

MASSACHUSETTS
GENERAL HOSPITAL

PARTNERS
ORTHOPAEDIC
TRAUMA
SERVICE
MASSACHUSETTS GENERAL HOSPITAL
BRIGHAM & WOMEN'S HOSPITAL
HARVARD MEDICAL SCHOOL

A PATIENT GUIDE TO ORTHOPAEDIC TRAUMA CARE AT MGH

expert care for trauma patients

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INTRODUCTION

Massachusetts General Hospital (MGH) provides expert clinical care in the management of trauma patients from all over New England. Our program provides for all needs of the trauma patient, including initial life-saving measures, critical care, surgery, and rehabilitation. Certified by the American College of Surgeons as a Level I trauma center, we are dedicated to using our outstanding clinical expertise and compassion to meet the needs of our patients and their families.

You are a patient on the Orthopaedic Trauma Service because your musculoskeletal system has been injured. Musculoskeletal system is the medical term used to refer to all your bones, joints, muscles and tendons. You may have injured a bone or a muscle in your arm or leg, or you may have injured a bone in your back, hip or pelvis. All of these are musculoskeletal injuries. Orthopaedic surgeons are the medical specialists who deal with the musculoskeletal system, caring for broken bones — called fractures — as well as other injuries to the musculoskeletal system. They are frequently consulted to care for patients with severe fractures or multiple injuries, but also care for basic fractures and other Orthopaedic problems. Depending on the type of injury and how severe it is, your recovery can take weeks, months, or longer. Your recovery will take place here in the hospital and in places like a rehabilitation hospital, skilled nursing facility or your own home.

The Orthopaedic Trauma Service is led by doctors who specialize in injury management. However, it takes a full team of people to start you on your way to recovery. This manual will introduce you to the team, and will try to give you some idea of what to expect while you are here. We realize that you and your family likely have many questions and concerns about your injury, treatments, recovery and about the patient experience at the MGH. We understand that unexpected injury can be a cause of great stress, and that hospitalization can be confusing and scary.

This manual uses common words and terms to describe Orthopaedic injuries, their treatments and the types of care and services you may receive while you recover from your injuries. The booklet also provides general information about MGH and its available services. This book is meant to add to — not replace — the information you receive from your care providers. Please do not hesitate to ask questions about any information you are given or read in this manual. You are a very important part of the team, and we want you to feel informed.

PATIENT RIGHTS

Patient Rights and Responsibilities

Our goal is to provide you with the care that is right for your injuries and to help you recover as soon as possible. The hospital aims to deliver this care with a clear understanding of and respect for your individual needs and rights as outlined in the Massachusetts Patient Bill of Rights. You may contact the MGH Office of Patient Advocacy for a copy of the Bill of Rights (*please see contact information below*), or view it on the website: <http://www.mgh.harvard.edu/visitor/advocacy.htm>.

Ethics

MGH has many resources in place for patients, families and staff to address ethical issues that may arise during treatment. The “MGH Guide to Hospital Ethics Resources,” available in the Blum Patient and Family Learning Center, is an informative booklet that outlines these resources. During weekday hours, you may contact a member of our Ethics Task Force directly at (617) 726-2000 and asking the operator to page beeper number 32097.

Health Care Proxy

Under the Massachusetts Health Care Proxy Law, you can name another person to make your health care decisions for you. This person becomes your health care agent or proxy, and will act for you only if your doctor determines in writing that you are unable to make or communicate your own health care decisions. Your agent would then have the legal authority to make all health care decisions for you — including decisions about life support treatments — and would be entitled to information and records from your doctor to help make decisions. You can name an agent by completing a Health Care Proxy form, which is available in the Admitting Department, the Office of Patient Advocacy, or through your nurse. Before you complete the form, we urge you to discuss the matter with your doctor, your family and the person you want to name as your health care agent.

To learn more about health care proxies, please contact the Office of Patient Advocacy at (617) 726-3370.

Office of Patient Advocacy

The Office of Patient Advocacy is responsible for managing the hospital’s patient complaint and commendation process. Patient advocates serve as liaisons between patients and families and the hospital. Located in Room 018 of the Wang Ambulatory Care Center, the office is open weekdays from 8:30 am to 5 pm. You may visit during these hours (no appointment is necessary) or contact a patient advocate at (617) 726-3370.

THE TEAM

Orthopaedic Trauma Professional Staff

Mark Vrahas, MD, is the Partners Chief of the Orthopaedic Trauma Service. Dr. Vrahas graduated from medical school and completed his residency at the University of Pittsburgh. Formerly Chief of Orthopaedic Trauma at the Charity Hospital in New Orleans, he is considered a national and international expert in the management and treatment of pelvic and acetabular fractures.

Malcolm Smith, MD, is the MGH Chief of Orthopaedic Trauma Services. Dr. Smith hails from Leeds in the United Kingdom, where he was a consultant surgeon at St. James Hospital. He is an expert in fractures of the pelvis and tibia and is interested in the management and treatment of spinal fractures.

Harry Rubash, MD, is the Chief of the Orthopaedic Surgery Department. Dr. Rubash graduated from medical school and completed his residency at the University of Pittsburgh. He completed a trauma fellowship in Munich, West Germany, and an arthroplasty fellowship at the MGH. He is an Orthopaedic surgeon whose clinical interests include total hip and knee arthroplasty (hip and knee replacements), and fractures.

David Lhowe, MD, is one of the Orthopedic Trauma Service Attendings. Dr. Lhowe graduated from Case Western Reserve Medical School. He completed his residency at Harvard. His interests include fracture care, nonunions and malunions, as well as hip and knee problems.

George Velmahos, MD, PHD, is the Chief of the Trauma, Emergency Surgery and Surgery Critical Care Service. Dr. Velmahos received both his medical degree and PHD at the University of Athens as well as an MEd at the University of Southern California. He is nationally recognized for his trauma research.

Alice Gervasini, PhD, RN, is the MGH's Trauma Program Nurse Manager. Dr. Gervasini earned her PhD in Nursing from Boston College, after completing degree programs at American University and the University of Maryland at Baltimore. She lectures frequently about trauma topics both locally and nationally, and is a member of the state's trauma systems development subcommittee.

Kathleen Myers, APRN, BC, ONC, is the Nurse Director of MGH's Orthopaedic inpatient units. Mrs. Myers graduated from the MGH Nursing program and later earned her nurse practitioner certificate at the MGH Institute of Health Professions. Her clinical interests include acute orthopaedics and general and oral-maxillofacial medicine.

Joanne Empoliti, MSN, RN, BC, ONC, is the Clinical Nurse Specialist for the White 6 inpatient unit. Mrs. Empoliti graduated from the MGH Nursing program and later earned advanced degrees from Salem State and Northeastern University and her Nurse Practitioner certificate from MGH. She holds several certifications through the American Nurses Credentialing Center. Her clinical interests include general surgery and oral/maxillofacial surgery in addition to orthopaedics.

Jill Pedro, MSN, RN, ONC, is the Clinical Nurse Specialist for the Ellison 6 inpatient unit. Mrs. Pedro earned degrees from Salve Regina College and Salem State College. She is a very active member of the National Association of Orthopaedic Nurses where she currently holds the position of Secretary. Her clinical interests include urology in addition to orthopaedics.

Amanda Savage, RN, is the Unit Nurse Leader for the Orthopedic Trauma Service Outpatient clinic. She acts as practice manager/administrator in the Orthopedic Trauma clinic. She is available to patients, families, and staff as a resource to information and a facilitator to care. Mandy graduated from the University of Massachusetts. She has clinical expertise working with orthopedic and surgical patients in the outpatient setting.

THE MGH ORTHOPAEDIC TRAUMA SERVICE

The MGH Orthopaedic Trauma Service is made up of many personnel responsible for providing services throughout all phases of trauma care. The attending Orthopaedic trauma physician is responsible for your overall clinical management. This doctor (referred to as your attending) works closely with you, your family, a team of Orthopaedic surgery residents, trauma coordinators, and registered nurses in organizing your daily medical care. Depending on your specific needs, other specialists and their teams may be involved in your care.

You and your family are the most important part of our team. Your fellow team members and descriptions of their roles are given below:

Attending Orthopaedic surgeon: The doctor who directs your care and assumes ultimate responsibility for all treatments and plans of care. He/she meets with the team daily and as needed to discuss treatment options and recommendations. Usually, the doctor listed as your attending is the one who will perform any surgeries you may need. If he/she is not available at the specific time of the surgery, another attending will conduct the surgery.

Resident Orthopaedic surgeon: A doctor who has completed medical school and is in the midst of obtaining specialized training in Orthopaedic surgery. On the trauma service we have residents who are just beginning their specialty training, and doctors who are just finishing (soon they will leave to practice on their own). The residents are critical members of the team. Although the attending surgeons are ultimately directing your care, they depend greatly on the residents for assistance. There is no question that these fully trained doctors help to improve the care we deliver.

Trauma Nurse Practitioner: A Masters prepared nurse who is board certified as a nurse practitioner with expertise in trauma who manages the care of patients with the orthopedic trauma team. The nurse practitioner coordinates the services involved in your care (i.e. physical therapy, case management, social services) throughout your hospitalization. These expert nurses work closely with all members of your team, and are an important resource for you and your family.

Inpatient unit nurse: A registered nurse who will work with you and your family to coordinate the day-to-day activities associated with your care. Stationed on your inpatient unit, he/she also will provide education, help manage your pain, prevent complications and increase your mobility.

Physical therapist: A rehabilitation professional trained to examine and evaluate physical impairments, functional limitations and disability. The physical therapist provides exercise therapy and functional training to help you achieve your best function.

