



ORTHOSCOPE

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Celebrating Orthopaedic Nurse Participation!



"No Nurse Left Behind"

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Orthopaedic Post Acute: The Post Operative-Pathway to Rehabilitation

By Kimberly Stewart, RN ONC(C)

Consider a petite elderly woman with white, curly hair, kind blue eyes and a face creased with years of life experience. Imagine her quietly resting in a hospital bed after receiving orthopaedic surgery on her left knee, knowing she has to recover in order to function on her own in her one-bedroom apartment. How can she successfully make the transition from hospital to home?

In the Edmonton area, patients undergoing orthopaedic surgery or experiencing bone and muscle impairments can receive additional rehabilitation through CapitalCare's Orthopaedic Post-Acute Programs to regain strength and functionality before returning home. Program criteria provide guidance for determining a patient's timely transfer as early as their third post-operative day.

Patients are welcomed into a home-like environment at CapitalCare Grandview – a continuing care centre providing person-centred care for 135 residents who live at the centre year-round, as well as up to 1,000 orthopaedic patients who flow through the Post-



Acute Unit's 45 spaces.

Patients are immediately assessed by a team of nurses, physical and occupational therapists. Recovery plans are developed for each patient based on one of four sub-programs:

1. **Elective Arthroplasty Program:** The client is pre-assessed at the Edmonton Musculoskeletal Centre, and undergoes screening, an educational session and an examination for planned surgery. This may be completed for a current total hip replacement, revision of a previous total hip replacement, total knee replacement or revision of a total knee replacement. Length of stay is up to

six days.

2. **Fractured Hip Program:** The client has experienced a fracture of the femur that is at the trochanter or proximal to the trochanter. Injuries may be treated conservatively or repaired surgically. Hardware used can include Austin Moore (hemiarthroplasty), IM nail or locking IM nail, dynamic hip screw, cannulated screws or a combination of these items. Length of stay is up to 14 days.
3. **Orthopaedic Trauma Program:** The client experiences a fracture involving the femoral shaft or any other skeletal bones, which may be treated conservatively or surgically. Length of stay is 21 to 28 days.
4. **Restorative Care Program:** The client possesses an injury that demands a longer recovery phase that cannot be managed at home with homecare. Length of stay is up to 28 days.

A day in the life of an accelerated rehabilitation patient in the Orthopaedic Post-Acute Unit is dedicated to goal-oriented recuperation according to the care pathways developed by Alberta Bone and Joint Health Institute and Alberta

Feature Article Continued

Health Services. Patients are encouraged to wash and dress themselves independently, or with minimal aid, and wear everyday clothing. They walk to one of two dining rooms for each meal with gradually reduced assistance, eventually making three round trips per day.

All arthroplasty and fractured hip patients participate in two 45-minute physiotherapy sessions seven days a week; arthroplasty knee patients complete a third set of exercises for flexion and extension. Program reference booklets provide each patient with guidance throughout their recovery period. Whiteboards are also positioned across from each pa-

tient's bed; they display personal information relating to their restoration plan, such as their discharge date, weight-bearing status and appointment dates.

Caregivers further assist patients to become more independent by sharing fall-prevention strategies and post-operative, anti-coagulation self administration in preparation for discharge.

Discharge dates are set on the day of admission and based on the expected length of stay. The projected discharge date is monitored and, in rare instances, adjusted as necessary to coincide with medical, nursing and rehabilitation management, including the completion of discharge criteria. The criteria patients must demonstrate

prior to being discharged home include independence with bed mobility, dressing and undressing, standing at the bedside, toilet management and walking with a two-wheeled walker (or with assistance as per their pre-injury environment). The ultimate goal of the Orthopaedic Post-Acute Program is to enable patients to manage safely at home and help prevent hospital re-admission. Supporting and rehabilitating patients in a home-like environment leaves them feeling more physically conditioned and emotionally confident in their ability to cope at home.

The difference in quality of life is easily recognizable when patients find the appropriate post-operative pathway to rehabilitation with CapitalCare.

