

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 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 LIP order.
4. GI Status:
  - a. Assess bowel sounds/flatus/bowel movement q 8 hrs and prn.
  - b. Irrigate (✓ placement 1<sup>st</sup>) 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. Change dressing per LIP orders using sterile technique.
  - b. Assess/monitor wound at each dressing change for signs/symptoms of infection:

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- 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 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 LIP order. Monitor/document patient response to pain regimen.

c. Pre-medicate appropriately before: ambulation, dressing changes, per 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, Infusion Record 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

REVIEWED DATES: 9/08