Occupational therapist: A rehabilitation specialist trained to evaluate and treat restrictions/limitations in your ability to function independently in daily life roles. The occupational therapist provides treatment to address identified limitations or to teach other strategies to compensate for any loss of function.

Case manager: A registered nurse who helps you and your family make plans for further care and treatment once you leave the hospital (i.e., in a rehabilitation or home environment). You will meet your case manager during the early part of your hospitalization and are encouraged to share any concerns you may have about the care you will receive once discharged from MGH.

Nutritionist: A professional with specific clinical training who addresses issues pertaining to diet and nutritional status.

Anesthesiologist: A physician who has special training in the branch of medicine that deals with anesthetics. He/she is the person who puts you to sleep before your surgery and monitors you during and immediately after surgery.

Pain service clinician: A physician or certified nurse anesthetist who has specialized training in the science of pain management. This person is consulted when routine methods of pain control are not effective.

Addiction services worker: A clinical professional — usually a nurse or a counselor — with specialized training in the field of alcohol and drug dependence. The team may consult this service when a patient’s injury was caused by or related to drug or alcohol use or if a patient’s social history shows potential drug and alcohol dependence.

Clinical nurse specialist: A nurse who has special knowledge and experience in a clinical area (in your case, Orthopaedics). This nurse gives advice to the nursing staff and health care team members on caring for a patient and is available to answer your questions about your injuries.

Social worker: A licensed mental health professional who is trained to help people find solutions to many problems — from everyday issues to life’s most difficult situations. Social work services are private and confidential.

PHASES OF CARE

There are different phases of care that a person goes through when they come into the hospital with an Orthopaedic injury. Usually patients enter the hospital through the Emergency Department (ED) and then go either to surgery, intensive care or to a general Orthopaedic nursing unit. The phases of care that you go through will depend on when your injury happened, where the injury is on your body and how severe the injury is. The phases of care are listed below:

Emergency department phase of care — “resuscitation” (initial life saving measures)

The first phase of care for an Orthopaedic trauma patient begins in the ED. This is where the trauma team made up of several emergency medicine doctors, surgeons and nurses work together to rapidly diagnose and treat injuries and decide what type of tests are needed. This can include blood tests, x-rays, CT scans, MRIs and/or other special tests that will help to quickly diagnose injuries. Sometimes the trauma team will call in a doctor from another medical service for further evaluation. Treatment will begin as soon as the injuries are evaluated and may include stabilizing the fractured (broken) bones and repairing any lacerations (cuts). Trauma patients usually stay in the ED for several hours to get care and treatment.

Our primary goal in this first stage of treatment is to make sure that there are no life- or limb-threatening injuries. It is possible that less serious injuries can be overlooked during the initial examination. If you are having pain somewhere other than where the injuries have been identified, please tell your doctor.

The ED can sometimes be a confusing place for both the patient and family. Because the ED is so busy, it may not be possible for family or friends to visit you while you are there. Please be assured that the Emergency Department staff will regularly update family members about your condition and progress.

After the emergency phase

The second phase of care depends on how stable a patient is and the type of injury that he or she has sustained. One of the following can happen:

- you will be discharged to your home with instructions on how to care for yourself, or ...
- you will be admitted to the hospital. If you are admitted,
 - you may first go to the operating room for surgical repair of your injury, or ...
 - you may be admitted to the intensive care unit if you have serious injuries, but do not need surgery right away, or ... you may be admitted to the TRACU which is the trauma step down unit if you have serious injuries
 - you may be admitted to one of the Orthopaedic floors for possible surgery at a later time.

If you have surgery

The medical team will decide early in your treatment and recovery whether your injuries will benefit from surgery. The goals of any Orthopaedic surgery are to maximize stability and strength and return function to the injured bones and soft tissues.

There are some types of Orthopaedic injuries that require immediate surgical repair. If the team decides that you have such an injury, you will be taken directly from the Emergency Department to the operating room for surgery. Most Orthopaedic injuries, however, do not need the surgery to take place right away. Many of our patients have their surgeries within 24 to 48 hours of their injury.

A team comprised of attending and resident Orthopaedic surgeons, an anesthesiologist and operating room nurses is involved with your care and treatment throughout your surgery. These team members will explain the details of surgery to you and describe their individual roles.

If you are admitted to the intensive care unit or to an Orthopaedic floor before you have surgery, you may expect the following. Your Orthopaedic surgeon will meet with you and your family to discuss what will happen during the surgery, how the team will repair your injury and what you can expect during your recovery. An anesthesiologist will meet with you to discuss your medical history to determine what type of anesthetic will be best for you. He or she will describe how the anesthesia will make your body feel and will inform you of his/her role during the surgery itself. We strongly encourage you to share any concerns and questions with both your surgeon and anesthesiologist. They are there to help you understand what happens during surgery to give you an idea of what you can expect.

On the day of surgery you will be asked not to eat or drink anything prior to the surgery (called NPO). You will be given an approximate time when your surgery will take place. Please forgive us if we have to change the day or time of your surgery, as we admit new patients for emergency surgery every day. Because there are only so many operating rooms, these emergencies can delay our scheduled surgeries. We will do our best to keep you and your nurse informed of any schedule changes.

After you have surgery, you will be taken to the Post Anesthesia Care Unit (PACU). Here, you will awake under the close observation of the nursing and anesthesia staff. Although the environment may be cool, noisy and busy, the nurse will be close by to make sure that you are as comfortable as possible. Visitors may reach the PACU by taking the Ellison elevators to the third floor and following the signs. Two visitors at a time may visit for up to 10 minutes every hour, depending on how busy it is. The PACU's number is (617) 726-2835.

Intensive care unit (ICU) floors

Trauma patients are monitored closely in the ICU. The ICU is the place where all treatments continue and your therapies begin (i.e. physical therapy and occupational therapy). You may be attached to equipment that monitors your heart rate, blood pressure, oxygen intake and any pressure from swelling inside of your head. This equipment often includes wires, tubes, monitors and digital machinery. You may look swollen because of all of the fluids required for treatment. Please be assured that this is normal.

You may be given oxygen through a facemask, nasal prongs or a breathing tube. If a breathing tube is used, it will be attached to a respirator to help you breathe. This is called intubation. If you are intubated, you will not be able to speak while the tube remains in place. The staff will continuously monitor you to determine when it is safe to remove the tube so that you can breathe on your own (this is called extubation). The extubation process is a gradual process and is commonly referred to as weaning from the vent. You may experience a sore throat once the tube is removed. Please be assured that this is normal, and that it will go away in a couple of days.

A number of intravenous (IV) lines may be placed so that you can receive fluids, blood products and medications. A blood transfusion may be necessary if your blood tests show that it would help. Medications may be used to keep your heart rate and blood pressure at normal rates. You will stay in the ICU until your heart rate, blood pressure and blood tests are stable.

Your nutritional needs will be addressed early on. If you cannot eat, you may be given feedings through a tube in the mouth or nose until you are able to eat again. You may have a tube in the nose or mouth that extends down into the stomach — called a nasogastric or NG tube. This type of tube keeps the stomach empty until it starts to work properly.

Most trauma patients who need intensive care go to the Surgical Intensive Care Unit (SICU) located on the fourth floor of the Ellison Building. The staff of this unit specializes in the care of trauma patients with multiple injuries. Visiting hours are flexible and based on the patient's condition, how busy the unit is at the time and the family's needs. The SICU's telephone number is (617) 724-5100.

TRACU

Some trauma patients with serious injuries will go to the TRACU (Trauma Acute Care Unit) for close observation. The TRACU is an inpatient unit with four patient beds on Ellison 7 that is staffed with two nurses. You will have IV lines and be attached to equipment to monitor your heart rate, blood pressure and oxygen levels. The physical therapist and occupational therapist will begin to work with you. After 24 to 48 hours when your condition is stable you will transfer to the orthopaedic floor. Family and friends are allowed to visit you while you are in the TRACU but they need to check with the nursing staff prior to visiting. The TRACU's telephone number is (617) 643-8376.

Orthopaedic Inpatient Floors

Many of the Orthopaedic trauma patients admitted to the hospital are admitted directly to an Orthopaedic floor. Ellison 6 and White 6 are the inpatient floors specifically for patients with Orthopaedic injuries. Most rooms on these floors accommodate two patients.

When you first arrive on an Orthopaedic floor, the nursing staff will help settle you into your room. Your family and/or significant other may be asked to wait outside of the room or in the waiting room until you are fully settled.

It is important for our patients to visit with their friends and family. Visiting times are flexible, with no set hours or age limitations and are based on individual patient and visitor needs.

You will need only a few simple items with you as you recover. These items include toiletries, sneakers or walking shoes, nightclothes and reading material. Some cash (less than \$20) may be needed for magazines, TV rental and incidentals. If you have dentures, eyeglasses, contact lenses or a hearing aid, it will be important to have these on hand as well. You may place these items in your bedside drawer when they are not in use.

While you are here, you should make a list of all of the medications you regularly take at home along with their dosages and give it to the nurse or doctor. You should not, however, bring medications in from home unless the doctor tells you to do so. You should not have valuables, jewelry, credit cards or large amounts of money with you while you are a patient. If a friend or family member cannot take these items home, please ask your nurse to place them in the hospital safe.

Each family is asked to choose one spokesperson who can call the patient’s nurse for updates. The spokesperson may call at any time but is asked to avoid the following hours, when the nursing staff changes shift: 7 to 7:30 am; 3 to 3:30 pm; 7 to 7:30 pm; 11 to 11:30 pm. If your nurse is involved with patient care when the spokesperson calls, it may be necessary for them to speak at a later time. The telephone numbers for Ellison 6 and White 6 are (617) 724-4610 and (617) 726-6106.

What to expect each day: The Orthopaedic Trauma Service team visits patients early each morning and as needed throughout the day to review progress and plan the daily and long-term care. These visits are called “rounds.” Your team will examine your injuries to assess healing and will determine whether the present treatments remain appropriate or need to be changed.

Staff from clinical departments such as Physical Therapy, Occupational Therapy, Nutrition, and Social Services will see you as needed to assess your progress and provide treatment. A case manager — who is a nurse by training — will visit with you and your family to assess hospital discharge needs and to set up a plan for your care once you leave the hospital.

Your main point of contact while you are on an inpatient unit is your nurse. She/he stays in touch with other team members throughout the day to ensure that your patient care plan is carried out as directed. Please do not hesitate to talk with your nurse about any questions or concerns you may have.

COMMON ISSUES AFTER TRAUMA

Pain

Pain and discomfort are expected after a major injury. Your team will make every effort to reduce your pain so that you are comfortable. In efforts to control your pain, the staff will periodically ask you to describe the pain level on a scale from 0 to 10:

< 0 1 2 3 4 5 6 7 8 9 10 >

No Pain

Severe Pain

If you ever feel that your pain is not well controlled, you should tell your nurse as soon as possible.

The two most common pain treatments are patient controlled analgesia (PCA) and oral medications. PCA is a system that you control with your hand that delivers pain medication into your IV line. When you feel the pain building up, you can give yourself a dose of pain medication by pushing a button that controls a pump. The pump will then deliver the medication into the IV line with a near instantaneous effect. At night, this pump may be automatically programmed so that the medication can be delivered safely during your sleep. There is no danger delivering pain medication in this form as the pump is set with limits on the number of doses that may be delivered.



Once you are able to tolerate food, your pain medications will be changed to pain pills. There are different types of pain medicine you can take by mouth. Some medicines are narcotics, which in rare cases can cause addiction in people who take them for pain for a long period of time. Most people who take narcotics for pain do not become addicted to them.

We have learned that pain makes recovery from surgery more stressful on the body so it is important to take your pain medicine to help your body heal. While you are in the hospital your doctors and nurses will work with you to create a smart and effective pain management plan to help control your pain. It is OK to take pain medicine while you are having pain. You should feel free to take strong pain medicine or narcotics for severe pain, and non-narcotic medications like Tylenol or Ibuprofen for mild or moderate pain. Please do not hesitate to ask your team about this very important part of your care.

Coughing, deep breathing

Many trauma patients need to cough and breathe deeply at least every two hours to prevent pneumonia and help the lungs expand. If necessary, you will be shown how to use a breathing device called an incentive spirometer to aid with this activity.

Skin Care

Many trauma patients are worried about moving in bed because of the pain they feel and worries about further injury. It is, however, very important that you move around in bed to prevent problems with your skin – called pressure areas or ulcers. Common pressure areas are your back, lower back, buttocks, heels, elbows, and hips. Your nurse will need to inspect your skin frequently, and will help you shift your position or turn from side to side several times a day. This moving around will help to prevent these kinds sores from developing on your skin.

Eating and drinking

A trauma patient's ability to eat or drink depends on several things, including the type of surgery or injury, the types of medicines required, the presence of nausea and how well the stomach and bowels are working after surgery. Once eating and drinking are allowed, you will be encouraged to start slowly and follow your doctor's recommendations.

Medications

In addition to your pain medication, you may receive antibiotics to help prevent and/or treat infection. You may also receive medication to prevent the formation of blood clots.

A stool softener may be given to you once you are able to eat in order to prevent constipation or bowel straining. It is not unusual that your ability to move your bowels will be slowed down by the anesthesia, bed rest or pain medications. Please notify your nurse if you cannot move your bowels.

Urinary catheter

Immediately following a trauma, some patients find urination to be difficult. For the first few days after trauma, you may have a catheter placed to drain your bladder. This catheter is usually placed while you are in the emergency room or the operating room. You may feel an urge to urinate even though the catheter is removing the urine from the bladder. While this feeling is normal, please feel free to discuss this with your nurse.

Pneumo/air boots

Pneumoboots (also called air boots) are made of soft plastic material that wraps around the legs to help prevent blood clots. The boots automatically inflate and deflate to help the circulation. You may also have to wear support stockings to help the circulation in your legs.

LEARNING ABOUT BONES AND FRACTURES

What bones are made of

People often think that a fracture is less severe than a broken bone, but fractures are broken bones. To understand why bones break, it helps to know what bones do and what they are made of. The bones of the body form the human frame, or skeleton, which supports and protects the softer parts of the body. Bones are living tissue. They grow rapidly during one's early years and renew themselves when they are broken.

Bones have a center called the marrow, which is softer than the outer part of the bone. Bone marrow has cells that develop into red blood cells that carry oxygen to all parts of the body and into white blood cells that help fight disease. Bones also contain the minerals calcium and phosphorus. These minerals are combined in a crystal-like or latticework structure. Because of their unique structure, bones can bear large amounts of weight.

How fractures occur

Bones are rigid, but they do bend or "give" somewhat when an outside force is applied to them. When this force stops, bone returns to its original shape. For example, if you fall forward and land on your outstretched hand, there is an impact on the bones and connective tissue of your wrist as you hit the ground. The bones of the hand, wrist and arm can usually absorb this shock by giving slightly and then returning to their original shape and position. If the force is too great, however, bones will break, just as a plastic ruler breaks after being bent too far.

Types of fractures

The severity of a fracture usually depends on the force that caused the fracture and the strength of the bone. If the bone's breaking point has been exceeded only slightly, then the bone may crack rather than breaking all the way through. If the force is extreme, such as in an automobile collision or a gunshot, the bone may shatter. If the bone breaks in such a way that bone fragments stick out through the skin or a wound penetrates down to the broken bone, the fracture is called an "open" fracture. This type of fracture is particularly serious because once the skin is broken, infection in both the wound and the bone can occur. "Closed" fractures — breaks in the bone that do not cause it to stick through the skin — are the more common type of fracture. All fractures are either open or closed.

Signs/symptoms of a fracture

Signs that a fracture has occurred include: being unable to move the affected area, complaints of pain with movement, deformity and swelling. The medical team will examine you to determine if any of these signs are present. They also will check to see if you have movement, sensation and circulation to the area below the fracture.

Dislocations

A dislocation occurs when a joint exceeds its range of motion so that the joint is no longer in its socket. When dislocations occur, there may be a large amount of soft tissue injury in the joint capsule and surrounding ligaments and muscle, with possible vein, artery and nerve damage.

Signs of dislocations include: severe pain, joint deformity, inability to move the joint and swelling. The team may attempt to relocate the limb (called a reduction) while in the ED or the operating room.

Risks and complications of a fracture and/or dislocation

The following are other injuries and potential complications that may occur when a bone has fractured.

Blood vessel injury: Patients who fracture a bone also may have injuries to the broken bone's surrounding veins and arteries. These types of injuries can cause bleeding or loss of blood flow below the injured area. The team will follow your bleeding studies, examine the injured limb and check your pulses and circulation closely. Sometimes further studies like an angiogram and/or surgery to repair the damaged vein or artery may be required.

Compartment syndrome: Patients with severe fractures or crush injuries are at risk for developing compartment syndrome — a condition that occurs most frequently in the leg or forearm. Compartment syndrome causes increased pressure in the soft tissues that, in turn, causes decreased blood supply to the affected muscles and nerves. This decreased blood supply can lead to damage if the pressures are not relieved. The

team will check you closely for signs of compartment syndrome, which include: throbbing pain that does not become better with pain medicine; swelling and increased pain to the muscle when it is stretched; and firmness over the compartment. Doctors have a device to check pressures in the compartment when this syndrome is suspected. If compartment pressures are high, you will be taken to surgery for a procedure called a fasciotomy. In this procedure, the compartments are opened up to relieve the pressure. Once swelling to the area goes down, the team will close and cover these wounds.

Damage to nerves: Patients with fractures may also experience damage to the nerves close to the injured area. To diagnose potential nerve injuries, the team will ask you if you can move and/or feel the affected limb. Some nerve injuries may improve with time as swelling decreases.

Deep Vein Thrombosis (DVT): A DVT is a blood clot that develops in one of the blood vessels in the leg or pelvis. Trauma patients are at risk for developing DVTs because of both the nature of the injury and the inactivity associated with it. Trauma patients often need to stay in bed for a period of time until their injuries are stabilized or repaired. Signs of DVT include pain or tenderness over the injury site, swelling, fevers and/or changes in skin color. The team will order a special radiological test that looks for blood clots in your body and may take measures such as giving you blood thinning medicine and devices to wear on your legs called “pneumo boots” to prevent DVTs from forming.

Infection: All fractures put you at increased risk for infection. Open fractures, though, are contaminated, which put patients at even higher risk for infection. Wound and bone infections can be disabling for patients because they can cause delayed or failed healing of the fracture. Open fractures are evaluated in the ED, where patients are given antibiotics and a tetanus vaccine. If you have an open fracture, you will be taken to surgery right away, so that the fracture site may be cleaned. If the wound is not completely clean, it will be kept open to the air, while the fracture will be immobilized with a cast, splint, traction or an external fixator. You will return for more surgery in about 48 hours to see if the wound needs cleaning. If it is clean at this time, the wound may be closed and internal fixation may be performed. There are times when the wound may be too big to close. When this occurs, a skin graft or local muscle flap will be placed to cover the wound.

