Alberta Hip Fracture
Restorative Care Pathway

Purpose: to provide hip fracture patients with safe, evidence informed care, including an emphasis on achieving an optimal level of function, good quality of life, return to their previous living environment, and reintegration into their community.

There are care pathways for each time period:

- Up to post-operative day 7
- From post-operative day 8 to 28

When transitioning a patient, refer to both:

- Transition Criteria/Considerations (page 3)
- Care pathway for specific transition destination (e.g., Rural Acute POD 8 to 28)

Abbreviations

ADL: activities of daily living; can be assessed using the **Barthel Index**

CAM: Confusion Assessment Method – tool to screen for delirium

DI: diagnostic imaging

DVT: deep vein thrombosis

IV: intravenous

kcal: kilocalorie

mL: millilitre

ONS: oral nutrition supplement

OT: occupational therapist

PCP: primary care provider or general practitioner (can include nurse practitioner)

POD: post-operative day

PT: physical therapist

Q2H: every 2 hours

TID: three times a day

TUG: Timed Up and Go test - mobility assessment

WBAT: weight bearing as tolerated

Definitions

Frailty: an important clinical state of increased vulnerability, such that exposure to a stressor is more likely to result in adverse health outcomes, or increased dependency, or dying

Long Term Care (LTC): also called long term residential care. Provides 24 hour care by nurses and health care aides.

Patient/Resident/Client: may include family and/or caregiver

Plan in Place: sending site includes what the restorative plan is with specific goals or the next steps for care

Rehabilitation: multidisciplinary team to provide intense therapy to improve the functional abilities of patients

Rehab/Sub-Acute: acute hospital care not required; multidisciplinary team provides therapy to improve function

Restorative Care: a philosophy where care is provided **WITH** the patient *instead* of **FOR** the patient to achieve and maintain their highest level of function

Rural Acute: rural hospitals outside of the urban acute surgical centres

Supportive Living (SL 3 or SL 4): The Supportive Living Level 3 (SL 3) provides access to a health care aide 24 hours a day for personal care and support as well as continued professional care through Home Care. SL 3 care can be provided in spaces such as lodges, supportive living facilities, or personal care homes. SL 4 provides 24 hour care with licensed practical nurses and health care aides in a facility setting, and SL 4 D provides care for those with dementia.

Transition Beds/Units: for patients awaiting placement or those who need an interim location prior to discharge home. Has 24 hour nursing care available, but variable rehab support.

Care	Transition Criteria – Documentation Required	Considerations & Suggestions
Assessment/ Monitoring	-Abnormal assessment findings (e.g., pressure areas) -Frailty assessment (see toolkit)	
Consults/ Referrals	-Consultant follow-up as required -Book and/or inform of follow-up appointments	-Inform patient regarding process for self-referral for Home Care services if required
Tests/ Diagnostics	-Lab work and x-rays completed -Patient specific orders for ongoing lab, DI, tests. Send initial requisition as needed	
Interventions	-Titrate oxygen to baseline as able -IV removed or plan in place -Catheter removed or plan in place -Remove staples day 10-14	-Wound care orders provided as required
Medications	-Medication reconciliation/review all medications with patient -Ensure prescription/medication list is provided 24 hours prior to transfer to allow time for ordering **ALL** medications -DVT prophylaxis teaching/return demonstration if self administering (or with family/caregiver)	-Bridge medications may be required (refer to policy) -Prescription given to patient on discharge as required -Minimize use of sedatives and antipsychotics -Make arrangements for patients not self-administering DVT prophylaxis
Fluid, Nutrition, Elimination	-Continue high protein/high calorie diet -Ensure proper elimination	-Consider referral to dietitian if patient at nutritional risk and for ONS recommendations -Consider supplementation (e.g., 1.5-2 kcal/mL ONS, 60mL TID)
Delirium	-For acute confusion follow delirium protocol and communicate plan/ability to manage patient safely	-Provide delirium teaching (e.g., booklet) if required
Fracture Prevention/ Osteoporosis Management & Fall Prevention	**OSTEOPOROSIS MANAGEMENT:** -Osteoporosis teaching (e.g., nutrition, supplements, exercise, and medication) -Follow-up letter reviewed with patient; send to PCP **FALL PREVENTION/FALL RISK MITIGATION:** -Falls awareness and prevention teaching with patient	-Consider interdisciplinary in-home assessment for fall risk -Encourage family to consider a medical alert system if at risk
Pain Management	-Pain management plan in place -Teach pain medication use with patient	
Activity/ Mobility/ Rehabilitation	-Weight bearing status indicated; if not WBAT, communicate reassessment date -Document pre-fracture function (e.g., environment, stairs, supports, baseline mobility) and current function -Equipment requirements arranged/in place for next destination -Restorative goals/plan in place to achieve independence in ADLs and mobility: ➢ Up for meals, grooming, dressed, up to bathroom (no bedpans or urinals); ambulation/exercise plan -Mobility teaching with patient including hip precautions for hemiarthroplasty, exercises, proper use of mobility and ADL aids: ➢ Able to demonstrate doing stairs and car transfers (if required)	

