Hip Fracture Surgery: Acute Phase Clinical Pathway

Site Applicability

Vancouver General Hospital (VGH)

UBC Hospital

Lions Gate Hospital (LGH)

Pathway Patient Goals

Inclusion Criteria

Home Discharge Criteria

Instructions

1. Assess ◆ outcomes each shift using Acute phase pathway until all outcomes met, then initiate sub-acute phase
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 for delay in transfer to sub-acute • Note reason patient taken off clinical pathway
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 • "Delirium – A Troubled Mind" education booklet reviewed with patient/ family • 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. • Deep Breathing encouraged Q1 Hr while awake encourage coughing if secretions present • **Clear Breath Sounds all lung fields (no resp complications identified) ◆** • **O2 sats greater than 91% on room air or as determined by MD ◆**
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 as per MD order • Surgical Dressing dry/Incision well approximated, free of redness or drainage. Notify MD if wound draining or reddened • Surgical wound exposed if no longer draining • **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. • Braden Score assessed as per policy • 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 • Foley catheter maintained as per MD order. • Review need for catheter daily – Notify MD if urine output less than 25 cc / hr or 150 cc/ 6 hrs • If catheter present, ensure it is secured and catheter care completed Q shift • Foley discontinued POD 1 as per MD order • **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 • If significant change in status : Risk assessed & Fall Care Plan revised/ new plan completed as required • **Patient free from falls q shift**
OT	• Consent obtained from patient/other • Assess Cognition: Intact, impaired • If wheelchair needed: specifications assessed/completed • Patient has comfortable and supportive seating that promotes mobility • Ensure patient is on appropriate mattress type • **ADL's** posted on Bedside care plan • Patient participated in ADL's as per Bedside Care plan • **OT Goals for discharge identified** • Discharge plan developed • Equipment needs identified for discharge • Equipment list given to patient and family; equipment in place • Home support recommended if required • HCOT referral completed if required
Mobility/ Functional Status (Physio)	• **Weight-bearing status** noted (WBAT, PWB, FeWB, NWB) ○ Precautions in place if required • Consent obtained from patient/other • **Transfers**: ○ Lie ←→ sit with/without assist ○ Sitting ←→ stand with/without assist; with/without aid ○ Note if patient requires OHL • Note **sitting tolerance** (time and frequency) • Note **ambulation** (distance, frequency, with/without aid/assist) • **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 is provided ○ 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, surgery & potential delirium • Patient / Family state information needs regarding patient's progress met
Discharge Planning	• Begin to assess home care needs • Patient/family given information related to surgery and typical post-operative course
Transition Planning	• Patient / Family aware of potential transfer to sub acute program & anticipated discharge plan • Note anticipated D/C destination (CAMU, 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:	
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Last Revised:	
Last Reviewed:	
Approved By:	
	Endorsed By: **Final Sign Off:**
Owners:	VCH
	Developer Lead(s): • Clinical Nurse Educator, Orthopaedics and Trauma, VGH