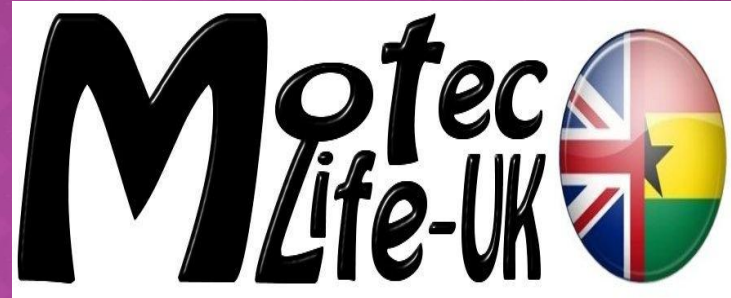


POSTOPERATIVE WARD NURSING MANAGEMENT

RGN JOY LAUDE
WATFORD GENERAL HOSPITAL, ENGLAND



AIM OF POSTOPERATIVE CARE

- ◉ Monitor patient on the ward to detect trends in vital signs and to manage accordingly
- ◉ To recognise deteriorating trends and request relevant medical/out reach input
- ◉ Assess patients needs to provide individual and holistic care postoperatively
- ◉ Provide safe and relevant nursing care

HANDOVER

When the patients care is transferred from the recovery staff to ward staff it is important to have handover to be able to carry on further recovery management:

- Patients name and age
- Relevant Past medical History
- Allergies/intolerances

HANDOVER

- Details of anaesthesia and surgery
- Fluid/blood loss and replacement
- Analgesia given during surgery
- Completed drug chart for required post-op analgesia, anti-emetics and IV fluids and other relevant drugs

HANDOVER

- Details of drains and wounds
- When can patient eat and drink
- Baseline vital signs and observations
- Specific postoperative plan

Once the patient leaves the recovery room and admitted to the ward nursing interventions for further 24hours include the following:

➤ Monitor vital signs including **Blood pressure, Respiration, Pulse rate , O2 saturation and Temperature**

- 15mins for first hour
- 30 mins for next 2hours
- Hourly for next 2
- Then if stable 4 hourly

While monitoring these vital signs it is also important to observe (look, feel, listen)

The results should be compared against the baseline preoperative and post anaesthetic vital signs readings.

POSTOPERATIVE NURSING INTERVENTIONS

- Assess resp rate, oxygen saturation and administer supplemental oxygen as prescribed
- Assess the surgical site and wound drainage systems
- Assess level of consciousness, orientation and ability to move extremities
- Assess pain level, pain characteristics (location and quality) and timing, type and route of administration of last pain medications
- Administer analgesics as prescribed and assess their effectiveness in relieving pain
- Position patient to enhance comfort and safety

POSTOPERATIVE NURSING INTERVENTIONS

- Assess Intravenous sites for patency and infusions for correct rate and solution
- Assess fluid input and urine output and fluid balance chart
- Provide information to patient and family

SHOCK

- Hypovoleamic
- Reduction in systolic bp can indicate hypovoleamic shock that leads to inadequate tissue perfusion , damage at a cellular level and ultimately major organ failure
- Early signs of reduced tissue perfusion in detecting signs of shock
 - Restlessness or confusion
 - Increased respiratory rate
 - Tachycardia
 - Low urine output
 - Cold peripheries

SHOCK

- Cardiogenic
- Death in many acutely ill patients as a result by failure of myocardial pump.
- In response to surgery metabolic demands of the body increases > adrenaline and nor-adrenaline are released > as the heart rate increases due to compensatory mechanism the body's tissues and cells then require more oxygen which exacerbates the performance of the already pressurised myocardium. This results to cardiac arrhythmia or myocardial infarction.

SHOCK

- ◉ Septic shock
- ◉ Life threatening low BP due to sepsis.
- ◉ Sepsis - a serious body wide response to bacteraemia or any other infection.

NURSING INTERVENTIONS FOR SHOCK

- Monitor patients closely
 - Vital signs
 - Fluid input and output
 - Adequate pharmacological interventions
 - Observe and record trends of improvement and deterioration
- Administer supplementary oxygen
- Fluid replacement/ blood transfusion of needed
- Seek medical specialist assistance

ASSESS BREATHING AND ADMINISTER SUPPLEMENTAL OXYGEN IF PRESCRIBED

- ◉ Give supplemental oxygen therapy
- ◉ Maintain oxygen saturation levels above 95% to prevent hypoxia
- ◉ Monitor oxygen saturation
- ◉ This is important because it can cause respiratory failure
- ◉ Breathing
 - Respiration rate, depth and regularity
 - Look, feel and listen
- ◉ Effect of pain on breathing

FLUID REPLACEMENT

- Assisting the replacement of fluids and electrolytes lost during surgery.
- Contributing factors for fluid imbalance post-op
 - Bowel preparations
 - Infiltrated cannula
 - Poor fluid prescription
 - Pre-operative fasting times

POST-OP FLUID REPLACEMENT

- Aim : ensuring adequate hydration equals to safe nursing practice
- Crystalloid
 - 0.9% Na saline
 - 5% dextrose
 - Hartmann's Solution
- Colloids
 - Volplex
- Blood/blood components

ASSESS THE SURGICAL SITE AND WOUND DRAINAGE SYSTEMS

- ◉ Wound - colour, infection, bleeding, stitches
- ◉ Drains - rate and volume of blood loss
- ◉ Urinary catheter - position, patency, hourly urine output/volume, colour and concentration

EXEMPLAR FLUID BALANCE CHART

TIME	INPUT				OUTPUT				
	ORAL	IV	OTHER	TOTAL	URINE	VOMIT	OTHER	DRAINS	TOTAL
0000									
0100									
0200									
0300									
0400									
0500									
0600									
0700									

Total Input	+/- Balance	Total Output

PAIN ASSESSMENT

“ Pain is whatever the patient says it is, and exists whenever the patient says it does.”

(McCaffrey 1968)

- Under treated pain causes harm
- No two people experience pain in the same way.
- Pain control is very important to the well being and recovery of a patient.
- 2 Classifications of Pain (Acute and Chronic)
- Pain assessment
- Key pain assessment factors
- Pain assessment tools

Commonly used post-operative uni-dimensional pain assessment tools

Verbal rating scale

No pain Mild pain Moderate pain Severe pain Very severe pain

Pain intensity scale

0 No pain

1 Mild pain

2 Discomforting

3 Distressing

4 Horrible

5 Excruciating

Visual analogue scale

No pain

Worst pain imaginable

Verbal analogue scale

No pain Mild pain Moderate pain Severe pain Very severe pain

Numerical rating scale

1 2 3 4 5 6 7 8 9 10

(Mackintosh 2005)

PAIN MANAGEMENT

- Types of Post operative pain relief used
 - IV, IM, PO opioids, PCAs
 - PO, PR non-steroidal anti inflammatory drugs
 - Epidurals
 - Local anaesthetic blocks

Table 1. Advantages and disadvantages of analgesia used in post-operative care

Type of analgesia and indication	Advantages	Disadvantages
<p>Paracetamol For minor surgery or the latter phase of major surgery</p>	<p>Can be used as an adjunct with codeine or a non-steroidal anti-inflammatory drug (NSAID)</p>	<p>Effective in only 25 per cent of cases as a single analgesic (McQuay 2003) Has analgesic but little anti-inflammatory effect (Charlton 1997)</p>
<p>Codeine For minor surgery or the latter phase of major surgery</p>	<p>Can be used with other analgesics for optimum pain relief</p>	<p>Often contributes to constipation in post-operative patients</p>
<p>Non-steroidal anti-inflammatory drugs (NSAIDs) For minor surgery or the latter phase of major surgery</p>	<p>COX-1 inhibitors, for example ibuprofen Effective in 50 per cent of patients as a single analgesic (McQuay 2003) Works by suppressing the release of prostaglandins, therefore reducing inflammation (Bandolier 2000) COX-2 inhibitors, for example parecoxib Do not inhibit the COX-1 enzyme and are, therefore, safer for patients with a history of gastric problems, as well as for patients with aspirin-induced asthma (Bandolier 2000, Stevenson and Simon 2001) Can be used effectively in acute post-operative pain management by intravenous or intramuscular injection (BNF 2004a) Reduces the risk of ulcer formation and gastrointestinal bleeding significantly (Hawkey <i>et al</i> 2000, Laine <i>et al</i> 1999, Lanza <i>et al</i> 1999, Simon <i>et al</i> 1999) Gastro-protective drugs such as ranitidine do not need to be prescribed with these NSAIDs (NICE 2001)</p>	<p>COX-1 inhibitors, for example ibuprofen Not suitable for patients with asthma as they interfere with prostaglandin activity in the smooth muscle of the airway causing bronchospasm (BNF 2003b, Pang and Knox 1998) Contraindicated with gastric ulcers as they damage the protective layer of the gut and can lead to bleeding (Trounce and Gould 2000) Not suitable for those who have had an episode of hypovolaemia as this can precipitate renal failure due to renal hypoperfusion (Cambitzi <i>et al</i> 2000)</p>
<p>Intermittent intramuscular analgesia For severe pain</p>	<p>Common and effective method of pain control</p>	<p>Has associated peaks and troughs and, therefore, should be written as a regular prescription rather than as required (Trounce and Gould 2000, Young 2000) Needs titrating to the individual patient to achieve optimum pain relief (McQuay 2003, Torrance and Serginson 2000, Trounce and Gould 2000) Patients whose circulation has been inadequate will have a slower intramuscular absorption level until the muscle regains perfusion (Kitcatt 2003)</p>
<p>Patient controlled analgesia (PCA) For major surgery</p>	<p>Overdose with intravenous opiates administered by the PCA is reduced as the machine is able to 'lock the patient out' theoretically preventing overdose (Anderson 2003) Promotes patient independence Less time-consuming compared to intramuscular analgesia, as syringes do not frequently need to be prepared or changed (Torrance and Serginson 2000)</p>	<p>Can lead to opioid toxicity and respiratory depression Frequent post-operative observations are required, with particular attention to respiratory rate, conscious level and oxygen saturation (Young 2000)</p>
<p>Epidural For major surgery</p>	<p>Provides good pain control in the post-operative period Less time-consuming for staff</p>	<p>Has associated problems similar to those of the PCA, such as nausea and vomiting, respiratory depression, pruritus and urinary retention Frequent checks are, therefore, necessary Risk of epidural haematoma and, if epidural analgesia is planned for patients, then anticoagulants should not be given before epidural catheter insertion (Rawal 1998)</p>
<p>Pre-emptive analgesia and local anaesthetics Wound pain</p>	<p>Can be used with other types of analgesics Infiltration of the wound with local anaesthetic can last for several hours (Charlton 1997)</p>	<p>Needs to be used with other methods of analgesia (Charlton 1997)</p>

