Hip Fracture Surgery: Pre-Op 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. 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-Op Phase	
Focus of Care	**Expected Outcomes**
Safety Checks	• Safety check completed as per unit standard
Delirium	• Previous diagnosis of Dementia noted in history/transfer notes • 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 • Personal medications ordered (meds prior to admission); Pharmanet search done • Consider Pharmacy review if > meds prior to admission • Orientated to person, place and time throughout shift • **No contributing factors for Delirium identified ◆** • **Free from Delirium according to CAMI tool ◆**

Pain/Sleep	• Pre Hospital Analgesia use reviewed and pain behaviors identified and noted in care plan
	  ○ If cognitively impaired consult family /caregivers for known pain behaviors.
	• Patient teaching brochure reviewed re: Pain Control After Surgery
	• Pain assessed Q 1 H until pain well controlled – Provide Analgesics as required per assessment
	  ○ Regular Tylenol / low dose opioid as ordered - 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 • 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 ○ Sequential compression device as ordered

	• If Sequential Compression Device to legs ordered, device removed Q shift x 20 minutes & for mobilization • Notify MD if Sequential Compression Device not available • Vital signs and O2 Sats assessed as ordered by MD and PRN. • Neurovascular status assessed Q4h and PRN until surgery 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	• IV access maintained as ordered pre-op and as per site PCG ○ Assess site of Peripheral IV, Saline Lock , CVC, or PICC (if present) • IV/CVC site free from pain, redness, swelling; document IV/CVC care • Patient drinking 1500 ml or as per fluid restrictions until NPO • Review lab results and report any abnormal findings to MD • **Blood values are within normal limits *(Lytes, BUN & Creat, Blood Glucose, INR, PTT)* ◆**
Anemia	• Assessed HBG – Notify MD if HBG < (less than) 90 gm, drops by 10 gm or more, or patient symptomatic • **HBG greater than 90 or as determined by MD ◆**
Infection	• Assessed for signs or symptoms of infection (Urinary tract, pneumonia, wound) on admission. Notify MD if infection suspected • **Temperature, WBC and Urinalysis within Normal Limits ◆** • **No Signs or Symptoms of Infection ◆**
Skin Breakdown	• Turned Q 2-3 hr. to unaffected side • Skin assessed on admission and Q shift for pressure areas and skin breakdown; alleviate pressure on heels, elbows & coccyx. • Braden Score assessed on admission • Note if and type of specialty mattress ordered • **Skin, Heels Coccyx, & Elbows free of redness, or skin breakdown ◆**
Swallowing, Nutrition	• Note NPO time, reason • 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 issues with swallowing 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	• Foley catheter – urine output assessed Q6H and as required. ○ Notify MD if urine output less than 25 cc / hr or 150 cc/ 6 hrs • Catheter secured and catheter care completed Q shift

	• **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
PT	• Consent obtained from patient/other
Hygiene	• Note if bed bath, shower is provided ○ Note if patient is total care, assisted care or independent • Note and document mouth care (frequency on each shift) • Note and document if dentures present at bedtime (upper and/or lower)
Anxiety/ Patient Teaching	• Patient / Family provided support, teaching regarding unexpected hospitalization and surgery • Provide and review "Welcome to the Hip Fracture Program" booklet with patient/family • Patient / Family state information needs met
Discharge Planning	• Begin to assess home care needs • Patient/family given information related to surgery and typical post-operative course
Transition Planning	• GP confirmed & notified of patient admission

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