MAJOR ABDOMINAL SURGERY

Objectives:
1. To optimize and maintain acceptable physiological parameters in order to enhance recovery.
2. To identify potential postoperative complications and implement appropriate nursing interventions to prevent and/or resolve identified problems.
3. To provide patient education in order to assure understanding of postoperative care and enhance patient compliance.
4. To provide adequate pain relief.

Process Standard:
1. VS, including HR, BP, and respirations will be documented upon admission and:
   Q 15 minutes x 4, then Q 30 minutes x 2, then Q 1 hour
2. Temperature will be documented on arrival and Q 4 hours
3. Intake and output will be recorded Q 1 hour. If urine OP is <30 cc/hr x 2 hours MD is notified. This is documented in the nurse’s record.
4. Additional drains (JP, NGT, sumps, etc.) are documented and output is recorded Q shift, or as ordered. MD will be notified of drainage > 100 cc/hr x 2 hours or of a sudden increase of decrease of drainage. Character of OP will be documented.
5. Fluid status and hemodynamics may be assessed using APCO device (arterial pressure CO). If present, SVV, SVI, and CI are monitored continuously and documented at least hourly. The MD shall be notified for SVI < 35 and SVV > 15.
6. Abdominal girth measurements are documented if ordered on assessment portion of flow sheet.
7. Blood count, ABGs, chemistry, and renal function studies should be monitored as ordered by physicians and acute changes will be reported to MD within 30 minutes of results.
8. After initial dressing change by MD, wound care performed as ordered should be performed Q shift or as ordered by physician
9. MD will be notified of any unusual wound discharge, separation or discoloration of wound assessed at time of dressing change. This will be documented in nursing record.
10. Aggressive pulmonary exercise should be initiated as soon as clinically possible, preferably within 12-24 hours.
11. Patient will be turned at least every 2 hours until patient is allowed out of bed unless otherwise indicated by physician.
12. Patient should be OOB and ambulated as soon as the clinical condition allows and as ordered by physician.
13. Assess for, document and provide pain medications as ordered by the physician.
14. The patient and or family will be educated regarding disease process, plan of care and procedures.
Expected Outcomes:

1. Postoperative complications have been avoided and/or treated.
2. Patient’s physiological parameters have returned to baseline and are stable with supportive agents.
3. Patient understands goals of postoperative care.
4. Patient will verbalize pain control.

Reference: