ICP Reference No: ACI

Pembrokeshire and Derwen NHS Trust
Integrated Care Pathway

FRACTURED NECK OF FEMUR

LEFT **Please circle** **RIGHT**

The following criteria must be met for this ICP to be appropriate for a patient:

- Definite diagnosis of a fractured neck of femur
- Fracture must not be pathological
- Patients must not have multiple fractures

Patient Addressograph:

Date of admission:

Consultant: …… Type of fracture: ……...

Department: …… Operation: ……..…

This ICP was developed by: Sally Gulliver, Trauma Liaison Nurse, Ward 1 and Multi-disciplinary team

Version: One – January 07

This Integrated Care Pathway (ICP) is a multi-disciplinary document and will serve as the ward based record of care for this particular admission episode.

This ICP is a guide to the provision of care to patients following a fractured neck of femur. However, professionals are encouraged to maintain their own judgement and assess suitability to remain on the pathway, according to changes in the patient's condition.

BLACK INK MUST BE USED TO COMPLETE THIS DOCUMENT

The ICP takes the place of all medical and nursing notes.

Everyone using the Pathway must document their name, signature and initials on the signature page provided (page 7).

Any deviations from the outlined Pathway should be documented by the relevant professional as and, where necessary, acted upon accordingly.

Where it has been necessary to remove the patient from the ICP documentation should continue in the medical/nursing notes, and see reasons for coming off the pathway be made clear.

Variations may or may not result in the discontinuing of the ICP, professional judgement should always be applied.

As far as possible, the ICP should stay as a complete document. Where this has not been possible the relevant professional must ensure that the documentation is returned to its complete state as soon as possible.

Contact No: Sally Gulliver, Trauma Liaison Nurse extension 3932
Viv Thirkill Recovery Sister extension 3274

Allergy.....

Warning.....

REFERENCES

Davis P and O'Neill C (2002) The potential benefits of intermittent pnueumatic compression in the prevention of deep venous thrombosis. Journal of Orthopaedic Nursing. 6. pp 95-100.

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Onslow L. (2003) An integral care pathway for fractured neck of femur patients. Professional Nurse. January. Vol 18. No 5.

PEP Trial (2000) The PEP study of Aspirin (86). Pulmonary Embolism Prevention. Lancet 355. pp 1295-1302.

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The Stationary Office. London.

Welsh Assembly Government (2004/2005) Welsh Emergency Care Access. Collaborative Programme. Appendix 8. p 30.

Affix patient label here

Date & Time	**MULTIDISCIPLINARY NOTES** **Medical / Nursing / Allied Health Professionals** Code: D= Doctor, N= Nurse, PT= Physiotherapist, OT= Occupational Therapist, S= Speech & Lang, Ph= Pharmacist, SRD= Dietitian, SW= Social Worker, SN= Specialist Nurse, LN= Liaison Nurse	Signature Designation Code Contact No.
	…… ……	

Definition of Nursing Interventions

A signature in the ICP against the nursing intervention containing the following:

Pain Controlled
Appropriate analgesia been given for pain score? The patient has been reassessed to check that the analgesia has been effective? The intervention/outcome has been documented?

Assessments Completed
The nutritional screening tool, falls screen, pressure sore prediction scale, moving and handling assessments have been completed/reviewed.

Observations completed
All observations have been undertaken in line with frequency prescribed on 'Track and Trigger' chart and the results fall within acceptable limits i.e.

Blood pressure – should be within normal limits
Pulse – 60-80 beats per minute
Respirations – 15-25 breaths per minute
S_aO_2 – should remain above 98%
Temperature – normal 37°
Document on 'track and trigger' chart

Intravenous infusion commenced if indicated and accurate fluid balance
A fluid balance chart has been commenced pre-operatively and maintained accurately.

Pre-op Paperwork
The following have been completed fully and checked for availability in notes:-

Theatre checklist
Anaesthetic questionnaire
Consent form

Patient placed on appropriate mattress for PSPS score
The pressure sore prediction score has been undertaken and the following actions taken:-

PSPS = 11 or below use 'premierglide' static mattress
PSPS = 12-16 use alternating mattress – nimbus

The fractured hip patient will <u>nearly always</u> require an 'air mattress'

Orientated
Patient is orientated as to time and place and what has happened to them?
Patient has been assessed for disorientation (due to medication, dehydration and/or confusion). Is it known if this is a new development?

Adequate fluid intake
Patient has received intervention to encourage fluids and/or if nil by mouth, ensure IV fluids prescribed at correct rate for patients and fluid balance chart maintained accurately.

GLOSSARY

Abbreviations:

PSPS	-	pressure sore prediction scale
BP	-	blood pressure
TPR	-	temperature, pulse, respirations
DVT	-	deep vein thrombosis
PE	-	pulmonary embolism
DHS	-	dynamic hip screw
HB	-	haemaglobin
U&E	-	urea and electrolytes
TLN	-	trauma liaison nurse
ADL	-	activities of daily living
ACAH	-	Acute Care at Home
OT	-	occupational therapist
W/B	-	weight bearing
PWB	-	partial weight bearing
NWB	-	non weight bearing
MDT	-	multidisciplinary team
V	-	variance
FBC	-	full blood count
LFT	-	liver function test
G+S	-	group and save
COAG	-	coagulation
CXR	-	chest x-ray
MSU	-	mid specimen of urine
CSU	-	catheter specimen of urine
BD	-	twice daily
TTO	-	take treatment out
CMS	-	colour, movement and sensation
IVI	-	intravenous infusion
IV ABS	-	intravenous antibiotics
Sa O_2	-	oxygen saturation

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	.....	

Affix patient label here

Date & Time	**MULTIDISCIPLINARY NOTES** **Medical / Nursing / Allied Health Professionals** Code: D= Doctor, N= Nurse, PT= Physiotherapist, OT= Occupational Therapist, S= Speech & Lang, Ph= Pharmacist, SRD= Dietitian, SW= Social Worker, SN= Specialist Nurse, LN= Liaison Nurse	Signature Designation Code Contact No.
	…… ……	

COLOUR CODES

Medical - Red pages

Nursing - Blue & white pages

Multidisciplinary team - White pages

NOTE

These are the sections for which you are responsible. Please ensure they are filled in.

