TOTAL HIP ARTHOPLASTY –ACUTE DATA FORM

Total Hip Arthoplasty-Acute Data Form. Revised

Demographics:

Demographic information, including the patient's ID number, age, and gender, are to be recorded at the top of the MDS form. Other general information that is important to the patient's outcome includes: the date of the surgery, the type of prosthetic hip components used in the procedure. In addition, any complications that may arise during the surgery or during recovery from the surgery may have serious implications on the patient's outcome. These complications may include a DVT, infection, prosthetic loosening or dislocation, as well as many other conditions. Any complications that arise and the time in which they occur are to be recorded in the space provided.

Co-Morbidities:

BP = blood pressure recorded as systolic/diastolic mmHg; needs to be measured and recorded on each data collection form. If a patient has more than one form, the recorded value needs to be carried over to each form. You only need to record BP once for the patient, as close to their first visit as possible. Check the box for either Student/CI or patient report measurement.

Height/Weight: Record for each patient on the form and check the box for either student/CI or patient report measurement.

Smoker: please ask the patient if they currently smoke, smoked in the past or have never smoked and record on the form. Past smoker according to ACSM is the person has not smoked in 6 months. If the person quit within the last 6 months than you must mark them as a current smoker.

CVD: please ask the patient or obtain from patient history any current, past CV conditions or family history of CVD. If the patient reports yes, you must check the box and circle whether it is the patient or family history. If the patient is taking any CV Meds (hypertension drugs, diuretics, beta blockers, platelet medications, Aspirin, Plavix, etc) you will need to check that box.

Diabetes Mellitus (DM): same protocol as listed for CVD. Any diabetic medication, including oral medications or insulin, would result in you marking the DM Meds box.

Pulm Disease: same protocol as listed for CVD and DM above. Any pulmonary medication, including the use of inhalers would result in you marking the Pulm Disease Meds box.

No Comorbidities: if the patient reports no meds, conditions, or family history of any of the conditions (CVD/meds, DM/meds, Pulm Disease/Meds) then you must check the box next to the no comorbidities line.

Physical Activity: according to the Surgeon General recommendations, an individual meets the physical activity recommendations if they have aerobic activity for a minimum of 30 minutes moderate-intensity physical activity/day most days of the week OR a minimum of 20 minutes vigorous activity 3 days a week. An individual does not meet the recommendations if they do not have either of the above.

Balance Assessments:

Routine for Diagnosis: Ask the PT whether he/she routinely examines balance in an individual with this diagnosis.

Degree of Patient perceived balance problem: Ask the patient, *" On a scale of 0-10, where 0 is no balance difficulties, and 10 would be balance problems so severe you could not stand, where would you place your balance abilities?"*

Single Limb Stance Test: Eyes Open (EO)—patient selects stance leg

Instructions to patient:

Lift your right/left leg from the floor by bending your knee; stay standing on one leg as long as you can. Keep your arms across your chest and don't touch your raised leg against your other leg. Hold this position until I tell you to stop. (max of 30 sec)

Standing on one leg/ Eyes Closed (EC)

Instructions to patient:

Lift your right/left leg from the floor by bending your knee; stay standing on one leg as long as you can. Keep your arms across your chest and don't touch your raised leg against your other leg. Close your eyes and hold this position until I tell you to stop. (max of 30 sec)

Examiner instructions:
Subject will stand with eyes open (prior to eyes closed) on a flat surface with no external support. Timing will begin when one foot is raised off the floor. Allow the patient two attempts and record the best time. Record number of seconds the person can hold this posture up to a maximum of 30 seconds. Stop timing when the subject moves their hands from chest, touches foot against stance leg, moves stance foot around, or touches foot/toe down. Subject is allowed to use preferred stance leg for test. Allow two attempts and record the best trial for each condition.
Strategy: record your assessment of ankle sway strategy/ hip strategy

Tandem Stance -EO (Sharpened Romberg)
Instructions to patient:
Place one foot directly in front of the other so that the toes of one foot are touching the heel of the other. Place your arms across your chest. Stand like this until I tell you to stop (max 30 sec).
Tandem Stance -EC
Instructions to patient:
Place one foot directly in front of the other so that the toes of one foot are touching the heel of the other. Place your arms across your chest and close your eyes. Stand like this until I tell you to stop (max 30 sec).
Examiner instructions:
Do the tests in order (EO then EC). Record the time the patient was able to stand in each condition up to a maximum of 30 seconds and average both times. If patient is unable to assume tandem stance position, record as unable.

