Hip Fracture Rehabilitation Protocol

OUTPATIENT or SUBACUTE PHYSICAL THERAPY---PHASE I
(Weeks 1-6 post-op)

Patient is evaluated weekly in outpatient PT unless deemed otherwise, or in inpatient setting

GOALS:
- Safe ambulation with or without assistive device, with min to no assist
- Independent in ADLs (OT)
- Balance adequate for ADLs
- Understanding of restrictions and goals

Evaluate and Document:
- Gait (correct any abnormal gait patterns noted)
- Hip ROM (stay within the precaution limits)
- Hip Strength
- Patient Exercise Demonstration (correct if improper form)
- Exercise and Precaution Compliance
- Screen for DVT
- Chemical anticoagulation for 30 days minimum after hip fracture

Most hip fracture surgeries allow weight-bearing as tolerated to the affected leg unless there is concurrent injury to the lower extremity without specific range of motion precautions. The exception is the anteriolateral approach to the hip, listed below. This would have been used to perform a hemiarthroplasty.

ANTERIORLATERAL (HARDINGE) PRECAUTIONS

- Hip flexion only to 90 degrees
- No hip external rotation (keep toes pointed up)
- Adduction only to neutral (don’t cross legs)
- Use hip abduction pillow except while standing or walking
- WBAT with contralateral cane or FFWB depending on quality of abductor repair
PHASE I OUTPATIENT EXERCISES

- Heel slides (flex) maintaining hip motion precautions
- Supine hip abduction for ROM
- Assisted SLR
- Side-lying hip abduction using pillow---ensure proper form (don’t roll hip back)
- Standing hip flexion in parallel bars---ensure proper form
- Standing hip abduction---ensure proper form

OUTPATIENT PHYSICAL THERAPY---Phase II
(6 weeks post-op and beyond)

If FFWB, may progress to full weight-bearing ambulation without cane (unless otherwise specified by surgeon, may extend to 8 weeks).

Can be performed as Home Exercise Protocol (HEP)

Outpatient PT 1-2x/week for evaluation and rehabilitation

Evaluate and Document:
- Gait (correct any abnormal gait patterns noted)
- Hip ROM.
  - Goal is -10 to 95 for performance of ADLs without noticeable impairment
- Hip Strength especially hip abduction
- Static and dynamic balance
- Initiate home walking program
- Evaluate leg length but NO correction until a minimum of 3 months post-op

PHASE II OUTPATIENT EXERCISES

- Gait training
- Stationery bicycle
- Stairmaster or Elliptical when tolerated
- Groin stretch
- Hip ROM
- Wall sits for time (start with at least 20-30 seconds and progress to a goal of 3 minutes)
● Step-downs: slowly lower eccentrically from the step (forward and lateral)
● Hip strengthening: especially hip ABD and ER
● Leg Presses (start with Total Gym)
● Mini-squats
● Well leg tubing
● Cone/obstacle walking for balance and proprioception as tolerated. Progress to more challenging balance activities, such as Plyoback ball toss in single stance
● Gluteus medius strengthening … hip hikes
● Pool therapy
● Sports/activity specific skill training as tolerated
● One time instruction in Gym Program when ready to discharge to home/gym program (approximately 10-12 weeks post-op)

**DISCHARGE CRITERIA:**

- At least 4/5 hip strength (esp. hip abduction in AL and P, flexion in DA)
- Normal gait
- Functional hip ROM

**LIFETIME PRECAUTIONS:**

Avoid extreme internal and external rotation, and combinations of flexion greater than 90 degrees with IR/ER or hip adduction with anteriolateral approach hemi or total hip.

The most recent evidence does not recommend suppressive/prophylactic antibiotics for routine dental procedures, but always ask you surgeon prior to a scheduled procedure to inquire about specific precautions. Colonoscopies or other bowel procedures may require prophylaxis.

Sustaining a fragility fracture puts patients at increased risk of repeat falls and fractures. Advise modification of home environment for safety. Starting VitD/Calcium supplementation with or without Forteo therapy depending on individual situation.