Information and Notes

My Room #_____ Room Phone _____
My Surgeon_____ Surgeon Office Phone _____
My Medical Doctor_____ Medical Doctor Office _____
My Case Manager_____ Case Manager Phone_____

Questions I Need Answered

1.
2.
3.
4.
5.
6.
7.

Discharge Options

1. Home Health: Must be homebound and need a skilled service such as physical therapy or nursing. Covered by Medicare and most insurances (may have co-pay).

2. Outpatient Therapy: (2-3 times a week) Must have transportation and be able to get in and out of car. Can go to the closest facility to your home. Covered by Medicare and most insurances (may have co-pay).

3. Skilled Nursing Facility: Inpatient stay at a nursing facility to receive skilled nursing care and physical and occupational therapy. Medicare & some insurances may cover this if admission criteria are met. The facility must review your records and accept you for admission.

4. Acute Rehab (e.g. Winchester Rehabilitation Center): Inpatient stay for those who have extensive inpatient need and can tolerate 3 hours of intensive therapy. Medicare & some insurances may cover this if admission criteria are met. Must meet admission criteria and be pre-certified.

Your Case Manager and Social Worker will discuss your discharge needs with you.

Post-Acute Hip Fracture Pathway

This is a guideline only.
All care is individualized to each patient's needs.

ValleyHealth
Orthopedics

POST ACUTE HIP FRACTURE PATHWAY

Medical Guidelines During Post-Acute Care After Hip Fracture Surgery

Physician/ LABS/ Pain Control/DVT

- Comprehensive medical assessment within 24-hours
- Review Post-Acute Hip Fracture Surgeon Guidelines
- Address wound care and DVT prophylaxis
- CBC/ BMP twice a week
- Per SNF Protocol
- No problems with vitals: No labs
- Limit use of narcotic pain medication: Oral Analgesics
- Wean to non-narcotic medication as tolerated
- Combine rehab and progressive mobility
- Clarify Weight Bearing status as defined by the surgeon, in DC orders
- Physician assessment for delirium/dementia as needed

DVT Care:
- Continue DVT prophylaxis 4-weeks post-op
- Meds of DVT will vary see discharge instructions
- TEDS or SCD per facility guidelines (optional)

Catheter / Bowel Care

Bowel Care
- Use stool softeners 1 or 2 daily or BID
- Increase fiber daily (Fibercon, Citracil, or Miralax)
- Dulcolax suppository prn or Fleets enema prn
- Use other Bowel Protocols as necessary

Catheter Care
- If pt has BPH and recently started on something like Flomax, we may leave in 24-36 hours until med can exert effect
- If no explainable reason for urinary retention or patient has not been seen by urology and has specific orders, leave in 24-36 hours, then discontinue
- Perform bladder scan every 6-8 hours if unable to void, in/out catheterizations.
- If patient cannot void after 8 hours after removal, and bladder scan is positive, repeat cycle 1-2 more times
- If the patient is unable to void in the subsequent eight hours and straight-catheterization yields greater than 300 cc, catheterization should again be initiated, and antibiotic prophylaxis continued until catheter removed

Vitals

- Blood Pressure: Monitor BP every shift, if hypo-tensive, work up for anemia
- Pulse: Rate and Rhythm
- Temperatures: Preferable late afternoon for 2-weeks, if elevated and greater than 100.4 degrees, consider urinalysis, CBC, Chest X-ray, and blood cultures
- If greater than 101.5 degrees, consider work up for wound infection **(Call Orthopedic Surgeon)**

Wound Care

- Assess for pressure ulcers: Full body assessment for pressure ulcers upon admission
- Assess for use of foam/alternating pressure mattress and/or turning /moving schedule
- Implement progressive mobility for lower functioning patients.
- Dress and clean hip wound on a daily basis
- Observe for obvious signs of infection, redness, swelling, heat production, pain, tenderness, drainage, pus, and systemic temperature
- Implement appropriate turning schedule consistent with functional level

Nutrition

- Dietary assessment
- Establish dietary POC
- Collaborative rounding with dietary and dietician
- Education on calcium intake
- Out of bed for every meal
- Consult with dietician if osteoporotic
- Community resources for local healthy shopping

Diabetic Educator

- Review blood sugar monitoring
- Educate on healthy eating for blood glucose control
- Educate on Diabetes/Survival Skills
- Educate Hypoglycemia/Hyperglycemia
- Educate on Diabetic Drugs / Insulin
- Family counseling
- Refer for OP Diabetic Education/ Counseling

Pharmacy & Medication

- Medication reconciliation
- Obtain drugs that patient needs if not in formulary
- Medicine education for patient and family/ upon reconciliation or upon request
- Review drug interactions with Coumadin/Lovenox
- F/U Education on medications
- Education on interactions/ provide drug handouts as necessary

Respiratory

- Perform respiratory assessment
- Initiate appropriate breathing treatments as needed
- Incentive spirometry 3-5x/day, provide home/family education
- Oxygen Management: Wean to baseline

Social Work & Rehab

- Home/Family/Care Support Assessment and Education: To include early ID, Continuous Reassessment and appropriate F/U
- Coordinate with Care Team
- Clarify Advance Directive/Living Will
- Educate patient and family with material given to both
- Establish DC Plan- within 48 hours of admission
- Care provider arrangements for DC
- Establish need for DC equipment early in the process
- Assess for Transition/Adaption after surgery: Depression, Dementia, Delirium on acute admission/preparation for post-acute placement

Case Management

- Perform insurance authorization/re-authorization
- Establish DC Plan- within 48 hours of admission
- Readiness to learn/Education assessment
- Send interdisciplinary care plan to Surgeon after team meetings
- Post DC test ordered/ authorized/ scheduled
- Schedule Post OP DC surgeon appointment
- Fax /Send DC to Surgeon/PCP
- Complete OP or HH referrals

Nursing

- Know surgical procedure
- Perform comprehensive nurse assessment, Review of Systems.
- Weight /I&O
- Monitor incision site / bandages are clean, bathed daily
- Control Pain
- Clarify the WB status prior to mobility and ambulation
- Progress mobility 2x/day in coordination with therapy
- Daily education on medications with patient verbalized understanding
- Plan Post DC anticoagulation
- Post DC medications education
- Post DC labs as necessary: Ordered/Authorized/Scheduled (Completed the day before the patient leaves)
- Schedule appointments for Post DC physician, nursing, and Rehab
- Schedule Post OP DC Surgeon appointment
- Patient and family able to clearly verbalize DC instructions

Discharge Criteria

- Patient will be hemo-dynamically stable (blood pressure), afebrile (temperature), tolerating a regular diet
- The wound is clean and dry
- Pain is well controlled and managed with oral analgesics
- Labs are near baseline and medical optimization has occurred
- Patient can complete **Activities of Daily Living**, utilize adaptive equipment, and complete home exercises
- Physical therapy and occupational therapy have cleared the patient agreeing that the patient is able to safely perform at basic level of functional independence
- Ensure patient/family understanding of DC medications and DC plans.

POST ACUTE HIP FRACTURE PATHWAY

Post-Acute Hip Fracture Rehabilitation Continuum

Hip Precautions/Functional Level

Precautions: Hemi-arthroplasty
- Do not bend operated hip past 90°
- Do not externally/internally rotate operated leg
- Do not cross legs at any time
- Keep a pillow between legs while in bed
- Avoid sitting in low chairs or sofas
- Use adaptive equipment to avoid forward bending
- Avoid hip extension greater than 20 degrees

Fixation
- No precautions
- No range of motion limitations
- See weight bearing status below

Level of Function:

Level	Description	Definition
7	Complete Independence	Fully independent
6	Modified Independence	Requires the use of a device but no physical help
5	Supervision	Requires only standby assistance or verbal prompt to help with set-up
4	Minimum Assistance	Requires incidental hands-on help only (patient performs greater than 75% of the task)
3	Moderate Assistance	Patient performs 50–75% of the task
2	Maximum Assistance	Patient provides less than half of the effort (25–49%)
1	Total Assistance	Patient contributes < 25% of the effort or is unable to do the task

(#) = Level of function for activity goals

Weight Bearing

- Per MD Order and progress as tolerated.

