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Contact: Clinical_Pathways_Program@health.qld.gov.au

DO NOT WRITE IN THIS BINDING MARGIN

Queensland Government

Total Hip 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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Clinical pathways never replace clinical judgement.
Care outlined in this pathway must be altered if it is not clinically appropriate for the individual patient

Clinical Pathway **Orthopaedic**

TOTAL HIP ARTHROPLASTY

DRG I 03A Hip Revision + CSCC (ALOS 19.64)
DRG I 03B Hip Replacement + CSCC/Hip Revision-CSCC (ALOS 13.95)
DRG I 03C Hip Replacement – CSCC (ALOS 7.87)

AN-DRG V5 Hospital Benchmarking Funding Model 2004/05

Consultant:	**Admission date:**	**Time:**

Documentation Key

1. **Initials –** Indicates action / care has been ordered / administered.
2. **N/A –** Indicates preceding care / order is not applicable.
3. **Crossing out –** Indicates that there is a change in the care outlined.
4. **V –** Indicates a variation from the pathway on that day, in that section. When applicable **flag it** in the "Variance column", then document in the free text area date / variance code variance / action / outcome.

Key ■ **Medical** ▲ **Nursing** ♣ **Occupational Therapy** Ⓟ **Pharmacy** ◆ **Physiotherapy**

Symbols guide care to a primary professional stream, it is a visual guide only and its direction is not intended to be absolute.

Signature Log Every person documenting in this clinical pathway MUST supply a sample of their initials and signature below

Initials	Signature	Print name	Role

TOTAL HIP ARTHROPLASTY CLINICAL PATHWAY

v0.01 - 04/2017

SW228

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Discharge Plan / Summary

Medical		Initials	Date
Referral source notified of discharge	GP / Practice		
	Referral doctor		
	Referral hospital		
Discharge letter	Copy given to patient		
	Sent to GP: ☐ Faxed ☐ Mailed		
Advice provided regarding	Return to normal activities		
	Follow-up plan confirmed		
	When to seek medical assistance		
	Emergency number given:		
Medical cert. / travel documents	Completed		
	Issued		
Follow-up	In .... weeks		
	On: ...... / ...... /		
	GP time: ...... :		
	OPD time: ...... :		
	Other:		
Discharge medication	Ordered		

Medications	Initials	Date
Drug Profile print out provided for at risk patients		
Discharge medications given to patient and educated r.e. regime		
Medication Discharge Summary provided to patient		
Discharge Summary / Referral form faxed to GP – Time faxed: ...... :		

Occupational therapy	Initials	Date
♣ Appropriate ADL function for discharge or strategies in place		
♣ Understands impact of surgery on ADL's and home environment		
♣ Discharge equipment / home mods in place and patient demonstrates appropriate use		
Occupational therapy referral to:		
Comments:		

Nursing		Initials	Date
Support person	Support person notified of discharge at: ...... :		
	QAS booked 24hrs prior to discharge		
	Patient transported home by:		
Belongings / Valuables returned	Private x-rays / scans		
	Patients own medications		
	Walking aids		
Advice	Patient able to state signs / symptoms requiring presentation; temp / feels feverish / pain and or problems with wounds		
	Other:		
	Other:		
	Post-op education and precautions stated		
Referrals	To: .... ☐ Booked		
	Anti-embolic therapies given to patient		
Follow-up appointment	Made and appointment card issued		
	Follow-up appointments posted		
	Patient will make their own booking		
	Not required		
Support Services	Information provided r.e. support services		

Physiotherapy	Initials	Date
◆ Independent and safe transfers / mobility		
◆ Home exercise programme provided		
Aid: .... Assist: .... Distance: ....m Stairs: .... TUG: ....sec		
Physiotherapy referral to: .... By whom: .... Date: ...... / ...... /		
Comments:		

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Clinical Pathway — Hip Arthroplasty

Expected Outcomes

Phase 1	**Assessment at pre-admission** • 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** • 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** • 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** • 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** • When you are ready for discharge, whether on day five or later, the Discharge Planning Checklist will be followed by your care providers and you will be discharged.

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. Admitted under Orthopaedic Team – surgery booked											
3. Blood tests, x-rays etc will be taken											
4. Assessed by Ortho Team											
5. IV fluids commenced											
6. Prepared for surgery											
7. Transferred to surgery, or ward then surgery											
8. Post-operation vital signs											
9. Not feeling sick and pain level ok											
10. Awake and know where you are											
11. Wound ooze minimal											
12. Can pass urine after operation											
13. Drains removed											
14. Compression device removed											
15. IV Cannula removed											
16. Drinking / eating normally											
17. Reviewed by Orthopaedic team											
18. Can walk with 2 sticks safely											
19. Ready to go home											
20. Carer available on going home											
21. Discharge check list completed											

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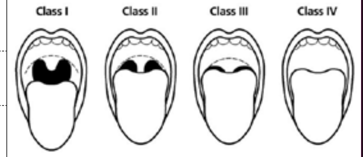
Pre-Anaesthetic Assessment

ASA status: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Airway

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



Anaesthetic discussed

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

Pain relief discussed

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

Outcome

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

Anaesthetic history

	Yes	No
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

	Name:	Signature:	Date:
Assessing Anaesthetist: ☐ RMO / ☐ Reg / ☐ Consultant			
Attending Anaesthetist: ☐ RMO / ☐ Reg / ☐ Consultant			

Airway image source: Lalwani AK: Current Diagnosis & Treatment - Otolaryngology: Head and Neck Surgery, Second Edition
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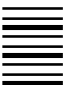

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Pre-Admission Assessment

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:

Further surgical review required: ☐ Yes ☐ No

Anaesthetic consult required: ☐ Yes ☐ No

Management plan (including results and investigations):

Consent sighted and signed: ☐ Yes ☐ No

Meets day surgery criteria: ☐ 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: ☐ Patient ☐ Hospital		
Booked date and time:		
Home care considerations		
Home with carer or alone: ☐ Carer ☐ Alone If *carer*, name:		
Discharged to own home or other ☐ Own home ☐ Other If *other*, details:		
List access problems:		
Community Health contacted: ☐ Yes ☐ No		
Service name: .... Phone: .... Fax:		
Contact name:		
Household shopping provided by:		
Meals supplied 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	Key	PRE-ADMISSION ASSESSMENT Date: .... / .... /	Initials	V
Reviews	■	Ortho review and admitted by medical staff *(see Pre-Admin Assessment form)*		
		Questions answered and informed consent form signed by patient		
		Anaesthetic consultation conducted		
		Physician consult required and referral completed		
		Medical certificate required: ☐ Yes ☐ No		
		Operation date confirmed		
Investigations	■	Following tests required: ☐ FBC ☐ ELFTs ☐ ECG ☐ MSU ☐ COAGS		
	▲	X-ray: Hip including proximal 1/3 femur and AP / Lateral Pelvis		
		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	■	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	♣	Patient education r.e. hip precautions and ADL function		
		Advice on equipment and home modifications given		
		Referral for pre-operative home visit: ☐ Yes ☐ No		
		Comments:		
Observations / Treatments	▲	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	▲	Bowel habit: ☐ Continent ☐ Normal ☐ Problems with constipation ☐ Loose ☐ Stoma ☐ Aperients needed		
		Bladder habits: ☐ Continent ☐ Frequency ☐ Other:		
		Hygiene assistance required: ☐ Nil ☐ Minimal ☐ Full		
Nutrition	▲	No special dietary requirements		
		Explanation given and advised to fast from – Date: ...... / ...... / ...... Time: ...... :		
Activity / Mobility	◆	L or R Hip active ROM flexion: .... Abduction: .... FFD:		
		Gait – Distance: ....m Aids: .... Observation:		
		Timed Up & Go: ....seconds		
		Deep breathing and leg exercises explained and demonstrated		
		Post-operative exercises and mobility regime discussed		
		Pre op exercise class booked: ☐ Yes ☐ No		
		Comments:		
Patient education / discharge planning	▲	Admission and ward process explained		
		Total Hip Booklet and Admission hospital booklet given to patient		
		Group education sessions performed and procedures explained		
		Pathway discussed and given to patient		
		Patient instructed to shower and wear fresh clothes on morning of surgery		
		Provided with: ☐ Betadine ☐ Chlorhexidine ☐ Triclosan		
		If NESB, Interpreter re-booked for day of surgery – Language:		
		Anticipated need for post-op Community Services *(see Discharge Plan)*		
Expected outcomes	▲	**Patient demonstrates: A – Achieved V – Variance**	**A**	**V**
	1:1	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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Pre-operative skin check		3 to 4 day pre-op	On admission	V
	Date	.... / .... /	.... / .... /	
	Skin integrity of operative site intact			

