Australia

SA Health

Orthogeriatric Admission Medical

Do not hand write these details, except when adhesive barcode labels are unavailable

UR No.: ____________________

Surname: ____________________

First Name: ____________________

D.O.B. ____________________ Sex: ____________________

	MANAGEMENT PLAN
Date & Time	PROGRESS NOTES (including procedural note). Time and sign each entry please.

SUSPECTED HIP FRACTURE

MR589.1

September 2018 NALHN 19041629

Nursing and Allied Health continue with MR589.2

September 2018 NALHN 19041629