Rural Acute to POD 7

Care	Care Pathway for Rural Acute to POD 7
Assessment/ Monitoring	-Systems assessment and vital signs based on clinical needs of patient -Routine skin assessment and consider pressure relieving surface/heel protection -Frailty assessment (see toolkit)
Consults/ Referrals	-Referral to OT/PT -Consider a referral to Recreation Therapy
Tests/ Diagnostics	-Patient specific orders for lab, DI, tests
Interventions	-Remove IV if not required -Remove catheter as soon as possible -Wound care as required -Titrate oxygen to baseline
Medications	-Medication reconciliation on admission; address polypharmacy -Minimize use of sedatives and antipsychotics: use lowest dose and review frequently -Validate DVT prophylaxis teaching with patient/family/caregiver as required
Fluid, Nutrition, Elimination	-Continue high protein/high calorie diet -Consider supplementation (e.g., 1.5-2 kcal/mL ONS, 60mL TID) -Ensure proper elimination (e.g., to avoid constipation or urinary retention)
Delirium	-For acute delirium (CAM +) follow delirium management protocol and provide delirium teaching (e.g., booklet); consider Geriatric/Seniors Health consult -Use delirium prevention and treatment strategies (e.g., orientation, fluid enhancement, availability of vision/hearing aids, mobility enhancement, non-pharmacological sleep enhancement) ➢ Consider behaviour tracking as needed
Fracture Prevention/ Osteoporosis Management & Fall Prevention	**OSTEOPOROSIS MANAGEMENT:** -Initiate or continue osteoporosis treatment (i.e., Calcium, Vitamin D, medication) -Osteoporosis teaching with patient including: nutrition, supplements, exercise, and medication -Ensure osteoporosis and fall prevention information letter reviewed with patient and sent to PCP **FALL PREVENTION/FALL RISK MITIGATION:** -Continue fall prevention strategies as per facility -Validate falls awareness/prevention teaching with patient
Pain Management	-Pain management plan to ensure ability to carry out ADLs: ➢ Wean off narcotics as tolerated ➢ Regular Tylenol® dosing, pain score goal of 3-4/10 (manageable) or contact PCP -Consider non-verbal pain scales if required -Teach patient about pain medication use
Activity/ Mobility/ Rehabilitation	-Maintain hip precautions if required -Progress ambulation to minimum 10-30 metres TID (modify as per baseline mobility) -Out of bed for meals (depending on baseline) -Up to bathroom for elimination (no bedpans or urinals) -Validate mobility teaching with patient including hip precautions for hemiarthroplasty, exercises, proper use of mobility and ADL aids -Comfort rounds Q2H (address pain, positioning, possessions, toileting, protection)

