
ICP APPLICATIONS

Southampton University Hospitals NHS Trust integrated care pathway for revision of total hip replacement

Merrilyn Dracass and Caroline Sharland

Southampton University Hospitals NHS Trust

INTRODUCTION

The orthopaedic unit at Southampton University Hospitals NHS Trust has been using a number of integrated care pathways (ICPs) since 1999 to manage patients having elective orthopaedic surgery, including total hip replacements. The ICP for total hip replacement patients was originally written and used for all hip replacements regardless of whether they were primary or revision procedures. However, early analysis of the variances of the total hip replacement ICP clearly

demonstrated a need for an additional pathway specifically written for the revision procedure. The ICP for revision of total hip replacement is shown as an example of how ongoing audit of an existing ICP can be used to identify the need for a modified pathway where significant variations in treatment regularly occur.

All orthopaedic ICPs currently in use at Southampton have been developed and written with reference to and with the agreement of the whole multidisciplinary team who care for the patients before, during and after their surgery.

Merrilyn Dracass BA, DMS, *Clinical Effectiveness Manager*; **Caroline Sharland RGN**, *Trauma & Orthopaedics Ward Sister*, Southampton General Hospital, Tremona Road, Southampton SO16 6YD, UK.

E-mail: Merrilyn.Dracass@suht.swest.nhs.uk

© Southampton University Hospitals NHS Trust.

All rights reserved.

REVISION OF TOTAL HIP REPLACEMENT

Consultant:

Patient Name:

Date of Birth:

Hosp. No:

Address:

GP:

(Attach sticky **addressograph** if available)

AGE _____ LEFT / RIGHT DATE OF OPERATION ___/___/_____

The following criteria must be met for this ICP to be appropriate for a patient:
REVISION of previous total hip replacement

Abbreviations Used in this ICP:

Abdo	Abdomen	mls	Millilitres
Abs	Antibiotics	MRSA	Methicillin-resistant <i>Staph. aureus</i>
AM	Morning	MSkel	Musculo-skeletal system
AP	Anterior posterior	MSU	Mid-stream urine
APTT	Actual prothrombin time	Neuro	Neurological system
A-V	Arterio-venous	No.	Number
BP	Blood pressure	NPU	Not passed urine
CVA	Cerebro-vascular accident	O ₂	Oxygen
CVS	Cardiovascular system	Obs	Observations
CXR	Chest X-ray	op	Operation
DOB	Date of Birth	OPA	Outpatient Appointment
DVT	Deep vein thrombosis	OT	Occupational Therapist
ECG	Electrocardiograph	PCA	Patient-controlled analgesia
FBC	Full blood count	PE	Pulmonary embolism
FWB	Full weight-bearing	PM	Afternoon
GI	Gastrointestinal	PONV	Post-operative nausea and vomiting
G&S	Group & save	Pre-op	Pre-operative(ly)
HMR	Discharge summary	PVD	Peripheral vascular disease
hr(ly)	Hour(ly)	PWB	Partial weight-bearing
HR	Heart rate	Resp	Respiratory system
HTN	Hypertension	SOB/OE	Shortness of breath/on exertion
ICP	Integrated care pathway	TED	Anti-emboli stocking
INR	International normalised ratio (blood clotting)	THR	Total hip replacement
IV	Intravenous	TTO's	Tablets to take home
IVAB	Intravenous antibiotic	TTWB	Touch toe weight-bearing
L	Lateral	U&E	Urea and electrolytes
MI	Myocardial infarction	XM	Cross match

HOW TO USE THIS ICP

Integrated Care Pathways (ICPs) are being used to make sure that the care we offer is :

- of the highest quality
- the best we can deliver
- evidence-based
- efficient.

The multidisciplinary team has met together to discuss and agree the care that is best for a typical patient who meets the criteria for this ICP.

The ICP is therefore a guideline for the best multidisciplinary care for a patient.

