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June 3, 2013

Ms. Catherine Winckler
718 Millyard Street
Vancouver, BC V5Z 4A1

Dear Ms. Winckler:

I am pleased to write again in response your letter of April 12, 2013 directed to Fraser Health Board Chair David Mitchell in which you requested an update on the status of actions taken by Fraser Health to address your family's questions and the recommendations arising from the Coroner's Inquest into your mother's passing while in care at Chilliwack General Hospital (CGH) in March 2000.

Since 2008 Fraser Health has been organized under a Program Management model. This means that all the services and programs offered at individual sites such as CGH are managed Fraser Health-wide. This ensures coordination and continuity as patients transition from one phase of care and/or location to another. Improvements made by the clinical programs are implemented at all the sites where care is delivered, allowing for standardization of leading practices across Fraser Health.

In the past few years, as Program Management has become well-established in Fraser Health, many changes have been made in the way care is communicated, delivered, and documented. Great strides have been made in improving patient safety, with particular attention paid to areas highlighted by Accreditation Canada such as medication reconciliation, the use of surgical safety checklists, care transition management, teamwork and communication, and culture. Central to all of this is partnerships between patients and their families and the health care team. Our Patient Advisory Council has been functioning for two years and has a very active role (supported by our Board and Executive team) in building a focus on partnership. We are redesigning care through a "Seamless Care" strategy, which has at its center the patients and families as our partners, and focuses on making the experience of our care and services as safe, effective and efficient as possible.

Fraser Health's initial responses to your family in 2003 are cited below in bold, followed by an update including examples of activities undertaken since that time across Fraser Health.

1. **"A chart audit tool has been developed to assist in the evaluation of documentation and in the identification of gaps in patient information. The**

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results of this evaluation will be used to make improvements in the documentation system as required."

Since the implementation of the Program Management model in 2009/10, teams have been supported to standardize their documentation, and work is underway to standardize forms that will be used with electronic health records in hospitals. A Documentation Policy was implemented in March 2013, and profession-specific documentation requirements are being developed with a target completion date of March 2014. A review of handover processes has been completed, and processes and tools have been developed to support these care transitions. Work is also taking place to standardize documentation requirements with a focus on patient outcome goals. This includes standardization of the 24-Hour Patient Care Record, Admission Assessment and Interdisciplinary Care Plan.

2. **"Medical Rounds will review the Winckler case in 2002/03 for educational purposes. The Family Practice Residency Program has already reviewed the case from an educational perspective."**

A number of educational initiatives have taken place at CGH over the years. These include numerous lectures to family practice residents, internists and family practitioners on the topics of pain, falls, and medications in the elderly.

The Medicine program has recruited a geriatrician for CGH. The geriatrician has worked with the seniors' clinic, which has resulted in improved quality of care for the elderly population.

Educational rounds, lectures and papers have included dementia protocol.

The 48/6 model of care for hospitalized seniors is to be implemented by the autumn of 2013. This is a Ministry of Health initiative that addresses six key care areas of functioning through patient screening and assessment as well as the development of a personalized care plan within 48 hours of the decision to admit a patient. The six functions critical for good patient-centered care for all hospitalized adults are bowel and bladder management, cognitive function, function mobility, nutritional hydration, medication management and pain management.

Health care practitioners are receiving education regarding the new 2012 Beers Criteria for potentially inappropriate medication use in older adults. The Beers Criteria have done more than any other tool in the past decade to improve the awareness of and clinical outcomes for older adults using multiple medications, and for the most vulnerable older adults at risk of adverse drug events. The new Criteria includes updated research on various drugs, new information about appropriate prescribing of medications for an expanded list of common geriatric conditions, and ratings of the quality of evidence supporting the panel's recommendations.

References:

American Geriatrics Society 2012 Beers Criteria Update Expert Panel (2012). American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults, Journal of American Society, 60(4):616-631. Beers list can be retrieved from www.americangeriatrics.org on May 17, 2013.

3. **"A program that will focus specifically on the care of the elderly or geriatric patient in the CGH acute care units is being developed. To support this program, best practices have been identified and Marcia Carr, Clinical Nurse Specialist and a Practice Consultant from RNABC have contributed expertise to the program components which include: Falls Management/Least Restraint, Pain Management, Incontinence, - Nutrition/Bowel, Management of Challenging Behaviors, and Transfer of Care between Units."**

   A Least Restraint Clinical Practice Guideline (CPG) was developed and implemented within a year of your mother's passing. This CPG is now standard practice. The Fraser Health Clinical Policy Office also supported the development of these policies and clinical decision support tools to be applied at CGH and across Fraser Health.

   The Least Restraint CPG is currently being further revised to support staff to make appropriate care decisions related to alternative strategies to restraint use except in situations where all other efforts have failed. This guideline applies to all Fraser Health clinical programs, and is supported by new documentation and monitoring tools, and a behavior observation record to track and trend patient behavior changes over time so that risks associated with these changes can be effectively mitigated.

4. **"Clinical practice guidelines for the use of restraints are currently at the final approval stage and will be ultimately implemented throughout the Fraser Health Authority."**

   A Least Restraint Policy and related approved equipment have been established and standardized. This has been implemented across Fraser Health. Please see #3 above.

5. **"Jocelyn Reimer-Kent, Clinical Nurse Specialist (Pain Management), agreed to assist with the development of evidence-based guidelines and education for pain management. Staff education session on Pain Theory and Guidelines for Pain Management will be completed by October, 2002 and will be an ongoing topic for staff education."**

   Jocelyn presented to the nursing staff on a Rapid Surgical Recovery (RSR) approach as part of the Reimer-Kent Postoperative Wellness Model. The model addresses the provision of preventive-based care around the issues of pain, nausea, constipation, immobility and respiratory compromise. There was interest in adopting this model as the standard of care for all surgical patients at CGH and other sites in recognition of its potential for improving care outcomes. There is an opportunity to spread this model across Fraser Health under the Program Management model of care delivery.

   For more information on RSR, please see article at http://www.cccn.ca/media.php?mid=241] or FH research website for resource manual http://researchdb.fraserhealth.ca/ersweb/Document.aspx?Id=189

6. **"Professional Practice Councils will be established at each hospital site, including CGH. Terms of Reference have been drafted for these Councils and the inaugural meeting at GCH is scheduled for September 30, 2002 and monthly thereafter. The purpose of this multi-disciplinary council will be to facilitate excellence in**

the provision of patient and family centered clinical services and organizational system support. This body can address practice issues such as documentation, pain management and reporting."

As part of the transition to Program Management in 2009/2010, site-based practice councils were dissolved in favor of inter-professional program-based councils. These councils allow for clinical sharing and problem solving, and provide clinical resources and support that focus on client-centered care and outcomes. In addition, much work has taken place since 2004 to establish regional profession-specific councils that focus on advancing practice and improving outcomes for patients, residents and clients.

7. **"Where transfers are appropriate, our policy for some time has been that the individual receiving nurse is to conduct an assessment. Staff education will be provided on an ongoing basis."**

   Staff education related to receiving nurse assessment is an ongoing responsibility of the Unit Manager, Patient Care Coordinator and Clinical Nurse Educator. There is a significant emphasis within care delivery redesign initiatives on patient assessment upon transfer to ensure that concerns are identified and addressed in a timely and effective manner.

8. **"A review of current transfer and discharge practices is underway with a goal to ensure that patients are transferred to the appropriate care areas with information that will best meet the patient's need. An examination of the communication of patient care information between units is ongoing - one tangible result is a card of patient's information that accompanies the patient to his/her new ward. Care paths will further promote continuity of care through ongoing assessment and inter-disciplinary communication, with special focus on variations in the processes and outcomes of case and treatment."**

   Baseline audits of care and discharge planning were coordinated during 2012. A discharge planning process was implemented across the Medicine program, as were as standardized care pathways, which are being spread across programs where applicable. Regular audits are done within the Medicine program to identify opportunities for continuous improvement. A care plan template is being developed and a final document will be ready for pilot and implementation during summer 2013. Review of the transfer process has led to development of tools that will be incorporated into standards for care delivery under Fraser Health's Seamless Care strategy.

