

NURSING CARE PLAN No 6a
Pre & Post-Operative Care (HODU)
 This Careplan is for use in St. Johns HODU

Full Name:

Address: **Addressograph**

HCR.....

Care Plan No 6a Problem	Pre & Post-Operative Care (HODU) Goals	Issue Date: August 2018 Review Date: August 2021
<p>..... is going to theatre on for.....</p>	<ul style="list-style-type: none"> Pre-operative care - the child/infant and family will be safely prepared for theatre physically and psychologically. Post-Operative care - The child/infant will have a safe and comfortable recovery post-operatively 	

Careplan 6a can be used for six consecutive admissions, date, time sign and grade each admission, discharge only after 6 admissions

No	NURSING INTERVENTION	Commencement, Date, Signature, Time, Grade	Discontinued, Date, time, Signature, Grade
1	Pre-Operative Care		
	<ul style="list-style-type: none"> 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		
	<ul style="list-style-type: none"> 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. <p>.....</p> <ul style="list-style-type: none"> Morphine as per Opioid guidelines OLCHC (2015) <i>(Prior to leaving Recovery Department, ensure Morphine infusion has been prepared correctly and secured in a locked pump.</i> 		

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3	Wound Care	Commencement , Date, Signature, Time, Grade	Discontinued, Date, time, Signature, Grade
	<ul style="list-style-type: none"> • 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		
	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Monitor/record first void post operatively. • Urinary catheter care as per OLCHC Guidelines (2014) (<i>see care plan number 7</i>) 		
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		

Created by Nursing Department
 Issue Date: August 2018 / Review Date: August 2021