Fractured Hip Surgery Acute Phase Clinical Pathway

Site Applicability

Providence Health Care

VCH Coastal - LGH

Pathway Patient Goals

1. The patient will return to pre-fractured physical, mental, and social level of functioning and residence
2. The post op Acute Phase Length of Stay goal less than or equal to 4 days
3. The patient will not develop a skin pressure ulcer
4. The patient will have pain managed to a level acceptable to the patient
5. The patient will have no **injurious** falls during her/his hospital stay
6. Patient/caregiver will verbalize understanding of discharge instructions and follow up

Inclusion Criteria

1. All hip fracture 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 (Cerner) or paper chart as per policy

Pre-Surgery (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
Assessment	• Baseline Admission Screening /Risk Assessments completed: ○ Violence risk ○ Delirium risk ○ Alcohol/Drug Screen, Smoking ○ Braden ○ Dysphagia ○ Falls ○ Advance Care planning • Height and weight recorded • Vital signs as per orders stable-afebrile and within patient's normal limits • Neurovascular assessments as per orders • CWMS within normal limits to both limb(s) • Capillary refill (less than 3 seconds) to foot of affected limb(s) • Chest sounds clear or as prior to admission (PTA)
Pain Management	• Acceptable comfort pain level (as stated by patient) documented (__/10) • Review pain control principles and encourage the reporting of any side effects of analgesics • Assess for any significant pain history • Able to tolerate turns without discomfort
Elimination	• Urine output greater than 200mL in 6 hours • No signs of urinary tract infection • Catheter in place and bag secured if applicable • Foley care completed if applicable • Bowel sounds present, abdomen soft, not distended • Date of last BM noted • Review with patient maintaining regular bowel care while on opioids
Nutrition / Hydration	• Diet maintained as per orders (NPO) • Fluid intake greater than 600mL in 12 hours or within restrictions
Skin	• Skin integrity intact, no redness or pressure points • Braden scare assessed
Activity	• Bedrest and repositioned in bed every two hours • Ankle pumping exercises 5 times every hour to unaffected leg while awake

	• Takes 10 deep breaths and coughs every hour while awake • Night time sleep acceptable to patient
Diagnostics	Ordered preoperative investigations are completed and results available (e.g. Lab work, radiology)
Medications	• Medications administered as per orders
Patient Teaching	• Patient orientated to room, call bell and peri-operative routine • Patient verbalizes understanding of teaching provided re: ○ No smoking before or after surgery ○ Post-anesthetic exercises for breathing and circulation ○ Pain management post operatively including oral/IV/SUBCUT, nerve blocks and PCA ○ Need for mobility aids and equipment ○ Pathway length of stay (less than or equal to 4 days) ○ Transfers and walking with physiotherapist immediately post (must be able to do safely prior to discharge) ○ Dangle or sit up in chair the evening of surgery • Day pathway reviewed
Discharge Planning	• Begin to assess home care needs • Patient/family given information related to surgery and typical post-operative course
Consults	Consults as needed: • Anesthesia • Occupational Therapy • Physiotherapy • Social Work • Pharmacy • Internal medicine

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) • 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 Qshift & PRN, site intact, no redness, IV patent
Skin/Dressings/Drains	• Dressing assessed Qshift & PRN. • Dressing dry and intact • Reinforce and/or change dressing as per orders • Drain in place and patent (if applicable) • Braden Score documented
Diagnostics	• Ensure ordered lab work is performed.
Activity	• Ankle pumping exercises 5 times per hour • Deep breathing and coughing exercises every hour (10 deep breaths per hour. Cough if secretions present

	• Patient stands or dangles at bedside (with supervision) • Completes personal care with assistance • Mobilize as per provider orders • Night time sleep acceptable to patient
Teaching & Discharge Planning	• Review with patient/caregiver. ○ Orientation to room/environment ○ Medications being given ○ Equipment/care needs when discharged ○ Hip precautions (if hemiarthroplasty) ○ Expected discharge or transfer to rehabilitation POD 4

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 • 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
Elimination	• Toilet every 4 to 6 hours while awake and PRN • Patient voiding more than 200 mL in 6 hours • 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. • 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; 10 deep breaths and coughs Q1H while awake • Note assistance level with transfers • Completes personal care with assistance • Activity as per provider orders:

	○ Patient stands and transfers to chair ○ Patient up to chair for 2 meals minimum- (avoid sitting for over 2 hours) • Completes range of motion (ROM) and muscle strengthening exercises with Physio • Night time sleep acceptable to patient
Teaching & Discharge Planning	• Patient/caregiver aware of expected ACUTE care length of stay- 4 days post op • Rehabilitation goals discussed with patient/caregiver • Hip precautions reviewed and maintained if patient had hemiarthroplasty • Patient has clothing for discharge at bedside or caregiver asked to bring in clothing