9. **"As noted in Recommendation 2, a Care Path that specifically addresses the care needs of the elderly or geriatric patient will be implemented in October 2002. The Care path includes the components of restraint use, pain management, sedation and the effects of analgesics on the elderly. An education program for staff to address the same needs will also begin in October and will be ongoing."**

   Due to the complexity of this patient population, there is no individual Care Path that integrates all aspects of acute care of the elderly patient. However, the Acute Care Geriatric Nurse Network (ACGNN) and Geriatric Emergency Network Initiative (GENI) have made great strides in leading improved care of older adults. The Ministry of Health's Seniors' Hospital Care Working Group has established practice standards to ensure evidence-based,

safe care for older adults in acute care. These standards are specifically related to an initiative entitled 48/6, described in #2 above. A 48/6 Steering Committee, Tools Standardization Working Group, and Implementation Committee have been organized to implement these improvements Fraser Health-wide. At this point, the work is focused on development of a Pre-Admission Screening Questionnaire, Admission Assessment, 24-Hour Patient Care Record, and an Interdisciplinary Care Plan. These tools will apply to patient care across clinical programs.

10. **"A number of CarePaths have been revised. As well, we have integrated care paths into individual patient records more effectively and made them a key document for accountability. There are three aspects to these CarePaths: expectations (e.g. degree of recovery to be expected on a given day of a particular illness or condition), addressing variations, end accountability for patient outcomes."**

    The Fraser Health Surgery program has developed care paths for orthopedic surgeries that identify both risks for problems as well as early identification of a problem. *See attached Total Hip/Knee Replacement Care Path.*

11. **"The revised CarePaths include a variance-tracking tool that capture deviation from expected recovery, specific actions required, and who is responsible for carrying out these actions."**

    Please see #10 above.

12. **"Across the Fraser Health Authority, we are looking at patient alert devices to help deal with such issues as wandering, unsafe bed/chair exits."**

    Patient alert devices have been implemented. New beds are being purchased have a built-in bed exit alarm. Other examples include the Wander Guard, which is in place in a number of sites, including CGH.

13. **"The recommendation was reviewed with a decision to not change the consent process (consent is a process as opposed to simply a form). The issue was determined to be one of process and communication between professionals. It was noted that while the issue should remain at a local or health area, work is underway (Fall 2002) to develop one policy and process (for the FHA)."**

    In September 2011 Fraser Health implemented a new Consent for Health Care Policy to guide physicians and staff in obtaining informed consent for health care in accordance with legislative requirements and professional practice standards. The policy aims to protect the rights of individuals and promote their full participation in making informed decisions with respect to care and treatment options by ensuring a consistent approach to the consent process across Fraser Health. This includes the requirement for health care providers to document consent discussions and treatment decisions in the health record.

14. **"A Practice Consultant from RNABC participates as an ad-hoc member of the Project team to provide expertise on standards of practice and professional**

responsibility. In addition, RNABC has assisted in the development of a new program that focuses on the care of the elderly patient in acute care."

The ACGNN and GENI were funded by the Ministry of Health Nursing Directorate for five years. This funding is no longer available. However, Clinical Nurse Specialists continue to collaborate on a voluntary basis to ensure an ongoing focus on the care of acutely ill older adults throughout the province. *(www.acgnn.ca)*

15. **"Dr. Dave Williams, chair of the former Medical Quality improvement Committee of the Fraser Valley Health Region, has sent a letter to the College requesting information regarding what action the College plans to take regarding this recommendation. To date a response from the College has not been received. (Recommendation: That the College or Physicians and Surgeons review this case for educational purposes deemed appropriate)."**

The College of Physicians and Surgeons of BC has performed a number of activities over the years involving education to family practitioners. The College has hosted various courses: narcotic use in chronic nonmalignant pain, medical record keeping for physicians, prescribing for patients with chronic pain, ethics and professionalism, and methodne workshops. The College also hosts a yearly education day. This has occurred over the last ten years. As well, the College website has numerous links to other educational organizations as well as professional standards and guidelines. Through the College website family physicians have access to an extensive library that includes Best Practice for up-to-date information for diagnosis as well as access to over sixty medical e-books, evidence-based Canadian drug and therapeutic information, and expert reviews of current diagnoses and treatments in North American clinics.
(www.cpsbc.ca)

16. **"As one of the initial steps in strengthening patient advocacy in the FHA, Bob Smith, CEO of the FHA, Cathy Weir, Director of Quality Improvement, Risk Management, and Helen Carkner, Director of Communications have met to discuss an FHA approach to customer service ensuring access to information, and opportunities for patients, clients and families to provide feedback and have their concerns addressed. (in Fall 2002). This strategy will be implemented in a timely and effective manner. A component of this will be to provide information brochures to patients and their families."**

The amalgamation of the three former Health Regions (Fraser Valley, South Fraser and Simon Fraser) into Fraser Health included the coordination of mechanisms for patients, clients, residents and their families across all our communities to seek information and provide feedback on their experience and ideas for improvement. A Client Relations team established in 2005 plays a key role in assisting individuals by ensuring their questions and concerns are addressed by the most appropriate clinical or support areas. Online access to information and support is also available via the Fraser Health website (feedback@fraserhealth.ca). In October 2008, legislation was enacted in BC entitled the Patient Care Quality Review Board Act. This legislation, along with Ministry of Health Directives, formalized and standardized the process for members of the public to request information, provide feedback and seek resolution to concerns related to quality of care. A Patient Care Quality Office was established in each health authority, replacing the former

Client Relations structure. An independent Patient Care Quality Review Board was also established to investigate concerns not addressed to the complainant's satisfaction by the health authority. Fraser Health's Patient Care Quality Office is responsible for coordinating follow up of requests for information and complaints from Fraser Health patients, residents and clients. The Patient Care Quality Office can be contacted via telephone, e-mail or in person, with information provided via the Ministry of Health, Fraser Health's public website, and brochures available within sites across the organization.

Significant effort is underway on an ongoing basis to engage patients and families in care planning and system improvement. In April, 2011 a Patient Advisory Council was established to provide guidance and stewardship of Fraser Health's focus on building and strengthening patient/provider partnerships. The Patient Advisory Council's vision is "*We are all in this together*" – in essence promoting shared ownership for creating health care excellence. Patient Advisors are involved in a number of high-priority initiatives, such as the 'Seamless Care" strategy, designed to coordinate and improve the patient's journey across the continuum of care, a "Patient Safety Briefings" initiative, designed to engage patients in promoting a safe experience while in care and sharing their improvement ideas, and the development of patient education materials. The Patient Advisory Council has developed an annual work plan that is focused on building capacity for patient engagement and partnership at the clinical program level to ensure the patient's experience is at the centre of all improvement activities.

17. **"The Fraser Health Authority is working to establish a Hospitalist Program at all acute sites in the region. A hospitalist is a physician who is contracted by the hospital to act not only as a provider of care, but as a coordinator of care throughout the patient's stay. They work with the patient, family, nursing staff and specialists, providing timely, efficient and effective care. With hospitalists on site, physician response time for assessing the patient and beginning diagnostic work-up is significantly reduced. The availability allows for timely reevaluation of the patient as well as greater communication between the hospitalist and other professional care providers resulting in improved continuity of care for each patient. At CGH, participants in the hospital's residency program will link with the hospitalists."**

In 2002 the Hospitalist service was just getting underway in Fraser Health. It has since evolved at a number of acute care sites to assume the role of the Most Responsible Physician for in-hospital medical care. Other sites, including CGH, have retained the family practitioner model with the support of Ministry of Health funding to enhance the family practitioner's presence in the hospital setting (e.g., daily rounds, phone consultations). This model promotes coordination and continuity of care for patients by their own family physicians throughout their hospital stay and as they transition between hospital and the community.

