

Appendix to: Lee JC, Koo K, Wong EKC, et al. Impact of an orthogeriatric collaborative care model for older adults with hip fracture in a community hospital setting. *Can J Surg* 2021. Copyright © 2021 The Author(s) or their employer(s). To receive this resource in an accessible format, please contact us at cmaigroup@cmaj.ca.

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Appendix 1

Data Abstraction Guide

Demographics

Age	Integer value in years
Sex	0 = Male 1 = Female
Charlson Co-morbidity index ¹⁹	Calculated
Place of residence prior to admission	0 = home 1 = retirement or assisted living facility 2 = skilled nursing facility or complex continuing care 3 = rehabilitation facility
Therapeutic anticoagulation status on admission	0 = no 1 = yes
Type of fracture	0 = displaced intracapsular 1 = stable intertrochanteric 2 = unstable intertrochanteric 3 = unstable subtrochanteric
Date and time of radiologic diagnosis	YYYY-MM-DD h:mm format
Type of surgery	0 = total hip arthroplasty 1 = hemiarthroplasty 2 = sliding hip screw 3 = intramedullary nail 4 = nonoperative
Mode of anesthesia	0 = regional (spinal) 1 = general
ICU stay	0 = no 1 = yes

Intervention

Seen by geriatric medicine	0 = no 1 = yes
Date and time of geriatric medicine assessment	YYYY-MM-DD h:mm format

Process Measures

Date and start time of surgery - Abstracted from time of anesthesia start	YYYY-MM-DD h:mm format
Use of standing Acetaminophen - At any time during admission	0 = no 1 = yes
Use of pre-operative peripheral nerve block	0 = no

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- By documentation on ED record, progress notes, or consultation notes	1 = yes
Identification of delirium prevention strategies - At least one delirium prevention strategy documented	0 = no 1 = yes
Osteoporosis assessment performed - at minimum requires documentation of osteoporosis/ bone-health as an issue with a plan for either further investigations or treatment	0 = no 1 = yes
Mental status assessment - documentation of absence/presence of cognitive impairment and/or delirium	0 = no 1 = yes
Falls assessment - Identify at least the precipitant and at least 1 predisposing factor - If there were no predisposing factors for increased risk of falls, then documentation of pertinent negatives must be present	0 = no 1 = yes

Outcome Measures

Admission date	YYYY-MM-DD format
Discharge date	YYYY-MM-DD format
Presence of delirium during hospital stay: - Delirium was defined by “ <i>any evidence from the chart of acute confusional state (e.g., delirium, mental status change, inattention, disorientation, hallucinations, agitation, inappropriate behavior, etc.</i> ” ¹⁸	0 = no 1 = yes
Delirium start date	YYYY-MM-DD format
Delirium end date	YYYY-MM-DD format
Discharge destination	0 = home 1 = retirement or assisted living facility 2 = skilled nursing facility or complex continuing care 3 = rehabilitation facility 4 = another acute care hospital
Vitamin D and/or Calcium prescribed - Prescribed in hospital or continued in hospital from home medication	0 = no 1 = yes

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Antiresorptive recommended - Prescribed in hospital, continued in hospital from a home medication, or a referral to the family physician or osteoporosis clinic was stated for consideration of antiresorptive medications	0 = no 1 = yes 2 = contraindicated
In-hospital mortality	0 = no 1 = yes
New UTI in hospital (more than 48hr post admission to hospital)	0 = no 1 = yes
Hospital-acquired pneumonia (new pneumonia acquired more than 48hr post admission to hospital)	0 = no 1 = yes
Deep vein thrombosis or Pulmonary embolism in hospital	0 = no 1 = yes
Acute coronary syndrome - Excludes demand ischemia	0 = no 1 = yes