Standard Operating Procedure on the Immediate Post Operative Nursing Care of the Child/Infant	
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1.0 Introduction

This document outlines the general post-operative nursing care of the child with rationales. This SOP can be used in conjunction with other specific nursing care documents.

2.0 Definition of Standard Operating Procedure

The term **'Standard Operating Procedure'** is a way of carrying out a particular course of action and includes operations, investigations, pharmaceutical treatment, examinations and any other treatment carried out

3.0 Applicable to

This document is applicable to the registered nurse caring for the child post operatively.

4.0 Objectives of Standard Operating Procedure

This SOP will guide the nurse when caring for the child postoperatively but must be used in conjunction with specific post-operative instructions advised by the surgeon and the specialty.

5.0 Definitions / Terms

O2 Sa – Oxygen Saturation
LPS – Low Pressure Suction
LOC - Loss of Consciousness
NGT – Nasal Gastric Tube

6.0 Procedures

It is important for registered nurses caring for children postoperatively is familiar with the steps of this SOP.

7.0 Implementation Plan

It is important that this document is highlighted to the registered nurse on induction to a surgical ward. It is also a useful resource to the student nurse gaining clinical experience in the surgical setting.

Procedure	Rationale
Preparing the bed space prior to the child arrival post-surgical event	
▪ Prepare bed space ▪ Check the oxygen and suction is in working order with access to ambubag ▪ Electric post op bed where possible (air mattress ordered if required)	It is important to prepare a safe bed space for the child post-operatively as this is a high-risk time post-surgery and anaesthetic (Hockenberry & Wilson 2015)
▪ Make post op bed with clean linen	Fresh clean linen for comfort and reduce risk of infection.
▪ Bed in middle of room for clear safe access	This ensures safe transfer from theatre trolley to ward bed.
▪ SPO2 monitor in room alongside BP monitor ▪ IV stand & pump(s) in room	The availability of equipment must be in working order and be appropriate for the child being cared for (Ball et al., 2015).
▪ Chest drain clamps x 2 available with the child nursed on a chest drain at all times	To reduce risk of lung collapse if chest drain should disconnect. (OLCHC 2015).
▪ Low pressure suction set up if required	Ensure low pressure suction is a written instruction by surgeon caring for the child (OLCHC 2015).
▪ Keep parents / guardians updated if child is having a long procedure in Theatre	This will help to reduce anxiety for the parents/guardians.
▪ When child is ready for collection, contact parents to wait in theatre reception when you go to collect child in the recovery room.	This will facilitate a nursing handover in the recovery room.
Collecting the child from the Recovery Room	
• Identify the patient	Ensure correct child is being transferred from theatre.
• Ensure the patient's airway is patent, assess respiratory effort and O2Sa in Room Air	It is important to ascertain the patient's airway status post operatively.
• Check the vital signs within normal limits and the last set of observations are recorded on the patient's PEWS chart.	Please be aware normal limits for the child's age as per APLS guidelines (2021) and PEWS Guideline CHI (2020) Consider medication given or infusing as it may influence vital signs.

• Pain – check analgesics administered and prescribed. Assess pain levels.	It is important to be able to plan the child's pain management regime to maintain comfort. Be familiar with the Pain Ladder CHI (2021) Be familiar with the appropriate pain assessment tools for children of all age groups. Recognition and assessment of acute pain in children Assessment RCN (2009)
• Wound & drain check	Consider the surgery the child has had; this will influence the requirement for drains (Ball et al., 2015)
• If NGT is in situ, is it for free drainage or to be clamped and released later?	It is imperative to be aware of the surgical instructions on the yellow sheet to be fully informed of what nursing care is required for the child post operatively.
• If repogyle in situ – is it on free drainage/ aspirates - Replacements to be given? • Chest drain, ensure LPS, how many cm of water is documented in surgical notes. Record drainage.	Check drainage level to ascertain drainage already and identify further losses.
• Check Urine output intraoperatively – if catheter in situ check it is draining, if dripping stent in situ visually check it is dripping continuously into nappy	This is to ensure stent is patent
• Fluids Analgesia & Antibiotics prescribed	To facilitate uninterrupted care to the patient and maintain comfort, administered as per medication policy CHI (2017)
• Ensure IV cannula flushed if not attached to an infusion.	Unused cannula must be flushed in Recovery due to the risk of induction agents being in the line. If not performed there is a risk the child could have LOC on the ward when flushed.
• Check opioid pump and prescription – read syringe level prior to discharge from recovery.	This is to ascertain the baseline level, correct prescription and promote safe care.
• If patient is nursed on an epidural or wound block ensure motor and sensory observations are assessed and documented	This will ensure safe care for the child. Be familiar with the Guidelines for Management of Epidural Infusions OLCHC (2008)
• It is important the child is as comfortable – they should be seen by anaesthetics prior to transfer if ongoing discomfort	It is important alleviate discomfort while anaesthetic team is close by.