18. **"The FHA is working hard to build a patient-focused culture across the organization by supporting our front-line care providers. One tangible example of this is the new role of the Patient Care Coordinators who provide nursing staff with on-site clinical leadership. We have developed a policy and protocol for interdisciplinary working relationships to identify and resolve communication issues, and are holding educational sessions about this policy."**

Fraser Health's Professional Practice and Integration team continues to promote the critical role of a healthy practice environment in the provision of quality care. The elements of healthy practice environments focus on shared purpose, dialogue, relationships, scope of practice, competency, hand-offs, evidence based practice and integrated documentation. This is built into the practice council network orientation for all staff and should be the platform for interprofessional practice discussions. The Patient Care Coordinator job description and role competencies have been standardized across acute care; orientation and education have been developed and implemented to support this role. Ongoing feedback from Patient Care Coordinators, Managers and Site Leaders is continuing to inform the development of this education. Work is also underway to standardize the role and supports for Managers and Site Leaders.

19. **"Under the direction of Dr. Robert Halpenny, we are working to standardize advance directives and DNR policy and procedures across the Fraser Health Authority, which meets best practices in the industry. A significant component of the process will be based on communication between health care providers, patients and families. It is anticipated that the initiative will be completed in 2003. The importance of clear, readily understood information for families, and for education and monitoring, will be a strong focus of this work."**

Over the past ten years Fraser Health has championed the development, implementation, evaluation and dissemination of various activities related to Advance Care Planning (ACP) and Do Not Resuscitate (DNR) including:

- Formation of an ACP Steering Committee (2004)
- Staff training and education (2005) by Respecting Choices© faculty from the Institute of Health Improvement best practice initiative.
- Implementation of the Fraser Health regional DNR for all acute sites (2005). The new DNR form includes documentation regarding the process by which the decision has been made (who the physician has spoken with) and the scope of treatment (comfort or medical therapy including or excluding critical care). Fraser Health also implemented a standardized communication system to promote clear communication on the patient's health record regarding treatment options to alert health care providers in the event of respiratory and/or cardiac arrest and ensure their response aligns with the patient's expressed wishes.
- Development of a number of tools and resources that are available to health care professionals/providers as well as the public in several languages on the Fraser Health website. (http://www.fraserhealth.ca/your_care/planning_for_your_care/): My Voice Workbook©; Making Informed Decisions About CPR brochure; Information Booklet about ACP; Planning in Advance for Your Future Healthcare Choices (e-book); Information DVDs; and posters. There is also a toll- free telephone number (1-877-TALK-034), public email address (advancecareplanning@fraserhealth.ca), and ongoing education for health care professionals. To date, more than 2000 health care professionals have attended Advance Care Planning education. Information about advance care planning is also provided in the regional on-line staff orientation sessions as well as at the program/site level.
- Launch of the "Making the MOST of Conversations" strategic initiative across all clinical programs to engage patients and their families in conversations to improve decision-making and advance care planning (2010). In October 2012 a new policy and form

(Medical Orders for Scope of Treatment or MOST form) were implemented that combined and replaced the Levels of Intervention form from residential care and the acute care DNR. Fraser Health continues to work on tools and resources to help care providers initiate and track advance care planning conversations and translate them into a clear plan of care and medical orders in collaboration with patients and their families. This work has been recognized by a BC Patient Safety and Quality Council Award for Excellence in Quality and Patient Safety in the category of *Coping with End of Life* (2010).

20. **"It is our responsibility to provide safe levels of staffing. The involvement of family is welcomed. Our least restraint policy and falls prevention strategy, to be implemented across FHA, both highlight the need to inform and involve family. New, soft cloth magnetic restraints, now in use, allow for greater patient mobility when restraints are indicated."**

    Approved restraints are identified in the Least Restraint Policy, and only these are authorized to be used. Please see #3 above.

21. **"This is an area where we recognize the need to continue working, if we are to make family involvement part of the culture, and of our expectations of nursing leadership."**

    Fraser Health participates in the provincial Patients as Partners committee and on the Board of the Patient Voices Network to ensure patients and families voices are heard, valued and acted on. The Fraser Health Patient Advisory Committee is recognized by the Fraser Health Board, Executive and clinical programs for its role in working with clinical and administrative leaders to bring the patient's perspective to all priority improvement initiatives.

22. **"This underlies the importance of assessment, e.g. monitoring intake of fluids and food. We are continuing to work on this area and seeking significant improvements as our Food and Nutrition Services leadership works closely with clinical staff."**

    48/6 (see #9 above) is a provincial mandate which includes Nutrition/Hydration as a functional area.

Fraser Health is committed to providing safe, quality health care and service, and I very much appreciate your ongoing efforts to work with the health care system to improve care for the elderly. It is uncommon for a family such as yours who has been so negatively impacted by their loved one's care experience to be as willing to share their experience for the purpose of learning and improvement. Esther's Voice continues to generate conversations within our leadership about the importance of keeping the patient and family at the centre of everything we do. Your recent letter serves as a yet another important reminder to our leadership that we must be relentless in our pursuit of improving the quality and safety of care for the elderly.

We trust the responses above are helpful in resolving your concerns, and invite you to direct any further questions or concerns you may have regarding this update to Ms. Cathy Weir, Director, Quality Improvement and Patient Safety.

Sincerely,

Dr. Nigel Murray
President and Chief Executive Officer

NJM/tls

Cc: David Mitchell, Chair, Board of Directors
Dr. Andrew Webb, Vice President, Medicine
Cathy Weir, Director, Quality Improvement and Patient Safety

Encl.

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TOTAL HIP/ KNEE REPLACEMENT CAREPATH
Day 0 - Operative Day-After Surgery
Regional Surgical Program

Date: _____ Time arrived from Recovery Room: _____
Procedure ☐ Right ☐ Left ☐ Hip ☐ Knee
☐ Revision ☐ Resurfacing ☐ Other:

D/E/N: Initial beside N/E: Not evaluated
FC: Focus Chart N/A: Not applicable
If ☐ appears before item, check if it applies to this patient

CARDIOVASCULAR

Time	220-	210-	200-	190-	180-	170-	160-	150-	140-	130-	120-	110-	100-	90-	80-	70-	60-	50-	40-	30-
Blood Pressure ▼▲ Pulse •																				
Temperature																				
Resps																				

RESPIRATORY

O_2 Sats	
Oxygen (lpm/fiO_2)	
Sedation Scale	
Initial	

Sedation scale ***0** Alert **1** occ. drowsy **2** freq drowsy **3** somnolent (falls asleep during contact) **4** severe/non-responsive*

Assess vital signs and sedation scale on admission, q1h x 1, then q4h x 24 hrs and PRN

☐ **EPIMORPHINE** bolus given _____ at hrs. Resps & sedation scale q1h X 24 hrs until _____ hrs

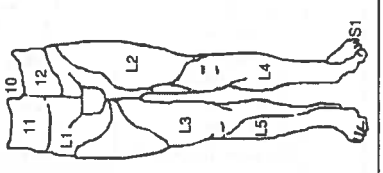
Deep breathing and coughing q1h while awake

Motor Block:
0 = None 1= Partial
2 = Almost complete
3 = Complete

Vital signs within patient's normal limits D____ E____ N____
Safety check complete: Emerg & patient specific D____ E____ N____
Clear breath sounds by auscultation D____ E____ N____
O_2 Sat ≥ 93% or as specified by MD D____ E____ N____

PAIN

Pain Scale	Time																								
Pain Scale (0-10)	At Rest																								
	Movement																								
Motor Block																									
Dermatone Level (ice)																									
Initial																									



Document chronic pain history/ treatment. Assess pain scale on admission, q1h x 1, then 4h. If poor pain control, initiate pain flowsheet.