Pneumonia: A patient who cannot or does not get out of bed frequently may develop pneumonia — a result of secretions building up in the lungs. Signs of pneumonia include fever, chills and a cough. The team may order an x-ray of your chest to detect pneumonia and may give you an antibiotic to treat it if diagnosed. You can help prevent pneumonia by coughing and breathing deeply and using the incentive spirometer on a regular basis. You should also get out of bed as soon as the team feels it is safe for you to do so.

Post-traumatic arthritis: Fractures that involve the joint have a higher risk of developing arthritis (inflammation of the joint) at some point after healing has taken place. Early management of these fractures and proper healing reduces this risk.

Pulmonary embolism (PE): A pulmonary embolism — commonly referred to as a “PE” — is a clot that develops in the leg or pelvis and then travels to the lungs. A trauma patient who is not active is at risk for developing a PE. Signs of this type of complication include shortness of breath, difficulty breathing and breathing short and rapid breaths. A patient who is suspected to have a PE will be given oxygen and placed on a monitor to evaluate heart rate and how much oxygen is entering the bloodstream. He/she will also undergo a special test that searches for this type of clot.

Swelling and blisters: Injury to the soft tissues near the fracture or dislocation site can occur, resulting in bruising and swelling to the area. The swelling can be significant and possibly cause blisters. You may be instructed to keep the affected limb elevated and/or apply ice to help decrease the swelling. The team will examine the fractured area to watch for the development of blisters. Significant swelling and blister formation can cause surgery to be delayed.

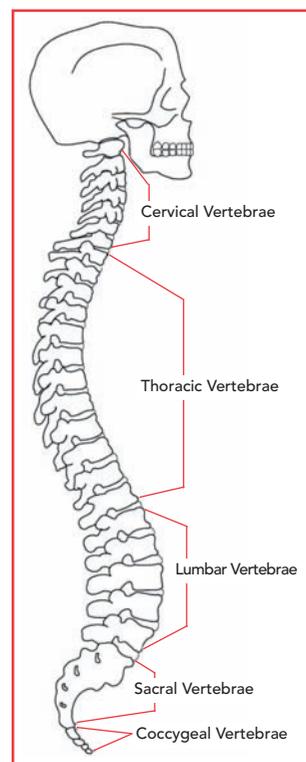
INJURY TYPES AND DESCRIPTIONS

Spine

The spine is the long bony column in the back that protects the spinal cord. The spinal cord is a bundle of nerves through which information about movement and sensation travels between the brain and body.

Trauma to this area is usually the result of car crashes, sports accidents, falls and gunshot wounds. Treatment of the spine is important so that the spinal cord may be protected from serious damage.

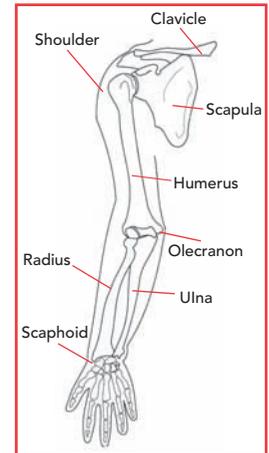
After a trauma, it may not be clear to the team whether your spine has been injured — despite radiographic evidence that shows no injury to the bones. If you are unable to move your neck, have other serious injuries requiring immediate medical attention, less-than-full consciousness or are under the influence of drugs or alcohol at the time of initial evaluation, the team will not rule out a spinal injury. If this is the case, the team will wait until you are awake, alert, and able to feel neck and back pain before making a decision about an injury. Until a decision is made, you will wear a collar around your neck and may remain on bed rest.



Shoulder/arm

Clavicular (collarbone) fracture usually is a result of a fall or direct force onto the arm or shoulder. It can occur in all age groups. The most common treatment is a sling and swathe. As the bone is healing a large “bump” may develop as part of the healing process. This usually disappears, although a small bump may remain.

Scapular fracture is rare, although it is seen in trauma patients as a result of high energy blunt trauma, such as motor vehicle crash, motorcycle crash or a fall. A sling is the usual treatment; however, this injury may require surgery. It is important to check with your doctor regarding moving your shoulder, as it may take six months to a year to get complete motion back in the shoulder. Because the injury is the result of a high energy trauma, other fractures usually accompany this injury.



Shoulder (glenoid, humeral head or humeral neck) fracture usually is a result from a fall onto an outstretched arm or from direct trauma to the shoulder. This injury may require surgery.

Humerus (upper arm) fracture usually is the result of a direct blow on the upper arm, a fall onto the arm or a motor vehicle crash. Depending on your age, the treatment may be a cast, a sling or surgery.

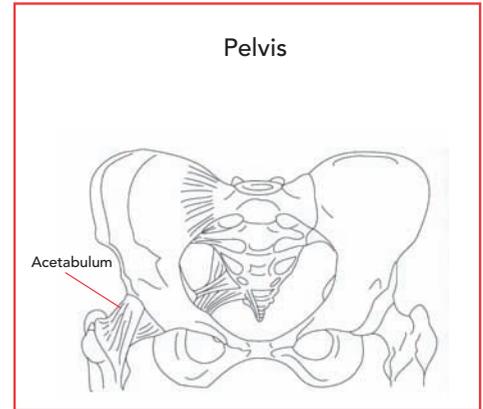
Olecranon (elbow) fracture usually is the result of a direct blow or fall onto the point of the elbow. There are different types of “elbow” fractures, so ask your doctor about your type. The most common treatment for this fracture is surgery.

Radius and/or ulna (lower arm) fracture usually is the result of a fall onto your extended arm or a direct blow to your lower arm. It is possible to fracture one or both bones in your lower arm. The treatment depends on the severity of the fracture, which bone is fractured and where the fracture is. Treatments for this type of fracture include a cast or surgery.

Scaphoid (wrist) fracture is a fracture that is located on the thumb side of your wrist. It usually is the result of a fall onto an outstretched wrist or a motor vehicle crash. The treatment of this fracture may begin with a cast. If the bone isn't healing, surgery may be necessary. This fracture typically takes some time to heal.

The pelvis and acetabulum

A **pelvic fracture** is usually the result of a major trauma like a motor vehicle crash, industrial accident, a fall from a tall height in young patients, or a fall from standing in elderly patients. There are three bones within the pelvis that can be fractured, with the treatment depending on the bone injured and the severity of its injury. In more severe pelvic fractures, there is a possibility of blood loss and other injuries. Common treatments for a fractured pelvis range from limited weight bearing on your legs to surgical repair of the fracture. Much relief is felt within the first six months of injury.



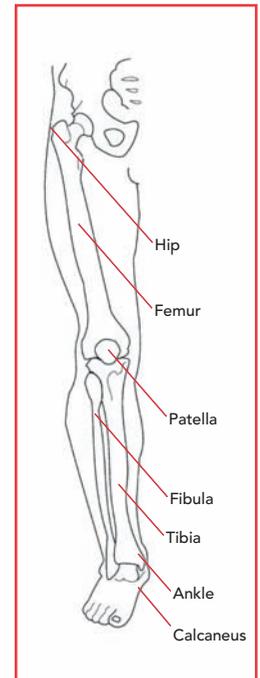
Acetabular fracture is usually the result of a motor vehicle crash. In this type of injury, the socket connecting the pelvis to the femur is broken. The most common treatment for this type of fracture is surgery.

Hip and leg

Hip fracture is more common in elderly persons who have fallen. It also can be caused by a direct blow or a motor vehicle or motorcycle crash. After the hip is fractured, it is common for your leg to turn outward and shorten. The usual treatment for a hip fracture is surgery with a stay in a rehabilitation hospital usually necessary as part of the recovery process.

Femur (thighbone) fracture usually is the result of a major force or trauma. It requires a considerable force to break a normal femur — the longest and strongest bone in the body. The usual treatment for this fracture is surgery. Traction is sometimes used to stabilize the fracture until surgery can be performed.

Patella (kneecap) fracture usually is the result of direct trauma to the knee. It can be caused by a fall, motor vehicle crash, motorcycle crash or automobile-pedestrian crash. This fracture may be treated with a knee immobilizer or by surgery depending on the severity.



Tibial and/or fibular (lower leg) fracture usually is the result of direct trauma to the lower leg. The causes of this type of fracture include falls from a height and motor vehicle collisions. The force of the trauma will directly influence the severity of the injury. Treatments range from a simple cast to surgery.

Ankle fracture can be caused by a variety of trauma types — such as a fall; a direct blow to the ankle; or a motor vehicle collision. The treatment of ankle fractures varies with the severity of the fracture. Ankle fractures are treated with splints, casts or surgery.

Calcaneus (heel) fracture usually is the result of a fall from a significant height when the patient lands directly on the feet. This type of injury usually causes great swelling and is often accompanied by fractures to the back. The treatment of these fractures varies from splints, to casts, to surgery. Surgery often is performed after the swelling has gone down.

HOW FRACTURES HEAL

Fracture healing is divided into three stages: the inflammatory stage, the healing stage, and the remodeling stage.

Inflammatory stage

This stage begins right as your bone breaks. For the first two weeks after your injury, your body will rush healing cells to the area to begin the process of fracture healing. At the end of this stage the bone will have started to knit together with fibrous tissue. You will not be able to see evidence of this tissue on your two-week x-ray, but be assured that this “healing” process has begun.

Healing phase

After the inflammatory phase, the healing phase begins. This phase usually lasts six weeks, but may last longer. For high-energy injuries, like a fall from a tall height or a motor vehicle crash, this phase can last 16 weeks. At the beginning of this phase the body starts to lay down tissue that acts as the bone’s “building blocks.” Later in this stage the body actually starts to lay down bone. At the end of the stage the body has actually bridged the fracture gap with new bone and the bone is considered healed. Although the bone will now be strong enough to support your weight and activity, there is still a long way to go in the injury’s healing process.