ABOUT THE AUTHOR

Kimberly Stewart received her Nursing education in Ottawa, Ontario, graduating in 1981. She was hired into Orthopaedics at the University of Alberta Hospital, in Edmonton in the fall of the same year. She quickly fell in love with Orthopaedic Nursing under the mentorship of many skilled Ortho Nurses. Her unit eventually moved to the current Walter C. McKenzie Health Sciences Centre. In the mid-eighties, she became involved in the Canadian Orthopaedic Nurses Assoc., Edmonton Chapter. She is on the Executive of this very busy chapter, hosting education seminar days semi-annually and being involved in many local activities. Kimberly states that achieving her CNA certification in Orthopaedics has been a validating experience for many years in this specialty. In recent years, she has been the Orthopaedic Post Acute Admissions Coordinator at CapitalCare Grandview. Kimberly enjoys spending many hours with her camera, photographing nature. She proudly shares that her greatest pleasure is being the mother to four children (now, young adults).



Criteria – All Programs

- Over 18 yrs of age
- Unable to function safely at home
- Requires more care or rehab than can reasonably be provided by Home Care
- Must be “medically stable”—e.g. may require routine treatment but not expected to deteriorate to a more acute level of illness;
Resolved delirium
 - ◇ Does not require more than daily lab work & labs are with normal ranges or at least at patients pre-hosp. baseline
 - ◇ Is not on intravenous antibiotics that require lab monitoring (ie-Vanco, Gent, Tobra-all aminoglycoside IV antibiotics)
 - ◇ Does not require O2 greater than 6 litres/min
 - ◇ Psychiatric conditions are stable
 - ◇ Has a PICC inserted prior to transfer if requiring IV antibiotic therapy greater than seven days
- Must be motivated and able to actively participate in all treatments
- Patient can understand, retain and follow through on instructions relating to **short term** goals
- Is able to transfer with 1-2 person assist & ambulate greater than 1 meter
- Is not disruptive and will not put others or self at risk
- Functionally ambulatory with or without gait aides in the pre-injury environment
- Must be able to manage pre-existing medical conditions that require self-care eg-CPAP, BIPAP, colostomy, self-catheterizations)
- Has a residence to be discharged to
- Has transportation home & understands associated costs are their responsibility
- Will be discharged when identified goals/criteria for discharge have been met
- Has an Orthopedic consultant identified & appt. booked for F/U, includes any additional off-service consult F/U appointments (e.g. swallowing issues/asses, etc.)

Rehab beds/equip rated for Max. 159 kg**

- Bariatric Referrals subject to appropriate equipment availability

Admission Criteria—Accelerated Rehab—Hip Fracture

- Walking to Dining room for all 3 meals (round trip)
- Physiotherapy sessions twice daily (30-45 minutes per session)
- Anticipate resumption of ADL’s per previous supports received
- Does not require Argo, Medi-Lift, or sit to stand for transfers
- Anticipated discharge 7-14 days from admission

Admission Criteria—Restorative Care (RCU)

- If pt is deemed as having rehab potential, RCU should be considered prior to being assessed for a higher level of care.
- Up to Dining room for all 3 meals (walking as appropriate to diagnosis)
- 1-2 P.T. sessions/day
- ADL’s as per previous supports received
- Discharge goal of 14-28 days
- Has O2 requirement preventing participation at the accelerated level (reduced activity/exercise tolerance)
- Dementia/cog. impaired pts- MMSE/MoCA scores of at least 15/30
- Transfers with the possibility, initially, of requiring a lift apparatus, and progressing to independence (with the pre-requisite motivation to participate in rehab and the desire to go home).
- # Hips with order for NWB > 2 weeks.



Feature Article Continued

Fractured Hip Post Acute Program Patient Information

The Fractured Hip Post Acute program provides rehabilitation services to patients after surgery for hip fractures. Our goal is to offer the best care and therapy to allow your discharge home to occur as quickly and safely as possible.

