SPTAR MATER DEI

Date _____

Time _____

Name & Surname: _____

Address: _____

_____

ID card no: _____
*(If possible, affix label)*

# The Emergency Department Hip Fracture Documentation Form

The following are the **inclusion** and **exclusion** criteria for the Hip Fracture Fast Track.

If the patient satisfies **all** criteria, they will be fast tracked to the ward.

***If any exclusion criteria are identified, a doctor will be assigned to the patient for a detailed assessment.***

**Inclusion criteria - ALL MUST BE present (should all be 'yes'):**

| | Yes | No |
|---|---|---|
| • an individual over 16 years who has sustained a fall *(and)* | ☐ | ☐ |
| • has pain in the upper thigh and groin area *(and)* | ☐ | ☐ |
| • is unable to bear weight since the fall *(and)* | ☐ | ☐ |
| • Has sustained a fracture at the neck of the femur only (i.e. intracapsular or pertrochanteric fracture). | ☐ | ☐ |

**Exclusion criteria – ALL MUST NOT BE present (should all be 'no'):**

| | Yes | No |
|---|---|---|
| • involved in a road traffic accident (or) | ☐ | ☐ |
| • fall from height greater than 1 meter (or) | ☐ | ☐ |
| • assault (or) | ☐ | ☐ |
| • has additional injuries to other limbs, chest, abdomen or head (or) | ☐ | ☐ |
| • has an underlying acute medical condition such as hypoglycaemia, hypothermia, shortness of breath, delirium (or) | ☐ | ☐ |
| • had an episode of loss of consciousness with inability to recall what happened (or) | ☐ | ☐ |
| • has any abnormal parameters (or) | ☐ | ☐ |
| • has other femoral fractures such as femoral shaft, subtrochanteric, pubic rami or acetabular fractures | ☐ | ☐ |

**The Lead Doctor should be immediately informed if any exclusion criteria are identified.**

**Drug History**

Allergies: ☐ No known drug allergies ☐ Yes

If yes, please specify name of drug/drugs:

_____

**Is the patient on the following medications?** *(Circle as appropriate)*

On anticoagulants (warfarin, rivaroxaban, apixaban, dabigatran) Yes No

On antiplatelets (aspirin, clopidogrel, dipyridamole, ticagrelor) Yes No

**Past Medical History** ***(tick as appropriate)***

Epilepsy ☐ IHD ☐ Diabetes ☐ Asthma/COPD ☐

CVA ☐ Hypertension ☐ Atrial fibrillation ☐ CHF ☐

Other: _____

**Initial Parameters:**

Respiratory rate: _____breaths/min SpO2 on air: _____%

Pulse: _____bpm Blood pressure: _____mmHg

AVPU: _____ HGT: _____mmol/L

T: _____ $^{o}$C

**If the patient requires additional parameters, these should be documented on the Nursing Red Sheet**

**Pressure area care:**

Inspect the pressure areas and document findings on the Nursing Red Sheet.

Please follow the departmental guideline for administering pain relief in ED.

