



**Total Knee Arthroplasty
Clinical Pathway**

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: M F I

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FOR USE**

Discharge Plan / Summary

Medical		Initials	Date	Nursing		Initials	Date
Referral source notified of discharge	GP / Practice			Support person	Support person notified of discharge at:		
	Referral doctor				QAS booked 24hrs prior to discharge		
	Referral hospital				Patient transported home by:		
Discharge letter	Copy given to patient			Belongings / Valuables returned	Private x-rays / scans		
	Sent to GP: <input type="checkbox"/> Faxed <input type="checkbox"/> Mailed				Patients own medications		
Advice provided regarding	Return to normal activities				Walking aids		
	Follow-up plan confirmed			Advice	Patient able to state signs / symptoms requiring presentation; temp / feels feverish / pain and or problems with wounds		
	When to seek medical assistance				Other:		
	Emergency number given:				Other:		
Completed			Post-op education and precautions stated				
Medical cert. / travel documents	Issued			Referrals	To:		
					<input type="checkbox"/> Booked		
Follow-up	In weeks			Anti-embolic therapies given to patient			
	On: / /			Follow-up appointment	Made and appointment card issued		
	GP time: :				Follow-up appointments posted		
	OPD time: :				Patient will make their own booking		
	Other:				Not required		
Discharge medication	Ordered			Support Services	Information provided r.e. support services		
Medications		Initials	Date	Physiotherapy		Initials	Date
Drug Profile print out provided for at risk patients				◆ Independent and safe transfers / mobility			
Discharge medications given to patient and educated r.e. regime				◆ Home exercise programme provided			
Medication Discharge Summary provided to patient				◆ Independent with home exercise programme			
Discharge Summary / Referral form faxed to GP – Time faxed: :				Physiotherapy referral to:			
Occupational therapy		Initials	Date	By whom:			
♣ Appropriate ADL function for discharge or strategies in place				Date: / /			
♣ Understands impact of surgery on ADL's and home environment				Comments:			
♣ Discharge equipment / home mods in place and patient demonstrates appropriate use						
Occupational therapy referral to:						
.....						
Comments:						
.....						
.....						

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Clinical Pathway

Knee Arthroplasty

Expected Outcomes

Phase 1	Assessment at pre-admission <ul style="list-style-type: none"> You can state the reason for admission, surgery and how long you will be in hospital. That all relevant investigations have been completed and the results reviewed.
Phase 2	Pre- and post-operation <ul style="list-style-type: none"> After the results have been explained, you can state an understanding of the usual pre- and post-operative care routines, the surgery and its effects. Your pain will be in a range that is OK with you, both before and after your operation. As soon as you are alert and orientated, you will not feel sick and can drink again. As soon as you are assessed as ready, you will also be able to eat.
Phase 3	Day 1 post-operative <ul style="list-style-type: none"> The Orthopaedic Surgical Team will have reviewed your progress. You will be drinking and eating normally now.
Phase 4	Day 2-7 post-operative until ready for discharge <ul style="list-style-type: none"> The Orthopaedic Surgical Team will continue to review you daily and once you are ready, will suggest follow-up care, which includes future appointments, wound care and pain management. The physiotherapist will help you to walk until you can do it by yourself.
Phase 5	Discharge <ul style="list-style-type: none"> When the Doctor says you are ready to go home, whether on day five or later, your care providers will follow the Discharge Planning Checklist and you will be able to go home.

Key Milestone (steps)	Pre-Adm Clinic	Admit	Pre-Op	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8
Date											
1. Placed on pathway											
2. Assessed by Orthopaedic Team											
3. Blood tests, x-rays etc will be taken											
4. IV fluids commenced											
5. Prepared for surgery											
6. Transferred to surgery											
7. Post-operation vital signs											
8. Not feeling sick and pain level ok											
9. Awake and know where you are											
10. Wound ooze minimal											
11. Can pass urine after operation											
12. Drains removed											
13. Compression device removed											
14. IV Cannula removed											
15. Drinking / Eating normally											
16. Reviewed by Orthopaedic team											
17. Can walk with 2 sticks safely											
18. Ready to go home											
19. Carer available on going home											
20. Discharge check list completed											

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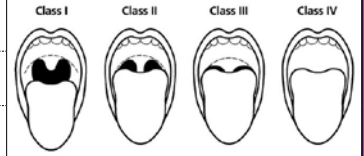
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Pre-Anaesthetic Assessment

ASA status: 1 2 3 4 5

Airway

- Abn neck mobility Yes No
- Abnormal teeth Yes No
- Hyoment dist <5cm Yes No



Anaesthetic discussed

- Premed Yes No
- LA/ML Yes No
- GA Yes No
- Spinal Yes No
- Epidural Yes No

Pain relief discussed

- Oral Yes No
- PR Yes No
- PCA Yes No
- S/C injection Yes No

Outcome

- Anaes info sheet read by patient Yes No
- Proceed as booked Yes No
- Anaes consultant notified Yes No
- Postponed Yes No

Anaesthetic history

- Previous GA Yes No
- Problems Yes No
- PON&V Yes No
- Difficult Intubation Yes No

Drug allergies / side effects Yes No

Respiratory

Abnormal / Smoker / Asthma / COAD

Circulatory

- Abnormal / Hypertension
- Coronary heart disease
- Poor exercise tolerance / Bleeding tendency

Endocrine

NIDDM / IDDM / Thyroid dysfunction

GIT

Reflux / Obese

Hepatic / Renal

Abnormal

CNS

Abnormal / Epilepsy

Present drug therapy

Check medication chart

- Steroids / Anti-hypertensive / Aspirin /
- Warfarin
- MAOI / Others

Assessing Anaesthetist:

RMO / Reg / Consultant

Name:

Signature:

Date:

Attending Anaesthetist:

RMO / Reg / Consultant

Name:

Signature:

Date:

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TOTAL KNEE ARTHROPLASTY CLINICAL PATHWAY



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Pre-Admission Assessment

Date / Time:

Planned procedure:

Presenting features:

Past medical history:

Past surgical history:

Current medications / allergies:

Medication reviewed and ward medications chart completed: Yes No

Patient informed of which medications to cease: Yes No

Medical or surgical or infection control alert:

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Pre-Admission Assessment (continued)

Social history:

Alcohol:

Smoking – current number per day:

History:

Examination:

Following test required: ECG Spirometry Pathology X-ray Yes No

Measured for anti-embolic therapies (devices or stockings): Yes No

Joint:

Range of movement:

Deformity:

Skin:

Pulses:

Consultant / Registrar review:

Consent sighted and signed: Yes No

Management plan (including results and investigations):

Further orthopaedic review required: Yes No

Anaesthetic consult required: Yes No

Implants (metal or other):

Signature:

Date:

Other Assessments

Education review Hospitalisation Costs Procedure Recovery / Post-op limitations
 Pain relief Exercises Anti-coagulant therapy Discharge options

Aids to daily living Vision: Hearing: Dentures: Other:

Social situation Home alone Home with spouse Home with relative Nursing home
 Special accommodation Hostel Psychiatric services Carer
 Community Health Nurse Other

Anti-embolic stockings Knee Ankle: cm IPC (Intermittent Pneumatic Compression) device size:
 Thigh Calf: cm Booked with ORS Holding Bay
 None Thigh: cm

Signature:

Date:

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Discharge Assessment Planning for hospitalisation and discharge

Language and understanding	Initials	Date
If patient NESB, Interpreter / family member booked for operation Date: _____ / _____ / _____ Time: _____ : _____ Ward: _____		
Other considerations:		
Home transportation		
Transport home booked with:		
Patient or hospital to arrange: <input type="checkbox"/> Patient <input type="checkbox"/> Hospital		
Booked date and time:		
Home care considerations		
Home with carer or alone: <input type="checkbox"/> Carer <input type="checkbox"/> Alone If <i>carer</i> , name:		
Discharged to own home or other <input type="checkbox"/> Own home <input type="checkbox"/> Other If <i>other</i> , details:		
List access problems:		
Community Health contacted: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Service name: Phone: Fax:		
Contact name:		
Household shopping provided by:		
Meals supplied by:		
Assistance with donn / doff of anti-embolic stockings provided by:		
Assistance with ADL's provided by:		
House duties assisted by:		
Document any other arrangements required:		
Patient signature:	RN signature:	
Request to ward when patient is admitted:		
RN signature:	Date:	

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Key
 Medical
 Nursing
 Occupational Therapy
 Pharmacy
 Physiotherapy

Category	PRE-ADMISSION ASSESSMENT	Date: _____ / _____ / _____	Initials	V
Reviews	<input type="checkbox"/> Ortho review and admitted by medical staff (<i>see Pre-Admin Assessment form</i>) Questions answered and informed consent form signed by patient Anaesthetic consultation conducted Physician consult required and referral completed Medical certificate required: <input type="checkbox"/> Yes <input type="checkbox"/> No Operation date confirmed			
Investigations	<input type="checkbox"/> Following tests required: <input type="checkbox"/> FBC <input type="checkbox"/> ELFTs <input type="checkbox"/> ECG <input type="checkbox"/> MSU <input type="checkbox"/> COAGS X-ray: standing knee including proximal 1/3 tibia and distal 1/3 of femur A/P lateral chest, lumbar spine X-rays returned to patient / x-ray department Cross match form completed and given to patient Autologous blood form given to patient			
Medications	<input type="checkbox"/> Medications reviewed and ward medication chart completed Consultants protocols documented on medication chart Patient informed of which medications are to be ceased and when			
Occupational therapy	<input type="checkbox"/> Patient education r.e. surgery implications and ADL function Advice on equipment and home modifications given Referral for pre-admission home visit: <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:			
Observations / Treatments	<input type="checkbox"/> Nursing assessment forms completed and inserted into pathway Pulse: _____ BP: _____ Resps: _____ Weight: _____ kg Height: _____ cm BMI: _____ Waterlow pressure ulcer assessment pre-op SCORE: _____ Falls risk assessment pre-op SCORE: _____			
Hygiene / Elimination	<input type="checkbox"/> Bowel habit: <input type="checkbox"/> Continent <input type="checkbox"/> Normal <input type="checkbox"/> Problems with constipation <input type="checkbox"/> Loose <input type="checkbox"/> Stoma <input type="checkbox"/> Aperients needed <input type="checkbox"/> Bladder habits: <input type="checkbox"/> Continent <input type="checkbox"/> Frequency <input type="checkbox"/> Other: _____ <input type="checkbox"/> Hygiene assistance required: <input type="checkbox"/> Nil <input type="checkbox"/> Minimal <input type="checkbox"/> Full			
Nutrition	<input type="checkbox"/> No special dietary requirements Explanation given and advised to fast from – Date: _____ / _____ / _____ Time: _____ : _____			
Activity / Mobility	<input type="checkbox"/> L or R Knee active ROM flexion: _____ Extension lag: _____ Lack: _____ Gait – Distance: _____ m Aids: _____ Timed Up & Go: _____ seconds <input type="checkbox"/> Deep breathing and circulation exercises explained and demonstrated <input type="checkbox"/> Lower limb exercises and mobility regime discussed Comments:			
Patient education / discharge planning	<input type="checkbox"/> Admission and ward process explained Total Knee Booklet and Admission hospital booklet given to patient Group education sessions performed and procedures explained Pathway discussed and given to patient <input type="checkbox"/> Patient instructed to shower and wear fresh clothes on morning of surgery Provided with: <input type="checkbox"/> Betadine <input type="checkbox"/> Chlorhexidine <input type="checkbox"/> Triclosan <input type="checkbox"/> If NESB, Interpreter re-booked for day of surgery – Language: _____ <input type="checkbox"/> Anticipated need for post-op admission to GARS and / or referral to relevant community services (i.e. TCP) (<i>see Discharge Plan</i>)			
Expected outcomes	<input type="checkbox"/> Patient demonstrates: A – Achieved V – Variance 1:1 Patient states the usual pre- and post-operative care routines, the surgery and its effects and their concerns have been adequately addressed		A	V

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Key Key Medical Nursing Occupational Therapy Pharmacy Physiotherapy

Pre-operative skin check	Date	3 to 4 day pre-op	On admission	V
	_____ / _____ / _____	_____ / _____ / _____	_____ / _____ / _____	
Skin integrity of operative site intact				

Category	ON ADMISSION	Date: _____ / _____ / _____	Initials	V
Reviews	<input type="checkbox"/> Ortho review and admitted by medical staff Patients status unchanged from pre admission Prophylactic IV antibiotics commenced			
	<input type="checkbox"/> Consent – completed, questions answered and Consent form signed Anaesthetic consultation performed: <input type="checkbox"/> Yes <input type="checkbox"/> No (see <i>Anaesthetic Assessment</i> form) Booked for operating room suite at: _____ : _____ Physio notified if patient not attended Pre-Admission Clinic			
Investigations	<input type="checkbox"/> FBC / EU&C / ECG / MSU <input type="checkbox"/> Cross match Autologous: <input type="checkbox"/> Yes <input type="checkbox"/> No Units: _____ X-rays – AP pelvis, chest, hip All results available and have been reviewed by medical staff Additional tests: _____			
	<input type="checkbox"/> Medications reviewed and ward medication chart complete <input type="checkbox"/> Medications given as ordered			
Observations / Treatments	<input type="checkbox"/> Orientated to ward and admission process explained Nursing admission complete Baseline observations – documented and within normal limits Patient has been clipped / site prepared Pre-operative neurovascular assessment completed Pre-operative checklist complete Waterlow pressure ulcer assessment pre-op SCORE: _____ Falls risk assessment pre-op SCORE: _____			
Hygiene / Elimination	<input type="checkbox"/> Showered and prepared for theatre			
Nutrition	<input type="checkbox"/> Fasted from – Diet: _____ : _____ Fluids: _____ : _____			
Wound / Dressings	<input type="checkbox"/> Anti-embolic therapies available			
Patient education / discharge planning	<input type="checkbox"/> Confirmation that patient pathway was given and that all procedures were explained and video (if applicable) shown in pre-admission clinic Patient can demonstrate in / out of bed technique, and practiced Existing community services suspended List: _____ _____ _____			
Expected outcomes	<input type="checkbox"/> Patient demonstrates: A – Achieved V – Variance		A	V
	2:1 Patient states the usual pre- and post-operative care routines, the surgery and its effects and their concerns have been adequately addressed			

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Comments:



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**All perioperative documentation to be inserted here
including ORMIS documentation
if applicable**

