**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 Knee (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 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 there is delay in transitioning to outpatient appointment patients should continue to be seen 2w1 for therapy 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 2w2, patients should transition to outpatient Lab by start week 3.

 Add 1w1 if delay in transition to outpatient therapy

PT; 4X1; 3w1; with possible addition of 2X1 if outpatient transition is delayed

 If ROM expected outcomes are not met after week one contact MD and continue 5X1 until they are met

OT (if needed); 1 X 1

**Recommended RN scheduling –Short Stay SNF 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 –Short Stay SNF anti coag management up to 4 visits**

RN schedule determined by MD orders for anti coag management anticipated not to exceed 6 visits total

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

(If patient has not met AROM expectations by end WK 1 contact MD and continue Week 1 schedule of 5W1 for Week 2)

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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** |  **Week 2** |
| Monday  | Tuesday |  2w1  | Tue, Fri | None |
| Tuesday | Wednesday | 2w1 | Wed, Fri | None |
| Wednesday | Thursday | 1w2 | Thur | Mon,  |
| Thursday | Friday | 1w2 | Fri | Tue |
| Friday | Friday | 1w2 | Fri  | Tue |
| Saturday | Monday | 2w1 | Mon, Thur | None |
| Sunday | Monday | 2w1 | Mon, Thur | None |

**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 and is independent in 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 bowel management, wound healing, anti coag management, and other health concerns
12. Patient/Caregiver verbalizes understanding of appropriate medical emergency plan
13. Anti-coag monitoring schedule in place if needed
14. Patient/Caregiver understands and is independent in use of CPM if ordered
15. Patient indep in use of incentive spirometer

16. Confirm follow up 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.
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 indep 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 understanding and is impendent in 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. Anti-coag monitoring performed (as needed) and MD contacted
12. Patient/Caregiver understands and is independent in use of CPM if ordered
13. Patient indep in use of incentive spirometer and lungs are clear
14. Staple removal if ordered
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**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, Circumference of involved and uninvolved joint, functional mobility, balance, home safety, and other indicated assessments.
2. Patient/Caregiver verbalizes and understands management including S/S of wound infection, healing.
3. Patient/Caregiver verbalizes and demonstrates understanding of edema management including icing & positioning
4. Patient/Caregiver understands and demonstrates use of pain management techniques including pharmacological and non pharmacological methods
5. Patient/Caregiver verbalizes understanding of signs and symptoms of DVT, PE, and increase bleeding risk while on anticoagulants.
6. Patient/Caregiver verbalizes understanding of optimal diet for bowel management, wound healing, anti coag management, and other health concerns
7. 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
8. 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
9. Patient/Caregiver given written initial HEP/activity program including basic Tissue Healing, and if appropriate AROM
10. Patient/Caregiver has scheduled follow-up appointment with ortho MD as indicated in post acute discharge plan.
11. Patient/Caregiver understands and is independent in use of CPM if ordered
12. Patient has information on how to schedule appointment for out patient therapy
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| PT visit 2-7 | 1. Complete PT assessment including vital signs, ROM and strength of involved and uninvolved limbs, circumference measurements of jt, functional mobility, balance, home safety, and other indicated assessments.
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 modified independent in all transfers (Bed to Stand, Sit to Stand to Sit, Shower, Car)
9. Patient modified independent in home and community ambulation including stairs if needed with appropriate assistive device 300’
10. Patient/Caregiver indep in performing written HEP/activity program including Tissue Healing, AROM, Stretching, Strengthening, and Balance/proprioceptive activities to improve body awareness and safety during functional activities
11. HEP program updated to include progressive skilled exercises/activities
12. Patient/Caregiver understands and is independent in use of CPM if ordered
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)
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**Occupational Therapy Plan of Care(1 visit 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.
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.
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