You will need to bring the following for your stay:

- Personal hygiene items (including incontinence products if you use these)
 - Comfortable clothes and proper footwear (rubber sole with a closed in heel)
 - Equipment you may have at home that will benefit your recovery (such as a reacher, sock-aide, shoe horn, walker).
- You and your family are part of the team that may include nursing staff, physicians, therapists, dietary, social work and pharmacy.

Expectations of Patient and Family:

- Your participation is expected and is important for successful discharge.
- You will be expected to follow physician orders to reduce complications and health risks.
- You will be expected to work to improve level of function by :
 - ◇ participating in rehab therapy two to three times per day
 - ◇ by taking part in 'day-to-day' activities such as washing, dressing
 - ◇ And walking to the dining room for all meals.
- You are responsible for arranging assistance at home, as well as ensuring equipment is in place by discharge.
- You are responsible for arranging a follow up appointment with your family doctor and surgeon at the time of discharge (if one has not been arranged already).
- You are responsible for arranging a ride home on your scheduled day of discharge.

Discharge time is ten o'clock in the morning

Our goal is for you to be discharged home within fourteen days or less and will be based on a number of safety factors that are individually assessed and may include:

- Ability to reposition, get into and out of bed safely.
- Ability to walk safely with appropriate gait aide.
- Ability to use the necessary equipment
- Able to manage stairs safely if necessary.
- Able to follow through with exercise program.
- Ability to get in and out of a car with minimal assistance.
- Appropriate assistance and support are available at home (if required) for all of the above needs (may include family/friend support, home care, community agencies, etc.)

Please provide the address where you will be discharged following your stay in Post Acute.

Address: _____

Please print and sign your name indicating that you have read the above and understand what is required. If you have any questions please discuss with the nurse prior to leaving the hospital.

Name: _____ Relationship (if not client) _____

Signature: _____ Date: _____

Original to Grandview

Copy to Patient/Family

Copy on Chart



Arthroplasty Post Acute Program Patient Information

The Arthroplasty Post Acute program provides rehabilitation services to patients after surgery for Joint Replacements / Revisions. Our goal is to offer the best care and therapy to allow your discharge home to occur as quickly and safely as possible.

You will need to bring the following for your stay:

- Personal hygiene items (including incontinence products if you use these)
- Comfortable clothes and proper footwear (rubber sole with closed in heel)
- Equipment you may have at home that will benefit your recovery (such as a reacher, sock-aide, shoe horn, walker).

You and your family are part of the team that may include nursing staff, physicians, rehabilitation therapists, dietary, social work and pharmacy.

Expectations of Patient and Family:

- Your participation is expected and is important for successful discharge.
- You will be expected to follow physician orders to reduce complications and health risks.
- You will be expected to work to improve level of function by :
 - ◇ participating in rehab therapy two to three times per day
 - ◇ by taking part in 'day-to-day' activities such as washing, dressing
 - ◇ And walking to the dining room for all meals.
 - ◇ You are responsible for arranging assistance at home, as well as ensuring equipment is in place by discharge.
 - ◇ You are responsible for arranging a follow up appointment with your family doctor and surgeon at the time of discharge (if one has not been arranged already).
 - ◇ You are responsible for arranging a ride home on your scheduled day of discharge.

Discharge time is one o'clock in the afternoon

Our goal is for you to be discharged home within six days or less and will be based on a number of safety factors that are individually assessed and may include:

- Ability to reposition, get into and out of bed safely.
- Ability to walk safely with appropriate gait aide.
- Ability to use the necessary equipment
- Able to manage stairs safely if necessary.
- Able to follow through with exercise program.
- Ability to get in and out of a car with minimal assistance.
- Appropriate assistance and support are available at home (if required) for all of the above needs (may include family/friend support, home care, community agencies, etc.)

Please provide the address where you will be discharged following your stay in Post Acute.

Address: _____

Please print and sign your name indicating that you have read the above and understand what is required. If you have any questions please discuss with the nurse prior to leaving the hospital.

Name: _____ Relationship (if not patient) _____

Signature: _____ Date: _____

Original to Grandview Copy to Patient/Family Copy on Chart