Remodeling phase

Once the body has healed the fracture, its work is not done. The body wants to “remodel” the bone to make it strong. You will notice once your fracture has healed, that you can still see where the bone was broken. The body attempts to make the bone look like it looked before it was broken. In kids the body can make the bone look like it did before the injury. [When children break bones, they won’t be able to tell where they were broken within a few years.] In adults, however, the process is never complete. During the first year after the injury the remodeling process is in full gear. This process generates considerable inflammation and causes both swelling and mild pain.

After a traumatic injury, patients often expect that they will be completely better and back to normal within a few weeks. Unfortunately, this is rarely the case — even for simple injuries. Take, for example, a little toe fracture. A little toe fracture does not need a cast and heals with no treatment at all. For six weeks, though, it is too painful to wear constricting shoes, and if you hit the toe while putting on your socks there is severe pain. The foot — and the toe especially — remain swollen. After six weeks the severe pain goes away, but the toe is still too swollen to fit in shoes. The severe pain is replaced by aches and stiffness that increases with activity. The pain is not severe, but is definitely an annoyance that will make you want to limit your walking. The toe will remain swollen for a year, with the pain becoming less and less over time. However, even at a year the toe will occasionally swell and ache with weather changes. You can probably now imagine how things are with larger bones.

TYPES OF TREATMENT

Open Reduction and Internal Fixation: In this type of treatment, the Orthopaedic surgeon must perform surgery on the bone. During the surgery, the bone fragments are first repositioned (reduced) into their normal alignment and then held together with special screws or by attaching metal plates to the outer surface of the bone. The bone fragments may also be held together by inserting rods down through the marrow space in the center of the bone. These methods of treatment can reposition the fracture fragments exactly.

External Fixation: In this type of treatment, pins or screws are placed into the broken bone above and below the fracture site. Then the Orthopaedic surgeon repositions the bone fragments. The pins or screws are connected to a metal bar or bars outside the skin. This device is a stabilizing frame that holds the bones in the proper position so they can heal. After an appropriate period of time, the external fixation device is removed. Internal fixation may then be necessary.

Traction: Traction is used to align a bone or bones by a gentle, steady pulling action. The pulling force may be transmitted to the bone through skin tapes or a metal pin through a bone. Traction may be used as a preliminary treatment to stabilize the bone fragments before surgery.

Casts, Splints, Slings and Braces: These devices are all designed to immobilize and protect the area of your surgery and/or injury to allow healing to occur. Some devices can be removed for bathing and/or exercise, but it will depend on your specific injury, surgery and the amount of healing that has occurred. Your doctor will determine the appropriate times when these devices can be removed.

- Casts are plaster or fiberglass cylinders applied to immobilize the injured area. They may be split in half (called “bivalve”) so the skin and the circulation can be checked. You should not get your cast wet by soaking in a bath, pool or shower. If your cast feels too tight and your toes or fingers look bluish or you feel numb or tingling, call your doctor right away. If your cast becomes too loose — which may occur as swelling decreases — you may need to have the cast changed. You should not bear weight directly on your cast unless you have been instructed to do so. If your doctor allows you to put weight on your cast, be sure to use a cast boot to avoid slipping and/or damage to the cast.
- Splints are removable protective devices — usually plastic with Velcro straps. They may be worn during the day or at night to protect and sometimes limit joint motion and allow optimal positioning. Your splint can be removed to wash and dry your skin and to clean the splint. Any areas of redness on your skin from rubbing of the splint should be reported to your therapist for adjustment. A cotton stockinette or liner is worn between your skin and the splint. This will minimize skin irritation from sweating.

Walkers, Crutches and Canes

All these devices provide support through your arms to limit the amount of weight going through the injured leg or to improve your balance and safety. The device will be chosen according to your ability and your weight-bearing restriction. Walkers, canes and crutches all need to be specifically adjusted to your height by the therapist who also will show you how to use them. If your doctor has restricted your weight bearing status, you may use a walker when you first start walking. If your strength and balance are good enough, you will progress to crutches, which offer more freedom to get around at home. Eventually, you may progress to a cane; however, you must first be able to put full weight on your leg before you can use a cane.

The weight bearing status determined by your doctor can be:

- **Non-weight Bearing** = No body weight should be put on the injured leg.
- **Touch Down Weight Bearing** = Almost no body weight should be placed on the injured leg; just touch the floor for balance.
- **Partial Weight Bearing** = About half the normal body weight should be placed through the injured leg.
- **Weight Bearing as Tolerated** = As much body weight as you are able to put on the injured leg without pain or instability can be applied.
- **Full Weight Bearing** = Full body weight may be put on the injured leg.

Each of these treatment methods can lead to a completely healed, well-aligned bone that functions well. Remember that the method of treatment depends on the type and location of the fracture, the seriousness of your injury, your physical condition and needs and the judgment of you and your doctor.

Successful treatment of a fracture also depends greatly on the patient's cooperation. A cast or fixation device may be inconvenient and cumbersome, but without one, a broken bone can't heal properly. The result may be a painful or poorly functioning bone or joint. Exercises during the healing process and after the bone heals are essential to help restore normal muscle strength, joint motion and flexibility. You can help your broken bone heal properly by listening to and following your doctor's advice.

REHABILITATION

Rehabilitation from your injuries

Your recovery from your trauma will start in the hospital and continue in other settings. This phase of care will, in most instances, last for several months. At different points during this phase, you may need to spend time in a hospital-like setting that delivers different types of care than the hospital, or you may be able to continue your recovery in an outpatient or home setting.

Rehabilitation Hospital

For many Orthopaedic trauma patients the next step in the recovery process occurs in a rehabilitation setting. Some patients who still need a considerable amount of care may need a rehabilitation hospital stay. In the rehabilitation hospital there are many skilled therapists, nurses and clinicians who will work with you daily to help you regain your independence and movement. A specific plan of care and goals will be determined with you and your family once you are transferred to a rehabilitation hospital.

Transitional Care Unit/Skilled Nursing Facility

If you need less medical supervision at discharge from the hospital but are not independent enough to return home, a transitional care unit (TCU) or a skilled nursing facility (SNF) will be the right level of care for you. In this setting, you will begin to regain the strength and function you had prior to your injury. A TCU is very similar to a SNF. The difference between the two is that a TCU is housed within a hospital setting, while a SNF is its own free-standing facility.

Visiting Nurses Association/Home Health Care

If the medical team thinks that your mobility has progressed to a point where it is safe for you to continue your recovery in the home setting, you may go directly home from the hospital. You may have ongoing rehabilitation needs that can be addressed by a therapist who can treat you in your home. This care is important for patients who are not able to get out of their house to an outpatient setting for therapy. The Visiting Nurses Association (VNA) or another home-health agency will send a team of therapists and/or nurses to you in your home. They will help you to continue your therapy and teach your family how to take care of you while you are homebound. This type of therapy may also be recommended for patients after they leave a rehabilitation hospital, skilled nursing facility or transitional care unit.

Outpatient therapy and follow-up appointments

Outpatient therapy visits are often needed after discharge from the hospital, rehabilitation setting or home care to continue to work on your specific rehabilitation goals. Patients will need to be able to get out of their home and travel to the outpatient clinic for treatment. Therapists can continually progress your program to restore full function.

Your surgeon(s) will want to see you in the office setting at different times after your discharge from the hospital to see how well you are recovering from your injuries. Before you leave the hospital, you will be given instructions for this type of follow-up care. The case manager in the hospital will help you and your family to identify the level of care that is right for you and coordinate the transition from one setting to the next.

FREQUENTLY ASKED QUESTIONS

How long do I have to use my crutches/walker/cane?

Many fractures require protection from weight bearing until they are fully healed. Your doctor will determine when it is safe for you to bear weight, so that you may stop using your crutches. Using the crutches/walker/cane for a shorter period of time than suggested may cause complications.

When can I put more weight on my leg?

Your weight bearing status will be explained to you before you are discharged from the hospital. If you are able to bear weight as tolerated, you can put more weight on your leg as it feels comfortable to do so. If you are considered non- or partial-weight bearing, your surgeon will evaluate you at your next appointment to determine whether it has become safe for you to bear more weight.

How long do I have to use the brace/splint?

Your doctor and therapist will instruct you on when and for how long you will need to use your brace or splint.

Can I shower?

You should not shower if you have any open wound or drainage coming from your incision site. If your wound is closed, there is no drainage and you feel that it is safe for you to shower, you can cover the incision with a plastic wrap (i.e., Saran Wrap) and shower safely. Please ask your doctor your questions if you have any worries about your incision or wound. If the incision gets wet, pat it dry. Your cast needs to be covered with a shower bag or plastic bag to keep it dry. If the cast gets wet, it must be changed.

When can I go back to work/school?

We recommend that you wait until your first outpatient appointment with your surgeon to see how you are healing. During this first appointment you should discuss the nature of your work and/or school with your surgeon.

When can I drive?

This is not an easy question to answer because it involves more than your doctor's medical clearance which is based on your safety and healing progress. Part of this answer involves the policies of the Registry of Motor Vehicles and your insurance company. For example, if you are involved in an accident and you are wearing a leg brace or have crutches in the car, it may appear that you are to blame for what happened. Once your doctor gives you medical clearance, you will need to decide if you feel able and well enough to drive.

What happens to the metal pins, screws, and plates? Will they set off a metal detector? Will they stay in my body permanently or will they be removed?

