Salisbury NHS
NHS Foundation Trust

Attach Patient Label Here
Name:……
Address:……
……
Hospital Number……..
Date of Birth……

Expected Date of discharge
…../…../……..

Integrated Care Pathway Total Hip Replacement

Consultant_____

Ward……..

Please note:

Operation notes and post op instructions are to be written in this Pathway and not in the Elective Surgery Patients Pathway A

Instructions for use of the pathway:

1. Patient is seen in Pre Admission Clinic and the Elective Surgery Pathway is completed The assessment sheets for Falls, Braden, Manual Handling, Nutrition and Bed Rails that are in the Integrated pathway will be completed and not the relevant sections in the Elective Surgery Patients Pathway

2. On the day of admission the relevant section of the Elective Surgery Pathway is completed. This process is the same if the patient is admitted directly to the ward before theatre or to S.A.L

3. Operation notes and post instructions and stickers will be put into the Integrated pathway and not the Elective Surgery Pathway.

4. The receiving recovery nurse and the receiving ward nurse must be aware of the patients relevant and past medical history.

5. On return to the ward all documentation must be written into the Integrated Care Pathway

6. All staff must be aware of the medical history recorded at the time of Pre Admission

7. The Integrated Care Pathway can only be discontinued if the patient s medical condition is such that it is no longer a useful documentation tool

8. The Integrated Care Pathway is a legal document and must be completed by all Health Care Professionals caring for the patient

Braden Score (©Copyright Barbara Braden & Nancy Bergstrom 1998 All rights reserved)

SENSORYPERCEPTION ability to respond meaningfully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 2 of body.	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift.	3. Occasionally Moist: Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals.
ACTIVITY degree of physical activity	1. Bedfast Confined to bed.	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours.
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance.	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. Slightly Limited Makes frequent though slight changes in body or extremity position independently.	4. No Limitation Makes major and frequent changes in position without assistance.
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than a of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding.	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered. OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.	

Patients name			**Hospital number**				
Braden Reassessment Record							
Document the score for each category below. Document any actions on the management plan and evaluate outcomes in the healthcare record.							
NOTE: Patients with a total score of 15 or less are considered to be at risk of developing pressure ulcers. (15 -18 = at risk; 13 or 14 = moderate risk; 10 -12 = high risk, 9 or below =very high risk) **If any of the following major risk factors are present, the risk level must be increased to the next level.** **Advanced age, fever, poor dietary intake of protein, diastolic pressure below 60, haemo-dynamic instability.**							
Assessment date							
Sensory perception							
Moisture							
Activity							
Mobility							
Nutrition							
Friction and shear							
Total score							
risk category (tick)	☐	☐	☐	☐	☐	☐	☐
low risk	☐	☐	☐	☐	☐	☐	☐
moderate risk	☐	☐	☐	☐	☐	☐	☐
high risk	☐	☐	☐	☐	☐	☐	☐
very high risk	☐	☐	☐	☐	☐	☐	☐
signature							
printed name							
band							
reassessment date							
Document any actions on the management plan and evaluate outcomes in the healthcare record							

Patient name and Hospital number…….

Manual Handling Assessment

Transfer	Independent	Requires assistance	Carers
Lie to sit on trolley/bed	□	□ use elbow to elbow method as one off □ use rope ladder □ electric profiling bed (EPB)	2 …….. ……..
Up/down trolley / bed	□	□ use slide sheet □ hoist	…….. ……..
On/off bed	□	□ rotacushion and handling belt □ hoist □ leg raiser and rotacushion □ use EPB as aid	…….. …….. …….. ……...
To turn /roll in bed	□	□ hoist □ slide sheet	…… 2
Lateral transfer	□	□ patslide with slide sheet (minimum 2 moves	Min 3
Sit to stand	□	□ handling belt □ standaid □ stedy □ rotastand □ hoist	…… …… …….. …… …… ……
Bed/chair to chair	□	□ rotastand □ stedy □ banana board □ handling belt □ standaid □ hoist	…….. …… …….. …….. …… ……
Walking	□	□ handling belt □ hoist & walking harness	…….. ……..
Toileting	□	□ rotastand □ stedy □ standaid □ hoist	…… …… …… …… ……
Bathing/ shower	□	□ assisted bath using bath hoist □ assisted bath using bathing sling □ assisted shower with hoist	□ □ □
Repositioning in chair	□	□ bottom shuffle □ hoist □ slide sheet □ handling belt □ remain in electric profiling bed	□ □ □ □ □

Patient name and Hospital number…….

Nutritional Assessment (must be completed on all patients)					
height		weight		Body mass index Weight (kg)/height (m^2)	

Item		Score
Age	1= <40 2 = 40-60 3 = 60-80 4 = > 80	
Reason for admission	1 = no planned surgery 2 = minor surgery 4 = chronic medical conditions 8 = major trauma 8 = major surgery 8 = infection with a pyrexia 8 = acute medical conditions 8 = existing pressure ulcer 8 = post operative complication 8 = substance abuse	
Diet	1 = normal 2 = restricted 3 = fluids only 4 = nil by mouth	
Appetite	1 = good (manages 3 meals a day) 2 = eating half meals or less 3 = refuses or is unable to drink 4 = vomiting and diarrhoea	
Weight	1 = no weight loss 2 = recent weight loss up to 10% 3 = recent weight loss > 10 % or BMI 16-18 4 = skeletal BMI < 16	
Ability to eat	1 = able to eat without help 2 = requires some help 3 = needs to be fed 4 = unable to swallow	
	Total score	

