Patient ID Sticker

POST OPERATIVE CARE PLAN
THORACIC SURGERY

1. Maintaining a safe environment

PROBLEM	OUTCOME / AIM	PLAN OF CARE
Potential arrhythmia's / cardiovascular instability	For observations to be within desired range and arrhythmia's identified and treated	<u>Initial post operative period</u> ♦ Nurse in HDU ♦ Monitor heart rate, monitor and record blood pressure every 30 minutes for 2 hours then hourly ♦ Monitor temperature 4 hourly ♦ Monitor central venous pressure if catheter insitu <u>Post operative day 1</u> ♦ Take bloods for full blood count and U&E's. Obtain and record result ♦ 1hourly observation of pulse, BP, respiratory rate, saturations, level of consciousness, temperature and urine output while in HDU. 4 hourly when wardable ♦ ECG ♦ Record EWS and follow track & trigger action plan <u>Post operative day 2</u> ♦ Take bloods for full blood count and U&E's. Obtain and record results ♦ Remove peripheral venflons if not in use ♦ 4 hourly temperature, pulse, BP, respiratory rate, oxygen saturation and level of consciousness. ♦ Record NEWS and follow track & trigger action plan <u>Daily post operative care</u> ♦ 4 hourly temperature, pulse, BP, respiratory rate, oxygen saturation and level of consciousness. Record NEWS and follow track & trigger action plan

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1a. Maintaining a safe Environment.

PROBLEM	OUTCOME/AIM	PLAN OF CARE
_____, has a plastic tube inserted into a vein called a cannula that is used to give drugs.	To prevent infection and discomfort and maintain safety.	♦ The cannula will be dated on insertion and should be removed or changed after 72 hours. ♦ Record VIP score twice daily

2. Breathing

PROBLEM	OUTCOME / AIM	PLAN OF CARE
Potential post operative chest infection and poor lung function	To return lung function to pre operative state.	♦ Administer humidified oxygen at ……. % ♦ Monitor oxygen saturations and respiratory rate as follows HDU -30 minutes for 2 hours -hourly thereafter Ward- 4 hourly ♦ Encourage patient to sit in an upright position ♦ Deep breathing exercises/physio ♦ Monitor sputum production ♦ Send sputum specimen for culture and sensitivity if clinically indicated ♦ Effective analgesia ♦ Ensure patient post pneumonectomy does not lie on unaffected side
Pleural drain(s) insitu Inserted on ……..	For safety to be maintained	<u>Initial post operative period</u> **<u>Pleural rocket drain</u>** ♦ Connect to -1.5Kpa suction ♦ Select correct drain chart ♦ Observe drainage for amount / type ♦ HDU -30 minutes for 2 hours - hourly Ward- 4 hourly ♦ Observe for presence of air leak ♦ Ensure drain remains patent and below chest level ♦ Chest x-ray on return to HDU **<u>Thopaz drain</u>**

		♦ Select correct drain chart ♦ Record,suction,flowrate, drainage at same frequency as rocket drain. **<u>Post Pneumonectomy</u>** ♦ **No suction to be attached** ♦ Clamp and unclamp drain as per consultants instruction ♦ Chest x-ray on return to HDU **<u>Continuing post operative care</u>** ♦ Chest x-ray as requested ♦ Monitor and record 24 hour drainage total daily at 08.00 ♦ Observe drain site daily, redress as indicated ♦ Remove drain (s) on instruction Apical removed …….. Basal removed …….. Pneumonectomy drain removed ……...… Remove chest drain sutures 5 days post drain removal

3. Eating and drinking

PROBLEM	OUTCOME / AIM	PLAN OF CARE
Potential dehydration or fluid overload	To prevent	♦ Maintain fluid balance chart ♦ Administer IV fluids as prescribed until adequate oral intake ♦ Daily weight
Potential poor dietary intake	To prevent	♦ Monitor dietary intake ♦ Nutritional / oral hygiene assessment ♦ Treat any nausea with anti-emetics

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4. Eliminating

PROBLEM	OUTCOME / AIM	PLAN OF CARE
Potential post operative	Normal urine	♦ Measure urine output at least 2 hourly if

fluid imbalance / urine retention	output	catheter insitu. Inform medical staff if output less that 1ml/kg/ hr body weight or balance greater than 500mls positive ♦ Monitor urine output until satisfactory output post catheter removal ♦ Report any abnormalities with U&E's ♦ if no urine has been passed 12 hours post operatively utilise bladder scanner+ Inform medical staff
Potential constipation	Prevention / treatment	♦ Monitor bowel movements daily ♦ Give laxatives orally as prescribed ♦ Give suppositories / enema as prescribed ♦ Ensure adequate hydration/nutrition

5. Mobility

PROBLEM	OUTCOME / AIM	PLAN OF CARE
Risk of deep vein thrombosis / pressure sore due to limited mobility	To prevent	♦ Braden score assessment daily and appropriate action ♦ Change of position-consider use of turn chart ♦ Early mobilisation ♦ Subcutaneous heparin as prescribed. ♦ TED stockings insitu until discharged home
Post operative wound pain	Accurate assessment and treatment	♦ Administer IV morphine PCA infusion / epidural /paravertebral as prescribed. Ensure PCA handset is in easy reach and patient is capable of using it. ♦ Ensure pump programmes are checked at every handover by the 2 RNs handing over and receiving patient ♦ Administer oral analgesia routinely at 6am ♦ Do not give oral codeine while on PCA or epidural ♦ Complete appropriate documentation, contact Anaesthetist / pain team if required ♦ Administer adequate oral analgesia when PCA / epidural discontinued ♦ Assess pain score at rest and on movement at least 4 hourly if pain well controlled, increase frequency to assess analgesia effectiveness/ as indicated ♦ Comfortable positioning

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6. Personal cleansing and dressing

PROBLEM	OUTCOME / AIM	PLAN OF CARE

Inability to maintain personal hygiene	To be maintained	♦ Assistance as required ♦ Promotion of independence
Risk of thoracotomy wound infection	To prevent	♦ Remove dressings 48 hours post-operatively ♦ Observe wounds daily thereafter ♦ 4 hourly temperature. Increase frequency if signs of infection/sepsis ♦ Swab wound for culture and sensitivity if clinically indicated

7. Communicating / rehabilitation

PROBLEM	OUTCOME / AIM	PLAN OF CARE
Patient fears during the recovery period	To allay anxieties as much as possible	♦ Full explanations to the patient and their family ♦ Give appropriate information booklets ♦ Ensure that stairs can safely be performed prior to discharge (if no contraindications)

Nurses name ……

Signature……

Date……