***NSAIDs should be omitted to patients eligible for hip fracture fast track***

**PATIENT LABEL**

**Allergies:**

**Pain relief taken at home: Yes ☐ No ☐**

**Name of drug:_____ Time:_____ Dose:_____**

**Patient refusing analgesia offered: Yes ☐ No ☐**

**Significant medical conditions:**

**INITIAL PAIN SCORE:_____ TIME:_____ INITIALS:_____**

**PARAMETERS: TIME:_____ BP:_____ HR:_____ RR:_____ SP02:_____**

**PAIN SCORE 1-3 PARAMETERS: TIME:_____BP:_____ HR:_____RR:_____SP02:_____**

**Non-pharmacological: Time:_____ Initials:_____**

**Paracetamol 1g PO/PR: Time:_____ Initials:_____**

**Reassess after 30 mins**

**PAIN SCORE 4-6 PARAMETERS: TIME:_____BP:_____ HR:_____RR:_____SP02:_____**

**Non-Pharmacological: Time:_____ Initials:_____**

**Paracetamol 1g PO/PR Time:_____ Initials:_____**

**Codeine 30mg PO Time:_____ Initials:_____**

**Reassess after 30 mins**

**PAIN SCORE 7-10 PARAMETERS: TIME:_____BP:_____ HR:_____RR:_____SP02:_____**

**ED Physician: Time:_____ Name:_____**

**Paracetamol 1g PR/IV Time:_____ Initials:_____**

**Morphine IV: Time:_____ Initials:_____**

**Morphine IV: Time:_____ Initials:_____**

**Morphine IV: Time:_____ Initials:_____**

**Morphine IV: Time:_____ Initials:_____**

**Morphine IV: Time:_____ Initials:_____**

**Reassess after 30 mins**

**PARAMETERS: TIME:_____BP:_____ HR:_____RR:_____SP02:_____**

**Delirium screening:**

4AT Rapid Clinical Test for Delirium: *(Circle score as appropriate)*

1. Alertness:
    - Normal (fully alert, but not agitated, throughout assessment) - 0
    - Mild sleepiness for <10 seconds after waking, then normal - 0
    - Clearly abnormal - 4

2. AMT4 – Ask age, date of birth, place (name of the hospital or building), current year
    - No mistakes - 0
    - 1 mistake - 1
    - 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:
    - Achieves 7 months or more correctly - 0
    - Starts but scores <7 months/refuses to start - 1
    - Untestable (cannot start because unwell, drowsy, inattentive) - 2

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 24 hours.
    - No - 0
    - Yes – 4

**4AT Score**: _____

4 or above: possible delirium +/- cognitive impairment

1-3: possible cognitive impairment

0: delirium or severe cognitive impairment unlikely (but delirium still possible if [4] information above is incomplete)

If the patient has a 4AT score of 4 or more, inform the caring ED doctor

**Investigations:**

1. **I.V. Access & Bloods**

Cannula gauge: _____G; Site: _____

Take the following blood tests:

CBC ☐; Renal function ☐; APTT/INR ☐; X-match (2 units in reserve) ☐; VBG ☐

2. **Electrocardiogram** ☐

3. **Radiography**

AP Pelvis + lateral hip + CXR ☐

Was a CT pelvis necessary? Yes ☐ No ☐

4. **Are other investigations required as directed by caring doctor**? Yes ☐ No ☐

If yes, document the tests below

_____

_____

**ED Nurse Name & Surname** (in blocks): _____

**Signature**: _____

**Doctors Documentation Form**

Has a fascia iliaca block been performed: Yes ☐ No ☐

**If yes, please refer to attached fascia iliaca block form**

Is the patient eligible for fast tracking? Yes ☐ No ☐

If no, assign team doctor to further manage the patient.

If yes, continue below.

Have the following been reviewed?
VBG ☐

ECG ☐

Do radiological investigations confirm the presence of a hip fracture? Yes ☐ No ☐

Intracapsular ☐ Pertrochanteric ☐

**Name & Surname** *(in blocks):*

_____

**Signature and Reg No**: _____

Orthopaedics BST/HST informed:

**Name & Surname** *(in blocks)*: _____

**Time**: _____ **Pager No**: _____

**Admission Plan:**

Admit under the care of the consultant orthopaedic surgeon on call

**Nil by mouth** ☐ No ☐ Yes – from _____*(insert time)*

**Parameter charting** (RR, SpO2, P, BP, T, HGT) _____ *(state frequency)*

**Maintenance IV fluids** _____ *(state fluid type and rate)*

**Analgesia** _____

_____

*(state name of drug/s, dose/s and frequency of administration)*

**Initiate standard pressure area care**

**Monitor for delirium**

**Treatment as per chart**

**Review by orthopaedic HST/BST in ward**

Hand over given to _____ (*name of doctor)*

ED doctor assigned to the patient:

**Name & Surname** *(in blocks)*: _____

**Signature and Reg No**: _____

This is to be filled in by the caring doctor only if the patient is being fast-tracked to the ward: