Postoperative Care

The postoperative period begins immediately after surgery and continues until the patient is discharged. A thorough assessment is always performed in order to identify actual and potential patient problems that may occur as a result of anesthesia and surgery and appropriate interventions are carried out.



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Head to Toe Assessment

Head-and-toe Assess-man

Along with a good hand-off from the intraoperative nursing and medical team, the postoperative nurse should perform a comprehensive assessment to determine or anticipate if surgical complications like hemorrhage or hypoxia are present in the postoperative patient. When patients return from surgery, perform a head-to-toe assessment beginning with a level of consciousness (LOC), vital signs, and ABCs.

Complications

Hemorrhage

Hemorrhage-hammer

Hemorrhage is a common immediately postoperative complication and can lead to the development of hypovolemic shock if not adequately managed. Understanding blood loss during the surgical procedure and pairing this information with the assessment can possibly predict the presence of uncontrolled hemorrhage. Assess for clinical indicators of uncontrolled hemorrhage including the pooling or saturation of blood at the surgical site, hypotension, tachypnea, weak and rapid pulses, cool, clammy skin, reduced urine output, and restlessness.

Clotting

Clogs

Clotting, or the development of stationary thrombus and/or mobile embolus, may occur as a result of hemostasis in an immobile patient. It is more common in the later postoperative period. Embolic migration in the postoperative patient can possibly lodge the embolus in areas of small diameter like the pulmonary arterial vessels or cerebral arteries. This act can further cause ischemia, infarction or affect oxygenation.

Pain

Pain-bolt

An adequate pain management strategy starts with planning before the surgical procedure. Oftentimes, the postoperative patient has a decreased LOC and is unable to receive teaching about how to manage immediate or later incidences of pain. It is best practice to provide written information and provide teaching/opportunity for questions to a responsible caregiver following surgery. Patients and their caregivers should understand how to contact their surgical team if pain is not controlled after discharge from the PACU.

Dehiscence or Evisceration

D-hissing and Everest-eviscerating

Wound dehiscence is the separation of the wound edges at the suture line, and more commonly occurs in the later postoperative period after discharge from the PACU. Risk factors for wound dehiscence include the presence of an infection, dehydration, malnutrition or extensivity of wound/injuries. Wound evisceration is the protrusion of the internal organs through an incision and is considered a surgical emergency. Evisceration more commonly occurs among obese patients, abdominal surgery patients, or those with poor wound-healing ability.

Respiratory Complications

Complicated Lungs

Atelectasis, or the collapsing of alveoli, may occur postoperatively (usually 1-2 days after surgery) due to accumulated secretions in the lungs obstructing the respiratory tree. It can affect one or both lungs, and/or include only portions of the lung (e.g. lobes). Pneumonia is another later-found postoperative complication arising from the presence of accumulated secretions used as a medium to grow a bacterial infection in the lungs.

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Paralytic Ileus

Wheelchair Eels

Peristalsis can slow in the postoperative period due to anesthesia, immobility/decreased activity, opioids and bowel handling (if abdominal surgery). A paralytic ileus occurs if peristalsis slows to a stop and intestinal gas development (secondary to normal digestion) builds up. Signs of this complication include abdominal distention, pain, absence of bowel sounds, and vomiting postoperatively.

Infection

Infectious-bacteria

Later postoperative complications of an infection can occur in some patients. Patients with a history of diabetes mellitus or immunocompromise are at greatest risk of this complication. Monitor for immediate (PACU) and delayed signs of infection such as chills, fever, increasing pain or tenderness at the incision site, or purulent drainage from the incision. Prophylactic antibiotics may be administered prior to the surgery to prevent an infection.

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