"What was the case"?

"Ligatured popliteal artery from gun-shot wound."

"He seems to be all right"?

"Yes, quite. He was found walking in the wood near the huts a few hours after the operation, being 'fed up' with bed."

N.B.—No one seemed to mind or to think it any slur on their nursing.

As far as possible, make it easy for the patient to lie in the desired position and help him or her to get over the first miserable days of helplessness.

This may be done in many ways. By a little pillow here or there to relieve pressure, without in any way altering position, by great care of the back and also in lifting and turning.

A look out should always be kept at meal-time to ensure that a junior nurse has *not*, with a cheerful "I didn't know he couldn't reach it," just left the feeder where it can be seen but not got at.

Chest bands of Liston splints should be looked at daily and readjusted firmly whenever necessary. This is an important point in keeping the Liston *immovable*. The lower bandages may be beautifully firm and neat, but if the chest one gets at all slack, you can always get a wobbly movement of the splint.

There seems to be as many ways of putting up fractures as there are different kinds of fractures.

Of all methods I have met with, putting up a fracture in plaster, to my mind, takes the palm. "You can't put it on when there is much swelling, or if it is a compound fracture, or if a dressing has to be done four hourly," I have been told again and again. And to all this I reply, "You can, you can, you can."

I admit a skilful surgeon must put on the plaster, but given that, it is easy enough. Like most recently certificated nurses, I was fully persuaded that all the ways of my beloved St. Botolph Hospital were right, and that anybody or anything that differed from it was wrong. After leaving I took a post at a provincial hospital, where the house surgeon was from St. James's.

He, too, thought *his* ways were the only ones, and one of his ways was plaster, for all sorts and conditions of fractures.

Of course, for some time I saw no good in it, "so uncomfortable," I thought, "for the patient; the foot goes black (or nearly), and one day something will happen! It makes the ward in a horrid mess."

And truly it did, till I learnt to cover my beautiful polished floors, and also my beds.

But as I began to see results I gave in completely and entirely. There was almost always good union, and rarely shortening. Also there was very little discomfort for the patient after the first few hours. Even this can be lessened by aiding the plaster to dry quickly. This is attained by baking all plaster before use (to get rid of any dampness) and by mixing in *cold* water. Plaster so treated should be firm in two hours if surrounded at once by hot bottles. You can tell by the sound of a sharp tap when it is "done." The extremity, whether hand or foot, needs careful watching, and should be warmly wrapped up. If on pressure on the toes or fingers the spot is left pallid, with the blood returning to it slowly or only after an interval, you know that a snip of the plaster or bandage is indicated. If the part gets swollen and blue and nothing will warm it, the surgeon must be summoned quickly, and if he cannot be got at, remove the plaster. This is seldom necessary when the plaster is put on by an experienced hand.

As the swelling of the limb decreases the bandages can be tightened up without moving the splint itself.

The flannel when cut for the plaster (good house-flannel is best) should have a gap between its two halves, so that it will surround the limb entirely when the swelling has ceased.

If used for compound fractures, say of the tibia and fibula, the plaster can be put on in two lateral halves, or as an anterior or posterior splint, according to the wound and its requirements of dressing.

The limb can always be left immovable on one half of the splint while the other is lifted off.

If drainage is required right through a limb it is always easy to cut a "window" in the plaster when wet. A fractured femur put up with a plaster from, and surrounding the abdomen to the ankle, with an extension and weight according to age, and a Liston on the bad side, must really be determined not to unite well, if it does not do so.

Further, with these appliances, I will defy Sampson himself to move his leg the smallest fraction of an inch.

In regard to the much vexed question of moving these cases, I always find it best to roll the patient gently, and as little as possible, on the bad side when replacing sheets, &c.

I am sure it disturbs the injured bone less than supporting it, however carefully, as you must do if you roll the patient on the good side.

Back and side wooden splints are still much used for fractures of the lower leg, and all nurses, therefore, should learn to pad them well.

The padding should be very even, but not too thick, as a very thickly-padded splint is likely to get lumpy.

Such splints have the disadvantage of having to be constantly adjusted, with a consequent shaking of the bone.

If they are used, pressure sores on the heels should be guarded against by careful padding of the heel either with wool, or, better, with tiny pillows made of tow.

A stock of these in varying sizes, toe-caps made of linen and quilted with wool, extension apparatuses of different lengths and breadths and pads of wool, all sizes, are small items which should all find a

previous page next page