



Grey Bruce Health Network

FRACTURED HIP CLINICAL PATHWAY

SITE: GBHS-Owen Sound

PATIENT ID _____

COMORBID CONDITIONS: diabetes, obesity

| PROCESS | PHASE 1 (0-3 Days) WAITING FOR SURGERY | DATE <i>30-04-06</i> | | | DATE <i>01-05-06</i> | | | DATE | | |
|---|---|-------------------------|------------|-----------|-------------------------|--|--|------|--|--|
| | | D | E | N | D | | | | | |
| CERNER ORDER | FRACTURED HIP PATHWAY | <i>gm</i> | | | | | | | | |
| ASSESSMENT (OBSERVATIONS/ MEASUREMENTS/ ELIMINATION) | VITAL SIGNS WITH O ₂ SATS Q4H UNTIL STABLE THEN ACCORDING TO UNIT PROTOCOL | <i>gm</i> | <i>Dy</i> | <i>AB</i> | <i>MR</i> | | | | | |
| | CHEST ASSESSMENT | <i>gm</i> | <i>Dy</i> | <i>AB</i> | <i>MR</i> | | | | | |
| | CIRCULATION / SENSATION / MOTION | <i>gm</i> | <i>Dy</i> | <i>AB</i> | <i>MR</i> | | | | | |
| | ASSESS NEED FOR DVT PROPHYLAXIS ACCORDING TO RISK FACTORS | <i>gm</i> | <i>Dy</i> | <i>AB</i> | <i>MR</i> | | | | | |
| | MONITOR INTAKE / OUTPUT | <i>gm</i> | <i>Dy</i> | <i>AB</i> | <i>MR</i> | | | | | |
| | MONITOR BOWEL MOVEMENT | <i>gm</i> | <i>Dy</i> | <i>AB</i> | <i>MR</i> | | | | | |
| | MENTAL STATUS—ORIENTED TO TIME/PLACE/PERSON | <i>gm</i> | <i>Dy</i> | <i>AB</i> | <i>MR</i> | | | | | |
| | NURSING HISTORY INCLUDING BRADEN RISK ASSESSMENT TOOL | <i>gm</i> | <i>N/A</i> | <i>Dy</i> | | | | | | |
| | OTHER: | <i>gm</i> | <i>N/A</i> | <i>Dy</i> | | | | | | |
| CONSULTS | INTERNIST AS ORDERED | <i>gm</i> | <i>N/A</i> | <i>Dy</i> | | | | | | |
| | ANAESTHETIST AS ORDERED | <i>gm</i> | <i>N/A</i> | <i>Dy</i> | | | | | | |
| | CCAC IF BLAYLOCK DISCHARGE PLANNING RISK ASSESSMENT SCREEN INDICATES | <i>gm</i> | <i>N/A</i> | <i>Dy</i> | | | | | | |
| DIAGNOSTICS/ LABORATORY | HIP X-RAY | <i>gm</i> | <i>N/A</i> | <i>Dy</i> | | | | | | |
| | CHEST X-RAY | <i>gm</i> | <i>N/A</i> | <i>Dy</i> | | | | | | |
| | ECG | <i>gm</i> | <i>N/A</i> | <i>Dy</i> | | | | | | |
| | COMPLETE ANY PRE-OP BLOOD WORK OR TESTS ORDERED (I.E. FBS) | <i>gm</i> | <i>N/A</i> | <i>Dy</i> | | | | | | |
| | OTHER: | <i>gm</i> | <i>N/A</i> | <i>Dy</i> | | | | | | |
| | OTHER: | <i>gm</i> | <i>N/A</i> | <i>Dy</i> | | | | | | |
| MEDICATIONS | SFF MAR SHFFT | <i>gm</i> | <i>Dy</i> | <i>AB</i> | <i>MR</i> | | | | | |
| | OTHER: | <i>gm</i> | <i>N/A</i> | <i>Dy</i> | | | | | | |
| | OTHER: | <i>gm</i> | <i>N/A</i> | <i>Dy</i> | | | | | | |

ALL NON-SHADED BOXES TO BE INITIALED UPON COMPLETION OR MARKED N/A AND INITIALED

| PROCESS | PHASE 1 (0-3 Days) WAITING FOR SURGERY | DATE | | | DATE | | | DATE | | |
|---------------------------------------|--|------|-----|-----|------|--|--|------|--|--|
| | | D | E | N | D | | | | | |
| TREATMENTS/ INTERVENTIONS | IV AS ORDERED | gm | D | AB | MR | | | | | |
| | APPLY TED STOCKINGS | gm | D | AB | MR | | | | | |
| | SKIN CARE INTERVENTION AS INDICATED | gm | D | AB | MR | | | | | |
| | FOLEY AS ORDERED | gm | D | AB | MR | | | | | |
| | O ₂ IF INDICATED | gm | D | AB | MR | | | | | |
| | REMOVE TED STOCKINGS PRIOR TO TRANSFER TO OR | N/A | N/A | N/A | | | | | | |
| | OTHER: | N/A | gm | | | | | | | |
| | OTHER: | N/A | gm | | | | | | | |
| NUTRITION | <input checked="" type="checkbox"/> REGULAR DIET <input type="checkbox"/> SPECIAL DIET: _____ | gm | D | AB | MR | | | | | |
| | NPO AS ORDERED | N/A | N/A | N/A | MR | | | | | |
| MOBILITY/ACTIVITY | TURN Q4H WITH PILLOW BETWEEN LEGS | gm | D | AB | MR | | | | | |
| | BED REST | gm | D | AB | MR | | | | | |
| PSYCHOSOCIAL SUPPORT/ EDUCATION | PRE-OP TEACHING (DEEP BREATHING & COUGHING, CALF PUMPING, PCA) | gm | D | AB | MR | | | | | |
| | INFORM FAMILY/PATIENT TO OBTAIN CONSENT (SPECIFY WHO): <u>pt</u> | gm | D | AB | MR | | | | | |
| DISCHARGE PLANNING | ASSESS DISCHARGE NEEDS | gm | D | AB | MR | | | | | |
| | BLAYLOCK DISCHARGE PLANNING RISK ASSESSMENT SCREEN COMPLETED | gm | D | AB | MR | | | | | |
| | OTHER: | N/A | N/A | N/A | | | | | | |

ALL NON-SHADED BOXES TO BE INITIALLED UPON COMPLETION OR MARKED N/A AND INITIALLED



Grey Bruce Health Network

FRACTURED HIP CLINICAL PATHWAY

SITE: GBHS-Owen Sound

PATIENT ID

| PROCESS | POST-OP DAY 1 | DATE 03-05-06 | | |
|---|---|------------------|---|-----------|
| | | D | E | N |
| PERFORMANCE INDICATORS | 1 ANTIBIOTIC DISCONTINUED 24 HOURS POST SURGERY | N/A gm | Record as "Met" or "Not Met" on Variance Record | |
| ASSESSMENT (OBSERVATIONS/ MEASUREMENTS/ ELIMINATION) | VITAL SIGNS WITH O ₂ SATS: Q4H | al | gm | DL |
| | CHEST ASSESSMENT | al | gm | DL |
| | CIRCULATION / SENSATION / MOTION Q4H | al | gm | DL |
| | ASSESS DRESSING | al | gm | DL |
| | MONITOR INTAKE / OUTPUT / ASSIST TO COMMUNE | al | gm | DL |
| | CATHETER | al | gm | DL |
| | MENTAL STATUS—ORIENTED TO TIME/PLACE/PERSON | al | gm | DL |
| | OTHER: | N/A al | N/A gm | N/A DL |
| CONSULTS | DISCHARGE PLANNING CONSULT INITIATED IF APPROPRIATE | al | N/A gm | N/A DL |
| DIAGNOSTICS/ LABORATORY | CBC & LYTES | al | --- | --- |
| | HIP X-RAY | al | --- | --- |
| | OTHER: | al | --- | --- |
| | OTHER: | al | --- | --- |
| MEDICATIONS | SEE MAR SHEET | al | gm | DL |
| | OTHER: | N/A al | --- | --- |
| | OTHER: | N/A al | --- | --- |
| TREATMENTS/ INTERVENTIONS | IV AS ORDERED | al | gm | DL |
| | EMPTY DRAIN Q SHIFT PRN | al | gm | DL |
| | REMOVE DRAIN IF DRAINAGE LESS THAN 50ML | N/A al | N/A gm | N/A DL |
| | REMOVE FOLEY (24 HOURS POST-OP) | N/A al | N/A gm | N/A DL |
| | SUPPLEMENTARY O ₂ AS PER PROTOCOL | al | gm | DL |
| | BED BATH WITH ASSIST | al | N/A gm | N/A DL |
| | TED STOCKINGS REMOVED FOR SKIN CARE | al | gm | DL |
| | OTHER: | N/A al | --- | --- |
| | OTHER: | N/A al | --- | --- |

ALL NON-SHADED BOXES TO BE INITIALLED UPON COMPLETION OR MARKED N/A AND INITIALLED

| PROCESS | POST-OP DAY 1 | DATE 03-05-06 | | |
|---------------------------------|--|------------------|-----|-----|
| | | D | E | N |
| NUTRITION | <input checked="" type="checkbox"/> SIPS - REGULAR DIET | al | gm | Dr |
| | <input type="checkbox"/> SIPS - SPECIAL DIET: _____ | | | |
| MOBILITY/ACTIVITY | UP IN CHAIR FOR 30 MIN | al | BH | N/A |
| | POSITIONING IN BED WITH PILLOW BETWEEN LEGS | al | gm | Dr |
| | LIE TO SIT WITH USE OF RAIL WITH ASSISTANCE | al | BH | N/A |
| | FOOT AND ANKLE EXERCISES | al | BH | N/A |
| | ISOMETRIC QUADS AND GLUTS | al | BH | N/A |
| | PHYSIO DATABASE INITIATED | N/A | BH | Dr |
| | WEIGHT BEARING STATUS: WBAT q PWB q FeWB q NWB q | al | BH | Dr |
| | COMPLETE LOWER EXTREMITY FUNCTIONAL SCALE (LFFS) AND PITT SCORE ON VARIANCE RECORD DISCHARGE SUMMARY | N/A | BH | Dr |
| PSYCHOSOCIAL SUPPORT/ EDUCATION | POST-OP NEEDS—DEEP BREATHING & COUGHING, CALF PUMPING | al | gm | N/A |
| | ROUTINE POST-OP TEACHING | al | gm | N/A |
| | REVIEW PATIENT PATHWAY | al | gm | N/A |
| | REVIEW HIP PRECAUTIONS IF HIP REPLACED | al | gm | N/A |
| DISCHARGE PLANNING | PLANS FOR DISCHARGE DISCUSSED WITH PATIENT/FAMILY AND DOCUMENTED ON PROGRESS NOTES | al | N/A | N/A |
| | ESTIMATED DATE OF DISCHARGE DISCUSSED WITH PATIENT/FAMILY | al | N/A | N/A |
| | ASSESS DISCHARGE CRITERIA DAILY | al | gm | N/A |
| | OTHER: | N/A | | |

ALL NON-SHADED BOXES TO BE INITIALLED UPON COMPLETION OR MARKED N/A AND INITIALLED



FRACTURED HIP VARIANCE RECORD

SITE: GBHS-Owen Sound

THIS VARIANCE RECORD IS USED FOR EVALUATIVE PURPOSES ONLY. DO NOT PUT PATIENT INFORMATION ON THIS FORM. REMOVE AND SEND TO SITE CHAMPION AT PATIENT DISCHARGE.

Patient Age: 68 Gender: M Admission Date: 30-04-06 Targeted LOS: 5 Days
 Patient transferred from another hospital? Yes (specify) Pathway Day: _____ No

| TIME FRAME | INDICATOR | MET | NOT MET | DATE/TIME | INITIAL | CODE | DESCRIBE CORRECTIVE ACTION (or N/A if not applicable) | DATE RESOLVED (or N/A) | INITIAL |
|------------|---|--------------------------|-------------------------------------|-----------|---------|------|---|------------------------|---------|
| DAY 1 | ANTIBIOTIC DISCONTINUED 24 HOURS POST SURGERY | <input type="checkbox"/> | <input checked="" type="checkbox"/> | 02-05-06 | JDM | B3 | N/A discontinued e 48 hrs | N/A | |

DISCHARGE SUMMARY: *(To be completed upon discharge off pathway or unii)*
 Date Pathway Completed: _____ Days on Pathway: _____
 Fractured Hip Pre-Printed Orders used: Pre-Op - Yes No Post-Op - Yes No
 Weight Bearing Status: _____ LEFS Score: _____
 Patient education materials given to Patient: Yes No If no, reason: _____
 Patient teaching completed: Yes No If no, reason: _____
 Patient removed from Pathway before discharge: Yes Reason: _____
 Discharge Destination: Home Home with CCAC Rehab Hospital (specify) _____
 Other (specify) _____

See back of page for instructions re: Transfer Patients or CCAC Clients

Signature: _____ Date: _____

VARIANCE DOCUMENTATION GUIDELINES

Variations to clinical pathway activities will be documented on a Variance Record. Upon completion, this form is to be sent to the Evidence-Based Care Program Coordinator for evaluation purposes.

1. On Admission:

- Complete the demographic section: patient age, gender, admission date.
- Place the Variance Record behind the clinical pathway on the chart.

2. Documenting the Variance:

- For each indicator, tick whether met or not met, indicate the date, time and initial.
- If not met, the indicator becomes a variance. State variance code as either A, B or C, and the number within the category.
- Indicate your action plan to correct the variance, or indicate N/A if not applicable.
- Indicate the date variance was resolved and initial, or indicate N/A if not applicable.

3. On Discharge:

- Complete the Discharge Summary.
- If patient is being discharged home, send Variance Record to Site Champion to be forwarded to Evidence-Based Care Program Coordinator.
- If appropriate, send a copy of the following to the receiving service provider:
 - Variance Record
 - Discharge Criteria
 - Smiley Face Tool
 - Blaylock Discharging Planning Tool

4. Transfer Patients:

- If patient is transferred to another hospital in Grey-Bruce, send the following:
 - Variance Record - copy with patient to receiving hospital
- original to Evidence-Based Care Program Coordinator
 - Discharge Criteria - copy with patient to receiving hospital
- original to stay on patient chart
 - MAR Sheet - copy with patient to receiving hospital
- original to stay on patient chart
 - Anticoagulant Record - copy with patient to receiving hospital
- original to stay on patient chart
 - Smiley Face Tool - original with patient to receiving hospital
 - Blaylock Discharge Tool - copy with patient to receiving hospital
- original to stay on patient chart
- A new Variance Record should be started in the new facility for the remainder of the patient's stay.
- When the patient is discharged from the transfer facility, fill out Discharge Summary, staple both Variance Records together and send to Site Champion to be forwarded to Evidence-Based Care Program Coordinator.

VARIANCE CODES

| VARIANCE CODES | | |
|---|--|----------------------------------|
| PATIENT OUTCOME VARIANCES | PERFORMANCE VARIANCES | |
| A) PATIENT/FAMILY | B) CARE PROVIDER | C) SYSTEM |
| A1) Inability to learn skill needed for self-care | B1) Lack of or inadequate documentation | C1) Bed availability |
| A2) Inadequate social support or systems at home | B2) Physician/provider response time | C2) Schedule conflict |
| A3) Failure to respond to treatment | B3) Physician preference | C3) Consultant unavailable |
| A4) Patient/caregiver unavailability | B4) Pre-Printed Orders not used | C4) OR time unavailable |
| A5) Unable to return to pre-admission environment | B5) Orders outside clinical pathway parameters | C5) Results/data unavailable |
| A6) Patient/caregiver decision | B6) Treatment or intervention omitted | C6) Supply/equipment unavailable |
| A7) Complication of condition (physiological/psychological) | B7) Other (please specify) | C7) Department closed |
| A8) Other (please specify) | | C8) Placement unavailable |
| | | C9) Home health care unavailable |
| | | C10) Transportation unavailable |
| | | C11) Other (please specify) |



GREY BRUCE HEALTH NETWORK

FRACTURED HIP VARIANCE RECORD

SITE: GBHS-Owen Sound

THIS VARIANCE RECORD IS USED FOR EVALUATIVE PURPOSES ONLY. DO NOT PUT PATIENT INFORMATION ON THIS FORM. REMOVE AND SEND TO SITE CHAMPION AT PATIENT DISCHARGE.

Patient Age: 68 Gender: M Admission Date: 30-04-06 Targeted LOS: 5 Days

Patient transferred from another hospital? Yes (specify) Pathway Day: _____ No

| TIME FRAME | INDICATOR | MET | NOT MET | DATE/TIME | INITIAL | CODE | DESCRIBE CORRECTIVE ACTION (or N/A if not applicable) | DATE RESOLVED (or N/A) | INITIAL |
|------------|---|--------------------------|-------------------------------------|-----------------|------------|-----------|---|------------------------|---------|
| DAY 1 | ANTIBIOTIC DISCONTINUED 24 HOURS POST SURGERY | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <u>02-05-06</u> | <u>gon</u> | <u>B3</u> | <u>N/A discontinued @ 48 hours</u> | <u>N/A</u> | |

DISCHARGE SUMMARY: (To be completed upon discharge off pathway or unit)

Date Pathway Completed: 04-05-06 Days on Pathway: 5

Fractured Hip Pre-Printed Orders used: Pre-Op - Yes No Post-Op - Yes No

Weight Bearing Status: FWB LEFS Score: 35

Patient education materials given to Patient: Yes No If no, reason: _____

Patient teaching completed: Yes No If no, reason: transferred to Southampton

Patient removed from Pathway before discharge: Yes Reason: _____

Discharge Destination: Home Home with CCAC Rehab Hospital (specify) Southampton

Other (specify) _____

See back of page for instructions re: Transfer Patients or CCAC Clients

Signature: G. Molester Date: 04-05-06

VARIANCE DOCUMENTATION GUIDELINES

Variations to clinical pathway activities will be documented on a Variance Record. Upon completion, this form is to be sent to the Evidence-Based Care Program Coordinator for evaluation purposes.

1. On Admission:

- Complete the demographic section: patient age, gender, admission date.
- Place the Variance Record behind the clinical pathway on the chart.

2. Documenting the Variance:

- For each indicator, tick whether met or not met, indicate the date, time and initial.
- If not met, the indicator becomes a variance. State variance code as either A, B or C, and the number within the category.
- Indicate your action plan to correct the variance, or indicate N/A if not applicable.
- Indicate the date variance was resolved and initial, or indicate N/A if not applicable.

3. On Discharge:

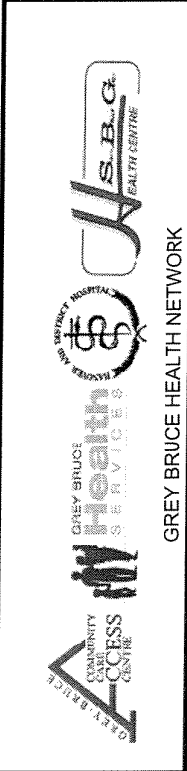
- Complete the Discharge Summary.
- If patient is being discharged home, send Variance Record to Site Champion to be forwarded to Evidence-Based Care Program Coordinator.
- If appropriate, send a copy of the following to the receiving service provider:
 - Variance Record
 - Discharge Criteria
 - Smiley Face Tool
 - Blaylock Discharging Planning Tool

4. Transfer Patients:

- If patient is transferred to another hospital in Grey-Bruce, send the following:
 - Variance Record - copy with patient to receiving hospital
- original to Evidence-Based Care Program Coordinator
 - Discharge Criteria - copy with patient to receiving hospital
- original to stay on patient chart
 - MAR Sheet - copy with patient to receiving hospital
- original to stay on patient chart
 - Anticoagulant Record - copy with patient to receiving hospital
- original to stay on patient chart
 - Smiley Face Tool - original with patient to receiving hospital
 - Blaylock Discharge Tool - copy with patient to receiving hospital
- original to stay on patient chart
- A new Variance Record should be started in the new facility for the remainder of the patient's stay.
- When the patient is discharged from the transfer facility, fill out Discharge Summary, staple both Variance Records together and send to Site Champion to be forwarded to Evidence-Based Care Program Coordinator.

