Clinical Pathway for

SHOULDER REPAIR

MRN		SURNAME	
OTHER NAMES			
DOB	SEX	AMO	WARD/CLINIC

(Please enter information or affix Patient Information Label)

PATIENT PROFILE **DATE OF SURGERY** / /

Lives with _____ Person for Notification _____

Relationship _____ Phone _____

Interpreter required Yes (type) ☐ _____ No ☐ Pastoral Care Yes ☐ No ☐

Medications taken at Home (please list) _____

_____

Medications brought into Hospital Yes ☐ No ☐ Medications sent Home Yes ☐ No ☐

Other Associated Problems/Co-existing morbidities _____

_____

ALLERGIES:

Drugs: _____ Food: _____ Other: _____

ORIENTATION TO WARD:

☐ Introduction to other patients ☐ Nurse uniform explanation ☐ Buzzer
☐ Telephone ☐ Visiting Hours ☐ Toilet/Bathroom
☐ Sitting Room ☐ No Smoking ☐ Meal Times

VALUABLES

☐ Sent Home ☐ Hospital Safe ☐ Other

DISCHARGE CHECKLIST

Destination on Discharge _____

Social Worker Yes ☐ No ☐ Occupational Therapist Yes ☐ No ☐

Community care necessary Yes ☐ No ☐ Community Care Nursing Yes ☐ No ☐

Escort required ☐ Not required ☐ Arranged ☐ Name: _____

Means of Transport:

Private car ☐ Taxi ☐ Ambulance ☐ Hospital Transport ☐

Aeroplane ☐ Booking made for Return Flight ☐ Other _____

	Yes	N/A	Comment
IPTAAS			
Referral Letter to GP			
Medical Certificate			
Discharge Medications: Ordered			
Obtained			
Explained			
Valuables returned to patient			
Clothing returned to patient			
Private Xrays returned to patient			
Follow-up appointments made			
Location of appointments explained			
Continuing problems on discharge			
Patient's own medications returned			

Discharge Nurse _____ Date Discharge: / / _____

(Please print name, designation)

Information regarding documentation of Clinical Pathways:

The Clinical Path is to remain with the patient's observation/medication charts and is to be utilised in conjunction with the ward rounds/case conferences. Always assess whether an intervention is appropriate for individual patient. **The Clinical Path does not take the place of a physician order.**

PROCEDURE: Complete details as required - affix patient bradma, insert date. The Clinical Path is designed as a multidisciplinary plan of care. Therefore, each discipline initials after the intervention has been attended to, (ie: if not signed, the action needs review as a variance or attention). If the event is not applicable to the patient, write N/A and initial. **VARIANCE:** Definition: 1) Any event noted on the clinical path not occurring within 24 hours. 2) An event not printed on the clinical path, eg: infected cannula site. To note the variance - indicate in the signature column an encircled **V**. **THE VARIANCE SHEET:** Ensure patient details are noted on the page as required; document ***DATE, DAY of STAY & VARIANCE CODE***, (eg: A3 = Infection). **Explanation of Variance Code**: briefly describe the variance, eg. infection, delay in drain removal, cancellation of procedure. **Action Taken**: briefly write the action taken, eg. IV cannula removed due to inflammation.
Sign each **Variance** entry noted, and document variance and evaluation of patient progress and care in progress notes.

STEP 1
Nursing Assessment

Name: _____

Designation: _____

Assessment At Pre - Admission/ Admission

What are the patient's living arrangements? _____

Are there any obstacles that might influence return home ? ☐ Yes ☐ No

If Yes, please record stated obstacle _____

Does the patient live alone? ☐ Yes ☐ No

If No , is the Carer in good health? ☐ Yes ☐ No

Is the Carer willing and/or able to assist following discharge? ☐ Yes ☐ No

Has the patient been receiving community services ? ☐ Yes ☐ No

If Yes, please indicate which services: ☐ Community Nurse ☐ Home Care

Meals On Wheels Other (specify) _____

Has the service been advised of the patients hospitalization? ☐ Yes ☐ No

Sensory Deficits: ☐ Absent ☐ Present Type _____

From Information gathered in steps 1-2(next page), plan patients discharge needs

Will the patient be able to cope when she/he is discharged? ☐ Yes ☐ No

If Yes, further assessment required? ☐ Yes ☐ No

If No, what help will the patient need? _____

☐ Social Worker	☐ Psychosocial Assessment ☐ Assistance with Legal matters ☐ Housing ☐ After care plans	☐ Community Support Services ☐ Assistance with Financial matters ☐ Support/Counselling	
☐ Community Liaison Nurse	☐ Home Nursing Assessment ☐ Continuity of Nursing	☐ Community Nurse Referral ☐ Wound Care/Hygiene Needs	☐ Dosette Box
☐ Occupational Therapist	☐ Home assessment		
☐ Pharmacist	☐ Medication Assessment ☐ Education	☐ Medication Card	☐ Dosette Box
☐ Physiotherapist	☐ Podiatrist	☐ Speech Pathologist	☐ Dietitian

Referral Made? ☐ Yes ☐ No Date of referral: _____ By Whom _____

RN Assessment Date: _____ Name/Designation: _____	
Social Worker Assess. Date: _____ Name/Designation: _____	
Occupational Therapist Date: _____ Name/Designation: _____	
Pharmacist Assess. Date: _____ Name/Designation: _____	
Community Liaison Date: _____ Name/Designation: _____	
Physiotherapy Assess. Date: _____ Name/Designation: _____	
Other Allied Health Ass. Date: _____ Name/Designation: _____	

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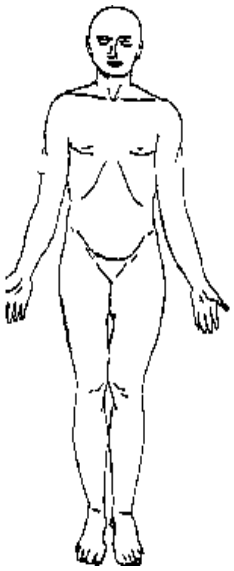
Patient Assessment - To be completed on Admission

Please circle/ tick as appropriate



EMOTIONAL WELL BEING
(Alert/ Apathetic/ Co-operative/ Withdrawn/ Hostile/ Anxious/ Other)

VISION ADEQUATE FOR A.D.Ls
(Yes/ No) Glasses -reading/other -Yes/No

HEARING ADEQUATE FOR A.D.Ls
(Yes/ No)
Hearing aid (Yes/No) left, right, both

MOUTH
(Clean/ Ulcerated/ Other)
Dentures (Yes/No) Full upper & lower
partial upper, partial lower

BREATHING
(Normal/ Distressed/ Shortness of breath)
Home oxygen(Yes/No)

SKIN TEARS
(Please Illustrate)

NUTRITIONAL STATUS
(Appetite: Good/ Fair/ Poor)
Complete nutrition screening tool below

CONTINENT
URINE - Yes/ No
Indwelling catheter -Yes/No
Type
Date last changed
FAECES - Yes/ No

STOMA- Yes/ No/ Type

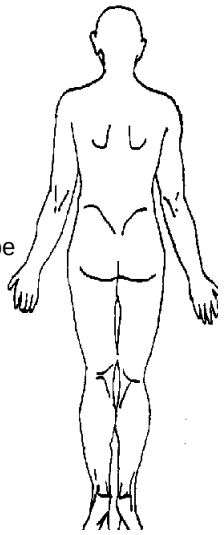
PROSTHESIS - Yes/ No/ Type

MOBILITY
(Independent/ dependent, with/ without supervision)
Walking aids Yes/No
Stick(s)/Frame
BED FAST

TRANSFER
(Independent/ dependent)

SKIN INTEGRITY: Good/ Poor
DRESSING REQUIRED: Yes/ No

PRESSURE AREA(S)/ ULCER(S)
(Please Illustrate)



*Nutrition Screening Tool	Answer	
Question A. Has the patient lost weight recently without trying?	Yes - Go to Q.B No - Go to Q.C Unsure - Go. to Q.C	
Question B. How much weight (kgs) has the patient lost?	0.5-5.0 5.1-10.0 10.1-15.0 greater than 15.0 unsure	
Question C. Has the patient been eating poorly because of decreased appetitie?	No Yes	
If the score is 3 or more, please refer this patient to the Dietitian ext. 2555	TOTAL SCORE	

**Falls Assessment Tool		
On Admission: Score patient according to criteria. If total score > 3 implement protocol and re-evaluate		
PRN	ACTIVITY	SCORE
Mobility	Ambulates independently	0
	Uses assistive devices	1
	Requires assistance to ambulate	1
	Unable to ambulate or transfer	1
Elimination	Independent with elimination	0
	History of nocturia/incontinence	1
	Requires assistance with elimination	1
Medications	No high risk medications	0
	Antihypertensives/aperients/diuretics/anticonvulsants/	
	Antiparkinsonian/benzodines/psychotropics	1
Sensory Status	Nil sensory deficits	0
	Visual, audio, sensory deficit	1
Mental Status	Alert & oriented	0
	Periodic/Nocte confusion	1
	History of confusion	1
Age No pain	18 -75	0
	75 +	1

Protocol

If patient scores 3 or more on assessment tool, implement the following protocol

1. High risk fall notice above bed
2. Bed lowered, esp. nocte, bed brakes on, bed rails elevated
3. Locate close to toilet and /or nurses station appropriately
4. Nurse call button within reach and use understood
5. Appropriate footwear
6. Toileting regime 4/24 and prior to settling
7. Area clear of hazards
8. Nightlights on where available
9. Side table/belongings within reach

Score on Admission _____

DATE	/ /	Initials
	PRE - ADMISSION CLINIC	
Resident Assessment	☐ FBC ☐ UEC ☐ G&H ☐ ECG ☐ CXR ☐ Urinaysis ☐ Anaesthetic Consult	
Physiotherapy	☐ Physiotherapy assessment completed	
Occupational Therapist Assessment	☐ Initial OT assessment completed - previous functional ability - assistive devices - function of non-operative hand/limb	
Nursing Assessment	☐ Orthopaedic Nursing Assessment Weight_____ kgs ☐ Baseline Vital Signs ☐ Urinalysis Height _____ cms ☐ Substance use record ☐ Ted stocking measurement - Size _____ ☐ Independent Mobility - Other_____	
Medications	☐ Medication history clarified 7 days pre-op: cease Aspirin cease NSAID's cease HRT cease anti-platelet drugs eg Iscover, Plavix ☐ ADR's & Allergies noted	
Patient Education	☐ Pain Management discussed ☐ Patient Clinical Pathway given & discussed with patient	
Discharge Planning	Patient living arrangements: ☐ House ☐ Flat ☐ Other Does the patient live alone? ☐ Yes ☐ No With whom does the patient live? _____ Is that person in good health? ☐ Yes ☐ No If no, why? _____ Does the patient have someone who can care for them on discharge? ☐ Yes ☐ No Has the patient been receiving community services? ☐ Yes ☐ No If Yes, state services _____ Has the community service been notified of hospitalisation? ☐ Yes ☐ No Other referrals required ☐ Pharmacist ☐ Smokers clinic ☐ Dietician Discuss discharge plan options Referral to _____ Refer to Post Acute Care Team ☐ Yes ☐ No Suitable for Home discharge ☐ Yes ☐ No	
Assessment Sign & Print Name	**RMO** _____ **Physiotherapist** _____ **Occupational Therapist** _____ **Care Coordinator** _____	

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DATE:	**/ /** **DAY OF SURGERY**	Initials AM	PM	ND
Outcomes	**SR 1.1** No evidence of narcotic toxicity **SR 1.2** Vital signs within normal limits **SR 1.3** Behavioural and emotional state stable **SR 1.4** Neurovascular observations within normal limits **SR 1.5** SaO_2 within normal limits **SR 1.6** Chest clear **SR 1.7** Patient scoring 3 or less on VAS with pain control			
Preoperative Care	Clip area as per VMO preferences - ☐ Axilla ☐ Deltoid Area Check list Fasted 6 hours pre surgery			
Consultations	Team Review_____			
Pain Management	☐ Narcotics ☐ PCA ☐ "Pain Buster" ☐ Scalene Block Patient comfortable with pain managagement ☐ Yes ☐ No Observe for signs of narcotic toxicity			
Treatment & Assessments	Vital signs - 1/24 for 4 hrs then 4/24 Circulation observations - 1/24 for 24 hrs 1/24 ankle exercises encouraged while awake Falls assessment score _____ Interventions_____			
Respiratory Care	Deep breathing & coughing exercises while awake O_2 therapy administered as ordered SaO_2 monitored			
Wounds & Drains	Dressing intact			
Medications	☐ Reviewed by Pharmacist _____ IV antibiotics as ordered			
Skin Integrity & Hygiene	Braden pressure area risk score _____ ☐ Heel raisers _____ Interventions _____			
Elimination	Check normal voiding If patient unable to void within 12 hours post op, assess for IDC insertion & 1/24 measures			
Nutrition & Hydration	IV therapy as ordered Fluid balance chart Commence fluids as tolerated 4/24 post op			
Education	Ensure patient has copy of Patient Clinical Pathway and booklet			
Discharge Plan	Check discharge plan has been documented Discharge destination _____			
RN Sign & Print name	**AM** _____ **PM** _____ **ND** _____			

