Postoperative care

Post operative note and orders

The patient should be discharged to the ward with comprehensive orders for the following:

- Vital signs
- Pain control
- Rate and type of intravenous fluid
- Urine and gastrointestinal fluid output
- Other medications
- Laboratory investigations

The patient's progress should be monitored and should include at least:

- A comment on medical and nursing observations
- A specific comment on the wound or operation site
- Any complications
- Any changes made in treatment

Aftercare: Prevention of complications

- Encourage early mobilization:
  - Deep breathing and coughing
  - Active daily exercise
  - Joint range of motion
  - Muscular strengthening
  - Make walking aids such as canes, crutches and walkers available and provide instructions for their use
- Ensure adequate nutrition
- Prevent skin breakdown and pressure sores:
  - Turn the patient frequently
  - Keep urine and faeces off skin
- Provide adequate pain control

Discharge note

On discharging the patient from the ward, record in the notes:

- Diagnosis on admission and discharge
- Summary of course in hospital
- Instructions about further management, including drugs prescribed.

Ensure that a copy of this information is given to the patient, together with details of any follow-up appointment

Postoperative Management

If the patient is restless, something is wrong.

Look out for the following in recovery:

- Airway obstruction
- Hypoxia
- Haemorrhage: internal or external
- Hypotension and/or hypertension
- Postoperative pain
- Shivering, hypothermia
- Vomiting, aspiration
- Falling on the floor
- Residual narcosis

The recovering patient is fit for the ward when:

- Awake, opens eyes
- Extubated
- Blood pressure and pulse are satisfactory
- Can lift head on command
- Not hypoxic
- Breathing quietly and comfortably
- Appropriate analgesia has been prescribed and is safely established

Post operative pain relief

- Pain is often the patient's presenting symptom. It can provide useful clinical information and it is your responsibility to use this information to help the patient and alleviate suffering.

- Manage pain wherever you see patients (emergency, operating room and on the ward) and anticipate their needs for pain management after surgery and discharge.

- Do not unnecessarily delay the treatment of pain; for example, do not transport a patient without analgesia simply so that the next practitioner can appreciate how much pain the person is experiencing.

Pain management is our job.

Pain Management and Techniques

- Effective analgesia is an essential part of postoperative management.

- Important injectable drugs for pain are the opiate analgesics. Nonsteroidal anti-inflammatory drugs (NSAIDs), such as diclofenac (1 mg/kg) and ibuprofen can also be given orally and rectally, as can paracetamol (15 mg/kg).

- There are three situations where an opiate might be given:
    - Preoperatively
    - Intraoperatively
    - Postoperatively
- Opiate premedication is rarely indicated, although an injured patient in pain may have been given an opiate before coming to the operating room.

- Opiates given pre- or intraoperatively have important effects in the postoperative period since there may be delayed recovery and respiratory depression, even necessitating mechanical ventilation.

- Short acting opiate fentanyl is used intra-operatively to avoid this prolonged effect.

- Naloxone antagonizes (reverses) all opiates, but its effect quickly wears off.

- Commonly available inexpensive opiates are pethidine and morphine.

- Morphine has about ten times the potency and a longer duration of action than pethidine.
(continued next page)

Post operative pain relief (continued)

- Ideal way to give analgesia postoperatively is to:
  - Give a small intravenous bolus of about a quarter or a third of the maximum dose (e.g. 25 mg pethidine or 2.5 mg morphine for an average adult)
  - Wait for 5–10 minutes to observe the effect: the desired effect is analgesia, but retained consciousness
  - Estimate the correct total dose (e.g. 75 mg pethidine or 7.5 mg morphine) and give the balance intramuscularly.
  - With this method, the patient receives analgesia quickly and the correct dose is given
- If opiate analgesia is needed on the ward, it is most usual to give an intramuscular regimen:
  - Morphine:
  – Age 1 year to adult: 0.1–0.2 mg/kg
  – Age 3 months to 1 year: 0.05–0.1 mg/kg
  - Pethidine: give 7–10 times the above doses if using pethidine

- ***Opiate analgesics should be given cautiously if the age is less than 1 year. They are not recommended for babies aged less than 3 months unless very close monitoring in a neonatal intensive care unit is available.***

Anaesthesia & Pain Control in Children

- Ketamine anaesthesia is widely used for children in rural centres (see pages 14–14 to 14–21), but is also good for pain control.

- Children suffer from pain as much as adults, but may show it in different ways.

- Make surgical procedures as painless as possible:

  - Oral paracetamol can be given several hours prior to operation

  - Local anaesthetics (bupivacaine 0.25%, not to exceed 1 ml/kg) administered in the operating room can decrease incisional pain

  - Paracetamol (10–15 mg/kg every 4–6 hours) administered by mouth or rectally is a safe and effective method for controlling postoperative pain

  - For more severe pain, use intravenous narcotics (morphine sulfate 0.05–0.1 mg/kg IV) every 2–4 hours

  - Ibuprofen 10 mg/kg can be administered by mouth every 6–8 hours

  - Codeine suspension 0.5–1 mg/kg can be administered by mouth every 6 hours, as needed.