*Affix patient label or enter details:*

Trust ID No.:

Surname (BLOCK LETTERS): First name:

**GYNAECOLOGY CORE CARE PLAN:**

**Care of Patient Following Gynaecology Surgery**

D.O.B.:

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| **PROBLEM: This patient has had:** | |
| **GOAL: To minimise the risk of complications following minor gynaecological surgery and ensure safe discharge home in a timely fashion** | |
| **ACTIONS** (Circle appropriate actions) | **AMENDMENTS**  (Date/Signature) |
| **1.** Pre-operatively, complete admission documentation including all risk assessments and prepare patient  for theatre by completing pre-op checklist.   Complete a full set of observations using NEWS to provide a baseline for post-op observations and to identify the triggers for their subsequent frequency   Following VTE assessment ensure TED stockings are in place prior to surgery and appropriate post-op thromboprophylaxis is prescribed if indicated.   Give advice on the importance of deep breathing, leg exercises and keeping mobile post operatively.  Give copy of Preventing Deep Vein Thrombosis Whilst in Hospital leaflet.   Ensure that there has been robust assessment of home situation so that discharge arrangements can be put in place as soon as possible. Check there is available person to care for her and stay with her if she is to be discharged within 24 hrs of anaesthetic. |  |
| **2.** Post-operatively ensure safe handover from Recovery and transfer to ward.  Monitor and record:   Observations including NEWS   Laparoscopic sites and wound dressings for strike through, redness or sign of infection   Drain output (if applicable)   Vaginal loss; amount, consistency and pad changes or if applicable vaginal pack.   Urine output, ensure patient passes urine within 6 hours of surgery or post TWOC.   Cannula sites core care plan.  Determine the frequency of these observations and report any concerns to the doctor increasing frequency  of observations as indicated by patients’ condition. |  |
| **3.** Assess, monitor and prevent post-operative pain and nausea.   Ask patient to describe location and severity of pain using pain score of 0-10   Ensure adequate analgesia is prescribed; monitor for effectiveness within 30 minutes of administration   If experiencing nausea or vomiting promptly give prescribed anti-emetics and monitor effectiveness within 30 minutes of administration. Provide vomit bowls, tissues, mouth wash and oral care if required. |  |
| **4.** Encourage mobilisation and independence but ensure this patient receives assistance with personal  hygiene as required. Encourage resumption of diet and oral fluids as soon as she is able and discontinue any intravenous fluids. Ensure that she has a chaperone whenever an intimate examination is required. |  |
| **5.** Ensure that this woman has been given sufficient information to manage her own care in the days  following surgery. She should be able to describe wound care, personal hygiene including management of any PV loss, how to build up her mobility, when to resume sex, and how to observe for potentially dangerous complications. Ensure she is given appropriate and relevant literature. Refer to practice nurse if |  |

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| necessary, obtain TTOs if required, organise follow up appointments. |  |
| **Signature of nurse generating care plan** | **Date:** |
| **Evidence:**   C032 Minimum Standards for Observations 2015   C038 Chaperone Policy for Patients Undergoing Intimate Examinations and Procedures 2016   C005 Consent to Examination or Treatment Policy 2016   C010 Discharge Policy for Adults + Children 2016   C021 Peripheral Intravenous Cannulation of Adults 2015   C031 Policy Prevention + Management of VTE 2016   C063 Venepuncture in Adults 2017   C093 Mouth Care Matters 2017 | |

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