Remember, however, that every patient is an individual and that this ICP is NOT a substitute for your clinical judgement and expertise. You should therefore use it as follows:

1. Complete the sample initial box on the opposite page of this document.
2. Look at what is planned for the patient today as set out in the ICP and decide if this is appropriate for your patient. If so, deliver the care and initial the box next to the activity. (NB Some sections require the actual times when something happens to the patient to be recorded, so be sure to note these times.)
3. If the planned care is not appropriate for your patient, then you need to record a 'variance', next to the activity as follows:
 - time the variance occurred
 - initial the variance recording
 - what action you did instead of that planned in the ICP
 - why the planned care was not considered appropriate
4. If more space is required to record variance, continue on the multi-disciplinary notes sheet, making sure it is clear to which activity your notes refer.

Once the ICP is well established, there will be regular feedback of the variances occurring. In this way, the team can regularly review its care and constantly maintain a high standard.

If you have any queries or problems please contact:
Sister Sharland, ward F3
Ext 6479

PAST MEDICAL HISTORY

A large, empty rectangular box with a thin black border, intended for recording a patient's past medical history. The box is centered on the page and occupies most of the lower half of the document.

**MULTIDISCIPLINARY
DISCHARGE PLAN**

Patient name:	
D.O.B.:	Hosp. No. :

Discharge destination: Planned discharge date:

MEDICAL					
HMR complete	<input type="text"/>	Sick note needed:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Done <input type="checkbox"/>
TTOs prescribed	<input type="text"/>				
I agree with the proposed date of discharge.		Signed:		Date:	
NURSING					
Transport	OPA	TTOs	District Nurse	Transfer letter	
Own <input type="checkbox"/>	In diary <input type="checkbox"/>	Needed <input type="checkbox"/>	Required <input type="checkbox"/>	Required <input type="checkbox"/>	
Hospital <input type="checkbox"/>	Booked <input type="checkbox"/>	Written <input type="checkbox"/>	Booked <input type="checkbox"/>	Written <input type="checkbox"/>	
Booked <input type="checkbox"/>	On ward <input type="checkbox"/>	In Notes <input type="checkbox"/>	
For ambulance:	.....	Given to	Written		
qualified <input type="checkbox"/>	Given to	patient <input type="checkbox"/>	Given to		
unqualified <input type="checkbox"/>	patient <input type="checkbox"/>	patient <input type="checkbox"/>		
sitting <input type="checkbox"/>					
stretcher <input type="checkbox"/>					
I agree with the proposed date of discharge.		Signed:		Date:	
PHYSIOTHERAPY					
Patient is safe mobilising with crutches <input type="text"/>		Requires follow-up at home:			
Patient is safe on stairs <input type="text"/>		Yes <input type="checkbox"/>			
		No <input type="checkbox"/>			
		Booked <input type="checkbox"/>			
		By:.....			
I agree with the proposed date of discharge.		Signed:		Date:	
OCCUPATIONAL THERAPY					
Patient has appropriate aids <input type="text"/>					
Requires follow-up at home: Yes <input type="checkbox"/>		No <input type="checkbox"/>			
		Booked <input type="checkbox"/>			
		By:.....			
I agree with the proposed date of discharge.		Signed:		Date:	
MULTIDISCIPLINARY DISCHARGE / SOCIAL WORKER NOTES				Sign/ Date	
Requires: MOW <input type="checkbox"/>					
Welcome Home <input type="checkbox"/>					
Careline <input type="checkbox"/>					
Other (please state):					
PATIENT SATISFACTION COMMENTS				Sign/ Date	

OCCUPATIONAL THERAPY

Community Pre-operative Home Assessment

Please paste in or insert the assessment sheet at this point or complete sections below

Mobility	Transfer
PADL	DADL

**ORTHOPAEDIC
PRE-ASSESSMENT
CLINIC**

Patient name: _____
 D.O.B.: _____ Hosp. No. : _____

Occupation: _____

Style of Accommodation

Home situation

Next of kin:

Smokes: Yes No
 Amount: _____

Alcohol: Yes No
 Amount: _____

Observations
 Temperature: _____
 Pulse: _____
 Respirations: _____
 Blood pressure: _____

ECG needed: Yes No Done

Weight: _____

Urinalysis: _____

MSU indicated: Yes No Done

Blood sugar? Yes No Result _____

MRSA risk? Yes No Swab

Other indicated tests as required:

