



	EMS Transport	Emergency
		Note: if patient goes directly to OR, the admitting surgeon must complete pre-
		operative orders in the emergency department
Assessment /	Neurovascular assessment Vital sign assessment	Systems assessment Wital since and Olegania Control C
Monitoring	Vital sign every 30 minutesGlasgow Coma Scale	Vital signs and Glasgow Coma Score q4h or as ordered Pain assessment as per hospital protocol
	Pain assessment	Peripheral neurovascular assessment
	• Faiii assessifient	Fluid balance monitoring
		Initiate pre-operative orders
		Initiate data collection re: allergies and alerts
		Skin assessment (e.g., Braden Risk Score)
		Admission assessment (function, falls history, caregiver)
Consults	Online Medical	Orthopaedic surgeon
	Consultation available for	 History and Physical Examination
	EMS	o Consent for surgery
	Community Health and Pre- bearital Support (CHAPS)	Internal medicine as required
	hospital Support (CHAPS) referral	
	reienai	
Tests /		CBC, electrolytes, creatinine, PT/INR, glucose
Diagnostics		X-ray AP chest, AP/lateral affected hip including pelvis (and CT or MRI prn)
Diagnostics		• ECG
Interventions	Splint only; pelvic binding	Ensure IV access
	(no traction)	Insert indwelling catheter as ordered
	Position of comfort	 Titrate oxygen to O₂ saturation ≥ 92% OR ≥ baseline
		Pressure ulcer prevention strategies if Braden Score is 18 or less
Medications	Start IV and use appropriate	Appropriate dosing of analgesia: avoid Meperidine
	pain medication as per EMS Pain Management protocol	Antiemetic: avoid Dimenhydrinate Antiemetic: avoid Dimenhydrinate Antiemetic: avoid Dimenhydrinate
	Medication reconcilitation	Anticoagulant (or SCDs) for VTE prophylaxis Hold Coumadin: administer Vitamin K (5 mg po or IVPB), repeat INR as
	- Wedication reconcilitation	ordered
		 If history of anticoagulant use, determine last dose taken
		Medication reconciliation; order patient specific medications as required
Fluid, Nutrition,	As per protocol	IV as ordered
Elimination		Monitor elimination
		Diet as ordered if not going to the OR
Delirium,	Limit pain control and anti-	Consider delirium prevention strategies: orientation, fluid enhancement,
Dementia,	emetic medications with	availability of vision/hearing aids, non-pharmacological sleep enhancement
Depression	patients ~ >65 (1/2 dose)	Assessment for delirium: CAM (Confusion Assessment Method) q8h and if change in patient's clinical status. Call MD if CAM positive.
		If distressed, consider pharmacological management only if necessary
Pain Mngmt	Goal: pain manageable or contact MD. Consider non-verbal pain scales if required.	
Fall Prevention		Document falls history with admission assessment
Fall Flevelition		Consider medication review for medications associated with high risk of falls
		or delirium
Activity /		Bedrest: position on either affected or unaffected side in position of comfort
Mobility		Change position q2h and provide skincare
Teaching		Pain management
		Provide "Patient Waiting on Call" information sheet
Discharge		Confirm with patient/family re: current home situation and use of resources/
Planning		services
	Look for Goals of Care	Consider pre-injury home/functional assessment Netify family/guardian
Pt / Family	LOOK TO GOALS OF CARE	Notify family/guardian Address concerns/questions
Perspective		Address concerns/questions Have conversations leading to Goals of Care Designation (GCD)
	l	- Have conversations reading to Goals of Oale Designation (GOD)





	Pre-Operative	
Assessment /	Systems assessment	
Monitoring	Vital signs, peripheral neurovascular assessment, SpO ₂ , LOC q4h	
	Pain assessment as per hospital protocol	
	Fluid balance monitoring: intake/output every shift	
	Consent for surgery if not done	
	Finish data collection re: allergies and alerts	
	Skin assessment completed: pressure ulcer prevention strategies if Braden score 18 or less Assess for ABO and serven if appropriets.	
	 Assess for ARO and screen if appropriate Admission assessment if not done (function, falls history, caregiver) 	
	Admission assessment in not done (idiction, fails history, caregiver) Alcohol history/management. If CAGE positive, then screen for alcohol withdrawal.	
