CLINICAL PRACTICE GUIDELINE
Guideline coverage includes NICU KEMH, NICU PMH and NETS WA

Post-Operative Care

This document should be read in conjunction with the Disclaimer

Collaborative management between surgical, medical and nursing staff is vital to achieve a positive surgical outcome.

Key Points

- Assess the infant's pain responses and ensure adequate analgesia is administered.
- The infant's vital signs should be monitored closely.
- A blood gas analysis is done on return to the unit and imbalances corrected.
- A strict fluid balance should be maintained, ensuring balance from theatre is accounted for.
- Observe the wound site(s), dressings and any drains.
- Infants' who require transportation to another hospital less than 24 hours post-surgical procedure:
    - Must be transported by the NETS team in the NETS transport cot. Nurse only is permissible if authorized by SR or Consultant.
    - Must be continuously cardiopulmonary monitored.
    - Require suction, oxygen and an appropriate sized bag and mask available **at all times** during transportation.

Minor Procedure - e.g. Hernia Repair, Eye Laser

1. Infant should receive full cardiorespiratory monitoring for 24 hours. Hourly observations for a minimum of 4 hours. Then 4 hourly for 24 hours if stable.
2. Assess the infant's pain responses and ensure adequate analgesia is administered. Hourly observations for a minimum 24 hours.
3. Thereafter the frequency of monitoring should be based on assessment of the infant's condition.

Major Procedure - Abdominal, Cardiac

1. Infant should receive full cardiorespiratory monitoring. Hourly observations for 24 hours. Hourly observations however should continue while the infant is ventilated or sedated. If ventilated consider end tidal CO_2 monitoring. Continue hourly observations if on narcotic infusion.
2. A full iSoBAR handover of the infant is given by theatre staff to the ward staff including wound sites, dressings and drains. The operation sheet MR841 should be read by the ward staff and any specific surgical instructions noted and clarified before the theatre staff leave the unit.

3. The parents should be notified of the infant's arrival back from theatre as soon as is practical.
4. If the infant was intubated in the operating theatre, it is important to obtain a chest X-ray on return to the unit to confirm the correct placement of the endotracheal tube. A blood gas should also be done as soon as possible.
5. Surgical Drains should be managed as per surgeon's instructions. Do not attach to suction unless specifically ordered by surgeon.
6. The preterm and ex-preterm are at an increased risk of apnoea following a general anaesthetic, therefore consider caffeine therapy BUT check it has not already been administered in theatre.

Documentation

The procedure and post-operative orders should be documented on the operation sheet (MR841) by the surgeon. Any intraoperative or postoperative blood loss should be documented on the anaesthetic record MR846.2. Any drugs given in theatre should be documented on the anaesthetic record MR846.2 and the paediatric medication chart MR860.

References

1. Boxwell G. Neonatal Intensive Care Nursing. 2nd ed. London: Routledge; 2010
2. Hansen A, Puder M. Manual of Neonatal Surgical Intensive Care, 2nd Edition, 2009. People's Medical Publishing House, Shelton, Connecticut.

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