

## AMPUTATION

In general, amputation of limbs is the result of trauma, peripheral vascular disease, tumors, and congenital disorders. For the purpose of this plan of care, amputation refers to the surgical/traumatic removal of a limb. Upper-extremity amputations are generally due to trauma from industrial accidents. Reattachment surgery may be possible for fingers, hands, and arms. Lower-extremity amputations are performed much more frequently than upper-extremity amputations. Five levels are currently used in lower-extremity amputation: foot and ankle, below knee (BKA), knee disarticulation and above (thigh), knee-hip disarticulation; and hemipelvectomy and translumbar amputation. There are two types of amputations: (1) open (provisional), which requires strict aseptic techniques and later revisions, and (2) closed, or “flap.”

### CARE SETTING

Inpatient acute surgical unit and subacute or rehabilitation unit.

### RELATED CONCERNS

Cancer  
Diabetes mellitus/diabetic ketoacidosis  
Psychosocial aspects of care  
Surgical intervention

## Patient Assessment Database

Data depend on underlying reason for surgical procedure, e.g., severe trauma, peripheral vascular/arterial occlusive disease, diabetic neuropathy, osteomyelitis, cancer.

### ACTIVITY/REST

**May report:** Actual/anticipated limitations imposed by condition/amputation

### CIRCULATION

**May exhibit:** Presence of edema; absent/diminished pulses in affected limb/digits

### EGO INTEGRITY

**May report:** Concern about negative effects/anticipated changes in lifestyle, financial situation, reaction of others  
Feelings of helplessness, powerlessness

**May exhibit:** Anxiety, apprehension, irritability, anger, fearfulness, withdrawal, grief, false cheerfulness

### NEUROSENSORY

**May report:** Loss of sensation in affected area

### SAFETY

**May exhibit:** Necrotic/gangrenous area  
Nonhealing wound, local infection

### SEXUALITY

**May report:** Concerns about intimate relationships

### SOCIAL INTERACTION

**May report:** Problems related to illness/condition  
Concern about role function, reaction of others

### TEACHING/LEARNING

**Discharge plan** DRG projected mean length of inpatient stay: 5.8–12.7 days

**considerations:** May require assistance with wound care/supplies, adaptation to prosthesis/ambulatory devices, transportation, homemaker/maintenance tasks, possibly self-care activities and vocational retraining  
Refer to section at end of plan for postdischarge considerations.

## DIAGNOSTIC STUDIES

Studies depend on underlying condition necessitating amputation and are used to determine the appropriate level for amputation.

**X-rays:** Identify skeletal abnormalities.

**CT scan:** Identifies soft-tissue and bone destruction, neoplastic lesions, osteomyelitis, hematoma formation.

**Angiography and blood flow studies:** Evaluate circulation/tissue perfusion problems and help predict potential for tissue healing after amputation.

**Doppler ultrasound, laser Doppler flowmetry:** Performed to assess and measure blood flow.

**Transcutaneous oxygen pressure:** Maps out areas of greater and lesser perfusion in the involved extremity.

**Thermography:** Measures temperature differences in an ischemic limb at two sites: at the skin and center of the bone.  
The lower the difference between the two readings, the greater the chance for healing.

**Plethysmography:** Segmental systolic BP measurements evaluate arterial blood flow.

**ESR:** Elevation indicates inflammatory response.

**Wound cultures:** Identify presence of infection and causative organism.

**WBC count/differential:** Elevation and “shift to left” suggest infectious process.

**Biopsy:** Confirms diagnosis of benign/malignant mass.

## NURSING PRIORITIES

1. Support psychological and physiological adjustment.
2. Alleviate pain.
3. Prevent complications.
4. Promote mobility/functional abilities.
5. Provide information about surgical procedure/prognosis and treatment needs.

## DISCHARGE GOALS

1. Dealing with current situation realistically.
2. Pain relieved/controlled.
3. Complications prevented/minimized.
4. Mobility/function regained or compensated for.
5. Surgical procedure, prognosis, and therapeutic regimen understood.
6. Plan in place to meet needs after discharge.