Pain rating 3/10 (2/5) or below, and/or non verbal behaviors acceptable level D____ E____ N____

TOTAL HIP/KNEE REPLACEMENT CAREPATH
Day 0 - Operative Day-After Surgery Cont'd
Regional Surgical Program

CARE FOCUS	OUTCOMES in Bold

DELIRIUM

Screen for Delirium using CAMI at 1600, and PRN (Check boxes that apply)
Delirious if both 1 and 2 and either 3 or 4 checked

1. Acute onset and fluctuating course ☐	3. Disorganized thinking ☐
2. Inattention ☐	4. Altered level of consciousness ☐

Screen for, and address potential causes of delirium using PRISM - E (pain, retention, restraint, infection, impaction, sensory, meds, alcohol, metabolic-hypoxia, malnutrition, fluids and lytes, environment, hx of dementia)
If delirium present and/or cognitive impairment; Encourage patient family/ care providers to stay

Oriented X 3 (Time, person, place) D____ E____ N____
CAMI negative D____ E____ N____
Family/care provider state that patients cognition is at baseline D____ E____ N____

Slept: ☐ **Well** ☐ **On and Off** ☐ **Poorly** N____

NEUROVASCULAR

Compare unaffected and affected leg

RL - Right Leg
LL - Left Leg

Indicate leg: U = Unaffected ____ A = Affected ____

		U	A	U	A	U	A	U	A	U	A	U	A	U	A
Time															
Cap Refill															
Pulses	Femoral														
	Dorsalis Pedis														
	Posterior Tibial														
Colour															
Temp															
Sensation	Femoral														
	Peroneal														
	Tibial														
Movement	Femoral														
	Peroneal														
	Tibial														
Pain (Y/N)	With passive Motion														
	Progressive Unrelieved														
Initial															
DVT Edema:															
Calf															
Full leg															
Foot															
Pain along vein															
Initial															

SENSATION	MOVEMENT
FEMORAL NERVE  Anterior thigh	 Press knee into bed
PERONEAL NERVE  Web space between great & 2nd toe	 → Dorsiflex ankle & extend toes
TIBIAL NERVE  Medial & lateral sole	 ← Plantar flex ankle & toes

CAPILLARY REFILL
< = < 3 secs
> = > 3 secs

PULSES:
0 = absent
+1 = weak
+2 = moderate
+3 = strong
+4 = bounding
D = pulse by Doppler

COLOUR:
N = normal
P = pale
C = cyanotic
M = mottle

TEMP:
1 = warm
2 = cool
3 = cold
4 = hot

SENSATION-
P = present
A = absent
N = numbness
T = tingling

MOVEMENT
S = strong
M = moderate
W = weak
A = absent

EDEMA:
0 = absent
1 = mild
2 = moderate
3 = severe
4 = pitting

REDNESS CALF/LEG PAIN
Y = Yes
N = No

Neurovascular and DVT checks q1h x 1, then q4h x 24 hours and PRN

Neurovascular within patient's normal limits D____ E____ N____
Edema 2 or less, no calf redness or pain along vein D____ E____ N____

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TOTAL HIP/KNEE REPLACEMENT CAREPATH
Day 0 -Operative Day-After Surgery Cont'd
Regional Surgical Program

FLUID BALANCE / ELI M I NATION

INTAKE D						OUTPUT D				
Start Time	IV Solutions, Amount, Meds Added	Rate	Amount Absorbed	Po/ Gastric	Initial	Time	Urine	Drain/ Blood		Initial
OR/PACU:		Fluid Replacment: _____				Urine: _____		EBL: _____		
						07				
						08				
						09				
						10				
						11				
						12				
						13				
						14				
						15				
						16				
						17				
						18				
						19				
	12 HR					**12 HR**				

Start Time	INTAKE N					OUTPUT N				
						20				
						21				
						22				
						23				
						24				
						01				
						02				
						03				
						04				
						05				
						06				
	12 HR					**12 HR**				

24 HR Total INTAKE: _____ **24 HR Total OUTPUT:** _____

Today's 24 hr Balance: + / - _____

IV Site _____ **satisfactory. D** ____ **E** ____ **N** ____

Maintain CA-UTI Prevention Strategies
If symptomatic for UTI send C&S and notify MRP

Specify reason if foley left in: _____

Foley removed at 0600 N ____

Asymptomatic for UTI D ____ **E** ____ **N** ____

Output > 120 mL / 4 hrs D ____ **E** ____ **N** ____

Last BM Date: _____

ANEMIA

Pre-op Hgb _____

Asymptomatic for anemia D ____ **E** ____ **N** ____

TOTAL HIP/KNEE REPLACEMENT CAREPATH
Day 0 - Operative Day - After Surgery Cont'd
Regional Surgical Program

CARE FOCUS	OUTCOMES in Bold
NUTRITION	Administer anti-emetic regularly if nausea or vomiting. **Tolerating diet.** ☐ **Regular** ☐ **Other** _____ **D** ____ **No nausea or vomiting. D** ____ **E** ____ **N** ____ **Patient states nausea under control with anti-emetic. D** ____ **E** ____ **N** ____
SKIN INTEGRITY	Turn q2h. Reinforce dressing as required. **Dressing dry and intact. D** ____ **E** ____ **N** ____ **Skin integrity maintained. D** ____ **E** ____ **N** ____
MOBILITY	*To be completed by nursing and/or physiotherapy:* ☐ PT Initial Assessment completed **PT** ____ WB Status: ☐ WBAT ☐ PWB ☐ FeWB ☐ NWB Encourage: up to commode / dangle / stand Teach / reinforce with patient: Bilateral foot and ankle exercises q1h while awake. ☐ Hip Precautions ☐ Other Precautions: _____ Bed knee gatch turned off. • lying to sitting _____ assist / sitting to lying _____ assist • sitting to standing _____ assist with walker • ambulation _____ assist _____ aid _____ meters ☐ Mobility impaired by: ☐ Nausea ☐ Vomiting ☐ Dizziness ☐ Pain **D** ____ **N** ____ Added Risk for falls (cognitive impairment) ☐ Yes ☐ No (If yes, Interventions.) ☐**No signs of hip dislocation (sudden, sharp, severe pain, malalignment) D** ____ **E** ____ **N** ____ **Universal fall precautions in place D** ____ **E** ____ **N** ____
DISCHARGE PLANNING	**Expected length of stay reinforced. D** ____ **Verify LMWH coverage form faxed to Ministry of Health (if applicable). D** ____ **Support person available x 48 - 72 hrs post discharge. D** ____

NOTES

TIME	FOCUS	DISCIPLINE	PATIENT CARE PROGRESS RECORD (Data/Action/Response/Plan)

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TOTAL HIP/KNEE REPLACEMENT CAREPATH
Day 0 - Operative Day After Surgery Cont'd
Regional Surgical Program

NOTES

TIME	FOCUS	DISCIPLINE	PATIENT CARE PROGRESS RECORD (Data/Action/Response/Plan)

TOTAL HIP/KNEE REPLACEMENT CAREPATH
Day 0 - Operative Day After Surgery Cont'd
Regional Surgical Program

NOTES

TIME	FOCUS	DISCIPLINE	PATIENT CARE PROGRESS RECORD (Data/Action/Response/Plan)

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TOTAL HIP/ KNEE REPLACEMENT CAREPATH
Day 1
Regional Surgical Program

PWXX102920D Rev: May 11/10

Date: _____

☐ Hip ☐ Knee ☐ Right ☐ Left

D/E/N: Initial beside N/E: Not evaluated FC: Focus Chart N/A: Not applicable
If ☐ appears before item, check if it applies. Consider discharge if all ◆ outcomes met.

CARDIOVASCULAR

Time																			
Blood Pressure ▼▲ Pulse ●	220-																		220
	210-																		210
	200-																		200
	190-																		190
	180-																		180
	170-																		170
	160-																		160
	150-																		150
	140-																		140
	130-																		130
	120-																		120
	110-																		110
	100-																		100
	90-																		90
	80-																		80
	70-																		70
	60-																		60
	50-																		50
	40-																		40
	30-																		30
Temperature																			
Resps																			
O_2 Sats																			
Oxygen (lpm/fiO_2)																			
Sedation Scale																			
Initial																			

Sedation scale ***0** Alert **1** occ. drowsy **2** freq drowsy **3** somnolent (falls asleep during contact) **4** severe/non-responsive*

Assess vital signs and sedation scale q4h and PRN

☐ **EPIMORPHINE** bolus given at _____ hrs. Resps & sedation scale q1h X 24 hrs until _____ hrs

Deep breathing and coughing q1h while awake

Vital signs within patient's normal limits D____ E____ N____
Safety check complete: Emerg & patient specific D____ E____ N____
Clear breath sounds by auscultation D____ E____ N____
O_2 Sat ≥ 93% or as specified by MD D____ E____ N____

PAIN

Pain Scale	Time																		
Pain Scale (0-10)	At rest																		
	Movement																		
	Initial																		

Assess pain scale q4h and PRN. If poor pain control, initiate pain flowsheet.