Depending on your fracture, the metal may stay in your body until healing occurs or until it is no longer necessary. Some fractures require that the metal remain permanently. Your surgeon will let you know. As for the metal detectors, they may not be sensitive enough to detect the metal. If they are, you should explain to the security personnel that you have had surgery requiring metal fixation. For more detailed instructions, please visit the Transportation Security Administration (TSA) website:

<http://www.tsa.gov/travelers/airtravel/specialneeds>

Should I put ice or heat on any of my swollen areas? If so, for how long?

You may apply ice to the area to decrease swelling and relieve pain for 10 to 15 minutes per hour as needed. Ice should be placed in a Zip-lock bag and wrapped in a cloth towel to protect your skin. You should not apply heat, as it will increase your swelling.

How long until I can go back to the gym or play sports again?

The answer to this question is almost the same as returning to work or school. You can discuss this question with your surgeon during your first office visit.

When may I resume sexual activity?

The answer to this question varies according to the injuries you have sustained. Your doctor or occupational therapist can give you information to help you decide when and how you can safely resume sexual activity.

How long will I be in the hospital?

Trauma patients, on average, stay in the hospital for four to five days. You may be discharged before or after this time depending on the nature of your injuries.

When should I see my doctor again?

Before you are discharged from the hospital, you will be given specific instructions about where and when you should see your doctor.

Do I need x-rays for my next office visit?

If you had surgery to repair a fractured bone, each of your regularly scheduled follow-up appointments will require an x-ray of the bone.

When do my sutures/staples come out? Should I take them out myself, see my local doctor or return to my surgeon?

Sutures and staples are removed by a doctor or nurse within two to three weeks of surgery. If the staples/sutures have not been removed while you were in the hospital or rehabilitation hospital, you should call your doctor for an appointment. You should not attempt to remove these yourself.

How often do I need to change my dressing?

The answer to this question depends on the type of wound or incision that you have. The team will discuss this issue with you before you leave the hospital, and your nurse will show you how to do dressing changes at home. Sometimes, the visiting nurse can assist with dressing changes at home or provide instructional support to you and/or your family.

What do I do with all of my insurance and disability forms?

We will complete any insurance, disability or transportation forms for you. Please send these forms to your surgeon's office with the patient sections completed and signed.

Can I apply for a handicap placard or license plate?

Yes, you may contact the Registry of Motor Vehicles in your state to request a disabled placard/plate form. Complete the patient information section of this form, and send it to your surgeon so that he/she may complete the sections related to your injury and treatment. The Registry may require you to retake a driver's test or outfit your car with appropriate modifying equipment before they grant such a placard or plate.

How long will I need to take medication?

The answer to this question depends on the type of medication(s) you have been prescribed. If you are on blood thinning medicine like aspirin, coumadin or fragmin, or antibiotics for infection you will need to take it as long as the doctor feels it is necessary. Pain medications should be taken only when needed, as it is expected that the pain will steadily lessen as the fracture heals. [Please see previous section on pain — in Common Issues after Trauma.]

How will the staff of the rehabilitation hospital or home care agency know what my injuries are and what my Orthopaedic surgeon's plan is?

Before you leave the hospital, the team writes a referral to the next "team" from the rehabilitation hospital or agency that will help you continue your recovery. The referral is a document that includes all of your medical and surgical history, your medications, your therapy plan and any restrictions you may have to keep you safe — such as reduced weight bearing on a leg.

Will my surgeon still manage my care during my rehabilitation?

If you go to a rehabilitation hospital, you will have a new physician from the rehabilitation hospital who will oversee the plan your MGH surgeon has set up. The staff of the rehabilitation hospital will contact your MGH surgeon should any issues arise. Patients who are discharged to the Spaulding Rehabilitation Hospital are visited by an attending physician from our team once a week to monitor their progress and healing in conjunction with the Spaulding Team.

PHONE NUMBERS, RESOURCES AND REFERENCES

Orthopaedic Department, Massachusetts General Hospital:
Services, staff and research resources within the Orthopaedic department at MGH
<http://www.massgeneral.org/ortho>

Phone Numbers

Main Number:	(617) 726-2000
White 6:	(617) 726-6106
Ellison 6:	(617) 724-4610
TRACU:	(617) 643-8376
Surgical ICU:	(617) 724-5100
Orthopaedic Offices:	(617) 726-2784; (617) 726-9111
Orthopaedic Trauma Clinic Nurse:	(617) 726-9437

American Academy of Orthopaedic Surgeons:
Patient/Public information on a variety of Orthopaedic conditions
<http://www.aaos.org>

The American Orthopaedic Foot and Ankle Society:
"Bone Up" on the foot educational materials for patients
<http://www.aofas.org>

National Institute of Arthritis and Musculoskeletal and Skin Diseases, National
Institute of Health website with fact sheets, brochures, health statistics and resources
<http://www.niams.nih.gov>

Ortho Gate: The Internet Society of Orthopaedic Trauma and Surgery
<http://www.orthogate.com>

Ortho Guide: Time saving Medline and Internet search for Orthopaedics
<http://www.orthoguide.com>

Orthopaedic Patient Education Collection: Medical Multimedia Group
<http://www.medicalmultimedialogroup.com>

Wheeless' Textbook of Orthopaedics: Comprehensive online medical text
<http://whelessonline.com>

National Spinal Cord Injury Association:
Spinal cord injury and disease overview as well as rehabilitation resources
<http://www.spinalcord.org>

Spinal Cord Injury Information Network:
University of Alabama's comprehensive database for spinal cord injury

<http://www.spinalcord.uab.edu>

EDUCATION RESOURCES AND LIBRARIES

The Blum Patient and Family Learning Center at the MGH

Patients and families can use the resources of this consumer health information library located on the first floor of the White Building in the main corridor. The Blum Center offers information searches and a variety of printed materials and videos that cover many health and disease related topics. Computers are available for Internet access and e-mail. The Blum Center is open Monday through Friday, 9am to 5pm, and closed on weekends and hospital holidays. Call (617) 724-7352 for more information. Also, visit the Blum Center web site at <http://www.massgeneral.org/pflc>.

The MGH Health Sciences (Treadwell) Library

Treadwell Library is one of the oldest and largest hospital health science libraries in the United States. Located in Bartlett Extension 1 on the main campus, the library is open Monday through Thursday, 8:30 am to 8 pm; Friday, 8:30 am to 7 pm; Saturday, 10 am to 4 pm; Sunday, 2 pm to 8 pm; and closed on all hospital holidays. Treadwell Library offers many excellent on-line resources through the web page, <http://www.mgh.harvard.edu/library/library.htm>, including the "Well Connected" consumer health reports edited by MGH physicians. Use the on-line catalog "Magic" to search through the collections of Treadwell Library and the Partners HealthCare System affiliated libraries. Link to the "Electronic Library" and gain access to many on-line resources including "STAT! Ref" a collection of over 30 major medical texts that can be searched by subject or text word: <http://www.massgeneral.org/library/default.asp>.

Warren Library

The Warren Library, established in 1841, is the oldest general hospital library in the country. Patients and staff are welcome to visit the library in the Bulfinch Basement Monday through Friday, 9:30 am to 4:30 pm. The library is non-medical and offers seven daily newspapers, a large selection of magazines, videotapes and cassettes. You also will find more than 10,000 books of all types, including best sellers available for borrowing free of charge. An off-hours book return is available. The library's phone number is (617) 726-2253.

Patient Education Television Channel

Located on Channel 31, the patient education television channel offers over 200 health education video titles for patients to view on-demand. There is no fee to access this service. Use the bedside telephone to dial 4-5212 to activate the channel.

GLOSSARY OF TERMS

Acetabulum: the part of the pelvis connecting with the femur (thighbone) to form the hip joint

Addiction Services Clinician: a clinical professional — usually a nurse or counselor — with specialized training in the field of alcohol and drug dependence

Angiogram: a set of x-ray-like pictures using a special dye that are taken to diagnose injuries to arteries and veins

Anesthesiologist: a physician who has special training in the branch of medicine that deals with anesthesia; he/she is the person who puts you to sleep prior to surgery

Anticoagulant: a medication that prevents or restricts the clotting of blood

Attending Orthopaedic Surgeon: the Orthopaedic doctor who directs your care and assumes ultimate responsibility for all treatments and plans of care (often referred to as the “attending”)

Bones: the hard, connective tissue that forms the body’s skeleton; functions as a structural support

Brace: a device — sometimes jointed — to support and hold any part of the body in the correct position to allow function.

Calcaneus: the heel of your foot

Cane: a sturdy wooden or metal shaft or walking stick used to give support and mobility to an ambulatory but partially disabled person.

Case Manager: a registered nurse who helps you and your family make plans for further care and treatment once you leave the hospital (i.e., in a rehabilitation hospital or home environment)

Cast: hard plaster or fiberglass device placed on the outside of the limb with the fracture that keeps the bones from moving

Cast Boot: a large open shoe with Velcro straps that fits over your cast and allows you to put weight on the leg without damaging the cast

Clavicle: the collarbone; the bone that connects the shoulder to the chest wall

Clinical Nurse Specialist: a nurse who has special knowledge and experience in a clinical area (in your case, Orthopaedics); this nurse gives advice to the nursing staff and health care team members on caring for a patient and is available to answer your questions about your injuries

Comminuted Fracture: an injury where the bone is broken in many places

Compartment Syndrome: a condition caused by the progression of pressure on the blood vessels and nerves of an extremity from severe swelling in the surrounding tissue. This results in reduced blood supply to an extremity, severe pain and limited movement. Treatment includes removal of restrictive dressings or casts or possibly surgery to release the pressure in the tissue.