Category	🗝	ON ADMISSION Date: .... / .... /	Initials	V
Reviews	■	Ortho review and admitted by medical staff		
		Patients status unchanged from pre admission		
		Prophylactic IV antibiotics commenced		
	▲	**Consent** – completed, questions answered and Consent form signed		
		Anaesthetic consultation performed: ☐ Yes ☐ No (see *Anaesthetic Assessment* form)		
		Booked for theatre suite at: .... :		
		Physio notified if patient not attended Pre-Admission Clinic		
Investigations	■ ▲	FBC / EU&C / ECG / MSU ☐ Cross match Autologous: ☐ Yes ☐ No Units:		
		X-rays – AP pelvis, chest, hip		
		All results available and have been reviewed by medical staff Additional tests:		
Medications / Pain management	■ ▲	Medications reviewed and ward medication chart complete		
		Medications given as ordered		
Observations / Treatments	▲	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	▲	Showered and prepared for theatre		
Nutrition	▲	Fasted from – Diet: .... : .... Fluids: .... :		
Activity / Mobility	▲	Anti-embolic therapies available		
Patient education / discharge planning	▲	Confirmation that patient pathway was given and that all procedures were explained and video (if applicable) shown in pre-admission clinic		
		Possible dislocating position explained and demonstrated		
		Patient can demonstrate in / out of bed technique, and practiced		
		Existing community services suspended List:		
Expected outcomes	▲	**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		

Comments:

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Category	Key	DAY 1 Date: ...... / ...... /	Time	Initials	V
		Time returned to ward			
Reviews	■	☐ Consultant ☐ Registrar ☐ RMO			
		Antibiotic cover ordered for IDC insertion			
		Post-operative instructions (IF NOT ON ORMIS):			

Category	Key		AM	PM	ND	V
Investigations	■	Post-operative hip x-ray performed				
Medications / Pain management	▲	Medications / Pain relief / antibiotics given as ordered				
	■	Pain management: ☐ PCA ☐ Infusion ☐ Epidural ☐ IMI ☐ Oral				
		Analgesia adequate / effective and without ill effects				
Observations / Treatments	▲	Post-op observations and wound checks attended				
		Acute Pain Management form and protocols completed				
		Neuro vascular observations performed				
		IV cannula – patent, no signs of inflammation				
		Anti-embolic therapies continued				
		Fluid balance chart maintained				
		Deep breathing and leg exercises performed				
		Waterlow pressure ulcer assessment pre-op SCORE:				
		Falls risk assessment pre-op SCORE:				
Hygiene / Elimination	▲	Hygiene needs attended – post-op sponge / pressure area care				
		No sign of urinary retention If IDC insitu – output >50mLs hour				
Wound / Dressings	▲	Dressing intact, wound ooze minimal				
		Drain insitu: ☐ Yes ☐ No				
		Reinfusion drains reinfused within 6 hours				
Nutrition	▲	Once alert, sips of water increasing to diet and fluids				
Activity / Mobility	▲	Resting in bed, abduction pillow in situ				
		Patient laying at no more than at 45° hip flexion				
		Breathing and circulation exercises encouraged				
Patient education / discharge planning	▲	Patient given explanation / understands treatment course				
		Patient given support and reassurance				

Category	Key		A	V
Expected outcomes	▲	**Patient demonstrates: A – Achieved V – Variance**		
	3:1	Patient understands usual pre- and post-operative care routines, the surgery and its effects		
	3:2	Management of patient pain ensures a level of discomfort that is acceptable for the patient		
	3:3	Post-operatively – once alert and orientated may resume an oral fluid intake and diet		

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Category	Key	DAY 2 Date: .... / .... /	Time	Initials	V
Reviews	■	☐ Consultant ☐ Registrar ☐ RMO			
		☐ Afebrile ☐ Wound satisfactory			
		Post-op hip x-rayed			
		Drain removal ordered			
		Plan:			

			AM	PM	ND	V
Investigations	■	Pathology within expected range, Hb checked – Hb:				
Medications / Pain management	▲	Given as ordered on medication chart				
	■	Pain management reviewed first by Acute Pain Service				
	℗	Medications reviewed and plan confirmed				
Epidural / PCA	▲	Epidural / PCA – Femoral / Lumbar block obs performed				
		Epidural / PCA – Femoral / Lumbar block site satisfactory				
Observations / Treatments	▲	Complete Acute Pain Management documentation as per protocol				
	■	Observations within patient's normal limits				
		IV cannula site – patent, no signs of inflammation				
		Anti-embolic therapies continued				
		Waterlow pressure ulcer assessment pre-op SCORE:				
		Falls risk assessment pre-op SCORE:				
Hygiene / Elimination	▲	Sponge in bed / pressure area care attended				
		No sign of urinary retention (if IDC insitu - output >50mLs hour)				
		Fluid balance chart completed				
Wound / Dressings	▲	Dressing reviewed, intact				
		Drains removed as ordered and checked by two RN's 1: 2:				
Nutrition	▲	IV Therapy as prescribed				
		No nausea or vomiting				
Activity / Mobility	◆	Rest in bed (abduction wedge insitu) when not with physio				
		Chest and calf check NAD				
		Breathing and circulation exercises – foot / ankle / static quads and gluts				
		Assisted hip / knee flexion to less than 60°, hip abduction, IRQ, bridging				
		Slide out of bed and stand in rollator: ☐ Yes ☐ No Assist: ☐ 1 ☐ 2				
		Mobilise short distance rollator: ☐ Yes ☐ No Assist: ☐ 1 ☐ 2				
		Weight bearing status: ☐ FWB ☐ PWB ☐ TWB ☐ NWB				
		Comments:				
Patient education / discharge planning	▲ ■	Levels of activity, wound care, diet and pain management explained and discussed				

Expected outcomes	▲	**Patient demonstrates: A – Achieved V – Variance**	A	V
	4:1	Orthopaedic team has reviewed patient's progress and explained their plan		
	4:2	Patient will be eating and drinking normally now		
	4:3	Pain controlled at rest		
	4:4	Observations within normal limits		
	4:5	Haemo-dynamically stable		

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Category	Key	DAY 3 Date: .... / .... /	Time	Initials	V
Reviews	■	☐ Consultant ☐ Registrar ☐ RMO			
		☐ Afebrile ☐ Wound satisfactory			
		Review IV access / fluids			
		Plan:			

Category	Key		AM	PM	ND	V
Investigations	■					
Medications / Pain management	▲	Given as ordered on medication chart				
	■	Pain management reviewed first by Acute Pain Service				
	℗	Medications reviewed and plan confirmed				
Epidural / PCA	▲	Epidural / PCA – Femoral / Lumbar obs performed and removed				
Observations / Treatments	▲	Observations within patient's normal limits				
		Compression device removed				
		Anti-embolic therapies continued				
		Pressure area care attended				
		Waterlow pressure ulcer assessment pre-op SCORE:				
		Falls risk assessment pre-op SCORE:				
Hygiene / Elimination	▲	Showered with assistance				
		Elimination recorded				
		Fluid balance chart ceased				
Wound / Dressings	▲	Dressing reviewed: ☐ Changed ☐ Reinforced				
Nutrition	▲	IV Therapy as prescribed				
		Tolerating full diet and free fluids				
		No nausea or vomiting				
Activity / Mobility	◆	Chest and calf check NAD, breathing and circulatory exercises				
		Active hip / knee flexion, hip abduction, IRQ, bridging				
		Walk in rollator: ☐ Yes ☐ No Assist: ☐ 1 ☐ 2 Distance: ....m				
		Sit / high perch: .... times / day				
		Comments:				
Patient education / discharge planning	♣	Recommendations / plan made at pre admission clinic reviewed				
		Reinforced implications of surgery for ADL's				
		Encouraged independence in ADL's and strategies developed				
		Day 2 OT interventions completed on: .... / .... /				
		Comments:				

Category	Key	**Patient demonstrates: A – Achieved V – Variance**	A	V
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 has been educated as to hip precautions		
	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	Key	DAY 4 Date: ....../....../......	Time	Initials	V
Reviews	■	☐ Consultant ☐ Registrar ☐ RMO ☐ Afebrile ☐ Wound satisfactory Anticoagulant therapy: ☐ Yes ☐ No IV removal ordered **Plan:**			

Category	Key		AM	PM	ND	V
Investigations	▲	INR checked (if on warfarin)				
		FBC and Hb within normal range				
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 hip / knee flexion, hip abduction, IRQ, bridging				
		Mobility aid – Assist: .... Distance: .... m				
		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				

Category	Key	Patient demonstrates: A – Achieved V – Variance	A	V
Expected outcomes	▲			
	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	Patient mobile with supervision		
	4:8	Pre op bowel / bladder habits back to normal		
	4:9	Pain is controlled		

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Category	Key	DAY 5 Date: ....../....../......	Time	Initials	V
Reviews	■	☐ Consultant ☐ Registrar ☐ RMO ☐ Afebrile ☐ Wound intact Anticoagulation therapy within normal limits Proceeding according to clinical pathway and applicable **Plan:**			

			AM	PM	ND	V
Investigations	▲					
Medications / Pain management	▲ ■ ℗	Given as ordered on medication chart				
		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 (assist x1)				
		Independant with showering				
		Toilet privileges allowed, bowels opened				
Wound / Dressings	▲	Wound redressed with:				
Nutrition	▲	Tolerating full diet and free fluids				
		No nausea or vomiting				
Activity / Mobility	◆	Chest and calf check NAD, breathing and circulatory exercises				
		Exercise program including standing ROM exs, mini squats and balance retraining				
		Transfer practised				
		Mobility aid – Assist: .... Distance: ....m Stairs:				
		Comments:				
Patient education / discharge planning	▲ ◆	Pain management explained and discussed				
		Mobility aids organised				
		Post discharge physiotherapy required				
		Referral form commenced and community agency contacted				

Expected outcomes	▲	**Patient demonstrates: A – Achieved V – Variance**	A	V
	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 and hip precautions		
	4:6	Pain controlled		

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Category	Key	DAY 6 Date: ...... / ...... /	Time	Initials	V
Reviews	■	☐ Consultant ☐ Registrar ☐ RMO ☐ Afebrile ☐ Wound intact **Plan:**			

Category	Key		AM	PM	ND	V
Investigations	▲					
Medications / Pain management	▲ ■ Ⓟ	Given as ordered on medication chart				
		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				
Wound / Dressings	▲	Wound dry and dressing applied – Type:				
Nutrition	▲	Tolerating full diet and free fluids				
		No nausea or vomiting				
Activity / Mobility	◆	Chest and calf check NAD, breathing and circulatory exercises				
		Review independent exercise program, practise transfers and gait				
		Mobility aid – Assist: .... Distance: ......m Stairs:				
		Comments:				
Occupational therapy	♣	Independence with ADL's reviewed: ☐ Indep ☐ Assist				
		Shower / bath transfers reviewed: ☐ Indep ☐ Assist				
		Toilet transfers reviewed: ☐ Indep ☐ Assist				
		Reinforced precautions and finalised equipment needs				
		Day 5 interventions completed on: ...... / ...... /				
		Comments:				

Expected outcomes	▲	**Patient demonstrates: A – Achieved V – Variance**	A	V
	4:1	Orthopaedic Team has reviewed patient's progress		
	4:2	Discharge arrangements completed		
	4:3	Pre-op bowel and bladder habits back to normal		
	4:4	Pain controlled		
	4:5	Patient mobilising with supervision		

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Category	Key	DAY 7 Date: .... / .... /	Time	Initials	V
Reviews	■	☐ Consultant ☐ Registrar ☐ RMO			
		☐ Afebrile ☐ Wound intact			
		Discharge medication ordered			
		Follow-up appointment confirmed			
		Plan:			

Category	Key		AM	PM	ND	V
Investigations	▲					
Medications / Pain management	▲ ■ Ⓟ	Given as ordered on medication chart				
		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	▲	Maintaining hygiene independently				
		Bowels opened				
Wound / Dressings	▲	Wound dry and dressing applied – Type:				
Nutrition	▲	Tolerating full diet and free fluids				
Activity / Mobility	◆	Chest and calf check NAD, breathing and circulatory exercises				
		Review independent exercise program, practise transfers and gait				
		Mobility aid – Assist: .... Distance: ......m Stairs:				
		Comments:				
Patient education / discharge planning	▲	Levels of activity, it's benefits, wound care, diet and pain management explained and discussed				
		Discharge plan commenced				

Category		**Patient demonstrates: A – Achieved V – Variance**	A	V
Expected outcomes	▲			
	4:1	Orthopaedic Team has review patient's progress		
	4:2	All follow-up arrangements made		
	4:3	Patient and family understand discharge plan		
	4:4	Patient mobilising independently		
	4:5	Patient understands home exercise program		

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Category	Key	DAY 8 Date: .... / .... /	Time	Initials	V
Reviews	■	☐ Consultant ☐ Registrar ☐ RMO			
		☐ Afebrile ☐ Wound free of infection			
		Anticoagulant Therapy within normal limits			
		Follow-up appointment confirmed			
		Plan:			

Category	Key		AM	PM	ND	V
Investigations	▲					
Medications / Pain management	▲ ■ ℗	Given as ordered on medication chart				
		Discharge medications given to patient and education				
Observations / Treatments	▲	Observations within patient's normal limits				
		Waterlow pressure ulcer assessment pre-op SCORE:				
		Falls risk assessment pre-op SCORE:				
Hygiene / Elimination	▲	Showered in high perched chair independently				
		Bowels opened				
Wound / Dressings	▲	Wound dry, water proof dressing applied				
Nutrition	▲	Tolerating full diet and free fluids				
		Patient experiencing no nausea or vomiting				
Activity / Mobility	◆	Chest and calf check NAD, breathing and circulatory exercises				
		Review independent exercise program, practise transfers and gait				
		Mobility aid – Assist: .... Distance: .... m Stairs:				
		Comments:				
Patient education / discharge planning	▲ ■	Levels of activity, it's benefits, wound care, diet and pain management explained and discussed				
		Courtesy call to relatives / nursing home / hostel r.e. discharge				
		Reinforce hip precautions in home environment				
		Discharge plan provided and instructions given				
		Discharge plan completed				

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Patient related = 1	**Staff related = 2**	**Hospital related = 3**	**Community related = 4**
1.1 Patient condition	2.1 Clinician decision	3.1 Bed availability	4.1 Community care booking
1.2 Patient choice	2.2 Other	3.2 Equipment availability	4.2 Community care availability
1.3 Other		3.3 Service availability	4.3 Family / carer support availability

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Clinical Pathway / Patient Copy — Hip Arthroplasty

Expected Outcomes

Phase	Outcomes
Phase 1	**Assessment at pre-admission** • 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** • 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** • 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** • 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** • When you are ready for discharge, whether on day five or later, the Discharge Planning Checklist will be followed by your care providers and you will be discharged.

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. Admitted under Orthopaedic Team – surgery booked											
3. Blood tests, x-rays etc will be taken											
4. Assessed by Ortho Team											
5. IV fluids commenced											
6. Prepared for surgery											
7. Transferred to surgery, or ward then surgery											
8. Post-operation vital signs											
9. Not feeling sick and pain level ok											
10. Awake and know where you are											
11. Wound ooze minimal											
12. Can pass urine after operation											
13. Drains removed											
14. Compression device removed											
15. IV Cannula removed											
16. Drinking / eating normally											
17. Reviewed by Orthopaedic team											
18. Can walk with 2 sticks safely											
19. Ready to go home											
20. Carer available on going home											
21. Discharge check list completed											

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