Joint Replacement Pathways Framework

Appendix 1

Local Health District Case Studies

The case studies form part of the Joint Replacement Pathways Framework. They are examples of current pathways used in NSW that have been implemented in specific local circumstances. Each facility should tailor their own pathway depending on best practice guidelines, local protocols, and staff preferences.

Same-day Hip and Knee Replacement – Grafton Base Hospital, NNSW LHD

Discharge of patient home on the day of surgery/Day 0 after a THR or TKR.

Should be considered if:

- Selection criteria met by patient during screening/pre-operative assessment.
- Patient has met all criteria to be able to be discharged home safely.

Pre-Operative Pathway

<table>
<tr><td rowspan="4">Pre-Operative Physiotherapy</td><td>• Patient referred to standard Physiotherapist Pre-operative Program Osteoarthritis Chronic Care Program (OACCP) * as per all Total Joint Replacement</td></tr>
<tr><td>• Further discussion regarding day stay pathway</td></tr>
<tr><td>• Screening for suitability via routine assessment as part of OACCP service includes physical measures (TUGT, 6MWT) and subjective history of social factors supportive of day stay eligibility (patient self-efficacy, home environment, social supports available at time of D/C)</td></tr>
<tr><td>• Patient willingness for day stay communicated to Orthopaedic Care Coordinator</td></tr>
<tr><td rowspan="2">Pre-Admission Clinic</td><td>• Pre-Admission (PAC) review as per all TJR includes nursing and anaesthetic review
○ Optimises medical condition, comorbidities (anaemia, MSSA (Methicillin sensitive staphylococcus aureus), MRSA (Methicillin resistant staphylococcus aureus carriage, symptomatic UTI (urinary tract infection) in female + any positive urine in male etc)
○ At 2 weeks prior to booked procedure, the patient will attend the PAC where the following tests will be performed: FBEU&E's, ECG, Urine M&C, nasal swabs.
○ The results will be checked by day surgery staff.
○ If a UTI is detected it will be treated with antibiotics, prescribed by the anaesthetist in the PAC. Follow up MSU (mid-stream urine test) is not required unless symptomatic.
○ If the nasal swab reveals MSSA then clearance therapy is undertaken for 5 days. If MRSA is detected, then clearance therapy is undertaken using Mupirocin 2% ointment, followed by repeat swabs and repeat clearance immediately prior to surgery. If MRSA persists, the surgery will be deferred.</td></tr>
<tr><td>• Anaesthetic review of ASA criteria and medical suitability for Day Stay pathway assessed and discussed with patient</td></tr>
</table>

Pre-operative Education	• This was main component of care that varied from typical pathway
	• The Orthopaedic Care coordinator provides education session (one off 30-minute consultation that took place 2 – 4 weeks prior to surgery)
	• Confirmed patient willingness to participate in Day Stay program
	• Provided education regarding discharge and recovery (outlined likely patient journey on day of surgery, post discharge pain management, wound management, typical mobility and follow up pathway, reviewed communication channels to contact team regarding any post operative issues of concern)
	• Orthopaedic Care Coordinator also responsible for liaison and communication with Surgical Services, Orthopaedic Ward and Allied Health teams to notify of Day Stay patients and to facilitate patients being listed for surgery where possible as first case of the day

Intra-Operative Pathway

Anaesthetic Pathway	• Anaesthetic compatible with day surgery can be spinal and or GA
	• Minimal benzodiazepines
	• With GA low systemic opioid, lowest volatile possible (BIS helpful)
	• High dose Dexamethasone with induction (12 or 16 mg)
	• NSAIDs, paracetamol
	• Tranexamic acid
As per standard for all Total Joint Replacement incorporating best practice to minimise pain and enhance recovery.	
Surgical Technique	• IDC is placed so fluids can be pushed and avoid retention (IDC removed in recovery
	• Single dose of antibiotic prophylaxis
	• Minimal or no tourniquet for TKR
	• Where feasible, a muscle sparing approach
	• Less invasive dissections for TKR THR used
	• Careful haemostasis
	• Tranexamic acid topically
	• Layered infiltration of structures, sub periosteal peri-femoral infiltration for TKR with ropivacaine low concentration high volume (150 ml for a knee) with added corticosteroid +/- opioid, NSAID)
	• Standard arthroplasty
	• No drain
	• Pain buster inserted into field, with Ropivacaine 0.4% at a rate of 5mL/hour.

	• Wound closure with subcuticular dissolvable stitches and waterproof dressing applied
	• Self-adhesive bandage from ankle with no padding straight over dressings removed after 2-3 days
	• VTE prophylaxis as per surgeon preference

Post-Operative Pathway

Recovery and DSU	• Transfer from recovery to surgical ward via x ray
	• Physiotherapy mobility review on ward/DSU > 3 hours post-surgery and after anaesthetic effects resolved

	• Discharge when meets standard discharge criteria
	  • Pain score <=3 and all other observations within the flags
	  • Able to walk 20 metres independently +/- walking aid without dizziness
	  • Able to manage stairs independently
	  • Assessed by Physiotherapist as safe to transfer
	  • No leakage through the bandage with knees and a dry dressing for hips
	  • Has tolerated fluids and a light meal
	  • Has passed urine
	  • Transport and discharge support arranged

Follow up Care	• The patient is transported home the same day following discharge review • The patient should be contacted 24-48 hours post-operatively by a member of the care team. • Ongoing physiotherapy sessions can be attended in the home or in an outpatient setting • If a pain buster was used, an appointment at the orthopaedic specialist rooms or outpatient department should be organised for the patient 2-3 days post-operatively. • Consider pain management assessment and a medication review. Arrange wound review at two weeks post-surgery, or as required. • As per usual reviews for the surgeon, physiotherapy, and general practitioner.

