**Homecare Expectations**

**Post op patients Short stay SNF or Rehab – (s/p 8-10 days post op (generally 1 week or less in SNF)**

**Total Hip ( 9-12 visits or less all disciplines)**

**Outcomes**

Patient/Caregiver verbalizes, demonstrates understanding and is independent in wound management including S/S of wound infection, healing and plan for staple removal

Patient/Caregiver verbalizes and demonstrates understanding and is independent in edema management including

icing & positioning

Patient/Caregiver understands and is independent in use of pain management techniques including pharmacological

and non pharmacological methods

Patient/Caregiver verbalizes, demonstrates understanding and is independent in use of anti-coagulant medication prescribed, need to continue monitoring if required, and which MD to follow up with if issues

Patient/Caregiver verbalizes understanding of signs and symptoms of DVT, PE, and increase bleeding risk while on anticoagulants.

Patient/Caregiver verbalizes understanding of optimal diet for bowel management, wound healing, anti coag management, and other health concerns

Patient maintains prescribed Hip precautions with all positioning and mobility

Patient modified independent in all transfers (Bed to Stand, Sit to Stand to Sit, Shower, Commode, Car)

Patient modified independent in dressing, bathing, and personal care. May use assistive device or aid

Patient has already purchased or has written information to purchase needed assistive or adaptive devices/equipment

Patient modified independent in community ambulation with appropriate assistive device 300’

Patient modified independent in stair mobility with assistive device if needed for home or accessing the community

Patient/Caregiver demonstrates understanding of and independent in performance of written HEP/activity program including tissue healing, AROM, Stretching, Strengthening, and Balance/proprioceptive activities to improve body awareness and safety during functional activities

Patient/Caregiver has scheduled follow-up appointment with ortho MD as indicated by post-acute discharge plan or by 3 weeks post op

Patient/Caregiver has scheduled outpatient therapy services if indicated. (Patient should be referred to outpatient services approx. 3 weeks post op or sooner if outcome criteria are met)

**Recommended Visit Frequency and Duration:**

Patients that have had short term stay in SNF or Rehab generally will require less skilled service than immediate post op patient. Each patient’s plan of care is determined based on the initial assessment. If it is determined patient has met homecare outcomes sooner patient should be transitioned to outpatient. If there is delay in obtaining out patient appointment patients should continue to be seen 2x1 until transition to outpatient is complete**. If the patient’s plan of care deviates from this recommendation please obtain approval for change by contacting the office ortho coordinator.**

For patients without anticoag management RN; 1 x 1, (add 1x1 if needed for wound or pain management only)

For patients needing anticoag management RN 2x2, patients should transition to outpatient Lab by start week 2

PT; 4x1, 3x1 with possible addition of 2x1 if outpatient transition is delayed;

OT (if needed); 1x1

**Recommended RN scheduling – Immediate Post op patients no anti coag management (Max 2 visits)**

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| --- | --- | --- | --- |
| **SOC by RN on** | **Anticipated schedule** | **Week 1** | **Week 2 (if needed)** |
| Monday | 1 x 1 (add 1x1 if needed) | Mon, | Mon, |
| Tuesday | 1 x 1 (add 1x1 if needed) | Tue, | Tue, |
| Wednesday | 1 x 1 (add 1x1 if needed) | Wed, | Wed, |
| Thursday | 1 x 1 (add 1x1 if needed) | Thur, | Thur, |
| Friday | 1 x 1 (add 1x1 if needed) | Friday | Friday |
| Saturday | 1 x 1 (add 1x1 if needed) | Sat | Friday |
| Sunday | 1 x 1 (add 1x1 if needed) | Sun | Friday |

**Recommended RN schedule – Immediate Post op patients anti coag management up to 4 visits**

RN schedule determined by MD orders for anti coag management anticipated not to exceed 5 visits total