<10 = low risk	**11 -17 = moderate risk**	**> 18 = high risk**
No action required	**Needs monitoring** Encourage eating and drinking. Observe and record intake. Supplement missed meals. Review weekly - if no improvement refer to dieticians. Reassessment date	**Needs action** Refer to dietician Consider nutritional support Review twice weekly

Signature & printed name	time	date	band
Supervisor Signature & printed name			band

Patient name and Hospital number……

Bed Rails Assessment

All patients to be assessed on admission and within 24hours of transfer to a ward and repeat assessment weekly or after a fall

Indications for use		**Indications for non- use**	
History of falls	□	Known to climb over the bed rails	□
Fluctuating conscious levels	□	Patient totally immobile	□
Sensory loss / confusion	□	Independently moving in bed	□
Lack of awareness, physical limitations	□	Aware of limitations	□
Patient or carer request			

If there is conflicting evidence then using professional judgement in conjunction with the above assessment will allow you to determine whether or not to use bed rails. Where appropriate ensure that the family are involved in the decision making process.

Outcome of assessment :	**Yes**	**No**
Are bed rails indicated?	□	□
Has the family been informed of the decision?	□	□

Comments

Document planned care on management plan

Signature and printed name	Time	date	band

Supervisor signature and printed name	band

Integrated Care Pathway **Total Hip Replacement** **Consultant**_____ **Ward**……..	Attach Patient Label Here Name:…… Address:…… …… Hospital Number…….. Date of Birth……

FALLS RISK ASSESSMENT

History of Falls (Admitted as a result of fall/fallen since)		Stability concerns (Unsteady gait/imbalance/weakness)	
Impaired Judgement (Confused/agitated/forgets limitations		Impaired vision	
If **NONE** of the above apply the patient is not considered at significant risk of falling.You do not need to fill in any more of this form			

All patients to be assessed on admission and within 24 hours of transfer of ward and repeat assessment weekly/or after a fall

	Assessment dates			
Item	**You may select more than item per group**	**Score**	**Score**	**Score**
Gender	1= Male 2= Female			
Age	1= 16-70 years 2= 71-80 years 3= 81+			
Falls History	0= None 1= Falls Outside 2= Falls Indoors			
Medication (add score if taken)	1= Sedation/Analgesics 1= Tranquillisers 1= cardiovascular Drugs 1= Diuretics			
Gait (with aid)	0= Steady 1= hesitant 2= Unsteady/ falls back 3= Variable ……..			
Cognition	0= Oriented to time/place 1= Disoriented to time/place 2= Lacks insight into own safety 3= Variable ……			
Sensory	0= Poor hearing 1= Poor sight 2= Poor balance 2= Uncoordinated limb movement/loss of sensation in lower limbs 3= Variable ……			
Activity & Mobility	1= Independently mobile 2= Needs assistance/supervision with transfers or mobility 2= 1-2 staff to transfer 3= Bed/Chair bound 3= Variable ……			
	Total/signature			

Level of Risk: LOW = 3-8 / MEDIUM = 9-12 / HIGH = 13+ See over for Action Plan

Falls Risk Action Plan

Date			
Low Risk • Inform all staff of patients risk of falling • Put call bell within easy reach/ respond promptly to calls • Orientate patient to ward environment • Remove Obstacles • Ask Medical Team to review patient in light of recent fall(s) • Check bed height – lower if necessary • Advice on nonslip footwear/no long or loose clothing • Ask Pharmacist/Medical Team to review medication • Ensure adequate lighting – day and night • Ensure frequently needed objects are within easy reach • Provide basic safety information to patient/family • Ensure patient is toileted frequently – especially early in the morning • Consider assessment for use of bedrails, follow policy, inform and seek consent of family			

Medium Risk • In addition to the above • Discuss with patient/family the risk factors • Explain the importance to the patient, of asking for help as needed • Ensure walking aids are within easy reach • Supervise/assist patient when transferring/walking • Supervise/assist personal hygiene and toileting as appropriate • Consider slip mat for chair • Consider patient alarm • Ensure patient is not left in an isolated position on the ward • Move bed to a less isolated area, if possible			

High Risk • In addition to the above • Supervise planned transfers or mobilisation • See intervention in low/medium risk action plan			
Signature			

For additional advice or if falls persist refer to the Falls Co-ordinator on 07876 740016 Ext 4869

Integrated Care Pathway **Total Hip Replacement** **Consultant**_____ **Ward**……..	Attach Patient Label Here Name:…… Address:…… …… Hospital Number…….. Date of Birth……

Operation Note:

Surgeons hand written operation note below or stick in typed notes

There is more space on the reverse of this page

Post op Instructions, including suture material, drains, and mobilisation with weight bearing status

Full weight bearing ☐ Partial weight bearing ☐ Toe touch weight bearing ☐ Non weight bearing ☐

Signature & print name **Date & Time**

Operation Note:

Surgeons hand written operation note below or stick in typed notes

Post op Instructions, including suture material, drains, and mobilisation with weight bearing status

Full weight bearing ☐ Partial weight bearing ☐ Toe touch weight bearing ☐ Non weight bearing ☐

