OUR LADY'S CHILDREN'S HOSPITAL, CRUMLIN
Nursing Care Plan 18b
Care of a child undergoing interventional radiology for vascular malformation

(All care plans must be used in conjunction with care plan 1. Care plan 7 can be used for complicated wound/drain care)

Care plan 18b **Problem**	**Pre and post-operative care** **Issue date: January 2012** **Goals** **Review date: January 2015**
…… is having interventional radiology for a vascular malformation in his/her _____	**1.** Pre-operative care: the child/infant and family will be safely prepared for theatre physically and psychologically. **2.** Post-Operative care: the child/infant will have a safe and comfortable recovery post-operatively.

Commenced date, time, signature, grade	No	**Nursing Intervention**	Discontinued date, time, signature, grade
	1	**Pre-operative care**	
		▪ Child will be admitted under the care of Mr. Orr on the day before the procedure. ▪ Explain procedure to patient and family. Involve play specialist in the process. ▪ Discuss with child his/her preferred method of induction if appropriate. Discuss any other requests that the parent or child may have in relation to surgery. ▪ Ensure child has a bath/shower prior to surgery. ▪ Fast from Milk solids from:_____ Clear fluids from:_____ ▪ Place fasting sign over bed and explain to parents and child the meaning of same. ▪ Remove food from child's reach. **Specific pre-operative needs** a) Assist with taking the following blood tests: **FBC, U&E, Coagulation Screen including a DIC panel** c) Child will have an intravenous cannula inserted (See below for related care). ***Other care:*** …… …… ▪ Inform Anaesthetic team to ensure child is reviewed prior to procedure. ▪ Complete pre-operative checklist, date and sign, ensure consent is signed. ▪ Administer pre-medication and or other medications if prescribed: ▪ Accompany child/infant and parent safely to the X-Ray Department ▪ Child/infant may bring comforter to X-Ray Department with him/her.	
	2	**Peripheral Intravenous Access**	
		▪ Check cannula is secure. ▪ Check cannula site for signs of infiltration, dislodgment or infection: - hourly if child is on intravenous fluids /medication - at each administration of medication ▪ Record intake and output. Record and report any deviation from the norm. ▪ Administer intravenous fluids as prescribed ***Note: intravenous fluids required for first 24 hours or until child is drinking well*** ▪ Administer intravenous medications as per OLCHC Formulary 2010 ▪ Change intravenous giving sets every 48 hours or as directed by Intravenous Policy ▪ Document when cannula sited/resited/removed	

Patient Name……

HCRN……

Ward……..

	3.	Post-Operative care	
		▪ **Check that Airway, Breathing, Circulation and Condition are stable** prior to safe transfer from Recovery Unit to the ward. ▪ Assess and respond promptly to altered **respiratory effort**, **shock** and **haemorrhage** ▪ Monitor colour, pulse, respirations, blood pressure, oxygen saturations, and temperature as directed by the surgeon/anaesthetist/ nursing staff ▪ Report and record any deviations from normal. ▪ When stable monitor observations as condition indicates **Wound care -** Following this procedure some swelling is expected. 1. If the swelling increases and is compromising function of the area, e.g. causing respiratory distress or impeding perfusion to limbs, please contact Plastics Team. 2. Nurse wound (injection) site exposed. If the wound is oozing, a light dressing can be applied. 3. Monitor wound site for redness, pain, ooze, haemorrhage **Nausea and vomiting** 1. Observe for nausea/vomiting. Assess possible cause. Support child, provide emesis bowl. 2. Administer anti-emetics and evaluate same 3. Record colour, consistency and volume of vomitus in intake/output chart 4. Child can eat and drink as soon as he/she tolerates. **Pain – Note: this procedure can be VERY painful** 1. Assess pain score on return from Theatre as per OLCHC guidelines (2010). 2. Utilize non pharmacological means of pain relief. 3. Administer analgesia as required and monitor effects of same, report and record. 4. Morphine as per Opioid guidelines OLHSC (2011) *(Prior to leaving Recovery Department ensure Morphine infusion has been prepared correctly and secured in a locked pump)* **Urinary output.** Monitor/record first void post operatively. **Day 1 Post-Operatively** A) Assist with taking the following blood tests: **FBC, U&E, Coagulation Screen including a DIC panel** B) Perform urinalysis to test for micro-haematuria. Report any abnormalities **Discharge:** Usually child is discharged 1-2 days post-operatively. To return to Outpatients Clinic in 4weeks.	

Patient Name……

HCRN……

Ward……..