NURSING CARE PLAN

Patient: AB, Age: 3 years

Diagnosis: Right femur fracture s/p ORIF, in spica cast

Date: January 20, 2026

1. ACUTE PAIN related to surgical intervention and tissue trauma

Outcome: Patient will demonstrate decreased pain as evidenced by FACES scale ≤3/10 within 24 hours.

Assessments:

• Assess pain using age-appropriate FACES pain scale every 2-4 hours and PRN

• Monitor vital signs for physiological indicators of pain (elevated HR, BP, respiratory rate)

• Observe nonverbal cues of pain (crying, grimacing, restlessness, guarding behavior)

• Assess effectiveness of pain interventions and medication side effects

Interventions:

• Administer prescribed analgesics (acetaminophen, opioids) on schedule and PRN as ordered

• Position patient comfortably with pillows for support and elevation as appropriate

• Provide age-appropriate distraction techniques (toys, books, music, tablet games)

• Educate parents on pain management strategies and when to notify nursing staff

2. RISK FOR INFECTION related to surgical incision and invasive procedure

Outcome: Patient will remain free from signs of infection throughout hospital stay.

Assessments:

• Monitor surgical incision site for redness, swelling, drainage, warmth, or odor

• Assess temperature every 4 hours and PRN for fever

• Monitor white blood cell count and inflammatory markers if ordered

• Assess capillary refill (<2 seconds), skin color (pink), and pedal pulse (strong) distal to cast

Interventions:

• Maintain strict hand hygiene and aseptic technique for all patient contact

• Administer prescribed antibiotics as ordered and monitor for effectiveness

• Keep cast clean and dry; monitor for any unusual odors or drainage through cast

• Educate parents on infection prevention and signs to report immediately

3. IMPAIRED PHYSICAL MOBILITY related to spica cast immobilization

Outcome: Patient will maintain optimal skin integrity and circulation during immobilization period.

Assessments:

• Assess skin integrity around cast edges and pressure points every shift

• Monitor neurovascular status (capillary refill, skin color, temperature, sensation, movement) every 2-4 hours

• Assess for signs of compartment syndrome (increased pain, pallor, paresthesia, paralysis, pulselessness)

• Evaluate patient's ability to participate in age-appropriate activities within mobility restrictions

Interventions:

• Reposition patient every 2 hours using log-roll technique to prevent pressure injuries

• Provide age-appropriate toys and activities that can be used while immobilized

• Perform gentle range of motion exercises to unaffected extremities as tolerated

• Collaborate with child life specialist for developmental support and coping strategies

Note: This care plan should be reviewed and updated each shift per hospital protocol.