Tolerating Oral Analgesia D____ E____ N____
Pain rating 3/10 or below, and/or non verbal behaviors acceptable level ◆ D____ E____ N____

Print Shop # 255939

TOTAL HIP/KNEE REPLACEMENT CAREPATH
Day 1 Cont'd
Regional Surgical Program

DELIRIUM

Screen for Delirium using CAMI at 1600, and PRN (Check boxes that apply)
Delirious if **both** 1 and 2 and either 3 or 4 checked

1. Acute onset and fluctuating course ☐	3. Inattention ☐
2. Disorganized thinking ☐	4. Altered level of consciousness ☐

Screen for, and address potential causes of delirium using PRISM - E (pain, retention, restraint, infection, impaction, sensory, meds, alcohol, metabolic-hypoxia, malnutrition, fluids and lytes, environment, hx of dementia)

If delirium present and/or cognitive impairment; Encourage patient / care providers to stay

Oriented X3 (Time, person, place) D____ E____ N____
CAMI negative ◆ D____ E____ N____
Family / care provider state that patients cognition is at baseline ◆ D____ E____ N____

Slept: ☐ Well ☐ On and Off ☐ Poorly N____

NEUROVASCULAR

Compare unaffected and affected leg

RL - Right Leg
LL - Left Leg

Indicate leg: U = Unaffected ____ A = Affected ____

		U	A	U	A	U	A	U	A	U	A	U	A	U	A
Time															
Cap Refill															
Pulses	Dorsalis Pedis														
	Posterior Tibial														
Colour															
Temp															
Sensation	Femoral														
	Peroneal														
	Tibial														
Movement	Femoral														
	Peroneal														
	Tibial														
Pain (Y/N)	With passive Motion														
	Progressive Unrelieved														
Leg Edema															
Redness Calf															
Leg Pain (vein related)															
Initial															

SENSATION	MOVEMENT
FEMORAL NERVE  Anterior thigh	 Press knee into bed
PERONEAL NERVE  Web space between great & 2nd toe	 → Dorsiflex ankle & extend toes
TIBIAL NERVE  Medial & lateral sole	 ← Plantar flex ankle & toes

CAPILLARY REFILL
< = < 3 secs
> = > 3 secs

PULSES:
0 = absent
+1 = weak
+2 = moderate
+3 = strong
+4 = bounding
D = pulse by Doppler

COLOUR:
N = normal
P = pale
C = cyanotic
M = mottle

TEMP:
1 = warm
2 = cool
3 = cold
4 = hot

SENSATION:
P = present
A = absent
N = numbness
T = tingling

MOVEMENT:
S = strong
M = moderate
W = weak
A = absent

EDEMA:
0 = absent
1 = mild
2 = moderate
3 = severe
4 = pitting

REDNESS
CALF/LEG PAIN
Y = Yes
N = No

Neurovascular and DVT checks q4h until bedtime then Qid and PRN

Neurovascular within patient's normal limits ◆ D____ E____ N____
Edema 2 or less, no calf redness or pain along vein ◆ D____ E____ N____

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TOTAL HIP/KNEE REPLACEMENT CAREPATH
Day 1 Cont'd
Regional Surgical Program

FLUID BALANCE / ELIMINATION

INTAKE D						OUTPUT D				
Start Time	IV Solutions, Amount, Meds Added	Rate	Amt Absorb	PO/ Gastric	Initial	Time	Urine	Drain/ Blood		Initial
						07				
						08				
						09				
						10				
						11				
						12				
						13				
						14				
						15				
						16				
						17				
						18				
						19				
	12 HR					12 HR				
Start Time	INTAKE N					OUTPUT N				
						20				
						21				
						22				
						23				
						24				
						01				
						02				
						03				
						04				
						05				
						06				
	12 HR									
	24 HR Total INTAKE:					**24HR Total OUTPUT:**				

24 HR Balance: + / - _____

Change IV to saline lock if antibiotics complete
Maintain CA - UTI Prevention Strategies
If symptomatic for UTI send C&S and notify MRP

IV Site _____ **satisfactory D**___ **E**___ **N**___

☐ **Foley removed if not already done D** ____

Specify reason if foley left in: _____

Asymptomatic for UTI D ____ **E** ____ **N**____
Output > 120 mL / 4 hrs D ____ **E** ____ **N**____

Last BM Date: _____

ANEMIA

Hgb _____. MD notified if < 90 or _____ , if symptomatic **or** platelets < 100,000.

Asymptomatic for anemia ◆ D ____ **E** ____ **N**____
No evidence of bleeding d/t LMWH. D ____ **E** ____ **N**____

Asymptomatic for anemia ◆ D ____

TOTAL HIP/KNEE REPLACEMENT CAREPATH
Day 1 Cont'd
Regional Surgical Program

NUTRITION

Administer anti-emetic regularly if nausea or vomiting.

Tolerating diet. ☐ **Regular** ☐ **Other** _____ ◆ **D** ____

No nausea or vomiting. D ____ **E** ____ **N** ____

- OR -

Patient states nausea under control with anti-emetic. D ____ **E** ____ **N** ____

SKIN INTEGRITY

Turn q2h.
Change dressing if ordered.

Wound approximated, clean, minimal or no clear drainage . ◆ D ____

Dressing dry and intact. D ____ **E** ____ **N** ____

Skin integrity maintained. D ____ **E** ____ **N** ____

MOBILITY

WB Status: ☐ WBAT ☐ PWB ☐ FeWB ☐ NWB
Reinforce with patient:
☐ Hip Precautions ☐ Other Precautions: _____

Nursing to complete:
Encourage up to commode/washroom.
Bed knee gatch turned off.
Sitting tolerance: _____ min/hrs
Encourage cryotherapy 3x/day x 15min (if sensation satisfactory) as per physiotherapy

Up in chair for at least 2 meals. . Tolerated well. D ____

☐ **No signs of hip dislocation (sudden, sharp, severe pain, malalignment) ◆ D** ____ **E** ____ **N** ____

Universal fall precautions in place D ____ **E** ____ **N** ____

Physiotherapy to complete:
☐ PT Initial Assessment completed
☐ Written home excercise program provided and initiated
- lying to sitting _____ assist / sitting to lying _____ assist
- sitting to standing _____ assist
- Ambulation: _____ assist _____ aid _____ meters

☐ Mobility impaired by: ☐ Nausea ☐ Vomitting ☐ Dizziness ☐ Pain
☐ Other: _____
☐ Knee ROM _____
☐ Cryotherapy initiated x 15 min. Sensation satisfactory
☐ Stair assessment _____ **PT** _____

Recommended mobility equipment discussed with patient PT _____

Mobility safe for discharge ◆ PT _____

FUNCTION

Occupational Therapy to complete:

	IND	STAND-BY	ASSIST	Equipment needed:
Toilet Transfer	☐	☐	☐	_____
Tub Transfer	☐	☐	☐	_____
Dressing	☐	☐	☐	_____
Grooming	☐	☐	☐	_____

Patient / family participated in mobility and ADLs as per care plan. OT ____

Precautions maintained throughout ADL assessment and practice. OT ____

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TOTAL HIP/KNEE REPLACEMENT CAREPATH
Day 1 Cont'd
Regional Surgical Program

DISCHARGE PLANNING	
	Discharge teaching: ☐ LMWH subcutaneous injection reviewed ☐ Wound / incision care ☐ Post-op complications (DVT infections, anemia, constipation) ☐ Pain management at home ☐ Methods to prevent / decrease edema **Patient has acquired recommended ADL equipment. (OT) ____** **Patient has acquired recommended mobility equipment. (PT) ____** **Outpatient physiotherapy set up and information provided. (PT) ____** **Patient verbalizes understanding of discharge teaching. D ____** **No concerns regarding support at home for meeting target discharge date. D ____** **Expected length of stay reinforced. D ____**

NOTES

TIME	FOCUS	DISCIPLINE	PATIENT CARE PROGRESS RECORD (Data/Action/Response/Plan)

NOTES

TIME	FOCUS	DISCIPLINE	PATIENT CARE PROGRESS RECORD (Data/Action/Response/Plan)

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TOTAL HIP/ KNEE REPLACEMENT CAREPATH
Day 2
Regional Surgical Program

Date: _____

☐ Hip ☐ Knee ☐ Right ☐ Left

D/E/N: Initial beside N/E: Not evaluated FC: Focus Chart N/A: Not applicable
If ☐ appears before item, check if it applies. Consider discharge if all ◆ outcomes met.

CARDIOVASCULAR

Time																				
Blood Pressure ▼▲ Pulse ●	220-																			220
	210-																			210
	200-																			200
	190-																			190
	180-																			180
	170-																			170
	160-																			160
	150-																			150
	140-																			140
	130-																			130
	120-																			120
	110-																			110
	100-																			100
	90-																			90
	80-																			80
	70-																			70
	60-																			60
	50-																			50
	40-																			40
	30-																			30
Temperature																				
Resps																				
O_2 Sats																				
Oxygen (lpm/fiO_2)																				
Sedation Scale																				
Initial																				

Sedation scale ***0** Alert **1** occ. drowsy **2** freq drowsy **3** somnolent (falls asleep during contact) **4** severe/non-responsive*

Assess vital signs and sedation scale qid and PRN
Deep breathing and coughing q1h while awake

Vital signs within patient's normal limits D____ E____ N____
Safety check complete: Emerg & patient specific D____ E____ N____
Clear breath sounds by auscultation D____ E____ N____
O_2 Sat ≥ 93% or as specified by MD D____ E____ N____

PAIN

Pain Scale	Time																			
Pain Scale (0-10)	At rest																			
	Movement																			
	Initial																			

Assess pain scale q4h and PRN. If poor pain control, initiate pain flowsheet.

Tolerating Oral Analgesia D____ E____ N____
Pain rating 3/10 or below, and/or non verbal behaviors acceptable level ◆ D____ E____ N____

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TOTAL HIP/KNEE REPLACEMENT CAREPATH
Day 2 Cont'd
Regional Surgical Program

DELIRIUM

Screen for Delirium using CAMI at 1600, and PRN (Check boxes that apply)
Delirious if **both** 1 and 2 and either 3 or 4 checked

1. Acute onset and fluctuating course ☐	3. Inattention ☐
2. Disorganized thinking ☐	4. Altered level of consciousness ☐

Screen for, and address potential causes of delirium using PRISM - E (pain, retention, restraint, infection, impaction, sensory, meds, alcohol, metabolic-hypoxia, malnutrition, fluids and lytes, environment, hx of dementia)
If delirium present and/or cognitive impairment; Encourage patient family/ care providers to stay

Oriented X 3 (Time, person, place, age) D____ E____ N____
CAMI negative D____ E____ N____
Family/care provider state that patients cognition is at baseline D____ E____ N____
Slept: ☐ well ☐ on/off ☐ poorly N____

DVT

CWMS within patient's normal limits D____ E____ N____
Edema 2 or less, no calf redness or pain along vein D____ E____ N____

ANEMIA

Hgb_____ . MD notified if < 90 or_____ if symptomatic **or** platelets < 100,000.

Asymptomatic for anemia ◆ D____ E____ N____
No evidence of bleeding d/t LMWH. D____ E____ N____

NUTRITION

Tolerating diet. ☐ Regular ☐ Other_____ ◆ D____
No nausea or vomiting. D____ E____ N____
-OR-
Patient states nausea under control with anti-emetic. D____ E____ N____

SKIN INTEGRITY

Change dressing if ordered.

Wound approximated, clean, minimal or no clear drainage. D____
Dressing dry and intact. D____ E____ N____
Skin integrity maintained. D____ E____ N____

MOBILITY

WB Status: ☐ WBAT ☐ PWB ☐ FeWB ☐ NWB
Reinforce with patient:
☐ Hip Precautions ☐ Other Precautions:_____

Nursing to complete:
Encourage up to commode/washroom.
Bed knee gatch turned off.
Sitting tolerance: _____ min/hrs
Encourage cryotherapy 3x/day x 15min (if sensation satisfactory) as per physiotherapy

Up in chair for all meals. Tolerated well. D____
☐ No signs of hip dislocation (sudden, sharp, severe pain, malalignment)◆ D____ E____ N____
Universal fall precautions in place D____ E____ N____

Physiotherapy to complete:
Written home exercise program reviewed. Pt. demonstrates satisfactory technique.

- lying to sitting _____ assist / sitting to lying _____ assist
- sitting to standing _____ assist
- Ambulation: _____ assist _____ aid _____ meters

☐ Mobility impaired by: ☐ Nausea ☐ Vomiting ☐ Dizziness ☐ Pain
☐ Other _____
☐ Knee ROM_____
☐ Cryotherapy x 15 min. Sensation satisfactory.
☐ Stair Assessment _____ **PT _____**

Recommended mobility equipment discussed with patient. PT _____
Mobility safe for discharge ◆ PT _____

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TOTAL HIP/KNEE REPLACEMENT CAREPATH
Day 2 Cont'd
Regional Surgical Program

FLUID BALANCE / ELIMINATION

INTAKE D						OUTPUT D				
Start Time	IV Solutions, Amount, Meds Added	Rate	Amt Absorb	PO/ Gastric	Initial	Time	Urine	Drain/ Blood		Initial
						07				
						08				
						09				
						10				
						11				
						12				
						13				
						14				
						15				
						16				
						17				
						18				
						19				
	12 HR					**12 HR**				
Start Time	INTAKE N					OUTPUT N				
						20				
						21				
						22				
						23				
						24				
						01				
						02				
						03				
						04				
						05				
						06				
	12 HR					**12 HR**				
	24 HR Total INTAKE:					**24HR Total OUTPUT:**				

24 HR Balance: + / - _____

Commode / urinal at bedside if needed.
Maintain CA - UTI Prevention Strategies
If symptomatic for UTI send C&S and notify MRP

☐ **Foley removed if not already done DEN ____**

Specify reason if foley left in: _____

Asymptomatic for UTI D ____ E ____ N____

Last BM Date: _____

TOTAL HIP/KNEE REPLACEMENT CAREPATH
Day 2 Cont'd
Regional Surgical Program

CARE FOCUS	OUTCOMES in Bold
FUNCTION	IND / STAND-BY / ASSIST / Equipment needed: Toilet Transfer ☐ ☐ ☐ ____ Shower/Tub Transfer ☐ ☐ ☐ ____ Dressing ☐ ☐ ☐ ____ Grooming ☐ ☐ ☐ ____ ☐ **Self-care practice opportunity provided. OT____** ☐ **Patient / family participated in mobility and ADLs as per care plan. OT____** ☐ **Precautions maintained throughout ADL assessment and practice. OT____**
DISCHARGE PLANNING	Discharge teaching: ☐ LMWH subcutaneous injection reviewed ☐ Wound / incision care ☐ Post-op complications (DVT infections, anemia, constipation) ☐ Pain management at home ☐ Methods to prevent / decrease edema **Patient has acquired recommended ADL equipment. (OT)____** **Patient has acquired recommended mobility equipment. (PT)____** **Outpatient physiotherapy set up and information provided. (PT)____** **Patient verbalizes understanding of discharge teaching. D____** **No concerns regarding support at home for meeting target discharge date. D____** **Expected length of stay reinforced. D____**

VARIANCE NOTES

TIME	FOCUS	DISCIPLINE	PATIENT CARE PROGRESS RECORD (Data/Action/Response/Plan)

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TOTAL HIP/KNEE REPLACEMENT CAREPATH
Day 2 Cont'd
Regional Surgical Program

NOTES

TIME	FOCUS	DISCIPLINE	PATIENT CARE PROGRESS RECORD (Data/Action/Response/Plan)

NOTES

TIME	FOCUS	DISCIPLINE	PATIENT CARE PROGRESS RECORD (Data/Action/Response/Plan)

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TOTAL HIP/ KNEE REPLACEMENT CAREPATH
Day 3
Regional Surgical Program

PWXX102920D Rev: May 11/10

Date: _____

☐ Hip ☐ Knee ☐ Right ☐ Left

D/E/N: Initial beside N/E: Not evaluated FC: Focus Chart N/A: Not applicable
If ☐ appears before item, check if it applies. Consider discharge if all ◆ outcomes met.

