Our Lady's Children's Hospital Crumlin
NURSING CARE PLAN 6b
PRE AND POST- OPERATIVE CARE with IV access care
For use in the MDU/SDU

Care plan 6b **Problem**	**Pre and post-anaesthetic care & IV Access** **Goals**	**Issue date: December 2015** **Review date: December 2018**
…………………….. is undergoing anaesthesia for _______________ _______________	**1.** Pre-anaesthesia, the child/infant and family will be safely prepared for anaesthesia physically and psychologically. **2.** Post-Anaesthesia care. The child/infant will have a safe and comfortable recovery post-anaesthesia Intravenous access.	

Commenced, date, time, signature & grade	No.	**Nursing Intervention**	Discontinued, date, time, signature & grade
	1	**Pre-Anaesthesia 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 / procedure • Ensure child is fasting as per OLCHC fasting guidelines • 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/radiology department • Child/infant may bring comforter to theatre with him/her	
	2	**Post- Anaesthesia Care**	
		• **Check that Airway, Breathing, Circulation and Condition are stable** prior to safe transfer from recovery 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___ • Document vital signs in PEWS chart, report and escalate as per recommendations on PEWS chart. • 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	

Patient Name………………………………….

HCRN …………………………………………

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	5	**Pain**	
		• Assess pain score on return from Theatre /Radiology • Utilise 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 is secured in a locked pump)*	
	6	**Urinary output.**	Discontinued, date, time, signature & grade
		• Monitor/record first void post operatively if indicated. • Urinary catheter care as per OLCHC guidelines (2013)(see care plan number 7)	
	7	**Peripheral IV access**	
		▪ Check cannula site for signs of infiltration, dislodgment or infection: 1. Hourly if child is on intravenous fluids /medication 2. After each administration of medication 3. Check cannula is secure. • Maintain patency of the cannula by flushing with Sodium Chloride 0.9%, 1. When the cannula is not in use 2. Prior to administration of treatment 3. Between administration of different fluids or medications and 4. Post administration of treatment using the 'positive-pressure technique'. 5. Record intake and output. 6. Record and report any deviation from the norm. ▪ Administer ***intravenous fluids*** as prescribed ,check prescription sheet at each shift to verify rate and type of infusion ▪ Administer ***intravenous medications*** as prescribed and as per Medication Policy ▪ Change intravenous giving sets every 48 hours or as directed by IV Guidelines ▪ Document and sign when cannula sited / resited / removed ▪ Consider blood sugar in infants/children fasting/ ▪ vomiting	
	8	**Discharge criteria met as per Anaesthetic guidelines OLCHC**	

Updated November 2015

Patient Name………………………………….

HCRN ………………………………………

Ward…………………………………………..