Hip and Knee Arthroplasty Clinical Pathway

Site Applicability

Providence Health Care Acute Care Inpatient Units using the Cerner Electronic Health Record

Pathway Patient Goals

1. Patient will be free of nausea/vomiting on POD 1
2. Patient will be discharged on POD 1 or 2
3. Patient will have pain managed to a level acceptable to the patient
4. Patient will have no injurious falls during their hospital stay
5. Patient/caregiver will verbalize understanding of discharge instructions and follow up

Inclusion Criteria

1. All elective arthroplasty 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-Surgery (Pre-admission Clinic Visit or Pre-op on ward (if applicable)	
Care Category	**Expected Outcomes**
Cognition	• Delirium Risk factors assessed and baseline CAM score recorded • Alert and Oriented x 3
Assessment	• Baseline Admission Screening /Risk Assessments completed: o Violence risk o Delirium risk o Alcohol/Drug Screen, Smoking o Braden o Dysphagia o Falls o Advance Care planning • Height and weight recorded
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
Elimination	• Review with patient maintaining regular bowel care while on narcotics
Nutrition / Hydration	Patient understands: • pre-op fasting from solids from midnight before surgery • Fasting from clear fluids 5 hours before surgery
Skin/Dressings/Drains	• Patient understands pre-op skin prep shower/bath procedure • Patient is aware of incision(s) and post-op dressings
Diagnostics	Ordered preoperative investigations are completed and results available (e.g. Lab work, radiology)
Medications	• Best possible medication history obtained and recorded • Preoperative medication instructions available for patient
Patient Teaching	• Patient verbalizes understanding of teaching provided re: o No smoking before or after surgery o Medications to start or stop before surgery o Post-anesthetic exercises for breathing and circulation o Pain management post operatively including oral/IV/SUBCUT, nerve blocks and PCA o Need for mobility aids and equipment o Pathway length of stay (3 days, 2 nights – home POD 1 or 2) o Hip Precautions following total hip arthroplasty o Transfers and walking with physiotherapist immediately post (must be able to do safely prior to discharge) o Dangle or stand in the evening of surgery day • Patient pathway reviewed
Discharge Planning	Planned discharge POD 1 or 2 Patient/caregiver understands need

	• Bring clothing for discharge POD 1 • Bring walker POD 1 • Arrange for patient's transport to the hospital and home POD 1 or 2 • Patient will receive prescriptions on discharge from the hospital • Any additional post operative equipment or other needs have been identified
Consults	Consults as needed: • Anesthesia • Occupational Therapy • Physiotherapy • Social Work

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 • Neurovascular assessments completed as per protocol are within patient normal limits (patients with blocks may have decreased sensation and decreased motor function to affected limb for up to 18 hours) • Capillary refill (less than 3 seconds) to operative foot • Chest sounds clear
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 360 mL in 12 hours • Catheter care, if Foley insitu • 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 • Drain in place and patent (if applicable) • Braden Score documented
Diagnostics	• Ensure all routine lab work is ordered, performed and results are available.
Activity	• Dangle (with supervision) at bedside or sit up in chair x 15 minutes • Deep breathing and coughing exercises every hour (10 deep breaths per hour. Cough if secretions present) • Ankle pumping exercises 5 times per hour • Completes personal care with assistance • Mobilize as per provider orders

Teaching & Discharge Planning	• Review with patient/caregiver. o Orientation to room/environment o Medications being given, including anticoagulation (start self-administration teaching) o Plan for discharge home POD 1 or 2 o Equipment/care needs when discharged o Hip precautions (if THA) o No pillow under knee (if TKA)

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 and within patient normal limits • Sensation of surgical limb within patient normal limits • Capillary refill (less than 3 seconds) to operative foot • Chest sounds clear
Pain Management	• Pain assessed Q4H and PRN • Pain level is acceptable to patient • Importance of pain control reviewed with patient
Elimination	• Urine output more than 360 mL in 12 hours • Foley discontinued (if present) • Bowel sounds present, abdomen soft, not distended
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	• Braden Scale • Dressing dry and intact, assessed Q shift • Dressing changed or reinforced as per provider order • Drain in place and patent (if applicable), drainage recorded
Activity	• Ankle pumping exercises 5 every hour; 10 deep breaths and coughs Q1H while awake • Completes personal care with assistance • Activity as per provider orders: o Patient stands and transfers to chair o Patient walking with walker or crutches safely and independently • Patient has home exercise booklet provided by physiotherapy • Completes range of motion (ROM) and muscle strengthening

	exercises with Physio • Physiotherapist has assessed patient's safety on stairs as applicable • Physiotherapist has assessed patient's safety for discharge • Night time sleep acceptable to patient
Teaching & Discharge Planning	• Patient/caregiver aware of expected discharge today or POD 2 at 1100 • Patient/caregiver able to administer anticoagulant (if ordered) • Patient/caregiver aware of who to contact if they need assistance after discharge • Prescriptions given if being discharged today • Medication counselling completed • "Pain and ways to manage it" pamphlet reviewed • Home preparations, follow up appointment with surgeon and equipment needs reviewed and patient ready for discharge • Outpatient physiotherapy arranged • Home care arranged if needed • Wound care reviewed • Hip or Knee precautions reviewed • Patient /caregiver concerns regarding discharge reviewed/resolved • Patient discharged if discharge criteria met and provider order

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 within patient normal limits, afebrile • 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
Pain Management	• Pain assessed Q4H and PRN • Pain level is acceptable to patient • Importance of pain control reviewed with patient
Elimination	• Up to bathroom, patient verbalizes voiding quantity sufficient • Bowel sounds present, abdomen soft, not distended
Nutrition / Hydration	• No nausea/vomiting • 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 walking with walker or crutches safely and independently • Patient completing ROM/Strengthening exercises independently • Patient has home exercise booklet provided by physiotherapy • Physiotherapy has assessed patient to be safe on stairs (if applicable) • Physiotherapist has assessed patient's safety for discharge
Teaching & Discharge Planning	• Patient/caregiver aware of expected discharge today at 1100 • Patient/caregiver able to administer anticoagulant (if ordered) • Patient/caregiver aware of who to contact if they need assistance after discharge • Prescriptions given and Medication counselling completed • "Pain and ways to manage it" pamphlet reviewed • Home preparations, follow up appointment with surgeon and equipment needs reviewed and patient ready for discharge • Outpatient physiotherapy arranged

	• Home care arranged if needed • Wound care reviewed • Hip or Knee precautions reviewed • Patient /caregiver concerns regarding discharge reviewed/resolved • Patient discharged if discharge criteria met and provider order

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