OG Survival Guide

Orthogeriatric care:

Role/expectation:
The peri- and post-operative management of elderly and frail patients with fragility fractures (NOF #). You will be expected to manage elderly patients with multiple comorbidities including dementia, Parkinson's disease, frequent falls, cardiac arrythmias, osteoporosis and polypharmacy.
You will be expected to undertake a Comprehensive Geriatric Assessment which is a multidimensional assessment on an older person.

Definition:
Orthogeriatric patients are patients > 65 years with a NOF #.
Who we don't see:

1. Social admissions
2. Patients for non-operative management
3. Peri-prosthetic hip #

Orthogeriatric bloods:
All Orthogeriatric patients require:

- FBC
- U+Es
- CRP
- Bone profile
- Transferrin:
    - All patients with low Hb and low Transferrin will require Ferrinject (iron infusion)
    - See hospital policy SOP0610 for prescribing guidance found on Q pulse
    - Ensure patient has been weighed prior to prescribing as dose is weight dependent
    - Prescribe on the infusion page of the drug chart
    - Ensure you have prescribed IV Hydrocortisone 200mg and IV Chlorphenamine 10mg on the PRN side of the drug chart
- Vitamin D:
    - >50: not indicated
    - 30-50: colecalciferol 800 units, PO, daily
    - <30: colecalciferol 50,000 units, PO, once weekly, 6 weeks total
- Phosphate:
    - Mild hypophosphataemia (0.3-0.8 mmol/L): Phosphate Sandoz 1-2 tablets PO TDS for 3 days
- Folate
- Vit B12 replacement:

- If anaemic, give hydroxocobalamin: 1 mg every other day, IM, 6 doses total
- If non-anaemic, give cyanocobalamin 100 mcg daily

Prescribing Ferrinject

Hb (g/L)	<35 kg	35-49 kg	50-69 kg	>70 kg
<100	500 mg	1,500 mg (as 2-3 single doses of 500 mg)	1,500 mg (as 2 divided doses)	2,000 mg (as 2 divided doses)
100-130	500 mg	1,000 mg (as 2 divided doses)	1,000 mg	1,500 mg (as 2 divided doses)

Laxatives:

- All post op NOF # patients should be initiated on:
  - Laxido: 1 sachet BD
  - Senna: 15 mg ON
- If BNO after 3-4 days of this regime then consider adding:
  - Glycerin suppository 4g PR
  - Phosophate enema 4g PR
  - Naloxogol (if suspecting opioid induced constipation)
- Patients need to open their bowels **before** they are made MFFD
- Patients should open their bowls **before** TWOC to reduce risk of going into urinary retention

Anticoagulation:

- Most NOF # patients require Dalteparin 5000 units ON for 30 days post-operatively
- However some elderly patients are sarcopenic and require dose reduction (usually to 2,500 units ON) if low body weight
- If anticoagulation regimes are to be completed as an outpatient, remember to prescribe a **sharps box on the edn** and fill out a **generic prescription** so that district nurses can give Dalteparin injections in the community
- Patients on warfarin:
  - Warfarin will need to be stopped pre-operatively
  - INR will need to be <2 for GA and <1.5 for spinal anaesthesia
  - High risk patients should be bridged with treatment dose Dalteparin

Osteoporosis management:

You may be asked to initiate Osteoporosis treatment which consists of:

- Alendronic acid 70 mg weekly +/- gastroprotection
- Adcal D3

Booking DEXA scans:

- Via DART-OCM
- Or: Fill out a paper form (nuclear medicine form) and hand it into the Osteoporosis unit on Level 2 blue zone (next to the Doctors Mess).

Contacting Osteoporosis Secretary:

- Very useful point of contact for advice on booking patients into Osteoporosis clinic (Consultant is Dr Maria Acosta)
- You can call them on extension 3892

Check X-rays:

Check X-rays (AP Pelvis and Lateral) are required for patients who have had:

1. Total hip replacements
2. Hemiarthroplasty's

They are not usually required for Dynamic Hip Screws or Femoral Nails (TFNA) unless specified in the Red Op-Notes.