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Category	DAY 2	Date: / /	Time	Initials	V	
Reviews	<input type="checkbox"/> Consultant <input type="checkbox"/> Registrar <input type="checkbox"/> RMO <input type="checkbox"/> Afebrile <input type="checkbox"/> Wound satisfactory Post-op knee x-rayed Drain removal ordered Plan:					
			AM	PM	ND	V
Investigations	<input type="checkbox"/> Pathology within expected range, Hb checked – Hb:					
Medications / Pain management	<input type="checkbox"/> Given as ordered on medication chart <input type="checkbox"/> Pain management reviewed first by Acute Pain Service <input type="checkbox"/> Medications reviewed and plan confirmed					
Epidural / PCA	<input type="checkbox"/> Epidural / PCA – Femoral / Lumbar block obs performed					
Observations / Treatments	<input type="checkbox"/> Complete Acute Pain Management documentation as per protocol <input type="checkbox"/> Observations within patient's normal limits IV cannula site – patent, no signs of inflammation Anti-embolic therapies continued Fluid balance form completed Waterlow pressure ulcer assessment pre-op SCORE: Falls risk assessment pre-op SCORE:					
Hygiene / Elimination	<input type="checkbox"/> Sponge in bed / pressure area care attended <input type="checkbox"/> No sign of urinary retention (if IDC insitu - output >50mLs hour)					
Wound / Dressings	<input type="checkbox"/> Dressing reviewed, intact (reinforced if wet) <input type="checkbox"/> Drains removed as ordered and checked by two RN's 1: 2:					
Nutrition	<input type="checkbox"/> IV Therapy as prescribed <input type="checkbox"/> No nausea or vomiting					
Activity / Mobility	<input type="checkbox"/> Chest and calf check NAD <input type="checkbox"/> Breathing and circulation exercises – foot / ankle / static quads and gluts Active knee flex to:° Ext lack:° SLR: <input type="checkbox"/> Yes <input type="checkbox"/> No with:° lag Stand / Walk aid: Assist: <input type="checkbox"/> 1 <input type="checkbox"/> 2 Weight bearing status: <input type="checkbox"/> FWB <input type="checkbox"/> PWB <input type="checkbox"/> TWB <input type="checkbox"/> NWB <input type="checkbox"/> WBAT <input type="checkbox"/> Cold therapy applied and skin test / warning given <input type="checkbox"/> Bed / Bar exercises performed Comments:					
Patient education / discharge planning	<input type="checkbox"/> Levels of activity, wound care, diet and pain management explained and discussed <input type="checkbox"/> Recommendations / Discharge plan made at pre-admission clinic reviewed <input type="checkbox"/> Reinforced implications of surgery for ADL's <input type="checkbox"/> Encouraged independence in ADL's and strategies developed <input type="checkbox"/> Day 2 OT interventions completed on: / / Comments:					
Expected outcomes	<input type="checkbox"/> Patient demonstrates: A – Achieved V – Variance 3:1 Orthopaedic team has reviewed patient's progress and explained their plan 3:2 Patient will be eating and drinking normally now 3:3 Pain controlled at rest 3:4 Observations within normal limits 3:5 Patient can transfer to stand with assistance 3:6 Haemo-dynamically stable				A V	

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Key Medical Nursing Occupational Therapy Pharmacy Physiotherapy

Category	DAY 3	Date:	Time	Initials	V	
Reviews	<input type="checkbox"/> Consultant <input type="checkbox"/> Registrar <input type="checkbox"/> RMO <input type="checkbox"/> Afebrile <input type="checkbox"/> Wound satisfactory Review IV access / fluids Plan:					
			AM	PM	ND	V
Investigations	<input type="checkbox"/> Given as ordered on medication chart <input type="checkbox"/> Pain management reviewed first by Acute Pain Service <input type="checkbox"/> Medications reviewed and plan confirmed					
Medications / Pain management	<input type="checkbox"/> Epidural / PCA – Femoral / Lumbar obs performed and removed					
Epidural / PCA	<input type="checkbox"/> Observations within patient's normal limits Anti-embolic therapies continued Pressure area care attended Waterlow pressure ulcer assessment pre-op SCORE: Falls risk assessment pre-op SCORE:					
Observations / Treatments	<input type="checkbox"/> Showered with assistance Elimination recorded Fluid balance chart ceased					
Hygiene / Elimination	<input type="checkbox"/> Dressing reviewed: <input type="checkbox"/> Changed <input type="checkbox"/> Reinforced					
Wound / Dressings	<input type="checkbox"/> IV Therapy as prescribed Tolerating full diet and free fluids No nausea or vomiting					
Nutrition	<input type="checkbox"/> Chest and calf check NAD, breathing and circulatory exercises Active knee flex to:° Ext lack:° SLR: <input type="checkbox"/> Yes <input type="checkbox"/> No with:° lag Mobility aid – Assist: Distance:m Sit out of bed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cold therapy applied Bed / Bar exercises performed Comments:					
Activity / Mobility	<input type="checkbox"/> Patient demonstrates: A – Achieved V – Variance					
Expected outcomes	4:1 Orthopaedic Team has review patient's progress and follow up care planned 4:2 Patient drinking and eating normally 4:3 Pain is controlled 4:4 Patient mobilising with rollator and assistance 4:5 Patient able to shower with minimal assistance 4:6 Pain management explained and discussed 4:7 Mobility aids organised 4:8 Discharge plan commenced					

