Orthopaedic Care Clinical Coach: Strengthening Postoperative Hip Fracture Care While Building Leadership Capacity

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Appendix

Appendix Table 1 . Clinical leader feedback on the orthopaedic care clinical coach

Commenter	Feedback
1A Nurse educator	• Dedicated focus on the project: Having you solely focused on the hip fracture transformation project allowed for a smoother implementation, without overloading other team members with additional responsibilities. • Cross-site insights: Your perspective from another site was valuable in understanding how the two different ortho units run as well as the very different workflows and processes. This not only helped customize the approach each unit took to the project rollout but also opened up opportunities for future collaboration and potential standardization across sites. • Adaptability and leadership growth: Though the role came with many unknowns in the beginning, you adapted quickly, growing into an enthusiastic emerging leader that bridged the gap between front-line staff, computer systems, and research. This played a key role in ensuring the success of the project. • Sustainability challenges: The six-month duration of the role made it difficult to sustain the same level of oversight and leadership once the project moved into the sustainability phase. Given the many components of the hip fracture pathway, mostly the single dose PNB and the hip fracture pathway, maintaining momentum without someone dedicated to the role has proven tough.

Commenter	Feedback
1J Nurse educator	My biggest take away from this change was the team that was put together to make the changes. In the past, the team was a lot smaller and did not require a lot of touch points and not as many hands on it. This time around, since the project was a lot bigger, having a bigger team to help manage it was helpful. Not only that but having someone, the coach, available at during go live and subsequent follow ups during the roll out with the teams was helpful in terms of consistency with utilizing the pathway via Epic. A bigger team allowed everyone to focus their attention on specialities input when it came to the change. In addition, having someone who is solely dedicated to working with the front-line staff with the change was instrumental with easing the changes to them. Having a person that staff can approach and ask questions and visibly present helped with any anxieties the staff might have had around that change. An expert on the unit is very much needed when it comes to such changes that affect the front-line staff's day to day work. For me, working and having a clinical coach around helped me focus on my other duties as the Clinical Educator, it allowed me to focus on my other day to day and ease some of the transition work away from me. I also loved the idea bouncing between us, trying to figure out what will work and what won't work. Given this roll out was going to two very similar yet very different units as well.
1J Clinical quality care leader	From my perspective, having you embedded on the floor in the "Ortho Coach" role was a real strength in supporting the rollout of the hip fracture care pathway. You provided consistent education, coaching, and reinforcement, which helped frontline staff feel more confident adopting new practices. What stood out most was your accessibility—you were available in real time to answer questions, troubleshoot challenges, and provide guidance. That hands-on presence really helped bridge the gap between system-level changes and day-to-day bedside care. If I had to point to a challenge, I'd say it was around shifting long-standing habits and routines. Even with strong support, some staff found it difficult to let go of old ways of doing things. Having the Ortho Coach role was critical in keeping the momentum going, but it also showed how much ongoing reinforcement and change management are needed when introducing a new pathway.

Note: The feedback survey examined perceived strengths, challenges and benefits of OCCC-supported implementation of the Hip Fracture Care Pathway. It was administered online with a four-day response period.

Appendix Table 2. Hip Fracture Care Pathway – daily patient care goals and healthcare providers' directives

Post-op day 0 (POD0)	Post-op day 1 (POD1)	Post-op day 2 (POD2)	Post-op day 3 (POD3)	Post-op day 4 (POD4)	Post-op day 5 (POD5)
Falls prevention strategies in place (primary nurse)	OT and PT treatment plans are in place (OT and PT)	Patient seen by Hospitalist (primary nurse)	Ambulation with distance or aid progressing (PT)	Readiness for transition confirmed with Hospitalist (CL/CQCL or CN)	Hospitalist confirms medical stability and clears for discharge/ transfer/ALC – communicates to Clinical Leader/CQCL or Charge Nurse (CL/CQCL or CN)
Pain well managed and diet advanced as tolerated (primary nurse)	Mobilizing with aid initiated (PT)	Osteoporosis management initiated by GIM/Geriatrics (primary nurse)	Patient progressing with their ADLs (OT or primary nurse)	In chair for all meals as tolerated (sitting tolerance of at least 1 hour) (OT or PT or primary nurse)	Discharge medication
Delirium precautions in place (primary nurse)	ADLs with assistance (OT/ primary nurse)	Up in chair for at least 1–2 meals (OT or PT or primary nurse)	Tolerating regular diet (greater than 50% of meal eaten) (primary nurse)	ADLs progressing to baseline (OT or primary nurse)	Reconciliation completed (nursing)
Welcome to the Unit/ Hip Fracture Education implemented (primary nurse)	Tolerating regular diet and Foley catheter removed (primary nurse)	Tolerating hip exercises (PT)	Rehab application submitted or home services ordered/notified (CL/CQCL or CN)	Review/update EDD and readiness for discharge (CL/CQCL or CN)	Ensure community supports/homecare in place, if applicable (nursing)
Bowel routine reinforced (primary nurse)	Patient performed bowel elimination within last 48 hours (primary nurse)	Establish estimated date of discharge (CL/CQCL or CN) and identify target discharge stream (OT or PT)	If there are anticipated barriers to timely discharge, interprofessional team notified (OT or PT)	Discharge plan discussed with patient/caregiver/ SDM (OT or PT or CL/ CQCL or DCP/SW)	Patient is progressing in their mobility or ADLs (OT or PT or primary nurse)
Pressure ulcer prevention strategies reinforced (primary nurse)	Review working plan for transition from acute care (CL/CQCL or primary nurse)	Initiate rehabilitation application (if applicable) (OT or PT or DCP/SW)		Update on recovery path, including discharge stream and EDD (PT or CL/CQCL)	
	Adequate nutrition reinforced (primary nurse)				

Note: These daily patient care goals and healthcare providers' directives constitute daily checklist items within the hip fracture pathway. Pathway users are expected to consider and address these items throughout their workflow when caring for postoperative hip fracture patients.

Appendix Table 3. List of abbreviations

Abbreviation	Definition
OT	Occupational therapist
PT	Physical therapist
CL	Clinical leader
CQCL	Clinical quality care leader
GIM	General internal medicine
DCP	Discharge planner
SW	Social worker
CN	Charge nurse
ADL	Activities of daily living
SDM	Substitute decision-maker
EDD	Estimated date of discharge
ALC	Alternate level of care

Note: Data are from the American Speech-Language-Hearing Association (2026).