Compound Fracture: an open fracture; an injury where the broken bone sticks out through the skin

Crutch: a wooden or metal staff, the most common kind of which reaches from the ground to the arm pit, used to aid a person in walking

CT Scan: specialized x-ray studies that can find and/or provide more detailed pictures about a patient's injury

Dislocation: an injury where the joint surfaces are separated

Emergency Department: the place where you are taken to receive your initial/life-saving hospital care; commonly referred to as the "ER" or "ED"

External Fixator: a metal device visible on the outside of the body that treats fractures by stabilizing the involved bones

Extubation: (see *intubation*) the process of removing a breathing tube from your throat; extubation takes place once intubated patients become able to breathe on their own

Fasciotomy: a surgical procedure where the connective tissues are cut open — or "released" — to relieve the pressure caused by reduced blood flow to the muscle compartments surrounding the fractured bone (see *compartment syndrome*)

Femur: the longest bone in both the leg and the body; known commonly as the thighbone

Fibula: the smaller of the two bones in the lower leg/shin area

Fracture: a broken bone

Glenoid: the "socket" portion of the shoulder; is also a part of the scapula (shoulder blade)

Greenstick Fracture: a fracture where the bone is not completely broken. Appearing most frequently in children, the bone does not break, but bends like a "green stick."

Health Care Proxy: the person you name to make medical decisions for you during times when you are not able to make them for yourself

Home Health Care: a team of nurses and/or therapists who go to your home to help you with your therapy and recovery process; they will teach your family how to care for you at home

Humerus: the bone of the upper arm located between your elbow and shoulder

Infection: the invasion of the body by bacteria that reproduce and multiply, causing disease through local cell injury and the release of toxins

Inpatient Unit Nurse: a registered nurse stationed on a patient care unit who works with you and your family to coordinate day to day activities

Intensive Care Unit (ICU): an inpatient nursing unit where patients go to recover when they are seriously ill or injured, or when they require very close medical and nursing observation following major surgery

Intravenous: the process during which fluid or medicine is passed by a tube and needle into a vein — usually in the arm

Intubation: the process during which a tube is placed in your throat to help you breath. Sometimes this tube is attached to a machine called a ventilator that helps you breathe.

Joint: a point of connection between two or more bones

Ligament: a stabilizing cord, band or sheet of soft tissue that links two or more bones or pieces of cartilage together

Mechanism of Injury: the way in which a traumatic injury happens; for example, a fall, motor vehicle crash or direct blow

MRI: a technique that uses magnetic fields to produce pictures of the body that show great detail about the part of the body being examined

Muscle Flap: a surgical procedure where muscle is transferred from an uninjured part of the body to the injured area/part of the body so that healing may take place

NPO: usually used on the night prior to or morning of surgery when a patient is not allowed to eat or drink anything — in order to keep the stomach empty for surgery. “You’re NPO,” means that you should not eat or drink anything until notified otherwise. This means no candy, mints, gum, or water as well.

Nutrition: the food and drink needed to help the body heal while in the hospital

Nutritionist: a professional with specific clinical training who addresses issues pertaining to a patient’s diet and nutritional status

Oblique Fracture: an angular break in the bone

Occupational Therapist: A rehabilitation specialist trained to evaluate and treat restrictions/ limitations in your ability to function independently in daily life roles. The occupational therapist provides treatment to address identified limitations or to teach other strategies to compensate for any loss of function.

Olecranon: the bony tip of the elbow; the upper end of the ulna – sometimes called the funny bone.

Open Reduction Internal Fixation: (ORIF); a surgical procedure used to fix a fracture, usually involving metal rods, plates or screws

Operating Room: a room in a hospital in which surgical procedures requiring anesthesia are performed

Operation: a surgical procedure

Orthopaedics: the medical specialty that includes the diagnosis, preservation and restoration of the form and function of limbs, spine and other muscle and bone structures by medical, surgical and physical methods

PACU: the Post Anesthesia Care Unit; commonly referred to as the recovery room

Pain Service Clinician: a physician or certified nurse anesthetist who has specialized training in the science of pain management; the team will consult this person when routine methods of pain control do not work as expected

Patella: the kneecap

Pelvis: the bony, ring-shaped part of the body connecting on top with the spine and on the bottom with the femurs

Phases of Care: the specific times for particular treatments you receive after your injury; these phases are emergency, surgery, intensive care, intermediate care and rehabilitation

Physical Therapist: a rehabilitation professional trained to examine and evaluate physical impairments, functional limitations and disability. The physical therapist provides exercise therapy and functional training to help you achieve your best function.

Pneumo Boots: a tubular device that is placed around a patient's leg and alternately inflated and deflated with air to maintain constant blood flow and good circulation in the extremities

PCA: patient controlled analgesia; a system where the patient controls the delivery of pain medication into his/her body (usually by pressing a button connected to an IV)

PO: may refer to food, drink and pills or other medications a patient must take orally

Radiologist: a physician with special training in the branch of medicine that deals with the use of x-rays, radioactive substances and other forms of radiant energy in the diagnosis and treatment of injury and disease

Radius: one of the two bones of the forearm located on the thumb side of the arm; it extends from the wrist to the elbow

Reduction: the physical process of correcting or restoring fracture fragments or joint dislocations to their normal anatomical position

Rehabilitation Hospital: a hospital a patient may go to after MGH where you will receive intensive therapies (i.e. physical and occupational) for injuries

Resident Orthopaedic Surgeon: a doctor who has completed medical school and is now obtaining specialized training in Orthopaedics (often referred to as a "resident")

Rounds: the physician team's early morning visits with and examinations of patients

Scaphoid: one of the small bones in the wrist located near the base of the thumb

Scapula: the broad bone on the back of the shoulder and upper back

SICU: the Surgical Intensive Care Unit; an inpatient nursing unit where the seriously ill are treated after surgery

Simple Fracture: one break in the bone, without a break in the skin

Skin Graft: repair of a wound site with skin from another part of the body or from a skin bank

Sling: a bandage or device used to support an injured part of the body, most often the arm

Sling and Swathe: a sling with an additional strap that holds the arm tightly to the body

SNF: skilled nursing facility; a hospital-like setting a patient may go to after discharge from MGH to continue recovery through appropriate therapies and nursing care

Soft Tissue: skin, fat, muscle, nerves and tendons

Spine: the long bony column from the base of the head to the pelvis that protects the spinal cord

Spiral Fracture: a long break in the shaft of the bone

Splint: an Orthopaedic device for immobilization, restraint or support of any part of the body

Sprain: a tension or stretching injury to a ligament that may cause swelling, pain, some loss of function or joint instability

Surgery: the field of medicine dedicated to the treatment of disease or injury by operation; an operation

TCU: transitional care unit; a unit or floor within a rehabilitation hospital to which a patient may go to after discharge from MGH to continue recovery through appropriate therapies and nursing care

Team: the patient, family and group of medical professionals who work together to diagnose, treat and rehabilitate patients with traumatic injuries

Tibia: the larger of the two bones in the lower leg or shin area

Traction: the process of putting a limb, bone, or group of muscles under tension by means of weights and pulleys to align or immobilize the part or to relieve pressure on it

Transverse Fracture: a type of fracture where the bone has been broken in half

Trauma Nurse Practitioner: an expert nurse who specializes in trauma; he/she functions to coordinate the services involved in a patient's care, and works closely with family and the staff

Ulna: one of the two bones of the forearm extending from the wrist to the elbow; located on the pinky side of the arm

Urinary Catheter: a slender, soft plastic tube that is inserted into the bladder for temporary or permanent drainage of urine

VNA: Visiting Nurses Association; a team of nurses and/or therapists who go to a patient's home to help with therapy and the recovery process; they will teach family members how to care for the patient at home
(also see, *Home Health*)

Walker: a light, movable metal frame, about waist high, used to aid a patient in walking

Weaning from the Vent: when a patient practices breathing on his or her own versus breathing with the assistance of a breathing machine (vent)

Weight Bearing Status: a recommendation as to the amount of weight one can place on an injured leg or arm when getting out of bed, standing, or walking. This is usually recommended as no weight, weight bearing as tolerated, partial weight bearing, or full weight bearing.

X-ray: an image taken by electromagnetic radiation that may be used to diagnose fractures

MGH INFORMATION

ALSO AVAILABLE AT www.massgeneral.org/visitor.html

Accommodations

We have both private and semi-private rooms. You are assigned a room based upon the type of care you need. All rooms have a bedside table for toiletries, a closet for personal belongings and a bedside control panel to call a member of the staff. If you would like a private room, let us know, and we will make every effort to accommodate you. You will, however, be expected to pay any room cost differential not covered by your insurance company.

Dining

You and your family and friends are encouraged to share meals whenever possible. You may order a guest tray from a nutrition assistant on the inpatient unit before 11 am for lunch and before 3 pm for dinner or breakfast the next day. Breakfast costs \$4. Lunch and dinner each cost \$6. There also are several dining options outside the patient room that we list below:

The Eat Street Café is located in the basement of the White Building. It is open from 6:30 am to 8 pm on weekdays, and from 7 am to 7 pm on weekends and holidays. Food offerings include a variety of entrees, salads, sandwiches, pizza, grill items, desserts and ice cream.

Coffee Central is located in the Main Corridor and is open weekdays from 6:30 am to midnight. Coffee Central offers coffee, tea, hot chocolate, non-alcoholic frozen drinks and baked goods.

