NURSING CARE OF THE CLIENT IN HALO FIXATION

NURSING RESPONSIBILITIES

- Maintain integrity of the halo external fixation device.
  a. Inspect pins and traction bars for tightness; report loosened pins to physician.
  b. Tape the appropriate wrench to the head of the bed for emergency intervention.
  c. Never use the halo ring to lift or reposition the client.
  *Loosening of the apparatus poses the risk of further damage to the cord. It is the responsibility of the nurse to maintain the integrity of the apparatus and the safety of the client.*
- Assess muscle function and skin sensation every 2 hours in the acute phase and every 4 hours thereafter.
  a. Assess motor function on a scale of 0 to 5, with 0 being no evidence of muscle contraction and 5 being normal muscle strength with full range of motion.
  b. Assess sensation by comparing touch and pain, moving from impaired to normal areas, and testing both the right and left sides of the body.

Monitoring muscle function and skin sensation allows early identification of potential neurologic deficits.

- Monitor pin sites each shift and follow hospital policy for pin care. Here are some general guidelines.
  a. Assess pin sites for redness, edema, and drainage.
  b. Depending on policy, clean each pin site with a sterile applicator dipped in hydrogen peroxide, apply a topical antibiotic, and cover with sterile 2-inch split gauze squares.
  *Organisms can enter the body through the pin-insertion site; assessments and care are provided to detect signs of and prevent infection.*
- Maintain skin integrity.
  a. Turn the immobile client every 2 hours.
  b. Inspect the skin around edges of the vest every 4 hours.
  c. Change the sheepskin liner when it is soiled and at least once each week.
  *These interventions prevent skin injury and irritation.*