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CLINICAL PATHWAY

Total Knee Replacement

DRG NO 209

PATIENT IDENTIFICATION

Diagnosis:		Initiating UNIT:		Initiating DATE:		Initiating TIME:		DRG NO: 209	LENGTH OF STAY: 5.0
	DAY 1 Pre-Op	DAY 1 or / PACU	DAY 1 on UNIT: _____ Post-Op	DAY 2 POD #1	DAY 3 POD #2	DAY 4 POD #3	DAY 5 POD #4		
ACTIVITY		<input type="checkbox"/> Bed rest	<input type="checkbox"/> Bed rest	<input type="checkbox"/> OOB in Chair (BID)	<input type="checkbox"/> OOB in Chair (BID) <input type="checkbox"/> Ambulation / Transfer with assistive devices as tolerated	<input type="checkbox"/> OOB in Chair (BID) <input type="checkbox"/> Demonstration of ADL's <input type="checkbox"/> Ambulation in room w/ assistive devices	<input type="checkbox"/> OOB in Chair (BID) <input type="checkbox"/> Demonstration of ADL's <input type="checkbox"/> Ambulation in room w/ assistive devices		
TEST SPECIMENS	<input type="checkbox"/> SMA7 <input type="checkbox"/> CBC <input type="checkbox"/> PT <input type="checkbox"/> PTT <input type="checkbox"/> U/A <input type="checkbox"/> CXR <input type="checkbox"/> EKG <input type="checkbox"/> PREAL-BUMIN	<input type="checkbox"/> CBC (Post-Op in PACU) [Call H.O. if H&H < 8&26] <input type="checkbox"/> Radiographs of knee	<input type="checkbox"/> Review results of CBC [Call H.O. if H&H < 8&26]	<input type="checkbox"/> CBC [Call H.O. if H&H < 8&26] <input type="checkbox"/> PT / INR (1-2 goal INR) if on Coumadin	<input type="checkbox"/> CBC [Call H.O. if H&H < 8&26] <input type="checkbox"/> PT / INR (1-2 goal INR) if on Coumadin <input type="checkbox"/> Stool for guaiac if on Lovenex	<input type="checkbox"/> CBC [Call H.O. if H&H < 8&26] <input type="checkbox"/> PT / INR (1-2 goal INR) if on Coumadin <input type="checkbox"/> Stool for guaiac if on Lovenex	<input type="checkbox"/> PT / INR (1-2 normal INR) if on Coumadin <input type="checkbox"/> Stool for guaiac if on Lovenex		
DIET	<input type="checkbox"/> NPO	<input type="checkbox"/> NPO	<input type="checkbox"/> Advance Diet as tolerated	<input type="checkbox"/> Advance Diet as tolerated	<input type="checkbox"/> Advance Diet as tolerated	<input type="checkbox"/> Diet as tolerated	<input type="checkbox"/> Diet as tolerated		
MEDS	<input type="checkbox"/> Maintenance meds as per anesthesiologist and/or physician. <input type="checkbox"/> Prophylactic antibiotics as prescribed	<input type="checkbox"/> As per Anesthesia	<input type="checkbox"/> Coumadin at 18:00 Hours if prescribed. (Notify Anesthesia before giving Coumadin). <input type="checkbox"/> Maintenance drugs as prescribed. <input type="checkbox"/> Antiemetic prn <input type="checkbox"/> Laxative/Stool softener PAIN MANAGEMENT: <input type="checkbox"/> As per Anesthesia if epidural catheter -OR- <input type="checkbox"/> As per MD order	<input type="checkbox"/> Coumadin at 18:00 Hours if prescribed. (Notify Anesthesia before giving Coumadin). <input type="checkbox"/> Lovenox BID if prescribed and no Epidural <input type="checkbox"/> Maintenance drugs as prescribed. <input type="checkbox"/> Antiemetic prn <input type="checkbox"/> Laxative/Stool softener PAIN MANAGEMENT: <input type="checkbox"/> As per Anesthesia if epidural catheter -OR- <input type="checkbox"/> As per MD order -OR- <input type="checkbox"/> Consider d/c epidural catheter and initiate PO pain management (Notify surgeon if epidural not D/C)	<input type="checkbox"/> Coumadin at 18:00 Hours if prescribed. (Notify Anesthesia before giving Coumadin). <input type="checkbox"/> Lovenox BID if prescribed and no Epidural <input type="checkbox"/> Maintenance drugs as prescribed. <input type="checkbox"/> Antiemetic prn <input type="checkbox"/> Laxative/Stool softener PAIN MANAGEMENT: <input type="checkbox"/> Consider d/c epidural catheter and initiate PO pain management (Notify surgeon if epidural not D/C)	<input type="checkbox"/> Coumadin at 18:00 Hours if prescribed. (Notify Anesthesia before giving Coumadin). <input type="checkbox"/> Lovenox BID if prescribed <input type="checkbox"/> Maintenance drugs as prescribed. <input type="checkbox"/> Antiemetic prn <input type="checkbox"/> Laxative/Stool softener PAIN MANAGEMENT: <input type="checkbox"/> D/C epidural catheter + initiate PO pain management	<input type="checkbox"/> Coumadin at 18:00 Hours if prescribed. <input type="checkbox"/> Lovenox BID if prescribed <input type="checkbox"/> Maintenance drugs as prescribed. <input type="checkbox"/> Antiemetic prn <input type="checkbox"/> Laxative/Stool softener PAIN MANAGEMENT: <input type="checkbox"/> PO pain management		