Consults	Internal medicine (IM) as required	
Consuits	Cardiac risk assessment: ASA	
	Geriatric Medicine within 72 hours of admission if applicable/available	
	If abnormal PT/INR, PTT, or patient on dabigatran, rivaroxaban, fondaparinux, consult Anaesthesia and IM	
	Discharge planner	
	Physical Therapy, Occupational Therapy	
	Dietitian, Social Worker, etc as required	
Tests /	Ensure lab and x-rays done:	
Diagnostics	• CBC, electrolytes, creatinine, PT/INR, PTT, glucose, albumin, calcium, magnesium, type and screen, TSH, B12	
	X-ray AP chest, AP/lateral affected hip including pelvis (and CT or MRI prn)	
Intomiontions	 ECG Titrate O₂ to keep SpO₂ ≥ 92% OR ≥ baseline. Call MD if > 4 L/min. 	
Interventions	 Tritate O₂ to keep SpO₂ ≥ 92% OK ≥ baseline. Call MD II > 4 D/IIIII. Complete pre-operative checklist 	
Medications	Appropriate dosing of analgesia. Avoid use of NSAIDs and Meperidine.	
Wedications	Appropriate dosing of analysesia. Avoid use of NoAlbs and Meperialite. Antiemetic. Avoid use of Dimenhydrinate.	
	Anticoagulant (or SCDs) for VTE prophylaxis	
	o Hold Coumadin: administer Vitamin K (5 mg po or IVPB): repeat INR as ordered	
	o Hold Cournadin: administer Vitamin K (5 mg po or IVPB): repeat INR as ordered o Hold dabigatran, rivaroxaban, or apixaban	
	o If history of anticoagulant use, determine last dose taken	
	Bowel management	
	Medication reconciliation (confirm admission medications) Aptibiotic to OR with potient	
	Antibiotic to OR with patient	
Florial Northitian	Acid reflux reduction as indicated IV as ordered	
Fluid, Nutrition,	NPO at midnight day of procedure	
Elimination		
Delirium,	Consider delirium prevention strategies: orientation, fluid enhancement, availability of vision/hearing aids, non-	
Dementia,	pharmacological sleep enhancement Assessment for delirium: CAM (Confusion Assessment Method) ash and if change in clinical status. If CAM is	
Depression	Assessment for delirium: CAM (Confusion Assessment Method) q8h and if change in clinical status. If CAM is positive, follow delirium management protocol.	
•	If distressed, consider pharmacological management only if necessary	
Pain Mngmt	Goal: pain 3-4/10 (manageable) or contact MD. Consider non-verbal pain scales if required.	
Fall Prevention	Document falls history with admission assessment	
rail Prevention	Consider medication review for medications associated with high risk of falls or delirium	
Activity /	Bedrest: change position q2h and provide skin/heel care	
	Foot and ankle exercises	
Mobility	DB&C 10 breaths/hour, cough if secretions	
Teaching	Pain management	
	Introduce Care Pathway to patient/family, provide 'After Your Hip Fracture' patient education book	
	DB&C, foot and ankle exercises	
	Pillow between knees	
Discharge	Confirm with patient/family re: current home situation and use of resources/services	
Planning	Consider pre-injury home/functional assessment (e.g., Blaylock tool) Interduce of inchange allowing to patient and foreith the pin to identify displaying a series.	
3	Introduce discharge planning to patient and family; begin to identify discharge options	
	Determine anticipated day of discharge (ADOD)	
Pt / Family	Obtain personal directive and Goals of Care Designation (GCD) Provide an extended a support.	
