


Postoperative Care

The Nurse Aide's Role


Post Operative Checks



- Note time of return
- Note level of consciousness
- Check dressings, location
- Check incision, report drainage, redness, edema
- Check IV site
- Report kinked tubing, no drips

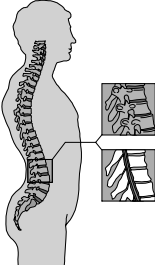
Post Operative Care Measures

- Assist in transfer from gurney
- Will be drowsy for several hrs.
- V/S pulse ox. upon arrival- elevated temp?
- What changes in V/S signals hemorrhage?
- Have extra blanket available
- Drainage tubes connected?
- Report heavy or light drainage
- If vomiting position on side, HOB up



Spinal Anesthesia

Precautions




- Patient unable to move
- Flat on back, no pillow x 8-12hrs.
- Maintain body alignment
- Report c/o headache to nurse
- Notify nurse of wet dressing
- Frequent B/P checks

Does the B/P increase or decrease with spinal anesthesia?


Post Op Observations

- **Comfort:** degree of pain/discomfort
- **Safety:** side rails up, call light in reach
- **Note type and amt. of vomit**
- **Check pulses distal to op. site**
- **Measure and record 1st. Void, report flatulence.**
- **Learn type, purpose, location of all tubes, and how to empty.**
- **Report change in character of drainage, notify nurse of need for dressing change.**
- **Report changes in skin color, pallor, gray, blue-tinged.**
- **Equipment-** report if disconnected or malfunctioning.




Preventing Complications

- TCDB, IS
- leg exercises, early ambulation.
- Apply TED hose and/or sequential compression devices if ordered.
- Do not use ointments with TEDS.
- Reposition @ least q2h- to prevent hypostatic pneumonia.
- Apply binders, if ordered.
- What type of patient would have an order for a binder?

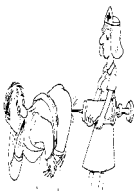


Post-Op Complications
Nurse Assistant's Actions




- Singultus (hiccups) assist patient to breathe into paper bag.
- Distention- gas in bowel ambulate, insert rectal tube or administer Harris Flush if instructed.
- Nausea/Vomiting- NPO, enc. deep breathing, bath basin, frequent mouth care.
- Urinary retention- Report to nurse if no void in 8 hrs.

Post Op Complications
Con't



- Pain- Note location, intensity, type. Change position, apply warmth if instructed, monitor for effects of medication.
- Hypoxia (lack of oxygen) dyspnea, rapid pulse, pallor, perspiring. REPORT NOW!
- Wound Infection- incisional pain increases, fever, chills, increased drainage. REPORT!
- Wound disruption(separation of wound edges) Pinkish drainage, patient reports that they feel open, etc. Support incision, call nurse. Binders may be worn.

More Post-Op Complications
slight calf soreness is never ignored



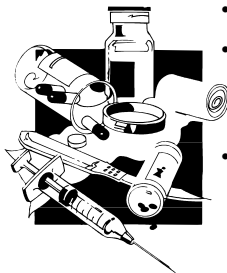
- Deep Vein Thrombosis
 - Pain or cramp in the calf or thigh
 - Painful swelling of leg
 - slight fever, chills, perspiration
 - painful tenderness over inner thigh
- Prevention:
 - early ambulation, T.E.D. hose
 - avoid legs in dependent position
 - avoid knee gatch when in bed
 - Never rub or massage the lower legs.

Safety Precautions



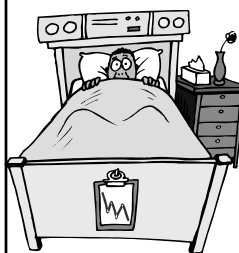
- Never disconnect tubing unless instructed to do so.
- Never raise drainage collection bag above the level of the insertion site.
- Never lower the IV below the level of the insertion site.
- Report any IV pump alarms, or low volume, Don't push pause.
- Maintain drain compression, J/P or hemovac.

Patient Controlled Analgesia Narcotic dosage controlled



- Nurse pre-sets machine
- Patient pushes button to release medication, but not to exceed certain parameters.
- Report to nurse immediately:
 - any change in consciousness
 - rate and pattern of respirations
 - pupil size
 - skin color

Epidural Catheter inserted near spinal cord at L1



- Report to the nurse immediately:
 - 1) if the catheter dislodges.
 - 2) any change in respirations
 - 3) the pt. c/o itching.
 - 4) the pt. c/o nausea/vomiting

Various Drains, Binders, Dressings



- Jackson/Pratt Drains
- Hemovac
- Abdominal (scultetus) binder
- Montgomery straps