VARIANCE CODES

| PATIENT OUTCOME VARIANCES | PERFORMANCE VARIANCES | |
|---|--|----------------------------------|
| A) PATIENT/FAMILY | B) CARE PROVIDER | C) SYSTEM |
| A1) Inability to learn skill needed for self-care | B1) Lack of or inadequate documentation | C 1) Bed availability |
| A2) Inadequate social support or systems at home | B2) Physician/provider response time | C2) Schedule conflict |
| A3) Failure to respond to treatment | B3) Physician preference | C3) Consultant unavailable |
| A4) Patient/caregiver unavailability | B4) Pre-Printed Orders not used | C4) OR time unavailable |
| A5) Unable to return to pre-admission environment | B5) Orders outside clinical pathway parameters | C5) Results/data unavailable |
| A6) Patient/caregiver decision | B6) Treatment or intervention omitted | C6) Supply/equipment unavailable |
| A7) Complication of condition (physiological/psychological) | B7) Other (please specify) | C7) Department closed |
| A8) Other (please specify) | | C8) Placement unavailable |
| | | C9) Home health care unavailable |
| | | C10) Transportation unavailable |
| | | C11) Other (please specify) |



**FRACTURED HIP
VARIANCE RECORD**

SITE: GBHS-Owen Sound

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Patient Age: 68 Gender: M Admission Date: 04-05-06 Targeted LOS: 5 Days
 Patient transferred from another hospital? Yes (specify) Owen Sound Pathway Day: 5 No

| TIME FRAME | INDICATOR | MET | NOT MET | DATE/TIME | INITIAL | CODE | DESCRIBE CORRECTIVE ACTION (or N/A if not applicable) | DATE RESOLVED (or N/A) | INITIAL |
|------------|---|--------------------------|--------------------------|--------------------------|---------|------|---|------------------------|---------|
| DAY 1 | ANTIBIOTIC DISCONTINUED 24 HOURS POST SURGERY | <input type="checkbox"/> | <input type="checkbox"/> | <u>already completed</u> | | | | | |

DISCHARGE SUMMARY: (To be completed upon discharge off pathway or unit)

Date Pathway Completed: 13-05-06 Days on Pathway: 9

Fractured Hip Pre-Printed Orders used: Pre-Op - Yes No Post-Op - Yes No

Weight Bearing Status: Full LEFS Score: N/A

Patient education materials given to Patient: Yes No If no, reason: _____

Patient teaching completed: Yes No If no, reason: _____

Patient removed from Pathway before discharge: Yes Reason: _____

Discharge Destination: Home Home with CCAC Rehab Hospital (specify) _____
 Other (specify) _____

See back of page for instructions re: Transfer Patients or CCAC Clients

Signature: Jordan Nie Date: 13-05-06

VARIANCE DOCUMENTATION GUIDELINES

Variations to clinical pathway activities will be documented on a Variance Record. Upon completion, this form is to be sent to the Evidence-Based Care Program Coordinator for evaluation purposes.

1. On Admission:

- Complete the demographic section: patient age, gender, admission date.
- Place the Variance Record behind the clinical pathway on the chart.

2. Documenting the Variance:

- For each indicator, tick whether met or not met, indicate the date, time and initial.
- If not met, the indicator becomes a variance. State variance code as either A, B or C, and the number within the category.
- Indicate your action plan to correct the variance, or indicate N/A if not applicable.
- Indicate the date variance was resolved and initial, or indicate N/A if not applicable.

3. On Discharge:

- Complete the Discharge Summary.
- If patient is being discharged home, send Variance Record to Site Champion to be forwarded to Evidence-Based Care Program Coordinator.
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VARIANCE CODES

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|---|--|----------------------------------|
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| A2) Inadequate social support or systems at home | B2) Physician/provider response time | C2) Schedule conflict |
| A3) Failure to respond to treatment | B3) Physician preference | C3) Consultant unavailable |
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| A5) Unable to return to pre-admission environment | B5) Orders outside clinical pathway parameters | C5) Results/data unavailable |
| A6) Patient/caregiver decision | B6) Treatment or intervention omitted | C6) Supply/equipment unavailable |
| A7) Complication of condition (physiological/psychological) | B7) Other (please specify) | C7) Department closed |
| A8) Other (please specify) | | C8) Placement unavailable |
| | | C9) Home health care unavailable |
| | | C10) Transportation unavailable |
| | | C11) Other (please specify) |



FRACTURE HIP CLINICAL PATHWAY

Confusion Assessment Method Tool

SITE: South Bruce Grey Health Centre

PATIENT ID

You will be able to answer the following questions after a few conversations with the patient, discussing patient behaviours with staff and family, and/or reading the chart.

Scoring: Patient diagnosed with Delirium if has a positive response to Sections 1 AND 2, as well as EITHER Sections 3 OR 4. Section 5 will help substantiate the diagnosis, but is not diagnostic criteria. If patient is diagnosed with Delirium, refer to Delirium Management Checklist, see back of page.

1. Acute Onset

Is there evidence of an acute change in mental status from the patient's baseline? Yes No

2. Inattention

Did the patient have difficulty focusing attention, for example being easily distractible or having difficulty keeping track of what was said? Not at any time
Sometimes, in mild form
Sometimes, in marked form
Uncertain

If present or abnormal, did the behaviour fluctuate during the conversation, that is tend to come and go, or increase/decrease in severity? Yes No
Uncertain Not applicable

If present or abnormal, please describe this behaviour:

not able to focus on questions

3. Disorganized Thinking

Was patient's thinking disorganized or incoherent, i.e. rambling/irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject? Yes No

4. Altered Level of Consciousness

How would you rate the patient's level of consciousness? (positive response is any response other than Alert (normal)) Alert (normal)
Vigilant (hyper alert, overly sensitive to stimuli, startled easily)
Lethargic (drowsy, easily aroused)
Stupor (difficult to arouse)
Coma (unarousable)

5. Other Clinical Descriptors that often accompany delirium:

Disorientation: Was the patient disoriented at any time during conversation, such as thinking that he/she was somewhere other than the hospital, using the wrong bed, or misjudging the time of day? Yes No

Memory Impairment: Did the patient demonstrate any memory problems during the interview, such as inability to remember events in the hospital or difficulty remembering instructions? Yes No

Perceptual Disturbance: Did the patient have any evidence of perceptual disturbance, for example hallucinations, illusions, or misinterpretations (such as thinking something was moving when it was not)? Yes No

Psychomotor Agitation (one of A or B):

A) At any time, did the patient have an unusually increased level of motor activity, such as restlessness, picking at bedclothes, tapping fingers, or making frequent sudden changes in position? Yes No
B) At any time, did the patient have any unusually decreased level of motor activity, such as sluggishness, staring into space, staying in one position for a long time, or moving very slowly?

Altered Sleep-Wake Cycle: Did the patient have evidence of disturbance of the sleep wake cycle, such as excessive daytime sleepiness with insomnia at night? Yes No

| If Delirium is positively identified, do the following: | |
|---|--|
| 1. Address immediate safety (self, others) | <input checked="" type="checkbox"/> |
| 2. Investigate cause | |
| a) Medications: - Review existing medications - Discontinue non-essential medications, especially analgesics, anticholinergics, sedatives | <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> |
| b) Metabolic Imbalance: - Check for high or low levels of Sodium, Sugar, Calcium - <i>lytes PD</i> - Check for dehydration - Check for organ failure | <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> |
| c) Infection: - Identify and treat systemic infection, e.g. UTI, pneumonia | <input checked="" type="checkbox"/> |
| 3. Ensure optimal sensory input: - Eyeglasses on and clean - Hearing aid working and in use - Avoid excessive stimulation, e.g. light, noise - Use night-light at night | <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> |
| 4. Encourage: - Familiar persons to visit - Consistent staffing, preferably primary nursing - Familiar objects at bedside, e.g. pictures | <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> |
| 5. Mobilize early | <input checked="" type="checkbox"/> |
| 6. Implement a toileting routine | <input checked="" type="checkbox"/> |
| 7. Provide comfort measures to reduce pain, anxiety, or agitation | <input checked="" type="checkbox"/> |
| 8. Avoid restraints (restraining a delirious patient invariably increases agitation) | <input checked="" type="checkbox"/> |
| 9. Provide adequate nutrition including fluid replacement, nutritional intake | <input checked="" type="checkbox"/> |
| 10. Enhance sleep: if conservative measures fail, a short/intermediate acting benzodiazepine, e.g. Lorazepam 0.5-1 mg | <input checked="" type="checkbox"/> |
| 11. Manage agitation: pharmacological management may involve a small dose of typical and atypical neuroleptics and small doses of short acting benzodiazepines. Because of the risk of side effects, these medications are used only when severity of symptoms place patients and others at risk. Re-evaluate the need for these medications daily. | <input checked="" type="checkbox"/> |

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