Foot and Ankle Surgery Clinical Pathway

Site Applicability

Providence Health Care

Pathway Patient Goals

1. Patient will be discharged POD 2
2. Patient will be medically stable of concurrent medical conditions
3. Patient will have pain managed to a level acceptable to the patient
4. Patient will have no **injurious** falls during his/her hospital stay
5. Patient/caregiver will verbalize understanding of discharge instructions and follow- up

Inclusion Criteria

1. All elective Foot and Ankle Surgery admissions

Home Discharge Criteria

1. Able to transfer safely and access home with available support

Instructions

1. Review pathway once per shift for patient care goals and expected outcomes
2. Do not document on this pathway, complete documentation in the Electronic Health Record or paper chart as per policy

Pre-Admission clinic visit (Pre-op on ward (if applicable)	
Care Category	**Expected Outcomes**
Safety/Risk Assessment	• Universal Fall Prevention strategies are in place (SAFE Step) • Fall risk care plan in place, if appropriate
Cognition	• Delirium Risk factors assessed and baseline CAM score recorded • Alert and Oriented x 3
Pain Management	• Patient understands how post-operative pain will be managed and information given about: o Oral/SC/IV medication modalities o Nerve Blocks o PCA
Elimination	• Provide information about maintaining regular bowel care while on narcotics
Nutrition & Hydration	• Patient verbalizes an understanding of: o Fasting from solids from midnight before surgery o Fasting from clear fluids 5 hours before surgery o Diet progression after surgery
Cast/ Walker boot	• Patient understands the operated foot will be in a slab cast and bandaged with a tensor immediately post-op. This must be left alone and kept dry. Usually a walker boot will be applied at the follow up appointment at 2 weeks but occasionally it is put on in the hospital prior to going home. The surgeon will let the patient know when the walker book will be put on.
Activity	• Patient/caregiver understands the following protocol: o They will need to **elevate the operated leg 6 inches above heart 22 of 24 hours per day** for 1 week. In week 2, the elevation of the foot can be decreased according to level of discomfort and swelling. They are allowed to move the hip and knee of the operated leg o They will practice transfers and walking with the physiotherapist immediately post- op using either a walker or crutches and must be able to do this safely before going home o Patients with fusions and total ankle replacements (TAR) are usually **non weight bearing for at least 6 weeks.** The surgeon will specify o Patients with bunion correction are generally **allowed to weight bear on their heel** but occasionally they are non weight bearing. The surgeon will specify

Patient Teaching	• Patient verbalizes an understanding of: o No smoking before or after surgery (interferes with healing) o Medications to start or stop before surgery o Post-Anesthetic exercises for breathing and circulation o Need for mobility aids and equipment o Patient pathway length of stay 3 days 2 nights- Home POD 2
Discharge Planning	• **The patient understands they will be discharged POD 2** • Patient/Caregiver encouraged to: o Bring clothing for discharge POD 1 o Bring crutches/walker POD 1 o Arrange for patient's transport to the hospital and discharge home POD 2 o Review patient pathway handout with PAC staff and ask questions o Ensure they receive surgeon instruction sheet and prescriptions upon discharge from hospital o Ensure post- operative and equipment needs have been assessed and recommendations identified
Key Interventions/Consults	• Patient is directed to lab for ordered lab work • Anesthetist consult completed (if necessary) • Occupational consult completed (if necessary) • Physiotherapy consult completed (if necessary) • Social work consult completed (if necessary)

Day of Surgery POD 0	
Tasks & Activities	**Expected Outcomes**
Safety/Risk Assessment	• Universal Fall Prevention strategies are in place (SAFE Step) • Fall risk care plan in place, if appropriate
Cognition	• CAM Assessment - Patient oriented x 3 (person, place, time) • Notify MRP if any evidence of altered level of consciousness (delirium, confusion, agitation)
Assessment	• Vital signs completed as per protocol are within patient normal limits, afebrile • Neurovascular assessments completed as per protocol (patients with blocks will have numbness to foot for minimum 12 hours) • Swelling of operated foot will be present. Assess and document. • If cast becomes too tight, split cast on anterior surface and wrap with tensor as per physicians orders • Colour and temperature of surgical limb within patient normal limits • Capillary refill (less than 3 seconds) to operative foot • Chest sounds clear or as prior to admission
Pain Management	• Pain assessed Q4H and PRN • Pain level is acceptable to patient • Perineural catheter secured, insitu (if applicable) • PCA in place as ordered (if applicable)
Elimination	• Urine output more than 200 mL in 6 hours • Catheter care, if Foley insitu • No signs of urinary tract infection • Bowel sounds present, abdomen soft, not distended. • Date of last bowl movement noted.
Nutrition / Hydration	• No nausea/vomiting • Fluid intake greater than 600 mL in 12 hours or in keeping with restrictions • Tolerating diet – eating more than 75% of meal trays • IV/CVC Site assessed Q shift & PRN, site intact, no redness, IV patent
Skin/Dressings/Drains	• Dressing assessed Q shift & PRN • Boot/cast dry and intact • Dressing remains dry and intact • Reinforce and/or change dressing as per orders • Drain in place and patent (if applicable) • Braden Score documented

Activity	• Ankle pumping exercises 5 times per hour on non-operative foot • Deep breathing and coughing exercises every hour (10 deep breaths per hour. Cough if secretions present • Operative foot elevated 6 inches above the level of the heart for 22 of 24 hours per day • Mobilizing as per non weight bearing restrictions (if applicable) • Completes personal care with assistance • Night time sleep acceptable to patient
Teaching & Discharge Planning	• Patient/caregiver aware of expected discharge POD 2 • Elevation of operative foot 6 inches above the level of the heart for 22 of 24 hours/day and non-weight bearing status reviewed • Home preparations, post-operative care and equipment needs reviewed