DATE	/ / DAY 1	Initials AM	PM	ND
Outcomes	**SR 2.1** No evidence of narcotic toxicity **SR 2.2** Vital signs within normal limits **SR 2.3** Patient scoring 3 or less on VAS with pain control **SR 2.4** Complete assigned exercises			
Consultations	Team review			
Investigations				
Pain Management	☐ PCA ☐ Narcotics ☐ Oral Analgesia Patient comfortable with pain management ☐ Yes ☐ No Observe for narcotic toxicity			
Treatment & Assessments	4/24 vital signs PCA observations as per analgesia chart 1/24 circulation observations, stop at 24 hrs if satisfactory			
Physiotherapy	Mobilise Wrist & finger exercises Elbow flexion/extension Shoulder - pendular exercises - other exercises as specified by VMO _____ Chest clear - see notes			
Wounds & Drains	Intact post-op dressing Reinforce if necessary			
Medications	☐ Reviewed by pharmacist _____ IV antibiotics as ordered			
Skin Integrity & Hygiene	Shower with arm in cotton sling or seated with arm on lap Into Arm Immobiliser after shower			
Elimination	Check voiding normally			
Nutrition & Hydration	IV therapy ceased if diet and fluids are tolerated			
Education	Wrist and finger exercises by physio and care coordinator Patient Clinical Pathway reviewed with patient			
Occupational Therapist	Assess - personal care with shoulder immobilised - assistance required on discharge ☐ brace ☐ domestics - functional mobility - transfers chair/toilet/bed/bathing			
Discharge Planning	Confirm discharge date _____ Confirm discharge destination _____			
RN Sign & Print name	**AM** _____ **PM** _____ **ND** _____			

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DATE	/ / DAY 2	Initials AM	PM	ND
Outcomes	**SR 3.1** Vital signs within normal limits **SR 3.2** Patient scoring 3 or less on VAS with pain control **SR 3.3** Managing sling application/hygiene **SR 3.4** No signs or sympoms of infection **SR 3.5** Discharged **SR 3.6** Patient is informed of new medications, understands and is confident in their use			
Consultations	Team review			
Pain Management	☐ PCA ceased ☐ Narcotics ☐ Oral Analgesia Patient comfortable ☐ Yes ☐ No			
Treatment & Assessments	BD vital signs			
Physiotherapy	Mobilise Wrist,finger & elbow exercises Shoulder - pendular exercises - exercises as specified by the VMO_____ Chest clear - see notes			
Wounds & Drains	Change dressing to Comfeel			
Medications	☐ Reviewed by pharmacist ☐ Counselled on new medications by pharmacist			
Skin Integrity & Hygiene	Shower with arm in cotton sling or seated in shower with arm on lap Put arm into Arm Immobiliser after shower			
Elimination	Check voiding normally Check bowels opened, if not give aperients			
Nutrition & Hydration	IV therapy ceased (if not on day 1) Diet and fluids as tolerated			
Education	Wrist and finger exercises by physio and care coordinator Patient Pathway reviewed with patient			
Occupational Therapist	Review problems identified Day 1 or complete outstanding assessment Consult Social Worker/Care Co-ordinator if personal care assistance needed for d/c Organise adaptive equipment prior to discharge			
Discharge Plan	Confirm discharge date_____ Confirm discharge destination_____ ☐ Appointment ☐ Discharge letter ☐ Medications ☐ Cotton sling for showering ☐ Staple remover Staples removed by ☐ Community Nurse ☐ LMO			
RN Sign & Print name	**AM** _____ **PM** _____ **ND** _____			

DATE / / DAY 3		Initials AM	PM	ND
Outcomes	**SR 4.1** Vital signs within normal limits **SR 4.2** Patient scoring 3 or less on VAS with pain control **SR 4.3** Managing sling application/hygiene **SR 4.4** No signs or sympoms of infection **SR 4.5** Discharged **SR 4.6** Patient is informed of new medications, understands and is confident in their use			
Consultations	Team review			
Pain Management	☐ PCA ceased ☐ Narcotics ☐ Oral Analgesia Patient comfortable ☐ Yes ☐ No			
Treatment & Assessments	BD vital signs			
Physiotherapy	Mobilise Wrist,finger & elbow exercises Shoulder - pendular exercises - exercises as specified by the VMO _____ Chest clear - see notes			
Wounds & Drains	Change dressing to Comfeel			
Medications	☐ Reviewed by pharmacist ☐ Counselled on new medications by pharmacist			
Skin Integrity & Hygiene	Shower with arm in cotton sling or seated in shower with arm on lap Put arm into Arm Immobiliser after shower			
Elimination	Check voiding normally Check bowels opened, if not give aperients			
Nutrition & Hydration	Diet and fluids as tolerated			
Education	Wrist and finger exercises by physio and care coordinator Patient Pathway reviewed with patient			
Occupational Therapist	Review problems identified Day 1 or complete outstanding assessment Consult Social Worker/Care Co-ordinator if personal care assistance needed for d/c Organise adaptive equipment prior to discharge			
Discharge Planning	Confirm discharge date Confirm discharge destination ☐ Appointment ☐ Discharge letter ☐ Medications ☐ Cotton sling for showering ☐ Staple remover Staples removed by ☐ Community Nurse ☐ LMO			
RN Sign & Print name	**AM** _____ **PM** _____ **ND** _____			

