

CARE OF THE POST-OPERATIVE PATIENT, BEFORE AMBULATION

OBJECTIVES:

1. To promote adequate respiratory function and prevent venous stasis.
2. To maintain hydration.
3. To prevent skin breakdown and promote comfort.

PROCESS STANDARDS:

1. The patient will be turned and re-positioned at least every two hours for optimal comfort, as surgical condition permits to facilitate breathing and ventilation.
2. The patient will be instructed regarding coughing, deep breathing, and use of incentive spirometry at least every two hours to prevent hypostatic pneumonia. Assess lung fields frequently by auscultation.
3. The patient will be instructed regarding pain management, including medication ordered and symptoms to report to the nurse. Position the patient to maximize comfort.
4. Dorsi/plantar flexion will be encouraged every 2-3 hours. Check for positive Homans' sign, calf pain on dorsi flexion of the foot which could indicate the presence of a DVT.
5. Administer fluids by vein or by mouth if tolerated and permitted.
6. Intake and output will be monitored and documented as ordered and/or if patient has an IV for fluid replacement, a Foley, or if nausea/vomiting have been identified as a problem.
7. Take vital signs per protocol, as clinical condition indicates, until the patient is stabilized. Then check vital signs as per MD order.

OUTCOME STANDARDS:

At the time prior to ambulation:

1. The patient will be free of respiratory compromise.
2. The patient will be free of thrombophlebitis/phlebitis.
3. The patient will be adequately hydrated as evidenced by normal skin turgor.
4. The patient will be free of skin breakdown.
 - a. Perform hand-washing before and after contact with patient.
 - b. Inspect dressing routinely and reinforce as necessary.
 - c. Record amount and type of wound drainage, if applicable.
5. The patient will report effective pain management.
6. The patient/significant other will express understanding of signs and symptoms to be reported to the nurse.

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HAVE I DOCUMENTED:

- * Dietary tolerance and advancement
- * I&O
- * Positioning
 - Frequency
 - With or without assistance
- * Vital signs
- * Respiratory assessment
- * Patient Education
 - Turn, cough, deep breath
 - Incentive spirometry
 - Dorsi/plantar flexion foot
 - Dietary restrictions
 - Activity
- * Pain Management
- * Discharge Teaching

Reference:

1. Patient Care Support Standard 7: Care of the Immobilized Patient.
2. Thompson, J. et. al. (2002). Mosby's Clinical Nursing, 5th ed. Part III: Perioperative Nursing; Chapter 21 Perioperative Nursing Care-Postoperative Complications. Accessed 11/17/2009 [Mosby's Nursing Consult - Reference Books](#). St. Louis: Mosby.