OUR LADY'S CHILDREN'S HOSPITAL
NURSING CARE Pathway 1
Care of a child pre and post orthopaedic surgery

Care Pathway 1 **Problem**	**Care of the child** **Issue date: June 2016** **Pre and Post Orthopaedic Surgery** **Goals** **Review date: June 2019**
……. Will have/has had Ortho surgery for: _____ Child is potentially at risk from : 1) Neurovascular Compromise 2) Inadequate pain management 3) Respiratory compromise 4) Wound infection / delayed wound healing 5) Urinary retention 8) Complications of bedrest 7) Nausea and Vomiting	• Pre Op: Child and family will be safely prepared for theatre physically and psychologically • Post Op: Child will be safe and comfortable post op • Any alterations in neurovascular observations status detected and reported promptly • Pain needs will be assessed and ensure patient comfort • Any complications of wound therapy are detected early • To prevent complications related to impaired mobility • Prompt detection and management of complications post Orthopeadic surgery e.g. Compartment syndrome, Complications of cast,

Can be used in combination with Care Plans 9, 14, 14a, 23, 24, if more detail required.

Commenced date, time signature & grade	**NO.**	**Nursing intervention**	**Discontinued date, time, signature, grade**
	1.	**Pre-Operative. Care**	
		• Explain procedure to Patient and Family, involve play specialist • Discuss with Child methods of induction if appropriate • Discuss any other requests that the Child/Parents may have in relation to surgery • Ensure child has bath/shower (Chlorohexidine where appropriate) • Fast from Milk solids from: _____ Clear fluids from: _____ • Place fasting sign over bed and explain to parents and child meaning of same, ensure correct understanding • Remove food from child's reach • Specific pre op checklist needs e.g.: IV fluids, Bowel prep, Swabs, Bloods Clinical photos, Clinical Nurse Specialist Involvement • Administer pre-medication and other medications if prescribed: • Accompany child to Theatre • Child may bring comforter to theatre with them	
	2.	**Post-Operative care**	
		• Ensure Airway, Breathing & Circulation are stable upon transfer to ward • Assess Child using PEWS, respond appropriately • Monitor colour, pulse, respirations, blood pressure, oxygen saturations and temperature as directed by child's condition / surgeon/anesthetist/nursing staff • …… • Nurse child on a monitor • Report and record any deviations from normal	
	3.	**Neurovascular Observations**	
		• Monitor colour of affected limb, report and record deviations from normal • Monitor movement of affected limb, all digits, report and record deviations • Monitor limb sensation, checking each digit separately, report and record	

Patient Name…….

HCRN……

Ward……..

		deviations • Monitor temperature of affected limb, (using the back of the assessors hand on each digit separately for effectiveness) report and record deviations (Kunkler, E.C. (1999)). **Compare all above with affected limb or use baseline assessment, Contact Ortho SHO/REG if any deviations from normal** • Palpate all pulses distal to fracture • If observations is restricted observe capillary refill • Observe affected limb for swelling, oozing. Report and record any deviations from normal • _____	
	3.	**Pain**	
		• Assess pain score in admission as per pain assessment guidelines • Utilize both pharmacological/non-pharmacological means of pain relief • Administer analgesia as prescribed as per OLCHC Formulary 2016 • Monitor and record effect of analgesia **<u>Opioid Infusion</u>** 1. All Infusions are administered in correct infusion pump 2. Patients and Family have received adequate information regarding PCA/NCA pump 3. Morphine Observations are recorded hourly (NB resps, O2 Sats) 4. Hourly volume infused, along with running total of the infusion will be recorded on fluid balance 5. Any problem regarding pump should be reported immediately 6. Alternative analgesia is prescribed and administered prior to discontinuing infusion.	
	5	**Wound Assessment**	
		• Assess wound daily for redness, pain, swelling, haemorrhage or ooze. Report and record accordingly. • Change wound dressing when clinically needed • Record dressing names and change made • Liaise with appropriate CNS re. Status of sutures etc. • Monitor TPR, any increase in same may indicate infection • Assess wound for signs of infection : redness, odour, pain • Specific Post op instructions from team re. wound • Administer antibiotic therapy as prescribed • Report any improvement /deterioration in wound site to appropriate team • Document and report any changes in wound progress • Liaise with PHN /Practice Nurse / GP regarding wound care following discharge	

Patient Name…….

HCRN……

Ward……..

Location Of Wound	Wound as a result of: surgery / trauma / old wound site / Pin sites	Wound description / Progression of improvement	Wound Dressing	Frequency of Dressing
Wound 1.				
Wound 2.				
Wound 3.				

	6	**Peripheral Venous Catheter**	
		• Decontaminate hand before and after each contact with cannula • Check if cannula is secure • Ensure limb above cannula is not restricted, ID band, BP cuff • Administration of IV Fluids as prescribed, ensuring correct fluids, correct infusion rate and duration. IV Fluids: _____ • Check cannula site for signs of infection or infiltration, dislodgement • Maintain patency of cannula by flushing with NaSl 0.9% when : 1. The cannula is not in use 2. Prior to administration of treatment 3. Between administration of different medications 4. Post administration of treatment using positive pressure technique	
	6a.	**Central Venous Assess Device (CVAD)**	
		PICC □ CVC □ Broviac /Hickman □ Other □ *Detail*_____ Indicate insertion site of CVAD_____ Dates inserted --/--/--/-- Reinserted --/--/--/--	
	7.	**Urinary Catheter**	
		Urinary catheter / **Date inserted** / **Size** / **Date for removal** • Provide catheter care as per urinary guidelines (OLCHC 2013) • Assess and monitor urinary output and ensure same above 1ml/kg/hr or as per surgeons instructions • Ensure output adequate to avoid urinary retention. IV fluid bolus as per surgeons/Anaesthetists instructions • Remove urinary catheter once IV morphine is discontinued to avoid potential risk of urinary retention	

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HCRN……

Ward……..

	8.	**Mobility**	
		• Assess pressure areas regularly and ensure skin is intact • Relieve pressure areas frequently +/- pressure relieving mattress • Observe pressure areas and maintain skin integrity • Movement as per surgeons instructions	
	9.	**Nausea and Vomiting**	
		• Observe nausea / vomiting, assess possible cause • Support child and provide emesis bowl • Administer anti –emetics and evaluate same • Record volume, colour and consistency of vomitus on intake / output chart/ • Dietician involvement if required, e.g. high protein diet, Cal shakes , TPN	
	10.	**Discharge Planning**	
		• Liaise with Public Health Nurse / GP / Practice Nurse • Complete appropriate documentation • Specific post op Instructions: _____ • OPD APPT / Follow Up: • Parental Information Leaflets • Additional Information	

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