Care	Care Pathway for Rural Acute POD 8 to 28
Frailty/Elder Friendly Care	-Frailty assessment (see toolkit) -If frailty found on assessment, consider interventions to minimize frailty -Establish goals with patient to maximize function and ensure a safe discharge to final destination -Comfort rounds Q2H (address pain, positioning, possessions, toileting, protection)
ADLs	-Progress as able to reach and improve upon pre-fracture level of independence in ADLs -OT assessment re: aids required and strategies for improving independence in ADLs -Demonstrate safe transfers with equipment as required (e.g., in/out of bed, chair, shower, etc): if unable, assistance is provided -Ensure adequate supports in home living environment (e.g., assistance from spouse, child, friend, caregiver or Home Care) -Encourage family to consider a medical alert system if at risk
ADLs-Bathing and Grooming	-Support independent activity (e.g., have patient comb hair, shave, brush teeth, etc daily) -Up to bathe/shower using equipment and assistance as required
ADLs-Dressing	-Up and dressed daily -If on hip precautions use dressing aids (e.g., reacher) if needed
ADLs-Toileting	-Up to bathroom: no bedpans or urinals -Regular toileting routine to promote continence -Ensure proper elimination (e.g., to avoid constipation or urinary retention)
ADLs-Eating	-Continue high protein/high calorie diet -Up in chair or dining room for meals -Consider referral to dietitian if patient at nutritional risk and for ONS recommendations -Consider providing ONS (e.g., 1.5-2 kcal/mL, 60mL TID) -Demonstrate or describe plans for meal preparation and kitchen safety (e.g., turn off stove) -Patient has initiated community resources if required (e.g., Meals on Wheels, grocery delivery)
Mobility	-Maintain hip precautions if required for 3 months or as otherwise ordered -Consider TUG/Barthel assessment on admission and discharge to track progress in mobility (see toolkit) -Consider strengthening exercises and targeted treatment of balance to offset frailty -Ambulation to minimum 50-100 metres TID (modify as per baseline mobility) -Demonstrate ability to walk distance required for meals at home setting -Able to mobilize outside safely (e.g., uneven sidewalks, curbs, various weather conditions)
Medications	-Medication reconciliation on admission; address polypharmacy -Minimize use of sedatives and antipsychotics: use lowest dose and review frequently -Pain management plan to ensure ability to carry out ADLs: ➢ Wean off narcotics as tolerated ➢ Regular Tylenol® dosing, pain score goal of 3-4/10 (manageable) or contact PCP -Consider trial of compliance packaging and self-medication program as early as possible
Delirium, Dementia and Depression	-For acute delirium (CAM +) follow delirium management protocol and provide delirium teaching (e.g., booklet); consider Geriatric/Seniors Health consult -Use delirium prevention and treatment strategies (e.g., orientation, fluid enhancement, availability of vision/hearing aids, mobility enhancement, non-pharmacological sleep enhancement) ➢ Consider behaviour tracking as needed -For patients with dementia or depression promote activity (e.g., walk to meals, participate in group or individual exercise and social activities) -Consider psychosocial needs and refer to social worker, counselor, Psychiatry, or Seniors Mental Health -Consider support for caregivers and provide community resources if available
Fracture Prevention/ Osteoporosis Management & Fall Prevention	**OSTEOPOROSIS MANAGEMENT:** -Initiate or continue osteoporosis treatment (i.e., Calcium, Vitamin D, medication) -Osteoporosis teaching with patient including: nutrition, supplements, exercise, and medication **FALL PREVENTION/FALL RISK MITIGATION:** -Continue fall prevention strategies as per facility; consider hip protectors -Validate falls awareness/prevention teaching with patient

Rehab/Sub-Acute/Transition to POD 7

Care	Care Pathway for Rehab/Sub-Acute/Transition to POD 7
Assessment/ Monitoring	-Systems assessment and vital signs based on clinical needs of patient -Routine skin assessment and consider pressure relieving surface/heel protection -Frailty assessment (see toolkit)
Consults/ Referrals	-Referral to OT/PT -Consider a referral to Recreation Therapy
Tests/ Diagnostics	-Patient specific orders for lab
Interventions	-Remove IV if not required -Remove catheter as soon as possible -Wound care as required -Titrate oxygen to baseline
Medications	-Medication reconciliation on admission; address polypharmacy -Minimize use of sedatives and antipsychotics: use lowest dose and review frequently -Validate DVT prophylaxis teaching with patient/family/caregiver as required
Fluid, Nutrition, Elimination	-Continue high protein/high calorie diet -Consider supplementation (e.g., 1.5-2 kcal/mL ONS, 60mL TID) -Ensure proper elimination (e.g., to avoid constipation or urinary retention)
Delirium	-For acute delirium (CAM +) follow delirium management protocol and provide delirium teaching (e.g., booklet); consider Geriatric/Seniors Health consult -Use delirium prevention and treatment strategies (e.g., orientation, fluid enhancement, availability of vision/hearing aids, mobility enhancement, non-pharmacological sleep enhancement) ➢ Consider behaviour tracking as needed
Fracture Prevention/ Osteoporosis Management & Fall Prevention	**OSTEOPOROSIS MANAGEMENT:** -Initiate or continue osteoporosis treatment (i.e., Calcium, Vitamin D, medication) -Osteoporosis teaching with patient including: nutrition, supplements, exercise, and medication -Ensure osteoporosis and fall prevention information letter reviewed with patient and sent to PCP **FALL PREVENTION/FALL RISK MITIGATION:** -Continue fall prevention strategies as per facility -Validate falls awareness/prevention teaching with patient
Pain Management	-Pain management plan to ensure ability to carry out ADLs: ➢ Wean off narcotics as tolerated ➢ Regular Tylenol® dosing, pain score goal of 3-4/10 (manageable) or contact PCP -Consider non-verbal pain scales if required -Teach patient about pain medication use
Activity/ Mobility/ Rehabilitation	-Maintain hip precautions if required -Progress ambulation to minimum 10-30 metres TID (modify as per baseline mobility) -Out of bed for meals (depending on baseline) -Up to bathroom for elimination (no bedpans or urinals) -Validate mobility teaching with patient including hip precautions for hemiarthroplasty, exercises, proper use of mobility and ADL aids -Comfort rounds Q2H (address pain, positioning, possessions, toileting, protection)

