Our Lady's Childrens Hospital Crumlin
NURSING CARE PLAN 6
PRE AND POST- OPERATIVE CARE

(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 6 **Problem**		**Pre and post-operative care** **Goals**	**Issue date: January 2012** **Review date: January 2015**
…….. 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.	
Commenced,date, time, signature & grade	No.	**Nursing Intervention**	Discontinued, date, time, signature 7 grade
	1	**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. • 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.	

Patient Name……..

HCRN ……..

Ward……..

		Administer anti-emetics and evaluate same _____ Record colour, consistency and volume of vomitus in intake/output chart	
	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 NPC (2011) *(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 2009(see care plan number 7)	
		Discharge criteria is met as per Anaesthetic guidelines OLHSC	

Patient Name……..

HCRN ……..

Ward……..