**Recommended scheduling PT short stay SNF (7 Visits) Patient should be transitioning to Outpatient week 3**

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| **SOC and**  **First PT visit on** | **Anticipated orders**  **In visit frequency** | **Week 1** | **Week 2** | **Week 3 routine order** | **Week 3 if delay in transition to outpatient services add 2w1 orders** |
| Monday | 4x1; 3x1, | Mon, Tue, Thur, Sat | Mon, Wed, Fri |  | Mon, Thur |
| Tuesday | 3x1; 4x1 | Tue, Wed, Fri, | Sun, Tue, Thur, Sat |  | Tue, Fri |
| Wednesday | 4x1; 3x1 | Wed, Thur, Fri Sat | Mon, Wed, Fri, |  | Tue, Fri |
| Thursday | 2x1; 3x1; 1w1; | Thur, Fri , | Sun, Tue, Thur, | Mon | Thur |
| Friday | 2x1; 3x1; 2x1 | Fri, Sat | Mon, Wed, Fri | Mon, Wed, | Fri |
| Saturday | 1x1; 3x1, 3x1; | Sat, | Sun, Tue, Thur, | Mon, Wed, Fri |  |
| Sunday | 4x1; 3x1; | Sun, Mon, Tue, Thu, Sat | Mon, Wed, Fri |  | Mon, Thur |

**Recommended scheduling OT short stay SNF (1 visit if needed/ordered)**

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| **SOC and**  **First PT visit on** | **OT First visit on** | **Anticipated schedule** | **Week 1** |
| Monday | Tuesday | 1x1 | Tue, |
| Tuesday | Wednesday | 1x1 | Wed, |
| Wednesday | Thursday | 1x1 | Thur |
| Thursday | Friday | 1x1 | Fri |
| Friday | Friday | 1x1 | Fri |
| Saturday | Monday | 1x1 | Mon, |
| Sunday | Monday | 1x1 | Mon, |

**RN CARE PLAN**

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| **Visit Number** | **Intervention/Objective/Goals** |
| RN Visit 1 SOC – RN  Scheduled early in day so PT can get in same day (before 11 if possible) | 1. Comprehensive Assessment performed 2. Med reconciliation and education performed including prevention of constipation with pain meds. 3. Patient/Caregiver verbalizes and understands wound management including S/S of wound infection, healing. 4. Determine plan for staple removal. 5. Order supplies if needed (staple remover, wound care supplies) 6. Patient/Caregiver verbalizes and demonstrates understanding of edema management including icing & positioning 7. Patient/Caregiver understands use of pain management techniques including pharmacological and non pharmacological methods. 8. Patient/Caregiver verbalizes understanding of bowel management including diet, medication and activity and prevention of constipation with pain meds. 9. Patient/Caregiver verbalizes and demonstrates understanding/use of anti-coagulant medication prescribed. 10. Patient/Caregiver verbalizes understanding of signs and symptoms of DVT, PE, and increase bleeding risk while on anticoagulants. 11. Patient/Caregiver verbalizes understanding of optimal diet for bowl management, wound healing, anti coag management, and other health concerns 12. Anti-coag monitoring schedule in place if needed 13. Patient maintains prescribed Hip precautions with all positioning and mobility 14. Patient indep in use of incentive spirometer   16. Confirm followup appointments with Ortho and other doctors are scheduled |
| RN Visit 2 (to 6 visits if need for Coumadin management) | 1. Comprehensive Assessment performed 2. Med reconciliation and education performed 3. Patient/Caregiver verbalizes and understands management including S/S of wound infection, healing. Wound care provided as ordered 4. Confirm supply arrival if ordered 5. Patient/Caregiver verbalizes and demonstrates understanding of edema management including icing & positioning 6. Patient/Caregiver understands and is independent in use of pain management techniques including pharmacological and non pharmacological methods 7. Patient/Caregiver verbalizes understanding of bowel management including diet, medication and activity and prevention of constipation with pain meds. 8. Patient/Caregiver verbalizes and demonstrates understanding/use of anti-coagulant medication prescribed. 9. Patient/Caregiver verbalizes understanding of signs and symptoms of DVT, PE, and increase bleeding risk while on anticoagulants. 10. Patient/Caregiver verbalizes understanding of optimal diet for bowel management, wound healing, anti coag management, and other health concerns 11. Patient/Caregiver verbalizes understanding of appropriate medical emergency plan 12. Anti-coag monitoring performed (as needed) and MD contacted 13. Patient maintains prescribed Hip precautions with all positioning and mobility. 14. Patient indep in use of incentive spirometer and lungs are clear 15. Staple removal if ordered |

**PHYSICAL THERAPY CARE PLAN**

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| **Visit Number** | **Intervention/Objective/Goals** |
| Visit 1 – PT Evaluation and Initial treatment  To be completed same day as RN admission | 1. Complete PT assessment including vital signs, ROM and strength of involved and uninvolved limbs, functional mobility, balance, home safety, circumference, and other indicated assessments using objective measures. 2. Assess for OT need if not ordered. If OT needed obtain MD order for service and notify office to schedule. 3. Patient/Caregiver verbalizes and understands management including S/S of wound infection, healing. 4. Patient/Caregiver verbalizes and demonstrates understanding of edema management including icing & positioning 5. Patient/Caregiver understands and demonstrates use of pain management techniques including pharmacological and non pharmacological methods 6. Patient/Caregiver verbalizes understanding of signs and symptoms of DVT, PE, and increase bleeding risk while on anticoagulants. 7. Patient/Caregiver verbalizes understanding of optimal diet for bowel management, wound healing, anti coag management, and other health concerns 8. Patient maintains prescribed Hip precautions with all positioning and mobility 9. Patient modified independent in all transfers (Bed to Stand, Sit to Stand to Sit, Shower, Car) or caregiver independent in assisting patient with all transfers 10. Patient modified independent in home ambulation with appropriate assistive device household distances and stairs if needed to access bathroom and bedroom or Caregiver independent in assisting patient with assistive device and all ambulation needs 11. Patient/Caregiver given written initial HEP/activity program including Stage 1 Exercises for Tissue healing and/or basic AROM, 12. Patient/Caregiver has scheduled follow-up appointment with ortho MD as indicated in post-acute discharge plan. 13. Patient has information on how to schedule appointment for outpatient therapy |
| PT visit 2-7 | 1. Complete PT assessment including vital signs, ROM and strength of involved and uninvolved limbs, functional mobility, balance, home safety, and other indicated assessments using objective measures. 2. Patient/Caregiver verbalizes and understands management including S/S of wound infection, healing. 3. Patient/Caregiver verbalizes, understanding and is independent in edema management including icing & positioning 4. Patient/Caregiver understands and is independent in use of pain management techniques including pharmacological and non pharmacological methods 5. Med Reconciliation performed 6. Patient/Caregiver verbalizes understanding of signs and symptoms of DVT, PE, and increase bleeding risk while on anticoagulants. 7. Patient/Caregiver verbalizes understanding of optimal diet for bowel management/prevention of constipation, wound healing, anti coag management, and other health concerns 8. Patient maintains prescribed Hip precautions with all positioning and mobility 9. Patient modified independent in all transfers (Bed to Stand, Sit to Stand to Sit, Shower, Car) 10. Patient modified independent in home and community ambulation including stairs if needed with appropriate assistive device 300’ 11. Patient/Caregiver indep in performing written HEP/activity program including appropriate level exercises for Tissue Healing, Joint mobility, AROM, Stretching, Strengthening, and if indicated Balance/proprioceptive activities to improve body awareness and safety during functional activities 12. HEP program updated to include progressive skilled exercises/activities 13. Staple removal if ordered and RN discharged 14. Confirm Patient/Caregiver has scheduled follow-up appointment with ortho MD by 3 weeks post op 15. Complete visit before MD appointment “MD progress report” for patient to give to MD 16. Patient/Caregiver has scheduled outpatient therapy services if indicated.(must be scheduled by visit number 5 or earlier) |

**Occupational Therapy (if indicated)**

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| **Visit Number** | **Intervention/Objective/Goals** |
| Visit 1 – OT Evaluation and Treatment (if indicated) | 1. Complete OT assessment including vital signs, ROM and strength of involved and uninvolved limbs, functional mobility, balance, home safety, and other indicated assessments using objective measures. 2. Patient/Caregiver understands use of pain management techniques including pharmacological and non pharmacological methods 3. Patient maintains prescribed Hip precautions with all positioning and mobility 4. Patient has all needed assist/adaptive equipment or has information on how to order 5. Patient modified independent in all bathroom transfers (Shower, Commode) 6. Patient modified independent in dressing, bathing, and personal care. May use assistive device or aid 7. Patient/Caregiver has equipment or written information for equipment recommendations and purchasing options 8. Patient/Caregiver given written HEP/activity program if appropriate for UE AROM, Stretching, Strengthening |