Hip Fracture Surgery: Sub Acute Phase Clinical Pathway

Site Applicability

Vancouver General Hospital (VGH)

UBC Hospital

Lions Gate Hospital (LGH)

Pathway Patient Goals

Inclusion Criteria

Home Discharge Criteria

Eligible for discharge when discharge criteria ◆ **outcomes** met after Post-op Day 0.

Instructions

1. Assess outcomes each shift each, subacute pathway until all outcomes met, then ready for discharge.
2. Do not document on this pathway, complete documentation in the Electronic Health Record (Cerner) or paper chart as per policy

Acute Phase – Post op day	
Focus of Care	**Expected Outcomes**
Safety Checks	• Safety check completed as per unit standard
Status Update	• Note reason patient taken off clinical pathway if applicable • Note reason resumed acute care pathway if applicable
Delirium	• Assessed for the presence of delirium using the Confusion Assessment Method Instrument (CAMI tool) • Assessed for contributing risk factors using PRISM-E (pain, retention, restraint, infection, impaction, sensory impairment, medications, alcohol, metabolic-hypoxemia, malnutrition, fluid electrolyte, environment, and history of dementia) • Notify MD if persistent confusion and consider pharmacy review if greater than 5 medications • Orientated to person, place and time throughout shift • **No contributing factors for Delirium identified** • **Free from Delirium according to CAMI tool ◆**
Pain/Sleep	• Pain assessed Q 4 H and PRN. Provide analgesics as required per assessment – (Regular Tylenol / low dose opioid - see eMAR) • Notify MD for uncontrolled pain • **Patient reports pain or pain behaviors at an acceptable level with rest and activity ◆** • **Sleeps at night between turns at least 4 hrs ◆**
Respiratory	• Respiratory assessment, including O2 Sats, completed minimum Q shift & PRN, or as ordered by MD. • Consult MD for diminished respiratory status • **Clear Breath Sounds all lung fields (no resp complications identified) ◆** • **O2 sats greater than 91% (or % as determined by MD) on room air ◆**
Cardiovascular	• VTE prevention ○ LMWH as ordered or Sequential compression device • Remove Sequential Compression Device Q shift x 20 minutes & for mobilization • Vital signs and O2 Sats assessed as ordered by MD and PRN. • Neurovascular status assessed PRN as per Orthopedic Neurovascular Assessment DST (D-00-12-30065) • **Neurovascular assessment within normal limits & No evidence of VTE ◆** • **VS within normal limits ◆**
Fluid/ Electrolyte/ Lab Values	• Patient drinking well, 1500 ml or as per fluid restrictions • IV maintained as ordered, IV assessed as per appropriate CPD ○ Assess site of Peripheral IV, Saline Lock, CVC, or PICC (if present) • IV/CVC site free from pain, redness, swelling; document IV/CVC care

	• Document if tubing changed • Document Saline Lock Flush • Document if IV catheter removed intact • Review lab results and report any abnormal findings to MD • **Blood values are within normal limits ◆**
Anemia	• Assessed HBG – Notify MD if HBG < (less than) 90 gm, drops by 10 gm or more, or patient symptomatic • **No evidence of bleeding d/t surgery or LMWH ◆** • **HBG greater than 90 or as determined by MD ◆**
Infection	• Assessed for signs or symptoms of infection (Urinary tract, pneumonia, wound) q shift & PRN. Notify MD if infection suspected • Dressing change daily and PRN (if still has dressing) • Note if incision OTA • Surgical Dressing dry/Incision well approximated, free of redness or drainage. Notify MD if wound draining or reddened • Staples removed as per MD's orders (day 10 – 14 if wound healed) • **Temperature & WBC within Normal Limits ◆** • **No Signs or Symptoms of Infection ◆**
Skin Breakdown	• Turned Q 2-3 hr. to either side • Skin assessed Q shift for pressure areas and skin breakdown, alleviate pressure on heels, elbows & coccyx and documented as appropriate • Braden Score assessed as per DST • Note if and type of specialty mattress ordered • **Skin, Heels Coccyx, & Elbows free of redness, or skin breakdown ◆**
Swallowing, Nutrition	• DAT – no nutrition issues identified • Note if Dietitian consulted and reason • Dietary supplements initiated (eg. Boost Plus) • Swallowing - no issues identified • SLP consulted for swallow assessment if swallowing issues noted • Independent with meals • See careplan/kardex if assist with meals required • **Tolerating oral intake greater than 75% of meals** • **Nutrition & Hydration needs assessed and met**
Elimination	• Noted number of voids per shift • Toilet/commode x 2 per days (minimum), avoid bedpans. • If unable to void scan bladder Q6h & PRN. If bladder volume greater than 350 cc, do intermittent catheterizations as ordered. Notify MD if patient not voiding after 24 hours or 3 in/outs or need for urology consult identified. • Note if incontinent of Urine and/or Stool • **Voiding sufficient quantity of urine - output greater than 25 cc/hr or 150cc / 6 hrs ◆**