Medical - inc: clerking notes
RED

Nursing - inc: all admission documentation and assessments
Blue & white

MDT - inc:
white

ACAH
Physio
OT
Pharmacy
Social worker
Doctor
nurse
Dietitian
Specialist Nurse

Attach A&E sheets here
with Cellotape

A&E casualty card
A&E care plan

Date	Code	Ongoing care, comments, interventions – all variances must be included with relevant code	Signature and Profession

Affix patient label here

POST-OP DAY ….. DISCHARGE DAY DATE ……

MULTIDISCIPLINARY NOTES
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	INTERVENTIONS	AM	PM	NIGHT	COMMENTS	
NURSING						
D1	Pain controlled					
D2	Orientated					
D3	Observations recorded					
D4	Personal hygiene self care					
D5	Wound dry					
D6	Discharge checklist + necessary documentation					
D7	Medication as prescribed – continue Asprin for 35 days from start date					
D8	Adequate diet and fluids taken					
D9	Pressure areas intact: heels, sacrum					
D10	Bowels opened					
PHYSIOTHERAPY						
D11	Consent to treatment					
	Exercise programme and transfer practice continued					
	Progress ambulation					
	Gait re-education					
	Walking aid issued					
OCCUPATIONAL THERAPY						
D12	Transfer assessments completed					
	Equipment required provided					
	ADL assessments completed					
MULTIDISCIPLINARY						
D13	Transport booked					
D14	Relatives aware					
D15	Discharge information given					
D16	Transfer documentation completed					
D17	Referral to other services					
D18	TTO’s explained and given					
D19	Own medication returned					
D20	Falls assessment completed					
D21	Referred to Falls Prevention Officer (if applicable)					
D22	Osteoporosis treatment commenced					

INITIALS	AM	PM	NIGHT	PT	OT	Ph	SRD

SIGNATURE SHEET

All staff using this pathway are required to sign below so that signatures and initials used within the pathway can be identified.

PRINT NAME	DESIGNATION	SIGNATURE	INITIALS

Affix patient label here

PRESENTING HISTORY

Presenting problem	-	pain in hip
	-	inability to weight bear
	-	deformity
History of present Problem	-	fall? - how
		- why
		- when
How long before seen by:	-	relative
	-	neighbour/friend
	-	GP
	-	ambulance personnel
Concurrent presenting Problem	-	hypothermia
	-	dehydration
	-	other

Date	Code	Ongoing care, comments, interventions – all variances must be included with relevant code	Signature and Profession

Affix patient label here

POST-OP DAY 10 DATE .....

MULTIDISCIPLINARY NOTES
Medical / Nursing / Allied Health Professionals

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INTERVENTIONS		AM sign	PM sign	NIGHT sign	INTERVENTIONS	√ / x
NURSING					**PHYSIOTHERAPY**	
10P1	Pain controlled				Consent to treatment	
10P2	Orientated				Exercise programme continued	
10P3	Temperature apyrexial				Transfer practice continued	
10P4	BP recorded				Gait re education	
10P5	Wound dry				Rehabilitation potential discussed	
10P6	Continent				**OCCUPATIONAL THERAPY**	
10P7	Adequate fluids taken				Transfer assessment	
10P8	Adequate diet taken				Personal ADL assessment	
10P9	Fluid balanced				Heights form collected	
10P10	Medication as prescribed				**PHARMACY**	
10P11	Pressure areas (sacrum) Intact, colour				Prescription checked	
10P12	Pressure areas (heels) intact, colour				Drug therapy monitored	
10P13	Personal hygiene with assistance				**LIAISON NURSE**	
10P14	Bowels opened					
10P15	Review discharge plan					
10P16	Discontinue venaflow pump when mobile					

INITIALS	AM	PM	NIGHT	PT	OT	Ph	SRD

Affix patient label here

Estimated length of stay:

TO BE COMPLETED BY ADMITTING SHO IN A&E

MEDICAL HISTORY		
PAST MEDICAL HISTORY	**DETAILS**	**DATE**
Ischaemic Heart Disease		
High Blood Pressure		
Atrial Fibrillation		
Previous Stroke		
Diabetes Mellitus		
Hepatitis		
Peptic ulcer		
Tuberculosis		
Asthma		
DVT-PE		
Epilepsy		
MEDICATION Is this likely to predispose to falls?		
OPERATIONS (State year)		
FAMILY HISTORY		
Ischaemic Heart Disease		
High Blood Pressure		
Stroke		
Diabetes Mellitus		
Tuberculosis		
Asthma		
Other		
RISK FACTORS Occupation Smoking Alcohol Cholesterol		

SYSTEM REVIEW

CARDIO RESPIRATORY SYSTEM

GASTRO-INTESTINAL

GENITO-URINARY

CENTRAL NERVOUS SYSTEM

OTHER

PHYSICAL EXAMINATION

Anaemia Cyanosis Clubbing Jaundice Lymphadenopathy

Hydration Temperature
Skin
Thyroid

Breasts Other

Date	Code	Ongoing care, comments, interventions – all variances must be included with relevant code	Signature and Profession

Affix patient label here

POST-OP DAY 9 DATE .....

MULTIDISCIPLINARY NOTES
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	INTERVENTIONS	AM sign	PM sign	NIGHT sign	INTERVENTIONS	√ / x
	NURSING				**PHYSIOTHERAPY**	
9P1	Pain controlled				Consent to treatment	
9P2	Orientated				Exercise programme continued	
9P3	Temperature apyrexial				Transfer practice continued	
9P4	BP recorded				Gait re education	
9P5	Wound dry				Rehabilitation potential discussed	
9P6	Continent				**OCCUPATIONAL THERAPY**	
9P7	Adequate fluids taken				Transfer assessment	
9P8	Adequate diet taken				Personal ADL assessment	
9P9	Fluid balanced				Heights form collected	
9P10	Medication as prescribed				**PHARMACY**	
9P11	Pressure areas (sacrum) Intact, colour				Prescription checked	
9P12	Pressure areas (heels) intact, colour				Drug therapy monitored	
9P13	Personal hygiene with assistance				**LIAISON NURSE**	
9P14	Bowels opened					
9P15	Review discharge plan					
9P16	Discontinue venaflow pump when mobile					

INITIALS	AM	PM	NIGHT	PT	OT	Ph	SRD

Affix patient label here

SYSTEM REVIEW

CARDIO VASCULAR SYSTEM

Pulse rate Rhythm Character

BP

Heart Sounds

Bruits

RESPIRATORY SYSTEM

Abdomen

PHYSICAL EXAMINATION

MUSCULOSKELETAL/ORTHOPAEDIC

PHYSICAL EXAMINATION

MENTAL TEST SCORE

Age	☐
DoB	☐
Year	☐
Time of Day	☐
Place	☐
Monarch	☐
WW1	☐
20-1	☐
2 people recognition	☐
Recall address	☐

Total 10

GLASGOW COMA SCORE

Eye Opening	Spontaneous	**4**
	To command	**3**
	To pain	**2**
	None	**1**
Verbal Response	Orientated	**5**
	Confused	**4**
	Random	**3**
	Grunts	**2**
	None	**1**
Motor Response	Obeys	**6**
	Localises pain	**5**
	Withdraws	**4**
	Flexes to pain	**3**
	Extends to pain	**2**
	None	**1**

Total 15

Date	Code	Ongoing care, comments, interventions – all variances must be included with relevant code	Signature and Profession

Affix patient label here

POST-OP DAY 8 DATE .....

