Our Lady's Children's Hospital Crumlin

NURSING CARE PLAN 6a

PRE AND POST- OPERATIVE CARE

(This Careplan for use in St. Johns Haem / Oncology Day Unit)

Care plan 6a **Problem**		**Pre and post-operative care** **Goals**	**Issue date: August 2018** **Review date: August 2021**
…… **i**s 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** *Careplan 6a can be used for six consecutive admissions, date, time sign and grade each admission, discharge only after 6 admissions*	Discontinued, date, time, signature , grade
ADMISSION 1	**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. Fasting from Milk solids since:_____ Clear fluids since:_____ • Place fasting sign over bed and explain to parents and child the meaning of same. • **Consider checking blood sugar** if fasting or refusing fluids • 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. • Assess pain score on return from Theatre as per OLCHC guidelines (2015). • Utilize non pharmacological means of pain relief. • Administer analgesia as required and monitor effects of same, report and record. _____ • Morphine as per Opioid guidelines OLCHC (2015) *(Prior to leaving Recovery Department ensure Morphine infusion has been prepared correctly and secured in a locked pump.*	

Reviewed August 2018

Name……

Patient

HCR No. ……

Ward:……

	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 vomit in intake/output chart **Urinary output.** • Monitor/record first void post operatively. Urinary catheter care as per OLCHC Guidelines (2014) *(see care plan number 7)*	
	5	**Discharge criteria is met as per Anaesthetic guidelines OLCHC**	
		Detail all discharge dates times and signature with grade in the spaces provided	
	6	**Other needs**	

Patient

HCR No. ……

Ward:……

Reviewed August 2018

Name……

Patient

HCR No. ……

Ward:……