CARE FOLLOWING MAJOR GYNAECOLOGY, ONCOLOGY OR UROGYNACOLOGY SURGERY

1. PURPOSE

- To identify post operative complications and provide appropriate management should they occur.
- To standardise the post operative care given to women at KEMH.

2. PROCEDURE

KEY POINTS

1. Routine management will be subject to an accurate assessment of each individual woman and may vary according to the woman's pre operative history, surgical events and necessary supportive therapies.

2. Patient acceptance to the gynaecology ward is subject to the woman having met the criteria for discharge from the recovery room following general anaesthetic clinical guideline. See Clinical Guideline Recovery Room Discharge Criteria.

3. Patient observations shall be recorded as often as dictated by the patient's condition. All deviations outside of normal limits shall be escalated as per the clinical guideline Recognising and Responding to Clinical Deterioration.

4. General post operative complications can include
   - **Respiratory system** – atelectasis, pneumonia, hypoxia, pulmonary embolism.
   - **Cardiovascular system** – haemorrhage, hypovolaemic shock, thrombophlebitis, embolism, myocardial infarction
   - **Gastrointestinal system** – abdominal distension from paralytic ileus, constipation, nausea and vomiting, intra operative injury
   - **Genitourinary system** – urinary retention, fluid imbalance, renal failure, intraoperative injury/ haemorrhage
   - **Integumentary system** – wound infection, dehiscence or evisceration, pressure areas, surgical emphysema / haemorrhage
   - **Nervous system** – intractable pain, cerebral vascular accident (CVA)

5. Should a patient's clinical condition deteriorate to the point where an ASCU admission is required, Clinical Guideline Guidelines for Consultant Responsibilities in ASCU shall be followed.

7. Patient self care shall be encouraged as early as possible and is dependent on the patient’s age, mobility, surgery performed and self caring ability prior to admission.

ON RETURN TO THE WARD FROM RECOVERY

1. Monitor and record vital signs. This includes
   - Temperature, pulse, respirations, colour / oxygen saturation.
   - Level of consciousness
   - Wound sites / drains – measure and record as a baseline
   - Urinary output – measure and record as a baseline
   - Intravenous therapy rate / site.
   - Vaginal loss.
   - Nasogastric tube drainage (if applicable).
   - Pain score / response to analgesia.
   - Opioid infusion- PCA / PCEA, inspect the site and record the dermatomes.

2. The above observations shall be performed as follows, and recorded on the Adult Observation and Response Chart (MR 285.02)
   - ½ hourly for the first 2 hours, then
   - 1 hourly for 2 hours, then
   - 2 hourly for 2 hours, then
   - 4 hourly for 24 hours, providing the woman’s condition remains stable.

WOUND SITES / DRAINS
- Monitor output- record on fluid balance chart (MR 740).
- Mark drainage bottles at 2400 hour.

URINARY OUTPUT: THIS IS TO BE PERFORMED WITH ALL OBSERVATIONS
- Assess urinary output/ patients urge to void or bladder distension.
- Record the urine output- amount and colour.
- Notify the medical officer if the volume is less than 30mL / hour.
- Ensure the drainage bag is securely attached and draining.

FLUID BALANCE / HYDRATION
- Manage intravenous therapy as ordered and assess site for complications as per Clinical Guideline A 4.2.3 Monitoring of a Peripheral IV Site.
- Monitor and record fluid intake / output from all sources on the MR 740
  - IV therapy.
  - Oral fluids / ice.
  - Urinary catheter.
  - Nasogastric drainage if in situ.
  - Drainage tubing
  - Emesis.
  - Any fistula or stoma

PAIN MANAGEMENT
- Assess pain and offer appropriate analgesia as prescribed.
- Position the patient for maximum airway ventilation and comfort.
POST OPERATIVE NAUSEA AND VOMITING
- See Clinical Guideline Post Operative Nausea and Vomiting

THROMBOEMBOLIC PROPHYLAXIS
- Administer anticoagulants as prescribed.
- Ensure graduated compression stockings are worn.
- Encourage deep breathing, coughing and a range of motion exercises. If required, refer the woman to the Physiotherapy Department.
- Encourage early mobilisation.

HYGIENE
- When the woman’s condition is satisfactory, attend to hygiene needs, mouth care and if appropriate change the woman into her own clothes.

ANTIBIOTICS
- Check the medication chart MR 810 and administer antibiotics if prescribed.

PRESSURE AREAS
- See clinical guideline Pressure Ulcer Prevention

FALLS RISK
- See clinical guideline Falls Prevention at KEMH

FIRST POST OPERATIVE DAY UNTIL DISCHARGE
- Continue to provide care as above.
- Assess for postural hypotension and motor / sensory loss prior to mobilising.
- Assess the need for continuing intravenous therapy. Diet and fluids to commenced as per the post op orders
- Administer an aperient in the evening of the third post operative day, unless ordered otherwise. Bowel management for oncology patients must be discussed with the oncology team prior to initiation.
- Remove the indwelling catheter as per post operative orders. Refer to Clinical Guideline A Trial Without Catheter for ongoing management.
- Administer antibiotics and other medications as prescribed.
- Remove the wound dressing prior to the first shower, or as per post operative orders.
- Assess the wound for signs of healing or infection. If complications are identified refer to the medical team.
- Re-apply a wound dressing if appropriate.
- Sutures / staples shall be removed as per post operative orders.

- Discharge planning shall be commenced at the time of admission. Review available home support and determine whether additional support is required. Liaise with the relevant staff / departments and confirm arrangements.

REFERENCES (STANDARDS)

| National Standards – 1.8.3, Clinical Practice |
| Legislation - Nil |

Related Policies: KEMH Recognising and Responding to Clinical Deterioration
Simple Dressing

Other related documents – Nil
DPMS : 8403

RESPONSIBILITY

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<tr>
<th>Policy Sponsor</th>
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