Post-Operative Nursing Care Plan

A five-column post-op plan ordered the way the risks actually arrive: airway and breathing, then pain, then infection, bleeding, VTE, ileus, and falls.

QUICK ANSWER

After surgery, prioritize: ineffective breathing pattern/airway clearance → acute pain → risk for infection → risk for bleeding or deficient fluid volume → risk for VTE → decreased GI motility → risk for falls. Core interventions are the pulmonary bundle (incentive spirometry 10 breaths/hour, splinted cough, HOB up, early ambulation), multimodal analgesia dosed 30 minutes before activity, sedation monitoring before every opioid dose, sterile incision care with normothermia and normoglycemia, VTE prophylaxis plus SCDs, ERAS early intake and early catheter removal, and fall precautions on the first walk.

Assessment (subjective + objective)

Subjective: incisional pain 7/10, nausea, dry mouth, "I'm afraid to move because of the drains", has not passed flatus, groggy but oriented.

Objective: POD 0 after open abdominal surgery; temp 36.8 °C, HR 98, BP 118/72, RR 20 shallow, SpO_2 93% on 2 L NC; incision approximated, dry dressing; JP drain with 40 mL serosanguinous output; hypoactive bowel sounds; Foley draining 35 mL/h; Braden 14; Caprini score 5; last opioid dose 40 min ago; POSS 2.

Priority NANDA-I diagnoses

1. **Risk for ineffective airway clearance / ineffective breathing pattern** related to anesthesia, pain-limited excursion, and immobility AEB shallow RR 20 and SpO_2 93%.
2. **Acute pain** related to surgical incision AEB self-report 7/10 and guarding.
3. **Risk for infection** (surgical site) related to a break in skin integrity and an indwelling drain and catheter.
4. **Risk for bleeding / deficient fluid volume** related to intraoperative losses and drain output.
5. Risk for venous thromboembolism related to immobility and surgery AEB Caprini 5.
6. Decreased gastrointestinal motility AEB hypoactive bowel sounds and no flatus.
7. Risk for falls related to sedation and orthostasis on first ambulation.

NOC outcomes (SMART)

- $SpO_2 \geq 94\%$ on room air by POD 1 with incentive spirometry ≥ 10 times/hour while awake.
- Pain ≤ 3/10 or at the patient's functional goal within 60 min of each intervention.
- Ambulates in the hallway on POD 1 and three times daily thereafter, without falling.
- Urine output ≥ 0.5 mL/kg/h; MAP ≥ 65; no drop in hemoglobin requiring transfusion.
- Surgical site remains free of purulence, spreading erythema, or dehiscence through discharge.
- Flatus or bowel movement by POD 2–3; tolerates advancing diet without vomiting.

NIC interventions and rationale

- **Pulmonary bundle: incentive spirometry 10 breaths/hour while awake, cough with pillow splinting, HOB elevated, early ambulation, oral care twice daily with chlorhexidine per protocol** — postoperative pulmonary complications are the most common serious post-op morbidity, and this bundle is what prevents them.
- **Multimodal analgesia and dosing 30 minutes before ambulation or dressing change** — untreated pain is the reason patients refuse spirometry and mobility, so pain control is a respiratory intervention.
- **Monitor sedation (POSS/RASS) and RR before every opioid dose; keep naloxone available** — sedation precedes respiratory depression.
- **Assess the incision and mark drainage every shift; maintain sterile technique for dressing changes; keep perioperative normothermia and normoglycemia** — temperature and glucose control measurably reduce surgical site infection.
- **Track cumulative drain and dressing output, vital-sign trends, and hemoglobin; escalate for tachycardia with narrowing pulse pressure** — early hemorrhage shows as trend change before hypotension.
- **VTE prophylaxis: pharmacologic per order plus sequential compression devices and mobility; assess daily for calf pain, unilateral swelling, and dyspnea**.
- **ERAS-aligned recovery: early oral intake as tolerated, gum chewing, opioid minimization, early Foley removal, early mobilization** — the ERAS bundle shortens ileus duration and length of stay.
- **Remove the urinary catheter within 24 h unless a documented indication persists** — prevents CAUTI and enables mobility.
- **Orthostatic and fall precautions on first ambulation: dangle, gait belt, two staff for the first walk**.
- **Discharge teaching: infection red flags, incision and drain care, activity and lifting limits, bowel regimen, opioid tapering and safe disposal, and when to call**.

Evaluation

POD 2: SpO_2 96% on room air with 10 spirometry breaths hourly, pain 2–3/10 at functional goal, ambulated the hallway three times without a fall, urine output 0.7 mL/kg/h with hemoglobin stable, incision clean and dry with declining drain output, flatus passed and clear-liquid diet tolerated, Foley removed POD 1. All outcomes met; discharge teaching completed with teach-back.

Frequently Asked Questions

What is the highest nursing priority immediately after surgery?

What is the difference between the immediate, intermediate, and late post-op phases?

How do I recognize post-operative hemorrhage early?

What is ERAS and why does it appear in a nursing care plan?

Enhanced Recovery After Surgery is an evidence-based bundle — early oral intake, opioid minimization, early mobilization, early catheter removal — and most of its elements are nurse-delivered, so they belong in the intervention column with rationale.

Sources & Further Reading

1. **Ljungqvist, O., Scott, M., & Fearon, K. C..** Enhanced Recovery After Surgery: A Review. JAMA Surgery, 152(3), 292–298.
2. **Berríos-Torres, S. I., et al..** Centers for Disease Control and Prevention Guideline for the Prevention of Surgical Site Infection. JAMA Surgery, 152(8), 784–791.

Related Resources

→ Full nursing care plan library→ Acute pain care plan→ UTI and CAUTI prevention care plan→ Pneumonia care plan