Perspective	Provide emotional support Address especially support	
	Address concerns/questions	







	OR / PACU	Day of Surgery – Post-Op
Assessment / Monitoring Consults	Confirm documentation required for surgery Systems assessment as per OR/PACU protocol	Systems assessment, CAM q8h Skin assessment daily Vital signs, peripheral neurovascular assessment Fluid balance monitoring: intake/output every shift Review patient history and pre-operative medications SpO ₂ , LOC, pain assessment, surgical dressing assessment as per protocol Medical follow-up
		Notify Physical Therapy, Occupational Therapy
Tests / Diagnostics	Intra-operative X-ray as required	
Interventions	Safe surgical checklist completed Surgery to optimize weight bearing status	 Titrate O₂ to keep SpO₂ ≥ 92% OR ≥ baseline. Call MD if > 4 L/min. Reinforce dressing prn Catheter care bid Change position q2h; pressure ulcer prevention strategies if Braden score 18 or less IV
Medications	Antibiotic < 1 hr prior to skin cut time Appropriate dosing of analgesic(s) Antiemetic Other medications as ordered	 Appropriate dosing of analgesic(s) Regular Acetaminophen dosing (maximum 3g/24h) Antiemetic. Call MD if nausea is not controlled. Anticoagulant/DVT prophylaxis Antibiotics Initiate bowel management Patient specific medications
Fluid, Nutrition, Elimination	NPO Indwelling catheter: monitor urine output	Diet as tolerated: high protein high calorie diet (or as ordered) and oral nutritional supplement tid
Delirium, Dementia, Depression		 Consider delirium prevention strategies: orientation, fluid enhancement, availability of vision/hearing aids, mobility enhancement, non-pharmacological sleep enhancement Consider OT consult for behaviours/dementia
Pain Management		 Goal: pain 3-4/10 (manageable) or contact MD. Consider non-verbal pain scales if required.
Fall Prevention Activity / Mobility		Follow standard fall prevention protocol and implement individual interventions (involve multidisciplinary team) DB&C 10 breaths/hour, cough if secretions Participate in ADLs
Teaching		 Activity as tolerated Observe joint precautions (as required) Joint precautions (as required) Provide instruction using 'After Your Hip Fracture' book
Discharge Planning		 Care coordinators involved as required Consider home/functional assessment (e.g., Blaylock tool) if not completed pre-operatively
Pt / Family Perspective		 Notify family spokesperson/guardian Provide emotional support; address concerns/questions







	Post-Op Day 1	Post-Op Day 2	
Assessment / Monitoring	Systems assessment, CAM q8h Vital signs q4h Peripheral neurovascular assessment Skin assessment daily Fluid balance monitoring: intake/output every shift Pain assessment as per hospital protocol Surgical dressing assessment	Systems assessment, CAM q8h Vital signs q shift Peripheral neurovascular assessment Skin assessment daily Fluid balance monitoring: intake/output every shift Pain assessment as per hospital protocol Incision check q shift	
Consults	Consultant follow-up as required	Consultant follow-up as required	
Tests / Diagnostics	CBC, electrolytes, creatinine, magnesium PT/INR daily if on Warfarin Call MD if Hgb < 80 or patient symptomatic Hip x-ray if not done intra-operatively (do on POD 1, 2, or 3)	CBC, electrolytes, creatinine Call MD if Hgb < 80 or patient symptomatic Hip x-ray if not done intra-operatively (do on POD 1, 2, or 3)	
Interventions	 Titrate O₂ to keep SpO₂ ≥ 92% OR ≥ baseline. Call MD if > 4 L/min required. Maintain O₂ x 24 hours post-op. Reinforce dressing prn IV lock if adequate fluid intake Consider removing catheter Change position q2h; pressure ulcer prevention strategies if Braden score 18 or less 	 Titrate O₂ to keep SpO₂ ≥ 92% OR ≥ baseline. Call MD if > 4 L/min required. D/C if SpO₂ > 92% on room air. Dressing change as per doctor's order D/C indwelling catheter in early AM if not done Change position q2h; pressure ulcer prevention strategies if Braden score 18 or less 	
Medications	 Appropriate dosing of analgesic(s) Regular Acetaminophen dosing (maximum 3g/24h) Anticoagulant/DVT prophylaxis / Antibiotics Antiemetic Consider Calcium: dietary and supplements 1200 mg Initiate Vitamin D: 2000 IU 	 Appropriate dosing of analgesic(s) Minimize narcotics: regular Acetaminophen dosing (maximum 3g/24h) Anticoagulant/DVT prophylaxis Antiemetic 	
Fluid, Nutrition, Elimination	 High protein high calorie diet (or as ordered) and oral nutritional supplement tid Complete Malnutrition Screening by POD 1. Consult dietitian as required per assessment. Ensure patient has had bowel movement since admission (by POD 2) Timed toileting QID: if unable to void within 6 hrs after catheter removal, perform bladder scan and intermittent catheterization if volume > 300 mL or patient has discomfort or feeling of fullness 		
Delirium, Dementia, Depression	 Post void bladder scan q6h until residual < 200 mL Consider delirium prevention strategies: orientation, fluid enhancement, availability of vision/hearing aids, mobility enhancement, non-pharmacological sleep enhancement For acute confusion (CAM positive), follow delirium management protocol Consider Geriatrics/Seniors Health for acute delirium 		
Osteoporosis Strategy	 Assume patient has osteoporosis unless fracture occurred as a result of high trauma in an individual considered to be at low risk for osteoporosis, and initiate treatment plan as appropriate 		
Pain Mngmt	Goal: pain 3-4/10 (manageable) or contact MD. Consider non-verbal pain scales if required.		
Fall Prevention	Follow standard fall prevention protocol and implement individual interventions (involve multidisciplinary team)		
Activity / Mobility	 Mobilize WBAT unless contraindicated Out of bed with assistance Joint precautions (as required) DB&C Encourage participation in own ADLs as able Physical Therapy assessment/treatments 	 Progress ambulation and exercises as tolerated Joint precautions (as required) DB&C Encourage participation in own ADLs as able Physical Therapy treatments 	
Teaching	 Reinforce pre-operative teaching Review Care Path, hip precautions (as required) Safe transfer techniques Falls awareness Reinforce info from 'After Your Hip Fracture' book 	Review Care Path, hip precautions (as required) Review transfer safety, equipment, including footwear Reinforce information from 'After Your Hip Fracture' book as required	
Discharge Planning	Consider pre-injury home/functional assessment (e.g., Blaylock tool) Establish discharge plans/goals with patient/family Care coordinators/Transition Services as required Consult Social Worker if necessary	Consider pre-injury home/functional assessment (e.g., Blaylock tool) Review discharge plan Care coordinators/Transition Services as required Confirm discharge location	







Pt / Family	Address concerns/questions
Perspective	

	Post-Op Day 3	Post-Op Day 4	
Assessment / Monitoring	 Systems assessment, CAM q8h Vital signs as per protocol Peripheral neurovascular assessment Skin assessment daily Fluid balance monitoring: intake/output every shift Pain assessment as per hospital protocol 		
Consults	Consultant follow-up as required		
Tests / Diagnostics	 CBC, electrolytes, creatinine PT/INR daily if on Warfarin Call MD if Hgb < 80 or patient symptomatic Hip X-ray if not done intra-operatively (do on POD 1, 2, or 3) 	 As ordered Call MD if Hgb < 80 or patient symptomatic 	
Interventions	 Titrate O₂ to keep SpO₂ ≥ 92% OR ≥ baseline. Call MD if > 4 L/min required. D/C if SpO₂ > 92% on room air. Dressing change as per doctor's orders Change position q2h; pressure ulcer prevention strategies if Braden score 18 or less Discontinue saline lock after blood work results assessed 		
Medications	 Appropriate dosing of analgesic(s) Transition to oral analgesics Minimize narcotics: regular Acetaminophen dosing Anticoagulant/DVT prophylaxis Antiemetic 	Appropriate dosing of analgesic(s) Minimize narcotics: regular Acetaminophen dosing Anticoagulant/DVT prophylaxis Antiemetic	
Fluid, Nutrition, Elimination	 High protein high calorie diet (or as ordered) and oral nutritional supplement tid Timed toileting QID Ensure patient has had bowel movement since admission Encourage po fluids if not contraindicated 	 High protein high calorie diet (or as ordered) and oral nutritional supplement tid Ensure proper elimination; timed toileting QID 	
Delirium, Dementia, Depression	 Consider delirium prevention strategies: orientation, fluid enhancement, availability of vision/hearing aids, mobility enhancement, non-pharmacological sleep enhancement For acute confusion, follow delirium management protocol Consider Geriatrics/Seniors Health for acute delirium 		
Osteoporosis Strategy	Osteoporosis assessment and follow-up including calcium, nutrition, Vitamin D orders/teaching		
Pain Mgmnt	Goal: pain 3-4/10 (manageable) or contact MD. Conside	r non-verbal pain scales if required.	