Returning to the ward • O2, Bed sides up, Drains, Pumps • Talk to the child explaining to them they are going to meet their Parent(s)/ guardian • Ensure a Porter is accompanying you and the child • Meet parents in reception	This ensures safe and comfortable transfer of the child to the ward. To alleviate anxiety (Hockenberry & Wilson 2015) Ensuring safe transfer
On return to the ward • Full set of PEWS and pain assessment • Wound assessment to be carried out with observations along with pressure area care • Continuous O2sats monitoring until stable – if on an opioid infusion or epidural they will require continuous O2sats monitoring • IV fluids to be connected if required as prescribed (100% maintenance unless indicated otherwise) • Administer IV medication / <u>regular</u> analgesia as prescribed • Monitor urine output: infant 2mls/kg, child > 1ml/kg/hr, adolescent >0.5ml/kg/hr	This assessment is important to ascertain the child's condition after transfer to the ward (Ball et al.,2015) Regular observations must be carried out to monitor the child's condition as per post-operative guidelines and surgeon's instructions. Please refer to appropriate CHI Guidelines n morphine infusions and epidural infusions Be cautious, assess the patient's hydration status throughout. To maintain comfort and healing (Hockenberry & Wilson 2015)
Please refer to the SOP on Post-Operative vital signs. **Fluid Balance** Intravenous fluid intake for a child is prescribed according to the child's weight. To calculate the fluid requirements for a child for 24 hours: The following formula is a guide	Reduced urinary output is a symptom of dehydration, sepsis and renal failure. Urinary retention can occur due to analgesia or epidural blocks. Urinary output should be monitored on all post-operative patients. This SOP is still in draft ….

• First 10 kgs of body weight 100mls/kg • Next 10 kgs of body weight 50mls/kg • Every kg thereafter 20mls/kg	Ensure accurate weight is recorded and adhere to the formula to guide fluid requirements. https://www.olchc.ie/Healthcare-Professionals/Nursing-Practice-Guidelines/Our-Lady-s-Ward-Surgical-Orientation-Booklet-2018.pdf
Fasting • After consultation with the team, generally when the patient is alert and orientated post anaesthetic • May start with clear fluids and progress as tolerated to light diet. **CHECK POST-OP NOTES.** • Ensure correct fasting / diet sign on patient door and that patient and family are aware of same	Please read post-operative instructions to ensure safe patient care.
• Depending on the surgery if the bowel was handled, the patient must remain fasting until bowel sounds are heard by the surgeon on review and this must be documented	
• Blood Sugar monitoring as required	
• Ensure oral hygiene is maintained.	Peristalsis must return prior to introducing fluids to prevent the risk of paralytic ileus (Hockenberry & Wilson 2015)
Elimination Urinary Output expected	
• Infant 2ml/kg/hour • Child: 1ml/kg/hour • Child > 12years: 0.5mls/kg/hour	To ensure blood sugars are maintained between 4 – 7 mmols To ensure comfort and freshness
Document fluid balance every hour and check iv site	This guide is important to consider when monitoring urinary output. As the infant has an immature renal system the expected urinary output is of higher volume. https://www.olchc.ie/Healthcare-Professionals/Nursing-Practice-Guidelines/Our-Lady-s-Ward-Surgical-Orientation-Booklet-2018.pdf
Wound and Skin Care	
• Always check wound when performing observations	Check for discharge or active bleeding- report if active bleeding and where appropriate apply pressure.
• Do not disturb dressing unless evidence of fresh blood/ discharge	Most wound closures have dissolvable sutures please take note of post-surgical instructions in post-operative note.

• Give wound care advice as appropriate to parents.	As per CHI information for parent's leaflets Check post-operative notes and follow specific instructions https://www.olchc.ie/Children-Family/Parent-Patient-Information-leaflets/Parent-Patient-Information-Leaflets.html
• Observe for redness, swelling, ooze, pain, dehiscing ->wound swab	Those signs later post op may indicate signs of infection
• Check pressure areas • Keep skin clean and dry	There is increased risk of pressure areas post-surgery Ball et al.,(2015)
Pain Management	
• Regular pain assessment using the age-appropriate pain assessment tool • Regular Analgesia as prescribed • Liaise with the pain specialist team • Patient may be nursed on an Epidural, ensure epidural assessment is performed regularly as per epidural guidelines	To ascertain pain score safely and act appropriately to alleviate pain sing non pharmacological and non-pharmacological methods. Assessing the epidural level is important to ascertain the level and maintain safe care. The nurse must have epidural competencies passed prior to caring for a child with an epidural.
• If the child is receiving an opioid – ensure an antiemetic is prescribed	To reduce risk of emesis
Age-appropriate Pain Tools • FLACC <5yrs • Faces Pain Scale 5 – 13years old • Verbal rating >13years old • Numerical scale • Visual Analogue Scale	As per CHI Guideline for the Management of Opioid infusions for Acute pain (2018)
Documentation of care Holistic care is guided by the Activities of Living Care plan No.1 ▪ Based on the Nottingham Model of Care adapted from Roper Logan and Tierney model of care ▪ Ensure all relevant care plans are included	Documentation of care is part of our professional duty. NMBI (2015) Smith (1995)
Involve parent / patient/guardian in the care planning process	
▪ Record PEWs scores and act appropriately ▪ Strict fluid balance – intake & output monitoring ▪ Commence appropriate care bundles – IVC, PICC, CVC, Urinary catheter ▪ Update nursing evaluation	PEWS Guideline CHI (2020) Royal College of Physicians in Ireland / Health Service Executive (2014) *Prevention of intravascular Catheter-related Infection in Ireland.* Dublin: HSE Health Protection Surveillance Centre. https://www.olchc.ie/Healthcare-Professionals/Nursing-Practice-Guidelines/Our-Lady-s-Ward-Surgical-Orientation-Booklet-2018.pdf

8.0 Evaluation and Audit

In the event of a risk or clinical incident regarding post-operative care, safety to the child is paramount. Surgical and/ anaesthetic assistance may be sought, the situation must be communicated to nursing management and then it must be documented on a clinical incident form. This may warrant an education refresher and / a change may be warranted on this SOP.

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