### **NURSING DIAGNOSIS: Self-Esteem, situational low**

#### **May be related to**

Loss of body part/change in functional abilities

#### **Possibly evidenced by**

Anticipated changes in lifestyle; fear of rejection/reaction by others

Negative feelings about body, focus on past strength, function, or appearance

Feelings of helplessness, powerlessness

Preoccupation with missing body part, not looking at or touching stump

Perceived change in usual patterns of responsibility/physical capacity to resume role

#### **DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:**

##### **Grief Resolution (NOC)**

Begin to show adaptation and verbalize acceptance of self in situation (amputee).

Recognize and incorporate changes into self-concept in accurate manner without negating self-esteem.

Develop realistic plans for adapting to new role/role modifications.

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Grief Work Facilitation (NIC)</b></p> <p><b>Independent</b></p> <p>Assess/consider patient's preparation for and view of amputation.</p> <p>Encourage expression of fears, negative feelings, and grief over loss of body part.</p> <p>Reinforce preoperative information including type/location of amputation, type of prosthetic fitting if appropriate (i.e., immediate, delayed), expected postoperative course, including pain control and rehabilitation.</p> <p>Assess degree of support available to patient.</p> <p>Discuss patient's perceptions of self related to change and how patient sees self in usual lifestyle/role functioning.</p> <p>Ascertain individual strengths and identify previous positive coping behaviors.</p>	<p>Research shows that amputation poses serious threats to patient's psychological and psychosocial adjustment. Patient who views amputation as life-saving or reconstructive may be able to accept the new self more quickly. Patient with sudden traumatic amputation or who considers amputation to be the result of failure in other treatments is at greater risk for self-concept disturbances.</p> <p>Venting emotions helps patient begin to deal with the fact and reality of life without a limb.</p> <p>Provides opportunity for patient to question and assimilate information and begin to deal with changes in body image and function, which can facilitate postoperative recovery.</p> <p>Sufficient support by SO and friends can facilitate rehabilitation process.</p> <p>Aids in defining concerns in relation to previous lifestyle and facilitates problem solving. For example, patient likely fears loss of independence, may lose ability to work, express sexuality, and may experience role/relationship changes.</p> <p>Helpful to build on strengths that are already available for patient to use in coping with current situation.</p>
<p><b>Self-Esteem Enhancement (NIC)</b></p> <p>Encourage participation in ADLs. Provide opportunities to view/care for stump, using the moment to point out positive signs of healing.</p> <p>Encourage/provide for visit by another amputee, especially one who is successfully rehabilitating.</p> <p>Provide open environment for patient to discuss concerns about sexuality.</p> <p>Note withdrawn behavior, negative self-talk, use of denial, or overconcern with actual/perceived changes.</p>	<p>Promotes independence and enhances feelings of self-worth. Although integration of stump into body image can take months or even years, looking at the stump and hearing positive comments (made in a normal, matter-of-fact manner) can help patient with this acceptance.</p> <p>A peer who has been through a similar experience serves as a role model and can provide validity to comments and hope for recovery and a normal future.</p> <p>Promotes sharing of beliefs/values about sensitive subject, and identifies misconceptions/myths that may interfere with adjustment to situation.</p> <p>Identifies stage of grief/need for interventions.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Self-Esteem Enhancement (NIC)</b></p> <p><b>Collaborative</b></p> <p>Discuss availability of various resources, e.g., psychiatric/sexual counseling, occupational therapist.</p>	<p>May need assistance for these concerns to facilitate optimal adaptation and rehabilitation.</p>