Fall Prevention	 Continue fall prevention strategies If deemed an ongoing risk to fall, consider OT in-home consult 	Fall prevention strategies	
Activity / Mobility	 Progress ambulation and exercises as tolerated Joint precautions (as required) DB&C Encourage participation in own ADLs as able Physical Therapy treatments OT assessment/intervention of ADLs and review of home equipment needs if plan for discharge home 		
Teaching	 Review: Care Path, hip precautions (if required), transfer safety, equipment including footwear Reinforce information from 'After Your Hip Fracture' book as required 		
Discharge Planning	 Review discharge plan Care coordinators/Transition Services involvement as required Confirm discharge location 		
Pt / Family Perspective	Address concerns/questions		







Assessment / Monitoring - Systems assessment / skin assessment daily visions of the sessment per		Post-Op Day 5 to Transfer / Discharge	Day of Discharge or Transfer	
Consults Consultant follow-up as required Discharge Summary: copy family doctor Tests / Diagnostics Interventions Interventions Titrate O, to keep SpO, ≥ 92% OR ≥ baseline. Call MD if > As ordered Dressing change as per doctor's orders Change position q2h, pressure ulcer prevention strategies if Braden score 18 or fess Medications Medications Medications Titrate O, to keep SpO, ≥ 92% OR ≥ baseline. Call MD if > As ordered Dressing change as per doctor's orders Change position q2h, pressure ulcer prevention strategies if Braden score 18 or fess Consider bishopshonate therapy Anticoagulant/DVT prophylaxis Consider bishopshonate therapy Anticoagulant/DVT prophylaxis Elimination Delirium, Dementia, Depression Depression Depression Osteoporosis Strategy Strategy Tell Mpmmt Costeoporosis Strategy Pain Mgmmt Goal: pain 3-4/10 (manageable) or contact MD. Consider non-verbal pain scales if required. Progress ambulation and exercises as tolerated Joint precautions (as required) Joint precautions (as required) Joint precautions (as required) Pain Mgmmt Fall Prevention Teaching Progress ambulation and exercises as tolerated Joint precautions (as required) Progress ambulation and exercises as tolerated Joint precautions (as required) Progress ambulation and exercises as tolerated Joint precautions (as required) Progress ambulation and exercises as tolerated Joint precautions (as required) Progress ambulation and exercises as tolerated Joint precautions (as required) Progress ambulation and exercises as tolerated Joint precautions (as required) Progress ambulation and exercises as tolerated Joint precautions (as required) Progress ambulation and exercises as tolerated Joint precautions (as required) Progress ambulation and exercises as tolerated Joint precautions (as required) Progress ambulation and exercises as tolerated Joint precautions (as required) Progress ambulation and exercises as tolerated Joint precautions (as required) Progress ambulation and exercises a	Assessment /			
Status.	Monitoring			
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Book and/or inform of follow-up appointments	Consults		Consultant follow-up as required	
Discharge Summany: copy family doctor	Conounc			
A rangements or follow-up made for outpatients or home collection service (lab tests), including GP		, ,, ,	Discharge Summary: copy family doctor	
Interventions - Titrate O₂ to keep SpO₂ ≥ 92% OR ≥ baseline. Call MD if > 4 L/min required. DiC if SpO₂ > 92% on room air. - Dressing change as per doctor's orders - Change position q2h, pressure ulcer prevention strategies if Braden score 18 or less - Medications - Anticoagulant/DVT prophylaxis - Anticoagulant/DVT prophylaxis - Consider bisphosphonate therapy - Antimemetic - Discontinue supplement after discharge unless RD consult advises to plan for continued supplementation. - Elimination - Elimination - Elimination - Elimination - Consider Gratinics/Seniors Health for acute delirium - Consider OT consult for cognitive assessment when medically stable - If CAM positive in hospital, include in Discharge Summary - Osteoporosis Strategy - Pain Mgmnt - Fall Prevention - Fall Prevention - Fall Prevention - Fall Prevention strategies - Progress ambulation and exercises as tolerated - Joint precautions (as required) - Disacci - Progress ambulation and exercises as tolerated - Joint precautions (as required) - Disacci - Preview Home Exercise program - Review Home Exercise program - Discontarge - Confirm discharge plan and ensure discharge - If exercise program - Precautions of the precaution of the precautions of the precautions of the precautions of the program and appropriate referrals initiated - Precaution of the precautions of required) - Disacci - Precautions of the program - Review Home Exercise program - Review Home Exercise program - Discharge - Confirm discharge plan and ensure discharge - Precautions trategies - Fall prevention of the precautions of t	Tests /	As ordered		
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Dressing change as per doctor's orders	Interventions			
Change position q2h; pressure ulcer prevention strategies if Braden score 18 or less (environmental) fall risk assessment (environmental) (environmental) fall risk assessment (environmental) environmental pale fall risk assessment (environmental pale fall risk (environmental pale fall risk assessment (environme				