CARDIOVASCULAR

Time	220	210	200	190	180	170	160	150	140	130	120	110	100	90	80	70	60	50	40	30
Blood Pressure ▼▲ Pulse •																				
Temperature																				
Resps																				
O_2 Sats																				
Oxygen (lpm/fiO_2)																				
Sedation Scale																				
Initial																				

Sedation scale ***0** Alert **1** occ. drowsy **2** freq drowsy **3** somnolent (falls asleep during contact) **4** severe/non-responsive*

Assess vital signs and sedation scale qid and PRN
Deep breathing and coughing q1h while awake

Vital signs within patient's normal limits D____ E____ N____
Safety check complete: Emerg & patient specific D____ E____ N____
Clear breath sounds by auscultation D____ E____ N____
0_2 Sat ≥ 93% or as specified by MD D____ E____ N____

PAIN

Pain Scale	Time																				
Pain Scale (0-10)	At rest																				
	Movement																				
	Initial																				

Assess pain scale q4h and PRN. If poor pain control, initiate pain flowsheet.

Tolerating Oral Analgesia D____ E____ N____
Pain rating 3/10 or below, and/or non verbal behaviors acceptable level ◆ D____ E____ N____

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TOTAL HIP/KNEE REPLACEMENT CAREPATH
Day 3 Cont'd
Regional Surgical Program

DELIRIUM

Screen for Delirium using CAMI at 1600, and PRN (Check boxes that apply)
Delirious if **both** 1 and 2 and either 3 or 4 checked

1. Acute onset and fluctuating course ☐	3. Inattention ☐
2. Disorganized thinking ☐	4. Altered level of consciousness ☐

Screen for, and address potential causes of delirium using PRISM - E (pain, retention, restraint, infection, impaction, sensory, meds, alcohol, metabolic-hypoxia, malnutrition, fluids and lytes, environment, hx of dementia)
If delirium present and/or cognitive impairment; Encourage patient family/ care providers to stay

Oriented X 3 (Time, person, place, age) D____ E____ N____
CAMI negative D____ E____ N____
Family/care provider state that patients cognition is at baseline D____ E____ N____
Slept: ☐ well ☐ on/off ☐ poorly N____

DVT

CWMS within patient's normal limits D____ E____ N____
Edema 2 or less, no calf redness or pain along vein D____ E____ N____

ANEMIA

Hgb_____ . MD notified if < 90 or_____ if symptomatic **or** platelets < 100,000.
Asymptomatic for anemia ◆ D____ E____ N____
No evidence of bleeding d/t LMWH. D____ E____ N____

NUTRITION

Tolerating diet. ☐ Regular ☐ Other _____ ◆ D____
No nausea or vomiting. D____ E____ N____
-OR-
Patient states nausea under control with anti-emetic. D____ E____ N____

SKIN INTEGRITY

Change dressing if ordered.
Wound approximated, clean, minimal or no clear drainage. D____
Dressing dry and intact. D____ E____ N____
Skin integrity maintained. D____ E____ N____

MOBILITY

WB Status: ☐ WBAT ☐ PWB ☐ FeWB ☐ NWB
Reinforce with patient:
☐ Hip Precautions ☐ Other Precautions:_____

Nursing to complete:
Encourage ambulation
Bed knee gatch turned off.
Sitting tolerance: _____ min/hrs
Encourage cryotherapy 3x/day x 15min (if sensation satisfactory) as per physiotherapy
Up in chair for all meals. Tolerated well. D____
☐ **No signs of hip dislocation (sudden, sharp, severe pain, malalignment)◆ D____ E____ N____**
Universal fall precautions in place D____ E____ N____

Physiotherapy to complete:
Written home exercise program reviewed. Pt. demonstrates satisfactory technique.
- lying to sitting _____ assist / sitting to lying _____ assist
- sitting to standing _____ assist
- Ambulation: _____ assist _____ aid _____ meters

☐ Mobility impaired by: ☐ Nausea ☐ Vomiting ☐ Dizziness ☐ Pain
☐ Other _____
☐ Knee ROM_____
☐ Cryotherapy x 15 min. Sensation satisfactory.
☐ Stair Assessment _____ **PT _____**
Recommended mobility equipment discussed with patient. PT _____
Mobility safe for discharge ◆ PT _____

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TOTAL HIP/KNEE REPLACEMENT CAREPATH
Day 3 Cont'd
Regional Surgical Program

FLUID BALANCE / ELIMINATION

INTAKE D						OUTPUT D				
Start Time	IV Solutions, Amount, Meds Added	Rate	Amt Absorb	PO/ Gastric	Initial	Time	Urine	Drain/ Blood		Initial
						07				
						08				
						09				
						10				
						11				
						12				
						13				
						14				
						15				
						16				
						17				
						18				
						19				
	12 HR					**12 HR**				
Start Time	INTAKE N					OUTPUT N				
						20				
						21				
						22				
						23				
						24				
						01				
						02				
						03				
						04				
						05				
						06				
	12 HR					**12 HR**				

24 HR Total INTAKE: _____ **24HR Total OUTPUT:** _____

24 HR Balance: + / - _____

Last BM Date: _____

If no BM within past 72 hrs, advance bowel protocol to supps or enema.

TOTAL HIP/KNEE REPLACEMENT CAREPATH
Day 3 Cont'd
Regional Surgical Program

FUNCTION

	IND	STAND-BY	ASSIST	Equipment needed:
Toilet Transfer	☐	☐	☐	_____
Shower/Tub Transfer	☐	☐	☐	_____
Dressing	☐	☐	☐	_____
Grooming	☐	☐	☐	_____

☐ **Self-care practice opportunity provided. OT ____**

☐ **Patient / family participated in mobility and ADLs as per care plan. OT ____**

☐ **Precautions maintained throughout ADL assessment and practice. OT____**

DISCHARGE PLANNING

☐ Home care referral initiated: concerns related to wound care management or medications.

☐ LMWH prescriptions provided to patient.

Discharge teaching continued and reinforced:

- ☐ Patient/family successfully demonstrates LMWH injection. Handout provided.
- ☐ Wound / incision care
- ☐ Post-op complications (DVT infections, anemia, constipation)
- ☐ Pain management at home
- ☐ Methods to prevent / decrease edema
- ☐ Preventing and managing constipation

Patient has acquired recommended ADL equipment. OT____

Patient has acquired recommended mobility equipment. PT____

Outpatient physiotherapy set up and information provided. PT____

Patient / family demonstrate LMWH administration. Kit provided. D____

No concerns regarding support at home for meeting target discharge date. D____

DELAYED DISCHARGE

If patient not prepared for discharge today or tomorrow, specify reason below.
Mark the most significant reason with an asterisk (*).

- ☐ delirium
- ☐ medical issues:_____
- ☐ wound related
- ☐ unmanaged pain
- ☐ nausea and vomiting; not tolerating diet
- ☐ anemia related concerns
- ☐ voiding difficulties
- ☐ mobility not satisfactory
- ☐ inadequate support at home
- ☐ patient cleared to go by team but reluctant to leave
  Explain: _____

☐ awaiting transfer to another hospital

☐ inadequate home environment for equipment set-up
Other:_____

NOTES

TIME	FOCUS	DISCIPLINE	PATIENT CARE PROGRESS RECORD (Data/Action/Response/Plan)

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TOTAL HIP/KNEE REPLACEMENT CAREPATH
Day 3 Cont'd
Regional Surgical Program

NOTES

TIME	FOCUS	DISCIPLINE	PATIENT CARE PROGRESS RECORD (Data/Action/Response/Plan)

TOTAL HIP/KNEE REPLACEMENT CAREPATH
Day 3 Cont'd
Regional Surgical Program

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TOTAL HIP/ KNEE REPLACEMENT CAREPATH
Day ____
Regional Surgical Program

PWXX102920D Rev: May 11/10

Date: _____

☐ Hip ☐ Knee ☐ Right ☐ Left

D/E/N: Initial beside N/E: Not evaluated FC: Focus Chart N/A: Not applicable
If ☐ appears before item, check if it applies. Consider discharge if all ◆ outcomes met.