Short-stay Hip and Knee Replacement - Advanced Recovery Orthopaedic Program (AROP) at SESLHD - Summary flow chart of pathway

Patient identified at initial Orthopaedic consult to meet eligible criteria for AROP and referred to Orthopaedic CNC and physiotherapist

Patient education given on AROP by Orthopaedic CNC and consent to participate in AROP and ACORN obtained

Initial Physiotherapy assessment attended for development of prehab goals and preparation for surgery

Patient reviewed in the multidisciplinary clinic 6 weeks prior to date of surgery by CNC, Physiotherapist, Occupational therapist, PACS team and Social worker for education, D/C planning, equipment required prior to surgery.

DOS patients drink 2 carbohydrate drinks prior to arrival at hospital AROP patients are prioritised for first on theatre list and ward bed post operatively. Anaesthetic and multimodal analgesic regime implemented on all AROP patients

AROP clinical pathway is commenced on arrival to recovery including multi modal analgesic regime, pre-emptive antiemetic's, aggressive fluid resuscitation and early mobilisation policy

Physiotherapy and early mobilisation commence day of surgery. 2 hours post operatively patients assisted to SOOB. 4 hours post operatively patient mobilises with FASF, progressing to RF or crutches when able. Patient encouraged to SOOB for all meals and mobilise throughout evening for short distances.

Patient discharged and transported home with the PACS team (OT/ RN/Physio) when discharge criteria met 24-48 hours post operatively. Ongoing physiotherapy sessions attended in the home by PACS .

Patient is contacted by Orthopaedic CNC 2-3 days post discharge to offer support and enquire on progress

Short-stay Hip and Knee Replacement - Advanced Recovery Orthopaedic Program (AROP) at SESLHD

Patients undergoing lower limb arthroplasty under the AROP model of care should meet the specified clinical criteria prior to being eligible for this pathway:

- Primary hip or knee replacement
- Independently mobile
- No significant cardiac or respiratory functional limitations (clinical judgment)
- Not a current chronic pain patient
- Pre-operative haemoglobin assessment within normal limits
- Lives within the catchment area negotiated with PACS (POW)/South Care (TSH)
- Suitable home and adequate support person at home on discharge for the first 24 hours

However, patients are eligible for the AROP model of care by the discretion of the AROP surgical, anaesthetic, nursing, physiotherapy and occupational therapy teams.

Use of Clinical Pathways

- The Clinical Pathway is a guide only.
- The Clinical Pathway is part of the medical record and therefore a legal document.
- Always view each patient as an individual and consider if the intervention is appropriate.
- Do not hesitate to depart from this Clinical Pathway if you consider it is appropriate to do so based on your own clinical judgment and consultation with the doctor.
- The Clinical Pathway is to remain with the patient's observation and medication charts and must accompany the patient to other departments.
- The Clinical Pathway is to be utilised in conjunction with the Doctors' rounds. It does not take the place of a Doctor's order.
- The Clinical Pathway is to be used as the bedside handover tool.

Guide to Care

- Affix patient label, insert date (each day/page of the Clinical Pathway).
- As the pathway is multidisciplinary, each discipline initials in the appropriate column after events have actually occurred or each intervention has been achieved.
- So that initials can be recognised staff must also sign, print name and designation in the signature log for each day of the Clinical Pathway.

- Enter N/A if the intervention is not applicable during your shift.
- If there is a deviation from the Clinical Pathway, then this is to be documented as a variance in the patient notes. The recording of variances is the responsibility of all health professionals.

Variance Documentation

A variance can be in relation to the patient, physician, system, or community/family and can be positive or negative. It can therefore be:

- Any event noted on the Clinical Pathway not occurring as outlined on the Pathway.
- Any event not pre-printed on the Clinical Pathway e.g. CVC removed due to inflammation.
- Any event that occurs earlier than outlined on the Clinical Pathway.

If a variance occurs, document a ‘V’ in red and your initials in the appropriate shift column, then record the variance in the continuation progress notes (SMR050.001)

- Document the date, time and Day of stay
- Describe the variance eg. Infection.
- Describe the action, eg. IV removed due to inflammation
- Document the outcome.
- Sign

Patient care MUST be documented in **the Progress Notes** at least once each shift