Non Weight Bearing → Touch Down Weight Bearing → Partial Weight Bearing 25% → Partial Weight Bearing 50% → Partial Weight Bearing 75% → Full Weight Bearing

	Phase I (POD 4-5 and DC to facility)	Phase II (Week 2)	Phase III (Week 3-4 to Discharge)
Goals	• Functional Mobility with minimal assist (4) • Standing - minimal assist (4) • Minimal assist - use of adaptive equipment (4) • Minimal assist - bathing & dressing (4) • Perform upper extremity exercises - minimal resistance (4) • Walking 50-100' - minimal assist and rolling walker (4)	• Continue Phase I goals • Functional mobility - supervision (5) • Standing - supervision (5) • Minimal assist for tub/shower transfers (4) • Perform exercises in lying, sitting, and standing (4) • Walking 200' - supervision and rolling walker (5)	• Continue Phase II goals • Perform home assessment for safety • Independent - functional mobility (6-7) • Standing - modified Independence (6) • Independent dressing and bathing (6-7) • Independent - adaptive equipment (6-7) • Walking 300' at modified independent level with appropriate Assistive Device (6-7)
Treatment	• Functional training • Upper extremity strengthening • Lower extremity strengthening • Gait training • Pain management • Home exercise program (sitting and lying) • Edema/swelling management: ankle sets, quad sets, gluteal sets, deep Breathing exercises • **R**est, **I**ce, **C**ompression, **E**levation • Sequential compression devices (per facility protocol) • Incision care and scar management	• Functional training • Balance training • Gait training • Resisted strength training • Pain management • Home exercise program (lying, sitting, and standing) • Incision care and scar management	• Functional training • Balance training • Gait training • Resisted strength training • Pain management • Home exercise program (lying, sitting, and standing) (6-7) • Incision care and scar management
Measurement	• Pain at 4/10 or less • Ambulation 50-100 feet with minimal assist and rolling walker (4) • Demonstrate knowledge of all precautions	• Pain at 3/10 or less • Walk 200 feet with supervision and rolling walker (5) • Verbalize knowledge of all precautions.	• Pain at 3/10 or less • Ambulate with modified independence • Verbalize knowledge of precautions. • Independent to minimal assist with functional mobility

Interdisciplinary Interventions for Delirium/Dementia:
- Sensory enhancement (Vision, Hearing, and Tactile)
- Mobility Enhancement (ambulation 3 times daily at minimum)
- Cognitive Orientation/Stimulation
- Pain control (emphasize non-narcotics when able)
- Other (Diet, Fluids, Sleep, Medication Management, and Social)

How You Can Help

- Ask questions
- Stop smoking
- Eat well balanced diet
- Have family assist and advocate
- Perform strengthening exercises
- Notify care team of any changes not expected

Read Discharge Instructions given by Nurse

- Follow hip precautions for 2-3 months
- Exercise 3 times/ day
- Pursue necessary blood work after discharge
- Use walker or crutches
- Use stool softener while on pain medications
- Wash around incision with soap & water (cover incision if drainage; leave open to air if no drainage)
- No driving until cleared by doctor or PT
- Consider enrolling in a driving assessment course/evaluation
- Walk frequently

Consider Your Discharge Options

- Home Health
- Outpatient Therapy
- Skilled Care Facility

Call Doctor if …

- Fever greater than 101° F
- Severe pain
- Drainage from incision excessive
- Increased redness or swelling around incision
- Swelling or tenderness in calf
- If experiencing unexplained shortness of breath