CARDIOVASCULAR

Time	220-	210-	200-	190-	180-	170-	160-	150-	140-	130-	120-	110-	100-	90-	80-	70-	60-	50-	40-	30-	-220	-210	-200	-190	-180	-170	-160	-150	-140	-130	-120	-110	-100	-90	-80	-70	-60	-50	-40	-30
Blood Pressure ▼▲ Pulse ●																																									
Temperature																																									
Resps																																								
O_2 Sats																																								
Oxygen (lpm/fiO_2)																																								
Sedation Scale																																								
Initial																																								

Sedation scale ***0** Alert **1** occ. drowsy **2** freq drowsy **3** somnolent (falls asleep during contact) **4** severe/non-responsive*

Assess vital signs and sedation scale qid and PRN
Deep breathing and coughing q1h while awake

Vital signs within patient's normal limits D____ E____ N____
Safety check complete: Emerg & patient specific D____ E____ N____
Clear breath sounds by auscultation D____ E____ N____
0_2 Sat ≥ 93% or as specified by MD D____ E____ N____

PAIN

Pain Scale	Time																							
Pain Scale (0-10)	At rest																							
	Movement																							
	Initial																							

Assess pain scale q4h and PRN. If poor pain control, initiate pain flowsheet.

Tolerating Oral Analgesia D____ E____ N____
Pain rating 3/10 or below, and/or non verbal behaviors acceptable level ◆ D____ E____ N____

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TOTAL HIP/KNEE REPLACEMENT CAREPATH
Day ____ Cont'd
Regional Surgical Program

DELIRIUM

Screen for Delirium using CAMI at 1600, and PRN (Check boxes that apply)
Delirious if **both** 1 and 2 either 3 or 4 checked

1. Acute onset and fluctuating course ☐	3. Inattention ☐
2. Disorganized thinking ☐	4. Altered level of consciousness ☐

Screen for, and address potential causes of delirium using PRISM - E (pain, retention, restraint, infection, impaction, sensory, meds, alcohol, metabolic-hypoxia, malnutrition, fluids and lytes, environment, hx of dementia)
If delirium present and/or cognitive impairment; Encourage patient family/ care providers to stay

Oriented X 3 (Time, person, place, age) D____ E____ N____
CAMI negative D____ E____ N____
Family/care provider state that patients cognition is at baseline D____ E____ N____
Slept: ☐ well ☐ on/off ☐ poorly N____

DVT

CWMS within patient's normal limits D____ E____ N____
Edema 2 or less, no calf redness or pain along vein D____ E____ N____

ANEMIA

Hgb_____ . MD notified if < 90 or_____ if symptomatic **or** platelets < 100,000.

Asymptomatic for anemia ◆ D____ E____ N____
No evidence of bleeding d/t LMWH. D____ E____ N____

NUTRITION

Tolerating diet. ☐ Regular ☐ Other _____ ◆ D____
No nausea or vomiting. D____ E____ N____
-OR-
Patient states nausea under control with anti-emetic. D____ E____ N____

SKIN INTEGRITY

Change dressing if ordered.

Wound approximated, clean, minimal or no clear drainage. D____
Dressing dry and intact. D____ E____ N____
Skin integrity maintained. D____ E____ N____

MOBILITY

WB Status: ☐ WBAT ☐ PWB ☐ FeWB ☐ NWB
Reinforce with patient:
☐ Hip Precautions ☐ Other Precautions:_____

Nursing to complete:
Encourage ambulation
Bed knee gatch turned off.
Sitting tolerance: _____ min/hrs
Encourage cryotherapy 3x/day x 15min (if sensation satisfactory) as per physiotherapy

Up in chair for all meals. Tolerated well. D____
☐ No signs of hip dislocation (sudden, sharp, severe pain, malalignment)◆ D____ E____ N____
Universal fall precautions in place D____ E____ N____

Physiotherapy to complete:
Written home exercise program reviewed. Pt. demonstrates satisfactory technique.

- lying to sitting _____ assist / sitting to lying _____ assist
- sitting to standing _____ assist
- Ambulation: _____ assist _____ aid _____ meters

☐ Mobility impaired by: ☐ Nausea ☐ Vomiting ☐ Dizziness ☐ Pain
☐ Other _____
☐ Knee ROM_____
☐ Cryotherapy x 15 min. Sensation satisfactory.
☐ Stair Assessment _____ **PT** _____

Recommended mobility equipment discussed with patient. PT _____
Mobility safe for discharge ◆ PT _____

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TOTAL HIP/KNEE REPLACEMENT CAREPATH
Day ____ Cont'd
Regional Surgical Program

FLUID BALANCE / ELIMINATION

INTAKE D							OUTPUT D				
Start Time	IV Solutions, Amount, Meds Added	Rate	Amt Absorb	Time	PO/ Gastric	Initial	Time	Urine	Drain/ Blood		Initial
							07				
							08				
							09				
							10				
							11				
							12				
							13				
							14				
							15				
							16				
							17				
							18				
							19				
	12 HR						**12 HR**				
Start Time	INTAKE N						OUTPUT N				
							20				
							21				
							22				
							23				
							24				
							01				
							02				
							03				
							04				
							05				
							06				
	12 HR						**12 HR**				
24 HR Total INTAKE:							**24HR Total OUTPUT:**				

24 HR Balance: + / - _____

Last BM Date: _____

If no BM within past 72 hrs, advance bowel protocol to supps or enema.

TOTAL HIP/KNEE REPLACEMENT CAREPATH
Day ____ Cont'd
Regional Surgical Program

FUNCTION

	IND	STAND-BY	ASSIST	Equipment needed:
Toilet Transfer	☐	☐	☐	_____
Shower/Tub Transfer	☐	☐	☐	_____
Dressing	☐	☐	☐	_____
Grooming	☐	☐	☐	_____

☐ **Self-care practice opportunity provided. OT ____**

☐ **Patient / family participated in mobility and ADLs as per care plan. OT ____**

☐ **Precautions maintained throughout ADL assessment and practice. OT ____**

DISCHARGE PLANNING

☐ Home care referral initiated: concerns related to wound care management or medications.

☐ LMWH prescriptions provided to patient.

Discharge teaching continued and reinforced:

- ☐ Patient/family successfully demonstrates LMWH injection. Handout provided.
- ☐ Wound / incision care
- ☐ Post-op complications (DVT infections, anemia, constipation)
- ☐ Pain management at home
- ☐ Methods to prevent / decrease edema
- ☐ Preventing and managing constipation

Patient has acquired recommended ADL equipment. OT____

Patient has acquired recommended mobility equipment. PT____

Outpatient physiotherapy set up and information provided. PT____

Patient / family demonstrate LMWH administration. Kit provided. D____

No concerns regarding support at home for meeting target discharge date. D____

DELAYED DISCHARGE

If patient not prepared for discharge today or tomorrow, specify reason below.
Mark the most significant reason with an asterisk (*).

- ☐ delirium
- ☐ medical issues:_____
- ☐ wound related
- ☐ unmanaged pain
- ☐ nausea and vomiting; not tolerating diet
- ☐ anemia related concerns
- ☐ voiding difficulties
- ☐ mobility not satisfactory
- ☐ inadequate support at home
- ☐ patient cleared to go by team but reluctant to leave
  Explain: _____

☐ awaiting transfer to another hospital

☐ inadequate home environment for equipment set-up

Other:_____

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