Post-Operative Day 2 (POD2)	
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 • 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
Elimination	• Toilet every 4 to 6 hours while awake and PRN • Patient voiding more than 200 mL in 6 hours • 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 600mL in 12 hours or keeping within restrictions • Tolerating diet – eating more than 75% of meal trays
Skin/Dressings/Drains	• Braden Scale • Dressing dry and intact, assessed Q shift • Dressing changed as per provider order • Incision healing, no signs of infection
Activity	• Ankle pumping exercises 5 every hour; 10 deep breaths and coughs Q1H while awake • Note assistance level with transfers • Activity as per provider orders:

	○ Patient up to chair for 2 meals minimum- (avoid sitting for over 2 hours) ○ Patient walks short distances (10 to 15 feet) with walking aid and assistance- minimum once per day • Completes range of motion (ROM) and muscle strengthening exercises with Physio • Completes am/pm care with/without assistance • Night time sleep acceptable to patient
Teaching & Discharge Planning	• Patient/caregiver aware of expected ACUTE care length of stay- 4 days post op • Rehabilitation goals discussed with patient/caregiver • Hip precautions reviewed and maintained if patient had hemiarthroplasty • Patient/caregiver aware of equipment needs for home • Patient/caregiver states information needs met

Post-Operative Day 3 (POD3)	
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 • 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 as per protocol and PRN • Pain level is acceptable to patient • Importance of pain control reviewed with patient
Elimination	• Toilet every 4 to 6 hours while awake and PRN • Patient verbalizes voiding quantity sufficient • 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 600mL in 12 hours or keeping within restrictions • Tolerating diet – eating more than 75% of meal trays
Skin/Dressings/Drains	• Braden Scale • Dressing dry and intact, assessed Q shift • Dressing changed as per provider order • Incision healing, no signs of infection
Activity	• Ankle pumping exercises 5 every hour; 10 deep breaths and coughs Q1H while awake • Note assistance level with transfers • Activity as per provider orders:

	○ Patient up to chair for all meals ○ Patient able to walk to washroom using walker with assistance/supervision as required ○ Increase walking distances (20 to 50 feet) with walker and assistance/supervision PRN minimum once per day • Completes range of motion (ROM) and muscle strengthening exercises with Physio • Night time sleep acceptable to patient
Teaching & Discharge Planning	• Hip precautions reviewed and maintained if patient had hemiarthroplasty • Patient has clothing for discharge or move to reactivation unit on POD 4 • Patient/caregiver aware of equipment needs for home • Patient or caregiver able to self-administer anticoagulant • Prescriptions on chart and information reviewed with patient and/or caregiver for discharge POD 4 • Patient/caregiver states information needs met

Post-Operative Day 4 (POD4) /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 • 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 as per protocol and PRN • Pain level is acceptable to patient • Importance of pain control reviewed with patient
Elimination	• Toilet every 4 to 6 hours while awake and PRN • Up to bathroom and patient verbalizes voiding quantity sufficient • 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 keeping within restrictions • Tolerating diet – eating more than 75% of meal trays
Skin/Dressings/Drains	• Braden Scale • Dressing dry and intact, assessed Q shift • Dressing changed as per provider order • Incision healing, no signs of infection
Activity	• Patient completing ROM/strengthening exercises independently • PT has assessed patient to be safe for discharge or transfer to rehabilitation • Patient walking shirt distances (20 to 50 feet) with walker safely and independently • PT has assessed patient to be safe on stairs • Completed am/pm care with/without assistance • Night time sleep acceptable to patient

Teaching & Discharge Planning	• Hip precautions reviewed and maintained if patient had hemiarthroplasty
	• If patient being discharged home ensure the following:
	  ○ Prescriptions give and Medication counselling completed
	  ○ Patient or caregiver able to self-administer anticoagulant
	  ○ Post-operative care and home care needs reviewed with patient/caregiver
	  ○ Patient has outpatient referral for physiotherapy if applicable
	  ○ Patient has homecare physiotherapy set up if applicable
	  ○ Patient knows to make follow up appointment with surgeon or has appointment date
	  ○ Patient/caregiver has recommended equipment for home
	  ○ Wound care reviewed with patient/caregiver
	  ○ "Pain and ways to manage it" pamphlet reviewed
	  ○ Personal items and medication returned to patient
	
	Patient is "off" pathway if they are not discharged home or if transferred to the reactivation/rehabilitation unit.

Developed By

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