MULTIDISCIPLINARY NOTES
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	INTERVENTIONS	AM sign	PM sign	NIGHT sign	INTERVENTIONS	√ / x
	NURSING				**PHYSIOTHERAPY**	
8P1	Pain controlled				Consent to treatment	
8P2	Orientated				Exercise programme continued	
8P3	Temperature apyrexial				Transfer practice continued	
8P4	BP recorded				Gait re education	
8P5	Wound dry				Rehabilitation potential discussed	
8P6	Continent				**OCCUPATIONAL THERAPY**	
8P7	Adequate fluids taken				Transfer assessment	
8P8	Adequate diet taken				Personal ADL assessment	
8P9	Fluid balanced				Heights form collected	
8P10	Medication as prescribed				**PHARMACY**	
8P11	Pressure areas (sacrum) Intact, colour				Prescription checked	
8P12	Pressure areas (heels) intact, colour				Drug therapy monitored	
8P13	Personal hygiene with assistance				**LIAISON NURSE**	
8P14	Bowels opened					
8P15	Review discharge plan					
8P16	Discontinue venaflow pump when mobile					

INITIALS	AM	PM	NIGHT	PT	OT	Ph	SRD

Affix patient label here

OBSERVATIONS

	Result	Initials	Time		Result	Initials	Time
Temperature				Weight			
Blood Pressure				Blood Sugar			
Pulse				Glasgow Coma Score			
Respirations							
O2 Sats							

INITIAL INVESTIGATIONS

Routine	Result	**May be required**	Result
Thyroid		LFT	
FBC		CXR	
U&E		COAG	
G&S X-Match		MRSA screen	
Urinalysis		Blood glucose	
ECG		Blood for culture	
		Echo	
		Other	

DIFFERENTIAL DIAGNOSIS

Intracapsular fractured femur

Intertrochanteric fractured femur

Subtrochanteric fractured femur

* Do not fast the patient until you have a definite theatre time!	* Decide on operation prior to booking theatre Operation type: ……
* Do not book theatre until patient is fit for theatre	Name of person theatre booked with: ……..

MANAGEMENT PLAN

IV Access	Remember to prescribe drugs
Assess for fluids	Sub-cut
Patient fit for surgery Yes ☐ No ☐	Date & Time of planned surgery ……..
Surgery cancelled Yes ☐ No ☐	Reason ……
Surgery cancelled Yes ☐ No ☐	Reason ……
Surgery cancelled Yes ☐ No ☐	Reason ……
Surgery postponed Yes ☐ No ☐	Reason ……
Surgery postponed Yes ☐ No ☐	Reason ……
Surgery postponed Yes ☐ No ☐	Reason ……

SHO Signature …… Print Name ……

Date …… Time ……

Date	Code	Ongoing care, comments, interventions – all variances must be included with relevant code	Signature and Profession

Affix patient label here

POST-OP DAY 7 DATE .....

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	INTERVENTIONS	AM sign	PM sign	NIGHT sign	INTERVENTIONS	√ / x
	NURSING				**PHYSIOTHERAPY**	
7P1	Pain controlled				Consent to treatment	
7P2	Orientated				Exercise programme continued	
7P3	Temperature apyrexial				Transfer practice continued	
7P4	BP recorded				Gait re education	
7P5	Wound dry				Rehabilitation potential discussed	
7P6	Continent				**OCCUPATIONAL THERAPY**	
7P7	Adequate fluids taken				Transfer assessment	
7P8	Adequate diet taken				Personal ADL assessment	
7P9	Fluid balanced				Heights form collected	
7P10	Medication as prescribed				**PHARMACY**	
7P11	Pressure areas (sacrum) intact, colour				Prescription checked	
7P12	Pressure areas (heels) intact, colour				Drug therapy monitored	
7P13	Personal hygiene with assistance				**LIAISON NURSE**	
7P14	Bowels opened					
7P15	Review discharge plan					
7P16	Discontinue venaflow pump when mobile					

INITIALS	AM	PM	NIGHT	PT	OT	Ph	SRD

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UAP / CORE INFORMATION / SHEET 1

UAP / CORE INFORMATION / SHEET 1

Care Team

Consultant: .....
GP: .....
Surgery: .....
Telephone: .....
Other professionals or agencies currently involved
e.g. District Nurse/Health Visitor/Social Worker/Dentist etc.
Role: ..... Tel. .....
Name: ..... Tel. .....
Role: ..... Tel. .....
Name: ..... Tel. .....
Role: ..... Tel. .....
Name: ..... Tel. .....

Current Medication / Complimentary Therapy

Drug Name	Dose	Frequency/Time

Is the Patient able to self medicate? Yes ☐ No ☐

Temporary Address

Temporary GP

Name: .....
Surgery: .....

Allergies/Latex Sensitivities

Previous Medical History/Dates

Patient Details

Hosp. No:
NHS No:
Surname:
Forenames:
E. No:
Present Address:
Post Code:
Likes to be known as:
Tel. No: .....
DOB:
Age:
Gender: M/F ..... Title ..... Marital Status .....
Pref. Language ..... Ethnic Origin .....
Occupation: ..... Religion .....
Do you want information about your religion to be passed to the hospital chaplaincy team Yes ☐ No ☐

Accommodation

☐ House ☐ Flat ☐ Bungalow
☐ Nursing/Resid. ☐ Private House ☐ Council ☐ Rented
☐ Warden Controlled ☐ Other [specify]
Heating: [specify]
ACCESS: [specify]
Toilet: ☐ Upstairs ☐ Downstairs ☐ Outside ☐ Commode
Bedroom: Upstairs Downstairs
Able to negotiate stairs Y ☐ N ☐ N/A ☐

Support Networks

Lives: ☐ Alone ☐ With Spouse
☐ Other [specify]

Reason for Admission / Patient's Perception

Reason ..... EDD.
Date ..... Time ..... via: GP ☐ A+E ☐ Other ☐
Reason .....
Date ..... Time ..... via: GP ☐ A+E ☐ Other ☐
Reason .....
Date ..... Time ..... via: GP ☐ A+E ☐ Other ☐
Reason .....
Date ..... Time ..... via: GP ☐ A+E ☐ Other ☐

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WML5510 01/06

Patient Details **Consultant/GP:**

Area Specific Information (e.g. vital signs, relevant results, directions, parents' address (Paeds), codes etc). Each entry must be dated and signed by the nurse.

Communicable Infection

- Past MRSA infection Yes ☐ No ☐
- Current MRSA infection Yes ☐ No ☐
- Other relevant communicable infection Yes ☐ No ☐

All Core Information must be re-checked on every admission.

Information on re-admission provided by: .....

Information on re-admission provided by: .....

Next of Kin THIS INFORMATION COMPLIES WITH THE REQUIREMENTS OF THE CALDICOTT REPORT

Name: .....

Relationship: .....

Address: .....

Tel. [H] ..... [W] .....

IS INFORMATION REGARDING YOUR CLINICAL CONDITION TO BE GIVEN TO THIS PERSON. (Named Relative) Yes ☐ No ☐

*IF YOU ANSWERED **NO** TO THE ABOVE QUESTION:-*

Name of person to discuss your clinical condition with:

Name: .....