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DATE	/ / DAY	Initials AM	PM	ND
Outcomes				
Consultations				
Pain Management				
Treatment & Assessments				
Physiotherapy				
Wounds & Drains				
Medications				
Skin Integrity & Hygiene				
Elimination				
Nutrition & Hydration				
Education				
Occupational Therapist				
Discharge Planning				
RN Sign & Print name	**AM** _____ **PM** _____ **ND** _____			

Clinical Pathway for SHOULDER REPAIR Variance Record

MRN		Ward/ Clinic
Surname		Given Names
D.O.B	Sex	AMO

(Please enter information or affix Patient Information Label)

AIM: To identify those factors which affect Length of Stay.

INSTRUCTIONS: Enter the Variance Code from the table below, eg: if there is a variance noted in the patient's clinical pathway due to transport availability enter D1

DATE	DAY OF STAY	VARIANCE CODE	EXPLANATION OF VARIANCE CODE	ACTION TAKEN	SIGNED

VARIANCE SOURCE CODE

A. PATIENT
1. Pressure Area
2. Post op/procedure complication
3. Infection
4. Co-existing morbidities
5. Mobilisation - early
6. Mobilisation - late
7. Delay in drain removal
8. Delay in suture/clips removal
9. Delay in IV removal
10. Unplanned return to OR/ITU/ACCA/ACCU
11. Non-compliance with treatment
12. Other
13. Taken off pathway

B. CLINICAL
1. Delay in medical consultation
2. Delay in allied health consultation
3. Delay in consultation due to ADO/PH/ Weekend
4. Inadequate discharge planning
5. Non attendance at pre-admission clinic
6. Other
7. Day of surgery admission

C. HOSPITAL
1. Delay in test results
2. Delay in OR/procedure
3. Cancellation of procedure
4. Delay in pt transfer to ward
5. Other

D. COMMUNITY/ FAMILY
1. Delay in availability of transport
2. Delay in availability of rehabilitation bed
3. Delay in availability of nursing home bed
4. Delay in availability of private hospital bed
5. Delay in availability of home care/community support/family support
6. Early availability of discharge option
7. Other

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Braden Pressure Ulcer Risk Management

	1. Completely limited	2. Very limited	3. Slightly limited	4. No impairment
Sensory Perception Ability to respond meaningfully to pressure related discomfort.	Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface.	Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	Responds to verbal commands but cannot always communicate discomfort or need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	Responds to verbal commands, has no sensory deficit which would limit ability to feel or voice pain or discomfort.
Moisture Degree to which skin is exposed to moisture.	**1. Constantly moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist** Skin is often, but not always, moist. Linen must be changed at least once a shift.	**3. Occasionally moist** Skin is occaisionally moist requiring an extra linen change approximately once a day.	**4. Rarely moist** Skin is usually dry, linen only requires changing at routine intervals.
Activitiy Degree of physical activity.	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and / or must be assisted into chair or wheelchair.	**3. Walks occasionally** Walks occasionally during day but for very short distances with or without any assistance. Spends majority of each shift in bed or chair.	**4. Walks frequently** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.
Mobility Ability to change and control body position	**1. Completely immobile** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited** Make occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly limited** Makes frequent though slight changes in body or extremity position independently.	**4. No limitatations** Makes major and frequent changes in position without assistance.
Nutrition Usual food intake pattern	**1. Very poor** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protien (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NPO and / or maintained on clear liquids or IVs for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protien (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered OR is on tube feeding or TPN regimen which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.
Friction and Shear	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity contractures or agitation lead to almost constant friction.	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheet, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time, but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.	

Note: Patients with a total score of 16 or less are considered to be at risk of developing pressure ulcers (15 or 16 = low risk; 13 or 14 = moderate risk; 12 or less = high risk)

Visual Analogue Scale (VAS)

Show patient VAS (4-6 hourly) and ask patient to indicate the number that corresponds to their level of pain at that time. Record the number on the appropriate section of Clinical Pathway

Pain Assessment Scale

0	1	2	3	4	5	6	7	8	9	10