ENSURE ADEQUATE ANTI-EMETICS ARE PRESCRIBED AND ADMINISTERED AS AN NEEDED

- **Post operative Nausea and Vomiting**
 - Very important for patient recovery, it can cause patients further distress, exhaustion, loss of fluid and electrolytes
- **Medications via PO, IM, IV**
 - Metoclopramide, domperidone, cyclizine, ondansetron,
- **Naso-gastric tube and drainage as required**
 - Excessive vomiting can be relieved with NG tube
- **Replacement IV fluids**
 - Replace loss of fluid and electrolytes

ASSESS LEVEL OF CONSCIOUSNESS, ORIENTATION AND ABILITY TO MOVE EXTREMITIES

- ◉ AVPU
- ◉ GCS
- ◉ Agitation, confusion, disorientation
- ◉ Movement of limbs and neurological changes

POSITION AND MOBILISATION OF THE PATIENT TO ENHANCE COMFORT AND SAFETY

- ⦿ Prevention of Thrombus formation ie. DVT, PE
- ⦿ Prophylactic treatment are used such as Clexane or continuous heparin infusions
- ⦿ Leg exercises in bed
- ⦿ Relieving pressure to at risk areas by repositioning patients and use of pressure relieving equipments

PATIENT POSTOPERATIVE CARE PLAN

- What is a care plan?
- A **nursing care plan** outlines the nursing care to be provided to a patient. It is a set of actions the nurse will implement to resolve nursing problems identified by assessment. The creation of the plan is an intermediate stage of the nursing process. It guides in the ongoing provision of nursing care and assists in the evaluation of that care.

ROPER, LOGAN AND TIERNEY MODEL OF NURSING

- Based on 12 Activities of Daily Living
 - Maintaining safe environment
 - Communication
 - Breathing
 - Eating and Drinking
 - Elimination
 - Washing and Dressing
 - Controlling Temperature
 - Mobilisation
 - Working and Playing
 - Expressing Sexuality
 - Sleeping
 - Death and Dying

EXAMPLE OF POSTOPERATIVE CARE PLAN USING ROPER ET.AL NURSING MODEL

Assessment/ usual routine	Patients problem	Goal	Nursing Action	Evaluation
<p>Mobilisation</p> <p>Louise mobilisation and distance she could walk without pain prior to surgery was approx 300 yards</p>	<p>Postoperatively , she has lack of confidence mobilising but her pain was under control</p>	<p>Louise to regain her confidence mobilising</p>	<ul style="list-style-type: none"> ➤ Give explanation and reassurance prior to and when mobilising ➤ Observe signs of dislocation 	<p>Louise can safely mobilise and transfer from bed to chair and bed to toilet with confidence</p>

THANK YOU