Relationship: .....

Address: .....

Tel. [H] ..... [W] .....

Main Carer if different from Next of Kin

Name: .....

Relationship: .....

Address: .....

Tel. [H] ..... [W] .....

ANY INFORMATION GIVEN WILL BE HELD IN CONFIDENCE BUT SOMETIMES IT MAY NEED TO BE SHARED WITH OTHER PROFESSIONALS SO THAT ALL OF YOUR NEEDS CAN BE MET.

Patient Sign: ..... Nurse Sign: ..... Date: .....

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UAP / CORE INFORMATION / SHEET 1

Date	Code	Ongoing care, comments, interventions – all variances must be included with relevant code	Signature and Profession

Affix patient label here

SAFF TARGET FOR LENGTH OF STAY EXCEEDED
STATE REASON WHY?.....
.....
.....

POST-OP DAY 6 **DATE .....**

MULTIDISCIPLINARY NOTES
Medical / Nursing / Allied Health Professionals

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	INTERVENTIONS	AM sign	PM sign	NIGHT sign	INTERVENTIONS	√ / x
	NURSING				**PHYSIOTHERAPY**	
6P1	Pain controlled				Consent to treatment	
6P2	Orientated				Exercise programme continued	
6P3	Temperature apyrexial				Transfer practice continued	
6P4	BP recorded				Gait re education	
6P5	Wound dry				Rehabilitation potential discussed	
6P6	Continent				**OCCUPATIONAL THERAPY**	
6P7	Adequate fluids taken				Transfer assessment	
6P8	Adequate diet taken				Personal ADL assessment	
6P9	Fluid balanced				Heights form collected	
6P10	Medication as prescribed				**PHARMACY**	
6P11	Pressure areas (sacrum) Intact, colour				Prescription checked	
6P12	Pressure areas (heels) Intact, colour				Drug therapy monitored	
6P13	Personal hygiene with assistance				**LIAISON NURSE**	
6P14	Bowels opened					
6P15	Review discharge plan					
6P16	Discontinue venaflow pump when mobile					

INITIALS	AM	PM	NIGHT	PT	OT	Ph	SRD

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PEMBROKESHIRE & DERWEN
NHS Trust

ACUTE CORE INFORMATION / SHEET 1B

PRESSURE SORE PREDICTION SCORE

	No	No, but	Yes, but	Yes
Sitting up? (long time)	0	1	2	3
Unconscious?	0	1	2	3
Poor general condition?	0	1	2	3
Incontinent?	0	1	2	3

	No	Yes & No	Yes	Score
Lifts up?	2	1	0	
Gets up and walks?	2	1	0	

If pressure sores present +10, complete Wound Assessment form and utilise appropriate aids e.g. cushions

SUPPORT SURFACE ALGORITHMS

PSPS = 11 or below →
USE STATIC MATTRESS (PREMIERGLIDE)

PSPS = 12-16 (very high risk of pressure sores) →
USE ALTERNATING MATTRESS

This algorithm is to be used as a tool but does not replace clinical judgement.

Date and time of assessment: .....

Required information forwarded to EME (WGH only) .....

i.e.: D Number, Location, Clinical Justification (if PSPS 11 or less)

Equipment received on .....

Equipment acquired from: Hospital stock ☐ Lease ☐ Rental ☐

Nurse signature: .....

Patient Details

Consultant/GP:

PSPS Screening must be conducted within 6 hours of admission (NICE2005) and re-assessment conducted on a daily basis or as the patient's condition changes.

REASSESSMENT OF PSPS

Date/ Time	PSPS Score	Equipment required - please document	Nurse Signature

ACUTE CORE INFORMATION / SHEET 1B

WML 5525 Rev. 01/06

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SITTING UP? (Long time)	Answer + Score
a] Bedfast and nursed flat b] Only sit up in a chair - short periods c] Does not sit for long periods (ambulant)	NO 0
a] Sits in self propelled chair (less than 10hrs) but flat when in bed	NO, But .. 1
a] Sits in self propelled chair for 10 hrs or more. b] Sits for short periods - both in bed and in fixed chair	YES, But .. 2
a] Propped up in bed - longish periods - most of the day b] Sits up both day and night	YES 3

UNCONSCIOUS	Answer + Score
a] Fully conscious and orientated b] Fully conscious and slightly confused	NO 0
a] Confused b] Withdrawn c] Semi-conscious at times	NO, But.. 1
a] Rousable - responds to commands of pain	YES, But.. 2
a] Deeply unconscious b] Does not respond to pain	YES 3

POOR GENERAL CONDITION	Answer + Score
a] Fairly good general condition b] Awaiting minor operation c] Minor problem (mental or physical)	NO 0
a] Recent operation (under G.A.) b] Some restriction of lower extremities c] Minor sensory neuropathy d] Perip. arterial disease e] diabetic f] Arthritic g] Anorexic h] Pyrexial i] Hypotensive j] On steroids k] Chemotherapy l] Radiotherapy m] Elderly and thin, or obese	NO, But.. 1
a] Some injuries to lower half of body, but fair general condition b] Severe injuries (lower half) but no restriction of movement c] Well established chronic disease/disability d] Young paraplegic e] Active hemiplegic f] Elderly and on steroids	YES, But.. 2
a] Limited mobility and great age b] Severe injuries - including legs/pelvis c] Seriously/critically ill d] Terminal (acute) illness e] Emaciated/Cachexic f] Severe general infection g] Severe uraemia h] Multiple pathology i] Iliac. thrombosis j] Severe M.S. k] Hansen's disease l] Extensive loss of pain m] Recent paraplegic n] Quadraplegic o] On narcotics (for pain) p] Combined chemotherapy, radiotherapy and /or steroids	YES 3

INCONTINENT?	Answer + Score
a] No incontinence, and no "accidents" recently b] Indwelling cath/stoma, but no leaks/accidents	NO 0
a] Sometimes wets bed/ spills urinal b] Occasional accidents with attached urinal c] Occasional leaks from indwelling catheter d] Occasional faecal incontinence	NO, But.. 1
a] Small amounts and infrequent b] Urine only and infrequent c] Faecal (infrequent) but some leaks (cath/urinel)	YES, But.. 2
a] Continual dribble/leak b] Frequent urine/faecal incontinence c] Doubly incontinent	YES 3

LIFTS UP?	Answer + Score
a] Lifts all of body clear of support b] Easily lifts pelvis clear	YES 0
a] Can only lift pelvis with some effort and soon tires b] Seldom lifts self c] Can lift with help d] Lifts slightly - shuffles along support	YES & NO 1
a] Unable to lift pelvis b] Can neither help with lift, nor shuffle	NO 2

GETS UP AND WALKS?	Answer + Score
a] Fully ambulant b] Slight impediment c] Uses side with no difficulty	YES 0
a] Has difficulty walking with aid b] Walks with help and encouragement c] Soon tires d] Can only walk to toilet	YES & NO 1
a] Bedfast b] Chairfast c] Stands and shuffles - with help and encouragement	NO 2

This pressure sore prevention aid was developed at the Royal National Orthopaedic Hospital (NHS) Trust, Stanmore, Middlesex.

