Multidisciplinary Transition Checklist for Patients with a Fractured Hip

**Instructions:** Initial and date when each activity is completed. Please sign your initials and designation on the bottom of the page (on the other side).

*If there is any variance, please document it on the transfer sheet* (can use comment section to make note of it).

If areas are not applicable, write “NA” in the date section (longer line).

This document **does not** get sent with the patient to the next destination; please destroy upon discharge.

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**Assessment/Monitoring:**

___ / ______ Abnormal assessment findings (e.g., pressure areas, wounds) documented on transfer sheet or home care referral.

Consults/Referrals:

___ / ______ Consults are closed or plan is in place to address issues.

___ / ______ Referral made for OT/PT to see at next facility if required.

___ / ______ Orthopedic follow-up visit booked or have informed patient/family/caregiver how to arrange. Include surgeon name, date, time, and place of appointment. Include cast clinic contact information.

**Tests/Diagnostics:**

___ / ______ POD 2-3 lab work drawn (CBC, electrolytes, creatinine) and reviewed.

___ / ______ Post-operative hip x-ray completed (if indicated).

___ / ______ Additional laboratory tests indicated on transfer sheet and/or requisition given to facility or patient/family/caregiver with instruction.

Interventions:

___ / ______ Care of the surgical incision documented on transfer sheet or provided to patient/family/caregiver. If receiving Home Care for dressing changes/wound care, doctor’s order and instruction for same provided to Home Care.

___ / ______ Indicate on discharge form to remove staples at 10-14 days. Staple remover sent with patient.

___ / ______ IV removed after blood work results have been assessed.

___ / ______ Catheter removed and patient voiding sufficiently.

___ / ______ Patient has had a bowel movement post-operatively. Indicate date of last BM on transfer sheet and list of effective bowel medications.

**Medications:**

___ / ______ Medication review has been completed with patient/family/caregiver (understand what medications are for, and how to properly take medications).

___ / ______ Medication reconciliation completed.

___ / ______ Medication list sent to next facility 24 hours prior to discharge to allow time to arrange medications.

___ / ______ Prescriptions given to patient/family/caregiver on discharge as required.

___ / ______ DVT prophylaxis return demonstration if self-administering. If unable to self-administer, arrangements made for Home Care or family to administer. Direction given for duration of therapy.

**Fluid, Nutrition, Elimination:**

___ / ______ Teaching about nutrition and need for high protein/high calorie diet with patient/family/caregiver.

___ / ______ Suggest initiating a dietitian referral at next location if concerned with nutritional status.

**Delirium:**

___ / ______ If CAM +, plan must be included in discharge summary for next destination and for GP/primary caregiver.

___ / ______ Delirium booklet and teaching provided to family/caregiver if CAM +.
Fracture and Fall Prevention Strategies:

___ / _______ Osteoporosis and fall prevention information letter has been given and reviewed with patient/family/caregiver. Copy of letter sent to GP/primary care provider.

___ / _______ Osteoporosis teaching has been completed with patient/family/caregiver.

___ / _______ Falls awareness and prevention teaching with patient/family/caregiver.

___ / _______ Home safety evaluation arranged if required (may self-refer to Home Care if needed).

Pain Management:

___ / _______ Pain management plan in place. Patient reporting manageable pain (goal 3-4/10). List effective pain medications on transfer sheet.

___ / _______ Pain management teaching completed.

Activity/Mobility/Rehab:

___ / _______ Weight bearing status has been determined and indicated on transfer sheet. If patient NWB, indicate plan for progression.

___ / _______ Mobility teaching completed with patient/family/care provider including: hip precautions, weight bearing, exercises, use of aids, safe transfers and stairs.

___ / _______ Progressive ambulation/exercise plan established with measurable goals and timeline to promote or enhance pre-fracture functioning.

___ / _______ ADL plan established with measurable goals and timeline to increase independence in performance.

___ / _______ Equipment requirements identified and arranged/in place for next destination.

Communication/Transfer of Care:

___ / _______ Discussion regarding final discharge destination has been initiated.

___ / _______ Frailty assessment completed and results documented in patient chart.

___ / _______ Discharge instruction sheet reviewed with/given to patient/family/caregiver if going home.

___ / _______ Provide Home Care contact information (e.g., phone number) to patient/family/caregiver if going home.

___ / _______ If transferring from acute surgical to rural/rehab facility, ensure case manager contact information from Supportive Living facility is on chart (as required).

___ / _______ Phone call handover provided to next receiving facility (including PT>PT, OT>OT, Nursing>Nursing).

Include:
- current behaviors, mobility status, frailty assessment/score
- current functional level for ADLs (include pre-fracture function and level of function at discharge from acute surgical unit)

___ / _______ If transferring patient prior to POD 5, send Fractured Hip Acute Care Pathway with patient.

Other Comments:
___________________________________________________________________________________
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___________________________________________________________________________________

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