Signature & print name **Date & Time**

Integrated Care Pathway **Total Hip Replacement** **Consultant**_____ **Ward……..**	Attach Patient Label Here Name:…… Address:…… …… Hospital Number…….. Date of Birth……

STICKERS

(Prosthesis/Equipment/ sutures etc)

Integrated Care Pathway **Total Hip Replacement** **Consultant**_____ **Ward**……..	Attach Patient Label Here Name:…… Address:…… …… Hospital Number…… Date of Birth……

Post Operation (on return to ward) as required

Date

To be used by Medical and Nursing staff

Medical:		
Ensure Patient has been VTE risk assessed and re assess regularly	☐	
Ensure patient has been prescribed VTE prohylaxis	☐	
Ensure patient has own medicines prescribed	☐	

All fields are mandatory and **must** be completed

Nursing assessment: (refer to Nursing Assessment Record)

1)Respiratory System:	**2)Cardiovascular System:**
02 therapy as prescribed	**Observations: (**Use EWS chart **)**
Comments and action:	Measure and record BP, Pulse, Resps & O_2 sats
	½ hourly for 2 hours — **As per** ☐
	1 hourly for 2 hours — Patients ☐
	2 hourly for 4 hours — Condition ☐
3)Gastrointestinal Tract:	Then 4 hourly ☐
Interventions:	
Personal hygiene / mouth care prn ☐	IV therapy as prescribed ☐
	Comments& Action:
4)Nutrition: (see page 5)	
Diet and fluids:	
Tolerating fluids ☐ Light diet ☐ Sips ☐ NBM ☐	Check VTE risk has been completed
Comments & action	Anti-coagulation therapy commenced ☐
	Comments & Action
6)Wound Assessment:	
Wound Check: and Drain check	
Check there is no swelling /strike through	Anti-embolic stocking on unaffected leg IF pt very high risk fo VTE ☐
½ hourly for 2 hours ☐	
1 hourly for 2 hours ☐	Foot pump as per consultant's guidelines Yes / No
2 hourly for 4 hours ☐	Comments & Action
Then 4 hourly ☐	
Check drain is patent ☐	**5)Braden assessment**: (see page 2&3)
Comments & Action:	Score:
	Comments &Action:
Prophylactic antibiotics given ☐	
Next dose due at:	**7)Genitourinary System:**
8)Pain Assessment:	Urinary Output
Epidural check site on return to ward ☐	Accurate fluid balance ☐
Opiates as per protocol ☐	Care of catheter ☐
PCAS Check 1hrly for 4 hours ☐	4 hourly urine volumes ☐
Then 4 hourly ☐	Comments & Action
Record pain score at same frequency as obs	
Manual Handling Assessment (page4)	**9) Musculoskeletal;**
Comments & Action:	Limb colour
	Limb sensation
	Limb movement
	Bed rails assessment : (see page 6)
	Falls assessment (see page 7&8)
	Pts own medicines prescribed ☐

AM time	PM time	Night time
Signature & print	Signature & print	Signature print

VARIANCE is located on page 22 **Variance Yes / No**

Integrated Care Pathway **Total Hip Replacement** **Consultant**_____ **Ward**……..	Attach Patient Label Here Name:…… Address:…… …… Hospital Number…… Date of Birth……

Post Operation Day 1 **Date**

To be used by Medical and nursing staff

Date and time	**Clinical Record – legible signature & grade MANDATORY for each entry**	
	Review general condition:- Review analgesia:- Review fluid balance:-	**Date & time** Hb WBC Plat Neut
	Check x-ray card written yes / no Confirm weight bearing status	
	Films reviewed yes / no	
		INR APTT
	Post operative bloods:- (write in results)	
	VTE risk assessment completed ☐	Na K Urea **eGFR** Creat CRP TP ALB Glo Bil ALT ALP GGT Amy

If required, extra clinical sheets can be added per day…document use on variance sheet

Post Operation Day 1

All fields are mandatory and **must** be completed

Nursing assessment: (refer to Nursing Assessment Record)

1)Respiratory System:	**2)Cardiovascular System:**
0_2 therapy as prescribed	**Observations: (**Use EWS chart **)**
Comments & Action:	Measure and record BP, Pulse, Resps & O_2 sats
	BP 4hourly ☐
	TPR 4 hourly ☐
3)Gastrointestinal Tract:	
Interventions:	IV therapy as prescribed ☐
mouth care prn ☐	Comments & Action:
	Check cannulae site ☐
4)Nutrition:	Ensure VTE risk assess is complete
Maintain an accurate fluid balance chart ☐	Anti-embolic stockings in situ Yes / No
Tolerating fluids ☐ Light diet ☐	Remove and re-apply, include affected leg, depending on swelling
Nutritional score: (see page 5)	Comments & Action
Comments & Action:	
	Swelling Yes / No
	Foot pump per consultant's guidelines Yes / No
6)Wound Assessment:	Comments& action
Review drainage and approve drain removal ☐	
(N.B. Dressing does not have to be removed totally to remove drain)	**5)Braden assessment**: (see page 2&3)
	Score:
	Comments & Action:
Comments & Action	
	7)Genitourinary System:
	Urinary Output
Check dressing for wound ooze, re-pad if required	Accurate fluid balance ☐
Comments & Action:	Care of catheter ☐
	9)Musculoskeletal
8)Pain Assessment:	Personal hygiene / mouth care prn ☐
Epidural check site : care as protocol ☐	Bed bath ☐
Opiates as per protocol ☐	**Manual Handling Assessment:** (See page 4)
PCAS 4hrly ☐	Comments & Action:
PCAS discontinued Yes / No	
Record pain score at same frequency as obs	2-4 hourly position change Yes / No / N/A
	Pressure lifts
Bed rails assessment : (see page 6)	Liaise with Physio ☐
Falls assessment (see page 7&8)	Liaise with OT ☐

AM time Signature & print	PM time Signature & print	Night time Signature & print

VARIANCE is located on page 22 **Variance Yes / No**

Integrated Care Pathway **Total Hip Replacement** **Consultant**_____ **Ward**……..	Attach Patient Label Here Name:…… Address:…… …… Hospital Number…… Date of Birth……

Day 1 Post op cont

Physiotherapy	**Date**
General Condition	
Pain relief (Epidural, PCAS etc)	Observations checked Yes / No
Respiratory Function O2 Therapy (%, frequency, delivery etc)	
Adequate expansion ☐ Absence of secretions ☐ Effective cough ☐ Deep breathing exercises ☐ Bed exercises (TAQG's) ☐	

Weight bearing status

Mobility	**Supervision**	**Assistance of 1**	**Assistance of 2**
Out of bed			
Into bed			
Sit			
Stand			
Gait			

Walking Aid Zimmer Frame ☐ Sticks ☐ Elbow Crutches ☐ Other ☐

Active / Active Assisted Hip movements ☐ Hip Flexion AROM_____° Hip Abduction AROM_____

Explanation of safety factors Yes / No If no state reasons

Comments & Plan:

Signature print & Time

Check for variance

Occupational therapy (OT's will not visit patient every day)

Occupational Therapy	**Yes**	**No**	**Unsure**
Pre-operative questionnaire reviewed			
Outstanding equipment needs			
Care package needed			
Dressing assessment carried out			
Need for OT home assessment			

Comments

Signature, print & time

do not write on this page

Integrated Care Pathway **Total Hip Replacement** **Consultant**_____ **Ward**……..	Attach Patient Label Here Name:…… Address:…… …… Hospital Number…… Date of Birth……

Post Operation Day 2 Date

To be used by Medical and nursing staff

Date and time	**Clinical Record – legible signature & grade MANDATORY for each entry**	
	Review general condition:- Review analgesia:- Review fluid balance:-	**Date & time** Hb WBC Plat Neut
	Check x-ray card written yes / no Confirm weight bearing status	
	Films reviewed yes / no	
		INR APTT
	Post operative bloods:- (write in results)	
	Complete VTE risk assessment – if patient has an epidural , document time (18 hours after Rivaroxiban or 10hrs-12hrs after Dalteparin) that it can be removed and inform nursing team **Date:** **Time:**	Na K Urea **eGFR** Creat CRP TP ALB Glo Bil ALT ALP GGT Amy

If required, extra clinical sheets can be added per day…document use on variance sheet

Post op Day 2

All fields are mandatory and **must** be completed

Nursing assessment: (refer to Nursing Assessment Record)

1)Respiratory System:	**2)Cardiovascular System:**
0_2 therapy as prescribed ☐	**Observations: (**Use EWS chart **)**
0_2 therapy discontinued ☐	Measure and record BP, Pulse, Resps & O_2 sats
Comments & Action:	BP 4hourly ☐
	TPR 4 hourly ☐
3)Gastrointestinal Tract:	
Bowels open Yes / No	IV therapy as prescribed ☐
	Comments & action:
4)Nutrition: (see page 5)	
Maintain an accurate fluid balance chart ☐	Venflon removed Yes / No
Tolerating fluids ☐ Normal Diet ☐ Light diet ☐	Anti- embolitic stockings in situ ☐ (Use ICP tool)
Nutritional score:	Remove and re-apply, include affected leg, depending on swelling
Comments & Action:	Comments & Action:
6)Wound Assessment:	Swelling Yes / No
Review drainage and approve drain removal ☐	Foot pump per consultant's guidelines Yes / No
(N.B. Dressing does not have to be removed totally to remove drain)	Comments & Action
Comments & Action:	
	5)Braden assessment: (see page 2&3)
	Score:
	Comments &Action:
Check dressing for wound ooze, re-pad if required Comments & action:	
	7)Genitourinary System:
	Urinary Output
	Accurate fluid balance ☐
8)Pain Assessment:	Care of catheter ☐
See Dr's instruction re epidural	Comments & Action:
Epidural removed Yes / No	
Tip intact Yes / No	
Sent for MC + S if appropriate ☐	**9)Musculoskeletal**
Check site , care as protocol ☐	Personal hygiene / mouth care prn ☐
Opiates as per protocol ☐	Self wash with assistance ☐
PCAS 4 hourly ☐	**Manual Handling Assessment:** (see page 4)
PCAS Discontinued Yes / No	Comments &Action:
Record pain score at same frequency as obs	
Comments & action:	2-4 hourly position change Yes / No / N/A
	Pressure lifts Yes / No / N/A
10)Social circumstances and discharge	Walk to Toilet:- 1nurse / 2nurses / Mobility Aid
Refer to Discharge planning list ☐	
Refer to MSW Yes / No	Up to commode:- 1nurse / 2nurses / Mobility Aid
Referred for……..	
Discuss transport home	Liaise with Physio ☐
Comments & Action:	Liaise with OT ☐
Bed rails assessment : (see page 6)	**Falls assessment** (see page 7&8)