- Name _____ Completed
- Name _____ Completed

Blood tests
 FBC U&Es Antibody screen Other (specify) _____
 Arrangement for group and save (TKR) or cross match (THR):
 Done Card given to patient To be done on admission

X-ray card given to patient

Community OT home visit done Form in ICP Yes No
 If not done, has been arranged Admission to be delayed until seen by OT

Social work referral needed Yes No

Written information on surgery given Yes No

PCA and Epidural booklets given Yes No

Other relevant information:

Signed: _____
 Date: _____

Please paste in or insert the typed operation notes at this point

**ORTHOPAEDIC
PRE-ASSESSMENT
FORM**

Patient name:	
D.O.B.:	Hosp. No. :

Date:..... TCI:..... Age:.....

Diagnosis:.....

Operation:.....

History:.....

.....

PAST MEDICAL/SURGICAL HISTORY

PROBLEMS

.....
.....
.....
.....
.....

DIRECT QUESTIONING

SYSTEMS REVIEW

- MI
- HTN
- CVA
- PVD
- DVT/PE
- ULCER
- GI bleed
- SOB
- DIABETES
- EPILEPSY

- CVS:**
- Orthopnoea
- Angina
- Palpitations
- SOB
- RESP:**
- SOBOE
- Cough
- Haemoptysis
- ABDO:**
- Bowel habit
- Stool colour
- Weight loss
- NEURO:**
- Numbness
- Tingling
- Headaches
- Blackouts
- URINARY:**
- Haematuria
- General

COMMENTS:.....
.....
.....

DRUG HISTORY

- 1..... 5.....
- 2..... 6.....
- 3..... 7.....
- 4..... 8.....

SOCIAL HISTORY

- Smoke...../day ALCOHOL.....units/wk
- WORK.....
- LIVES IN.....
- RESTRICTIONS.....

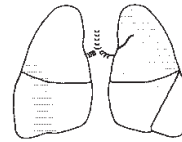
ALLERGIES

ON EXAMINATION

APPEARANCE:..... BP:..... HR:.....reg/irreg

CVS:

Resp:



Neuro:

MSkel:

Abdo:

Pulses:

PLAN: (remember G&S/XM lasts 7 days only)

- | | | |
|------------------------------|-------------------------------|---|
| FBC <input type="checkbox"/> | INR <input type="checkbox"/> | DRUG CHART <input type="checkbox"/> |
| U&E <input type="checkbox"/> | APTT <input type="checkbox"/> | ANTIBIOTIC COVER <input type="checkbox"/> |
| G&S <input type="checkbox"/> | CXR <input type="checkbox"/> | DVT PROPHYLAXIS <input type="checkbox"/> |
| XM <input type="checkbox"/> | ECG <input type="checkbox"/> | REPEAT XRAYS <input type="checkbox"/> |
| | | ANTIBODY SCREEN <input type="checkbox"/> |

THINGS TO DO ON ADMISSION

- 1.
 - 4.
 - 2.
 - 5.
 - 3.
 - 6.

DOCTOR:

PRINT NAME..... SIGN..... BLEEP.....

**WARD ADMISSION -
NURSE**

Patient name:	
D.O.B.:	Hosp. No. :

Date: Ward: Preferred name:

Previous nurse documentation complete

Named Nurse:.....

Religion:.....

Waterlow score:
Skin condition:
Pressure areas on admission:
.....

Social work department contacted re admission

First part of theatre checklist & information complete <input type="checkbox"/>
Nil by mouth from:

Other information:

Moving and handling assessment complete

Baseline observations:
Temperature Pulse
Respirations BP

Pain / discomfort

Communication

Elimination

Dietary needs

Sleep pattern

Work / leisure activities

Valuables / where held

Cross match done

Pre-op nurse documentation complete

Signed:..... Date:.....