<p><b>NURSING DIAGNOSIS: Pain, acute</b></p> <p><b>May be related to</b></p> <p>Physical injury/tissue and nerve trauma Psychological impact of loss of body part</p> <p><b>Possibly evidenced by</b></p> <p>Reports of pain Narrowed self-focus Autonomic responses, guarding/protective behavior</p> <p><b>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</b></p> <p><b>Pain Level (NOC)</b></p> <p>Report pain is relieved/controlled. Appear relaxed and able to rest/sleep appropriately. Verbalize understanding of phantom pain and methods to provide relief.</p>
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ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Pain Management (NIC)</b></p> <p><b>Independent</b></p> <p>Document location and intensity of pain (0–10 scale). Investigate changes in pain characteristics, e.g., numbness, tingling.</p> <p>Elevate affected part by raising foot of bed slightly or use of pillow/sling for upper-limb amputation.</p> <p>Acknowledge reality of phantom-limb sensations, that they are usually self-limiting, and that various modalities will be tried for pain relief.</p>	<p>Aids in evaluating need for and effectiveness of interventions. Changes may indicate developing complications, e.g., necrosis/infection.</p> <p>Lessens edema formation by enhancing venous return; reduces muscle fatigue and skin/tissue pressure. <i>Note:</i> After initial 24 hr and in absence of edema, stump may be extended and kept flat.</p> <p>Knowing about these sensations allows patient to understand this is a normal phenomenon that may develop immediately or several weeks postoperatively. Although the sensations usually resolve on their own, some individuals continue to experience the discomfort for several months/years. <i>Note:</i> Phantom pain is not well relieved by traditional pain medications. A transcutaneous electrical nerve stimulator (TENS) has proved to offer short-term relief, when used in addition to managing stump tissue and prosthesis problems.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Pain Management (NIC)</b></p> <p><b>Independent</b></p> <p>Provide/promote general comfort measures (e.g., frequent turning, back rub) and diversional activities. Encourage use of stress management techniques (e.g., deep-breathing exercises, visualization, guided imagery) and Therapeutic Touch.</p> <p>Provide gentle massage to stump as tolerated once dressings are discontinued.</p> <p>Investigate reports of progressive/poorly localized pain unrelieved by analgesics.</p> <p><b>Collaborative</b></p> <p>Administer medications, as indicated, e.g., analgesics, muscle relaxants. Instruct in/monitor use of PCA.</p> <p>Maintain electrical stimulating device (e.g., TENS), if used.</p> <p>Provide topical heat as indicated.</p>	<p>Refocuses attention, promotes relaxation, may enhance coping abilities and may decrease occurrence of phantom-limb pain.</p> <p>Enhances circulation; reduces muscle tension.</p> <p>May indicate developing compartmental syndrome, especially following traumatic injury. (Refer to CP: Fractures; ND: Peripheral Neurovascular, risk for dysfunction.)</p> <p>Reduces pain/muscle spasms. PCA provides for timely drug administration, preventing fluctuations in pain with associated muscle tension/spasms.</p> <p>Provides continuous low-level nerve stimulation, blocking transmission of pain sensation. <i>Note:</i> There is some evidence that abnormal nerve stimuli and feedback mechanisms are present, possibly because of actual interrupted nerve pathways and partly because of abnormal activity of the remaining nerve fibers. Electrical stimulation offers a short-term rerouting or stimulation of different nerve pathways, thus reducing the activity of the usual pain patterns.</p> <p>May be used to promote muscle relaxation, enhance circulation, and facilitate resolution of edema.</p>

