Spinal Cord Injury

OBJECTIVES:

To provide and facilitate total physiologic support of patient during acute and chronic phase in order to enhance recovery.
To provide emotional support as well as ongoing education to family and patient order to enhance recovery and adaptive coping mechanism.
Prevention of complications secondary to physiologic changes due to spinal cord trauma.[1]
To prevent malnutrition.[1]

PROCESS STANDARDS:

1. Complete assessment will be performed and documented every 4 hours.

    A. Vital signs should be monitored at least every 15-30 minutes or less if patient's condition is unstable.

    B. Vital signs to include: HR, Respirations, BP.

    C. The physician will be notified of significant changes in the patient's status including rising or lowering HR, BP, and RR from baseline. This will allow for assessment of airway, breathing, and circulation.

2. Neurological assessment utilizing the Glasgow Coma Scale should be done every 1-2 hours until neurological status is stable.[1]

3. If spine is stable, then it should be clearly documented on the flow sheet.

4. Type of traction with amount of weight is documented every shift with assessment of insertion site. Weights should hang freely and unobstructed. Pin site care q shift.

5. Strict bedrest with proper body alignment should be maintained at all times unless otherwise ordered by MD.

6. A physician's order must be obtained prior to turning patients.

    A. Patients should be turned every 1-2 hours unless contraindicated.

    B. If the patient is ventilated, the patient should be ambu-bagged on 100% oxygen during implementation.

7. A physician's order must be obtained prior to getting the patient out of bed. Patients are properly supported in proper body alignment.

8. Notify the MD for urine output <30 cc or >300 cc for 2 consecutive hours.

9. Gardener Wells long sites should be cleaned every shift with H202 and swabbed with betadine and left open.

10. Skin integrity should be assessed frequently and documented every 4 hours. The Wound, Ostomy, and Continence Nurse (WOCN) should be consulted for any evidence of breakdown, or if the patient is at high risk for skin breakdown.[2]

11. Any transport of patient with an unstable spine or with cervical traction in place should be accompanied by the physician.

EXPECTED OUTCOMES:

1. Neurological status is stable and tolerated prescribed activity level without a decline in function.

2. Verbalized understanding of condition and rehabilitation goals.

Reference:

[1] Urden, L., Stacy, K., & Lough, M. (2006). *Thelan's Critical Care Nursing: Diagnosis and Management.* (5th ed). St. Louis: Mosby.

[2] Alspach, J. (1998). *Core Curriculum for Critical Care Nursing (5th ed).* Philadelphia: Saunders.

Jordan, K. (Ed). (2000). *Emergency Nursing Core Curriculum (5th ed)*. Philadelphia: Saunders.

Newberry, L. (2003). *Sheehy's Emergency Nursing, Principles and Practices (5th ed*). St. Louis: Mosby.