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ACUTE CORE INFORMATION / SHEET 1B

Date	Code	Ongoing care, comments, interventions – all variances must be included with relevant code	Signature and Profession

Affix patient label here

POST-OP DAY 5 DATE .....

MULTIDISCIPLINARY NOTES
Medical / Nursing / Allied Health Professionals

Code: D= Doctor, N= Nurse, PT= Physiotherapist, OT= Occupational Therapist, S= Speech & Lang, Ph= Pharmacist, SRD= Dietitian, SW= Social Worker, SN= Specialist Nurse, LN= Liaison Nurse

INTERVENTIONS		AM sign	PM sign	NIGHT sign	INTERVENTIONS	√ / x
NURSING					**PHYSIOTHERAPY**	
5P1	Pain controlled				Consent to treatment	
5P2	Orientated				Exercise programme continued	
5P3	Temperature apyrexial				Transfer practice continued	
5P4	BP recorded				Gait re education	
5P5	Wound dry				Rehabilitation potential discussed	
5P6	Continent				**OCCUPATIONAL THERAPY**	
5P7	Adequate fluids taken				Transfer assessment	
5P8	Adequate diet taken				Personal ADL assessment	
5P9	Fluid balanced				Heights form collected	
5P10	Medication as prescribed				**PHARMACY**	
5P11	Pressure areas (sacrum) Intact, colour				Prescription checked	
5P12	Pressure areas (heels) Intact, colour				Drug therapy monitored	
5P13	Personal hygiene with assistance				**LIAISON NURSE**	
5P14	Bowels opened					
5P15	Review discharge plan					
5P16	Discontinue venaflow pump when mobile					

INITIALS	AM	PM	NIGHT	PT	OT	Ph	SRD

Consultant/GP

Nurse Sign .....

Nurse Date .....

NEEDS IDENTIFIED
Pre-Admission / Current Status

Patient Details

Hosp. No:
NHS No:
Surname:
E. No:
Forenames:
Present Address:
Post Code:
Likes to be known as:
Tel. No:
.....
DOB:
Age:

1. **User's Perspective**
   - Problems and issues in the **user's own words**
   - User's expectations, needs, strengths, abilities and motivation including cultural and social expectations
   - Recent life events — including strengths and coping mechanisms
   - Personal and spiritual fulfilment and life-style choices
   - Issues surrounding the patient's level of anxiety, fears, self esteem and body image.
   - Health perception, spiritual beliefs, mental health. Advocacy needs.

2. **Carer's perspective and need for carer assessment**
   - Physical difficulties in caring
   - Psychological difficulties and pressures arising from caring role, including shock, grief, inadequacy
   - Life constraints arising from caring role, e.g. clashes with employment, child care responsibilities, leisure activity
   - Carer's strengths, expectations, motivation and perception of her/his needs and user's needs
   - Issues around support/relationships with family, carers, friends
   - Issues around the patient's ability to cope at home. **Current care received**

3. **Clinical background**
   - Issues around the patient's environment and how he/she is able to cope
   - Issues around mobility/aids used, physical activity, patterns of exercise, history of falls (complete Stratify)
   - Breathing difficulties, history of obstructive airway disease.
   - Issues around the patient's respiratory function, consider referral to Respiratory CNS

4. **Disease prevention**
   - History of blood pressure monitoring
   - Issues around the patient's **nutritional intake**, preferences and hydration, alcohol intake.
   - Vaccination history - including Flu vacine
   - Does the patient smoke, how many?
   - Issues around mobility, physical activity, patterns of exercise, consider referral to Physio
   - History of screening clinics attended

UAP / NURSING ASSESSMENT / SHEET 2

	NEEDS IDENTIFIED Pre-Admission / Current Status
5. Personal care and physical well-being · Pain - complete pain screening/consider referral to CNS acute or chronic pain, if wound/pressure sore present complete wound assessment, **record PSPS**. · **Foot-care**, consider referral to Podiatry · Issues around cardiovascular and peripheral system, systemic perfusion, skin integrity - consider referral to TV Nurse Practitioner · Issues around mobility, physical activity, patterns of exercise, ability to climb stairs · Issues round **excretory function** and abnormalities. (Bowel, urine output, menstruation). Consider referral to Continence CNS/Stoma CNS · Consider patient's pattern of **sleep, rest,** relaxation and perception of energy levels	
6. Activities of Daily living · Issues around the **patient's personal hygiene**, dressing and self care ability · Grooming, including hair care and shaving · Transfer in/out of chair/bed (refer to M&H). Complete M&H assessment · Issues around the patient's nutritional intake, preferences and hydration, complete nutritional screening/assessment, **oral health**, alcohol intake · Issues around the patient's environment and how he/she is able to cope	
7. Senses · Issues around the patient's ability to express self including **pain, sensory loss, speech** problems · Speech and communication, first/preferred language, consider referral to SALT · Consider the patient's conscious level, is he/she orientated and responsible for self	
8. Mental health · Cognition and dementia, including orientation and memory · Mental health including confusional states, paranoid states, depression and reaction to loss, and other emotional difficulties · Substance misuse (including tranquillisers or alcohol) · Issues surrounding the patient's level of anxiety, fears, self esteem and body image. Health perception, spiritual beliefs, mental health	
9. Relationships · Social support and network, personal **relationships**, and involvement in leisure, hobbies, religious groups · Carer support and strength of caring arrangements · Ability to care for others where necessary, eg partner · Issues around support/relationships with family, carers, friends	
10. Safety · Abuse and neglect. Refer to Vulnerable Adult Policies and Procedures) · Issues around the **patient's environment** and how he/she is able to cope · Public safety/hazards · Complete manual handling assessment (risk assessment)	
11. Instrumental Activities of Daily Living · Meal and snack preparation, make hot drink, consider referral to OT · Heavy housework (cleaning), shopping, care of the home · Keeping warm · Managing affairs (finances, paperwork)	
12. Immediate environment and resources · Accommodation (including noise), heating or physical hazards, location and access, see Sheet 1 · Level and management of finances and need for benefit advice (risk assessment) · Access to local facilities and services · Work, education, learning and participating in community activities · Transport needs, benefits	

Date	Code	Ongoing care, comments, interventions – all variances must be included with relevant code	Signature and Profession

Affix patient label here

POST-OP DAY 4 DATE .....

