Children's Health Ireland at Crumlin

NURSING CARE PLAN No 6a
Pre & Post-Operative Care
This careplan for use in St. John's Haem / Onc Day Unit
All careplans must be used in conjunctions with careplan 1

Full Name: ………………………………………
Address: Addressograph
………………………………………
HCR………………………………………

Care Plan No 6a Problem	Pre & Post-Operative Care Goals	**Issue Date:** August 2018 **Review Date:** August 2021
……………………………………… is going to theatre on ……………………………………… for ………………………………………	• 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

Admission 1	NURSING INTERVENTION	Commencement, Date, Signature, Time, Grade	Discontinued, Date, time, Signature, Grade
	Pre-Operative 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. • 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**		
• **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. ____ • Morphine as per Opioid guidelines OLCHC (2015) *(Prior to leaving Recovery Department, ensure Morphine infusion has been prepared correctly and secured in a locked pump)*			

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3	Wound Care	Commencement, Date, Signature, Time, Grade	Discontinued, Date, time, Signature, Grade
• Monitor wound site for redness, pain, ooze, haemorrhage. • Dressing: ____ • Change dressing: ____ (for complicated wounds / drains / tubes use careplan 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 vomit in intake/output chart **Urinary output** • Monitor/record first void post operatively. • Urinary catheter care as per OLCHC Guidelines (2014) *(see care plan number 7)*			
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 The Nursing Department
Issue Date: August 2018 / Review Date: August 2021

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