Northern Health

Term Description – Handbook – ROVER

1. Term details:			
Health Service:	Northern Health	**Term duration:**	Maximum: 13 weeks
Location/Site:	Northern Hospital Epping	**Clinical experience - Primary**:	C: Acute and critical illness patient care
Parent Health Service:	Northern Health	**Clinical experience - Secondary**:	B: Chronic illness patient care
Speciality/Dept.:	Aged Care Orthogeriatrics	**Non-clinical experience:**	*(PGY2 only)*
PGY Level:	PGY2	**Prerequisite learning:**	*(if relevant)*
Term Descriptor:	*Acute geriatric medicine term under the supervision of the geriatric medicine advance trainee and liaising closely with the orthopaedic surgical team to ensure eligible patients have their medical conditions optimised prior to orthopaedic surgery, receive appropriate post-operative medical care and access appropriate rehabilitation post the acute phase of care. Management of patient on the ward in liaison with the orthopaedic team and attendance at orthopaedic handover daily.*		

2. Learning objectives:		
EPA1: Clinical Assessment	Domain 1	Filters, prioritises, and synthesises relevant information for clinical problem-solving.
	Domain 2	Recognises their own limitations and seeks help when required in an appropriate way.
	Domain 3	Recognises and takes precautions where the patient may be vulnerable.
	Domain 4	Demonstrates the ability to manage uncertainty in clinical decision-making.
EPA2: Recognition and care of the acutely unwell patient	Domain 1	Identifies deteriorating or acutely unwell patients
	Domain 2	Works effectively as a member of a team and uses other team members, based on knowledge of their roles and skills, as required.
	Domain 3	Recognises the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community.
	Domain 4	Complies with escalation protocols and maintains up-to-date certification in advanced life support appropriate to the level of training.
EPA3: Prescribing	Domain 1	As appropriate, monitors and adjusts medications.
	Domain 2	Works collaboratively with the multidisciplinary team, including pharmacists and nursing staff.
	Domain 3	Acknowledges and respects patients' cultural and religious background, attitude and beliefs, and how these might influence the acceptability of pharmacological and non-pharmacological management approaches.
	Domain 4	Safely uses electronic prescribing systems as appropriate.
EPA4: Team communication – documentation, handover and referrals	Domain 1	Documents and prioritises the most important issues for the patient.
	Domain 2	Informs patients that handover of care will take place and to which team, service, or clinician as appropriate.
	Domain 3	Recognises the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community.

	Domain 4	Maintains records to enable optimal patient care and secondary use of the document for relevant activities such as adequate coding, incident review, research or medico-legal proceedings.