Day of ICP: PRE-OP ON DAY OF SURGERY	Date:
---	-------

MEDICAL			
ACTIVITY	TIME	SIGN	REASON FOR VARIANCE & ACTION TAKEN
Patient understands procedure			
Admission documentation complete			
Relevant DVT prophylactic medication prescribed as per Directorate protocol			
IV Vancomycin & Cefuroxime to be prescribed			
PCA & epidural explanation given			
NURSING			
ACTIVITY		SIGN	REASON FOR VARIANCE & ACTION TAKEN
Previous nurse documentation complete			
Discharge plan commenced			
Plan of care explained			
Team leaflet given			
Information on PCA/epidural given			
Menu ordering explained			
Moving and handling assessment			
Shown around ward			
A-V impulse machine available/with patient			
Wedge with patient			
Measured for TED stockings (State size: _ _ _ _ _)			
TEDS on before theatre? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Theatre checklist started			
Record time of start of Nil By Mouth: _ _ _ _ _			
Deep breathing exercises taught			

Date:

COMPLETE THIS BOX
Patient Name:
Hospital Number: _____

TIME	MULTIDISCIPLINARY NOTES	SIGN
------	-------------------------	------

Day of ICP: POST-OP ON DAY OF SURGERY	Date:
--	-------

MEDICAL				
ACTIVITY	TIME	SIGN	REASON FOR VARIANCE & ACTION TAKEN	
Review patient				
Cards written for FBC, U&E and X-ray				
IV Vancomycin & Cefuroxime to be administered until get result of cultures				
IV fluids prescribed: Yes <input type="checkbox"/> No <input type="checkbox"/>				
NURSING				
ACTIVITY	SIGN	REASON FOR VARIANCE & ACTION TAKEN		
Record time patient returned to ward: _ _ _ _ _				
Wound dressing satisfactory				
PONV controlled: Yes <input type="checkbox"/> No <input type="checkbox"/>				
Waterlow score: _ _ _ _ _ If more than 10, take action & document				
Drains patent and draining				
Moving and handling assessment done				
O ₂ therapy: _ _ _ _ _ litres/min (Record as variance if rate has to change) 24 hrs <input type="checkbox"/> or 48 hrs <input type="checkbox"/>				
<i>Obs. are recorded on MEWS chart: routine post-op recovery as follows: half-hourly x 4; hourly x 4; 4-hourly obs. once stable. PLEASE RECORD ANY VARIANCE FROM THIS PATTERN ON THIS ICP.</i>				
Variance of Obs. recording (if applicable)				
IV ABs due at: (1) _ : _ (2) _ : _ (3) _ : _ Give until culture results known				
Record time patient first passed urine Catheterise patient if unable to pass urine for 24 hours (needs Gentamicin cover)	XXX			
IF patient catheterised: Record time of catheterisation Gentamicin prescribed Yes <input type="checkbox"/> No <input type="checkbox"/>				
Patient eating : Yes <input type="checkbox"/> No <input type="checkbox"/> Patient drinking : Yes <input type="checkbox"/> No <input type="checkbox"/>				
PUT INITIALS IN COLUMN	AM	PM	NIGHT	PLEASE INCLUDE TIME OF ANY VARIANCE
Pain score recorded.....	.....	.....	.....
Sedation score recorded.....	.....	.....	.....
A-V impulse boots on.....	.....	.....	.....
PCA/Epidural obs done.....	.....	.....	.....
Wedge in place.....	.....	.....	.....
Fluid chart complete.....	.....	.....	.....
TEDs on.....	.....	.....	.....

Day of ICP: DAY ONE POST-OP	Date: _____
------------------------------------	-------------

MEDICAL			
ACTIVITY	TIME	SIGN	REASON FOR VARIANCE & ACTION TAKEN
Review vital signs			
Analgesia effective			
Urine output satisfactory			
Check X-ray of AP is satisfactory			
Mobilize 48 hrs post-op if X-ray satisfactory, unless otherwise specified			
Wound drainage satisfactory			
Discontinue IV line			

