**CNA Professor**

RESTORATIVE CARE AFTER HIP SURGERY QUIZ

Mark the correct response.

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1. Which of the following is NOT a problem associated with hip fractures?
   - a. Increased mortality
   - b. Hip precautions
   - c. Functional limitations
   - d. Pressure ulcers

2. What is the most common type of hip fracture?
   - a. Femoral head
   - b. Femoral neck
   - c. Intertrochanteric
   - d. Subtrochanteric

3. Which of the following is considered a typical outcome from hip fractures?
   - a. Complete recovery
   - b. Need for long-term care
   - c. Death within 12 months related to complications
   - d. All of the above

4. Some physicians do not permit a resident to perform full weight-bearing activities for as long as four to six weeks after hip surgery.
   - a. True
   - b. False

5. Restorative care activities that nursing facility staff perform for a resident after hip surgery may include ________.
   - a. directing the resident to twist the torso in the direction of the affected hip
   - b. ensuring the resident doesn’t move around in bed
   - c. facilitating range of motion exercises for the resident’s unaffected extremities
   - d. encouraging the resident to stand with the toes of the affected leg pointed outward as often as possible

6. What is an abduction pillow used for?
   - a. To provide extra cushioning on the seat of a chair when the resident is sitting
   - b. To help the resident sit upright
   - c. To keep a resident’s legs apart
   - d. To assist with moving a resident

7. Which of the following is NOT a potential hip precaution?
   - a. Applying a trapeze to the bed frame to assist with movement
   - b. Allowing the affected leg to hang limply when moving the resident on to his or her side in bed
   - c. Providing a fracture or flat bariatric bedpan, urinal, or elevated toilet seat for elimination
   - d. Ensuring the affected leg is in good alignment without internal or external rotation

8. What is one activity that a resident should avoid doing following hip surgery?
   - a. Sleeping on the stomach or operative side
   - b. Keeping the legs 3–6 inches apart when sitting
   - c. Keeping the toes of the affected leg pointed forward when standing, sitting, or walking
   - d. Sitting in chairs that keep the knees lower than the hips

9. A heel protector relieves pressure from a patient’s heel to prevent pressure ulcers.
   - a. True
   - b. False

10. How often should a CNA check a resident’s skin for signs of red or open areas?
    - a. Every day
    - b. Twice a week
    - c. Once a week
    - d. Once every other week

A supplement to CNA Training Advisor
A hip fracture is a break of the proximal femur where it connects or angles into the hip socket. An authentic hip fracture involves the joint. Most hip fractures in people who are elderly are due to a change in ground level; experts believe that only a very small percentage of hip fractures occur spontaneously as a result of osteoporosis.

Distinguishing between the different varieties of hip fractures is essential because each is treated differently. The four types of hip fractures are:

- **Femoral head fractures.** These fractures are usually the result of high-impact trauma and are often associated with dislocation of the joint.

- **Femoral neck fractures.** Also called subcapital or intracapsular fractures, these fractures are in the neck of the femur, adjacent to the femoral head, and 1–2 inches distal to the joint. They are often accompanied by a high risk of blood vessel damage, inadequate blood flow to the head of the femur, and avascular necrosis (death of bone tissue due to a lack of blood supply).

- **Intertrochanteric fractures.** These fractures occur on the intertrochanteric line between the greater and lesser trochanter, 3–4 inches distal to the joint. They are the most common type of hip fractures.

- **Subtrochanteric fractures.** These fractures occur on the femur shaft immediately below the lesser trochanter and may extend down the shaft.

For older adults, there is a high rate of morbidity associated with hip fractures. Although there are many causes for this association, complications from the fractures, such as deep vein thrombosis, pressure ulcers, and pneumonia, are often at play. Hip fracture outcomes range wildly and include:

- Complete recovery
- Need for long-term care
- Need for cane or walker
- Death within 12 months related to complications

Dislocation of a hip prosthesis can occur during the first 90 days after hip replacement surgery, though this problem was much more common when older types of prostheses were used.

**General restorative care after hip surgery**

Restorative care activities that nursing facility staff should perform for a resident after hip surgery may include:

- Facilitating range of motion (ROM) exercises on the resident’s unaffected extremities

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Restorative care activities that nursing facility staff should perform for a resident after hip surgery may include:

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RESTORATIVE CARE FOR RESIDENTS AFTER HIP SURGERY

- Turning and repositioning the resident
- Helping the resident perform coughing and deep-breathing exercises if he or she is bedfast
- Directing the resident to use an incentive spirometer, if ordered
- Taking measures to prevent pressure ulcers (see sidebar for specific strategies)
- Assisting the resident with using the continuous passive motion machine to improve ROM, if ordered

Hip precautions

People who are admitted or readmitted to nursing facilities following hip repair or replacement surgery may need special accommodations, called hip precautions, which are typically implemented for the first six to eight weeks after surgery, or as ordered by the physician. If these precautions are not listed on the transfer form or admitting orders, contact the physician to determine whether they are necessary. If they are, list the resident-specific precautions on the care plan and flow sheet.

The physician will specify how long the resident must avoid weight bearing after surgery. In some cases, residents may be able to ambulate with a walker soon after their procedure. However, some physicians may not permit full weight bearing for as long as four to six weeks after surgery. Make sure to clarify ambulation and weight bearing orders. If the physician does not order therapy, inquire whether physical and occupational therapy evaluations are needed.