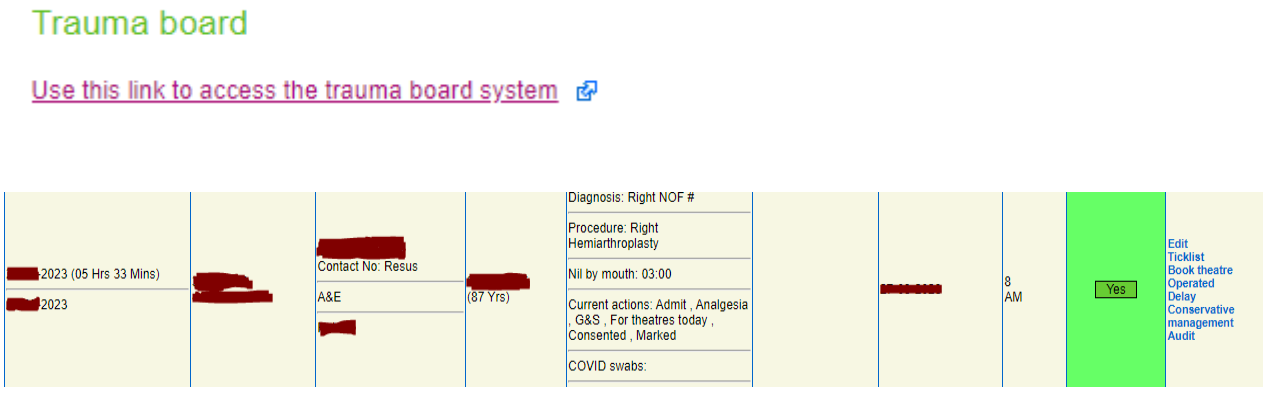
It is the job of the **Orthopaedic** team to request, chase and review these X-rays. However, you may be required to chase if it is delaying discharges.

KCH referrals:

- After you have created your KCH login (see login section) you can refer patients to KCH neurosurgery
- Fill out the referral criteria including history, examination, scan results.
- Send images to Kings Neurosurgery:
    - Fill out IEP transfer request form found on the intranet under Internal Systems
    - Or alternatively call PACS to expedite the images
    - Or head straight to either CT or MRI (depending on which image modality you want to send) and given them a paper copy of the IEP transfer request form

Keeping the list up-to-date

Ensure access to Trauma Board (via Trust Intranet) so that new patients can be identified each morning. Look for patients with NOF# in the "diagnosis" column (as seen below).



Add these patients to the ongoing Orthogeriatrics Handover List.

The FY1/FY2s not going to the Board Meeting should instead prepare and see the new NOFs with a senior.

Reviewing the new NOFs

These patients will typically be seen in ED - check Trauma Board for location. Need to be reviewed by Consultant. FY1/FY2 to prepare the notes ready for Consultant review

Things to include in documentation:

- Fall Hx:
    - LOC? Head injury? Pre-syncope?
- PMHx:
    - Any relevant previous clinic letters, studies e.g. echocardiograms
    - Check ambulance notes & KMCR/CITO in EPR to double check
- Medications Hx:
    - On any anti-coagulation - if so, when were last doses?
    - On anti-hypertensives? If so, to be held peri-operatively? (typically yes)
- Social Hx:
    - Does pt live in a house or bungalow - package of care?
    - Lives alone?
    - Mobility status?
- NEWS score?
- ECG?
- Admission bloods?

To be included in plans:

- OG bloods post-operatively
- 4ATs daily for pts at risk of delirium
- Slow IVF post-operatively
- FRAX scoring
- Red-tray feeding if concerns re: independent feeding
- Laxatives for every pt
- PT/OT post-operatively
- MUST scoring

Common post-operative issues

Pain: typically morphine sulfate 10 mg BD, to be reduced when pain well managed. Can additionally prescribe morphine PRN. PaidAID scoring for dementia patients

BNO: normal laxatives doses 1 sachet Macrogol BD, 7.5 mg Senna OD (night). If bowels haven’t opened in >3 days then to do PR and assess for impaction. If impaction then prescribe phosphate enema (1 tube), if no impaction then glycerol suppository 4 g STAT

Delirium: investigate for causes other than post-operative. Daily 4ATs to assess for fluctuation/improvement

Postural drop: LSBP - postural drop if symptomatic/>20 mmHg systolic drop. Start with non-pharmacological management e.g. bilateral full-length pressure stockings. If still indicated then consider commencing fludrocortisone 100 mcg OD.

Timetable

	Monday – Friday	Friday
08:30	- Check trauma board for any new patients and add to OG list - Print OG list	
09:00	- Attend the trauma meeting with the orthopaedic team in Hasbury room (third floor red zone in theatres). One person (F1/F2) usually attends and the rest can prepare to see any new patients or just start their ward round.	
10:00 – rest of the day	- See new and sick patients with the consultant first. - Sometimes will want to do a ward round (Pembroke or outliers). Otherwise, continue seeing all patients.	
End of the day:	- Update OG list - If any patient is MFFD, update this on the orthopaedic list as well by removing purple “OG” shadowing and adding “Handed back to ortho *insert date*” with white shadowing.	
16:30 (Fridays only)		- Weekend handover in Hasbury Room with orthopaedic team - Update the Ortho list as well