

PROTOCOL FOR: Fractured Hip: Care of the Post-Operative Patient

DESIRED PATIENT

- OUTCOMES:
1. Patient will experience adequate pain relief.
 2. Patient will experience no/minimal postop complications.
 3. Patient will demonstrate proper use of assistive devices.

CLINICAL
ASSESSMENT/
AND CARE:

1. Cardiovascular/Circulation:
 - a. Monitor vital signs every 4 hours for 24 hours, then every 8 hours.
 - b. Monitor CSM every 4 hours X 24 hours, then every 8 hours including: color, sensation, movement, blanching/capillary refill, blood pulses of lower extremities, flexion/extension of the foot, ability to spread toes, edema.
 - c. Assess antiembolytic stockings (PAS) or AV-Foot Pumps. Remove and reapply stockings or foot pumps at least every 8 hours and PRN. Perform a thorough skin assessment after the stockings or foot pumps are removed and document any changes from baseline in the condition of the skin.
 - d. Monitor labs as ordered.
 - e. Monitor intake and output.
2. Pulmonary:
 - a. Assess lung sounds every 4 hours x 24 hours, then every 8 hours and PRN.
 - b. Assess patient ability/compliance to cough, deep breathe, use IS every 1-hour while awake, per MD order.
 - c. Maintain O₂ per MD order.
3. Fluid Volume Status:
 - a. Maintain intravenous fluid as ordered.
 - b. Monitor I & O.
4. Wound Care:
 - a. Do not change dressing immediately post-op. Observe and document condition of dressing every four hours until first dressing change (MD performs first dressing change). Then change dressing as ordered, using sterile technique.
 - b. Assess wound for symptoms of infection: erythema, heat swelling, pain, drainage, and odor.
 - c. Assess wound for bleeding.

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- d. Inspect area around wound for tape irritation.
- e. Administer antibiotics as ordered.
- 5. Pain Management
 - a. Assess and document patient's report of pain: location, type, duration, severity - use pain scale:
0-10 = 0 pain, 10 = worst pain imaginable.
 - b. Medicate for pain as needed. Assess and document patient response to medication regimen.
 - c. Pre-medicate per LIP order before PT, exercises, ADL.
 - d. Institute comfort measures as needed: re-positioning, relaxation, and reassurance.
 - e. Initiate appropriate pain management protocols (Adult or Acute).
- 6. Progressive Activity:
 - a. Maintain alignment of affected extremity.
 - b. Progress activity per MD order.
 - c. Consult with Physical/Occupational Therapy as ordered.
 - d. Weight bearing status per MD.
 - e. Initiate immobility and skin care protocols.
- 7. Notify House Officer if:
 - a. Vital signs outside MD parameters.
 - b. Lab values outside accepted range.
 - c. Signs/symptoms of wound infection.
 - d. Malalignment of body part or changes in CSM of affected extremity.
 - e. Ineffective pain relief.

APPROVAL: Medical-Surgical Standards Review
Nursing Standards Committee

EFFECTIVE DATE: 1/92

REVISION DATES: 2/94, 12/97, 6/03, 11/03, 11/05