Hip precautions can include any combination of the following directives:
- Use an abduction pillow to keep the resident’s legs apart. Keep the pillow in place at all times when in bed, including when the resident is turned on one side.
- Apply a trapeze to the bed frame to assist with movement. Instruct the resident not to press down on the foot of his or her affected leg when using the trapeze.
- Apply anti-embolism stockings. Remove the hose completely at least once each shift (or as ordered) to check circulation, signs of skin breakdown, and presence of pedal pulses.
- Provide a fracture or flat bariatric bedpan, urinal, or elevated toilet seat for elimination.
- Avoid head-of-bed elevation of more than 45° without a specific physician order.
- Ensure the affected leg is in good alignment without internal or external rotation. A trochanter roll may be used next to the affected hip and leg to prevent external rotation when in bed. Avoid rolling the affected leg inward during turning. Keeping the abduction pillow in place will prevent this problem.
- Help the resident avoid acute flexion of the hip and legs. The therapist will give directions for positioning and the degree of flexion permitted. As a rule, avoid flexion of more than 90°.
- Ensure the resident doesn’t twist or turn the torso in the direction of the affected hip. When sitting, the resident should swivel the whole body rather than twisting the upper body.
- Support the affected leg when moving the resident to her side in bed.

Resident education

Teaching residents to be aware of postoperative limitations is critical to minimizing setbacks, facilitating a successful recovery process, and promoting resident autonomy. CNAs and other care providers should help residents understand and implement any additional necessary hip precautions, such as the following:
- Avoid sleeping on the stomach or operative side.
- Avoid crossing the legs.
- Avoid sitting on low chairs or couches. Sit only in chairs that have arms and allow the knees to remain lower than the hips.
- Avoid leaning forward while sitting.
- Avoid picking up items from the floor or bending to put on shoes and socks.
- Avoid raising the knee higher than the hip on the operative side.
- Keep the legs at least 3–6 inches apart when sitting. If this proves challenging, use an abduction pillow.
- Avoid stretching the affected hip back.
RESTORATIVE CARE FOR RESIDENTS AFTER HIP SURGERY

• Avoid kneeling on one knee.
• Avoid twisting the body away from the affected hip.
• Avoid standing with the toes pointed outward. Instead, keep the toes of the affected leg pointed forward when standing, sitting, or walking.

• Avoid assuming a straddling position.

When a person is admitted to a nursing facility following hip surgery, it’s essential for staff to take preventive measures against pressure ulcers, which can crop up due to the resident’s new functional limitations. CNAs can aid other staff in implementing and ensuring proper compliance with the following prevention tactics:

- Apply a pressure-reducing mattress to the resident’s bed.
- Apply a bed cradle, if necessary, to relieve downward pressure on feet from bed linen.
- Position pillows lengthwise under the calves to elevate the heels from the surface of the bed; this tactic can help prevent heel pressure ulcers, which hip surgery residents are particularly prone to develop. However, this advice can also pose problems for many providers. For example, it may be difficult to find two spare pillows around the facility, especially ones that are thick enough to elevate the heels sufficiently. It can also be time-consuming to regularly reposition a resident’s legs to maintain proper alignment. An alternate strategy is to apply heel protectors to residents’ feet; be aware, however, that while these devices can prevent friction and shearing, they do not relieve pressure, so other measures may be more effective. Many providers report success with a heel suspension boot, which floats the heel above the surface of the bed. This option can be easier to maintain and more supportive for the resident than others. When selecting a brand, make sure the boot doesn’t apply pressure to the tibia or hyperextend the knee.
- Check the resident’s skin (particularly the heels) daily for signs of red or open areas, paying special attention to bony prominences. All at-risk residents should have a systematic skin inspection at least once per day. When evaluating the heels, the provider should gently palpate the tissue. A mushy or boggy feeling suggests breakdown will soon follow. In most cases, CNAs will be asked to conduct these inspections and report their findings to the licensed nurse, who should follow up with his or her own evaluation weekly, or according to facility policy.

Pressure ulcer risk is always variable. Accurate and complete documentation of risk assessments ensures continuity of care and forms the basis for effective skin care plans.

Treating pressure ulcers

If a resident does develop a pressure ulcer, he or she is often at high risk for developing additional ulcers. This makes implementing a care plan that combines preventive steps with aggressive measures to heal the existing ulcer essential for ensuring resident relief and recovery. A written skin care plan detailing these approaches should be available to all team members who provide direct care to residents.

Nursing assistants can play a pivotal role in monitoring the resident’s condition and fostering improvement. The following are just some of the activities that CNAs may be asked to assist with:

- Turning/repositioning the resident at least every two hours (more often if requested; required by the resident’s clinical condition; stated in facility protocols, policies, and procedures; or according to physician’s orders).
- Keeping the resident clean and dry through regular bathing and incontinent care. Perineal cleansers are kinder to the skin than soap and water.
- Providing adequate nutrition and hydration based on recommendations from the registered dietitian.
- Promoting a clean wound base and preventing infection.
- Notifying the physician for further orders if the ulcers are worsening or not responding to treatment.