Forward Reach
Instructions to patient:
Stand normally. Lift your arm straight in front of you. Stretch your fingers and reach forward as far as you can. Please do not touch the ruler. Once you have reached as far forward as you can, return to a normal standing position. I will ask you to do this twice. Do not lift your heels from the floor.
Examiner instructions:
Place a ruler at shoulder height at the end of the fingertips when the arm is out at 90 degrees. The fingers should not make contact with the ruler. The patient may not lift heels, rotate trunk, or protract scapula excessively. The patient must keep their arm parallel to ruler and may use the less involved arm. The recorded measure is the maximum horizontal distance reached by the patient. Record best reach and strategy used (ankle or hip).
Walking VOR Test- with horizontal head turns
Instructions to patient:
Begin walking at your normal speed, when I say "right", turn your head and look to the right; when I say "left" turn your head and look to the left. Try to keep yourself walking in a straight line.
Examiner instructions:
Allow the patient to reach their normal gait speed, and call the commands, "right, left" every 3-5 steps. Record the most appropriate score:
(3) Normal, performs head turns smoothly with no change in gait.
(2) Mild, performs head turns smoothly with slight change in gait speed, minor disruption to smooth gait path, veering right or left.
(1) Moderate, performs head turns, but slows down OR staggers, but recovers and continues to walk.
(0) Severe impairment, performs task with severe disruption of gait, OR staggers outside a 15" path, loses balance, stops, reaches for assistance and needs assistance to prevent a fall.
To grade: mark the lowest category that applies.
Balance Problem Identified? Mark Yes or No, by your or PT's assessment.
Balance Problem Treated? Make Yes or No, whether you/PT believe treatment was oriented to improving balance.

Intervention:
The letters representing the four primary interventions used to treat the patient are to be recorded in the intervention column. These treatments should be documented in such a way that the intervention that is used most often is placed in the first box. If over four interventions are implemented, only the four that are used most frequently and thought to be the most beneficial should be documented.
Weight-Bearing Status:
Document the current weight-bearing status of the patient as instructed by the surgeon. Use the following documentation:
FWB-- Full weight bearing
WBAT –Weight bearing as tolerated
TDWB – Touch-down weight bearing

PWB ---- Partial weight bearing
NWB --- Non weight bearing

Pain Rating Score:

During each session, the patient should be asked to rate his or her pain on a scale of zero to ten, with zero representing no pain and ten representing excruciating pain. Record the patient's report of pain during the last session of each day.

Transfers:

The patient's ability to perform transfers must be assessed. The primary transfers to be tested are supine to sit, and sit to stand. In addition, any other functional transfers (i.e. car transfers) that are necessary for the patient to return home must be assessed. Use table 1A to document the level of patient independence with these transfers. In the first box, record the letter corresponding to the amount of assistance the patient requires to consistently transfer in a safe manner. If the level of independence is different for different transfers, record the highest level of assistance required. In the second box, record the number of clinicians necessary to assist the patient in a safe transfer. For example, if a patient requires Mod A * 2 to transfer safely, this would be recorded as F 2 on the MDS form.

Ambulation:

Assess the patient's ability to safely ambulate on even and uneven surfaces using the least restrictive assistive device. In the first box, record the distance in feet that the patient is able to safely ambulate. In the second box, document the least restrictive assistive device required for safe ambulation using the abbreviations provided in table 1B. In the third box, use table 1A to document the level of patient independence with this task. The number of clinicians required to assist the patient in this task should be recorded in the fourth box. In addition, the terrain on which the ambulation was performed should be documented. Therefore, in the fifth box, record the letter that appropriately describes the surface on which the patient ambulated: E representing an even, smooth surface only, and U representing both even and uneven terrain.

Stairs:

Assess the patient's ability to safely negotiate stairs using the least restrictive assistive device. In the first box, record the number of stairs that the patient is able to safely negotiate. In the second box, use table 1B to document the least restrictive assistive device necessary for safe stair negotiation. In box three, use table 1A to document the patient's level of independence with this task. Finally, the number of clinicians needed to assist with this task should be recorded in the fourth box. The number of stairs that the patient is required to safely ascend and descend in order to return home should be documented with the demographic information during the PT evaluation.

Table 1A

A	Complete independence
B	Modified independence- requires no human assistance but uses furniture, bed rails, etc to assist with a task.
C	Supervision---requires that a therapist be present and giving verbal cues, but requires no manual contact
D	Contact guard—requires manual contact, but no significant assistance from the therapist when performing a task.
E	Minimal assistance – the patient performs at least 75% of the task.
F	Moderate assistance – the patient performs 50-75% of the task.
G	Maximum assistance –the patient performs 25-50% of the task.
H	

Table 1B

O	res no assistive device
SC	Standard J-cane
QC	Quad cane
LC	Loftstrand crutches
WW	Wheeled walker
OT	Other – specify device