Full Name: .....
Address: Addressograph
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HCR.....

NURSING CARE PLAN 6
PRE & POST – OPERATIVE CARE

All care plans must be used in conjunction with Careplan 1. Careplan 7 can be used for complicated wound

Care Plan 6 Problem	PRE AND POST-OPERATIVE CARE	**Issue Date:** April 2018 **Review Date:** April 2021
..... Is going to theatre on..... For.....	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	

1	NURSING INTERVENTION	Commencement, Date, Signature Grade	Discontinued Date, time, Signature, grade
	PRE-OPERATIVE CARE		
	• 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. • **Consider checking blood sugar** if < 1 year or refusing fluids or theatre delayed • Remove food from child's reach. • **Specific pre-operative needs** e.g I.V. fluids, bowel preparation, stoma siting, swabs, transfusions etc. • 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 theatre • Child / infant may bring comforter to theatre with him/her		
2	**POST-OPERATIVE CARE**		
	• **Check that Airway, Breathing, Circulation and Condition are stable** prior to safe transfer from theatre 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.		
3	**WOUND CARE**		
	• Monitor wound site for redness, pain, ooze, haemorrhage. • Dressing: ..... • Change dressing: ..... (for complicated wounds / drains / tubes use care plan number 7)		
4	**NAUSEA AND VOMITING**		
	• Observe for nausea / vomiting. • Assess possible cause. • Support child and provide emesis bowl. • Administer anti-emetics and evaluate same …….. • Record colour, consistency and volume of vomitus in intake/output chart		

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5	**PAIN**		
• Assess pain score on return from Theatre. • Utilize non pharmacological means of pain relief. • Administer analgesia as required and monitor effects of same, report and record. • Morphine as per Opioid Guidelines *(Prior to leaving Recovery Department ensure Morphine infusion has been prepared correctly and secured in a locked pump)*			
6	**URINARY OUTPUT**		
• Monitor / record first void post operatively. • Urinary catheter care as per NPC Guidelines (see care plan number 7) • Discharge criteria is met as per Anaesthetic Guidelines OLCHC			
7	**OTHER**		