Care	Care Pathway for Rehab/Sub-Acute/Transition POD 8 to 28
Frailty/Elder Friendly Care	-Frailty assessment (see toolkit) -If frailty found on assessment, consider interventions to minimize frailty -Establish goals with patient to maximize function and ensure a safe discharge to final destination -Comfort rounds Q2H (address pain, positioning, possessions, toileting, protection)
ADLs	-Progress as able to reach and improve upon pre-fracture level of independence in ADLs -OT assessment re: aids required and strategies for improving independence in ADLs -Demonstrate safe transfers with equipment as required (e.g., in/out of bed, chair, shower, etc): if unable, assistance is provided -Ensure adequate supports in home living environment (e.g., assistance from spouse, child, friend, caregiver or Home Care) -Encourage family to consider a medical alert system if at risk
ADLs-Bathing and Grooming	-Support independent activity (e.g., have patient comb hair, shave, brush teeth, etc daily) -Up to bathe/shower using equipment and assistance as required
ADLs-Dressing	-Up and dressed daily -If on hip precautions use dressing aids (e.g., reacher) if needed
ADLs-Toileting	-Up to bathroom: no bedpans or urinals -Regular toileting routine to promote continence -Ensure proper elimination (e.g., to avoid constipation or urinary retention)
ADLs-Eating	-Continue high protein/high calorie diet -Up in chair or dining room for meals -Consider referral to dietitian if patient at nutritional risk and for ONS recommendations -Consider providing ONS (e.g., 1.5-2 kcal/mL, 60mL TID) -Demonstrate or describe plans for meal preparation and kitchen safety (e.g., turn off stove) -Patient to initiate community resources if required (e.g., Meals on Wheels, grocery delivery)
Mobility	-Maintain hip precautions if required for 3 months or as otherwise ordered -Consider TUG/Barthel assessment on admission and discharge to track progress in mobility (see toolkit) -Consider strengthening exercises and targeted treatment of balance to offset frailty -Ambulation to minimum 50-100 metres TID (modify as per baseline mobility) -Demonstrate ability to walk distance required for meals at home setting -Able to mobilize outside safely (e.g., uneven sidewalks, curbs, various weather conditions)
Medications	-Medication reconciliation on admission; address polypharmacy -Minimize use of sedatives and antipsychotics: use lowest dose and review frequently -Pain management plan to ensure ability to carry out ADLs: ➢ Wean off narcotics as tolerated ➢ Regular Tylenol® dosing, pain score goal of 3-4/10 (manageable) or contact PCP -Consider use of compliance packaging and self-medication program prior to discharge (x 7 days)
Delirium, Dementia and Depression	-For acute delirium (CAM +) follow delirium management protocol and provide delirium teaching (e.g., booklet); consider Geriatric/Seniors Health consult -Use delirium prevention and treatment strategies (e.g., orientation, fluid enhancement, availability of vision/hearing aids, mobility enhancement, non-pharmacological sleep enhancement) ➢ Consider behaviour tracking as needed -For patients with dementia or depression promote activity (e.g., walk to meals, participate in group or individual exercise and social activities) -Consider psychosocial needs and refer to social worker, counselor, Psychiatry, or Seniors Mental Health -Consider support for caregivers and provide community resources if available
Fracture Prevention/ Osteoporosis Management & Fall Prevention	**OSTEOPOROSIS MANAGEMENT:** -Initiate or continue osteoporosis treatment (i.e., Calcium, Vitamin D, medication) -Osteoporosis teaching with patient including: nutrition, supplements, exercise, and medication **FALL PREVENTION/FALL RISK MITIGATION:** -Continue fall prevention strategies as per facility; consider hip protectors -Validate falls awareness/prevention teaching with patient