AM time **Signature & print**	PM time **Signature & print**	Night time **Signature & print**

Write variance on page 22 Variance Yes / no

Integrated Care Pathway **Total Hip Replacement** **Consultant**_____ **Ward**……..	Attach Patient Label Here Name:…… Address:…… …… Hospital Number…… Date of Birth……

Post operation Day 2 cont'd

Physiotherapy	**Date:**
General Condition	
O_2 Therapy (%, frequency, delivery etc)	
Pain relief (Epidural, PCAS etc)	Observations checked Yes / No
Respiratory Function	
Absence of secretions ☐ Adequate expansion ☐ Deep breathing exercises ☐ Effective cough ☐	
Bed exercises (TAQG's) ☐	

Weight bearing status

Mobility	**Independent**	**Supervision**	**Assistance of 1**	**Assistance of 2**
Out of bed				
Into bed				
Sit				
Stand				
Gait				

Walking Aid Zimmer Frame ☐ Sticks ☐ Elbow Crutches ☐ Other walking aid ☐
Distance
Stairs
Re-education board exercises Hip Flexion AROM_____° Hip Abduction AROM_____°
Standing exercises Hip Flexion AROM _____Hip abduction AROM_____ Hip extension AROM_____
Explanation of safety factors Yes / No If no state reasons
Comments & Plan:
Referred for OPPT Yes/ No

Signature, print & time	Signature, print & time

Write Variance on page 18

Occupational therapy (OT's will not visit patient every day)

Occupational Therapy	**Yes**	**No**	**Unsure**
Pre-operative questionnaire reviewed			
Outstanding equipment needs			
Care package needed			
Dressing assessment carried out			
Need for OT home assessment			

Comments
Signature, print & time

Write Variance on page 22 **Variance Yes/ no**

VARIANCE				
Date and time	Variance	Action taken	Result of action taken	Sign.

Integrated Care Pathway **Total Hip Replacement** **Consultant**_____ **Ward**……..	Attach Patient Label Here Name:…… Address:…… …… Hospital Number…… Date of Birth……

Post Operation Day3 Date

To be used by Medical and nursing staff

Date and time	**Clinical Record – legible signature & grade MANDATORY for each entry**	
	Review general condition:- Review analgesia:- Review fluid balance:-	**Date & time** Hb WBC Plat Neut
	Check x-ray card written yes / no Confirm weight bearing status	
	Films reviewed yes / no	
		INR APTT
	Post operative bloods:- (write in results)	
	Complete VTE risk assessment ☐	Na K Urea **eGFR** Creat CRP TP ALB Glo Bil ALT ALP GGT Amy

If required, extra clinical sheets can be added per day…document use on variance sheet

Post op Day 3

All fields are mandatory and **must** be completed

Nursing assessment: (refer to Nursing Assessment Record)

1)Respiratory System:	**2)Cardiovascular System:**
0_2 therapy as prescribed ☐	**Observations:** **(**Use EWS chart **)**
0_2 therapy discontinued ☐	Measure and record BP, Pulse, Resps & O_2 sats
Comments& Action:	BP 4hourly ☐
	TPR 4 hourly ☐
3)Gastrointestinal Tract:	IV therapy as prescribed ☐
Bowels open Yes / No	Comments & Action:
4)Nutrition: (see page 5)	Remove venflon ☐
Maintain an accurate fluid balance chart ☐	Anti-embolitic stockings in situ ☐
Tolerating fluids ☐ Light diet ☐ Normal Diet ☐	Remove and re-apply, include affected leg, depending on swelling
Nutritional score:	Comments & Action:
Comments & Action:	
	Ensure VTE assessment is complete ☐
	Swelling Yes / No
	Foot pump per consultant's guidelines Yes / No
6)Wound Assessment:	Comments & Action:
Check dressing for wound ooze, repad if necessary	
Comments & Action:	Teach patient to give Dalteparin if applicable ☐
	5)Braden assessment: (see page 2 &3)
	Score:
8)Pain Assessment:	Comments & Action:
Check Epidural site (care as protocol) Yes / No	
Opiates as per protocol ☐	
PCAS 4 hourly ☐	**7)Genitourinary System:**
PCAS Discontinued Yes / No	Remove catheter if not already removed ☐
Record pain score at same frequency as obs	Monitor urinary output ☐
Comments & action:	Comments & action
10)Social circumstances and discharge	**9)Musculoskeletal**
Refer to Discharge planning list ☐	Personal hygiene / mouth care prn ☐
Refer to MSW Yes / No	Self wash with assistance ☐
Referred for……..	**Manual Handling Assessment:** (see page 4)
FAX1 faxed Yes/No	Comments & Action:
Discharge prescription written Yes/No	
Discuss transport home	
Comments & Action	2-4 hourly position change Yes / No / N/A
	Pressure lifts Yes / No / N/A
	Walk to Toilet:-1nurse / 2nurses / Mobility Aid
Is estimated discharge date realistic, if no state why	Up to commode:-1nurse / 2nurses/ Mobility Aid
Liaise with Physio ☐	**Bed rails assessment :** (see page 6)
Liaise with OT ☐	**Falls assessment** (see page 7&8)