Post-Operative Day 1 (POD1)	
Tasks & Activities	**Expected Outcomes**
Safety/Risk Assessment	• Universal Fall Prevention strategies are in place (SAFE Step) • Fall risk care plan in place, if appropriate
Cognition	• CAM Assessment - Patient oriented x 3 (person, place, time) • Notify MRP if any evidence of altered level of consciousness (delirium, confusion, agitation)
Assessment	• Vital signs completed as per protocol are within patient normal limits, afebrile • Neurovascular assessments completed as per protocol • Colour and temperature of surgical limb within patient normal limits • Swelling of operated foot will be present. Assess and document. • If cast becomes too tight, split cast on anterior surface and wrap with tensor as per physicians orders • Sensation of surgical limb within patient normal limits • Capillary refill (less than 3 seconds) to operative foot • Chest sounds clear or as prior to admission
Pain Management	• Pain assessed Q4H and PRN • Pain level is acceptable to patient • Importance of pain control reviewed with patient • Perineural catheter secured, insitu (if applicable) • PCA in place as ordered (if applicable)
Elimination	• Patient voiding more than 200mL in 6 hours • Catheter discontinued (if applicable) • No signs of UTI or urinary retention • Bowel sounds present, abdomen soft, not distended • Bowels are moving as per patient norm
Nutrition / Hydration	• No nausea/vomiting • Fluid intake greater than 600 mL in 12 hours or in keeping with restrictions • Tolerating diet – eating more than 75% of meal trays
Skin/Dressings/Drains	• Dressing assessed Q shift & PRN • Boot/cast/dressing dry and intact • Reinforce and/or change dressing as per orders • Drain in place and patent (if applicable) • Braden Score documented

Activity	• Ankle pumping exercises 5 every hour on non-operative foot • 10 deep breaths and coughs Q1H while awake • Operative foot elevated 6 inches above the level of the heart for 22 of 24 hrs per day • Mobilizing non- weight bearing safe and independently with aids • Completes am/pm care with/without assistance • Night time sleep acceptable to patient
Teaching & Discharge Planning	• Patient/caregiver aware of expected discharge POD2 • Patient's non- weight bearing status and elevation of operative foot 6 inches above the level of the heart for 22 out of 24 hours per day reviewed • Patient verbalizes understanding of who to contact for post op follow up • Home preparations, post-operative care, and equipment needs reviewed and patient ready for discharge • Patient has clothing at bedside for discharge POD 2 • Patient has pain medication prescription on chart • Prescription(s) information reviewed with patient and/or caregiver

Post-Operative Day 2 (POD2) - Discharge Day	
Tasks & Activities	**Expected Outcomes**
Safety/Risk Assessment	• Universal Fall Prevention strategies are in place (SAFE Step) • Fall risk care plan in place, if appropriate
Cognition	• CAM Assessment - Patient oriented x 3 (person, place, time) • Notify MRP if any evidence of altered level of consciousness (delirium, confusion, agitation)
Assessment	• Vital signs completed as per protocol are within patient normal limits, afebrile • Neurovascular assessments completed as per protocol • Colour and temperature of surgical limb within patient normal limits • Swelling of operated foot will be present. Assess and document. • If cast becomes too tight, split cast on anterior surface and wrap with tensor as per physicians orders • Sensation of surgical limb within patient normal limits • Capillary refill (less than 3 seconds) to operative foot • Chest sounds clear or as prior to admission
Pain Management	• Pain assessed Q4H and PRN • Pain level is acceptable to patient • Importance of pain control reviewed with patient • Perineural catheter discontinued by APS if not done POD 1 (if applicable)
Elimination	• Up to bathroom patient verbalizes voiding quantity sufficient • Bowel movement (ensure patient has BM prior to discharge)
Nutrition / Hydration	• No nausea/vomiting • Tolerating diet – eating more than 75% of meal trays
Skin/Dressings/Drains	• Skin integrity intact • Boot/cast dry and intact • Dressing intact • Incision healing (Not applicable if obstructed by cast and dressing)
Activity	• Ankle pumping exercises 5 times every hour on non- operative foot • Operative food elevated 6 inches above the level of the heart for 22 of 24 hours per day • Mobilizing non-weight bearing safe and independent with aids • Completes am/pm care • Physiotherapist has assessed patient to be safe for discharge • Physiotherapist has assessed patient to be safe on stairs (if applicable) • Night time sleep acceptable to patient

Teaching & Discharge Planning	• If patient being discharged ensure the following: o Verbalizes an understanding to elevate the operative foot for two weeks, 22 of 24 hours/day & that elevation may decrease week 2 based on the swelling of the operative foot and level of discomfort o Prescriptions given and Medication counselling completed o "Pain and ways to manage it" pamphlet reviewed o Post-operative care and home care needs reviewed with patient/caregiver o Patient/caregiver aware of time of discharge today o Patient has follow-up appointment sheet or will book appointment with physician o Patient/caregiver has recommended equipment at home o Personal items and medications returned to patient

Developed By

Nurse Educators, Surgery PHC

Effective Date:	02-OCT-2019
Posted Date:	02-OCT-2019
Last Revised:	02-OCT-2019
Last Reviewed:	
Approved By:	PHC
	Professional Practice Standards Committee
Owners:	PHC
	Surgery (Orthopedics)