3. Outcome statements:

Domain 1: *The prevocational doctor as practitioner*	**Domain 2:** *The prevocational doctor as professional and leader*	**Domain 3:** *The prevocational doctor as a health advocate*	**Domain 4:** *The prevocational doctor as a scientist and scholar*
☒ 1.1 Place the needs and safety at the centre of the care process, working within statutory and regulatory requirements and guidelines. Demonstrate skills including effective handover, graded assertiveness, delegation and escalation, infection control, and adverse event reporting. *☒ 1.2 Communicate sensitively and effectively with patients, their family and carers, and health professionals, applying the principles of shared decision-making and informed consent.* *☒ 1.3 Demonstrate effective, culturally safe interpersonal skills, empathetic communication, and respect within an ethical framework inclusive of indigenous knowledges of wellbeing and health models to support Aboriginal and Torres Strait Islander patient care* *☒ 1.4 Perform and document patient assessments, incorporating a problem-focused medical history with a relevant physical examination, and generate a valid differential diagnosis and/or summary of the patient's health and other relevant issues* *☒ 1.5 Request and accurately interpret common and relevant investigations using evidence-informed knowledge and principles of sustainability and cost-effectiveness* *☐ 1.6 Safely perform a range of common procedural skills required for work as a PGY1 and PGY2 doctor.* *☐ 1.7 Make evidence-informed management decisions and referrals using principles of shared decision-making with patients, carers and health care team* *☒ 1.8 Prescribe therapies and other products including drugs, fluids, electrolytes, and blood products safely, effectively and economically* *☒ 1.9 Recognise, assess, communicate and escalate as required, and provide immediate management to deteriorating and critically unwell patients.* *☐ 1.10 Appropriately use and adapt to dynamic systems and technology to facilitate practice, including for documentation, communication, information management and supporting decision-making*	*☒ 2.1 Demonstrate ethical behaviours and professional values including integrity, compassion, self-awareness, empathy, patient confidentiality and respect for all.* *☒ 2.2 Identify factors and optimise personal wellbeing and professional practice, including responding to fatigue, and recognising and respecting one's own limitations to mitigate risks associated with professional practice.* *☒ 2.3 Demonstrate lifelong learning behaviours and participate in, and contribute to, teaching, supervision and feedback.* *☒ 2.4 Take increasing responsibility for patient care, while recognising the limits of their expertise and involving other professionals as needed to contribute to patient care.* *☒ 2.5 Respect the roles and expertise of healthcare professionals, and learn and work collaboratively as a member of an inter-personal team.* *☒ 2.6 Contribute to safe and supportive work environments, including being aware of professional standards and institutional policies and processes regarding bullying, harassment and discrimination for themselves and others.* *☒ 2.7 Critically evaluate cultural safety and clinical competencies to improve culturally safe practice and create culturally safe environments for Aboriginal and Torres Strait Islander communities. Incorporate into the learning plan strategies to address any identified gaps in knowledge, skills, or behaviours that impact Aboriginal and Torres Strait Islander patient care.* *☐ 2.8 Effectively manage time and workload demands, be punctual, and show ability to prioritise workload to manage patient outcomes and health service functions.*	*☒ 3.1 Incorporate disease prevention, relevant health promotion and health surveillance into interactions with individual patients, including screening for common diseases, chronic conditions, and discussions of healthcare behaviours with patients* *☒ 3.2 Apply whole-of-person care principles to clinical practice, including consideration of a patients physical, emotional, social, economic, cultural and spiritual needs and their geographical location, acknowledging that these factors can influence a patient's description of symptoms, presentation of illness, healthcare behaviours and access to health services or resources.* *☒ 3.3 Demonstrate culturally safe practice with ongoing critical reflection of the impact of health practitioner's knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism and discrimination.* *☐ 3.4 Demonstrate knowledge of the systemic and clinician biases in the health system that impact on the service delivery for Aboriginal and Torres Strait Islander peoples. This includes understanding current evidence around systemic racism as a determinant of health and how racism maintains health inequity.* *☐ 3.5 Demonstrate knowledge of the ongoing impact of colonisation, intergenerational trauma and racism on the health and wellbeing of Aboriginal and Torres Strait Islander peoples.* *☒ 3.6 Partner with the patient in their healthcare journey, recognising the importance of interaction with and connection to the broader healthcare system. Where relevant, this should include culturally appropriate communication with caregivers and extended family members while also including and working collaboratively with other health professionals (including Aboriginal Health Workers, practitioners and Liaison Officers).*	*☒ 4.1 Consolidate, expand and apply knowledge of the aetiology, pathology, clinical features, natural history and prognosis of common and important presentations in a variety of stages of life and settings.* *☐ 4.2 Access, critically appraise and apply evidence form the medical and scientific literature to clinical and professional practice.* *☐ 4.3 Participate in quality assurance and quality improvement activities such as peer review of performance, clinical audit, risk management, incident reporting and reflective practice.* *☐ 4.4 Demonstrate a knowledge of evidence-informed medicine and models of care that support and advance Aboriginal and Torres Strait Islander health.*

4. Supervision details:			
Supervision Role	***Name***	***Position***	***Contact***
DCT/SIT	***Dr Chiu Kang***	Supervisor of HMO Training	Chiu.Kang@nh.org.au
Term Supervisor	***Dr Sandra Brown***	Divisional Director of Sub-Acute Services	Sandra.Borwn3@nh.org.au
Clinical Supervisor (primary)	***Dr Rohan Wee***	Geriatrician	Rohan.Wee@nh.org.au
Cinical Supervisor (day to day)	***Allocated Advanced Trainee on ward service***	Geriatric Medicine Advanced Trainee	Click or tap here to enter text.
EPA Assessors *Health Professional that may assess EPAs*	• All Consultants • All Geriatric Medicine Advanced Trainees • Click or tap here to enter name and role		

Team Structure **- Key Staff**		
Name	**Role**	**Contact**
Dr Sandra Brown	Divisional Director	Sandra.Brown3@nh.org.au
Dr Rohan Wee	Geriatrician	Rohan.Wee@nh.org.au
Dr Juliette Gentle	Orthopaedic Head of Unit	Juliette.Gentle@nh.org.au
Click or tap here to enter text.	NUM	Click or tap here to enter text
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text

5. Attachments:	
R-over document	See below
Unit orientation guide	See below
Timetable (sample in appendix)	See below

6. Accreditation details *(PMCV use only)*		
Accreditation body:	Click or tap here to enter text.	
Accreditation status:	Click or tap here to enter text.	
Accreditation ID:	Click or tap here to enter text.	
Number of accredited posts:	PGY1: number	PGY2: number
Accredited dates:	Approved date: date.	Review date: date.

7. Approval

Northern Health

Term Description – Handbook – ROVER

Reviewed by:	Click or tap here to enter text.	Date:Click or tap to enter a date.
Delegated authority:	Click or tap here to enter text.	Date:Click or tap to enter a date.
Approved by:	Click or tap here to enter text.	Date:Click or tap to enter a date.

Appendix

Timetable example

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time
	Orthopaedic team handover	Orthopaedic team handover	Orthopaedic team handover	Orthopaedic team handover	Orthopaedic team handover	Click or tap here to enter text.	Click or tap here to enter text.
Afternoon	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time
	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	12:30 – 13:30 HMO Education	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Evening	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time	Enter Time
	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Hours	Total	Total	Total	Total	Total	Total	Total

REG ORTHOGERIATRICS	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Reg	0800-1630	0800-1630	0800-1200	0800-1630	0800-1630			0800-1630	0800-1630	0800-1200	0800-1630	0800-1630		
			Registrar Training							Registrar Training				
HMO ORTHOGERIATRICS														
HMO	0800-1700	0800-1230	0800-1700	0800-1700	0800-1700			0800-1700	0800-1230	0800-1700	0800-1700	0800-1700		

9. Hospital Orientation		
Hospital orientation occurs at the beginning of each term. Attendance is mandatory and paid non-clinical time. This is separate to the unit orientation. Follow the link for details, password: NorthernDoctors		
Location	NCHER, Northern Hospital – Epping	185 Cooper Street, Epping 3076
Facilitator	Medical Education Unit	Email: MedicalEducationUnit@nh.org.au
Date	First day of each term	
Start	08:00	

10. Unit Orientation	
Unit Orientation occurs at the beginning of each term. Attendance is mandatory and paid time. Orientation that occurs outside of your rostered hours should be submitted as overtime on the overtime reporting portal.	
Location	NHE Ward 19
Facilitator	Aged Care Registrar
Date	First day of rotation
Start	

11. Unit Overview	
Department	Aged Care
Location	NHE Ward 19
Inpatient Beds	Automatic referral from Orthopaedic unit
Outpatients Clinics	N/A
Day Procedures	N/A
Virtual Unit	N/A

12. Safety
Unit Specific Safety & Risks - Acutely unwell patients Peri-op patients can be acutely unwell and require timely support and intervention. This can require escalation. - Delirium OGS patients have a high rate of delirium and can become agitated. Care in management and prescribing in delirium is required. - Falls - Pressure injuries - Consent and capacity Many patients under the care of OGS have cognitive impairment and capacity issues mean that there is a high rate of substitute decision makers. Care is needed in the identification of a need for a MTDM and the appropriate person to act in this role.

13. Communication	
Medtasker	Yes
WhatsApp	Ortho-Geriatrics Group Chat (OGS AT, OGS RMO, Ortho Reg/RMO/Interns)
Pager	?
MS Teams	N/A

14. Handover Process	
Morning	Direct hand over from overnight cover and direct communication with Ortho unit
Afternoon	Direct communication with ortho team and hand over to afterhours Peri-op as needed
Night	N/A

15. Shift Structure			
	Intern	HMO	Registrar
Day	N/A	M-F 08:00 – 17:00	M-F 08:00 – 16:30
Afternoon	N/A	N/A	N/A
Night	N/A	N/A	N/A
Weekend	N/A	N/A	N/A