<p><b>NURSING DIAGNOSIS: Tissue Perfusion, risk for ineffective: peripheral</b></p> <p><b>Risk factors may include</b></p> <p>Reduced arterial/venous blood flow; tissue edema, hematoma formation</p> <p>Hypovolemia</p> <p><b>Possibly evidenced by</b></p> <p>[Not applicable; presence of signs and symptoms establishes an <i>actual</i> diagnosis.]</p> <p><b>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</b></p> <p><b>Tissue Perfusion: Peripheral (NOC)</b></p> <p>Maintain adequate tissue perfusion as evidenced by palpable peripheral pulses, warm/dry skin, and timely wound healing.</p>
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ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Circulatory Care: Arterial [or] Venous Insufficiency (NIC)</b></p> <p><b>Independent</b></p> <p>Monitor vital signs. Palpate peripheral pulses, noting strength and equality.</p> <p>Perform periodic neurovascular assessments, e.g., sensation, movement, pulse, skin color, and temperature.</p> <p>Inspect dressings/drainage device, noting amount and characteristics of drainage.</p> <p>Apply direct pressure to bleeding site if hemorrhage occurs. Contact physician immediately.</p> <p>Investigate reports of persistent/unusual pain in operative site.</p> <p>Evaluate nonoperated lower limb for inflammation, positive Homans' sign.</p> <p>Encourage/assist with early ambulation.</p>	<p>General indicators of circulatory status and adequacy of perfusion.</p> <p>Postoperative tissue edema, hematoma formation, or restrictive dressings may impair circulation to stump, resulting in tissue necrosis.</p> <p>Continued blood loss may indicate need for additional fluid replacement and evaluation for coagulation defect or surgical intervention to ligate bleeder.</p> <p>Direct pressure to bleeding site may be followed by application of a bulk dressing secured with an elastic wrap once bleeding is controlled.</p> <p>Hematoma can form in muscle pocket under the flap, compromising circulation and intensifying pain.</p> <p>Increased incidence of thrombus formation in patients with preexisting peripheral vascular disease/diabetic changes.</p> <p>Enhances circulation, helps prevent stasis and associated complications. Promotes sense of general well-being.</p>
<p><b>Collaborative</b></p> <p>Administer IV fluids/blood products as indicated.</p> <p>Apply antiembolic/sequential compression hose to nonoperated leg, as indicated.</p> <p>Administer low-dose anticoagulant as indicated.</p> <p>Monitor laboratory studies, e.g.: Hb/Hct;</p> <p>PT/activated partial thromboplastin time (aPTT).</p>	<p>Maintains circulating volume to maximize tissue perfusion.</p> <p>Enhances venous return, reducing venous pooling and risk of thrombophlebitis.</p> <p>May be useful in preventing thrombus formation without increasing risk of postoperative bleeding/hematoma formation.</p> <p>Indicators of hypovolemia/dehydration that can impair tissue perfusion.</p> <p>Evaluates need for/effectiveness of anticoagulant therapy and identifies developing complication, e.g., posttraumatic disseminated intravascular coagulation (DIC).</p>

**NURSING DIAGNOSIS: Infection, risk for**

**Risk factors may include**

Inadequate primary defenses (broken skin, traumatized tissue)  
Invasive procedures; environmental exposure  
Chronic disease, altered nutritional status

**Possibly evidenced by**

[Not applicable; presence of signs and symptoms establishes an *actual* diagnosis.]

**DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:**

**Wound Healing: Primary Intention (NOC)**

Achieve timely wound healing; be free of purulent drainage or erythema; and be afebrile.

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Wound Care (NIC)</b></p> <p><b>Independent</b></p> <p>Maintain aseptic technique when changing dressings/caring for wound.</p> <p>Inspect dressings and wound; note characteristics of drainage.</p> <p>Maintain patency and routinely empty drainage device.</p> <p>Cover dressing with plastic when using the bedpan or if incontinent.</p> <p>Expose stump to air; wash with mild soap and water after dressings are discontinued.</p> <p>Monitor vital signs.</p>	<p>Minimizes opportunity for introduction of bacteria.</p> <p>Early detection of developing infection provides opportunity for timely intervention and prevention of more serious complications (e.g., osteomyelitis).</p> <p>Hemovac, Jackson-Pratt drains facilitate removal of drainage, promoting wound healing and reducing risk of infection.</p> <p>Prevents contamination in lower-limb amputation.</p> <p>Maintains cleanliness, minimizes skin contaminants, and promotes healing of tender/fragile skin.</p> <p>Temperature elevation/tachycardia may reflect developing sepsis.</p>
<p><b>Collaborative</b></p> <p>Obtain wound/drainage cultures and sensitivities as appropriate.</p> <p>Administer antibiotics as indicated.</p>	<p>Identifies presence of infection/specific organisms and appropriate therapy.</p> <p>Wide-spectrum antibiotics may be used prophylactically, or antibiotic therapy may be geared toward specific organisms.</p>

**NURSING DIAGNOSIS: Mobility, impaired physical**

**May be related to**

Loss of a limb (particularly a lower extremity); pain/discomfort; perceptual impairment (altered sense of balance)

**Possibly evidenced by**

Reluctance to attempt movement  
Impaired coordination; decreased muscle strength, control, and mass

**DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:**

**Risk Control (NOC)**

Verbalize understanding of individual situation, treatment regimen, and safety measures.  
Maintain position of function as evidenced by absence of contractures.

**Mobility Level (NOC)**

Demonstrate techniques/behaviors that enable resumption of activities.  
Display willingness to participate in activities.

