

PROTOCOL FOR: Appendectomy (Laparoscopic or Open): Care of the Patient

DESIRED PATIENT  
OUTCOMES:

1. Patient will experience minimal/no complications.
2. Patient and/or significant other will verbalize understanding of surgical procedure and post-operative expectations.

CLINICAL  
ASSESSMENT/  
AND CARE:

1. Vital signs q 4° or per MD order - q 4° x 24°, post-op, then q 8° if stable per MD order.
2. Check abdomen for presence or absence of bowel sounds, abdominal distention, and tenderness q 8°/prn.
3. Administer intravenous fluid as ordered.
4. Assess I+O and record on flow sheet q 8°.
5. Assess for nausea and vomiting with vital signs and after initiation of oral nutrition. Medicate patient with antiemetic as per MD order and assess response.
6. Assess labs as ordered.
7. Assess location and level of pain (0-10). Level of pain may be assessed using a rating scale from 0-10, 0 being no pain and 10 being the worst pain. Medicate for pain as needed - assess patient's response to pain regimen.
8. Assess lungs q 4° x 24°, then q 8° if stable/per MD order.
9. Instruct patient in coughing and deep breathing exercises with use of abdominal splint.
10. Instruct patient in use of incentive spirometer and encourage use q 1° x 10 minutes while awake.
11. Assess dressing for drainage with vital signs - note amount and characteristics of drainage. After first dressing change by MD, assess incision line for hematoma, evisceration and for signs and symptoms of infection, i.e., erythema, purulent exudate, warmth, induration, ↑ temp. Change dressing per MD order. If laparoscopic, assess puncture sites.
12. Maintain anti-embolic compression stockings as per LIP order. Remove and reapply every 8°.
13. Encourage and assist with ambulation at least three times a day or as per MD order.
14. Administer antibiotics as ordered.
15. Assess appetite and nutritional intake. Advance diet as ordered.

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PATIENT TEACHING: Educate the patient to the importance of the following:

1. Meeting nutritional and fluid requirements
2. Need to verbalize level of comfort and request pain medication when necessary
3. Need to TCDB, use of incentive spirometer and need for ↑ ambulation
4. Avoid taking a laxative or applying heat to abdomen when abdominal pain of unknown cause is experienced
5. Wound care (if appropriate)

REPORTABLE  
CONDITIONS:

Consult with House Officer for:

1. Signs and symptoms of peritonitis or post-op wound infection
2. Ineffective pain relief
3. Intolerance to advancement of diet.
4. Evisceration or hematoma at wound site
5. Abnormal lab values

DOCUMENTATION:

1. Document assessments, physical findings and interventions on the unit flow sheets, MAR, progress note and Infusion Record.
2. Document patient response to care in the patient progress notes per Unit/Department Documentation Standards.
3. Document patient teaching on the Patient and Family Teaching Record, and the patient's response to education.

APPROVAL: Medical-Surgical Standards Review  
Nursing Standards Committee

EFFECTIVE DATE: 4/93

REVISION DATES: 2/94, 12/97, 5/03, 8/05