AROP Clinical Pathway Total Hip Replacement

Day of Surgery	Date:_______________	AM	PM	N D	V
Observations	• Transfer to post op ward @_________hrs • Post op orders checked and implemented • Vital signs within PACE criteria • Neurovascular observations as per post op protocol • Complete ADRAT/ Pressure injury risk assessment • Falls risk score_______ • DRAT attended and documented • Patient orientated to ward • VIP score______. If >2 document on variance page • Insertion date on cannula site and in notes				
Analgesic Regime	• Pain management : Intrathecal Oral (circle) • Post op pain management discussed and understood by patient • Pain assessment attended and documented • Analgesia effective • Pre emptive antiemetic given				
Elimination	• IDC Insitu Y☐ N☐ N/A☐ • Date bowels last opened: __________ • Oral aperients charted				
Wound/ Drain	• Dressing intact/ wound ooze minimal • Drain insitu, Y N N/A • Documented on fluid balance chart				
Nutrition/ Hydration	• Commence diet and fluids as tolerated				
Thrombo Prophylaxis/ **Mobiltiy**	• Chemical/Mechanical thromboprophylaxis commenced • Sit up in bed to 45 degrees 2 hours post op • Patient assisted to transfer & SOOB 3 hours post op • Patient mobilised with FASF for short distance 4 hours post operatively • Patient progressed by physiotherapist to crutches/ rollator frame when clinically appropriate. • Patient to remain SOOB for all meals • Observe and reinforce hip precautions if required • Encourage deep breathing and ankle exercises • Pressure area care – as per patient requirements/ reassess daily or as per change of condition				
Discharge planning	• Patient provided education and demonstrates understanding of hip precautions if required • Treatment plan and EDD discussed with patient • Discharge summary attended				

All charts checked	ND/AM	AM/PM	PM/ND
Nurse giving handover (name, sign & designation.)			
Nurse receiving handover (name, sign & designation.)			

Post op Day 1	Date:____________	AM	PM	ND	V
TEAM Review	• Consultant./ Registrar/ RMO (circle) • Post-operative Hip X-Ray ordered: Y N N/A • Pathology reviewed and within expected range, checked HB: ______ • Drain removal: Y N N/A • Urinary catheter Removal : Y N Signature:________________________				
Observations	• Neurovascular observations within normal limits/ cease after 24 hours • Vital signs as per protocol & within PACE criteria • Cognition assessment attended as per hospital policy • VIP score______. If >2 document on variance page				
Analgesic Regime	• Oral analgesia regime discussed with patient and understood • Pain assessment attended and recorded on SAGO • PRN analgesia given prior to physiotherapy or if pain score >4 • Ice therapy applied regularly				
Elimination	• IDC removed: Y N N/A • No sign of urinary retention (Bladder scan if clinically indicated) • Bowel chart maintained • Oral aperients charted				
Wound/ Drain	• Dressing intact/ wound ooze minimal • Wound drain removed as per orders: Y N N/A				
Nutrition/ Hydration	• Patient tolerates diet and fluids • Accurate Fluid Balance chart maintained with intake & output				
Hygiene / ADLs	• Mobilise patient with mobility aid to and from shower/ toilet • Encourage to be self-caring with personal hygiene & ADLs • Encourage deep breathing and ankle exercises • Maintain hip precautions				
Thrombo Prophylaxis	• Continue chemical/mechanical thromboprophylaxis • Encourage patient to SOOB for all meals & 3 hours in morning and afternoon / attend to exercises • Patient educated on VTE prevention				
Mobility / Current Functional Assessment	• Patient independent with In and out of bed transfers Y N • Patient independent with sit to stand transfers Y N • Mobilising independently with the aid of___________ • Patient functionally suitable for Discharge home Y N • Assessed by: Physiotherapist _____________ Occupational therapist__________________				
Discharge planning	* Discharge plan discussed and confirmed with patient and family • PACS/OT/SW review completed: Y N • Discharge criteria met: Y N • Follow up referrals completed: Y N • CNC notified of discharge: Y N				

All charts checked	ND/AM	AM/PM	PM/ND
Nurse giving handover (name, sign & designation.)			
Nurse receiving handover (name, sign & designation.			

XXX0000 –

Post op Day 2	Date:_______________	AM	PM	ND	V
TEAM Review	• Consultant./ Registrar/ RMO (circle) • IVC removal: Y N • Confirm EDD with patient and family Signature: ________________________				
Observations	• Vital signs attended minimum 8/24 and within PACE criteria • Cognition assessment attended as per hospital policy • VIP score______. If >2 document on variance page • IVC removed: Y N				
Analgesic Regime	• Pain assessment attended and recorded on SAGO • PRN analgesia given prior to physiotherapy or if pain score >4 Ice therapy applied regularly				
Elimination	• No sign of urinary retention • Oral aperients charted/ bowel chart maintained				
Wound/ Drain	• Dressing reviewed / minimal ooze • Intact / changed (circle)				
Nutrition/ Hydration	• Patient tolerating diet and fluids • Fluid Balance chart ceased				
Hygiene / ADLs	• Mobilise patient with mobility aid to and from shower/ toilet • Encourage to be self-caring with personal hygiene & ADLs • Maintain hip precautions				
Thrombo Prophylaxis	• Continue chemical/mechanical thromboprophylaxis • Encourage patient to SOOB for all meals & 3 hours in morning and afternoon / attend to exercises • Patient educated on VTE prevention				
Mobility/ Current Functional Assessment	• Patient independent with In and out of bed transfers Y N • Patient independent with sit to stand transfers Y N • Mobilising independently with the aid of___________ • Patient independent with stair mobility Y N • Patient functionally suitable for Discharge home Y N • Assessed by: Physiotherapist _____________ Occupational therapist__________________				
Discharge planning	• Patient demonstrates understanding of hip precautions • Discharge plan discussed and confirmed with patient and family • PACS/OT/SW review completed: Y N • Discharge criteria met: Y N • Follow up referrals completed Y N • CNC notified of discharge Y N				

All charts checked	ND/AM	AM/PM	PM/ND
Nurse giving handover (name, sign & designation.)			
Nurse receiving handover (name, sign & designation.)			

