

Document Title	Technical Operation Standards and Protocols for Pelvic Fracture Nursing Care	Document No./Version	LEY-HL-CZBZ-135/1.0
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## Pelvic Fracture Nursing Technical Operation Standards and Protocols

Ward \_\_\_\_\_ Name \_\_\_\_\_ Score \_\_\_\_\_ Preceptor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Item	Procedure	Points	Deduction Reasons	Deduction
Preparations (20 points)	1. Nurse Preparation: (1) Professional attire: Wear nurse uniform, ID badge; neat hair, no long nails. (2) Hand hygiene: 7-step handwashing, sterile gloves. (3) Master emergency protocols (shock, fat embolism management).	5	<ul style="list-style-type: none"> <li>•Improper attire (-1)</li> <li>•Incorrect hand hygiene (-2)</li> <li>•Unfamiliar with protocols (-2)</li> </ul>	
	2. Equipment Preparation: (1) Emergency devices: ECG monitor, oxygen supply, suction, emergency drugs. (2) Nursing supplies: Pelvic binder/external fixator, turning pads, skin protectors, thermometer, BP monitor, pain scale. (3) Special items: Urinary catheter kit, IPC devices, traction system.	10	<ul style="list-style-type: none"> <li>•Missing critical equipment (-3)</li> <li>•No turning aids (-2)</li> <li>•Unverified traction function(-2)</li> </ul>	
	3. Environment Preparation: (1) Room temperature 22-24°C, humidity 50%-60%. (2) Anti-decubitus mattress, functional bed rails. (3) Dry floors, clear emergency access.	5	<ul style="list-style-type: none"> <li>•Unadjusted environment (-1)</li> <li>•Improper pressure relief setup (-2)</li> <li>•Unresolved safety hazards (-2)</li> </ul>	
Assessment Criteria (25 points)	1. Specialized Assessment: (1) Injury mechanism: Fall/crush history. (2) Fracture classification: Tile (A/B/C) or Young-Burgess system. (3) Complication alerts: Monitor Hb trends (retroperitoneal hematoma), perineal ecchymosis, rectal exam.	8	<ul style="list-style-type: none"> <li>•Unclear injury mechanism (-2)</li> <li>•Incomplete classification (-3)</li> <li>•Missed rectal exam/perineal signs (-3)</li> </ul>	
	2. Systemic Assessment: (1) Vital signs: Continuous BP (hemorrhagic shock), RR (fat embolism). (2) Neurologic exam: Lower limb sensation/motion (L5/S1 root injury). (3) Urinary status: Output/color (urethral injury). (4) Pain: NRS scale q4h.	15	<ul style="list-style-type: none"> <li>•Inadequate BP monitoring (-3)</li> <li>•Missed neuro exam (-3)</li> <li>•Incomplete I/O records (-3)</li> <li>•Delayed pain assessment (-3)</li> </ul>	
	3. Risk Assessment: (1) DVT risk: Caprini score $\geq 5$ = pharmacologic + mechanical	5	<ul style="list-style-type: none"> <li>•Non-standard tools (-2)</li> <li>•Unadjusted care plan (-3)</li> </ul>	

	<p>prophylaxis.</p> <p>(2) Pressure injury: Braden score <math>\leq 12</math> = intensified care.</p> <p>(3) Nutritional risk: NRS2002 <math>\geq 3</math> = nutritional support.</p>			
Key Procedures (40 points)	<p>1. Immobilization:</p> <p>(1) Pelvic binder: Upper edge at iliac crest, lower at greater trochanter; 2-finger tightness.</p> <p>(2) Positioning: Supine on hard bed, legs abducted 15-20°; no turning (unstable fractures).</p> <p>(3) Traction care: Verify alignment/weight (8-12kg), check pedal pulses.</p>	12	<ul style="list-style-type: none"> <li>•improper binder placement (-3)</li> <li>•Unauthorized repositioning (-5)</li> <li>•Traction failure (-4)</li> </ul>	
	<p>2. Complication:</p> <p>(1) Hemorrhage: Hourly abdominal distension monitoring, document paracentesis.</p> <p>(2) DVT prophylaxis: IPC <math>\geq 18</math>h/day, ankle pumps 10x/hour.</p> <p>(3) Pulmonary care: Log-roll q2h (post-stabilization), vibration therapy BID, breathing exercises.</p> <p>(4) Skin care: R-type pads, hydrocolloid dressings, smooth linens.</p>	15	<ul style="list-style-type: none"> <li>•Delayed abdominal monitoring (-4)</li> <li>•Insufficient IPC time (-3)</li> <li>•Missed turns (-4)</li> <li>•No pressure relief (-4)</li> </ul>	
	<p>3. Catheter Care:</p> <p>(1) Urinary catheter: Perineal cleaning BID, bag below bladder, monitor urine.</p> <p>(2) Drain care: Document output/character (<math>&gt;200</math>ml/h = report), maintain suction.</p> <p>(3) IV access: Two 18G+ lines (avoid lower limbs).</p>	8	<ul style="list-style-type: none"> <li>•Improper cleaning (-2)</li> <li>•Unreported drainage issues (-3)</li> <li>•Lower limb IV (-3)</li> </ul>	
	<p>4. Functional Rehabilitation:</p> <p>(1) Acute phase (days 1-3): Isometric exercises (quadriceps/glutes) 5-10x/set, 3 sets/day.</p> <p>(2) Stable phase (days 4-7): CPM machine (hip/knee <math>\leq 30^\circ</math>), breathing training.</p> <p>(3) Recovery phase: Leg raises (15cm <math>\times</math> 10s), walker-assisted standing.</p>	5	<ul style="list-style-type: none"> <li>•Incorrect techniques (-2)</li> <li>•Delayed guidance (-3)</li> </ul>	
Comprehensive Evaluation (15 points)	<p>1. Quality Assurance:</p> <p>(1) SBAR compliance: Situation-Background-Assessment-Recommendation handoff.</p> <p>(2) Documentation: Real-time records, medical terminology (such as: "pelvic compression test (+)").</p> <p>(3) Emergency readiness: Shock positioning, dual IV access, blood prep within 5min.</p>	10	<ul style="list-style-type: none"> <li>•Incomplete handoff (-3)</li> <li>•Delayed records (-2)</li> <li>•Slow response (-5)</li> </ul>	
	<p>2. Humanistic Care:</p> <p>(1) Therapeutic communication: "3-step explanation" (purpose-steps-cooperation).</p> <p>(2) Privacy: Screens during perineal care, minimal exposure.</p> <p>(3) Psychological support: SAS screening, CBT interventions.</p>	5	<ul style="list-style-type: none"> <li>•Inadequate education (-2)</li> <li>•Privacy breach (-2)</li> <li>•No psychosocial care (-1)</li> </ul>	

