STANDARD OF CARE
ORTHOPEDIC PATIENT

Objectives:

1. To maintain neurovascular function
2. To maintain proper alignment of extremity.
3. To minimize bleeding.
4. To prevent postoperative complications.
5. To experience no or minimal pain.
6. To maintain skin free of breakdown and assist patient to achieve optimal mobility.
7. To instruct and educate the patient and family on disease processes, plan of care and procedures performed.

Process Standards:

1. Monitor and document neurovascular checks every 1 hour X 24 hours, then every 4 hours as ordered. Notify physician of any deterioration immediately. If not ordered then minimally every 4 hours. Assessment of compartment syndrome shall be done as ordered. The following are signs of compartment syndrome. If such occurs the MD shall be notified and Compartment Syndrome Cart shall be obtained from CMS.
   * pain-at rest, with passive extension/flexion, or out of proportion to chief complaint
   * swelling, muscle may feel tight or full
   * tense limb
   * paresthesia (tingling or burning sensation)
   * warm, shiny skin
   * paresis
   * loss of two-point discrimination
   * hypoesthesia followed by anesthesia
   * complete neuropathy
   * loss of pulses, cap refill, pallor or coolness of extremity (late sign)
2. Proper positioning of extremity; elevated for comfort if indicated.
3. Drain output recorded every 1 hour X 4 hours, then every 4 hours as ordered by physician. If not ordered then minimally every 4 hours. Excessive bleeding is to be documented and physician notified immediately.
4. Assess pain level and administer pain medication as ordered. If the patient is intubated Critical Care Observation Tool (CPOT) shall be used.
5. Observe/treat potential skin breakdown areas. WOCN consult is ordered.
6. For pelvic fractures, abdominal girth measurements are documented if ordered.
7. Blood count, ABG’s, chemistry and renal function studies should be monitored as ordered and acute changes will be reported to the physician within 30 minutes of receiving results.
8. Meticulous wound care shall be performed to prevent nosocomial infections.
9. After initial dressing change by physician, wound care may be performed by the nurse according to the physician order.
10. Aggressive pulmonary toiletry should be initiated as soon as clinically possible.
11. The patient should be turned every two hours until patient is allowed out of bed, unless contraindicated.
12. The patient should have assistive devices to assist in mobilization when possible.
13. The patient should be out of bed and ambulating as the clinical condition allows and as ordered by the physician.
14. The patient and or family will be educated regarding disease process, plan of care and procedures performed. Documentation of education should be present.

Expected Outcomes:
1. Neurovascular checks will not be compromised.
2. Proper alignment shall be maintained.
3. Minimal drainage from site, drain and/hemovac.
4. Patient verbalizes adequate pain relief.
5. Skin remain free from breakdown.
6. The patient and or family will verbalize understanding of disease processes, plan of care and procedures performed.

Reference: