Adult Post-Operative Care

Contents

Purpose

To maintain the comfort of the patient

To ensure the early detection and treatment of post-operative complications.

Scope

Nursing Staff

Midwifery Staff

Student Nurse/Midwife under the direct supervision of an Registered Nurse (RN)/Registered Midwife (RM)

Agency/Casual RN after discussion with their ward RN buddy

Associated documents

Peri-Operative Care Plan C170003

Anaesthesia & PACU Record C17002B

Nausea and Vomiting Procedure

Operation Report QMR0014

Adult Observation Chart C280010

CDHB Early Warning Protocol Policy (Volume 11)

Neurovascular Observation Form C280041

Fluid Balance 24 hour A4 Chart C280020B

Fluid Balance Summary QMR0006

Fluid Prescription Chart: QMR004B

Regional Infusion Treatment Form C160039

Regional Bolus Treatment Sheet C260038

Adult PCA Treatment Sheet C160012

After spinal Morphine Naloxone Rescue Treatment Standing Order C160006

Drug Treatment Sheet QMR0004 / 8 Day National Medication Chart NMC8D

Clinical Notes QMR0003

CDHB Fluid and Medication Management Manual (Volume 12)

Please Note: Ensure the patient meets the PACU discharge criteria If the patient doesn't meet this criteria they must remain in PACU until the meet the criteria or have a review by medical staff

Patient Handover

Refer to CDHB policy requirements below and the Lippincott procedure link in the Additional Post Op Nursing Care section

- Obtain a patient handover from Post Anaesthetic Care Unit (PACU) staff and read the patients intra operative and recovery documentation to obtain
- Stability and trends of the patient's observations including Early Warning Score (EWS), Pain score and Sedation score
- Type and number of drains and catheters including amount and characteristics of any drainage and that multiple drains are labelled.
- Condition of the wound/s.
- Any specific post-op instructions.
- Any pain management system in progress, e.g. PCA, Epidural, or Regional.

PCA/Epidural

Refer to CDHB Fluid and Medication Manual for PCA/Epidural specific management

Assessment/Monitoring for CDHB

Minimum Observation Frequency Guidelines

- On return to the ward/department from PACU
- Hourly for the first four hours, then,
- Two hourly for the next four hours, then
- Four hourly, until directed otherwise by Medical staff.
  OR more frequently as per EWS protocol/pathway

- The frequency of the following observations may alter as otherwise directed by Medical staff, local policy or if the patient's condition should indicate the need for increased frequency of the observations.
- Patients undergoing minor procedures or procedures under local anaesthetic may be an exception, refer to medical staff/speciality specific instructions.

Observations to include

- Observations to inform a EWS
- Patient's respiratory status including rate and depth of respirations and chest movement.
- Ensure adequate urinary output, ie. 0.5mL/kg/hour if urinary catheter insitu. If no catheter insitu ensure patient has passed urine within 6 – 8 hours post op.
- Assess Pain – Pain Scale should be used in conjunction with the patient to assess their pain level.
- Patients who have a PCA or Epidural insitu, refer to PCA or Epidural Standards and Procedures, CDHB Volume 12, Fluid and Medication Manual, for observations required.
- General patient colour, warmth and perfusion.
- If the patient has had vascular/orthopaedic/neurovascular surgery, assess appropriate extremity/s for:
  - vascularity
  - warmth
  - sensation

  - movement
- Presence and quality of pulses.

Please Note: Refer to speciality specific instructions.

- To detect bleeding observe dressings, drains and wound sites including quantity and nature of drainage, i.e. Colour, type, consistency, and odour.
- To detect signs of infections or bleeding observe wound for redness or tenderness.
- If a new stoma is present, check stoma hourly for colour. The colour of the stoma should be pink, if stoma is dark or dusky, inform medical staff immediately

Additional Post–Operative Nursing Care

Refer to CDHB policy requirements below and the Lippincott procedure link

- Check the patients skin integrity for pressure injuries post anaesthesia, follow the patients plan to manage pressure injury risks or pressure injury management.
- Advise the patient against crossing of legs or ankles to prevent constriction of blood supply and swelling.
- Report any complaints of calf, thigh or chest pain to Medical staff immediately. Early detection of DVT or PE.
- Encourage early mobilisation, unless otherwise advised by Medical staff to prevent complications, eg. DVT.
- Ensure the patient is comfortable and safe, eg. by positioning, ensuring the bell and vomit bowl are within easy reach and bed sides are insitu if patient still drowsy and recorded as an enabler.
- Maintain fluid balance/weight recordings as required
- Provide/assist patient with mouth care if patient is NBM or has a nasogastric tube insitu.

Lippincott Procedures - Postoperative care

Measurement and Evaluation

- Incident management review
- Care plan and clinical note reviews

References

Fernandez, R., & Griffiths, R. (2005). A comparison of an evidence based regime with the standard protocol for monitoring postoperative observation: a randomised control trial. Journal of Advanced Nursing, 23(1), 15-21.

Liddle, C. (2013). How to reduce the risk of deterioration after surgery. Nursing Times, 109(23). 16-17.

World Health Organisation. (2003). WHO Surgical Care at the District Hospital. Retrieved from https://WHO.org

Policy Owner	CNS and CNE group Burwood and Christchurch Hospital Campus
Policy Authoriser	Executive Nursing Director
Date of Authorisation	27th July 2016