

Surname:  
Forename:  
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## **Assessment Proforma**

### **Orthopaedic Hip fracture Service**

Surname:  
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<b>Date:</b>	<b>Time:</b>
<b>Admitting Doctor:</b>	<b>Bleep:</b>
<b>Orthopaedic Consultant:</b>	
<b>Orthogeriatric Consultant:</b>	
<b>Presenting Complaint(s):</b>	
<b>History of Presenting Complaint</b>	
<p>History given by: Patient <input type="checkbox"/> Relative <input type="checkbox"/> Relationship _____</p> <p>Associated Injuries:</p> <p>Previous falls/ Collapses in past year: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes number of falls in last year _____</p> <p><b>Pre- Fall Symptoms:</b></p> <p><input type="checkbox"/> Clear history of trip/slip/accident</p> <p><input type="checkbox"/> SOB/ CP/ Palpitations</p> <p><input type="checkbox"/> Aura/ Fit/ Incontinence</p> <p><input type="checkbox"/> Dizzy/ Light-headed</p> <p><input type="checkbox"/> Loss of consciousness</p> <p><input type="checkbox"/> Other symptoms</p>	
<b>Past Medical</b>	<b>Details + Others:</b>
<input type="checkbox"/> Angina / MI <input type="checkbox"/> Anti-coagulation <input type="checkbox"/> Asthma/ COPD <input type="checkbox"/> Dementia <input type="checkbox"/> Diabetes <input type="checkbox"/> DVT/ PE <input type="checkbox"/> Epilepsy	<input type="checkbox"/> Heart Failure <input type="checkbox"/> Hypertension <input type="checkbox"/> Malignancy <input type="checkbox"/> Pacemaker <input type="checkbox"/> Parkinsons <input type="checkbox"/> PVD <input type="checkbox"/> Stroke/ TIA
<b>Past Surgical History</b>	

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<b>System Enquiries</b>			
CVS		Respiratory	
GI		Urinary	
CNS		MSK	
<b>Allergies</b>			
Drug History			
Medication	Dose	Medication	Dose
Note exact time of Parkinson's Medications. <b>Avoid Metoclopramide, Prochlorperazine Or Haloperidol.</b>			
<b>Social History</b>			
<b>Admitted From</b>		<b>Home Support</b>	<b>Mobility</b>
<input type="checkbox"/> Own Home <input type="checkbox"/> Own Bungalow <input type="checkbox"/> Sheltered accomodation <input type="checkbox"/> Residential home _____ <input type="checkbox"/> Nursing Home _____ <input type="checkbox"/> Hospital _____		<input type="checkbox"/> Lives alone <input type="checkbox"/> Lives with _____ <input type="checkbox"/> Lives with carer <input type="checkbox"/> Care Package <input type="checkbox"/> OD <input type="checkbox"/> BD <input type="checkbox"/> TDS <input type="checkbox"/> QDS	<input type="checkbox"/> Independent <input type="checkbox"/> Uses Aid <input type="checkbox"/> 1 stick <input type="checkbox"/> 2 sticks <input type="checkbox"/> Frame <input type="checkbox"/> 3 wheeled walker <input type="checkbox"/> 4 wheeled walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Housebound <input type="checkbox"/> Bedbound
<b>Additional Information</b>		<b>Other</b>	
		<b>Exercise Tolerance</b> <input type="checkbox"/> Few meters on flat <input type="checkbox"/> Unable to do stairs <input type="checkbox"/> To local shops <input type="checkbox"/> One flight of stairs <input type="checkbox"/> Two flights of stairs <input type="checkbox"/> unlimited <b>Car Driver</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Alcohol</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Units per week _____ <b>Smoker</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Pack Years _____	
<b>AMTS</b>		<b>Date</b>	<b>Date</b>
1. Age 2. Time to nearest Hr 3. DOB 4. Present Year 5. Name of Place 6. Address Recall 7. End of WWII 8. Current Monarch 9. Recognition x2 10. 20-1		<b>Pre-OP</b> ..... .....	<b>Post-OP</b> ..... .....
<b>Score out of 10</b>			



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<b>Fascia Iliaca Block</b>	
Date _____ Time _____	
Pre-Procedure Pain score: /10	
Verbal Consent <input type="checkbox"/> Pt unable to Consent <input type="checkbox"/>	
Cardiac Monitoring Yes <input type="checkbox"/> No <input type="checkbox"/> Unavailable <input type="checkbox"/>	
Procedure	
Aseptic Technique <input type="checkbox"/> Drugs Used _____	
Post- procedure pain score: /10	
Post- procedure cardiac ECG monitoring Y <input type="checkbox"/> N <input type="checkbox"/> Unavailable <input type="checkbox"/>	
Post-Procedure Observations: Pulse BP SpO2	

ASA Class	
I	Completely healthy
II	Mild systemic disease
III	Severe systemic disease – not incapacitating
IV	Incapacitating disease threatening life
V	Moribund – unlikely to survive +/- surgery

Nottingham Hip Fracture Score	Variable	Score
Age	66-85	3
	>=86	4
Sex	Male	1
Admission HB	<10g/L	1
Living in a home	Yes	1
No. of comorbidities	>=2	1
Admission AMTS	<6/10	1
Malignancy	Yes	1
<b>Total</b>		