Strategies if Braden score 18 or less				
## Appropriate dosing of analgesic(s) # Minimize narcotics: regular Acetaminophen dosing Anticoagulant/DVT prophylaxis Consider bisphosphonate therapy Anticoagulant/DVT prophylaxis Consider bisphosphonate therapy Anticoagulant/DVT prophylaxis Discontinue supplement after discharge unless RD consult advises to plan for continued supplementation. ### Discontinue supplement after discharge unless RD consult advises to plan for continued supplementation. ### Discontinue supplement after discharge unless RD consult advises to plan for continued supplementation. ### Discontinue supplement after discharge unless RD consult advises to plan for continued supplementation. ### Discontinue supplement after discharge unless RD consult advises to plan for continued supplementation. ### Discontinue supplement after discharge unless RD consult advises to plan for continued supplementation. ### Discontinue supplement after discharge unless RD consult advises to plan for continued supplementation. ### Discontinue supplement after discharge unless RD consult advises to plan for continued supplementation. ### Discontinue supplement after discharge unless RD consult advises to plan for continued supplementation. ### Discontinue supplement after discharge unless RD consult advises to plan for continued supplementation. ### Discontinue supplement after discharge unless RD consult advises to plan for continued supplementation. ### Discontinue supplementatio				
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Fluid, Nutrition, Elimination Fluid, Nutrition, Discontinue supplement after discharge unless RD consult advises to plan for continued supplementation. Ensure proper elimination; timed toileting QID as required Consider delirium prevention strategies: orientation, fluid enhancement, availability of vision/hearing aids, mobility enhancement, non-pharmacological sleep enhancement Consider OT consult for loude delirium Consider OT consult for cougnitive assessment when medically stable If CAM positive in hospital, include in Discharge Summary Osteoporosis Strategy Pain Mgmnt Fall Prevention Goal: pain 3-4/10 (manageable) or contact MD. Consider non-verbal pain scales if required. Fall prevention strategies Fall prevention strat			Consider bisphosphonate therapy	
Fluid, Nutrition, Elimination		Consider bisphosphonate therapy		
Discontinue supplement after discharge unless RD consult advises to plan for continued supplementation.				
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Dementia, Depression	Delinione			
- For acute confusion, follow delirium management protocol - Consider Geriatrics/Seniors Health for acute delirium - Consider OT consult for cognitive assessment when medically stable - If CAM positive in hospital, include in Discharge Summary - Osteoporosis Strategy - Osteoporosis & Fall Prevention information letter faxed to primary care provider and reviewed with patient/family - Goal: pain 3-4/10 (manageable) or contact MD. Consider non-verbal pain scales if required. - Fall Prevention - Fall Prevention strategies - Fall prevention strategies - Fall prevention strategies - If fall risk factors persist, ensure the receiving facility or Home Care services is aware and appropriate referrals initiated - Joint precautions (as required) - DB&C - Encourage participation in own ADLs as able - OT assessment/intervention of ADLs and review of home equipment needs if plan for discharge home - Physical Therapy treatments - Review Care Path, hip precautions (if required), transfer safety, equipment including footwear - Review Home Exercise program - Review Gare Path, hip precautions (if required), transfer safety, equipment including footwear - Review Gare Path, hip precautions (if required), transfer safety, equipment including footwear - Review Gare Path, hip precautions (if required), transfer safety, equipment including footwear - Review Gare Path, hip precautions (if required), transfer safety, equipment including footwear - Review Gare Path, hip precautions (if required), transfer safety, equipment including footwear - Review Gare Path, hip precautions (if required), transfer safety, equipment including footwear - Review Gare Path, hip precautions (if required), transfer safety, equipment including footwear - Review Gare Path, hip precautions (if required), transfer safety, equipment including footwear - Review Gare Path, hip precautions (if required), transfer safety, equipment including footwear - Review Gare Path, hip precautions (if required), transfer safety, equipment including footwear - Review Gare Path	The state of the s			
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Confirm discharge plan and ensure discharge				
Planning	Planning		criteria met	
 Ensure appropriate level of care arranged Complete Orthopaedic Transfer Order if 			Complete Orthopaedic Transfer Order if	
transferring				







Pt / Family Perspective

- Address concerns/questions; patient/family expresses confidence in activity level and safe precautions
- Patient or caregiver able to demonstrate administration of DVT prophylaxis medication, or alternate arrangements have been made