MULTIDISCIPLINARY NOTES
Medical / Nursing / Allied Health Professionals

Code: D= Doctor, N= Nurse, PT= Physiotherapist, OT= Occupational Therapist, S= Speech & Lang, Ph= Pharmacist, SRD= Dietitian, SW= Social Worker, SN= Specialist Nurse, LN= Liaison Nurse

INTERVENTIONS		AM sign	PM sign	NIGHT sign	INTERVENTIONS	√ / x
NURSING					**PHYSIOTHERAPY**	
4P1	Pain controlled				Consent to treatment	
4P2	Orientated				Exercise programme continued	
4P3	Temperature apyrexial				Transfer practice continued	
4P4	BP recorded				Gait re education	
4P5	Wound dry				Rehabilitation potential discussed	
4P6	Continent				**OCCUPATIONAL THERAPY**	
4P7	Adequate fluids taken				Transfer assessment	
4P8	Adequate diet taken				Personal ADL assessment	
4P9	Fluid balanced				Heights form collected	
4P10	Medication as prescribed				**PHARMACY**	
4P11	Pressure areas (sacrum) Intact, colour				Prescription checked	
4P12	Pressure areas (heels) Intact, colour				Drug therapy monitored	
4P13	Personal hygiene with assistance				**LIAISON NURSE**	
4P14	Bowels opened					
4P15	Review discharge plan					
4P16	Discontinue venaflow pump when mobile					

INITIALS	AM	PM	NIGHT	PT	OT	Ph	SRD

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SCREENING TOOLS

PAIN SCREENING TOOL

	Yes	No	Please comment
1. Are you in any pain now? *Complete pain scoring (eg. 0-3)*	☐	☐	.....
2. Is this pain new?	☐	☐	.....
3. Do you experience pain as part of an ongoing problem?	☐	☐	.....
4. Have you been seen by a Specialist Nurse. e.g. Pain SN/Macmillan Nurse/Consultant/ Tissue Viability/Rheumatology etc) for your ongoing problem? *Note previous referral; re-refer if necessary*	☐	☐	.....
5. Is surgery planned? *Complete acute pain score; refer to SN if pain is still problem.*	☐	☐	.....
6. Is further intervention required? ***Please detail action taken in comments section.***	☐	☐	.....

Please record any action taken in the Nursing Documentation: seek advice from Specialist Nurse if required

Referral to the Specialist Nurse YES ☐ NO ☐

Signature:..... Date: .....

Re Screen Date: .....

Patient Details

Hosp. No:

NHS No:

Name:

Address:

Post Code:

Tel. No:

DOB:

Likes to be known as:

.....

Age:

Screening of Patient falls, pain and nutrition must be carried out on admission to the Service and at identified intervals thereafter.

STRATIFY RISK SCREENING TOOL (Management of Falls)

If you answer yes to any of the following questions (or are unsure) ***you must*** complete the Stratify Risk Assessment, implement a Plan of Care and record all evaluations in the nursing documentation.

	YES	NO
1. Has the patient fallen within the last 3 months?	☐	☐
2. Is the patient agitated?	☐	☐
3. Is the patient visually impaired to the extent that everyday function is affected?	☐	☐
4. Does the patient needs to use the toilet frequently?	☐	☐
5a. Does the patient need assistance/supervision to get from sitting to standing?	☐	☐
5b. Does the patient need assistance/supervision to mobilise?	☐	☐
Stratify Risk Assessment completed?	☐	☐

Signature:..... Date:.....

Re Screen Date: .....

Adapted from STRATIFY (Dr. D. Oliver - 1997)

SCREENING TOOLS

NUTRITIONAL RISK SCREENING TOOL

1. Measure patient height ..... metres
2. Measure patient weight ..... kg
3. Work out the patient's BMI (normal 20-25) .....
4. What is your normal weight? ..... kg
5. Have you unintentionally lost weight? ☐ Yes ☐ No
6. Have you been eating less than usual? ☐ Yes ☐ No
7. Are any of the following risk factors for malnutrition present? Tick any that apply:

(NB: Patients with a BMI above 25 may require health promotional literature)

☐ BMI<20	☐ chronic disease	☐ infection/sepsis
☐ wounds	☐ pressure sores	☐ unconscious
☐ decreased appetite	☐ eating/digestive difficulties	☐ inability to feed independently
☐ NBM	☐ reduced dietary intake	☐ no dietary intake for more than 3-4 days
☐ diarrhoea and/or vomiting	☐ excessive weakness	☐ apathy/fatigue

Other .....

A "YES" response to Question 5, 6 or 7 **requires** a **full nutritional assessment** to be completed **NOW.** If you are unable to measure the patient you **must** complete full nutritional assessment.

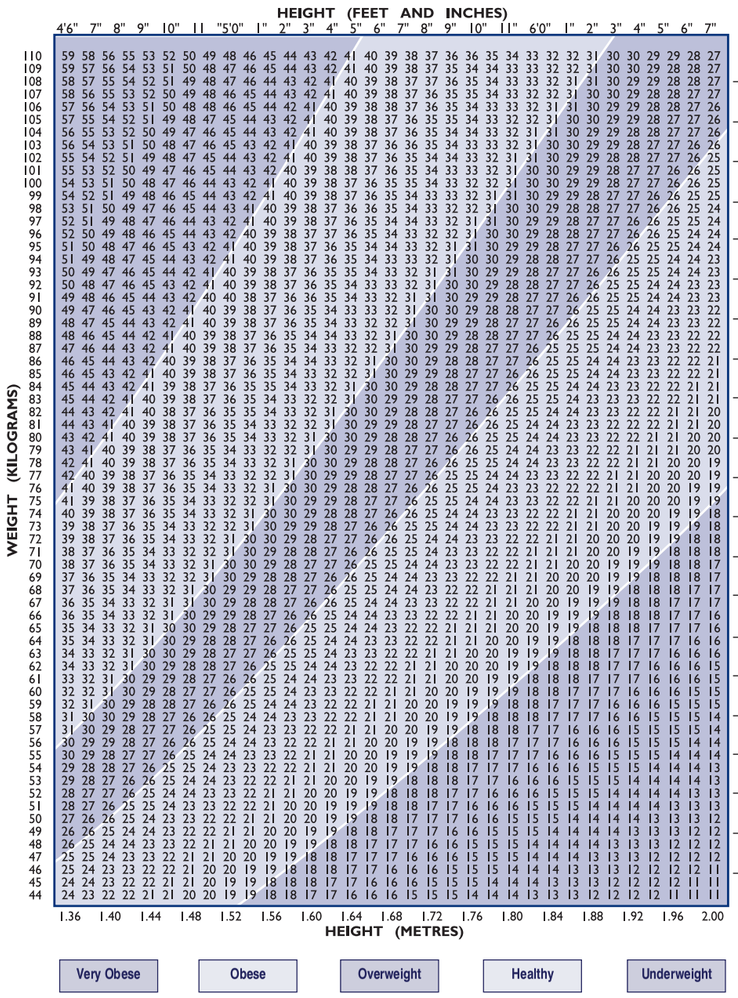
Full Assessment Completed Yes ☐ N/A ☐

Signature..... Date .....

Rescreen Date .....

Nutritional Screening must be carried out on admission to the service and at **weekly** intervals thereafter, or if risk factors develop.