Post op Day 3	Date:_______________	AM	PM	N D	V
TEAM Review	• Consultant/ Registrar/ RMO (circle) • Discharge criteria met: ☐ ☐ • Discharge plan discussed with patient Signature: ______________________				
Observations	• Vital signs attended minimum 8/24 and within PACE criteria • Cognition assessment attended as per hospital policy				
Analgesic Regime	• Pain assessment attended and recorded on SAGO • PRN analgesia given prior to physiotherapy or if pain score >4 • Ice therapy applied regularly				
Elimination	• Patient voiding without discomfort • Oral aperients charted/ bowel chart maintained				
Wound/ Drain	• Dressing reviewed / minimal ooze Intact / changed (circle)				
Nutrition/ Hydration	• Patient tolerating diet and fluids				
Hygiene / ADLs	• Mobilise patient with mobility aid to and from shower/ toilet • Encourage to be self-caring with personal hygiene & ADLs				
Thrombo Prophylaxis	• Continue chemical/mechanical thromboprophylaxis • Encourage patient to SOOB for all meals & 3 hours in morning and afternoon / attend to exercises Patient educated on VTE prevention				
Mobility / Current Functional Assessment	• Patient independent with In and out of bed transfers Y N • Patient independent with sit to stand transfers Y N • Mobilising independently with the aid of____________ • Patient independent with stair mobility Y N • Patient functionally suitable for Discharge home Y N • Assessed by: Physiotherapist ______________ Occupational therapist___________________				
Discharge planning	• Patient demonstrates understanding of hip precautions • Discharge plan confirmed with patient and family • PACS/OT/SW review completed Y N • Discharge criteria met: Y N • Follow up referrals completed: Y N • CNC notified of discharge: Y N				

All charts checked	ND/AM	AM/PM	PM/ND
Nurse giving handover (name, sign & designation.)			
Nurse receiving handover (name, sign & designation.)			

AROP Clinical Pathway Total Knee Replacement

Day of Surgery	Date:_______________	AM	PM	ND	V
Observations	• Transfer to post op ward @__________hrs • Post op orders checked and implemented • Vital signs within PACE criteria • Neurovascular observations as per post op protocol • Complete ADRAT/ Pressure injury risk assessment • Falls risk score_______ • DRAT attended and documented • Patient orientated to ward • VIP score______. If >2 document on variance page • Insertion date on cannula site and in notes				
Analgesic Regime	• Pain management: Intrathecal Oral (circle) • Post op pain management discussed and understood by patient • Pain assessment attended and documented • Analgesia effective • Pre emptive antiemetic given				
Elimination	• IDC Insitu Y ☐ N☐ N☐ • Date bowels last opened: __________ • Oral aperients charted				
Wound/ Drain	• Dressing intact/ wound ooze minimal • Drain insitu, Y N N/A • Documented on fluid balance chart				
Nutrition/ Hydration	• Commence diet and fluids as tolerated				
Thrombo Prophylaxis/ **Mobiltiy**	• Chemical/Mechanical thromboprophylaxis commenced • Sit up in bed to 45 degrees & commence knee ROM exercises 2 hours post op • Patient assisted to transfer & SOOB 3 hours post op • Patient mobilised with FASF for short distance 4 hours post operatively • Patient progressed by physiotherapist to crutches/ rollator frame when clinically appropriate. • Patient to remain SOOB for all meals • Encourage deep breathing and ankle exercises • Pressure area care – as per patient requirements/ reassess daily or as per change of condition				
Discharge planning	• Patient provided education • Treatment plan and EDD discussed with patient • Discharge summary attended				

All charts checked	ND/AM	AM/PM	PM/ND
Nurse giving handover (name, sign & designation.)			
Nurse receiving handover (name, sign & designation.)			

