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NCP 33.0
CARE PLAN FOR THE PATIENT WITH SPINAL CORD COMPRESSION

Problem/Issue

The patient has signs and symptoms of spinal cord compression

Goals

1. To identify potential problems at the earliest opportunity, maintain comfort and safety and manage associated problems as effectively as possible

Plan of Care

THIS CARE PLAN SHOULD BE USED IN CONJUNCTION WITH SPINAL CORD COMPRESSION GUIDELINES

1. Ensure that the patient remains on strict bed rest until spinal instability is ruled out. If spinal instability is suspected, nurse flat and log role when moving/turning.
2. Carry out a holistic nursing assessment but assess for specific signs and symptoms of spinal cord compression e.g. back pain, upper and lower motor deficits, sensory deficits and autonomic dysfunction.
3. Ensure the log roll pictorial sign is displayed above the patient's bed on the magnetic board.

Pain:-

4a. Observe for any pain and allow the patient to describe the nature of this pain (is it in one specific area, is it burning or shooting, does it feel like a pulling sensation, is it made worse by lying flat, coughing, sneezing or taking in a deep breath etc). Instigate **Pain Care Plan (NCP 2.0)**

4b. Give prescribed analgesia and observe effect. Seek advice from palliative care support team if Indicated, once initial assessments and management has been initiated by the medical team. Also refer to 'pain in spinal cord compression guidance'

4c. Continue strict bed rest, nurse flat, log roll and ensure careful positioning and handling to minimise further back pain, seek advice from physiotherapist

4d. If cervical lesion is responsible for the cord compression then refer to physiotherapist to fit cervical collar and give further advice to prevent movement of head.

Autonomic dysfunction: -

5a. Observe for signs of urinary hesitancy or retention or incontinence, encourage regular toileting and promote forced diuresis. If incontinent of urine, catheterise on doctors instructions and ensure catheter/skin care is carried out, adequate intake of oral fluids and monitor for infection. Instigate **Urinary Catheter Care Plan (NCP 18.0)** as applicable

5b. Observe the patient's bowel habit daily; assessing for constipation, loss of urge to defecate or incontinence. Give prescribed laxatives, administer suppositories/enema if necessary, providing dignity, support and skin care as appropriate. (refer to **bowel management guidelines**)

Motor deficits (weakness, heaviness, stiffness, loss of coordination or paralysis in limbs) **and Sensory deficits** (numbness, paraesthesia**):-**

6. Refer to physiotherapists as soon as possible who will conduct assessment of motor function and

sensory deficits; and provide advice/instruction in respect of nursing management

7. Observe pressure areas daily and avoid injury to skin. Nurse the patient on a profiling bed & pressure relieving mattress **but not airflow**. Instigate **Prevention & Management of Pressure Ulcers Care Plan (NCP 4.0)**
8. Assist with personal hygiene ensuring spine stays in line, give effective analgesia prior to activity if required. Maintain privacy, dignity and (as far as possible) independence. Instigate **Assistance with Personal & Oral Hygiene Care Plan (NCP 8.0)**
9. Observe for signs of chest infection (increased respirations, pyrexia, cough, sputum) and report.
10. Observe for any signs of DVT due to immobility and ensure medical team have completed the VTE assessment **(**refer to **thromboprophylaxis protocol)**
11. Assess the patient's psychological state, listen, support, explain and reassure as appropriate. If required refer for psychological assessment by trained personnel
12. Assist patient at all mealtimes to encourage good oral diet and fluid intake. Use the tilt action on the bed to enable safe eating and minimise risk of choking whilst maintaining spinal stability. Refer to the dietetics team and offer dietary supplements if necessary

Bed-End Documentation Required

- Nursing Care Plan & Evaluation
- Prevention & Management of Pressure Ulcers Care Plan (NCP 4.0)
- Assistance with Personal & Oral Hygiene Care Plan (NCP 8.0)
- MEWS chart
- Urinary Catheter Care Plan (NCP 18.0) as applicable
- Pain Care Plan (NCP 2.0) as applicable
- Stool chart + Altered Bowel Function Care Plan (NCP 16.0) as applicable

References/Evidence Base

1. Christie Guidelines for spinal cord compression (2009) incl. (available on Intranet)
   - thromboprophylaxis
   - bowel management
   - pain management
2. Royal College of Nursing (2004) Digital rectal examination & manual removal of faeces, Guidance for nurses RCN publication
3. Norton C et al, (2007) Management of faecal incontinence in adults: summary of NICE guidance, BMJ; 334:1370-1
4. NHS West of Scotland Cancer Network (2006) West of Scotland guidelines for malignant spinal cord compression
5. NICE (2008) Metastatic spinal cord compression: clinical guideline 75

Procedure Reference:		Version:	*V4*
Document Owner:	Dr V. Misra	Accountable Committee:	*Acute Oncology Group Network MSCC Group*
Date Approved:	*November 2013*	Review date:	*January 2020*
Target audience:	*All Clinicians*		

For more information and protocols on management of MSCC see: http://www.christie.nhs.uk/MSCC

CONSULTATION, APPROVAL & RATIFICATION PROCESS

All documents must be involved in a consultation process either locally within a department or division or throughout the trust at relevant board/committee meetings before being submitted for approval.

VERSION CONTROL SHEET

Version	Date	Author	Status	Comment
V1	Aug 2007		Creation	
V2	Dec 2010	Gillian Goodwin Vivek Misra	Update Review	Updated document Reviewed content
V3	Nov 2013 Jan 2016	Matthew Bilney Olivia Samuel	Review Review Review	Reviewed document Reviewed content No updates
V4	Jan 2018	Denise Saunt Aislinn Giles	Update	Updated document