Consented/Limb marked:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Discussed with NOK/relatives:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Requires further orthogeriatric/medical input prior to surgery:	Yes <input type="checkbox"/> No <input type="checkbox"/>



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**Trauma & Orthopaedics: Risk Assessment for Venous Thromboembolism (VTE)**

**Risk assessment is recommended for all patients on admission to hospital. It is recommended that all patients are periodically reassessed during inpatient stay as risk may change. Reassessment within 24 hours is recommended.**

**Trauma & Orthopaedic patients are at risk if:**

- If expected to have significant reduction in mobility
- If surgery includes any of the procedure/patient related risk factors (see overleaf)
- If any other VTE risk factor exists

**Step one:**

Review the patient-related factors shown on the assessment sheet against thrombosis risk, ticking each box that applies (more than one box can be ticked). Any tick for thrombosis risk should prompt thromboprophylaxis according to local policy. The risk factors identified are not exhaustive. Clinicians may consider additional risks in individual patients and offer thromboprophylaxis as appropriate.

**Step two:**

Review the patient-related factors shown against bleeding risk and tick each box that applies (more than one box can be ticked). Any tick for bleeding risk should prompt clinical staff to consider if bleeding risk is sufficient to preclude pharmacological intervention (Discuss with Seniors).

**Step three:**

If the form has been filled out correctly and no boxes are ticked, then the patient is at low risk of venous thrombo-embolism and no intervention is indicated

Patient measured for anti-embolism stockings (unless not suitable e.g. peripheral vascular disease, ulcers; limb size)      Yes     No     Not appropriate   
Size required:.....

Risk assessment for VTE undertaken on admission (based on NICE recommendations)

Yes       No

Signature ..... Print name ..... Date .....

Patient commenced on prophylactic treatment      Yes     No

If no please state reason for not prescribing  
.....  
.....

Written/verbal information given to patient on VTE information      Yes     No

Signature ..... Print name ..... Date .....

Risk assessment reviewed within 24hours.      Yes     No

Signature ..... Print name ..... Date .....

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**Trauma & Orthopaedics: Risk Assessment for Venous Thromboembolism (VTE)**

Upper Limb Surgery  if ticked, VTE typically not required except clinically indicated.

Lower Limb Surgery

Any tick in **thrombosis risk** columns, consider VTE prophylaxis and complete documentation on page overleaf.

<b>Thrombosis risk - Patient related</b>	√
Age >60yrs	
Previous pulmonary embolism or deep vein thrombosis	
Critical care admission	
Use of hormone replacement therapy	
Use of oestrogen-containing contraceptive therapy	
Known thrombophilias	
BMI >30kg/m <sup>2</sup>	
Active cancer/ chemotherapy treatment	
Period of prolonged immobility	
Travel > 4 hours in previous month	
Varicose veins with phlebitis/ Chronic leg oedema/ Leg ulceration	
One or more significant co-morbidities <b>Please circle</b> (e.g. heart disease, metabolic, endocrine or respiratory pathologies, acute infectious diseases, inflammatory conditions, CVA, Spinal cord injury)	
Plaster cast immobilisation of lower limb, with <b>1 or more</b> positive risk factors being <b>treated as outpatients</b> .	
<b>Thrombosis risk - Procedure related</b>	
Minor surgery lasting >45 minutes	
Major / Athroscopic surgery lasting >45 mins	
Elective hip/knee arthroplasty, hip/pelvic or leg fracture surgery, spinal cord injury, major trauma	

<b>Potential contra-indications: if any tick below, VTE prophylaxis may be inappropriate. Discuss with Seniors ± Haematologist</b>	
<b>Bleeding risk - Patient related</b>	√
Acquired bleeding disorders (such as acute liver failure)	
Concurrent use of anticoagulants (with INR > 2)	
Thrombocytopenia (platelet count < 75 x 10 <sup>9</sup> /l) Clotting Screen: APPT.....PT.....	
Acute stroke in previous month (haemorrhagic or ischaemic)	
Uncontrolled systolic hypertension (200/120 mmHg or higher)	
Severe liver disease (prothrombin time above normal or known varices)	
Active bleeding	
Untreated inherited bleeding disorders (e.g. haemophilia, Von Willebrands's Disease)	
Lumbar puncture/epidural/spinal anaesthesia within the previous 4 hours	
Recent neurosurgery, spinal surgery or eye surgery	
Other procedure with high bleeding risk	
Bleeding history (excessive bleeding post dental /post-operative)	
Known Peptic Ulcer disease; Concomitant antiplatelet drug therapy (Aspirin, NSAIDs, Clopidogrel)	
<b>Bleeding risk - Procedure related</b>	
Spinal surgery	

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**OrthoGeriatric review:**

**Seen by:**  
**Date:**  
**Time:**

Medical History:

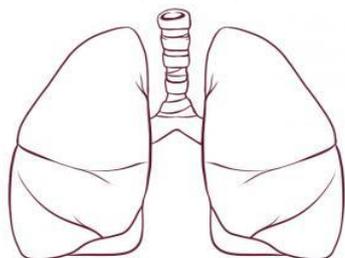
Current/Outstanding issues:

**Examination**

General Appearance:

Temp

**Cardio/Respiratory**

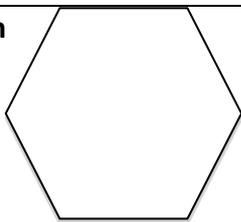


Pulse:  
 BP:

Resp rate:  
 Sats:

**Musculoskeletal:**

**Abdomen**



Catheter present No  Yes   
 If Yes short term ; Long-term ; Supra-pubic

**CNS:**

GCS: E    V    M    (Total=    )

**Peripheral pulses**

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<b>ECG:</b>		
<b>CXR:</b>		
<b>Other imaging:</b>		
<b>Bloods</b>	<b>Pre-admission ( _ / _ / _ )</b>	<b>Admission ( _ / _ / _ )</b>
Haemoglobin	.....	.....
MCV	.....	.....
WCC	.....	.....
Platelets	.....	.....
Na+	.....	.....
K+	.....	.....
Ca+	.....	.....
Urea	.....	.....
Creatinine	.....	.....
eGFR	.....	.....
Albumin	.....	.....
INR	.....	.....
PT/APTT	.....	.....
Glucose (RBG)	.....	.....

Falls risk assessment.....

Bone Health assessment.....

Plan/Recommendations:

- 1.
- 2.
- 3.
- 4.
- 5.

Outpatient Orthogeriatric review required	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Memory Clinic referral required	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Please advise patient/carer ± handover information leaflets		
“MK falls prevention service information”	Yes <input type="checkbox"/>	No <input type="checkbox"/>
“How to avoid falls”	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Please send off referral to Falls Service at discharge:	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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### Clinical Frailty Scale\*



**1 Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.



**2 Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.



**3 Managing Well** – People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.



**4 Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being “slowed up”, and/or being tired during the day.



**5 Mildly Frail** – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.



**6 Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.



**7 Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).



**8 Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.



**9. Terminally Ill** - Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise evidently frail**.

#### Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

\* 1. Canadian Study on Health & Aging, Revised 2008.  
 2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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Left Intentionally Blank

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## Care Pathway for Fractured Neck of Femur

### Orthopaedic Department

Admission	Date:	Time:
Admitting Ward		
Consultant		
Planned Discharge	Date:	
	Please tick if out of area <input type="checkbox"/>	
Resuscitation Status	DNAR in place? No <input type="checkbox"/> Yes <input type="checkbox"/>	
Allergies		

**Exclusion Criteria: Not suitable for patients undergoing another scheduled procedure / admitted with another emergency condition**

**This care pathway replaces all previous clinical documentation for nursing, allied health professionals and medical staff involved in patient care**

**If in your clinical judgement this pathway is not most appropriate for the patient, it may be suspended at any time and alternative documentation implemented**



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**Admission Day**

Date.....

Nursing	Initials	Time
Ward environment explained to patient / relatives		
Patient received broken hip information booklet with ward contact details		
Patient / relatives informed of theatre plan		
Consent		
Limb Marked		
Drug chart completed, including guideline analgesia		
Cannula sited / Fluid regime prescribed		
Admission Booklet Completed (including This Is Me" if appropriate)		
ECG		
Bloods taken for FBC / U&Es / Group and Save / Other _____		
Check glucose levels if required		
Thrombosis risk assessment completed		
TEDS applied		
MRSA swabs taken		
Assisted with hygiene needs		
Assisted with oral hygiene		
Passed urine _____ (time) ward urine test		
Bowel chart commenced		
Predicted Discharge Date _____		
Physiotherapy	Initials	Time
Chest Physiotherapy Yes / No / N/A*		

Shift (please initial per shift)	Early	Late	Night
Observations carried out as per NEWS policy (triggers documented as variance if applicable)			
Pain score documented on nNEWS			
Analgesia given as per guidelines (IV paracetamol pre-op)			
Nausea / Vomiting documented on NEWS			
V.I.P score up to date			
IVI in progress			
Fluid balance (input / output monitoring)			
Neurovascular status of affected limb intact			
Check traction if applied			
Pressure areas checked and intact			

Date/Time	MDT Communication Instructions / Variance	Signature



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**Pre-Operative Day One**

Date.....

Nursing	Initials	Time
NBM from Diet _____ Clear Fluids _____ (times)		
Assisted with hygiene / foot care / mouth care		
Anaesthetic assessment		
Routine medication as directed by anaesthetist		
Pre med prescribed Yes / No*		
Glucose levels recorded if required		
Consent form signed Yes / No* Limb marked Yes / No*		
Theatre checklist complete		
TEDS available Yes / No*		
Passing urine		
Sleeping needs met		

Shift (please initial per shift)	Early	Late	Night
Observations carried out as per NNEWS policy (triggers documented as variance if applicable)			
Pain score documented on NNEWS			
Analgesia given as per guidelines (IV paracetamol pre-op)			
Nausea / Vomiting documented on NNEWS			
VIP score up to date			
IVI in progress			
Fluid balance (input / output monitoring)			
Neurovascular status of affected limb intact			
Check traction if applied			
Pressure areas checked and intact			

Date/Time	MDT Communication Instructions / Variance	Signature
	Reason for delay in surgery: Patient and family informed? Yes / No*	



**Pre-operative Day Two**

Surname:  
Forename:  
DOB:  
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Date.....

Nursing	Initials	Time
NBM from Diet _____ Clear Fluids _____ (times)		
Assisted with hygiene / foot care / mouth care		
Anaesthetic assessment		
Routine medication as directed by anaesthetist		
Pre med prescribed Yes / No*		
Glucose levels recorded if required		
Consent form signed Yes / No* Limb marked Yes / No*		
Theatre checklist complete		
TEDS available Yes / No*		
Passing urine		
Sleeping needs met		

Shift (please initial per shift)	Early	Late	Night
Observations carried out as per NEWS policy (triggers documented as variance if applicable)			
Pain score documented on NEWS			
Analgesia given as per guidelines (IV paracetamol pre-op)			
Nausea / Vomiting documented on NEWS			
VIP score up to date			
IVI in progress			
Fluid balance (input / output monitoring)			
Neurovascular status of affected limb intact			
Check traction if applied			
Pressure areas checked and intact			

Date/Time	MDT Communication Instructions / Variance	Signature
	Patient and family informed? Yes / No* Reason for delay in surgery:	



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**Theatre Day Post Operative**  
Date.....

Nursing	Initials	Time
Received patient from recovery with report		
Post Op instructions:		
Weight bearing status NWB / TWB / PWB / FWB* ROS / Clips* ____ days		
Passing urine _____ (time) or already catheterised		
Oral fluids commenced and tolerated		
Light diet commenced and tolerated		
Assisted wash / mouth care		
Patient / Relatives informed or care plan		
Waterlow & M&H updated		
Physiotherapy	Initials	Time
Chest physiotherapy Yes / No / N/A*		

Shift (please initial per shift)	Early	Late	Night
Post op observations, NEWS trigger scores, variations documented (½ hourly for 2 hours, hourly for 2 hours, four hourly for 48 hours)			
Pain score documented on NEWS			
Analgesia given as per guidelines (IV paracetamol 24 hours post-op)			
Nausea / Vomiting documented on NEWS			
Neurovascular state of affected limb intact			
TEDS in situ			
Abduction wedge in situ (if applicable)			
Dressing clean / dry			
VIP Score updated			
IVI / Blood transfusion in situ as prescribed			
Maintain fluid balance (input / output monitoring)			
Pressure areas checked and intact			



**Post Operative Day One**  
Date.....

Surname:  
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Medical	Initials	Time
Patient assessed		
Check X-ray ordered		
Check bloods ordered (FBC, U&E's)		
Analgesia reviewed		
Nursing	Initials	Time
Assisted with hygiene / foot care (including removal of TEDS) / mouth care		
Patient assisted to dress		
Assessed fluid balance and need for IVI / blood transfusion		
Passing urine in good volume		
Adequate diet and fluids tolerated (if not, commence food chart)		
Bowels open Yes / No*		
Laxatives given Yes / No*		
Wound check at 24 hours (if not indicated earlier)		
If unwell, commence appropriate care plans		
Sleeping needs met		
Fluid balance totalled at midnight		
SPA / Social worker referral made Yes / No / N/A*		
Physiotherapist	Initials	Time
Check chest & circulatory exercises		
Check Quad / Glut control		
Check foot drop / hip precautions		
Commence flexion / abduction exercises, assisted / active		
Transfer bed to chair with _____ assistance of _____		
Mobilising with _____ Distance _____		
Occupational Therapy	Initials	Time
Initial interview complete		
Issue height sheet and hip booklet		

Shift (please initial per shift)	Early	Late	Night
Observations carried out as per NNEWS policy (triggers documented as variance if applicable) (four hourly for 48 hours post-op)			
Lying and Standing BP's			
Pain score documented on NNEWS			
Analgesia given as per guidelines (IV paracetamol 48 hours post op)			
Nausea / Vomiting documented on NNEWS			
VIP score up to date			
IVI if clinically indicated / Maintain fluid balance (input / output monitoring)			
Neurovascular state of affected limb intact			
Dressing clean			
Pressure areas checked and intact			







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**Post Operative Day Two**  
Date.....

Medical	Initials	Time
Patient assessed		
Check X-ray ordered		
Check bloods ordered (FBC, U&E's)		
Analgesia reviewed		
Nursing	Initials	Time
Assisted with hygiene / foot care (including removal of TEDS) / mouth care		
Patient assisted to dress		
Assessed fluid balance and need for IVI / blood transfusion		
Passing urine in good volume		
TWOC (if applicable)		
Adequate diet and fluids tolerated (if not, commence food chart)		
Bowels open Yes / No*		
Laxatives given Yes / No*		
Wound check at 24 hours (if not indicated earlier)		
If unwell, commence appropriate care plans		
Sleeping needs met		
Fluids balance totalled at midnight		
SPA / Social worker referral made Yes / No / N/A*		
Physiotherapist	Initials	Time
Check chest & circulatory exercises		
Check Quad / Glut control		
Check foot drop / hip precautions		
Commence flexion / abduction exercises, assisted / active		
Transfer bed to chair with _____ assistance of _____		
Mobilising with _____ Distance _____		

Shift (please initial per shift)	Early	Late	Night
Observations carried out as per NEWS policy (triggers documented as variance if applicable) (four hourly for 48 hours post-op)			
Lying and Standing BP's			
Pain score documented on NEWS			
Analgesia given as per guidelines			
Nausea / Vomiting documented on NEWS			
VIP score updated			
IVI if clinically indicated / Maintain fluid balance (input / output monitoring)			
Neurovascular state of affected limb intact			
Dressing clean / dry			
Pressure areas checked and intact			







**Post Operative Day Three**

Date.....

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Medical	Initials	Time
Patient assessed Medically fit for discharge Yes / No*		
Check X-ray Yes / No* Check Bloods Yes / No*		
Pain control assessed and analgesia reviewed		
Nursing	Initials	Time
Encouraged independence with hygiene / dressing / mouth care		
Patient assisted with foot care (including removal of TEDS)		
Passing urine in good volume		
TWOC (if applicable)		
Adequate diet and fluids tolerated (if not, commence food chart)		
Bowels open Yes / No*		
Laxatives given Yes / No*		
Nursing Risk Assessments up to date		
Physiotherapist	Initials	Time
Transfer bed to chair with _____ assistance of _____		
Mobilising with _____ Distance _____		
Occupational Therapy	Initials	Time
Bed Transfer Independent / Requires Practice*		
Chair Transfer Independent / Requires Practice*		
Toilet Transfer Independent / Requires Practice*		
Washing and Dressing Assessment Yes / No / N/A*		
Kitchen Assessment Yes / No / N/A*		

Shift (please initial per shift)	Early	Late	Night
Observations carried out as per NEWS policy (triggers documented as variance if applicable)			
Lying and Standing BP's			
Pain score documented on NEWS			
Analgesia given as per guidelines			
Maintain fluid balance			
Neurovascular state of affected limb / Reinforce hip precautions			
Dressing clean / dry			
Walking practice/Transferring practice			
Pressure areas checked and intact			







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**Post Operative Day Four**

Date.....

Medical	Initials	Time
Patient assessed Medically fit for discharge Yes / No*		
Check X-ray Yes / No* Check Bloods Yes / No*		
Pain control assessed and analgesia reviewed		
Discharge Summary / TTO's commenced Yes / No / N/A*		
Nursing	Initials	Time
Encouraged independence with hygiene / dressing / mouth care		
Patient assisted with foot care (including removal of TEDS)		
Adequate diet and fluids tolerated (if not, commence food chart)		
TWOC (if applicable)		
Bowels open Yes / No*		
Laxatives given Yes / No*		
Social Worker referral made Yes / No / N/A*		
Nursing Risk Assessments up to date		
Physiotherapist	Initials	Time
Transfer bed to chair with _____ assistance of _____		
Mobilising with _____ Distance _____		
Occupational Therapy	Initials	Time
Bed Transfer Independent / Requires Practice*		
Chair Transfer Independent / Requires Practice*		
Toilet Transfer Independent / Requires Practice*		
Washing and Dressing Assessment Yes / No / N/A*		
Kitchen Assessment Yes / No / N/A *		

Shift (please initial per shift)	Early	Late	Night
Observations carried out as per NEWS policy (triggers documented as variance if applicable)			
Pain score documented on NEWS			
Analgesia given as per guidelines			
Maintain fluid balance (input / output monitoring)			
Neurovascular state of affected limb / Reinforce hip precautions			
Dressing clean / dry			
Walking practice/Transferring practice			
Pressure areas checked and intact			







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**Post Operative Day Five**

Date.....

Medical	Initials	Time
Patient assessed      Medically fit for discharge Yes / No*		
Pain control assessed and analgesia reviewed		
Post-Operative AMT Score documented in pro forma		
Discharge Summary / TTO's commenced    Yes / No / N/A*		
Nursing	Initials	Time
Encouraged independence with hygiene / dressing / mouth care		
Patient assisted with foot care (including removal of TEDS)		
Adequate diet and fluids tolerated (if not, commence food chart)		
TWOC (if applicable)		
Bowels open Yes / No*		
Laxatives given Yes / No*		
Nursing Risk Assessments up to date		
Physiotherapist	Initials	Time
Transfer bed to chair with _____ assistance of _____		
Mobilising with _____ Distance _____		
Occupational Therapy	Initials	Time
Bed Transfer      Independent / Requires Practice*		
Chair Transfer      Independent / Requires Practice*		
Toilet Transfer      Independent / Requires Practice*		
Washing and Dressing Assessment Yes / No / N/A*		
Kitchen Assessment Yes / No / N/A*		

Shift (please initial per shift)	Early	Late	Night
Observations carried out as per NEWS policy (triggers documented as variance if applicable)			
Pain score documented on NEWS			
Analgesia given as per guidelines			
Maintain fluid balance (input / output monitoring)			
Neurovascular state of affected limb / Reinforce hip precautions			
Dressing clean / dry			
Walking practice/Transferring practice			
Pressure areas checked and intact			







Surname:  
Forename:  
DOB:  
Hospital No:  
Or affix Patient Label

**Post Operative Day Six**

Date.....

Medical	Initials	Time
Patient assessed Medically fit for discharge Yes / No*		
Pain control assessed and analgesia reviewed		
Post-Operative AMT Score documented in pro forma		
Discharge Summary / TTO's commenced Yes / No / N/A*		
Nursing	Initials	Time
Encouraged independence with hygiene / dressing / mouth care		
Patient assisted with foot care (including removal of TEDS)		
Adequate diet and fluids tolerated (if not, commence food chart)		
TWOC (if applicable)		
Bowels open Yes / No*		
Laxatives given Yes / No*		
Nursing Risk Assessments up to date		
Physiotherapist	Initials	Time
Transfer bed to chair with _____ assistance of _____		
Mobilising with _____ Distance _____		
Occupational Therapy	Initials	Time
Bed Transfer Independent / Requires Practice*		
Chair Transfer Independent / Requires Practice*		
Toilet Transfer Independent / Requires Practice*		
Washing and Dressing Assessment Yes / No / N/A*		
Kitchen Assessment Yes / No / N/A*		

Shift (please initial per shift)	Early	Late	Night
Observations carried out as per NEWS policy (triggers documented as variance if applicable)			
Pain score documented on NEWS			
Analgesia given as per guidelines			
Maintain fluid balance (input / output monitoring)			
Neurovascular state of affected limb / Reinforce hip precautions			
Dressing clean / dry			
Walking practice/Transferring practice			
Pressure areas checked and intact			







Surname:  
Forename:  
DOB:  
Hospital No:  
Or affix Patient Label

**Post Operative Day Seven**

Date.....

Medical	Initials	Time
Patient assessed      Medically fit for discharge Yes / No*		
Pain control assessed and analgesia reviewed		
Post-Operative AMT Score documented in pro forma		
Discharge Summary / TTO's commenced    Yes / No / N/A*		
Nursing	Initials	Time
Encouraged independence with hygiene / dressing / mouth care		
Patient assisted with foot care (including removal of TEDS)		
Adequate diet and fluids tolerated (if not, commence food chart)		
TWOC (if applicable)		
Bowels open Yes / No*		
Laxatives given Yes / No*		
Nursing Risk Assessments up to date		
Physiotherapist	Initials	Time
Transfer bed to chair with _____ assistance of _____		
Mobilising with _____ Distance _____		
Occupational Therapy	Initials	Time
Bed Transfer      Independent / Requires Practice*		
Chair Transfer      Independent / Requires Practice*		
Toilet Transfer      Independent / Requires Practice*		
Washing and Dressing Assessment Yes / No / N/A*		
Kitchen Assessment Yes / No / N/A*		

Shift (please initial per shift)	Early	Late	Night
Observations carried out as per NEWS policy (triggers documented as variance if applicable)			
Pain score documented on NEWS			
Analgesia given as per guidelines			
Neurovascular state of affected limb / Reinforce hip precautions			
Dressing clean / dry			
Walking practice/Transferring practice			
Pressure areas checked and intact			







**Post Operative Day Eight**

Date.....

Surname:  
Forename:  
DOB:  
Hospital No:  
Or affix Patient Label

Medical	Initials	Time
Patient assessed      Medically fit for discharge Yes / No*		
Pain control assessed and analgesia reviewed		
Post-Operative AMT Score documented in pro forma		
Discharge Summary / TTO's commenced    Yes / No / N/A*		
Nursing	Initials	Time
Encouraged independence with hygiene / dressing / mouth care		
Patient assisted with foot care (including removal of TEDS)		
Adequate diet and fluids tolerated		
Bowels open Yes / No*		
Laxatives given Yes / No*		
Nursing Risk Assessments up to date		
Physiotherapist	Initials	Time
Transfer bed to chair with _____ assistance of _____		
Mobilising with _____ Distance _____		
Occupational Therapy	Initials	Time
Bed Transfer      Independent / Requires Practice*		
Chair Transfer    Independent / Requires Practice*		
Toilet Transfer   Independent / Requires Practice*		
Washing and Dressing Assessment Yes / No / N/A*		
Kitchen Assessment Yes / No / N/A*		

Shift (please initial per shift)	Early	Late	Night
Observations carried out as per NEWS policy (triggers documented as variance if applicable)			
Pain score documented on NEWS			
Analgesia given as per guidelines			
Neurovascular state of affected limb / Reinforce hip precautions			
Dressing clean / dry			
Walking practice/Transferring practice			
Pressure areas checked and intact			



Surname:  
 Forename:  
 DOB:  
 Hospital No:  
 Or affix Patient Label

**Post Operative Day Nine**

**Date.....**

Medical	Initials	Time
Patient assessed      Medically fit for discharge Yes / No*		
Pain control assessed and analgesia reviewed		
Post-Operative AMT Score documented in pro forma		
Discharge Summary / TTO's commenced    Yes / No / N/A*		
Nursing	Initials	Time
Encouraged independence with hygiene / dressing / mouth care		
Patient assisted with foot care (including removal of TEDS)		
Adequate diet and fluids tolerated		
Bowels open Yes / No*		
Laxatives given Yes / No*		
Nursing Risk Assessments up to date		
Physiotherapist	Initials	Time
Transfer bed to chair with _____ assistance of _____		
Mobilising with _____ Distance _____		
Occupational Therapy	Initials	Time
Bed Transfer      Independent / Requires Practice*		
Chair Transfer    Independent / Requires Practice*		
Toilet Transfer    Independent / Requires Practice*		
Washing and Dressing Assessment Yes / No / N/A*		
Kitchen Assessment Yes / No / N/A*		

Shift (please initial per shift)	Early	Late	Night
Observations carried out as per NEWS policy (triggers documented as variance if applicable)			
Pain score documented on NEWS			
Analgesia given as per guidelines			
Neurovascular state of affected limb / Reinforce hip precautions			
Dressing clean / dry			
Walking practice/Transferring practice			
Pressure areas checked and intact			



Surname:  
 Forename:  
 DOB:  
 Hospital No:  
 Or affix Patient Label

**Post Operative Day Ten**

Date.....

