RIE ED FRACTURED NECK OF FEMUR PROTOCOL

Patient Label	If Hip Fracture identified as likely at triage assign triage category 2 – inform Nurse in Charge and where possible move to RESUS 2 for analgesia and X-ray – rest of assessment can happen in IC once NOF fracture confirmed
	If Hip Fracture unexpected and identified late tick here ☐

Date of arrival and time

Residential status (Home, NH, POC etc)

BIG 6 ED Assessments (tick when complete)

- IV access, bloods inc coag and G+S ☐
- Analgesia offered (document in notes if patient refused or had pre-hospital) ☐
- 12 lead ECG ☐
- NEWS score recorded ☐
- Pressure areas inspected and managed ☐
- 4AT score to screen for delirium (see overleaf) ☐

Medical Red Flags – Inform ED Senior Early

- NEWS > 6 at any point in the ED ☐
- Collapse, syncope or long lie ☐
- Chest Pain/ Palpitations at any point ☐
- New SOB, O2 required, RR< 9 or > 20 ☐
- HR <60 or > 100 or Systolic BP <110 ☐
- RR <9 HR < 60 ☐
- Ischaemic ECG or arrhythmia ☐
- Warfarin, NOAC or coagulopathic ☐
- Malignancy or immunocompromised ☐
- Function limiting acute or chronic respiratory disease or heart failure ☐

PATIENT FELT TO BE FIT FOR THEATRE ☐

REQUIRES EARLY PREOP OPTIMISATION ☐

- Once Hip Fracture seen on X-Ray request orthopaedic bed ☐
- Start IV fluids on all patients unless contraindicated (i.e. acute heart failure – document in notes reason if not started) ☐
- Patients who look unwell, have multiple injuries or have any medical red flags require ED senior and ortho review to decide if ward fit (tick if any present) ☐
- All other patients can be FAST TRACKED to the ward without ortho registrar review in the ED – ORTHO REG MUST BE INFORMED (tick if suitable to FAST TRACK) ☐
- Offer Fascia-iliaca block to all patients unless contra-indicated – see separate FI block protocol available on EMIBANK (tick box when complete or tick shaded if contraindicated and document) ☐ ☐

Coagulopathic patients have significant delays to theatre. If on warfarin for AF alone give 5mg IV vitamin K while in the ED (can be prior to INR result). All other patients should be flagged to orthopaedics at time of referral for early pre-op optimisation and assessment

****COMPLETE \hip on TRAK in ALL PATIENTS**** Version 1.2 22/07/2019

4AT

The 4 'A's Test: screening instrument for delirium and cognitive impairment

(label)

Patient name:

Date of birth:

Patient number:

.....

Date: **Time:**

Tester:

CIRCLE

[1] ALERTNESS

This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

Normal (fully alert, but not agitated, throughout assessment)	0
Mild sleepiness for <10 seconds after waking, then normal	0
Clearly abnormal	4

[2] AMT4

Age, date of birth, place (name of the hospital or building), current year.

No mistakes	0
1 mistake	1
2 or more mistakes/untestable	2

[3] ATTENTION

Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.

Months of the year backwards	Achieves 7 months or more correctly	0
	Starts but scores <7 months / refuses to start	1
	Untestable (cannot start because unwell, drowsy, inattentive)	2

[4] ACUTE CHANGE OR FLUCTUATING COURSE

Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs

No	0
Yes	4

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4 or above: possible delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: delirium or severe cognitive impairment unlikely (but delirium still possible if [4] information incomplete)

4AT SCORE ☐

GUIDANCE NOTES Version 1.1. Information and download: **www.the4AT.com**

The 4AT is a screening instrument designed for rapid initial assessment of delirium and cognitive impairment. A score of 4 or more *suggests* delirium but is not diagnostic: more detailed assessment of mental status may be required to reach a diagnosis. A score of 1-3 suggests cognitive impairment and more detailed cognitive testing and informant history-taking are required. A score of 0 does not definitively exclude delirium or cognitive impairment: more detailed testing may be required depending on the clinical context. Items 1-3 are rated *solely on observation of the patient at the time of assessment*. Item 4 requires information from one or more source(s), eg. your own knowledge of the patient, other staff who know the patient (eg. ward nurses), GP letter, case notes, carers. The tester should take account of communication difficulties (hearing impairment, dysphasia, lack of common language) when carrying out the test and interpreting the score.

Alertness: Altered level of alertness is very likely to be delirium in general hospital settings. If the patient shows significant altered alertness during the bedside assessment, score 4 for this item. **AMT4 (Abbreviated Mental Test - 4):** This score can be extracted from items in the AMT10 if the latter is done immediately before. **Acute Change or Fluctuating Course:** Fluctuation can occur without delirium in some cases of dementia, but marked fluctuation usually indicates delirium. To help elicit any hallucinations and/or paranoid thoughts ask the patient questions such as, "Are you concerned about anything going on here?"; "Do you feel frightened by anything or anyone?"; "Have you been seeing or hearing anything unusual?"