LTC to POD 7

Care	Care Pathway for LTC to POD 7
Assessment/ Monitoring	-Systems assessment and vital signs based on clinical needs of resident -Routine skin assessment and consider pressure relieving surface/heel protection -Frailty assessment (see toolkit)
Consults/ Referrals	-Referral to OT/PT -Consider a referral to Recreation Therapy
Tests/ Diagnostics	-Resident specific orders for lab work with PCP follow-up
Interventions	-Remove catheter as soon as possible -Wound care as required
Medications	-Medication reconciliation on admission; address polypharmacy -Minimize use of sedatives and antipsychotics: use lowest dose and review frequently
Fluid, Nutrition, Elimination	-Continue high protein/high calorie diet -Consider supplementation (e.g., 1.5-2 kcal/mL ONS, one can per day) -Ensure proper elimination (e.g., to avoid constipation or urinary retention)
Delirium	-For acute delirium, follow delirium management protocol per facility guidelines and provide delirium teaching (e.g., booklet) -Use delirium prevention and treatment strategies (e.g., orientation, fluid enhancement, availability of vision/hearing aids, mobility enhancement, non-pharmacological sleep enhancement) ➢ Consider behaviour tracking as needed
Fracture Prevention/ Osteoporosis Management & Fall Prevention	**OSTEOPOROSIS MANAGEMENT:** -Initiate or continue osteoporosis treatment (i.e., Calcium, Vitamin D, medication) -Ensure osteoporosis and fall prevention information letter reviewed with resident and given to PCP **FALL PREVENTION/FALL RISK MITIGATION:** -Continue fall prevention strategies as per facility -Validate falls awareness/prevention teaching with resident
Pain Management	-Pain management plan to ensure ability to carry out ADLs: ➢ Wean off narcotics as tolerated ➢ Regular Tylenol® dosing, pain score goal of 3-4/10 (manageable) or contact PCP -Consider non-verbal pain scales if required -Teach resident about pain medication use
Activity/ Mobility/ Rehabilitation	-Maintain hip precautions if required -Progress ambulation to minimum 10-30 metres TID (modify as per baseline mobility) -Out of bed for meals (depending on baseline) -Up to bathroom for elimination (no bedpans or urinals) -Validate mobility teaching with resident including hip precautions for hemiarthroplasty, exercises, proper use of mobility and ADL aids -Comfort rounds Q2H (address pain, positioning, possessions, toileting, protection)

Care	Care Pathway for LTC POD 8 to 28
Frailty/Elder Friendly Care	-Frailty assessment (see toolkit) -If frailty found on assessment, consider interventions to minimize frailty -Establish individual goals to maximize function -Comfort rounds Q2H (address pain, positioning, possessions, toileting, protection)
ADLs	-Progress as able to reach and improve upon pre-fracture level of independence in ADLs -OT assessment re: aids required and strategies for improving independence in ADLs -Demonstrate safe transfers with equipment as required (e.g., in/out of bed, chair, etc)
ADLs-Bathing and Grooming	-Support independent activity (e.g., have resident comb hair, shave, brush teeth, etc daily) -Up to bathe/shower using equipment and assistance as required
ADLs-Dressing	-Up and dressed daily, using aids as required (e.g., reacher)
ADLs-Toileting	-Up to bathroom: no bedpans or urinals -Regular toileting routine to promote continence -Ensure proper elimination (e.g., to avoid constipation or urinary retention)
ADLs-Eating	-Continue high protein/high calorie diet -Up to dining room for meals -Consider referral to dietitian if resident at nutritional risk and for ONS recommendations -Consider supplementation (e.g., 1.5-2 kcal/mL ONS, one can per day)
Mobility	-Maintain hip precautions if required for 3 months or as otherwise ordered -Demonstrate safe use of mobility aids while maintaining precautions (if required) -Consider TUG/Barthel assessment upon admission/return and at POD 28 to track progress in mobility (see toolkit) -Consider strengthening exercises and targeted treatment of balance to offset frailty -Ambulation to minimum 50-100 metres TID (modify as per baseline mobility) -Progress as tolerated to mobilize outside safely (e.g., uneven sidewalks, curbs, various weather conditions) if required
Medications	-Medication reconciliation on admission; address polypharmacy -Minimize use of sedatives and antipsychotics: use lowest dose and review frequently -Pain management plan to ensure ability to carry out ADLs: ➢ Wean off narcotics as tolerated ➢ Regular Tylenol® dosing, pain score goal of 3-4/10 (manageable) or contact PCP
Delirium, Dementia and Depression	-Use delirium prevention and treatment strategies (e.g., orientation, fluid enhancement, availability of vision/hearing aids, mobility enhancement, non-pharmacological sleep enhancement) -Contact PCP with any acute changes in condition -Follow delirium management protocol per facility guidelines -Provide teaching for family if signs of delirium -For residents with dementia or depression promote activity (e.g., walk to meals, participate in group or individual exercise and social activities) -Consider psychosocial needs and refer for counseling if available
Fracture Prevention/ Osteoporosis Management & Fall Prevention	**OSTEOPOROSIS MANAGEMENT:** -Initiate or continue osteoporosis treatment (i.e., Calcium, Vitamin D, medication) **FALL PREVENTION/FALL RISK MITIGATION:** -Continue fall prevention strategies as per facility; consider hip protectors -Validate falls awareness/prevention teaching with resident

Supportive Living to POD 7

Care	Care Pathway for Supportive Living to POD 7
Assessment/ Monitoring	-Systems assessment and vital signs based on clinical needs of resident -Routine skin assessment and consider pressure relieving surface/heel protection -Frailty assessment (see toolkit)
Consults/ Referrals	-Referral to OT/PT -Consider a referral to Recreation Therapy -Short term enhanced care is in place if required
Tests/ Diagnostics	-Resident specific orders for lab work with PCP follow-up
Interventions	-Wound care as required
Medications	-Medication reconciliation on admission; address polypharmacy -Minimize use of sedatives and antipsychotics: use lowest dose and review frequently -Validate DVT prophylaxis teaching with resident
Fluid, Nutrition, Elimination	-Continue high protein/high calorie diet -Consider supplementation (e.g., 1.5-2 kcal/mL ONS, one can per day) -Ensure proper elimination (e.g., to avoid constipation or urinary retention)
Delirium	-Use delirium prevention and treatment strategies (e.g., orientation, fluid enhancement, availability of vision/hearing aids, mobility enhancement, non-pharmacological sleep enhancement) ➢ Consider behaviour tracking as needed -Contact PCP with any acute changes in condition
Fracture Prevention/ Osteoporosis Management & Fall Prevention	**OSTEOPOROSIS MANAGEMENT:** -Initiate or continue osteoporosis treatment (i.e., Calcium, Vitamin D, medication) through PCP -Ensure osteoporosis and fall prevention information letter reviewed with resident and sent to PCP **FALL PREVENTION/FALL RISK MITIGATION:** -Continue fall prevention strategies as per facility -Validate falls awareness/prevention teaching with resident
Pain Management	-Pain management plan to ensure ability to carry out ADLs: ➢ Wean off narcotics as tolerated ➢ Regular Tylenol® dosing, pain score goal of 3-4/10 (manageable) or contact PCP -Consider non-verbal pain scales if required -Teach resident about pain medication use
Activity/ Mobility/ Rehabilitation	-Maintain hip precautions if required -Progress ambulation to minimum 10-30 metres TID (modify as per baseline mobility) -Out of bed for meals (depending on baseline) -Up to bathroom for elimination (no bedpans or urinals) -Validate mobility teaching with resident including hip precautions for hemiarthroplasty, exercises, proper use of mobility and ADL aids -Consider comfort rounds regularly upon admission or return to supportive living (e.g., regularly ask about pain, assist to toilet, assist for repositioning, possessions within easy reach, remove hazards)

Care	Care Pathway for Supportive Living POD 8 to 28
Frailty/Elder Friendly Care	-Frailty assessment (see toolkit) -If frailty found on assessment, consider interventions to minimize frailty -Establish individual goals to maximize function -Consider comfort rounds regularly upon admission or return to supportive living (e.g., regularly ask about pain, assist to toilet, assist for repositioning, possessions within easy reach, remove hazards)
ADLs	-Progress as able to reach and improve upon pre-fracture level of independence in ADLs -OT assessment re: aids required and strategies for improving independence in ADLs -Demonstrate safe transfers with equipment as required (e.g., in/out of bed, chair, etc)
ADLs-Bathing and Grooming	-Support independent activity (e.g., have resident comb hair, shave, brush teeth, etc daily) -Up to bathe/shower using equipment and assistance as required -Short term enhanced care is in place if required
ADLs-Dressing	-Up and dressed daily, using aids as required (e.g., reacher)
ADLs-Toileting	-Up to bathroom: no bedpans or urinals -Regular toileting routine to promote continence -Ensure proper elimination (e.g., to avoid constipation or urinary retention)
ADLs-Eating	-Continue high protein/high calorie diet, and up to dining room for meals -Consider referral to dietitian if resident at nutritional risk and for ONS recommendations -Consider supplementation (e.g., 1.5-2 kcal/mL ONS, one can per day)
Mobility	-Notify case manager of any concerns with mobility and ADLs -Maintain hip precautions if required for 3 months or as otherwise ordered -Demonstrate safe use of mobility aids while maintaining precautions (if required) -Consider TUG/Barthel assessment upon admission/return and at POD 28 to track progress in mobility (see toolkit) -Consider strengthening exercises and targeted treatment of balance to offset frailty -Ambulation to minimum 50-100 metres TID (modify as per baseline mobility) -Progress as tolerated to mobilize outside safely (e.g., uneven sidewalks, curbs, various weather conditions) if required
Medications	-Medication reconciliation on admission; address polypharmacy -Minimize use of sedatives and antipsychotics: use lowest dose and review frequently -Pain management plan to ensure ability to carry out ADLs: ➢ Wean off narcotics as tolerated ➢ Regular Tylenol® dosing, pain score goal of 3-4/10 (manageable) or contact PCP
Delirium, Dementia and Depression	-Use delirium prevention and treatment strategies (e.g., orientation, fluid enhancement, availability of vision/hearing aids, mobility enhancement, non-pharmacological sleep enhancement) -Contact PCP with any acute changes in condition -Provide teaching for family if signs of delirium -For residents with dementia or depression promote activity (e.g., walk to meals, participate in group or individual exercise and social activities) -Consider psychosocial needs and refer for counseling if available
Fracture Prevention/ Osteoporosis Management & Fall Prevention	**<u>OSTEOPOROSIS MANAGEMENT:</u>** -Initiate or continue osteoporosis treatment (i.e., Calcium, Vitamin D, medication) -Encourage resident to follow up with PCP regarding osteoporosis treatment **<u>FALL PREVENTION/FALL RISK MITIGATION:</u>** -Continue fall prevention strategies as per facility; consider hip protectors -Validate falls awareness/prevention teaching with resident -Encourage family to consider a medical alert system if at risk

Home +/- Home Care to POD 7

Care	Care Pathway for Home +/- Home Care to POD 7
Consults/ Referrals	-Referral to OT/PT
Tests/ Diagnostics	-Client specific orders for lab work with PCP follow-up -Arrange for mobile lab collection if required
Interventions	-Wound care as required
Medications	-Review and complete medication reconciliation with Home Care case manager as required -Home Care can validate DVT prophylaxis teaching and return demonstration if self administering, or provide assistance if required -Encourage client to follow up with PCP/pharmacist re: current medication list and addressing polypharmacy
Fluid, Nutrition, Elimination	-Continue high protein/high calorie diet -Up for meals -Consider supplementation (e.g., 1.5-2 kcal/mL ONS, one can per day) -Teach client about proper bowel and bladder elimination
Delirium, Dementia, and Depression	**DELIRIUM:** -Teach client/family/caregiver regarding identification and prevention of delirium and depression -Instruct family to contact PCP with any acute changes in condition **DEPRESSION:** -Promote social activities and consider community resources -Encourage client to contact PCP if feeling depressed -Provide information on supports for caregivers to access community resources if available (e.g., day programs, Seniors Mental Health, respite beds)
Fracture Prevention/ Osteoporosis Management & Fall Prevention	**OSTEOPOROSIS MANAGEMENT:** -Continue taking Calcium and Vitamin D and osteoporosis medication (if started) -Encourage client to follow-up with PCP for osteoporosis treatment **FALL PREVENTION/FALL RISK MITIGATION:** -Review fall prevention strategies at home -Inform client that Home Care can perform an in-home assessment for fall risk mitigation -Encourage client/family to consider a medical alert system if at risk -Consider hip protectors
Pain Management	-Encourage client to follow-up with PCP for ongoing pain issues (greater than 3-4/10)
Activity/ Mobility/ Rehabilitation	-Maintain hip precautions if required -Progress ambulation to minimum 10-30 metres TID (modify as per baseline mobility) -Validate mobility teaching with client including hip precautions for hemiarthroplasty, exercises, proper use of mobility and ADL aids -Consider Home Care rehab, outpatient rehab and/or community resources (e.g., exercise or day programs) -Encourage client to talk to PCP about an exercise program or use of a personal trainer