NURSING		
ACTIVITY	SIGN	REASON FOR VARIANCE & ACTION TAKEN
Vital signs 6 hrly : 6 <input type="checkbox"/> 12 <input type="checkbox"/> 18 <input type="checkbox"/> 24 <input type="checkbox"/> <small>(Tick when done and initial underneath)</small>		
Assisted with hygiene needs		
On canvas for X-ray (AP only)		
Record time that IV infusion discontinued: _____		
Blood taken		
X-ray taken		
O ₂ therapy: _____ litres/min 24 hrs <input type="checkbox"/> or 48 hrs <input type="checkbox"/>		
TEDs removed & legs/heels inspected		
PCA/epidural site checked		
Drains removed within 24 hrs: Yes <input type="checkbox"/> No <input type="checkbox"/> If "No", record time drains removed: _____		
Record total drainage amount: _____ mls		
Dressing reduced: Yes <input type="checkbox"/> No <input type="checkbox"/>		

<i>PUT INITIALS IN COLUMN</i>	AM	PM	NIGHT	<i>PLEASE INCLUDE TIME OF ANY VARIANCE</i>
Pain score recorded.....	
Sedation score recorded.....	
A-V impulse boots on.....	
PCA/Epidural obs done.....	
Wedge in place.....	
Fluid chart complete.....	
TEDs on.....	

PHYSIOTHERAPY		
ACTIVITY	DONE	REASON FOR VARIANCE & ACTION TAKEN
Sliding board with patient		
Exercises taught		
Precautions explained		
Time _____ Sign _____		

Day of ICP: DAY TWO POST-OP	Date: _____
------------------------------------	-------------

MEDICAL			
ACTIVITY	TIME	SIGN	REASON FOR VARIANCE & ACTION TAKEN
Review patient			
Blood results are satisfactory			
Check cultures & review antibiotic regime			

NURSING				
ACTIVITY	SIGN			REASON FOR VARIANCE & ACTION TAKEN
Vital signs 6 hrly : 6 <input type="checkbox"/> 12 <input type="checkbox"/> 18 <input type="checkbox"/> 24 <input type="checkbox"/> <small>(Tick when done and initial underneath)</small>				
Assisted with hygiene needs				
Wound dressing checked				
Wound dressing changed: Yes <input type="checkbox"/> No <input type="checkbox"/>				
Pressure areas checked				
Pressure areas intact: Yes <input type="checkbox"/> No <input type="checkbox"/>				
TEDs removed & legs/heels inspected				
TEDs replaced: Yes <input type="checkbox"/> No <input type="checkbox"/>				
Moving & handling assessment complete				
<i>PUT INITIALS IN COLUMN</i>	AM	PM	NIGHT		PLEASE INCLUDE TIME OF ANY VARIANCE
Pain score recorded .....	.....	.....	.....
Sedation score recorded .....	.....	.....	.....
A-V impulse boots on .....	.....	.....	.....
Wedge in place .....	.....	.....	.....
PCA/epidural discontinued: Yes <input type="checkbox"/> No <input type="checkbox"/>				
If "Yes", time discontinued: _____				
If "No", PCA/epidural obs. done.				

PHYSIOTHERAPY		
ACTIVITY	DONE	REASON FOR VARIANCE & ACTION TAKEN
Exercises explained		
Able to perform leg exercises		
Assisted out of bed		
State walking aid used: _____		Time: _____ Sign: _____

OCCUPATIONAL THERAPY		
ACTIVITY	DONE	REASON FOR VARIANCE & ACTION TAKEN
Reviewed by OT		
Reinforced precautions		
Time: _____ Sign: _____		

Day of ICP: DAY THREE POST-OP	Date:
--------------------------------------	-------