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TREATMENTS		<input type="checkbox"/> I & O <input type="checkbox"/> Cough & deep breathe <input type="checkbox"/> Turn + reposition q 2 hr <input type="checkbox"/> Place foot of bed and knee gatched <input type="checkbox"/> Ice to operative site <input type="checkbox"/> Drsg to operative site <input type="checkbox"/> Pneumatic compression device <input type="checkbox"/> TEDS <input type="checkbox"/> Knee immobilizer <input type="checkbox"/> Auto transfusion as per order <input type="checkbox"/> Call MD for Temp > 101 F	<input type="checkbox"/> I & O <input type="checkbox"/> Cough & deep breath <input type="checkbox"/> Turn + reposition q 2 hr <input type="checkbox"/> Place foot of bed and knee gatched <input type="checkbox"/> Ice to operative site <input type="checkbox"/> Drsg to operative site <input type="checkbox"/> Pneumatic compression device <input type="checkbox"/> TEDS <input type="checkbox"/> Knee immobilizer <input type="checkbox"/> Auto transfusion as per order and convert to Hemovac post transfusion <input type="checkbox"/> Incentive Spirometry q 1 hour while awake <input type="checkbox"/> Foley (indwelling) if unable to void within 8 hrs Post-Op <input type="checkbox"/> CPM as per order <input type="checkbox"/> Call MD for Temp > 101F	<input type="checkbox"/> I & O <input type="checkbox"/> Cough & deep breath <input type="checkbox"/> Turn + reposition q 2 hr <input type="checkbox"/> Place foot of bed and knee gatched <input type="checkbox"/> Ice to operative site <input type="checkbox"/> Drsg to operative site <input type="checkbox"/> Pneumatic compression device <input type="checkbox"/> TEDS <input type="checkbox"/> Hemovac <input type="checkbox"/> Knee immobilizer <input type="checkbox"/> Incentive Spirometry q 1 hour while awake <input type="checkbox"/> CPM as per order <input type="checkbox"/> Consider discontinue of Foley if appropriate <input type="checkbox"/> Call MD for Temp > 101F	<input type="checkbox"/> I & O <input type="checkbox"/> Cough & deep breath <input type="checkbox"/> Turn + reposition q 2 hr <input type="checkbox"/> Place foot of bed and knee gatched <input type="checkbox"/> Ice to operative site <input type="checkbox"/> Pneumatic compression device <input type="checkbox"/> TEDS <input type="checkbox"/> Knee immobilizer <input type="checkbox"/> Dressing change <input type="checkbox"/> CPM as per order <input type="checkbox"/> D/C Hemovac <input type="checkbox"/> D/C Foley <input type="checkbox"/> Evaluate need for laxative <input type="checkbox"/> Call MD for Temp > 101F	<input type="checkbox"/> Cough & deep breath <input type="checkbox"/> Place foot of bed and knee gatched <input type="checkbox"/> Pneumatic compression device <input type="checkbox"/> TEDS <input type="checkbox"/> Knee immobilizer <input type="checkbox"/> CPM as per order <input type="checkbox"/> Evaluate need for laxative <input type="checkbox"/> Call MD for Temp > 101F	<input type="checkbox"/> Cough & deep breath <input type="checkbox"/> Place foot of bed and knee gatched <input type="checkbox"/> Pneumatic compression device <input type="checkbox"/> TEDS <input type="checkbox"/> Knee immobilizer <input type="checkbox"/> CPM as per order <input type="checkbox"/> Evaluate need for laxative <input type="checkbox"/> Call MD for Temp > 101F
IVS	<input type="checkbox"/> As per Anesthesia	<input type="checkbox"/> IV as per order	<input type="checkbox"/> IV as per order & convert to saline lock once tolerating PO	<input type="checkbox"/> IV as per order & convert to saline lock once tolerating PO	<input type="checkbox"/> DC saline lock if appropriate		
VITAL SIGNS	<input type="checkbox"/> Per protocol	<input type="checkbox"/> Per protocol	<input type="checkbox"/> As ordered	<input type="checkbox"/> As ordered	<input type="checkbox"/> As ordered	<input type="checkbox"/> As ordered	<input type="checkbox"/> As ordered