AM time Signature & print	PM time Signature & print	Night time Signature & print

Check for Variance (Write them on page 22)

Integrated Care Pathway **Total Hip Replacement** **Consultant**_____ **Ward**……..	Attach Patient Label Here Name:…… Address:…… …… Hospital Number…… Date of Birth……

Day 3 Post op cont

Physiotherapy			**Date**	
General Condition				
Mobility	**Independent**	**Supervision**	**Assistance of 1**	**Assistance of 2**
Out of bed				
Into bed				
Sit				
Stand				
Gait				
Walking Aid Zimmer Frame □ Sticks □ Elbow Crutches □ Other walking aid □				
Distance				
Stairs				
Re-education board exercises Hip Flexion AROM_____° Hip abduction AROM_____°				
Standing exercises Hip Flexion AROM _____Hip abduction AROM_____ Hip extension AROM_____				
Action				
Explanation of safety factors Yes / No				
If no state reasons				
Comments & Plan:				
Referred for OPPT Yes/ No				
Signature, pritn & time			Signature, print & time	

Check for Variance (Write variance on page 22)

Occupational Therapy (OT's will not visit patient every day)

Occupational Therapy	**Yes**	**No**	**Unsure**
Pre-operative questionnaire reviewed			
Outstanding equipment needs			
Care package needed			
Dressing assessment carried out			
Need for OT home assessment			
Comments			
Signature, print & time			

Check for Variance (Write them on page 22)

do not write on this page

Integrated Care Pathway **Total Hip Replacement** **Consultant**_____ **Ward**……..	Attach Patient Label Here Name:…… Address:…… …… Hospital Number…… Date of Birth……

Post Operation Day 4 Date

To be used by Medical and nursing staff

Date and time	Clinical Record – legible signature & grade MANDATORY for each entry	
	Review general condition:- Review analgesia:- Review fluid balance:-	**Date & time** Hb WBC Plat Neut
	Check x-ray card written yes / no Confirm weight bearing status	
	Films reviewed yes / no	
		INR APTT
	Post operative bloods:- (write in results)	
	Complete VTE risk assessment ☐	Na K Urea **eGFR** Creat CRP TP ALB Glo Bil ALT ALP GGT Amy

If required, extra clinical sheets can be added per day…document use on variance sheet

Post op Day 4

All fields are mandatory and **must** be completed

Nursing assessment: (refer to Nursing Assessment Record)

1)Respiratory System:	**2)Cardiovascular System:**
0_2 therapy as prescribed ☐	**Observations: (**Use EWS chart **)**
0_2 therapy discontinued ☐	Measure and record BP, Pulse, Resps & O_2 sats
Comments & Action:	BP 4hourly ☐
	TPR 4 hourly ☐
3)Gastrointestinal Tract:	
Bowels open Yes / No	Ensure Venflon removed ☐
	Ensure VTE assessment is complete ☐
	Anti-embolitic stockings in situ ☐
4)Nutrition: (see page 5)	Remove and re-apply, include affected leg, depending on swelling
Maintain an accurate fluid balance chart ☐	Comments& Action:
Free Fluids ☐ normal diet ☐	
Nutritional score:	Swelling Yes / No
Comments & Action:	Foot pump per consultant's guidelines Yes / No
	Comments& Action
6)Wound Assessment:	
Check dressing for wound ooze, repad if necessary	Teach patient to give Dalteparin if applicable ☐
Comments & Action:	
	5)Braden assessment: (see page 2 & 3)
	Score:
8)Pain Assessment:	Comments & Action:
Check Epidural site (care as protocol) Yes / No	
Analgesia as required ☐	
Record pain score at same frequency as obs	**7)Genitourinary System:**
Comments & Action:	Monitor urinary output ☐
	Comments & Action:
10)Social circumstances and discharge	
Refer to Discharge planning list ☐	
Refer to MSW Yes / No	**9)Musculoskeletal**
Referred for……..	Personal hygiene / mouth care prn ☐
FAX1 faxed Yes/No	Self wash with assistance ☐
Discharge prescription written Yes/No	Self dress ☐
Discuss transport home	**Manual Handling Assessment:** (see page 4)
Comments& Action:	Comments & Action:
Is discharge tomorrow realistic, if no why not?	Encourage position change Yes / No / N/A
	Walk to Toilet:-1nurse + aid ☐
	Up to commode:-1nurse + aid ☐
Liaise with Physio ☐	
Liaise with OT ☐	
	Bed rails assessment : (see page 6)
	Falls assessment (see page 7&8)

AM time Signature& print	PM time Signature & print	Night time Signature & print

Check for Variance page 30

Integrated Care Pathway **Total Hip Replacement** **Consultant**_____ **Ward**……..	Attach Patient Label Here Name:…… Address:…… …… Hospital Number…… Date of Birth……

Post Operation Day 4

Physiotherapy			**Date**	
General Condition				
Mobility	**Independent**	**Supervision**	**Assistance of 1**	**Assistance of 2**
Out of bed				
Into bed				
Sit				
Stand				
Gait				
Walking Aid: Zimmer Frame □ Sticks □ Elbow Crutches □ Other walking aid □				
Distance				
Stairs				
Re-education board exercises Hip Flexion AROM _____° Hip abduction AROM _____°				
Standing exercises Hip Flexion AROM _____Hip abduction AROM_____ Hip extension AROM_____				
Action				
Explanation of safety factors Yes / No				
If no state reasons				
Comments & Plan:				
Referred for OPPT Yes/ No				
Signature & print Time			Signature & print Time	

Write and Check for Variance page 30

Occupational Therapy (OT's will not visit patient every day)

Occupational Therapy	**Yes**	**No**	**Unsure**
Pre-operative questionnaire reviewed			
Outstanding equipment needs			
Care package needed			
Dressing assessment carried out			
Need for OT home assessment			
Comments			
Signature, print & time			

Write and Check for Variance page 30

VARIANCE				
Date and time	Variance	Action taken	Result of action taken	Sign.

