Children's Health Ireland at Crumlin

NURSING CARE PLAN No 14b
Post Spinal Surgery
Please use careplan in conjunction with Careplan 1

Full Name: ………………………………………
Address: Addressograph
………………………………………
HCR………………………………………

Care Plan No 14b Problem	Post Spinal Surgery Goals	Issue Date: August 2018 Review Date: August 2021
………………………………… 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**	

No	NURSING INTERVENTION	Commencement, Date, Signature, Time, Grade	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	Commencement, Date, Signature, Time, Grade	Discontinued, Date, time, Signature, Grade
• 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 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) • Liaise with CNS re. status of sutures			
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**		
• 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**		
• 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			

Wound table (section 6):

Wound 1	
Wound 2	
Wound 3	

Drain table (section 8):

	Date inserted	Size	Date for removal
Redivac Drain ®			

Urinary catheter table (section 9):

	Date inserted	Size	Date for removal
Urinary Catheter			

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10	Mobility	Commencement, Date, Signature, Time, Grade	Discontinued, Date, time, Signature, Grade
• 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			

Created by The Nursing Department
Issue Date: August 2018 / Review Date: August 2021

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