	• **Note last BM, administration of laxatives**

Falls Risk	• Falls Risk/ Care Plan
	  ○ Not at risk: reviewed & no concerns
	  ○ At Risk: Fall Protocol in place: reviewed and no change
	• Significant change in status : Risk assessed & Fall Care Plan revised/ new plan completed
	• **Patient free from falls q shift**

OT	• Consent obtained from patient/other • Assess Cognition: Intact, impaired • Patient has comfortable and supportive seating that promotes mobility • Ensure patient has specialty mattress if required • Assess the following **ADL's** as **Independent** or requiring **Assistance:** ○ Bathing, Dressing, Feeding, Toileting • Referred to Rehab Assistant for ADL training • Patient and Family asked to bring in personal items for ADL's • ADL's posted on bedside Care Plan • Home Safety and Falls Prevention Education provide • Education provided re: functional implications of hip fracture and post-op precautions • Discharge plan developed • OT Goals for discharge identified • Equipment needs identified for discharge • Equipment list given to patient and family; equipment in place • Home support recommended • HCOT referral completed

Mobility/ Functional Status (Physio)	• **Weight-bearing status** noted (WBAT, PWB, FeWB, NWB)
	  ○ Precautions in place
	• Consent obtained from patient/other
	• **Transfers**:
	  ○ Lie ←→ sit with/without assist
	  ○ Sitting ←→ stand with/without assist; with/without aid
	  ○ Note if OHL is used
	• Note **sitting tolerance** (time and frequency)
	• Note **ambulation** (distance, frequency, with/without aid/assist)
	• **Classes:** Note if participated or refused to participate in the following:
	  ○ Seated class, standing class/exercises, bed exercises
	• Note **stairs** (number, with/without assistance)
	• Note TUG (timed up and go)
	• **Transfer/Mobility** updated on Bedside Care plan

Physical Status (Physio)	• Assess the following for **ROM** and **Strength**, and indicate whether **Passive**, **Active-Assisted** or **Active**:
	  ○ Hip flexion, extension, and abduction (left, right)
	  ○ Knee flexion and extension (left, right)

	○ Ankle – normal active ROM • Exercise program/sheet provided
Nursing Mobility	• Note if up to chair (frequency and sitting tolerance) • Note ambulation (distance, frequency, with/without aid/assist)
Hygiene	• Note if bed bath, shower ○ total care, assisted care or independent • Note mouth care (frequency on each shift) • Note if dentures present at bedtime (upper and/or lower)
Anxiety/ Patient Teaching	• Patient / Family supported re: patient response to hospitalization and surgery • Patient / Family state information needs regarding patient's progress met
Transition Planning	• Note Target Discharge Date • Patient / Family aware of anticipated discharge plans and length of stay • Note anticipated D/C destination (TCU, Home, HFH, Care facility, other) • Notify CML If patient ready for direct return to nursing home, all ◆ outcomes must be met ○ PCC updated daily re: patient's progress towards meeting discharge goals.

Developed By

Effective Date:	
Posted Date:	
Last Revised:	
Last Reviewed:	
Approved By:	
	Endorsed By: **Final Sign Off:**
Owners:	VCH
	Developer Lead(s): • Clinical Nurse Educator, Orthopaedics and Trauma, VGH • Clinical Nurse Educator, Complex Medical Activation Unit, UBCH