

usually sufficient to restore normal mobility, and physical or occupational therapy is rarely indicated.

Children are most frequently hospitalized for fractures of the femur and supracondylar area of the distal humerus. If simple reduction cannot be achieved or a neurovascular problem is detected after the injury, observation in a hospital setting may be indicated. The trend is to avoid hospitalization. The major methods for immobilizing a fracture, casting and traction, are described later.

Nursing Care Management

Nurses are frequently the persons who make the initial assessment of a child with a suspected fracture (see [Emergency Treatment](#) box). The child and parents may be frightened and upset, and the child is often in pain. Therefore, if the child is alert and there is no evidence of hemorrhage, the initial nursing interventions are directed toward calming and reassuring the child and parents so that a more extensive assessment can be more easily accomplished.

Emergency Treatment

Fracture

Determine the mechanism of injury.

Assess the 6 Ps.

Move the injured part as little as possible.

Cover open wounds with a sterile or clean dressing.

Immobilize the limb, including joints above and below the fracture site; do not attempt to reduce the fracture or push protruding bone under the skin.

Use a soft splint (pillow or folded towel) or rigid splint (rolled newspaper or magazine).

Uninjured leg can serve as a splint for a leg fracture if no splint is available.