Medical	Initials	Time
Patient assessed Medically fit for discharge Yes / No*		
Pain control assessed and analgesia reviewed		
Post-Operative AMT Score documented in pro forma		
Discharge Summary / TTO's commenced Yes / No / N/A*		
Nursing	Initials	Time
Encouraged independence with hygiene / dressing / mouth care		
Patient assisted with foot care (including removal of TEDS)		
Adequate diet and fluids tolerated		
Bowels open Yes / No*		
Laxatives given Yes / No*		
Nursing Risk Assessments up to date		
Clips / sutures* removed (if appropriate)		
Physiotherapist	Initials	Time
Transfer bed to chair with _____ assistance of _____		
Mobilising with _____ Distance _____		
Occupational Therapy	Initials	Time
Bed Transfer Independent / Requires Practice*		
Chair Transfer Independent / Requires Practice*		
Toilet Transfer Independent / Requires Practice*		
Washing and Dressing Assessment Yes / No / N/A*		
Kitchen Assessment Yes / No / N/A*		

Shift (please initial per shift)	Early	Late	Night
Observations carried out as per NEWS policy (triggers documented as variance if applicable)			
Pain score documented on NEWS			
Analgesia given as per guidelines			
Neurovascular state of affected limb / Reinforce hip precautions			
Dressing clean / dry			
Walking practice/Transferring practice			
Pressure areas checked and intact			



Surname:  
Forename:  
DOB:  
Hospital No:  
Or affix Patient Label

**Post Operative Day Eleven**

Date.....

Medical	Initials	Time
Patient assessed Medically fit for discharge Yes / No*		
Pain control assessed and analgesia reviewed		
Post-Operative AMT Score documented in pro forma		
Discharge Summary / TTO's commenced Yes / No / N/A*		
Nursing	Initials	Time
Encouraged independence with hygiene / dressing / mouth care		
Patient assisted with foot care (including removal of TEDS)		
Adequate diet and fluids tolerated		
Bowels open Yes / No*		
Laxatives given Yes / No*		
Nursing Risk Assessments up to date		
Clips / sutures* removed (if appropriate)		
Physiotherapist	Initials	Time
Transfer bed to chair with _____ assistance of _____		
Mobilising with _____ Distance _____		
Occupational Therapy	Initials	Time
Bed Transfer Independent / Requires Practice*		
Chair Transfer Independent / Requires Practice*		
Toilet Transfer Independent / Requires Practice*		
Washing and Dressing Assessment Yes / No / N/A*		
Kitchen Assessment Yes / No / N/A*		

Shift (please initial per shift)	Early	Late	Night
Observations carried out as per NEWS policy (triggers documented as variance if applicable)			
Pain score documented on NEWS			
Analgesia given as per guidelines			
Neurovascular state of affected limb / Reinforce hip precautions			
Dressing clean / dry			
Walking practice/Transferring practice			
Pressure areas checked and intact			



Surname:  
 Forename:  
 DOB:  
 Hospital No:  
 Or affix Patient Label

**Post Operative Day Twelve**

Date.....

Medical	Initials	Time
Patient assessed      Medically fit for discharge Yes / No*		
Pain control assessed and analgesia reviewed		
Post-Operative AMT Score documented in pro forma		
Discharge Summary / TTO's commenced    Yes / No / N/A*		
Nursing	Initials	Time
Encourage independence with hygiene / dressing / mouth care		
Patient assisted with foot care (including removal of TEDS)		
Adequate diet and fluids tolerated		
Bowels open Yes / No*		
Laxatives given Yes / No*		
Nursing Risk Assessments up to date		
Clips / sutures* removed (if appropriate)		
Physiotherapist	Initials	Time
Transfer bed to chair with _____ assistance of _____		
Mobilising with _____ Distance _____		
Occupational Therapy		
Bed Transfer      Independent / Requires Practice*		
Chair Transfer      Independent / Requires Practice*		
Toilet Transfer      Independent / Requires Practice*		
Washing and Dressing Assessment Yes / No / N/A*		
Kitchen Assessment Yes / No / N/A*		

Shift (please initial per shift)	Early	Late	Night
Observations carried out as per NEWS policy (triggers documented as variance if applicable)			
Pain score documented on NEWS			
Analgesia given as per guidelines			
Neurovascular state of affected limb / Reinforce hip precautions			
Dressing clean / dry			
Walking practice /Transferring practice			
Pressure areas checked and intact			



**Post Operative Day Thirteen**

Date.....

Surname:  
Forename:  
DOB:  
Hospital No:  
Or affix Patient Label

Medical	Initials	Time
Patient assessed      Medically fit for discharge Yes / No*		
Pain control assessed and analgesia reviewed		
Post-Operative AMT Score documented in pro forma		
Discharge Summary / TTO's commenced    Yes / No / N/A*		
Nursing	Initials	Time
Encouraged independence with hygiene / dressing / mouth care		
Patient assisted with foot care (including removal of TEDS)		
Adequate diet and fluids tolerated		
Bowels open Yes / No*		
Laxatives given Yes / No*		
Nursing Risk Assessments up to date		
Clips / sutures* removed (if appropriate)		
Physiotherapist	Initials	Time
Transfer bed to chair with _____ assistance of _____		
Mobilising with _____ Distance _____		
Occupational Therapy	Initials	Time
Bed Transfer      Independent / Requires Practice*		
Chair Transfer      Independent / Requires Practice*		
Toilet Transfer      Independent / Requires Practice*		
Washing and Dressing Assessment Yes / No / N/A*		
Kitchen Assessment Yes / No / N/A*		

Shift (please initial per shift)	Early	Late	Night
Observations carried out as per NEWS policy (triggers documented as variance if applicable)			
Pain score documented on NEWS			
Analgesia given as per guidelines			
Neurovascular state of affected limb / Reinforce hip precautions			
Dressing clean / dry			
Walking practice /Transferring practice			
Pressure areas checked and intact			



**Post Operative Day Fourteen**

Date.....

Surname:  
Forename:  
DOB:  
Hospital No:  
Or affix Patient Label

Medical	Initials	Time
Patient assessed Medically fit for discharge Yes / No*		
Pain control assessed and analgesia reviewed		
Post-Operative AMT Score documented in pro forma		
Discharge Summary / TTO's commenced Yes / No / N/A*		
Nursing	Initials	Time
Encouraged independence with hygiene / dressing / mouth care		
Patient assisted with foot care (including removal of TEDS)		
Adequate diet and fluids tolerated		
Bowels open Yes / No*		
Laxatives given Yes / No*		
Nursing Risk Assessments up to date		
Clips / sutures* removed (if appropriate)		
Physiotherapist	Initials	Time
Transfer bed to chair with _____ assistance of _____		
Mobilising with _____ Distance _____		
Occupational Therapy	Initials	Time
Bed Transfer Independent / Requires Practice*		
Chair Transfer Independent / Requires Practice*		
Toilet Transfer Independent / Requires Practice*		
Washing and Dressing Assessment Yes / No / N/A*		
Kitchen Assessment Yes / No / N/A*		

Shift (please initial per shift)	Early	Late	Night
Observations carried out as per NEWS policy (triggers documented as variance if applicable)			
Pain score documented on NEWS			
Analgesia given as per guidelines			
Neurovascular state of affected limb / Reinforce hip precautions			
Dressing clean / dry			
Walking practice /Transferring practice			
Pressure areas checked and intact			



Surname:  
Forename:  
DOB:  
Hospital No:  
Or affix Patient Label

**Physiotherapy**

Date set	Short Term Goals	Date achieved	Signature

Date	Long Term Goals	Signature

Discharge Checklist	Signature
Mobility _____	
Walking Aid _____ Issued <input type="checkbox"/>	
Step Assessment Completed Yes / No / N/A	
Stair Assessment Completed Yes / No / N/A	
Referral Completed <input type="checkbox"/> Sent to _____	
Falls: Referral Completed Yes / N/A Outcome Measure _____	
<b>Discharged from physiotherapy</b> Date _____	

Date	Further progress notes e.g. if picked up again after discharge	Signature

Surname:  
 Forename:  
 DOB:  
 Hospital No:  
 Or affix Patient Label

**Occupational Therapy**

**Furniture Heights and Measurements**

<b>Bed</b>	
<b>Chair</b>	
<b>Toilet</b>	
<b>Heel-Knee Length</b>	

<b>Equipment Required</b>	<b>Date ordered</b>	<b>Due for delivery</b>

**Access Visit Outcome (if required)**


**Discharged from Occupational Therapy Date \_\_\_\_\_ Signed:**

<b>Date</b>	<b>Further progress notes e.g. if picked up again after discharge</b>	<b>Signature</b>

Surname:  
Forename:  
DOB:  
Hospital No:  
Or affix Patient Label

### MDT Meetings Documentation

MDT Meetings are held on Mondays and Thursdays at 10:30am

<b>In attendance (please tick):</b>		<b>Date:</b>	
D/C Co-ordinator		Ortho-geriatrician	
Physiotherapist		Occupational Therapist	
Nurse		Fragility ANP	
Other _____		Other _____	
<b>Communication:</b>			
<b>Outstanding Assessments / Referrals (please tick):</b>			
SPA		Social Work	
Rehabilitation (Community)		Phoenix Ward	
Medical Report		Physiotherapist Report	
OT Report		Nursing Assessment	
CHC		Other _____	

<b>In attendance (please tick):</b>		<b>Date:</b>	
D/C Co-ordinator		Ortho-geriatrician	
Physiotherapist		Occupational Therapist	
Nurse		Fragility ANP	
Other _____		Other _____	
<b>Communication:</b>			
<b>Outstanding Assessments / Referrals (please tick):</b>			
RAHT / RAHT/ Nil		Social Work	
Rehabilitation (Community)		Phoenix Ward	
Medical Report		Physiotherapist Report	
OT Report		Nursing Assessment	
CHC		Other _____	