PROTOCOL

TITLE: **POST OPERATIVE CARE MANAGEMENT**

PURPOSE: To outline the management of the post operative patient after the patient is discharged from the post anesthesia care unit (PACU).

LEVEL: ___ Dependent ___ Independent X Interdependent

SUPPORTIVE DATA:
1. Care of the patient outlined is specifically regarding the general care within the first 48 hours after surgery.
2. The care outline is recommended and does not supercede physician orders.

CONTENT: A) Receiving patient from the PACU B) Assessment C) Monitoring D) Infection Control E) Patient Education F) Documentation G) Reportables

A. Receiving patient from the PACU

1. Receive hand off from the PACU nurse. This verbal hand off includes the following:
   a. Type of procedure
   b. Estimated Blood Loss (EBL)
   c. Type of anesthesia and patient response
   d. Vital signs before, during and after procedure including Cardiac Rhythm
   e. All medications given post procedure and time given
   f. Wounds and dressing integrity. Drainage if present
   g. Drains if present, note color and amount.
   h. Current IV access status and IV therapy
   i. Neurological status/LOC
   j. Overall respiratory/cardiovascular status
   k. Intake and output measurements

2. Upon Arrival to the unit:
   a. Maintain patient safety (room uncluttered, items within reach)
   b. Orient patient to room and unit routine
   c. Discuss plan of care
   d. Review post operative orders with PACU nurse

B. Assessment

1. Assess respiratory status, at the same frequency of vital signs
   a. Maintain airway and oxygenation
   b. Apply and maintain supplemental oxygen if applicable
   c. Auscultate lung sounds

2. Assess circulatory status, at the same frequency of vital signs
   a. Assess edema
   b. Assess pulses
   c. Overall fluid status

3. Assess neurological status and consider effects of anesthesia and pain medication, at the same frequency of vital signs
   a. Assess level of consciousness
   b. Assess orientation

4. Assess surgical site and dressing, at the same frequency of vital signs.
    a. If surgical dressing is present, assess integrity of dressing, presence of drainage. Reinforce if necessary.
    b. If no surgical dressing present, assess surgical wound for color, drainage and temperature.

5. Assess IV therapy, every 4 hours
    a. Assess IV site per hospital protocol
    b. Follow physician orders for IV solutions, rate and additives
    c. Evaluate fluid status

6. Assess Drainage tubes, at the same frequency of vital signs.
    a. Assure all drainage tubes are connected to suction or proper drainage device.
    b. If nasogastric tube present, validate placement and irrigate as ordered.
    c. Assess drainage from all devices for color, amount and odor.

7. Assess GI/GU function, every 4hours
    a. Assess bladder distention if patient doesn't have an indwelling catheter
    b. Record all sources of fluid intake and output.
    c. Assess for nausea and administer medications if applicable
    d. Assess bowel sounds
    e. Assist patient to bathroom, commode or use of bedpan/urinal

8. Assess pain management, screen patient's pain level at same frequency of vital signs.
    a. Assess pain level using hospital approved pain scales.
    b. Follow hospital policy for documentation of completed pain assessments and reassessments.
    c. Discuss pain management protocol and intervention with the patient

9. Safety assessment, assess every 4 hours for the first 24 hours then per hospital protocol.
    a. Complete Braden scale assessment and institute prevention as needed per hospital protocol
    b. Complete Fall risk assessment and institute prevention as needed per hospital protocol.

C. Monitoring

1. Obtain Vital signs (temperature, BP, pulse, respirations and pulse oximetry) immediately upon arrival to the unit, then every 30 minutes x2, then every 1h x4, then every 4hours for 24 hours.
2. Vitals signs per unit routine after 24 hours post op.
3. Monitor dressing for bleeding or discharge. Reinforce as necessary. First surgical dressing to be removed/changed by surgeon. Unless ordered by physician.
4. Monitor oral care and assist patient if necessary. If patient is NPO, offer frequent oral care.
5. Monitor diet progression.
6. Monitor activity progression.
7. Monitor for signs of respiratory depression
8. Monitor patient compliance with incentive spirometry, cough/deep breathing exercises
9. DVT prevention
    a. May include the use of mechanical devices and medications.
    b. Evaluate the patient's activity level. If patient has limited mobility assure DVT prevention has been addressed by the physician.
    c. Encourage the patient to frequently move their legs and maintain any mechanical device in place.

D. Infection Control

1. Observe for signs and symptoms of surgical site infection
2. Observe for changes in drainage from surgical site and drains
3. Encourage patient to ambulate, use incentive spirometry and reinforce HRMC hand hygiene policy.
4. Maintain isolation hospital protocols/policies if applicable.

E. Patient Education

1. Instruct patient on use and rationale of Incentive spirometry.
2. Instruct and encourage patient to cough and deep breathe.
3. Educate patient on prevention of post operative complications related to;
    a. DVT prevention
    b. Surgical site
    c. Respiratory complications
4. At discharge, if applicable, care of any drains/tubes/wounds
5. Pain Management

F. Documentation

1. Record all vital sign data
2. Document all assessment findings including drains/tubes and dressing conditions.
3. Document all patient education discussion
4. Document reportables to the physician
5. Document any equipment/devices in use for DVT prevention, safety maintenance and incentive spirometry

G. Reportables

1. New onset of signs and symptoms related to infection
2. If dressing needs reinforcement more than once in a shift
3. New onset of bleeding from surgical site
4. Inability to manage patient's pain with current pain management orders
5. Changes from initial assessment data, other than improvements.

REFERENCES:

Perry, Anne Griffin, RN, EdD, FAAN, Potter, Patricia A. RN, MSN, PhD, FAAN, Clinical Nursing Skills & Techniques, Performing Postoperative Care of a Surgical Patient, 7th ed, St. Louis, Mosby Elsevier, 2010, pages 955-965.

Lippincott Manual of Nursing Practice, 8th ed, Lippincott, Williams and Wilkins, Philadelphia, 2006, Postoperative Care, pages 114-134.