Union Hospital Total Joint Replacement Program
Post-Acute Guideline for SNF *(Publish date: November 2018)*

Admission Education	Complete review of discharge instructions & materials provided at Union Hospital All discharge orders must be integrated with the SNF plan of care All f/up physician appointments verified & scheduled
Discharge Planning	Discharge planning begins within 24 hours of SNF admission Average Length of Stay (ALOS) = 7 days or less Verify scheduled physician f/up appointments scheduled after SNF discharge Verify any other scheduled post-acute service for patient post-SNF d/c. Example: home health or outpatient therapy f/up if needed.
Discharge from SNF when:	The required care could be provided at a lower level of care. This means skilled care in a SNF environment is no longer needed Plan is established for home re-entry Can perform sit to stand, stand pivot transfer (bed to chair & toilet), and bed mobility safely with available assist Able to walk in-home distance safely Demonstrate safe performance of HEP Order received from surgeon to next level of care
At Discharge, provide patient and family with	Written medication reconciliation Order for next level of care from surgeon. Inform the surgeon of discharge. List of Union Hospital Preferred Provider for post acute care. Pt may select from this list Verified schedule of next physician/surgeon appointment Verified schedule of next post-acute care service visit or appointment if needed Copy of Home Exercise Program (HEP) Durable Medical Equipment (if needed)
Call Surgeon if	Questions/concerns or if there is lack of progress Temp is greater than 101F, dressing becomes saturated with drainage, or knee flexion does not range 5-80 degrees by POD 4. Inability to bear weight or ambulate Severe swelling that does not resolve with interventions. Consult with PT Suspect Infection, DVT, severe SOB or cough For clarification of orders or changes to orders
Send to Emergency Department if	***Life-threathening emergency***: chest pain; sudden SOB; extreme sudden onset of pain that is not relieved; fall; bleeding that does not stop

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Therapy (Rehab orders)

Therapy (PT and/or OT) plan of care must be individualized to patient-specific needs and pre/post-op condition. Please refer to specific protocol from the patient's surgeon. ***There is no substitute for sound clinical judgement.*** If there is ever a question about the proposed course of treatment, or patient condition, the patient's physician should be contacted immediately.

Physical Therapy (PT) initiated within 24 hours of discharge from the hospital unless otherwise specified
Individual 1:1 PT sessions will be provided 7 days/week; minimum of 1 hour formal therapy session excluding group or routine activities.

Ice/cold therapy provided consistently. Appropriate elevation after exercise/activity

Review of Home Exercise Program (HEP). Educate patient that this must be performed outside of the formal therapy session 2-3x/day

Educate patient to stay active by doing the following: Perform ankle pumps and circles every hour; stand and walk a short distance every waking hour.

Therapy interventions should include Bed Mobility and Transfer training; Gait training including Stair training; Therapeutic exercises; ADL and IADL training; Static and Dynamic Balance training. Home evaluation as needed.

Therapy note will be available on demand within 24 hours if request

TKR - ROM Goals

Knee flexion to at least 90 degrees by 2 weeks post-op

Knee flexion to at least 110 degrees by 4 weeks post-op

AAROM-AROM. Be careful not to cause the wound to split or rupture the patellar tendon with early aggressive passive knee flexion.

Do not allow patients to push themselves to the point of extreme pain. Maintain 90 degrees for the first 2 weeks until swelling is controlled.

Severe knee swelling may prevent progress. It may be appropriate to back off on the frequency and intensity of ROM exercises if swelling is severe. Do not push a patient too hard with swollen or painful knee. Allow to subside before progressing
TERMINAL KNEE EXTENSION is very important
Pillow under the ankle while in bed to help keep knees extended

THR Goals

Independent with Home Exercise Program (HEP)
Patient is able to "teach-back" hip precautions accurately and able to demonstrate hip precautions correctly
Demonstrate hip ROM within functional range, good trunk control and sitting and standing balance to allow for safe and independent performance of ADLs including but not limited to bathing, upper & lower body dressing, bed mobility, transfers, walking, stairs and car transfers. Activities must be patient-specific

Sufficient strength to allow to return to normal function/ADLs as above

Safe ambulation on even and uneven surface (with assistive device if indicated) Household = up to 150 ft; community = 1000 ft

Shoulder Replacement (Total, Hemi or Reverse)

Please refer to individual surgeon protocol

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Leg/Knee Swelling

Goal for first 2 weeks = CONTROL SWELLING

Less swelling = less pain = improved ROM and movement = less side effects due to narcotics.

MINIMIZE LEG DEPENDENT POSITION TO 45-60 MINUTES AT A TIME

Keep leg elevated when possible

Encourage icing/use of ice packs every 2-3 hours for the first 2 weeks. Change ice packs every 30 minutes or when no longer cold.

Severe knee swelling may prevent progress. It may be appropriate to back off on the frequency and intensity of ROM exercises if swelling is severe. Do not push a patient too hard with swollen or painful knee. Allow to subside before progressing

Wound Care

Your dressing is waterproof. **You may take a shower**. Do not take tub baths, spa or enter pool/ocean unless cleared by the physician

Keep the waterproof dressing clean and dry. Observe daily for signs of infection. If dressing becomes saturated with drainage, call your doctor.

Do not remove the waterproof dressing. This dressing will be removed at the physician's office on your first follow-up visit.