TOTAL JOINT CLINICAL PATHWAY

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PRESENTATION OVERVIEW

- Case Path
- Documentation
- Challenges
- Lessons Learned
- Where do we go from here?
**TJN Case Path**

**Total Joint Network**

**CASEPATH:**

**PRE - OP**

- RN in pre-op clinic provides patient with education
- Total Joint booklet is given to and reviewed with patient
- Physiotherapist interviews patient and decides what stream is appropriate:
  - Stream 1) Acute Care
  - Stream 2) IRU

Inpatient Rehabilitation Stream Average **LOS 10 days**

Home Care /Community Stream Average **LOS 5 days**
CASEPATH: ACUTE CARE

- 4 day stay
- Admission Criteria:
  - Rehab Candidate
  - Medically Stable
  - Rehab Ready
- Admission to the Inpatient Rehab Unit (IRU)

Acute Care Documentation

- Electronic Casepath for Acute documentation is currently being developed
GOAL:
- 7 day LOS
- EDD is determined early so that staff, patients and families are aware
- PT/OT assess patient’s equipment needs before discharge

IRU STANDARDS

<table>
<thead>
<tr>
<th>Day 1 (Day 4 Post-op)</th>
<th>Day 4 (Day 7 Post-op)</th>
<th>Day 7 (Day 10 Post-op)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NUTRITION/HYDRATION</strong></td>
<td><strong>NUTRITION/HYDRATION</strong></td>
<td><strong>NUTRITION/HYDRATION</strong></td>
</tr>
<tr>
<td>Meals tolerated with set up (x)</td>
<td>Meals tolerated with set up (x)</td>
<td>Meals tolerated with set up (x)</td>
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<tr>
<td>Constipation status free text, p. ou (x)</td>
<td>Constipation status free text, p. ou (x)</td>
<td>Constipation status free text, p. ou (x)</td>
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<tr>
<td><strong>ACTIVITY/MOBILITY</strong></td>
<td><strong>ACTIVITY/MOBILITY</strong></td>
<td><strong>ACTIVITY/MOBILITY</strong></td>
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<tr>
<td>Transfer from bed to chair/commode assist x 1-2 (x)</td>
<td>Transfer from bed to chair/commode assist x 1-2 (x)</td>
<td>Transfer from bed to chair/commode assist x 1-2 (x)</td>
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<tr>
<td>Count box for working/identify what assist of one means, need to include patient instruction, insist on bed and chair mobility (x)</td>
<td>Count box for working/identify what assist of one means, need to include patient instruction, insist on bed and chair mobility (x)</td>
<td>Count box for working/identify what assist of one means, need to include patient instruction, insist on bed and chair mobility (x)</td>
</tr>
<tr>
<td>All teaching minutes needs to be distributed with all activities. Nurse must review ambulation sign during all shift</td>
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<td>All teaching minutes needs to be distributed with all activities. Nurse must review ambulation sign during all shift</td>
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<tr>
<td><strong>UP IN CHAIR X 30 MIN (X COUNT BOX FOR WEEKEND)</strong></td>
<td><strong>UP IN CHAIR X 30 MIN (X COUNT BOX FOR WEEKEND)</strong></td>
<td><strong>UP IN CHAIR X 30 MIN (X COUNT BOX FOR WEEKEND)</strong></td>
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<tr>
<td><strong>PAIN</strong></td>
<td><strong>PAIN</strong></td>
<td><strong>PAIN</strong></td>
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<tr>
<td>Minimal pain as per protocol</td>
<td>Minimal pain as per protocol</td>
<td>Minimal pain as per protocol</td>
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<tr>
<td><strong>ELIMINATION BLADDER</strong></td>
<td><strong>ELIMINATION BLADDER</strong></td>
<td><strong>ELIMINATION BLADDER</strong></td>
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<tr>
<td>Voiding as per standard (x), record urine output day one only, monitor first 24 hrs urine output &gt; 2400 cc in 24 hrs, if less bladder scan, toilet via commode, urine output (x)</td>
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</tbody>
</table>
DOCUMENTATION:
NURSING - IRU

- Shortened time for charting
- Provides snapshot of patient condition
- Drives EDD
- Created standards and parameters based on what the patient will look like on the case path when building documentation screens
- Improved Quality of Care
- Defined parameters – nurses know what to chart
- The e-documentation can be used for other patient conditions (i.e. stroke, amputees)
- Ensures that charting adheres to College Standards

IRU Standards
Example: Surgical Site

Nursing Interventions:

**DAY 1**
- Dressing to be removed and changed once daily on day shift and PRN
- Wound assessed, swabbed for MRSA
- Any deviations to be reported to physician
- Wound swabbed for C&S if signs of infection present

**DAY 2-7**
- Dressing to be removed and changed once daily on day shift and PRN
- Wound assessed during dressing changes and deviations reported to physician
- If patient d/c with sutures or staple intact, the nurse should ensure a follow-up appointment is made with Family Doctor or Orthopedic Surgeon to have them removed
<table>
<thead>
<tr>
<th>Wound Type</th>
<th>Status</th>
<th>Surgical wound WNP &gt;</th>
<th>Surgical drain site WNP &gt;</th>
<th>Skin tear WNP &gt;</th>
<th>Pressure ulcer Stage 1/II WNP &gt;</th>
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<td>Surgical</td>
<td>Edge approx/attached</td>
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<td>Site</td>
<td>Drain/tube insitu</td>
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<td>Right ischial tuberosity</td>
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<td>Landmark</td>
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<td>R HIP</td>
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<tr>
<td>Fundate</td>
<td>Cleansing solution</td>
<td>Packing material</td>
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<td>Serosanguineous</td>
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<tr>
<td>Amount</td>
<td>Irrigating solution</td>
<td>Packing detail</td>
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<tr>
<td>Small</td>
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<td>Packing solution</td>
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<td>Character</td>
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<td>Other wound care</td>
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**DOCUMENTATION: ALLIED HEALTH**

- Changes the way allied health document
- Not as timely to document on patient
- Drives an early EDD
- Patients will have equipment arranged ahead of discharge
Occupational Therapy Standards
Example: Functional Transfers

Patient's Expectations:

Patient will be able to:
- independently complete Lie<>Sit transfer upon discharge from IRU
- complete sit<>stand, bed<>chair, tub<>shower, and car transfers independently, or with assist X 1, with or without aid(s)

Therapist's Expectations:

Therapist will:
- document regarding patient's transferring abilities upon initial assessment and whenever there is a change in status
- provide the following: education of hip/knee precautions and restrictions, education and demonstrations of aids, toileting practice, equipment assessment and recommendation, provision of equipment list and vendor information, dynamic standing balancing training, strengthening exercises and ROM exercises.
Physiotherapy Standards
Example: Gait

Protocol:
Patient is ambulating with or without an aid with assistance or independently based on home environment and/or caregiver support.

Physio Interventions:

Rehab Day 1:
- Assess and document current ambulation status.
- Issue appropriate gait aid if required.

Rehab Day 2-7:
- Document any changes in level of assistance and/or gait aid.
### Interventions

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Status</th>
<th>Directions</th>
<th>Doc</th>
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<th>D</th>
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</tbody>
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**Gait in Room**: Independent

**Gait in Therapy**: Supervision

**Distance Progression**: Stage 5, 50m

**Plan**: Progress daily

- Gait training, amb
CHALLENGES

- Continuity and development of Acute Care E-documentation
- Educating the staff
  - To change way of thinking
  - To ensure continuum of process
    - Pre-op – Acute – IRU – Post D/C
- Educating the Patient/Family
  - Reduce expectations of long hospital stay
    - 20 days vs. 10 days
  - To take responsibility for own care
  - The importance of family support

CHALLENGES

- Educating the Physician
  - Access to information as end users
  - Communication to patient and family
- Who decides if a patient falls off the case path?
- Cumbersome to find specific documentation
- Timely a.m. discharge of patients from acute care to IRU to ensure continuum of therapy days (no lost therapy time)
LESSONS LEARNED

- Have stakeholders involved at the initial stages of the process
- IT involvement and continued support is essential
- Vendor support for computer software
- Should have acute care develop documentation screen first so that e-documentation has a flow
- To recognize and consider the differences in documentation between Nursing and Allied Health
- To develop easy access to documentation across the continuum of patient stay

WHERE DO WE GO FROM HERE?

- Work with acute care to develop documentation and solidify the case path process
- Refine and enhance the documentation process
- Build other patient population case paths i.e.: Stroke, Fractured Hip, Amputee
Lakeridge E-Case Path

Pre-Op Assessment → Surgical Procedure → Acute Care (3 Day LOS) → Patient Discharged

Inpatient Rehab (7 Day LOS) → 6M Fast Track (2 Day LOS)

DATC Pre-Op Home Assessment (if required) → DATC Transfers to O/P Physio if Required

DATC (8 visits) → Outpatient Physio (20 visits)

KEEP REFINING THE PROCESS