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Category	🗝️	DAY 4	Date:	Time	Initials	V		
Reviews	■	<input type="checkbox"/> Consultant <input type="checkbox"/> Registrar <input type="checkbox"/> RMO <input type="checkbox"/> Afebrile <input type="checkbox"/> Wound satisfactory Anticoagulant therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No Plan:						
				AM	PM	ND	V	
Investigations	▲	INR checked (if on warfarin)						
Medications / Pain management	▲ ■ Ⓟ	Given as ordered on medication chart Pain management reviewed first by Acute Pain Service Medications reviewed and plan confirmed						
Observations / Treatments	▲	Observations within patient's normal limits Anti-embolic therapies continued Waterlow pressure ulcer assessment pre-op SCORE: Falls risk assessment pre-op SCORE:						
Hygiene / Elimination	▲	Toileted / Showered in high perched chair (assist x1) Bowels opened IDC removed						
Wound / Dressings	▲	Wound assessed – no excess redness or swelling / incision apposed, dressed with:						
Nutrition	▲	IV Therapy as prescribed Tolerating full diet and free fluids						
Activity / Mobility	♦️	Chest and calf check NAD, breathing and circulatory exercises Active knee flex to:° Ext lack:° SLR: <input type="checkbox"/> Yes <input type="checkbox"/> No with:° lag Mobility aid – Assist: Distance:m Bed / Bar exercises performed Comments:						
Patient education / discharge planning	▲ ■	Levels of activity, wound care, diet and pain management explained and discussed Signs and symptoms requiring medical advice after discharge explained and discussed						
Expected outcomes	▲	Patient demonstrates: A – Achieved V – Variance					A	V
	4:1	Orthopaedic Team has review patient's progress and follow up care planned						
	4:2	Patient tolerating diet and fluids						
	4:3	Patient able to shower with assistance and minimal discomfort						
	4:4	Patient able to shower independently with minimal discomfort						
	4:5	Incision free from signs of infection						
	4:6	Patient remains afebrile						
	4:7	Pre-op bowel / bladder habits back to normal						
	4:8	Patient mobile with supervision						
	4:9	Pain is controlled						

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Category	DAY 5	Date:	Time	Initials	V	
Reviews	<input type="checkbox"/> Consultant <input type="checkbox"/> Registrar <input type="checkbox"/> RMO <input type="checkbox"/> Afebrile <input type="checkbox"/> Wound intact Anticoagulation therapy within normal limits Proceeding according to clinical pathway Plan:					
			AM	PM	ND	V
Investigations	<input type="checkbox"/> FBC and Hb within normal range					
Medications / Pain management	<input type="checkbox"/> Given as ordered on medication chart <input type="checkbox"/> Medications reviewed and plan confirmed					
Observations / Treatments	<input type="checkbox"/> Observations within patient's normal limits <input type="checkbox"/> Anti-embolic therapies continued <input type="checkbox"/> Waterlow pressure ulcer assessment pre-op SCORE: <input type="checkbox"/> Falls risk assessment pre-op SCORE:					
Hygiene / Elimination	<input type="checkbox"/> Toileted / Showered (assist x1) <input type="checkbox"/> Bowels opened					
Wound / Dressings	<input type="checkbox"/> Wound redressed with:					
Nutrition	<input type="checkbox"/> Tolerating full diet and free fluids <input type="checkbox"/> No nausea or vomiting					
Activity / Mobility	<input type="checkbox"/> Chest and calf check NAD, breathing and circulatory exercises <input type="checkbox"/> Active knee flex to: ^o Ext lack: ^o <input type="checkbox"/> SLR: <input type="checkbox"/> Yes <input type="checkbox"/> No with: ^o lag <input type="checkbox"/> Mobility aid – Assist: Distance:m <input type="checkbox"/> Bed / Bar exercises performed <input type="checkbox"/> Comments:					
Occupational therapy	<input type="checkbox"/> Independence with ADL's reviewed: <input type="checkbox"/> Indep <input type="checkbox"/> Assist <input type="checkbox"/> Shower / bath transfers reviewed: <input type="checkbox"/> Indep <input type="checkbox"/> Assist <input type="checkbox"/> Toilet transfers reviewed: <input type="checkbox"/> Indep <input type="checkbox"/> Assist <input type="checkbox"/> Reinforced precautions and finalised equipment needs <input type="checkbox"/> Day 5 interventions completed on: / / <input type="checkbox"/> Comments:					
Patient education / discharge planning	<input type="checkbox"/> Levels of activity, wound care, diet and pain management explained and discussed <input type="checkbox"/> Mobility aids organised <input type="checkbox"/> Community services contacted <input type="checkbox"/> Queensland Ambulance Service (QAS) booked <input type="checkbox"/> Reinforce Home Exercise Program in home environment <input type="checkbox"/> Discharge plan commenced <input type="checkbox"/> Post discharge physiotherapy required					
Expected outcomes	<input type="checkbox"/> Patient demonstrates: A – Achieved V – Variance 4:1 Orthopaedic Team has review patient's progress 4:2 All follow-up arrangements made 4:3 Patient transferring independently 4:4 Patient performing exercise program independently 4:5 Educate r.e. wound care 4:6 Pain controlled 4:7 Discharge plan provided and instructions given				A	V

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Clinical Pathway / Patient Copy

Knee Arthroplasty

Expected Outcomes

Phase 1	Assessment at pre-admission <ul style="list-style-type: none"> You can state the reason for admission, surgery and how long you will be in hospital. That all relevant investigations have been completed and the results reviewed.
Phase 2	Pre- and post-operation <ul style="list-style-type: none"> After the results have been explained, you can state an understanding of the usual pre- and post-operative care routines, the surgery and its effects. Your pain will be in a range that is OK with you, both before and after your operation. As soon as you are alert and orientated, you will not feel sick and can drink again. As soon as you are assessed as ready, you will also be able to eat.
Phase 3	Day 1 post-operative <ul style="list-style-type: none"> The Orthopaedic Surgical Team will have reviewed your progress. You will be drinking and eating normally now.
Phase 4	Day 2–7 post-operative until ready for discharge <ul style="list-style-type: none"> The Orthopaedic Surgical Team will continue to review you daily and once you are ready, will suggest follow-up care, which includes future appointments, wound care and pain management. The physiotherapist will help you to walk until you can do it by yourself.
Phase 5	Discharge <ul style="list-style-type: none"> When the Doctor says you are ready to go home, whether on day five or later, your care providers will follow the Discharge Planning Checklist and you will be able to go home.

DO NOT WRITE IN THIS BINDING MARGIN

Key Milestone (steps)	Pre-Adm Clinic	Admit	Pre-Op	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8
Date											
1. Placed on pathway											
2. Assessed by Orthopaedic Team											
3. Blood tests, x-rays etc will be taken											
4. IV fluids commenced											
5. Prepared for surgery											
6. Transferred to surgery											
7. Post-operation vital signs											
8. Not feeling sick and pain level ok											
9. Awake and know where you are											
10. Wound ooze minimal											
11. Can pass urine after operation											
12. Drains removed											
13. Compression device removed											
14. IV Cannula removed											
15. Drinking / Eating normally											
16. Reviewed by Orthopaedic team											
17. Can walk with 2 sticks safely											
18. Ready to go home											
19. Carer available on going home											
20. Discharge check list completed											