Post op Day 1	Date:____________	AM	PM	ND	V
TEAM Review	• Consultant./ Registrar/ RMO (circle) • Post-operative knee X-Ray ordered: Y N N/A • Pathology reviewed and within expected range, checked HB: ______ • Drain removal: Y N N/A • Urinary catheter Removal : Y N Signature:______________________				
Observations	• Neurovascular observations within normal limits/ cease after 24 hours • Vital signs as per protocol & within PACE criteria • Cognition assessment attended as per hospital policy • VIP score______. If >2 document on variance page				
Analgesic Regime	• Oral analgesia regime discussed with patient and understood • Pain assessment attended and recorded on SAGO • PRN analgesia given prior to physiotherapy or if pain score >4 • Ice therapy applied regularly				
Elimination	• IDC removed: Y N N/A • No sign of urinary retention (Bladder scan if clinically indicated) • Bowel chart maintained • Oral aperients charted				
Wound/ Drain	• Dressing intact/ wound ooze minimal • Wound drain removed as per orders: Y N N/A				
Nutrition/ Hydration	• Patient tolerates diet and fluids • Accurate Fluid Balance chart maintained with intake & output				
Hygiene / ADLs	• Mobilise patient with mobility aid to and from shower/ toilet • Encourage to be self-caring with personal hygiene & ADLs • Encourage deep breathing and ankle exercises • Maintain hip precautions				
Thrombo Prophylaxis	• Continue chemical/mechanical thromboprophylaxis • Encourage patient to SOOB for all meals & 3 hours in morning and afternoon / attend to exercises • Encourage knee ROM exercises • Patient educated on VTE prevention				
Mobility / Current Functional Assessment	• Patient independent with In and out of bed transfers Y N • Patient independent with sit to stand transfers Y N • Mobilising independently with the aid of___________ • Patient functionally suitable for Discharge home Y N • Assessed by: Physiotherapist _____________ Occupational therapist_________________				
Discharge planning	* Discharge plan discussed and confirmed with patient and family • PACS/OT/SW review completed: Y N • Discharge criteria met: Y N • Follow up referrals completed: Y N • CNC notified of discharge: Y N				

All charts checked	ND/AM	AM/PM	PM/ND
Nurse giving handover (name, sign & designation.)			
Nurse receiving handover (name, sign & designation.			

Post op Day 2	Date:_______________	AM	PM	ND	V
TEAM Review	• Consultant/ Registrar/ RMO (circle) • IVC removal: Y N • Confirm EDD with patient and family Signature: ________________________				
Observations	• Vital signs attended minimum 8/24 and within PACE criteria • Cognition assessment attended as per hospital policy • VIP score______. If >2 document on variance page • IVC removed: Y N				
Analgesic Regime	• Pain assessment attended and recorded on SAGO • PRN analgesia given prior to physiotherapy or if pain score >4 Ice therapy applied regularly				
Elimination	• No sign of urinary retention • Oral aperients charted/ bowel chart maintained				
Wound/ Drain	• Dressing reviewed / minimal ooze • Intact / changed (circle)				
Nutrition/ Hydration	• Patient tolerating diet and fluids • Fluid Balance chart ceased				
Hygiene / ADLs	• Mobilise patient with mobility aid to and from shower/ toilet • Encourage to be self-caring with personal hygiene & ADLs • Maintain hip precautions				
Thrombo Prophylaxis	• Continue chemical/mechanical thromboprophylaxis • Encourage patient to SOOB for all meals & 3 hours in morning and afternoon / attend to exercises • Encourage knee ROM exercises • Patient educated on VTE prevention				
Mobility/ Current Functional Assessment	• Patient independent with In and out of bed transfers Y N • Patient independent with sit to stand transfers Y N • Mobilising independently with the aid of___________ • Patient independent with stair mobility Y N • Patient functionally suitable for Discharge home Y N • Assessed by: Physiotherapist _____________ Occupational therapist__________________				
Discharge planning	• Patient demonstrates understanding of hip precautions • Discharge plan discussed and confirmed with patient and family • PACS/OT/SW review completed: Y N • Discharge criteria met: Y N • Follow up referrals completed Y N • CNC notified of discharge Y N				

All charts checked	ND/AM	AM/PM	PM/ND
Nurse giving handover (name, sign & designation.)			
Nurse receiving handover (name, sign & designation.)			

Post op Day 3	Date:_______________	AM	PM	ND	V
TEAM Review	• Consultant/ Registrar/ RMO (circle) • Discharge criteria met: ☐ ☐ • Discharge plan discussed with patient Signature: ______________________				
Observations	• Vital signs attended minimum 8/24 and within PACE criteria • Cognition assessment attended as per hospital policy				
Analgesic Regime	• Pain assessment attended and recorded on SAGO • PRN analgesia given prior to physiotherapy or if pain score >4 • Ice therapy applied regularly				
Elimination	• Patient voiding without discomfort • Oral aperients charted/ bowel chart maintained				
Wound/ Drain	• Dressing reviewed / minimal ooze Intact / changed (circle)				
Nutrition/ Hydration	• Patient tolerating diet and fluids				
Hygiene / ADLs	• Mobilise patient with mobility aid to and from shower/ toilet • Encourage to be self-caring with personal hygiene & ADLs				
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Mobility / Current Functional Assessment	• Patient independent with In and out of bed transfers Y N • Patient independent with sit to stand transfers Y N • Mobilising independently with the aid of___________ • Patient independent with stair mobility Y N • Patient functionally suitable for Discharge home Y N • Assessed by: Physiotherapist _____________ Occupational therapist__________________				
Discharge planning	• Patient demonstrates understanding of hip precautions • Discharge plan confirmed with patient and family • PACS/OT/SW review completed Y N • Discharge criteria met: Y N • Follow up referrals completed: Y N • CNC notified of discharge: Y N				

All charts checked	ND/AM	AM/PM	PM/ND
Nurse giving handover (name, sign & designation.)			
Nurse receiving handover (name, sign & designation.)			

