## Care Pathway 1

### Problem

Will have/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
6. Complications of bedrest
7. Nausea and Vomiting

### Goals

- 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 Orthopaedic surgery e.g. Compartment syndrome, Complications of cast,

*Can be used in combination with Care Plans 6, 7, 8, 9, 11, 23, 24, if more detail required.*

### Nursing Intervention

<table>
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<tr>
<th>Commenced date, time signature &amp; grade</th>
<th>NO.</th>
<th>Discontinued date, time, signature, grade</th>
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#### 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/anaesthetist/nursing staff
- Nurse child on wall mounted 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 deviations

*Compare all above with affected limb or use baseline assessment, Contact Ortho SHO/REG*
### 3. Pain

- Assess pain score on admission as per pain assessment guidelines
- Utilize both pharmacological and non-pharmacological means of pain relief
- Administer analgesia as requires as prescribed as per OLCHC Formulary 2015
- Monitor and record effect of analgesia
- Monitor and record use and effectiveness of PCA/NCA (as per Opioid guidelines 2015)

### 4A Epidural Infusion

- All infusions are administered in correct infusion pump.
- Epidural infusion administered as per OLCHC Medication policy, epidural guidelines and as prescribed on epidural prescription sheet.
- Nursing staff should ensure following: prescription and dosage are correct, Pump is programmed correctly, pump is running accurately
- Nursing staff monitor signs of toxicity and report same to Anaesthetist on bleep 8528
- Medication, epidural catheter and tubing all labeled “epidural use only”
- Urinary catheter in situ and managed appropriately
- Alternative analgesia is prescribed and administered prior to discontinuing infusion
- Catheter is removed and discarded appropriately once infusion completed

### 4B Morphine infusion

- All infusions are administered in correct infusion pump.
- Patients and Family have received adequate information regarding PCA/NCA
- Morphine observations are recorded hourly (NB: Resp rate and O2 Sats)
- Hourly volume infused, along with running total of the volume of epidural will be documented on fluid balance
- Any problem regarding pump should be reported immediately
- Alternative analgesia is prescribed and administered prior to discontinuing infusion

### 5A Wound Care

- 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.

<table>
<thead>
<tr>
<th>Wound 1</th>
<th>Wound 2</th>
<th>Wound 3</th>
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</table>

### 5B Wound Assessment

- 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: (Route, Duration, Dose)
- 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

<table>
<thead>
<tr>
<th>Location Of Wound</th>
<th>Wound as a result of: surgery / trauma / old</th>
<th>Wound description / Progression of</th>
<th>Wound Dressing</th>
<th>Frequency of Dressing</th>
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Patient Name……………………………

HCRN………………………………

Ward………………………………
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 NaSI 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

7. **Urinary Catheter**

<table>
<thead>
<tr>
<th>Urinary catheter</th>
<th>Date inserted</th>
<th>Size</th>
<th>Date for removal</th>
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   - Provide catheter care as per urinary guidelines (OLCHC 2009)
   - 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

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/

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**Reviewed Dec 2015**

**Patient Name**

**HCRN**

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

- 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:

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*Reviewed Dec 2015*

**Patient Name…………………………….
HCRN………………………………..
Ward………………………………..**