Our Lady's Children's Hospital Crumlin
Nursing Care Plan 3B
Post Operative Cardio-thoracic Surgery
(Please use in conjunction with Careplan 1)

Care plan 3B Problem		**Cardiothoracic post-operative care** **Goals**	**Issue date: October 2016** **Review date: October 2019**
……. Returned from theatre following _____ _____		1. Airway, breathing ,circulation 2. Wound care 3. Altered nutrition/Hydration 4. Pain	
Commenced, date, time and signature	**No**	**Nursing Intervention**	Discontinued, date, time and signature
		Post operative care	
		Check that Airway, Breathing, Circulation and Condition are stable upon transfer to the ward. Assess and respond promptly to altered respiratory effort, shock and haemorrhage.	
	1	**Airway, Breathing and Circulation**	
		Monitor baseline observations of temperature, pulse, respirations, blood pressure and oxygen saturations as directed, reducing frequency as condition dictates…….. …….. • Assess respiratory rate, rhythm and depth as condition indicates *(2-4 Hrly on* • *T/F from ICU).* • Administer humidified Oxygen as prescribed…… ……..…… • …….. to maintain O2 sats at prescribed level ……nurse on oxygen saturation monitor if required • Wean oxygen as indicated ..…… • Nurse on telemetry • Monitor arrythmias, report and record. • Liaise with physiotherapist regarding treatment …… • Administer nebulisers as prescribed ……..... • Suction as required. • Observe colour, amount tenacity of sputum. • Sputum for C&S if indicated, date sent…….. • Weigh daily / alternate days • Administer diuretics as prescribed and observe and record effect. • Monitor fluid balance (weigh nappies)	
	2.	**Wound care**	
		• Monitor wound site for redness, pain, ooze, swelling, hemorrhage. • Wound swab as per NPC guidelines (2013), date taken__ • Dressing removed on day 5 unless indicated prior to this: • Dressing 1: _____ • Dressing 2: _____ • Dressing 3: _____ • Remove sutures as per cardiothoracic team on (date)---------- • **Chest drain in …….** • Provide care as per Chest Drain guidelines (NPC 2015) • **Low pressure suction:** ▪ 1. Maintain on low pressure suction if	

Patient Name…….

HCRN……

Ward…….

		2. Level of water in chamber to be prescribed in medical notes ……..…Maintain level prescribed at all times 3. Observe drainage, colour & consistency, sample for C+S as ordered, date…….. • Chest drain removed **Date**: …… • **Pacing wires in situ** …….. 1. Pacemaker checks 4 hourly and when settings altered. 2. Battery change every 3 days by Cardiothoracic team or at 7.5 volts, spare battery in room at all times. 3. Tape and secure pacing wires to chest wall when not in use 4. Nurse on telemetry for 24hrs post wire removal 5. Observe vital signs post wire removal. 6. Cover wire sites with dressing if required.	
	3	**Altered nutrition/hydration**	
		• Monitor nutrition and hydration status, with strict intake and output. Report and record deviation • Adhere to fluid and feeding restrictions, involve parents. • Nasogastric feeds as per NPC guidelines (2013)…… …… …… • Commenced special feeds as per dietitians regime. • Document when NGT is changed (weekly) …… • Commence parental education regarding feeding and diet. • Regular oral care as required, report and record deviations. • Commence oral feeds as indicated and tolerated …… …… …… ……	
		Nausea and vomiting • Observe for nausea/vomiting. Assess possible cause. • Administer anti-emetics and evaluate same _____ Record colour, consistency and volume of vomitus in intake/output chart. • Consider need for IV fluids (If commenced see care plan 9)	
	4	**Pain**	
		• Assess pain score as per NPC guidelines 2015. • Utilize non pharmacological means of pain relief. • Administer analgesia as required and monitor effects of same, report and record._____ _____ _____ Opioid guidelines NPC (2015)	

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