

PROTOCOL FOR: Cholecystectomy: Care of the Post-operative Patient

DESIRED

- PATIENT OUTCOMES:
1. Patient and/or significant other will verbalize understanding of surgical procedures and pre and post-operative expectations.
 2. Patient's fluid balance and electrolytes will be within normal limits.
 3. Wounds will heal without any complications.
 4. Patient will verbalize adequate relief of pain.
 5. Patient will meet and/or maintain appropriate nutritional requirements.
 6. Patient will resume baseline elimination patterns prior to discharge.

CLINICAL
ASSESSMENT/
AND CARE:

1. Assess vital signs every four hours x 24 hours. Advance to every eight hours after the first 24 hours or per MD order.
2. Initiate the appropriate Pain Management Protocol. Assess and document patient's report of pain. Have patient rate pain level on scale of 0 - 10 (0 = no pain, 10 = worst pain imaginable). Medicate prn for pain per MD order and document patient response to pain management regimen.
3. Administer IV fluids as ordered.
4. Monitor and record fluid intake and output every eight hours. Monitor urine output every four hours for first 24 hours post-op, or per MD order.
5. Assess abdomen for bowel sounds, distention, and tenderness every 8 hours and prn.
6. Assess for complaints of nausea or vomiting. Medicate with antiemetic as ordered by LIP and assess and document response.
7. Assess incision for erythema, edema, warmth, and purulent drainage every 8 hours and prn.
8. Assess lung sounds every 8 hours and prn.
9. Encourage patient to turn, cough, and deep breath at least every hour while awake.
10. Instruct patient in use of incentive spirometer and encourage use every hour for 10-15 minutes while awake.
11. Maintain anti-embolic compression stockings as ordered. Remove and replace every 8 hours.
12. If drain (T-tube) is present, empty and record output every 8 hours. Note color and consistency of drainage on unit flow sheet.
13. If applicable, assess T-tube insertion site for erythema,

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edema, tenderness, warmth and purulent drainage. Also assess for any leakage around tube insertion site and skin excoriation. Every eight hours, cleanse skin around tube insertion site with 1/2 strength hydrogen peroxide, followed by normal saline, then apply dry sterile dressing.

14. If nasogastric tube (NGT) present, maintain on wall suction as ordered. Assess placement per protocol (Lippincott) and flush with 20 cc normal saline every eight hours to maintain tube patency. Empty and record output from NGT every 8 hours.
15. Encourage post-operative ambulation at least three times a day or per MD order.
16. Monitor for and record first post-op bowel movement on unit flow sheet, as well as any subsequent bowel movements.
17. Advance diet as ordered and assess patient tolerance to diet.

REPORTABLE
CONDITIONS:

Notify MD for:

1. Vital signs outside parameters.
2. Signs and symptoms of fluid alteration.
3. Signs and symptoms of wound infection, hematoma or evisceration.
4. Excessive bleeding from incision, NGT or T-tube.
5. Inadequate pain management.
6. Poor tolerance to diet.

PATIENT TEACHING:

1. Consult with dietician in instructing patient in low fat diet.
2. Instruct patient in care of incision, signs and symptoms of wound infection, activity restrictions if any, and discharge medications.
3. Some patients may be discharged with T-tube intact. Instruct patient in care of T-tube if applicable.
4. Instruct patient to notify MD for increased pain, signs/symptoms of infection, or poor tolerance of diet.

APPROVAL: Medical-Surgical Standards Review
Nursing Standards Committee

EFFECTIVE DATE: 4/93

REVISION DATES: 2/94, 12/97, 5/03, 9/03, 6/06