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Amputation Care (NIC)</b></p> <p><b>Independent</b></p> <p>Provide stump care on a routine basis, e.g., inspect area, cleanse and dry thoroughly, and rewrap stump with elastic bandage or air splint, or apply a stump shrinker (heavy stockinette sock), for “delayed” prosthesis.</p> <p>Measure circumference periodically.</p> <p>Rewrap stump immediately with an elastic bandage, elevate if “immediate/early” cast is accidentally dislodged. Prepare for reapplication of cast.</p> <p>Assist with specified ROM exercises for both the affected and unaffected limbs beginning early in postoperative stage.</p> <p>Encourage active/isometric exercises for upper torso and unaffected limbs.</p> <p>Provide trochanter rolls as indicated.</p> <p>Instruct patient to lie in prone position as tolerated at least twice a day with pillow under abdomen and lower-extremity stump.</p> <p>Caution against keeping pillow under lower-extremity stump or allowing BKA limb to hang dependently over side of bed or chair.</p>	<p>Provides opportunity to evaluate healing and note complications (unless covered by immediate prosthesis). Wrapping stump controls edema and helps form stump into conical shape to facilitate fitting of prosthesis. <i>Note:</i> Air splint may be preferred, because it permits visual inspection of the wound.</p> <p>Measurement is done to estimate shrinkage to ensure proper fit of sock and prosthesis.</p> <p>Edema will occur rapidly, and rehabilitation can be delayed.</p> <p>Prevents contracture deformities, which can develop rapidly and could delay prosthesis usage.</p> <p>Increases muscle strength to facilitate transfers/ambulation and promote mobility and more normal lifestyle.</p> <p>Prevents external rotation of lower-limb stump.</p> <p>Strengthens extensor muscles and prevents flexion contracture of the hip, which can begin to develop within 24 hr of sustained malpositioning.</p> <p>Use of pillows can cause permanent flexion contracture of hip; a dependent position of stump impairs venous return and may increase edema formation.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Amputation Care (NIC)</b></p> <p><b>Independent</b></p> <p>Demonstrate/assist with transfer techniques and use of mobility aids, e.g., trapeze, crutches, or walker.</p> <p>Assist with ambulation.</p> <p>Help patient continue preoperative muscle exercises as able/when allowed out of bed; e.g., patient should (while holding on to chair for balance) perform abdominal-tightening exercises and knee bends; hop on foot; stand on toes.</p> <p>Instruct patient in stump-conditioning exercises, e.g., pushing the stump against a pillow initially, then progressing to harder surface.</p> <p><b>Collaborative</b></p> <p>Refer to rehabilitation team, e.g., physical and occupational therapy, prosthetic specialists.</p> <p>Provide foam/flotation mattress.</p>	<p>Facilitates self-care and patient's independence. Proper transfer techniques prevent shearing abrasions/dermal injury related to "scotting."</p> <p>Reduces potential for injury. Ambulation after lower-limb amputation depends on timing of prosthesis placement. For example: (1) Immediate postoperative fitting: A rigid plaster-of-paris dressing is applied to the stump and a pylon and artificial foot are attached. Weight bearing begins within 24–48 hr. (2) Early postoperative fitting: Weight bearing does not occur until 10–30 days postoperatively. (3) Delayed fitting: More common in areas that do not have facilities available for immediate/early application of prosthesis or when the condition of the stump and/or patient precludes these choices. <i>Note:</i> Amputation of an upper extremity can affect patient's sense of balance, necessitating monitoring/assistance with ambulation.</p> <p>Contributes to gaining improved sense of balance and strengthens compensatory body parts.</p> <p>Hardens the stump by toughening the skin and altering feedback of resected nerves to facilitate use of prosthesis.</p> <p>Provides for creation of exercise/activity program to meet individual needs and strengths, and identifies mobility functional aids to promote independence. Early use of a temporary prosthesis promotes activity and enhances general well-being/positive outlook. <i>Note:</i> Vocational counseling/retraining also may be indicated.</p> <p>Reduces pressure on skin/tissues that can impair circulation, potentiating risk of tissue ischemia/breakdown.</p>

**NURSING DIAGNOSIS: Knowledge, deficient [Learning Need] regarding condition, prognosis, treatment, self-care, and discharge needs**

**May be related to**

Lack of exposure/recall  
Information misinterpretation

**Possibly evidenced by**

Questions/request for information, verbalization of the problem  
Inaccurate follow-through of instructions, development of preventable complications

**DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:**

**Knowledge: Disease Process (NOC)**

Verbalize understanding of condition/disease process and potential complications.