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PHYSICAL & OCCUPATIONAL THERAPY			<input type="checkbox"/> Physical & Occupational Therapy consult requested	<input type="checkbox"/> PT - Initiate bedside exercises (quadriceps, sets, gluteal sets, ankle pumps and SLR) <input type="checkbox"/> OT - ADL Training, progress to highest functional level	<input type="checkbox"/> PT - initiate gait training, transfer training, and exercises (quadriceps, sets, gluteal sets, ankle pumps and SLR, AROM /AAROM, knee flexion + terminal knee extension) <input type="checkbox"/> OT - ADL Training, progress to highest functional level <input type="checkbox"/> Ambulation with standard walker with appropriate level of assistance. Progress level of assistance and distance as appropriate.	<input type="checkbox"/> PT - Gait training, transfer training, and exercises (quadriceps, sets, gluteal sets, ankle pumps and SLR, AROM /AAROM, knee flexion + terminal knee extension) <input type="checkbox"/> OT - ADL Training, progress to highest functional level <input type="checkbox"/> Ambulation with standard walker with appropriate level of assistance. Progress level of assistance and distance as appropriate.	<input type="checkbox"/> PT - Gait training, transfer training, and exercises (quadriceps, sets, gluteal sets, ankle pumps and SLR, AROM /AAROM, knee flexion + terminal knee extension, stairs). <input type="checkbox"/> OT - ADL Training, progress to highest functional level <input type="checkbox"/> Ambulation with standard walker with appropriate level of assistance. Progress level of assistance and distance as appropriate. P.T.-PT will demonstrate the following: <input type="checkbox"/> AROM/AAROM knee flexion (60-80 degrees or according to MD) <input type="checkbox"/> Independence in functional transfer and activities <input type="checkbox"/> Independence in ambulation and std walker on level surfaces (100ft) and stairs
TEACHING	<input type="checkbox"/> Encourage Pre-Op TJA class attendance <input type="checkbox"/> Did Pt attend Pre-op TJA class? ___Y___N <input type="checkbox"/> Pre-Op & Post-Op care	<input type="checkbox"/> Discuss pain management (pain scale) & side effects <input type="checkbox"/> Teach ankle pumps <input type="checkbox"/> Explain treatments	<input type="checkbox"/> Discuss pain mgmnt (pain scale) & side effects <input type="checkbox"/> Teach ankle pumps <input type="checkbox"/> Explain treatments	<input type="checkbox"/> Reinforce education from DAY 1 <input type="checkbox"/> Explain rationale for physical therapy + need for patient participation <input type="checkbox"/> Teach fall prevention (Hospital based + home based precautions).	<input type="checkbox"/> Continue to reinforce education from DAY 1 + DAY 2. <input type="checkbox"/> Teach signs + symptoms to report (signs of wound infection, DVT, Temp>101F, unrelieved knee pain, neurovascular changes). <input type="checkbox"/> Teach PO pain mgmnt	<input type="checkbox"/> Reinforce education from DAYs 1, 2 & 3. <input type="checkbox"/> Teach methods to prevent infection of prosthesis (prophylactic antibiotics prior to dental work or out patient surgery, and prompt treatment of systemic infections)	<input type="checkbox"/> Reinforce education from DAYs 1, 2, 3 & 4. <input type="checkbox"/> Discharge instructions