MEDICAL				
ACTIVITY	TIME	SIGN	REASON FOR VARIANCE & ACTION TAKEN	
Review patient				
NURSING				
ACTIVITY	SIGN			REASON FOR VARIANCE & ACTION TAKEN
Vital signs 6 hrly : 6 <input type="checkbox"/> 12 <input type="checkbox"/> 18 <input type="checkbox"/> 24 <input type="checkbox"/> <i>(Tick when done and initial underneath)</i>				
Assisted with hygiene needs				
Wound site satisfactory? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If "No", give details in Variance column</i>				
Patient performing exercises				
TEDs removed & legs/heels inspected				
TEDs replaced: Yes <input type="checkbox"/> No <input type="checkbox"/>				
Bowels open: Yes <input type="checkbox"/> No <input type="checkbox"/> If "No", have laxatives been offered? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes", has catheter been removed with gentamicin cover? Yes <input type="checkbox"/> No <input type="checkbox"/>				
<i>PUT INITIALS IN COLUMN</i>	AM	PM	NIGHT	<i>PLEASE INCLUDE TIME OF ANY VARIANCE</i>
Pain score recorded .....	.....	.....	.....
Sedation score recorded.....	.....	.....	.....
A-V impulse boots on .....	.....	.....	.....
Wedge in place .....	.....	.....	..
PCA/epidural discontinued: Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (not in place) <input type="checkbox"/> If "Yes", time discontinued: _____				
If "No", PCA/epidural obs. done....				
PHYSIOTHERAPY				
ACTIVITY	DONE			REASON FOR VARIANCE & ACTION TAKEN
Mobile around room				
Mobile out to toilet one way				
Time _____ Sign _____				

MEDICAL				
ACTIVITY	TIME	SIGN	REASON FOR VARIANCE & ACTION TAKEN	
Review patient				
NURSING				
ACTIVITY	SIGN		REASON FOR VARIANCE & ACTION TAKEN	
Assisted with mobilising to washroom				
Wound site satisfactory? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If "No", give details in Variance column</i>				
Patient performing exercises				
TEDs removed & legs/heels inspected				
TEDs replaced: Yes <input type="checkbox"/> No <input type="checkbox"/>				
Waterlow score: _____ <i>If more than 10, take action & document</i>				
Bowels open: Yes <input type="checkbox"/> No <input type="checkbox"/> If "No", have laxatives been offered? Yes <input type="checkbox"/> No <input type="checkbox"/>				
PUT INITIALS IN COLUMN	AM	PM	NIGHT	PLEASE INCLUDE TIME OF ANY VARIANCE
Pain score recorded .....	.....	.....	.....
Sedation score recorded .....	.....	.....	.....
A-V impulse boots on .....	.....	.....	.....
Obs 4-hourly.....	.....	.....	.....
Wedge in place.....	.....	.....	.....
PHYSIOTHERAPY				
ACTIVITY	DONE		REASON FOR VARIANCE & ACTION TAKEN	
Mobile around room independently				
Mobile out to toilet both ways				
Time _____ Sign _____				
OCCUPATIONAL THERAPY				
ACTIVITY	DONE		REASON FOR VARIANCE & ACTION TAKEN	
Safe and independent transfer from: Bed..... Chair..... Toilet.....				
Time _____ Sign _____				

MEDICAL				
ACTIVITY	TIME	SIGN	REASON FOR VARIANCE & ACTION TAKEN	
Review patient				
X-ray lateral of hip (Mondays)				
NURSING				
ACTIVITY	SIGN		REASON FOR VARIANCE & ACTION TAKEN	
Assisted with mobilising to washroom				
On canvas for X-ray				
Wound site satisfactory? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If "No", give details in Variance column</i>				
Patient performing exercises				
TEDs removed & legs/heels inspected				
TEDs replaced: Yes <input type="checkbox"/> No <input type="checkbox"/>				
Discharge plan updated				
PUT INITIALS IN COLUMN	AM	PM			NIGHT	PLEASE INCLUDE TIME OF ANY VARIANCE
Pain score recorded.....	.....	.....	.....
A-V impulse boots on.....	.....	.....	.....
Obs @ 10:00 and 18:00.....	.....	.....	XXX	
Wedge in place.....	.....	.....	.....
PHYSIOTHERAPY				
ACTIVITY	DONE		REASON FOR VARIANCE & ACTION TAKEN	
Mobile around room independently				
Mobile out to toilet both ways				
Time _____ Sign _____				
OCCUPATIONAL THERAPY				
ACTIVITY	DONE		REASON FOR VARIANCE & ACTION TAKEN	
All equipment issues				
Discharge checklist complete				
Time _____ Sign _____				