Blossom Street Café is located on the first floor of the Blake Building near the Cox Building. Open weekdays from 7:30 am to 3 pm, Blossom Street Café offers foods that focus on the needs of patients with cancer. Choices include nutrient-fortified soups, sandwiches, beverages and desserts.

Tea Leaves and Coffee Beans Cafeteria is located on the lobby level of the Wang Ambulatory Care Center. Open weekdays from 7 am to 3 pm, Tea Leaves offers breakfast, light lunches, soups, desserts and beverages.

Vending machines that offer hot and cold beverages, snacks, sandwiches, soups and breakfast items are located in the first floor lobby of the Gray Building.

Smoking policy

MGH has a smoke-free policy. If you would like to smoke, you must obtain permission from your physician or nurse. There are two designated smoking shelters on the campus. They are located on Blossom Street next to the Jackson Building and on North Grove Street next to the Fruit Street garage.

Telephones

Every hospital bed has a phone with a direct telephone number. There is no charge for local calls. Long distance calls should be billed to your home, business, a telephone card or placed collect. Cell phone use is restricted in certain areas of the hospital. Please read and follow the signs for cell phone use. Public telephones are available throughout the patient care areas and also are in the lobbies of the Cox, White, Gray, Wang, and Yawkey buildings.

To call a hospital extension from another hospital extension, dial only the last 5 digits of the number.

Television (needs to be updated)

All patient rooms have a television. Basic service (Channel 2, a public broadcasting channel; Channel 4, CBS; Channel 9, a Spanish language channel; Channel 10, PAX TV; and Channel 31, the patient education channel) is offered to patients free of charge. A selection of cable stations is available for a daily fee of \$5 (payable by cash or check). To order the additional channels, call (617) 726-8888 and leave your name, room number and the name of your building. Television representatives visit the patient care units every afternoon and evening.

For your relaxation, MGH offers free of charge the C.A.R.E channel 45 (Continuous Ambient Relaxation Environment), showing beautiful nature images and soothing instrumental music. Channel 46 offers relaxation and humor programs around the clock.

Visiting hours

It is important for our patients to visit with their families and friends. Visiting hours are flexible, with no set hours or age limitations, and are based on individual patient and visitor needs.

Waiting rooms for families

There are unstaffed waiting areas located on each inpatient unit. For families and friends of patients who have surgery, there is a quiet waiting area located on the first floor of the Gray Building, called the Gray Family Waiting Area. This area has small consultation rooms where family members may speak privately with the patient's surgeon. Volunteers staff the reception desk from 9 am until 8 pm, Monday through Friday. Complimentary beverages are available.

Wireless Internet Access

MGH offers free wireless Internet access for patients and families for the length of time a patient is in the hospital. Laptops that are being used in a patient's room must first have an electrical safety test conducted by a hospital Information Systems (IS) technician. Please notify the patient's nurse before using a laptop. The nurse will call the IS department and request a safety test that will be done Monday - Friday between 8:00am and 4:30pm. Certain restrictions may apply for using a laptop in a patient's room. MGH does not guarantee that your laptop will work with the Partners Guest wireless connection and cannot provide technical support or troubleshoot hardware, software or connection problems.

MGH OFFICES

Chaplain

Concern for a person's physical, emotional and spiritual health is basic to patient care. Our chaplains, who represent all religions, can offer you spiritual support and comfort. Your nurse may arrange for a chaplain to visit, or you may contact them directly at (617) 726-2220. The chapel is located on the first floor of the Ellison Building, directly across from the MGH General Store.

International Patient Center

The International Patient Center offers services to international patients to help meet medical and personal needs both prior to and during a patient's hospitalization. Please call (617) 726-2787 or visit <http://www.massgeneral.org/international.html> for more information.

Interpreter Services

Medical interpreters are available to facilitate communication between non-English speaking patients and the MGH clinical staff. Interpreters for the deaf and hard of hearing may also be booked through Interpreter Services or through your medical team. It is recommended that interpreters be scheduled in advance whenever possible.

This service may be reached during business hours at (617) 726-6966 and after hours by calling the MGH page operator at (617) 726-2000, and asking the operator to page the interpreter on call for the language required. Advance notice is required in all instances, except in emergencies.

Lost and Found

Lost and Found is located in the Police and Security Dispatch Office in the basement of the Gray Building, Room 011. Please visit or call (617) 726-2121 to locate any missing item(s).

Medical records

Your medical record serves as a basis for planning your care, provides a means of communication between you and the professionals taking care of you and gives documented evidence of the course and treatment of your illness. The contents of your medical record are confidential and are released only with your written permission. Your family and friends may read your record ONLY with your permission. Hospital staff must be present any time a patient's record is reviewed while he/she is still in the hospital. To request a copy of your record after discharge, please call the Medical Records Department at (617) 726-2361.

Notary public

Notary public services are available through the Office of Patient Advocacy. To arrange this complimentary service, please call (617) 726-3370 or visit the office located in Room 018 of the Wang Ambulatory Care Center.

Patient financial services

The Patient Financial Services Office provides information about hospital billing. You may visit one of our offices (no appointment is necessary) on the first floor of the Wang Ambulatory Care Center or the second floor of the Yawkey Center for Outpatient Care. You may call them directly at (617) 726-2191.

Social services

Social workers help you and your family cope with the stress of your injuries and being in the hospital. They provide emotional support, short-term counseling, information and referrals to resources in your community. They also can help with practical matters like finding a place to stay, financial matters and transportation. If you would like to see a social worker, you may ask your nurse or doctor to arrange a meeting or call (617) 726-2640 for an appointment.

HOSPITAL SERVICES

Banking

ATM machines are located on the first floor of the White Building (Main Corridor), the first floor of the Cox Building, and the first floor of the Yawkey Center for Outpatient Care.

Blood bank

The MGH Blood Donor Center located on the first floor off the Gray Lobby is open Monday through Friday from 8:30 am to 4:30 pm. The blood donor program serves MGH, Shriners Burn Institute for Children, Spaulding Rehabilitation Hospital and the Massachusetts Eye and Ear Infirmary. Please call (617) 726-8183 for more information.

Child care

The Backup Day Care Center was established to help families who need temporary child care. The Center's staff will take care of your child for a minimum amount of two hours, providing space is available. Located on the first floor of the Warren Building, the Backup Day Care Center is open Monday through Friday from 6:30 am to 6 pm. Please call (617) 724-7100 to pre-register your child.

The MGH General Store — flowers and gifts

The MGH General Stores, located on the first floor of the Ellison Building, and the first floor of the Yawkey Building has many novelty and “must have” items. Services include a wide assortment of greeting cards, gourmet food, and healthy snacks and beverages. The MGH General Store also carries a wide selection of flowers and floral arrangements that may, upon request, be delivered to hospital rooms. The store is open Monday through Friday from 8:30 am to 7:30 pm and from 10 am to 6 pm on weekends. For more information, please call (617) 726-2227 or visit their web site: <http://www.mghgeneralstore.com>.

Hair and skin care — Images

Images is a full service, non-profit hair and skin salon located within MGH. Images specializes in services and products for adult and pediatric patients with cancer, but all patients and visitors are welcome to use their services. Images is located on the first floor of the Blake Building, between the Cox Building and the General Store. For an appointment, please call (617) 726-3211.

Mail

To send mail to a patient, please use the following address format:

Patient Name
Inpatient Unit or Building Name
Room Number
Massachusetts General Hospital
55 Fruit Street
Boston, MA 02114

Newspapers

There are newspaper vending machines on the lobby levels of the White and Gray buildings. Newspapers are also available at the MGH General Store’s Yawkey location.

Outpatient pharmacy

The outpatient pharmacy fills prescriptions from MGH and Partners-affiliated physicians only. Located on the first floor of the Wang Ambulatory Care Center, the pharmacy is open Monday through Friday, 9 am to 5:30 pm, and on weekends and holidays from 9 am to 12:30 pm. You may reach them at (617) 724-3100.

TRANSPORTATION AND ACCOMMODATIONS

Hotels

There are many hotels near the hospital where family members and friends may stay during their loved one's hospitalization. Some of these hotels offer reduced rates. For information about local hotel accommodations, you may call our Social Services department at (617) 726-2640 or visit their website: <http://mghsocialwork.org/main.html>.

Parking and transportation

The Fruit Street and Parkman Street garages are located outside of the main entrance to MGH. The maximum daily charge for patients and visitors is \$8, with tickets validated at the kiosk near the main entrance to the hospital. Valet parking is available during daytime hours and is located at the entrance to the Wang Ambulatory Care Center. This cost is \$9 per day.

There are metered parking spaces managed by the City of Boston that are available at a cost of \$.25 per 15 minute interval. The meters are in service from 8 am to 8 pm, Monday through Saturday. You may park for free on Sundays, most holidays and during hours when the meters are not in service.

Our Commuter Services department — (617) 726-8886 — provides a customized profile of available transportation options to MGH by bus, train, boat, car routes and offers information about parking. There are several shuttles that run between MGH and convenient parking and subway stops. Shuttle schedules can be picked up at the White information desk or in the Blum Patient and Family Learning Center. Taxis are available at the main entrance to the hospital.

MY TEAM:

Attending Orthopaedic Surgeon: _____

Resident Orthopaedic Surgeons: _____

Primary Care Doctor: _____

Consults: _____

Trauma Coordinator: _____

Nurses: _____

Clinical Nurse Specialist: _____

Care Coordinator: _____

Nutritionist: _____

Social Worker: _____

Physical Therapist: _____

Occupational Therapist: _____

Additional Caregivers: _____

MY INJURIES

Spine:

Arm/Shoulder:

Hip/Leg:

Pelvis:

Other Injuries:

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