**Knowledge: Treatment Regimen (NOC)**

Verbalize understanding of therapeutic needs.  
Correctly perform necessary procedures and explain reasons for the actions.  
Initiate necessary lifestyle changes and participate in treatment regimen.

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Teaching: Disease Process (NIC)</b></p> <p><b>Independent</b></p> <p>Review disease process/surgical procedure and future expectations.</p> <p>Instruct in dressing/wound care, inspection of stump using mirror to visualize all areas, skin massage, and appropriate wrapping of the stump.</p> <p>Discuss general stump care, e.g.:</p> <ul style="list-style-type: none"> <li>Massaging the stump after dressings are discontinued and suture line is healed;</li> <li>Avoiding use of lotions/powders;</li> <li>Wearing only properly fitted, clean, wrinkle-free limb sock;</li> <li>Using clean cotton T-shirt under harness for upper-limb prosthesis.</li> </ul> <p>Demonstrate care of prosthetic device. Stress importance of routine maintenance/periodic refitting.</p> <p>Encourage continuation of postoperative exercise program.</p>	<p>Provides knowledge base from which patient can make informed choices.</p> <p>Promotes competent self-care; facilitates healing and fitting of prosthesis and reduces potential for complications.</p> <p>Massage softens scar and prevents adherence to the bone, decreases tenderness, and stimulates circulation.</p> <p>Although a small amount of lotion may be indicated if skin is dry, emollients/creams soften skin and may cause maceration when a prosthesis is worn. Powder may cake, potentiating skin irritation.</p> <p>Stump may continue to shrink for up to 2 yr, and an improperly fitting sock or one that is mended or dirty can cause skin irritation/breakdown.</p> <p>Absorbs perspiration; prevents skin irritation from harness.</p> <p>Ensures proper fit, reduces risk of complications, and prolongs life of prosthesis.</p> <p>Enhances circulation/healing and function of affected part, facilitating adaptation to prosthetic device.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Teaching: Disease Process (NIC)</b></p> <p><b>Independent</b></p> <p>Identify techniques to manage phantom pain, e.g., good stump care, properly fitted prosthesis, gentle massage/pressure to stump. Emphasize stress management and relaxation training, and discuss various medications that may be used for pain management.</p> <p>Stress importance of well-balanced diet and adequate fluid intake.</p> <p>Recommend cessation of smoking. Offer referral resources for smoking cessation.</p> <p>Identify signs/symptoms requiring medical evaluation, e.g., edema, erythema, increased/odorous drainage from incision; changes in sensation, movement, skin color; persistent phantom pain.</p> <p>Identify community and rehabilitation support, e.g., certified prosthetist-orthotist, amputee groups, home care service, homemaker services, as needed.</p>	<p>Reduces muscle tension and enhances control of situation and coping abilities.</p> <p>Provides needed nutrients for tissue regeneration/healing, aids in maintaining circulating volume and normal organ function, and aids in maintenance of proper weight (weight changes affect fit of prosthesis).</p> <p>Smoking potentiates peripheral vasoconstriction, impairing circulation and tissue oxygenation.</p> <p>Prompt intervention may prevent serious complication and/or loss of function. <i>Note:</i> Chronic phantom-limb pain may indicate neuroma, requiring surgical resection.</p> <p>Facilitates transfer to home, supports independence, and enhances coping.</p>

**POTENTIAL CONSIDERATIONS following acute hospitalization (dependent on patient's age, physical condition/presence of complications, personal resources, and life responsibilities)**

In addition to considerations in Surgical Intervention plan of care:

Trauma, risk for—balancing difficulties/altered gait, muscle weakness, reduced muscle coordination, lack of safety precautions, hazards associated with use of assistive devices.

Self-Esteem, situational low—loss of body part, change in functional abilities.

Self-Care deficit/Home Maintenance, impaired (dependent on location of amputation)—musculoskeletal impairment, decreased strength/endurance, pain, depression.