BODY MASS INDEX READY RECKONER



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SCREENING TOOLS

Page 22 of 60

Date	Code	Ongoing care, comments, interventions – all variances must be included with relevant code	Signature and Profession

Affix patient label here

POST-OP DAY 3 DATE .....

MULTIDISCIPLINARY NOTES
Medical / Nursing / Allied Health Professionals

Code: D= Doctor, N= Nurse, PT= Physiotherapist, OT= Occupational Therapist, S= Speech & Lang, Ph= Pharmacist, SRD= Dietitian, SW= Social Worker, SN= Specialist Nurse, LN= Liaison Nurse

INTERVENTIONS		AM sign	PM sign	NIGHT sign	INTERVENTIONS	√ / x
NURSING					**PHYSIOTHERAPY**	
3P1	Pain controlled				Consent to treatment	
3P2	Orientated				Exercise programme continued	
3P3	Temperature apyrexial				Transfer practice continued	
3P4	BP recorded				Gait re education	
3P5	Wound dry				Rehabilitation potential discussed	
3P6	Continent				**OCCUPATIONAL THERAPY**	
3P7	Adequate fluids taken				Transfer assessment	
3P8	Adequate diet taken				Personal ADL assessment	
3P9	Fluid balanced				Heights form collected	
3P10	Medication as prescribed				**PHARMACY**	
3P11	Pressure areas (sacrum) Intact, colour				Prescription checked	
3P12	Pressure areas (heels) intact Review PSPS daily, colour				Drug therapy monitored	
3P13	Personal hygiene with assistance				**LIAISON NURSE**	
3P14	Bowels opened					
3P15	Review discharge plan					
3P16	Discontinue venaflow pump when mobile					

INITIALS	AM	PM	NIGHT	PT	OT	Ph	SRD

Ymddiriedolaeth GIG SIR BENFRO a DERWEN PEMBROKESHIRE & DERWEN NHS Trust

PATIENT PROPERTY DISCLAIMER FORM

Patient Details

Consultant/GP:

Patient Property Disclaimer Form

Ward / Area: ..... Date: .....

I (name) .....

of (address) .....

.....

understand that Pembrokeshire & Derwen NHS Trust cannot accept any responsibility for the loss or damage to items of property unless they are handed in for safekeeping, and an official receipt obtained. I understand that any property I decide not to hand in remains my responsibility, and the production of a receipt is required for recovery of any property held by the Trust.

I am the Patient ☐ Relative ☐ Carer ☐

Name (Print) .....

Signature: .....

Date: .....

Nurse Name (Print) .....

Nurse Signature .....

Patient Property Disclaimer Form

Ward / Area: ..... Date: .....

I (name) .....

of (address) .....

.....

understand that Pembrokeshire & Derwen NHS Trust cannot accept any responsibility for the loss or damage to items of property unless they are handed in for safekeeping, and an official receipt obtained. I understand that any property I decide not to hand in remains my responsibility, and the production of a receipt is required for recovery of any property held by the Trust.

I am the Patient ☐ Relative ☐ Carer ☐

Name (Print) .....

Signature: .....

Date: .....

Nurse Name (Print) .....

Nurse Signature .....

PATIENT PROPERTY DISCLAIMER FORM

Ymddiriedolaeth GIG SIR BENFRO a DERWEN PEMBROKESHIRE & DERWEN NHS Trust

WML9600 - Rev. 04-05

Patient Details

Consultant/GP:

To be re-used for FOUR admissions

Ymddiriedolaeth GIG SIR BENFRO a DERWEN PEMBROKESHIRE & DERWEN NHS Trust

PATIENT PROPERTY DISCLAIMER FORM

Patient Property Disclaimer Form

Ward / Area: ..... Date:.....

I (name) .....

of (address) .....

.....

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I am the Patient ☐ Relative ☐ Carer ☐

Name (Print) .....

Signature: .....

Date: .....

Nurse Name (Print) .....

Nurse Signature .....

Patient Property Disclaimer Form

Ward / Area: ..... Date:.....

I (name) .....

of (address) .....

.....

understand that Pembrokeshire & Derwen NHS Trust cannot accept any responsibility for the loss or damage to items of property unless they are handed in for safekeeping, and an official receipt obtained. I understand that any property I decide not to hand in remains my responsibility, and the production of a receipt is required for recovery of any property held by the Trust.

I am the Patient ☐ Relative ☐ Carer ☐

Name (Print) .....

Signature: .....

Date: .....

Nurse Name (Print) .....

Nurse Signature .....

Date	Code	Ongoing care, comments, interventions – all variances must be included with relevant code	Signature and Profession

Affix patient label here

POST-OP DAY 2 DATE .....

MULTIDISCIPLINARY NOTES
Medical / Nursing / Allied Health Professionals

Code: D= Doctor, N= Nurse, PT= Physiotherapist, OT= Occupational Therapist, S= Speech & Lang, Ph= Pharmacist, SRD= Dietitian, SW= Social Worker, SN= Specialist Nurse, LN= Liaison Nurse

INTERVENTIONS		AM sign	PM sign	NIGHT sign	INTERVENTIONS	√ / x
NURSING					**PHYSIOTHERAPY**	
2P1	Pain controlled				Consent to treatment	
2P2	Remove drains				Exercise programme continued	
2P3	Orientated				Transfer practice continued	
2P4	Temperature apyrexial				Gait re education commenced	
2P5	BP recorded				Rehabilitation potential discussed	
2P6	Check HB & U+E					
2P7	Wound dry				**OCCUPATIONAL THERAPY**	
2P8	Fluid balanced				Liaise with Physiotherapist	
2P9	Medication as prescribed				**PHARMACY**	
2P10	Pressure areas intact ? Colour (Sacrum, Heels)				Prescription checked	
2P11	Personal hygiene with assistance				Drug therapy monitored	
2P12	Bowels opened				**LIAISON NURSE**	
2P13	Rehabilitation planned Continue discharge plan					
2P14	Sub-cut cannulae removed					
2P15	Sat out of bed					
2P16	Taking some steps					

INITIALS	AM	PM	NIGHT	PT	OT	Ph	SRD

Ymddiriedolaeth GIG SIR BENFRO a DERWEN PEMBROKESHIRE & DERWEN NHS Trust

CARE PLAN / SHEET 3

Consultant/GP:

Continuation Page No.

Prescribed Action	Identified Problem	Desired Outcome	Date for Evaluation Sign	Date of Outcome Sign

Patient Details

Hosp. No:
Name:
Address:
Post Code:
Tel. No:
DOB:
NHS No:
Age:

Date	Prob No

Consultant/GP:

CARE PLAN / SHEET 3

WML 5535 Rev. 12/02

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CARE PLAN / SHEET 3

Date	Prob No	Identified Problem	Desired Outcome	Prescribed Action	Date for Evaluation Sign	Date of Outcome Sign

CARE PLAN / SHEET 3

WML 5535 Rev. 12/02

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PEMBROKESHIRE & DERWEN
NHS Trust

Date	Code	Ongoing care, comments, interventions – all variances must be included with relevant code	Signature and Profession

Affix patient label here

POST-OP DAY 1 **DATE .....**

MULTIDISCIPLINARY NOTES
Medical / Nursing / Allied Health Professionals
Code: D= Doctor, N= Nurse, PT= Physiotherapist, OT= Occupational Therapist, S= Speech & Lang, Ph= Pharmacist, SRD= Dietitian, SW= Social Worker, SN= Specialist Nurse, LN= Liaison Nurse

	INTERVENTIONS	AM sign	PM sign	NIGHT sign	INTERVENTIONS	√ / x
	NURSING				**PHYSIOTHERAPY**	
1P1	Pain controlled				Consent to treatment	
1P2	Order check x ray – not required for D.H.S.				Range of movement & quads	
1P3	CMS to affected limb				Transfers commenced	
1P4	Temperature apyrexial				Bed mobility encouraged	
1P5	BP recorded					
1P6	Wound dry				**OCCUPATIONAL THERAPY**	
1P7	Continue Venaflow & Asprin				Initial interview	
1P8	IVI removed				Height form given	
1P9	Catheter removed				**PHARMACY**	
1P10	Fluid balanced				Prescription checked	
1P11	Commence Alendronate 70mg once weekly				Drug therapy monitored	
1P12	Commence Calcichew D^3 forte BD				**DIETITIAN**	
1P13	Pressure areas intact ? Colour (Sacrum, Heels)				Admission noted	
1P14	Sat out of bed				**LIAISON NURSE**	
1P15	Personal hygiene with assistance					
1P16	Nutrition screening completed?					
1P17	Nutrition assessment completed if necessary?					
1P18	Rehabilitation Reviewed Plan discharge / transfer					
1P19	Bowels opened					

INITIALS	AM	PM	NIGHT	PT	OT	Ph	SRD

DVT Prophylaxis Guidelines for patients with Fractured Neck of Femur

Standard Prophylaxis

Venaflow + aspirin 150mg od x 35/7

If patient cannot tolerate aspirin or no venaflow available then Enoxaparin 40mg od x 10/7 + TEDs

High Risk Patient

Venaflow + Enoxaparin 40mg od x 10/7

SIGN guideline 62* defines as high risk a patient who has more than one of the following:-

>80 years
Obesity
Varicose Veins
Previous VTE
Heart failure
Recent MI or Stroke
Inflammatory bowel syndrome
Nephroticsyndrome
Polycythaemia
Paraproteinaemia
Bechets disease
Tamoxifen
Paralysis
Malignancy

Reference

* SIGN Guidelines

Agreed with Dr H Grubb (Consultant Haematologist)

Affix patient label here

ADMISSION PHASE **DATE ……**

Time of ward admission

	INTERVENTIONS	AM sign	PM sign	NIGHT sign	Additional info
	NURSING				
AP1	Pain controlled				
AP2	Assessments completed				
AP3	Observations completed				
AP4	Gutter in-situ to affected limb				
AP5	Plan of care discussed with patient and relatives				
AP6	Commence pneumatic venous compression (venaflow) to <u>both</u> limbs if not contraindicated and commence Asprin 150mg (soluble) AM				
AP7	Intravenous infusion commenced if indicated and accurate fluid balance				
AP8	Pre-operative paperwork completed				
AP9	Patient placed on appropriate mattress for PSPS score				

Seen by Initial:	Physiotherapist	Pharmacist	Trauma Liaison Nurse	

Date	Code	Ongoing care, comments, interventions – all variances must be included with relevant code	Signature and Profession

Affix patient label here

SAFF TARGET FOR LENGTH OF STAY = 6 DAYS

OPERATION DAY **DATE .....**

MULTIDISCIPLINARY NOTES
Medical / Nursing / Allied Health Professionals
Code: D= Doctor, N= Nurse, PT= Physiotherapist, OT= Occupational Therapist, S= Speech & Lang, Ph= Pharmacist, SRD= Dietitian, SW= Social Worker, SN= Specialist Nurse, LN= Liaison Nurse

INTERVENTIONS		AM sign	PM sign	NIGHT sign	Additional info
Pre-operative					
OP1	Consent form checked				
OP2	Pain controlled				
OP3	Patient to wear 'venaflow' to theatre				
OP4	IVI commenced				
OP5	Nil by mouth from				
OP6	Prepared for theatre				
OP7	Give usual medication				
Post-operative					
OP8	Handover from recovery				
OP9	Observations recorded				
OP10	Relatives informed				
OP11	IV ABS as prescribed				
OP12	Monitor progress if spinal anaesthetic used, inform Anaesthetist of delay of return of sensation				
OP13	Drainage recorded				
OP14	Pain controlled				
OP15	Discontinue gutter splint				
OP16	Wound dry: Check for - Haematoma - Haemorrhage				
OP17	Catheter care given				
OP18	Monitor colour, movement & sensation of affected limb				
OP19	Medication as prescribed				
OP20	Check cot sides in situ				
PHARMACY					
OP21	Drug history checked				
	Prescriptions checked				
	Drug therapy monitored				
	Supply ensured				

INITIALS	AM	PM	NIGHT	PT	OT	Ph	SRD

Assessment reminder	Fasting instructions	Observations
Pain score and outcome Nutritional screen Falls screen PSPS Moving and handling	**AM operations**: no food after 12 midnight, clear fluids until 06:30am **PM Operations**: light breakfast 07:00am, clear fluids until 10:30am ADMINISTER USUAL MEDICATIONS UNLESS ADVISED OTHERWISE	Temperature Blood pressure Pulse 0^2 saturation Respirations Urinalysis Blood sugar Bowels

Date	Code	Ongoing care comments, interventions – all variances must be included with relevant code	Signature and Profession

Affix patient label here

PRE-OP DAY **DATE .....**

MULTIDISCIPLINARY NOTES
Medical / Nursing / Allied Health Professionals

Code: D= Doctor, N= Nurse, PT= Physiotherapist, OT= Occupational Therapist, S= Speech & Lang, Ph= Pharmacist, SRD= Dietitian, SW= Social Worker, SN= Specialist Nurse, LN= Liaison Nurse

INTERVENTIONS		AM sign	PM sign	NIGHT sign	INTERVENTIONS	√ / x
NURSING					**PHYSIOTHERAPY**	
P1	Pain controlled					
P2	Orientated					
P3	Temperature apyrexial					
P4	BP recorded					
P5	Adequate fluid intake				**OCCUPATIONAL THERAPY**	
P6	Medication as prescribed					
P7	Pressure areas intact					
P8	Personal hygiene with assistance				**PHARMACY**	
P9	Bowels opened				Prescription checked	
P10	Rehabilitation planned				Drug therapy monitored	
P11	Reason for delay recorded					
P12	Health check list					
P13	Consent form completed and signed				**LIAISON NURSE**	

INITIALS	AM	PM	NIGHT	PT	OT	Ph	SRD

Date	Code	Ongoing care, comments, interventions – all variances must be included with relevant code	Signature and Profession