Integrated Care Pathway **Total Hip Replacement** **Consultant**_____ **Ward**……..	Attach Patient Label Here Name:…… Address:…… …… Hospital Number…… Date of Birth……

Post Operation Day 5 Date

To be used by Medical and nursing staff

Date and time	**Clinical Record – legible signature & grade MANDATORY for each entry**	
	Review general condition:- Review analgesia:- Review fluid balance:-	**Date & time** Hb WBC Plat Neut
	Post operative bloods:- (write in results)	
	Discharge letter written? Yes ☐ Prescribe TTO's Yes ☐	
		INR APTT
	Complete VTE risk assessment ☐	
		Na K Urea **eGFR** Creat CRP TP ALB Glo Bil ALT ALP GGT Amy

If required, extra clinical sheets can be added per day…document use on variance sheet

Post op Day 5

All fields are mandatory and **must** be completed

Nursing assessment: (refer to Nursing Assessment Record)	
1)Respiratory System:	**2)Cardiovascular System:**
0_2 therapy as prescribed ☐	**Observations: (**Use EWS chart **)**
0_2 therapy discontinued ☐	Measure and record BP, Pulse, Resps & O_2 sats
Comments & Action:	BP daily ☐ TPR daily ☐
3)Gastrointestinal Tract:	Venflon removed Yes / No
Bowels open Yes / No	Ensure VTE assessment is complete ☐
	Anti-embolitic stockings in situ ☐ Remove and re-apply, include affected leg, depending on swelling
	Comments & Action:
4)Nutrition: (see page 5)	
Free fluids ☐ normal diet ☐	Swelling Yes / No
Nutritional score:	Foot pump per consultant's guidelines Yes / No
Comments & Action:	Comments& Action:
6)Wound Assessment:	
Check dressing for wound ooze, repad or redress if necessary	Teach patient to give Dalteparin if applicable ☐
Comments & Action:	**5)Braden assessment** :(See Page 2&3)
	Score:
	Comments & Action:
8)Pain Assessment:	
Check Epidural site (care as protocol) Yes / No	
Analgesia as required ☐	**7)Genitourinary System:**
Record pain score at same frequency as obs	Monitor urinary output ☐
Comments & Action:	
	Comments & Action:
10)Social circumstances and discharge	
Refer to Discharge planning list ☐	**9)Musculoskeletal**
Refer to MSW Yes / No	Personal hygiene / mouth care prn ☐
Referred for……..	Self wash with assistance ☐
FAX1 faxed Yes/No	Self dress ☐
FAX 2 faxed Yes/No	**Manual Handling Assessment:** (see page 4)
Discharge prescription written Yes/No	Comments & Action:
Discuss transport home	
Comments& Action	
	Encourage position change Yes / No / N/A
	Comments and action
Is discharge today realistic, if no why not?	
Liaise with Physio ☐	
Liaise with OT ☐	
	Bed rails assessment : (see page 6)
	Falls assessment (see page 7&8)

AM time **Signature& print**	PM time **Signature & print**	Night time **Signature & print**

Write and check for variance on page 30

Integrated Care Pathway **Total Hip Replacement** **Consultant**_____ **Ward**……..	Attach Patient Label Here Name:…… Address:…… …… Hospital Number…… Date of Birth……

Post op Day 5

Physiotherapy			**Date**	
General Condition				
Mobility	**Independent**	**Supervision**	**Assistance of 1**	**Assistance of 2**
Out of bed				
Into bed				
Sit				
Stand				
Gait				
Walking Aid: Zimmer Frame □		Sticks □	Elbow Crutches □	Other walking aid □
Distance				
Stairs				
Re-education board exercises Hip Flexion AROM _____° Hip abduction AROM _____° Standing exercises Hip Flexion AROM _____Hip abduction AROM_____ Hip extension AROM_____				
Explanation of safety factors		Yes / No		
If no state reasons				
Comments & Plan:				
Referred for OPPT		Yes/ No		
Signature & print Time			Signature & print Time	

Complete signature sheet at front of pathway) **Check & Write for Variance on page 30**

Occupational Therapy (OT's will not visit patient every day)

Occupational Therapy	Yes	No	Unsure
Pre-operative questionnaire reviewed			
Outstanding equipment needs			
Care package needed			
Dressing assessment carried out			
Need for OT home assessment			
Comments			
Signature, print & time			

Check & Write for Variance on page 30

do not write on this page

Integrated Care Pathway **Total Hip Replacement** **Consultant**_____ **Ward**……..	Attach Patient Label Here Name:…… Address:…… …… Hospital Number…… Date of Birth……

Post Operation Day 5 + Date

To be used by Medical and nursing staff

Date and time	**Clinical Record – legible signature & grade MANDATORY for each entry**	
	Review general condition:- Review analgesia:- Review fluid balance:-	**Date & time** Hb WBC Plat Neut
	Post operative bloods:- (write in results)	
	Discharge letter written? Yes ☐ Prescribe TTO's Yes ☐	
		INR APTT
	Complete VTE risk assessment ☐	
		Na K Urea **eGFR** Creat CRP TP ALB Glo Bil ALT ALP GGT Amy

If required, extra clinical sheets can be added per day…document use on variance sheet

Post op Day 5 +

All fields are mandatory and **must** be completed

Nursing assessment: (refer to Nursing Assessment Record) Date Time	
1)Respiratory System:	**2)Cardiovascular System:**
Comments& Action::	**Observations: (**Use EWS chart **)**
	Measure and record BP, Pulse, Resps & O_2 sats
	BPdaily ☐ TPR daily ☐
	Venflon removed Yes / No
3)Gastrointestinal Tract:	Anti-embolitic stockings in situ ☐ Remove and re-apply, include affected leg, depending on swelling
Bowels open Yes / No	Ensure VTE assessment is complete ☐
	Comments & Action:
4)Nutrition: (see page 5)	
Free fluids ☐ normal diet ☐	Swelling Yes / No
Nutritional score:	Foot pump per consultant's guidelines Yes / No
Comments & Action:	Comments & Action:
6)Wound Assessment:	
Redress wound as per protocol ☐	Teach patient to give Dalteparin if applicable ☐
Comments & Action:	
	5)Braden assessment: (see page 2 & 3)
	Score:
8)Pain Assessment:	Comments & Action:
Check Epidural site (care as protocol) Yes / No	
Analgesia as required ☐	
Record pain score at same frequency as obs	**7)Genitourinary System:**
Comments & Action:	Monitor urinary output ☐
	Send urine for MC&S (if required) ☐
10)Social circumstances and discharge	Comments & Action
Refer to Discharge planning list ☐	
Refer to MSW Yes / No	
Referred for……..	**9)Musculoskeletal**
FAX1 faxed Yes/No	Personal hygiene / mouth care prn ☐
FAX 2 faxed Yes/No	Self wash with assistance ☐
Discharge prescription written Yes/No	Self dress ☐
Discuss transport home	**Manual Handling Assessment:** (see page 4)
Comments & Action	Comments & Action:
Liaise with Physio ☐	Encourage position change Yes / No / N/A
Liaise with OT ☐	Comments & Action:
Bed rails assessment : (see page 6)	
Falls assessment (see page 7&8)	

AM time Signature & print	PM time Signature & print	Night time Signature & print

Write & Check for Variance on page 38

Integrated Care Pathway **Total Hip Replacement** **Consultant**_____ **Ward**……..	Attach Patient Label Here Name:…… Address:…… …… Hospital Number…… Date of Birth……

Physiotherapy			**Date**	
General Condition				
Mobility	**Independent**	**Supervision**	**Assistance of 1**	**Assistance of 2**
Out of bed				
Into bed				
Sit				
Stand				
Gait			Assistance with 1	Assistance with 2
Walking Aid: Zimmer Frame □ Sticks □ Elbow Crutches □ Other walking aid □				
Stairs				
Distance				
Re-education board exercises Hip Flexion AROM _____° Hip abduction AROM _____°				
Standing exercises Hip Flexion AROM _____Hip abduction AROM_____ Hip extension AROM_____				
Explanation of safety factors Yes / No				
If no state reasons				
Comments & Plan:				
Referred for OPPT Yes / No				
Signature & print Time			Signature & print Time	

Write & Check for Variance page 38

Occupational Therapy (OT's will not visit patient every day)

Occupational Therapy	**Yes**	**No**	**Unsure**
Pre-operative questionnaire reviewed			
Outstanding equipment needs			
Care package needed			
Dressing assessment carried out			
Need for OT home assessment			
Comments			
Signature, print & time			

Write & Check for Variance page 38

VARIANCE				
Date and time	Variance	Action taken	Result of action taken	Sign.

Shared Discharge Planning = Nursing Staff/OT/Physio

Integrated Care Pathway
Total Hip Replacement

Consultant_____

Ward……..

Attach Patient Label Here

Name:……

Address:……

……

Hospital Number……..

Date of Birth……

	Yes	No	N/A					
Planned discharge Date								
Multi Disciplinary Team consent for discharge				Nursing		Medical		Please initial
				OT		Physio		
Residential home notified								
Nursing home notified								
Discussed with patient								
NOK / Contact informed								
Transport arranged(medical need only)								
Own								
Stretcher								
Chair								
Property returned								
District nurse arranged								
Home care arranged								
Social Work dept aware								
TTO's prescribed								
TTO's obtained								
Blister pack ready								
Medication card written								
Dalteparin Instruction sheet if appropriate								
Sharps bin (if appropriate)								
Dressing pack ready								
Joint replacement card								
Patient information given								
Physiotherapy referral				Details:				
Physiotherapist signature								
OT equipment				Details:				
OT equipment Delivery Date:								
Occupational Therapist signature								
Out patient appointment made								
GP's letter								
Signature of Nurse responsible for discharge								
Print name				Date and time				