16. Shift Roles & Responsibilities			
	Intern	HMO	Registrar
Day	N/A	Ward round + tasks	Ward round + tasks Review referrals
Afternoon	N/A	N/A	N/A
Night	N/A	N/A	N/A
Weekend	N/A	N/A	N/A

17. Common Conditions

#NOF
#SNOH
ankle
Complications

- Renal impairment
- Post op pneumonia
- Hypotension
- VTE
- Delirium

18. Common Procedures

IVC
IDC insertion

19. Clinical Guidelines

The My Favourite Links page on the intranet contains the links to a number of useful clinical guidelines
https://intranet.nh.org.au/applications/
ETG- Electronic Therapeutic Guidelines
AMH- Australian Medicines Handbook
Up to Date

PROMPT- This site contains the hospital policy and procedure manuals. It can only be accessed from the intranet - https://intranet.nh.org.au/departments-and-services/prompt-policy-procedures-guidelines/prompt-policies-procedures-and-forms/

Some (but not all) relevant PROMPT guides are listed below:

- Diabetes Management – Adults
- GEM at Residential Care
- Falls Prevention and Management
- Blood – Administration of Blood/Blood Products (Adults)
- Dementia, delirium, and Cognitive Impairment Management

20. Routine Orders

Pathology	Pre-op investigations are usually managed by the ortho team but include: - FBE, U&E, LFTs, Ca/Mg/PO4, coags, G&H - Osteoporosis investigations: - Vit D, TSH ECG pre-op

Radiology	DEXA scan may be required for osteoporosis management and planning on discharge
Pharmacology	A decision must be made about analgesia for every patient even if a decision NOT to prescribe is made. Clexane 20-40mg SC daily should be prescribed for every patient UNLESS ortho indicate otherwise.

21. IT Programs	
EMR	The EMR is in use for documentation, medication ordering and radiology/pathology requests. It is being used for all inpatients, as well as maternity clinics and pre-anaesthetic clinics. Located in the intranet > My Favourite Links > EMR Live Environment EMR Training courses are located on the LMS- https://mylearning.nh.org.au/login/start.php Training is compulsory; you will need to complete the elearning within the first week of commencing. Please contact medical workforce, or check the EMR website for more information on how to complete EMR training https://emr.nh.org.au/ When starting a new rotation, please reach out to Term Supervisor to ensure you are oriented to the EMR specific workflows for that unit as well. EMR is NOT a primary communication system. Please use Medtasker and phones for referrals and communication.
CPF	The source of information for all outpatients' clinics, investigations, GP referrals and scanned admission notes prior to September 2023. Located in the intranet > My Favourite Links > CPF https://cpf.nh.org.au/udr/
PACS	XERO Viewer Pacs- https://nivimages.ssg.org.au/ or located in My Favourite Links, look for the CXR icon This is where you can find radiology images
My Health Record	Centralised health record https://shrdhipsviewer.prod.services/nhcn
Safe Script	Monitoring system for restricted prescription medications https://www.safescript.vic.gov.au/

22. Documentation	
Admission	Patients are admitted under the orthopaedic bed care. OGS sees all patients >50 with a lower limb fracture, all patients >60 with and upper limb fracture, elective ortho patients who have been seen in complex and high-risk pre-op clinics and any orthopaedic patient on the request of the ortho team for medical review.
Ward Rounds	Tues/Fri consultant round. Other days with Geriatric Medicine Advanced Trainee
Discharge Summary	Edit and contribute to Ortho unit DCS.
Outpatient Clinics	N/A
CDI Queries	
Death Certificates	These should be completed by the ortho unit. https://www.bdm.vic.gov.au/medical-practitioners
Coroners	Referral made in conjunction/consultation with the ortho unit. https://coronerscourt.vic.gov.au/report-death-or-fire/how-report-death

23. Referrals	
Internal	Made via EMR/Medtasker as appropriate
External	As needed

24. Clinical Deterioration	
Escalation Process	Escalate to OGS Registrar (except Thursday afternoon when escalation should be to OGS consultant directly)
PreMet	As per hospital protocol
Code	As per hospital protocol

25. Night Shift Support	
Unit	N/A
Periop	Out of hours support is via Peri-op.
Take 2 @ 2	

26. Assessments: PGY1 & PGY2	
All forms are located on the Northern Doctors website under the Assessments tab	
Beginning of Term	Meet with Term Supervisor to set learning goals for the term using the Term Description Learning Objectives as a basis for the discussion
Mid-Term & End of Term	To be completed at the mid and end of term meetings
EPAs	Minimum of x2 EPA assessments to be completed per term

27. Mandatory Training

- Mandatory Training is located on the LMS- https://mylearning.nh.org.au/login/start.php
- Mandatory training is compulsory and part of your contract with Northern Health and needs to be completed by the first month of your start date. If not completed you will come of the floor to complete.
- Hand Hygiene needs to be completed by the end of your first week.
- If you have completed the mandatory training elsewhere you may be able to apply for recognition of prior learning

28. Unit Education

HMO teaching

29. Unit Meetings

HMO is welcome to attend Complication meeting on Thursday morning (0700) in person or via Teams but this is not considered mandatory.

30. Research and Quality Improvement
NH OGS and Orthopaedic unit participate in the Australian and New Zealand Hip Fracture Registry.

31. Career Support
Direct discussion with Head of Unit (Dr Rohan Wee).

32. Medical Students on the Unit
On an ad hoc basis

33. Rostering	
Shift Swap	The doctor initiating the roster swap is responsible for arranging with an appropriate colleague. Once you have arranged a colleague to perform the swap, please email your MWU coordinator and cc in the colleague. All swaps should be kept to within the pay period fortnight where possible. In exceptional circumstances where this cannot be achieved, please discuss with the MWU coordinator prior. All shift swaps should be like hours for like hours. Proposed shift swaps must be emailed to your MWU coordinator for approval.
Unplanned Leave- Notification and documentation process	**Personal Leave documentation required:** For 3 single absences per year, the doctor will not be required to provide any supporting evidence to substantiate their personal leave. For other days absent due to personal illness or injury the doctor is required to provide evidence of illness. To be eligible for payment, the doctor is required to notify the Health Service **two hours** before the start of their shift, or as soon as practicable.

<table>
<tr><td></td><td>
<table>
<tr><td>In hours Monday to Friday
0730 - 1630</td><td>Step 1:
Medical Workforce Reception
8405 8276</td><td>Step 2:
Notify unit</td><td>Please ensure you notify both MWU & your unit</td></tr>
<tr><td>After hours Monday to Friday
Between 1630 – 2200

After hours Monday to Friday
Between 2200-0730</td><td>Step 1:
Between 1630 – 2200
Medical Workforce On-call Phone
0438 201 362

Between 2200-0730
Hospital / After Hours Coordinator
(8405 8110 or via switch)</td><td>Step 2:
Notify unit (at a suitable time)</td><td>Please ensure you notify both MWU or After Hours (depending on the time) & your unit at a suitable time.</td></tr>
<tr><td>In hours Weekends & Public Holidays
0700 - 2200</td><td>Step 1:
Medical Workforce On-call Phone
0438 201 362</td><td>Step 2:
Notify</td><td>Please ensure you notify both MWU & your unit</td></tr>
<tr><td>After hours Weekends & Public Holidays
2200-0700</td><td>Step 1:
Hospital / After Hours Coordinator
(8405 8110 or via switch)</td><td>Step 2:
Notify unit</td><td>Please ensure you notify both MWU & your unit</td></tr>
</table>
</td></tr>
<tr><td>Overtime</td><td>All overtime should be submitted into the Overtime Portal
This can be accessed via the intranet whilst onsite at Northern Health
Please include the reason for your overtime- i.e. ward workload, delayed handover, include UR where relevant.</td></tr>
</table>

34. JMO Rover

ORTHO-GERIATRIC SERVICE

To address the high utilisation of public hospital beds by elderly patients with lower limb fractures, an Ortho-Geriatric Service was established in 1991 at Preston and Northcote Community Hospital (PANCH) in conjunction with Bundoora Extended Care Centre, and subsequently at The Northern Hospital. In November 2001 after review of the service, there was a change of name to Orthopaedic Aged Care and Rehabilitation Service (OARS). In recent years, to distinguish it from the Aged Care, Rehabilitation and Consult Service (ARC), the name has reverted to the Ortho-Geriatric Service (OGS).

The aims of the service are:

1. To reduce the length of stay of elderly patients with Orthopaedic conditions.
2. To enhance and improve the care provided to older orthopaedic patients.
3. To facilitate flow through the hospital service by early discharge planning.
4. To ensure a collaborative team approach to patient care

INCLUSION CRITERIA

Any patient admitted under the Orthopaedic bed card who meets the following criteria:

1. Patients >50 with a pelvic or lower limb fracture
2. Patients >50 with a vertebral fracture
3. Patients >60 with an upper limb fracture
4. Elective orthopaedic patients >50 who have been assessed in a complex or high-risk pre-admission clinic

are routinely seen by OGS. In addition

5. Any patient on request of the orthopaedic unit for medical support or advice.

TIPS

Falls

- "Mechanical fall" is not a diagnosis. A fall is the end result of a number of risk factors and events. A falls history should aim to identify these risks and events.

Social history

- A social history is critical to understanding the person we are caring for and will assist in formulating the best discharge plan

Pain

- Poorly controlled pain is not just unpleasant for the patient, it can also lead to complications such as delirium, pressure areas and delayed recovery/mobility
- If a patient's pain is hard to control under OGS, Northern Health has an Acute Pain Service (APS) that can assist with more complex analgesic techniques.

Delirium

- Is extremely common with the OGS patient group
- Non-pharmacological management is the key to good care
- Medications for delirium (e.g. antipsychotic medications) are second line and should be discussed with the OGS registrar if possible

Osteoporosis

- All patients with a #NOF, #SNOH or vertebral crush fracture should be considered to have osteoporosis requiring treatment
- Other fractures should trigger osteoporosis investigations and a plan for follow up

VTE

- The use of LMWH for VTE prophylaxis is routine for OGS patients. If it is not being used, the reasons for this need to be documented in the EMR.

Team work

- Ward 19, the OGS registrar/consultant and the Orthopaedic team are all working towards the best outcomes for their patients. If you have questions, please ask – we want to help and teach so your time on OGS is good for you and your patients!

GUIDELINES TO THE MANAGEMENT OF OGS PATIENTS WITH A HIP FRACTURE

The most common fracture the OGS is involved with, and the reason for the establishment of ortho-geriatric services worldwide, is a fractured NOF in an older person.

To help you, a guide to managing the issues associated with #NOF is attached:

Principals of Management of Older patients with fractured hip:

1. Older patients are at increased risk of peri-operative morbidity and mortality.
2. Delays to surgery increase the risk of poor outcomes.
3. Close attention to good medical care peri-operatively both decreases the risks associated with a #NOF and improves the outcomes.

Specific Issues:

1. Time to Surgery
    a. Unless there is a medically or surgically indicated reason to delay, surgery should occur within 36 hours of admission to ED.
    b. Medical co-morbidities, unless they can be positively addressed within the 36 hour timeframe, should not be a cause of delay. Examples that might lead to delay include APO, sepsis or unstable IHD. Each of these may benefit from appropriate treatment for 24-48 hours prior to surgery. Delay beyond this time is likely to lead to an increase in adverse outcomes without improving the underlying medical condition significantly more.
2. Type of surgical repair
    a. This is entirely within the realm of the treating surgical team. A procedure that allows early weight bearing and mobilisation is preferable, if possible.
3. Pain
    a. Pre-operatively the use of an IFB can provide good temporary analgesia and minimise the use of opiate analgesia. An IFB should be used pre-operatively in every patient with a #NOF unless contra-indicated.
    b. Routine, regular analgesia post-operatively is preferred. The combination of paracetamol regularly with and opiate analgesic (like TARGIN) provides good, consistent and easily titrated analgesia for most patients. The use of PCA analgesia in this patient group is not ideal as compliance is poor and the need to maintain IV access restricts early mobility.
    c. The addition of other agents such as NSAIDs is NOT routine and should be an unusual occurrence because of the associated gastric and renal effects in older patients.
4. Pressure Care
    a. All patients with a #NOF should have a heel wedge pillow whenever they are in bed.
    b. Other pressure relieving devices (such as air cell mattresses) may be used as otherwise indicated in Nursing Care plans
    c. Early mobility and sitting out of bed forms an integral part of good pressure care.
5. Bladder care
    a. IDC use should be minimised and is NOT routine. If inserted, an IDC should be removed on Day 1 post op regardless of whether bowels have opened for a trial of void.
    b. PVRV scans should be undertaken following removal of an IDC
6. Bowel Management
    a. Immobility and the use of opiate analgesia increase the risk of constipation. Bowels should be monitored and aperients used to get bowels open as soon as possible post-op.
7. Mobilisation
    a. Early mobilisation decreases the risk of post operative complications like pressure ulceration, delirium and pneumonia as well as speeding the rehabilitation process. Patients should begin to sit out of bed on Day 1 post surgery if BP and Hb allow.

   b. Early PT intervention beginning on Day 1 with the goal of early ambulation should occur for every #NOF patient unless medically or surgically contra-indicated.
8. VTE Prophylaxis
   a. Despite improvements in surgical and anaesthetic techniques, older patients with a #NOF are amongst the highest risk patients for the development of VTE. The use of LMWH for DVT prophylaxis combined with non-pharmacological techniques (such as TED stockings and pneumatic foot/calf pumps) is the default treatment for VTE prophylaxis.
   b. Variations to the use of LMWH (e.g. because of local wound bleeding) must be documented in the medical record.
9. Delirium
   a. Delirium is a common and often under recognised complication of admission to hospital. Delirium can contribute to adverse outcomes for patients. Delirium may be prevented in some instances by optimising medical risk factors, minimising the use of medical interventions (like IDCs), optimising pain relief and regularly re-orientating patients. Not all cases of delirium can be prevented.
   b. When delirium occurs the focus must be on
      i. identifying the precipitant to ensure that a secondary acute medical illness (beyond the # and surgical repair) is not present (e.g. excluding AMI, UTI or other infection, polypharmacy etc)
      ii. avoiding complications associated with delirium such as pressure areas, dehydration and over sedation/over medication
   c. the use of non-pharmacological interventions (reassurance, nursing in a supervised room, re-orientation, maintenance of appropriate day/night cycles, 1:1 nursing etc) is the MAIN intervention
   d. if required, low dose anti-psychotics (e.g. RISPERIDONE 0.25-0.5mg daily-bd) may be instituted. In the first instance PRN but if this is required more than occasionally, then regularly for a few days is more appropriate than larger PRN doses. Anti-psychotic medication works best with the ongoing use of non-pharmacological techniques.

OARS Management Flow Chart

Pre-Op (Day 0) or Admission by OARS if not seen pre-op

- medical history (incl falls history)
- establish usual medications
- liaise with LMO (if required)
- ensure pre-op work up completed (FBE, U&E, Coags, Grp and Hold, ECG, CXR)
- analgesia (IFB, paracetamol, Targin)
- optimise medical conditions within 24/24
- VTE prophylaxis ordered to commence post op
- Consent for surgery is the responsibility of the Orthopaedic unit

Post op - Day 1

- check HB and U&E
- complete 3 doses of prophylactic IV antibiotics
- analgesia
- encourage oral input. If eating cease IV fluids ASAP.
- VTE prophylaxis commenced (unless documented otherwise)
- Pressure care/areas

- Sit out of bed and commence PT
- IDC out (if inserted)
- Bowels open? If not consider aperients.
- Wound review – this is the duty of the orthopaedic unit.
- Consider likely discharge destination – home vs sub-acute

Post op – Day 2

- pressure care/areas
- review analgesia. Is it adequate?
- Review oral intake/hydration
- Bladder/bowels? Are aperients required?
- Is repeat Hb/U&E clinically required?
- PT/mobilise
- VTE prophylaxis
- Is delirium present? Are non-pharmacological measures in place?
- Wound review – this is the duty of the orthopaedic unit.
- Consider plans for discharge – is it likely patient will go directly home or require sub-acute care? Begin discharge planning and discussion.

Post op – Day 3 and beyond

- analgesia review
- pressure care/areas
- bladder/bowels
- oral intake/hydration
- Hb/U&Es on Day 3 then as indicated
- PT/mobilise
- VTE prophylaxis
- Delirium
- Wound review – this is the duty of the orthopaedic unit.
- Discharge plan – referrals as clinically appropriate

At any point this flow chart may be varied by clinical need e.g.:

- acute medical complications such as IHD, pneumonia, delirium, pulm oedema, acute anaemia, wound problems
- rapid improvement allowing early discharge or referral to sub-acute

Part of discharge planning includes planning for osteoporosis management.

35. Document Status		
Updated by	Dr Rohan Wee	30/01/2024
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