Care	Care Pathway for Home +/- Home Care POD 8 to 28
Frailty/Elder Friendly Care	-Home Care to consider completing a frailty assessment (see toolkit) -If frailty found on assessment, consider interventions to minimize frailty -Establish individual goals to maximize function
ADLs	-Progress as able to reach and improve upon pre-fracture level of independence in ADLs -OT assessment re: aids required and strategies for improving independence in ADLs -Instruct client not to drive until allowed by PCP
ADLs-Bathing and Grooming	-Support independent activity (e.g., have client comb hair, shave, brush teeth, etc daily) -Up to bathe/shower using equipment as required
ADLs-Dressing	-Up and dressed daily, using aids as required (e.g., reacher)
ADLs-Toileting	-Teach client about proper bowel and bladder elimination
ADLs-Eating	-Up for meals -Provide client with information about community resources (e.g., Meals on Wheels, grocery delivery) -Consider referral to dietitian if client at nutritional risk
Mobility	-Maintain hip precautions if required for 3 months or as otherwise ordered -Consider TUG/Barthel assessment by Home Care to track progress in mobility on initiation and termination of services (see toolkit) -Consider strengthening exercises and targeted treatment of balance to offset frailty -Ambulation to minimum 50-100 metres TID (modify as per baseline mobility) -Progress as tolerated to mobilize outside safely (e.g., uneven sidewalks, curbs, various weather conditions) if required -Consider Home Care rehab or outpatient rehab -Encourage client to talk to PCP about an exercise program or use of a personal trainer
Medications	-Home Care can validate DVT prophylaxis teaching and return demonstration if self administering, or provide assistance if required -Encourage client to follow up with PCP/pharmacist re: current medication list and minimizing polypharmacy -Encourage client to follow-up with PCP for ongoing pain issues (greater than 3-4/10)
Delirium, Dementia and Depression	**DELIRIUM:** -Teach client/family/caregiver regarding identification and prevention of delirium and depression -Instruct family to contact PCP with any acute changes in condition **DEPRESSION:** -Promote social activities and consider community resources -Encourage client to contact PCP if feeling depressed -Provide information on supports for caregivers to access community resources if available (e.g., day programs, Seniors Mental Health, respite beds)
Fracture Prevention/ Osteoporosis Management & Fall Prevention	**OSTEOPOROSIS MANAGEMENT:** -Continue taking Calcium and Vitamin D and osteoporosis medication (if started) -Encourage client to follow-up with PCP for osteoporosis treatment **FALL PREVENTION/FALL RISK MITIGATION:** -Review fall prevention strategies at home -Inform client that Home Care can perform an in-home assessment for fall risk mitigation -Encourage client/family to consider a medical alert system if at risk -Consider hip protectors

NOTES:

Hip Fracture Resources

For access to Healthcare Provider resources available, please visit the **AHS Bone & Joint Health Strategic Clinical Network** Hip Fracture Care Pathway Toolkit web page at:

http://www.albertahealthservices.ca/hfcptoolkit.asp

For access to Patient and Family information resources, please visit **MyHealth.Alberta.ca** and search"Hip Fracture"

https://myhealth.alberta.ca/Alberta/Pages/guide-after-hip-fracture.aspx

Additional Websites of Interest

Alberta Bone & Joint Health Institute: http://albertaboneandjoint.com/

Bone and Joint Canada: http://boneandjointcanada.com/

Canadian Coalition for Seniors Mental Health: http://www.ccsmh.ca/en/default.cfm

Finding Balance Alberta: http://www.findingbalancealberta.ca/

Inform Alberta: http://www.informalberta.ca/public/common/search.do

Ortho Connect: http://www.orthoconnect.org/

Osteoporosis Canada: http://www.osteoporosis.ca/