MEDICAL				
ACTIVITY	TIME	SIGN	REASON FOR VARIANCE & ACTION TAKEN	
Review patient				
NURSING				
ACTIVITY	SIGN		REASON FOR VARIANCE & ACTION TAKEN	
Assisted with mobilising to washroom				
Wound site satisfactory? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If "No", give details in Variance column</i>				
Patient performing exercises				
TEDs removed & legs/heels inspected				
TEDs replaced: Yes <input type="checkbox"/> No <input type="checkbox"/>				
Moving and handling assessment				
Observations daily at 18:00				
PUT INITIALS IN COLUMN	AM	PM			NIGHT	PLEASE INCLUDE TIME OF ANY VARIANCE
Pain score recorded .....	.....	.....	.....
Sedation score recorded .....	.....	.....	.....
A-V impulse boots on .....	.....	.....	.....
Wedge in place .....	.....	.....	.....
PHYSIOTHERAPY				
ACTIVITY	DONE		REASON FOR VARIANCE & ACTION TAKEN	
Mobile around room independently				
Mobile out to toilet both ways independently				
Safe on stairs				
Time _____ Sign _____				

MEDICAL				
ACTIVITY	TIME	SIGN	REASON FOR VARIANCE & ACTION TAKEN	
Review patient				
NURSING				
ACTIVITY	SIGN		REASON FOR VARIANCE & ACTION TAKEN	
Assisted with mobilising to washroom				
Wound dressing satisfactory? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If "No", give details in Variance column</i>				
Patient performing exercises				
TEDs removed & legs/heels inspected				
TEDs replaced: Yes <input type="checkbox"/> No <input type="checkbox"/>				
Bowels open: Yes <input type="checkbox"/> No <input type="checkbox"/>				
Observations daily at 18:00				
<i>PUT INITIALS IN COLUMN</i>	AM	PM	NIGHT	<i>PLEASE INCLUDE TIME OF ANY VARIANCE</i>
Pain score recorded	
Sedation score recorded	
A-V impulse boots on	
Wedge in place	
PHYSIOTHERAPY				
ACTIVITY	DONE		REASON FOR VARIANCE & ACTION TAKEN	
Mobile around room independently				
Mobile out to toilet both ways independently				
Safe on stairs				
Discharge checklist complete				
Time _____ Sign _____				
OCCUPATIONAL THERAPY				
Notes on continued intervention / plan for discharge				
Time _____ Sign _____				

Day of ICP: DAY EIGHT POST-OP	Date:
--------------------------------------	-------

MEDICAL				
ACTIVITY	TIME	SIGN	REASON FOR VARIANCE & ACTION TAKEN	
Review patient				
NURSING				
ACTIVITY	SIGN			REASON FOR VARIANCE & ACTION TAKEN
Assisted with mobilising to washroom				
Wound dressing satisfactory? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If "No", give details in Variance column</i>				
Patient performing exercises				
TEDs removed & legs/heels inspected				
TEDs replaced: Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Do not replace if patient being discharged</i>				
Moving and handling assessment				
Waterlow score: _____ <i>If more than 10, take action & document</i>				
Observations daily at 18:00				
<i>PUT INITIALS IN COLUMN</i>	AM	PM	NIGHT	<i>PLEASE INCLUDE TIME OF ANY VARIANCE</i>
Pain score recorded	
A-V impulse boots on.....	
Wedge in place.....	
PHYSIOTHERAPY				
ACTIVITY	DONE			REASON FOR VARIANCE & ACTION TAKEN
Mobile around room independently				
Mobile out to toilet both ways independently				
Safe on stairs				
Time _____ Sign _____				
OCCUPATIONAL THERAPY				
Notes on continued intervention / plan for discharge				
Time _____ Sign _____				

Date:

COMPLETE THIS BOX

Patient Name: _____

Hospital Number: _____

TIME	MULTIDISCIPLINARY NOTES - DAY 8	SIGN
------	---------------------------------	------

DISCHARGE PLANNING	
Patient ready for discharge? Yes <input type="checkbox"/> No <input type="checkbox"/>	SIGN
If "Yes", record time patient discharged: _____	
If "No", record what factors are preventing discharge:	