AROP Clinical Pathway Total Hip/Total Knee Replacement Discharge Criteria

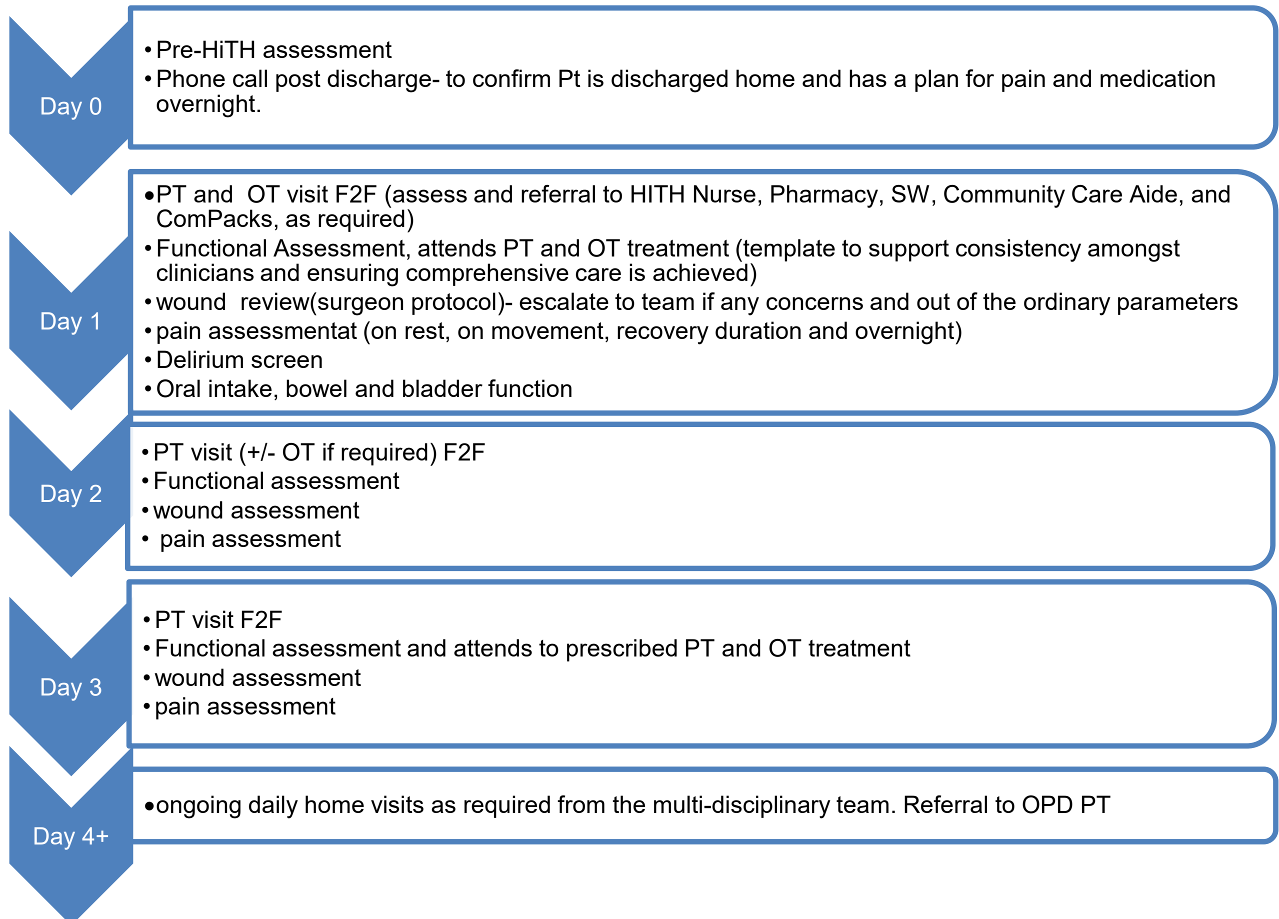
Discharge of patient home on Day 1 or Day 2 after a THR or TKR.

Following consultation with Districts Should be considered if:

- Selection criteria met by patient during screening/pre-operative assessment
- Patient does not meet criteria for same day discharge and short stay pathway identified as ideal pathway during day of surgery

Observations within normal range	
Pain managed with oral analgesia	
Wound observed without signs of redness, heat, discharge	
Patient has been cleared for discharge by Orthopaedic surgeon	
Patient has been cleared for discharge by Physiotherapist	
Patient has been cleared for discharge by Occupational therapist	
Patient understands level of activity, pain management, VTE prevention and wound care following discharge	
Patient understands signs and symptoms requiring medical review after discharge	
Follow up appointment made	
Patient discharged on (date) _____________	

Same-day Total Joint Replacement Project Hospital in The Home Royal North Shore -NSYD LHD

