TEACHING PLAN FOR: Hysterectomy (Post): Self-Care Educational Needs

PURPOSE: To delineate the educational needs/self care instruction for a patient who has had a hysterectomy.

SUPPORTIVE DATA: Following a hysterectomy, there is a period of physiological and psychosocial adjustment. This may very depending on what procedure was done during the hysterectomy. This protocol addresses the self care educational needs of a hospitalized patient as well as her preparation for discharge. This protocol is to be used as a guide in adjunct to physicians' orders for each patient.

DESIRED PATIENT OUTCOMES:

1. Patient will verbalize understanding of physiologic changes related to hysterectomy.
2. Patient will demonstrate and/or verbalize appropriate care of self.
3. Patient will void spontaneously within 6 - 8 hours after catheter removed.
4. Patient’s pain will be controlled/reduced to a level acceptable to the patient.

ASSOCIATED STANDARDS: OB-GYN/MFICU Unit Practice Manual:

Protocol For: Hysterectomy: Care of the Patient Admitted to OB-GYN

Protocol For: Admission: Nursing Responsibilities for the Patient being Admitted to OB-GYN Unit

Nursing Practice Manual:

Protocol For: Discharge Planning

Protocol For: Pain: Care of the Adult Patient with Pain

ASSESSMENT:

1. Assess patient for pain following the assessments delineated in the associated standard – Protocol for: Pain: Care of the Adult Patient with Pain.
2. Assess patient's previous experience with self care after medical/surgical procedures.
3. Assess ability to understand instruction - note any language barriers, disabling mental/emotional capacity.

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4. Assess alertness and level of consciousness secondary to narcotic medication administration.

5. Assess physical ability to perform self care.

INTERVENTIONS:

1. Initiate Self care Educational Needs Flowsheet upon admission to unit.

2. Instruct patient in a quiet environment.

3. Instruct patient using lay terms.

4. Reinforce verbal instructions with handouts, videos and pamphlets as appropriate.

5. When possible, have patient perform a return demonstration and/or verbalize understanding of instructions given.

PATIENT EDUCATION: The nurse is responsible for identifying the educational needs of the patient and teaching basic self care measures using the following guidelines:

1. Elimination patterns:

   a. Bladder and bowel function patterns may be temporarily disrupted after procedure/surgery as a result of Foley catheter placement, surgical manipulation, anesthesia/analgesia, patient activity and diet restrictions. Patient should void spontaneously within 6-8 hours after catheter is removed. Normal bowel function should return by third or fourth post-op day. Instruct patient:

      1) To call for assistance out of bed as needed.

      2) In the use of measures to enhance spontaneous void
         a) warm water to perineum
         b) voiding in shower or sitz bath
         c) running tap water or shower

      3) To report S/S infection: burning, frequency, urgency and retention.

      4) In the importance of fluids, fiber and ambulation in re-establishing regular bowel habits.

      5) To report first BM.

   b. Provide measures to promote comfortable BMs

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1) meds per MD orders: MOM, suppositories and stool softeners
2) nutritional guidance: increase fluids and fiber
3) assistance with ambulation

c. Reassure patient that BM will not affect abdominal incision.

2. Incision/abdominal care: caretaking measures following a laparotomy/laparoscopy involve maintaining physical stability, and informing the patient of the healing process and instructing them in the care of the incision/abdomen. Education should include:

   a. Type of incision closure used - staples or subcuticular.
   b. Splinting of incision with bath blanket or pillow while turning, coughing and deep breathing.
   c. Instructing patient to air dry incision and to avoid restrictive clothing over abdominal area.
   d. Instructing patient to report S/S infection: redness around incision, purulent discharge from incision and extreme abdominal tenderness.
   e. Encouraging ambulation for abdominal distention related to gas.
   f. Instructing patient that she may shower after removal of dressing and to "pat-dry" incisional area.
   g. Instructing patient not to use oils or lotions over incisional area.
   h. Instruct patient not to use vaginal douches.

3. Activity: patient activity level is dependent on patient. Generally a patient may be out of bed when able and comfortable to ambulate with minimal assistance. The following guidelines should be addressed when patient is alert and oriented:

   a. Instruct patient to call RN first time out of bed.
   b. Encourage patient ambulation.
   c. Instruct patient to balance activity with rest.
   d. Encourage patient not to lift heavy objects for 4-6 weeks post-op.
   e. Instruct patient to slowly increase activity with tolerance.
   f. Instruct patient not to drive for two weeks after surgery.
   g. Instruct patient to avoid excessive stair climbing for two weeks post-op.
   h. Instruct patient not to engage in strenuous exercise or resume sexual intercourse until checkup with MD.

4. Nutrition: well balanced meals from basic food groups are needed to regain strength, and promote healing of tissues. Review of nutrition should include:

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a. Encouraging patient to eat nutritional meals from all food groups.
b. Instructing patient on progression of diet while hospitalized - food and fluids are advanced per MD orders bowel function returns.
c. Encouraging fluids and fiber to promote comfortable bowel movements and avoid abdominal distention.

REPORTABLE CONDITIONS:

1. Patient unable to comprehend instructions.
2. Patient physically unable to perform tasks.

DOCUMENTATION:

1. Document teaching on Educational Needs Flowsheet.
2. Document patient response to teaching activities in progress notes as per Unit/Department documentation standards.

APPROVAL: Nursing Standards Committee

CREDENTIALS: RN

EFFECTIVE DATE: 2/96

REVISION DATES: 1/09