

CLINICAL PATHWAYS
REHABILITATION - FAST TRACK TOTAL KNEE REPLACEMENT

Inclusion Criteria:(must have 2 or more of the following)

- Unable to ambulate greater than 5-10m by postop day 3 to 5
- ROM: less than 45 degree active flexion or lacking 30 degrees or more of active extension by postop day 3 to 5
- Decreased exercise tolerance such that patient would not be able to tolerate outpatient therapy
- Patient must be willing to participate in therapy

Clinical Pathways are not considered a substitute for professional judgement.

Phase:	Assessment Phase (2 days)			V
	Start Date:	End Date:	Date Initial	
PATIENT OUTCOMES	Occupational Therapy: Initial assessment completed and documented in health record ___/___/___ ___			
	Physiotherapy: Patient demonstrates safe transfer & mobility with appropriate equipment and assistance as required Equipment: <input type="checkbox"/> HWW <input type="checkbox"/> rollator <input type="checkbox"/> 2WW <input type="checkbox"/> 4WW <input type="checkbox"/> cane Assistance <input type="checkbox"/> independently <input type="checkbox"/> supervision <input type="checkbox"/> min. <input type="checkbox"/> mod PROM: Flexion _____ Extension: _____ timed up & go: _____ AROM: Flexion _____ Extension: _____ Quads Lag: _____			
TEACHING	Occupational Therapy: Patient was provided with and educated regarding proper use of the following assistive devices: <input type="checkbox"/> long handled shoe horn <input type="checkbox"/> dressing stick <input type="checkbox"/> reacher <input type="checkbox"/> sock-aid <input type="checkbox"/> elastic shoelaces <input type="checkbox"/> long handled sponge			
	Physiotherapy: Patient shown safe use of mobility aid ___/___/___ ___			
DISCHARGE PLANNING	Care Coordinator Estimated discharge date sent to team via mox +/- Patient to be reviewed at next available progress rounds ___/___/___ ___			
Pathway Reviewed with Patient/Family: (Care Coordinator)	___ Yes ___ No			
Patient/Family Satisfied with Progress? (Care Coordinator)	___ Yes ___ No If NO, see progress notes			
Signatures:		Initials		Initials
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____



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Phase:	Phase: Assessment - Interventions	V
Assessments	<p>Multidisciplinary team: Admission FIM completed within 72 hours of admission</p> <p>Occupational Therapy: Referral acknowledged and chart reviewed Dressing assessment completed, patient needs identified and findings documented Grooming assessment completed, patient needs identified and findings documented</p> <p>Physiotherapy: Referral acknowledged and chart reviewed Acute care PT assessment reviewed Timed up and go and knee ROM assessment completed Transfer assessment completed and instructions posted above patient's bed</p> <p>Nursing: Admission assessment completed and documented in health record VS, Neurovascular and wound assessment as per policy</p>	
Consults/ Referrals	<p>Medicine: Request OT & Physio consults to assess and treat SW consult initiated if required</p> <p>Physiotherapy: Walk and wheel referral sent to recreation</p>	
Tests	<p>Nursing: INR completed and anticoagulation order obtained as appropriate</p>	
Treatments	<p>Occupational Therapy: Dressing aids demonstrated and provided as required</p> <p>Physiotherapy: Strengthening/ROM program initiated Progress ambulation as tolerated Gait aid supplied as indicated</p>	
Medications	<p>Nursing: Administration of all ordered medications and monitoring of therapeutic and side effects</p>	
Nutrition	<p>Nursing: Diet as tolerated</p>	
Elimination	<p>Nursing: Laxatives, suppositories, prn</p>	
Pain Management	<p>Nursing: Administer pain medications prior to therapy and as required</p>	



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Phase:	Treatment Phase (3-7 days)			V	
	Start Date:	End Date:	Date Initial		
PATIENT OUTCOMES	<p>Nursing: Pain will be controlled Incision will be clean, dry and free of infection Monitor & manage elimination status Able to manage perineal hygiene and clothing during toileting Dresses independently using adaptive aids Able to transfer on/off toilet using appropriate adaptive aids Completes transfers during dressing tasks independently Completes transfer during grooming tasks independently</p> <p>Therapeutic Recreation: Attending Walk and Wheel Walk and Wheel Distance: _____ Date/Time/Signature: ___/___/___ @ _____</p> <p>Physiotherapy: Equipment: [] HWW [] rollator [] 2WW [] 4WW [] cane Assistance [] independently [] supervision [] min. [] mod [] max [] x1 [] x2 PROM: Flexion _____ Extension: _____ AROM: Flexion _____ Extension: _____ Demonstrates ability to perform ROM and strengthening exercises ROM improved from admission status Mobility improved from admission status Demonstrates safe and independent ambulation to washroom with aid</p>			___/___/___ ___/___/___ ___/___/___ ___/___/___	
TEACHING	<p>Nursing: Signs and symptoms of infection/D.V.T. Side effects of anticoagulant Effective management of pain with analgesics and medication side effects</p> <p>Physiotherapy: Reinforce need for regular ROM exercises & ambulation</p>			___/___/___ ___/___/___ ___/___/___ ___/___/___	
DISCHARGE PLANNING	<p>Care Coordinator Discharge date set; patient, family, CCAC and MD team informed</p>			___/___/___	
Pathway Reviewed with Patient/Family: (Care Coordinator)	<p>___ Yes ___ No</p>				
Patient/Family Satisfied with Progress? (Care Coordinator)	<p>___ Yes ___ No If NO, see progress notes</p>				
Signatures:	_____	Initials _____ _____ _____	_____	Initials _____ _____ _____	



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Phase:	Phase: Treatment - Interventions	V
Assessments	Physiotherapy: Assessment on stairs if not already completed Assessment of car transfers if necessary Ongoing ROM & mobility assessment	
Tests	Nursing: INR completed and anticoagulation order obtained	
Treatments	Physiotherapy: Strengthening/ROM program Progress ambulation as tolerated Endurance training Progress mobility gait aid as able Therapeutic Recreation: Scheduled for Walk and Wheel	
Medications	Nursing: Administration of all ordered medications and monitoring of effects and side effects	
Nutrition	Nursing: Diet as tolerated	
Elimination	Nursing: Laxatives, suppositories, prn	
Pain Management	Nursing: Receives pain medications prior to therapy and as required	



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Phase:	Discharge Phase (2 days)				v
	Start Date:	End Date:	Date	Initial	
PATIENT OUTCOMES	<p>Nursing: Pain controlled Incision clean, dry and free on infection Normal elimination pattern Demonstrates awareness of purpose of medications and is able to safely use medications independently.</p> <p>Occupational Therapy: Able to dress independently with: <input type="checkbox"/> reacher <input type="checkbox"/> long-handled shoe horn <input type="checkbox"/> dressing stick <input type="checkbox"/> sock aid <input type="checkbox"/> elastic shoelaces <input type="checkbox"/> no aids Able to transfer on/off toilet independently using <input type="checkbox"/> RTS <input type="checkbox"/> RTS with arms <input type="checkbox"/> grab bars <input type="checkbox"/> commode chair <input type="checkbox"/> versa frame Able to transfer in/out of tub independently using <input type="checkbox"/> PTTB <input type="checkbox"/> bath stool <input type="checkbox"/> bath chair <input type="checkbox"/> detachable tub side rail <input type="checkbox"/> grab bars <input type="checkbox"/> one person moderate assistance <input type="checkbox"/> one personal minimal assistance <input type="checkbox"/> supervision <input type="checkbox"/> independently Completes transfers during dressing tasks independently Completes transfer during grooming tasks independently Able to safely mobilize independently in the kitchen environment with <input type="checkbox"/> rollator <input type="checkbox"/> 4WW <input type="checkbox"/> 2WW <input type="checkbox"/> cane <input type="checkbox"/> no gait aid Able to prepare light meal and hot drink independently Demonstrates plan to cope with <input type="checkbox"/> grocery shopping <input type="checkbox"/> community transportation <input type="checkbox"/> laundry</p> <p>Physiotherapy: Equipment: <input type="checkbox"/> HWW <input type="checkbox"/> rollator <input type="checkbox"/> 2WW <input type="checkbox"/> 4WW <input type="checkbox"/> cane Assistance <input type="checkbox"/> independently <input type="checkbox"/> supervision <input type="checkbox"/> min. <input type="checkbox"/> mod <input type="checkbox"/> max <input type="checkbox"/> x1 <input type="checkbox"/> x2 PROM: Flexion _____ Extension: _____ Timed Up & Go: _____ AROM: Flexion _____ Extension: _____ Quads Lag: _____ Able to ambulate on stairs Able to ambulate household distance with recommended gait aid ROM: passive extension better than - 10 degrees, passive flexion greater than 75 degrees Time up and go test less than 40 sec</p>		____/____/____	____	
TEACHING	<p>Nursing: Abnormal signs and symptoms, wound management, review signs of DVT & discharge meds</p> <p>Occupational Therapy: Safe use of mobility aid in kitchen environment</p> <p>Physiotherapy: Reinforce home exercise program and safe ambulation</p>		____/____/____	____	
DISCHARGE PLANNING	<p>Care Coordinator Appropriate services arranged for discharge including CCAC (professional services, homemaking, equipment) outpatient PT & community resources Confirmation of transportation</p>		____/____/____	____	
Pathway Reviewed with Patient/Family: (Care Coordinator)					
_____ Yes _____ No					
Patient/Family Satisfied with Progress? (Care Coordinator)					
_____ Yes _____ No If NO, see progress notes					
Signatures:	_____	Initials _____ _____ _____	_____	Initials _____ _____ _____	



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Phase:	Phase: Discharge Planning - Interventions	V
Assessments	<p>Multidisciplinary Team: Discharge FIM completed by discharge</p> <p>Occupational Therapy: Bathroom equipment assessment completed, recommendations made and findings documented Kitchen assessment completed if indicated, recommendations made and findings documented</p> <p>Physiotherapy: D/C Timed up and go and knee ROM assessment completed Assess car transfer if necessary</p> <p>Clinical Indicator #1: PROM limits met: Yes [] No []</p> <p>If No, Reason: _____</p> <p>Date: _____ Signature: _____</p>	
Consults	<p>Discharge orders written Prescriptions written</p> <p>Nursing: Liaise with CCAC as required</p> <p>Physiotherapy: Coordinate appropriate services for discharge, CCAC, Outpt physio, gait aid</p> <p>Clinical Indicator #2: Referral made to Outpatient Phyio: Yes [] No []</p> <p>If No, Reason: _____</p> <p>Date: _____ Signature: _____</p>	
Tests	<p>Nursing: INR completed and anticoagulation order obtained if required</p>	
Treatments	<p>Physiotherapy: Strengthening/ROM program Progress ambulation and stairs as tolerated Progress endurance program</p>	
Medications	<p>Nursing: Administration of all ordered medications and monitoring of effects and side effects</p>	
Nutrition	<p>Nursing: Diet as tolerated</p>	
Elimination	<p>Nursing: Laxatives, suppositories, prn</p>	
Pain Management	<p>Nursing: Receives pain medications prior to therapy and as required</p>	

