Care plan 14b **Problem**	**Spinal Surgery** **Issue date: January 2012** **Goal** **Review date: January 2015**
…….. is undergoing Spinal Surgery	▪ **Pre-operative care:** the child/infant and family will be safely prepared for theatre physically and psychologically. ▪ **Post-operative care:** The child will have a safe and comfortable post-operative recovery ▪ **Prompt detection and management of complications**

Commenced date, time, signature, grade		**Nursing Intervention**	Discontinued date, time, signature, grade
	1	**Pre-Operative care**	
		▪ Explain procedure to patient and family. Involve play specialist in the process. ▪ Discuss with child his/her preferred method of induction if appropriate. Discuss any other requests that the parent or child may have in relation to surgery. ▪ Ensure child has a bath/shower prior to surgery. Fast from Milk solids from:_____ Clear fluids from:_____ ▪ Place fasting sign over bed and explain to parents and child the meaning of same. ▪ Attend to any specific pre-operative needs ▪ Complete pre-operative checklist, date and sign, ensure consent is signed. ▪ Administer pre-medication and or other medications if prescribed. ▪ Accompany child/infant and parent safely to theatre ▪ Child/infant may bring comfort item to theatre with him/her	
	2	**Post-Operative Care** **Airway, Breathing and Circulation**	
		▪ Ensure Airway, Breathing & Circulation are stable upon transfer to the ward. ▪ Assess and respond appropriately to altered respiratory effort, shock or haemorrhage ▪ Monitor colour, pulse, respirations, blood pressure, oxygen saturations and temperature as directed by child's condition / surgeon / anaesthetist / nursing staff …… …… ▪ Nurse child on wall mounted monitor ▪ Report and record any deviations from normal	
	3	**Neurovascular Observations**	
		▪ Assess Neurovascular Status of all limbs including: - Colour - Movement - Sensation - Temperature ▪ Record frequently and as condition indicates and report deviations from the norm ▪ Palpate all pulses, report and record any deviations ▪ Compare all of the above with pre- operative baseline assessment. ▪ Contact Orthopaedic SHO/Registrar if any deviations from the norm	
	4	**Pain**	
		▪ Assess pain score as per OLCHC guidelines (2011) ▪ Utilise non-pharmacological means of pain relief. ▪ Administer analgesia and monitor effects of same. ▪ Report & record as per OLCHC guidelines. ▪ Monitor and record use and effectiveness of PCA/NCA (as per Opioid guidelines 2011)	
	5	**Nausea and vomiting**	
		▪ Observe for nausea/vomiting - Assess possible causes ▪ Support child, provide emesis bowl. ▪ Administer anti-emetics and evaluate the effectiveness of same ▪ Record colour, consistency and volume of vomitus in intake/output chart ▪ Ensure presence of bowel sounds is documented before administering diet & fluids as there	

Patient name…….

HCRN……..

Ward……..

		is a potential risk of paralytic ileus or CAST syndrome	
	6	**Wound Care**	
		▪ Assess wound daily for redness, pain, swelling, haemorrhage or excessive ooze. Report and record accordingly ▪ Change wound dressings when clinically indicated ▪ Record dressing name and changes made (if necessary) ▪ Liase with CNS re. status of sutures **Wound 1** …… **Wound 2**…… **Wound 3**……	
	7	**Chest Drain (Anterior Fusion Only)**	
		▪ Provide care as per chest drain guidelines(OLCHC 2010) ▪ Observe oozing around the site ▪ Record drainage amount, monitoring colour and consistency ▪ Report and record reduction or increase in drainage	
	8	**Drain**	
		<table><tr><td></td><td>Date inserted</td><td>Size</td><td>Date for removal</td></tr><tr><td>Redivac Drain ®</td><td></td><td></td><td></td></tr></table> ▪ Ensure drain is free from kinks. ▪ Observe for oozing around the site ▪ Record drainage amount, monitoring colour and consistency. ▪ Report and record reduction or increase in drainage amount. ▪ Maintain suction to Redivac ® as requested	
	9	**Urinary output**	
		<table><tr><td></td><td>Date inserted</td><td>Size</td><td>Date for removal</td></tr><tr><td>Urinary catheter</td><td></td><td></td><td></td></tr></table> ▪ Provide catheter care as per urinary guidelines (OLCHC 2009) ▪ Assess and monitor urinary output and ensure same is above 1ml/kg/hr or as per surgeon's instructions. ▪ Ensure urinary output adequate in order to avoid urinary retention. IV bolus fluids administered as per anaesthetist's instructions ▪ Remove urinary catheter once IV morphine is discontinued to avoid the potential risk of urinary retention	
	10	**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 surgeon's instructions – Note: the potential risk of movement / slippage of metalwork: …… ……	
		Additional Information: …… …… ……	

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Ward……..