

SUPPLEMENTARY FILE


Older trauma patients are at high risk of delirium, especially those with underlying dementia or baseline frailty

Supplementary Methods

Definitions of clinical conditions

Cardiac complications included myocardial infarction, stroke, cardiovascular death, new heart failure or new arrhythmia. Respiratory complications included pneumonia, other chest infection requiring antibiotics, and respiratory failure; pulmonary embolus and deep venous thrombosis fell under the bracket of venous thromboembolism (VTE). Pressure injury included all stages of pressure injury.[Edsberg 2016] As this was a retrospective observational study, complications were identified where recorded in the patient's medical notes.

Appendix 1: Excerpt from South Western Sydney Local Health District Adult Admission and Transfer of Care Checklist (page 1 of 4-page document)



Health
South Western Sydney
Local Health District

SURNAME		MRN	
OTHER NAMES		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
D.O.B. ____/____/____		M.O.	
ADDRESS			
LOCATION			

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Admission Date: ____/____/____ Time: ____:____:____ Interpreter required? Yes No Language _____
 Does the patient have an Advanced Care Directive? Yes No Unsure
 Resuscitation Plan? Yes No Comments: _____

SECTION 1: REQUIRED IN THE FIRST 4 HOURS

Orientation to Ward Patient Relative/Friend Carer

<input type="checkbox"/> Toilet/Bathroom <input type="checkbox"/> Buzzer/Call Bell <input type="checkbox"/> Ward/Unit Routine REACH explained <input type="checkbox"/> Yes <input type="checkbox"/> No Comments: _____	<input type="checkbox"/> TV/Visiting Hours <input type="checkbox"/> Meal Times My Passport of Care given <input type="checkbox"/> Yes <input type="checkbox"/> No Comments: _____	<input type="checkbox"/> Telephone/Mobile/Public Phone <input type="checkbox"/> Patient informed of treating doctor <input type="checkbox"/> Aware of Rights & Responsibilities/Privacy
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Admission Checklist	Initial	Admission Checklist	Initial
Vital Signs (on appropriate chart)		Check placement of drains/catheters	
Pain		Correct armband (insitu/allergies)	
Blood Glucose Level		IV line labelled/NA	
Urinalysis		Suction/oxygen units in working order	
Falls Risk Assessment		FRAMP (if applicable)	
Waterlow Assessment		Air mattress ordered (if applicable)	
Skin integrity checked		Additional forms in folder (e.g. stoma chart, food chart)	
Height (eMR)		Medical admission completed	
Weight (eMR)		Medication chart completed	
IVC on eMR & dated		Medication Management Plan completed	
Vascular Access Device		Medications in trolley	
Delirium Risk Screen & Delirium Screen		Update handover on eMR	
Confirm Local Medical Officer		Confirm Next of Kin contact details	

Medical History

Presenting Health Problem: _____
 Relevant Coexisting Conditions & Past History: _____
 Are you a carer for someone? Yes No Details: _____
 Medication All allergies & adverse reactions must be recorded in the eMR Yes No
 Patient's own medication: Stored on Ward S4D/S8 Cupboard Dose Administration Aid Herbal/Complimentary
 Does the patient usually take three or more medications: Yes No
 Have their medications changed in the last week: Yes No
 Is the patient on therapeutic anticoagulation therapy/Novel Oral Anticoagulants (NOACS) Yes No
If Yes, override on the Falls Risk Assessment, flag patient as high risk and commence FRAMP

Valuables

Description	Ward	None	Self	Family	Security
Money (including bank cards)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glasses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aids: (i.e. walking stick/hearing aids)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rings/other jewellery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electronic devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Completed by: _____ Print: _____
 Designation: _____ Ward: _____ Date: ____/____/____

ADULT ADMISSION AND TRANSFER OF CARE ASSESSMENT AND CHECKLIST

AMR 060.001

FILE IN CLINICAL RECORD

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