**Scoring Notes:**

- Deductions per item  $\leq$  its total points. Total score = 100.
- Grading:  $\geq 90$  = Excellent; 80-89 = Pass;  $< 80$  = Retraining required.

- Time-critical priorities: Hemorrhage control within “Golden 1-Hour,” DVT prophylaxis within “24-hour window,” dynamic reassessment.

# 骨盆骨折护理技术操作规范和标准

病区\_\_\_\_\_ 姓名\_\_\_\_\_ 得分\_\_\_\_\_ 带教签名\_\_\_\_\_ 日期\_\_\_\_\_

项目	操作内容	标准分值	扣分原因	扣分
操作准备 (10分)	4. 护士准备： (4) 仪表规范：着护士服、佩戴胸牌，头发整洁，无长指甲 (5) 手卫生：七步洗手法规范，佩戴无菌手套 (6) 掌握应急预案（休克、脂肪栓塞等并发症处理流程）	5	<ul style="list-style-type: none"> <li>• 仪表不规范扣 1 分</li> <li>• 未正确执行手卫生扣 2 分</li> <li>• 不熟悉应急流程扣 2 分</li> </ul>	
	5. 用物准备： (4) 急救设备：心电监护仪、吸氧装置、负压吸引装置、急救药品 (5) 护理用物：骨盆固定带/外固定架、翻身垫、皮肤减压贴、体温计、血压计、疼痛评估量表 (6) 特殊用物：导尿管、下肢静脉血栓预防装置（IPC）、牵引装置液	10	<ul style="list-style-type: none"> <li>• 遗漏关键急救设备扣 3 分</li> <li>• 未准备翻身辅助用品扣 2 分</li> <li>• 未核对牵引装置功能扣 2 分</li> </ul>	
	6. 环境准备： (4) 病房温度 22-24℃，湿度 50%-60% (5) 床单位铺防压疮气垫床，护栏功能完好 (6) 地面干燥防滑，急救通道无障碍物	5	<ul style="list-style-type: none"> <li>• 未调节温湿度扣 1 分</li> <li>• 未正确放置减压用具扣 2 分</li> <li>• 环境安全隐患未处理扣 2 分</li> </ul>	
评估要点 (25分)	4. 专科评估 (4) 损伤机制评估：高处坠落/挤压伤等病史采集 (5) 骨折分型评估：Tile 分型（A/B/C 型）或 Young-Burgess 分型记录 (6) 并发症预警：监测 Hb 动态变化（警惕腹膜后血肿）、观察会阴部瘀斑、肛门指诊检查	8	<ul style="list-style-type: none"> <li>• 未询问受伤机制扣 2 分</li> <li>• 骨折分型记录不全扣 3 分</li> <li>• 未执行肛门指诊或观察会阴体征扣 3 分</li> </ul>	
	5. 系统评估 (5) 生命体征：持续监测血压（警惕失血性休克）、呼吸频率（警惕脂肪栓塞） (6) 神经功能：检查下肢感觉运动（特别是 L5/S1 神经根损伤表现） (7) 排尿情况：记录尿量、颜色，观察有无血尿（警惕尿道损伤） (8) 疼痛评估：使用数字评分法（NRS）每 4 小时评估记录	15	<ul style="list-style-type: none"> <li>• 未动态监测血压变化扣 3 分</li> <li>• 遗漏神经功能检查扣 3 分</li> <li>• 未规范记录出入量扣 3 分</li> <li>• 疼痛评估间隔超时扣 3 分</li> </ul>	
	6. 风险评估 (4) 深静脉血栓风险评估（Caprini 评分 $\geq 5$ 分需药物+机械预防） (5) 压疮风险评估（Braden 评分 $\leq 12$ 分需强化干预） (6) 营养风险筛查（NRS2002 $\geq 3$ 分需营养支持）	5	<ul style="list-style-type: none"> <li>• 未使用标准化评估工具扣 2 分</li> <li>• 未根据评分调整护理计划扣 3 分</li> </ul>	
	5. 制动管理： (4) 骨盆固定带使用：上缘平髂嵴、下缘平股骨大转子，松紧度以能插入两指为宜		<ul style="list-style-type: none"> <li>• 固定带位置不当扣 3 分</li> <li>• 擅自改变体位扣 5 分</li> </ul>	

操作要点 (40分)	<p>(5) 骨盆固定带使用：上缘平髂嵴、下缘平股骨大转子，松紧度以能插入两指为宜</p> <p>(6) 体位摆放：绝对卧硬板床，双下肢外展 15-20° 中立位，禁止翻身（不稳定骨折急性期）</p> <p>(7) 牵引护理：保持牵引有效性，每日检查牵引力线/重量（一般 8-12kg），观察足背动脉搏动</p>	12	<ul style="list-style-type: none"> <li>未检查牵引装置有效性扣 4 分</li> </ul>	
	<p>6. 并发症的预防：</p> <p>(5) 出血监测：每小时观察腹部膨隆程度、记录腹腔穿刺结果</p> <p>(6) 血栓预防：间歇充气加压装置（IPC）每日使用≥18 小时，指导踝泵运动每小时 10 次</p> <p>(7) 肺部护理：轴线翻身 Q2h（稳定后），震动排痰 bid，指导深呼吸训练</p> <p>(8) 皮肤护理：使用 R 型翻身垫，骨突处贴水胶体敷料，保持床单平整</p>	15	<ul style="list-style-type: none"> <li>未按时观察腹部体征扣 4 分</li> <li>机械预防时间不足扣 3 分</li> <li>翻身间隔超时扣 4 分</li> <li>未使用减压敷料扣 4 分</li> </ul>	
	<p>7. 管路护理：</p> <p>(4) 导尿管护理：每日会阴消毒 bid，保持引流袋低于膀胱位置，监测尿液性状</p> <p>(5) 引流管护理：记录引流液量/性质（如出血&gt;200ml/h 需报告），保持负压有效性</p> <p>(6) 输液通路管理：建立两条静脉通道（18G 以上），避开下肢静脉</p>	8	<ul style="list-style-type: none"> <li>会阴消毒不规范扣 2 分</li> <li>未及时报告引流异常扣 3 分</li> <li>下肢静脉穿刺扣 3 分</li> </ul>	
	<p>8. 功能康复：</p> <p>(4) 急性期（1-3 天）：指导等长收缩训练（股四头肌、臀肌收缩）5-10 次/组，3 组/日</p> <p>(5) 稳定期（4-7 天）：CPM 机被动活动髌膝关节（屈曲≤30°），指导呼吸训练</p> <p>(6) 恢复期：直腿抬高训练（离床面 15cm 维持 10 秒），使用助行器床旁站立训练</p>	5	<ul style="list-style-type: none"> <li>训练方法错误扣 2 分</li> <li>未按时指导功能锻炼扣 3 分</li> </ul>	
综合评价 (15分)	<p>3. 操作质量：</p> <p>(4) 操作流程符合 SBAR 标准：病情-背景-评估-建议完整交接</p> <p>(5) 记录规范性：护理记录单实时记录，使用医学术语（如“骨盆挤压分离试验（+）”）</p> <p>(6) 应急预案执行：能在 5 分钟内完成休克体位摆放、建立两条静脉通路、备血等抢救准备</p>	10	<ul style="list-style-type: none"> <li>交接班内容缺失扣 3 分</li> <li>记录不及时扣 2 分</li> <li>应急响应超时扣 5 分</li> </ul>	
	<p>4. 人文关怀：</p> <p>(4) 使用治疗性沟通技巧：解释操作时采用“三步告知法”（目的-步骤-配合要点）</p> <p>(5) 隐私保护：进行会阴护理时使用屏风遮挡，检查时不暴露患者</p> <p>(6) 心理支持：运用焦虑自评量表（SAS）筛查，提供疾病认知行为干预</p>	5	<ul style="list-style-type: none"> <li>未履行告知义务扣 2 分</li> <li>暴露患者隐私扣 2 分</li> <li>未实施心理干预扣 1 分</li> </ul>	

**评分说明：**

✧ 每个子项扣分不超过该条目总分值，总分 100 分。

✧ 90 分以上为优秀，80-89 分为合格，低于 80 分需重新培训考核。

✧ 本标准特别强调“黄金 1 小时”内出血控制、“24 小时血栓预防时间窗”等时效性要求，需结合动态评估调整护理措施。