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DISCHARGE PLANNING	<input type="checkbox"/> Assess Living Situation 1. Functional & Clinical Status 2. Supportive Systems 3. Community Services		<input type="checkbox"/> Assess Living Situation 1. Functional & Clinical Status 2. Supportive Systems 3. Community Services	<input type="checkbox"/> Assess Living Situation 1. Functional & Clinical Status 2. Supportive Systems 3. Community Services DISCHARGE DISPOSITION 1. Assisted Living or OTHER REHAB FACILITY <input type="checkbox"/> Input Rehab Benefits <input type="checkbox"/> Initiate Medicaid Application (if appropriate) <input type="checkbox"/> Complete Referral <input type="checkbox"/> Target D/C date completed <input type="checkbox"/> Rehab assessment completed <input type="checkbox"/> Assisted Living decision completed, or: 2. HOME: <input type="checkbox"/> Input Home Care Benefits <input type="checkbox"/> Initiate Referrals <input type="checkbox"/> Confirm target D/C date <input type="checkbox"/> Coordinate Discharge Arrangements	<input type="checkbox"/> Assess Living Situation 1. Functional & Clinical Status 2. Supportive Systems 3. Community Services DISCHARGE DISPOSITION 1. Assisted Living or OTHER REHAB FACILITY <input type="checkbox"/> Input Rehab Benefits <input type="checkbox"/> Initiate Medicaid Application (if appropriate) <input type="checkbox"/> Complete Referral <input type="checkbox"/> Target D/C date completed <input type="checkbox"/> Rehab assessment completed <input type="checkbox"/> Assisted Living decision completed, or: 2. HOME: <input type="checkbox"/> Input Home Care Benefits <input type="checkbox"/> Initiate Referrals <input type="checkbox"/> Confirm target D/C date <input type="checkbox"/> Coordinate Discharge Arrangements	<input type="checkbox"/> Assess the following: 1. Review / Rehab Clinical Progress 2. Adjust / Update Plans as appropriate 3. Finalize Discharge Arrangements DISCHARGE DISPOSITION 1. Assisted Living or OTHER REHAB FACILITY <input type="checkbox"/> Assisted Living forms on chart. <input type="checkbox"/> Nursing Transfer Form Completed <input type="checkbox"/> MIMR Screen <input type="checkbox"/> Medical Record copied or: 2. HOME: <input type="checkbox"/> Home Care Form completed (MD,CN,CM) <input type="checkbox"/> Equipment <input type="checkbox"/> Supplies <input type="checkbox"/> Services <input type="checkbox"/> Agencies <input type="checkbox"/> Medications <input type="checkbox"/> Transportation arranged <input type="checkbox"/> Discharge order obtained <input type="checkbox"/> Discharge Instruction Form completed (MD, CN, CM)	<input type="checkbox"/> Assess the following: 1. Review / Rehab Clinical Progress 2. Adjust / Update Plans as appropriate 3. Finalize Discharge Arrangements DISCHARGE DISPOSITION 1. Assisted Living or OTHER REHAB FACILITY <input type="checkbox"/> Assisted Living forms on chart. <input type="checkbox"/> Nursing Transfer Form Completed <input type="checkbox"/> MIMR Screen <input type="checkbox"/> Medical Record copied <input type="checkbox"/> Medical Record dictated <input type="checkbox"/> DC summary completed (before 3pm) <input type="checkbox"/> Discharge order obtained <input type="checkbox"/> Transportation arranged <input type="checkbox"/> Report to CM by Clinical Nurse, or 2. HOME: <input type="checkbox"/> Home Care Form completed (MD,CN,CM) <input type="checkbox"/> Equipment <input type="checkbox"/> Supplies <input type="checkbox"/> Services <input type="checkbox"/> Agencies <input type="checkbox"/> Medications <input type="checkbox"/> Transportation arranged <input type="checkbox"/> Discharge order obtained <input type="checkbox"/> Discharge Instruction Form completed (MD, CN, CM)
EVALUATION	_____ Init'ls _____ Unit	_____ Init'ls _____ Unit	_____ Initials _____ Unit	_____ Initials _____ Unit	_____ Initials _____ Unit	_____ Initials _____ Unit	_____ Initials _____ Unit

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