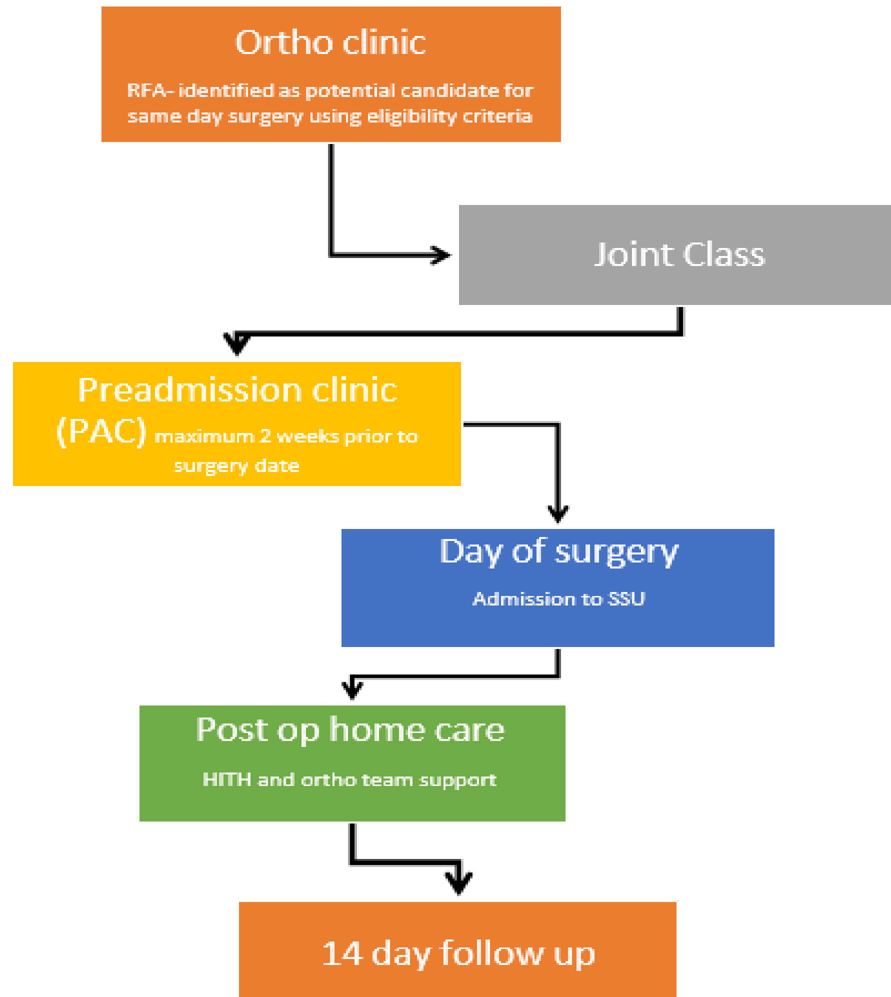


HITH Orthopaedic Day Surgery Trial Pathway Royal North Shore Hospital, NSYD LHD

	HITH requirements/service
Referral via 1300 XXX XXX	Patients selected by orthopaedic consultant to be suitable for day surgery trial (hip, knee arthroplasty or ACL repair) that live in RNSH catchment area are eligible (no requirements for a specific/number of disciplines to be involved)
Requirements from Acute ward	Acute ward discharge criteria met: • Patient safe to go home (OT: safe to shower, toilet and transfer, has required equipment) (PT: safe to mobilise at home, has required walking aide) • No active wound ooze, No drips or drains • Discharge letter includes post op protocol, VTE prophlaxis if hip precautions, confirm obs BTF or if additional obs required. • Referral to Outpatient Physio completed to ensure continuity of care post HITH without delay **TBC- TKR:** functional ROM approx. -10Ext 65-70Flex. **THR:** Understand hip precautions (if applicable)
Standard service (Weekday staffing: RN, OT, PT, Pharmacist and SW Weekend staffing: PT, RN)	5-7 days: - Day 0: HITH Evening in charge phone call to patient to establish any concerns since discharge home and identify clinical need eg. RN, PT, OT or Pharmacy - Day 1: PT and OT visit *(assess and referral to HITH Nurse, Pharmacy, SW, Community Care Aide, and ComPacks, as required)* - Day 2: PT visit(+/- OT if required) - Day 3: PT visit - Day 4+: ongoing daily home visits as required from the multi-disciplinary team.
Referral options while with HITH	If wound or pain management concerns: refer to Orthopaedic contact via bone phone: 04XX XXX XXX **Prior to discharge: all patients referred to OP PT.**

HITH Discharge criteria	*(Criteria as per discharge from Acute Care)* AND: Managing ADLs (including VTE prophylaxis Independently or with assistance provided within the home) Managing exercise program Medically well (afebrile, vital signs stable, dressing dry/intact, no signs of infection, pain well controlled) **TBC- TKR:** 0-5 Ext, ASLR, functional ROM maintained THR**:** Observing hip precautions
Escalation criteria to Ortho clinic if concerns:	*Wound concerns: leaking, bleeding, signs of cellulitis e.g., redness.* *TKR: loss of functional ROM post discharge, not progressing towards pre-surgery flexion.* *Ortho contact:* - *Bone phone* ***04XX XXX XXX*** *Review in orthopaedic outpatient clinic can be arranged on the day via bone phone*

Road Map for Same-day Joint Replacement, Royal North Shore Hospital, NSYD LHD



Eligibility Criteria

Criteria	Indicators
Pre-operative functional assessment	Independently mobile (or mobile with a walking aid) No faints or falls within the last 12 months Primary joint replacement Consider assessment of the home environment Identified as not-at-risk of worse pain or disability after surgery Patient selection is consultant led
Comorbidity profile	Patient suitability determined by anaesthetist based on clinical assessment Consideration of factors for example: • BMI < 35 • Age < 75 years • ASA 1 or 2 • No significant opioid use • No OSA, poorly controlled diabetes, history of IHD or CVA/significant cardiac history or other medical issue requiring inpatient care • Consider cognitive assessment, risk of delirium, use of anticoagulants, medication review, renal function assessment, and urinary retention in male patients.
Psychosocial profile	Patient competent and willing to be involved in a day-stay program Availability of carer or support person to stay with the patient for 48 hours after discharge
Distance or location	Lives within RNSH catchment area Suitable vehicle for transport available

Actions

- ✓ Consultant identifies eligible patients
- ✓ JMO, registrar or consultant notify Ortho CNC on [redacted]; page: [redacted]
- ✓ Ortho CNC to notify nurse screener
- ✓ IBU to notify CNC when patient has been booked into PAC along with date of surgery
- ✓ Ortho CNC to call patient and explain process, runs through criteria and then forwards information to MDT- OT, Physio, SSSU NUM, HITH, Pharmacy, Anaesthetics, APS
- ✓ Ortho CNC makes referral on eMR to HITH

Joint class education session

Ortho CNC will conduct an education session with the patient and their carer- outlining what to expect from their joint replacement surgery, common complications, what the patient expectations are, how to prepare for PAC, how to keep fit and active for surgery, post op wound care, what will happen

on the day and how the recovery at home will work.

Preadmission clinic (PAC)

Note: If a patient has already attended PAC, he/she need to be recalled to attend the orthopaedic outpatient clinic for consent, education and review regarding day only admission

Optimally should occur a week prior to surgery (maximum 2 weeks).

Patients will be seen by OT, PT, Pharmacy, Anaesthetics, ortho CNC, JMO, HITH, PAC Nurse

Discussions around final preparations for surgery to be done at this appointment- Pre op fasting minimisation, skin integrity education, infection risk screening, PROMS, confirm patient willingness and appropriateness for same-day joint replacement surgery, equipment checks, MRO swabs, bloods, baseline vitals, bone donation counselling and consent.

Actions

- ✓ PAC ward clerk notifies
  - HITH on
  - Outpatient OT
  - PT on page:
- ✓ CNC reviews patient
- ✓ Anaesthetics review patient
- ✓ PT and OT review patient
- ✓ JMO medically admits patient
- ✓ Pharmacy provides discharge medication counselling
- ✓ PAC Nurse reiterates same day surgery process and conducts baseline vitals and ECG
- ✓ HITH hospital liaison reviews and consents patient

Day of surgery- SSU

- First on list
- No catheters or drains
- Early mobilisation
- Clear written and verbal discharge and wound care instructions
- Strong and supported analgesia plan for the first week, and next 24 hours

particularly.

- Aim discharge 1800hrs

Discharge Criteria	
Post op void, tolerated diet and fluids	
Cleared by Physio and OT	
Vital signs between flags, Neurovascular Obs satisfactory	
No excessive wound exudate	
Pain management plan in place and effective- seen by APS	
Discharge information and discharge summary given	
Orthopaedic Outpatient Clinic appointment made for 14 days post Op	
TEDS applied to both legs	
Discharge medication given- patient able to explain med instructions to you	
HITH notified of discharge from SSSU- call via switch	

Actions:

- ✓ Physiotherapist conducts 2 or more sessions and refers to outpatient physio for 14 day post op follow up
- ✓ Ortho CNC reviews patient and ensures care is coordinated
- ✓ OT reviews patient and provides equipment as required for discharge
- ✓ Post op Xray (Prof [redacted] patients)
- ✓ SSSU nursing notifies HITH of discharge from SSSU and confirms HITH attendance following day via switch
- ✓ SSSU nursing review wound
- ✓ SSSU nursing to provide patient information discharge information and TED stockings
- ✓ SSSU nurses to administer Post op IV Antibiotic and TXA 4 hours post op
- ✓ APS reviews patient
- ✓ Pharmacist supplies discharge medications and does counselling
- ✓ SSSU ward clerk will make 14 day follow up appointments for

orthopaedic clinic (Don't need to do this for Prof Walter patients, they will be seen in his rooms instead)

- ✓ HITH evening in charge contacts patient when they get home

Post op- home care

Patient to remain on admitting team patient list for 4 days post op Hospital in the Home for 7 days post op

Patient will be followed up at next VMO clinic after 14 days and review in outpatient physio clinic after 14 days

HITH to call switch and ask to be put through to admitting orthopaedic team JMO to escalate concerns within hours- can contact the ortho CNC if unable to reach JMO.

Bone phone first POC for medical queries and escalations by patient (24/7) or HITH out of hours. Ortho team can contact acute pain service contact via ext [redacted]

Ortho OPD clinic on standby to provide collegiate review: preferential direct to OPD on the day of concern, rather than an ED presentation

Actions:

- ✓ Admitting team to ring patient daily for 4 days as part of their daily rounds (PRN thereafter)
- ✓ APS contact patient day one to titrate analgesia; further contact as deemed necessary
- ✓ HITH provides Hospital in the Home service as per protocol

If patient requires more analgesia- Ortho JMO to call patients local pharmacist- fax or email script and have patient/carer pick up medications.