

PROTOCOL FOR: Exploratory Laparotomy: Care of the Post-Operative Patient

DESIRED
PATIENT OUTCOMES: 1. The patient will experience minimal/no complications from surgery.
2. The patient will regain optimal level of bowel function post surgery.

CLINICAL
ASSESSMENT
AND CARE: 1. Circulation:
a. Assess vital signs q 4 hrs. x 24 hrs. then q 8 hrs. if stable or per LIP order.
b. Assess labs as ordered.
c. Assess need for Anti-embolytic devices, DVT prophylaxis and consult with MD/LIP.
2. Pulmonary:
a. Monitor lung sounds q 4 hrs. x 24 hrs. post-op, then q 8 hrs. or prn.
b. Assess ability to turn, cough and deep breath.
c. Encourage incentive spirometer q 1 hour while awake.
3. Fluid Volume/Electrolyte Status:
a. Monitor I+O.
b. Monitor lab work, (especially potassium levels).
c. Assess/monitor diet tolerance and advancement of diet prn.
d. Maintain IV infusion as ordered.
e. Replacement fluids/lytes per MD/LIP order.
4. GI Status:
a. Assess bowel sounds/flatus/bowel movement q 8 hrs and prn.
b. Irrigate (✓ placement 1st) NG per LIP order.
c. Monitor patient response to N/G tube being discontinued.
d. Maintain nutritional support per LIP order.
e. Monitor patient response to advancement of diet.
5. Wound Care:
a. Assess dressing immediately post-op - observe/document condition of dressing q 4 hrs. x 24 hrs. then q. shift. Change dressing per MD/LIP orders using sterile technique.
b. Assess/monitor wound at each dressing change for

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signs/symptoms of infection:

- 1) redness
 - 2) heat
 - 3) swelling
 - 4) pain
 - 5) drainage
 - 6) odor
- c. Assess/monitor approximation of incision and whether sutures/staples are intact with each dressing change.
- d. Administer antibiotics per MD/LIP order.
6. Pain Management:
- a. Assess and document patient's report of pain: location, type, duration and severity. Use pain scale: 0-10 (0 = no pain, 10 = worst pain imaginable).
 - b. Medicate patient with analgesics per MD/LIP order. Monitor/document patient response to pain regimen.
 - c. Pre-medicate appropriately before: ambulation, dressing changes, per MD/LIP order.
 - d. Institute comfort measures: positioning, relaxation and reassurance.

REPORTABLE

CONDITIONS: Notify House Officer if:

1. Vital signs outside ordered parameters.
2. Wound shows signs/symptoms of infection, bleeding.
3. GI status reveals signs of new/increased distention.
4. N/G tube is removed/improperly placed or ↑ in output.
5. ↓ urine output.

DOCUMENTATION: 1. Document assessments/findings/interventions on the appropriate forms: unit flow sheet, MAR, and Patient and Family Teaching Record

2. Document patient response to care in patient progress notes per Unit/Department Documentation Standards.

APPROVAL: Medical-Surgical Standards Review
ICU Standards Committee
Nursing Standards Committee

EFFECTIVE DATE: 12/90

REVISION DATE(S): 3/94, 12/97, 6/03, 9/03, 9/05, 10/09 (moved from L&D, OB-GYN, Med-Surg, ICU unit manuals to general Nursing Practice Manual)

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