NURSING CARE PLAN

Patient Name:	**AB**	**Age:**	**3 years old**
Diagnosis:	**Right femur fracture (post-ORIF)**	**Date:**	**2026-01-14**
Current Status:	**PACU recovery, Spica cast applied**	**Allergies:**	**NKDA**

NURSING DIAGNOSIS 1: Acute Pain

Related to: Surgical tissue trauma and fracture

Expected Outcome:

- Patient will report pain level ≤3/10 on FACES scale within 2 hours post-operatively

Assessments:

- Assess pain level using age-appropriate FACES pain scale every 30 minutes x 2 hours, then every 2 hours
- Monitor vital signs (HR, BP, RR) for physiological indicators of pain
- Evaluate location, quality, and radiation of pain using developmentally appropriate communication
- Assess effectiveness of analgesics using pain scores before and after administration

Interventions:

- Administer prescribed analgesics (acetaminophen, ibuprofen, or opioids) per physician orders on schedule
- Provide non-pharmacologic comfort measures: repositioning, distraction with toys/games, parental presence
- Apply ice packs wrapped in cloth distal to cast (20 minutes on/off) to reduce swelling and pain
- Elevate affected extremity on pillows to promote venous return and reduce swelling

NURSING DIAGNOSIS 2: Risk for Infection

Related to: Surgical incision, invasive procedure (ORIF), and presence of foreign body (hardware)

Expected Outcome:

- Patient will remain free from signs/symptoms of surgical site infection throughout hospitalization

Assessments:

- Monitor temperature every 4 hours; report temperature >38°C (100.4°F) immediately
- Assess surgical site (if visible at cast edges) for erythema, warmth, drainage, or odor every shift
- Monitor complete blood count (CBC) for elevated WBC or left shift indicating infection
- Assess for increased pain, swelling, or foul odor from cast that may indicate infection

Interventions:

- Perform hand hygiene before and after every patient contact; use soap and water or alcohol-based sanitizer
- Administer prophylactic antibiotics per physician orders to prevent surgical site infection
- Maintain sterile technique for any dressing changes or invasive procedures per aseptic protocol

- Keep cast dry and clean; educate parents on cast care and signs of infection to report

NURSING DIAGNOSIS 3: Impaired Physical Mobility

Related to: Spica cast immobilization and post-surgical pain

Expected Outcome:

- Patient will maintain adequate circulation and neurovascular function in affected extremity throughout recovery

Assessments:

- Assess neurovascular status distal to cast: capillary refill (<2 seconds), skin color/temperature, pulse quality every 1 hour x 4, then every 4 hours
- Evaluate cast for proper fit, ensuring no excessive tightness, pressure points, or constriction
- Assess for signs of compartment syndrome: severe pain unrelieved by medication, pallor, paresthesia, pulselessness
- Monitor ability to move toes on affected extremity and compare to unaffected side

Interventions:

- Position patient with cast elevated on pillows above heart level to promote venous return
- Perform passive range of motion exercises on unaffected extremities to maintain mobility
- Use trapeze or assistive devices for safe movement and positioning per physical therapy recommendations
- Educate parents on proper positioning, transfer techniques, and signs of neurovascular compromise

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