<table>
<thead>
<tr>
<th>GOAL</th>
<th>INTERVENTION</th>
<th>RATIONALE</th>
<th>EXPECTED OUTCOME</th>
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<tbody>
<tr>
<td><strong>Preoperative Care</strong></td>
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<tr>
<td>1. Knowledge deficit related to preoperative and postoperative events</td>
<td>NIC Priority Intervention: <strong>Teaching, Preoperative.</strong> Assisting a patient to understand and mentally prepare for surgery and postoperative recovery</td>
<td>Prior knowledge and understanding can be reinforced and used to guide your presentation. Developmental level determines the cognitive approach that works best for teaching. Learners must have opportunity to ask questions.</td>
<td>The child and family are able to verbalize details about expected preoperative and postoperative events. They ask questions that demonstrate understanding. The child demonstrates skills needed in the postoperative period.</td>
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<td>The child and family will acquire knowledge related to the operation.</td>
<td>▪ Ask questions of the parent and child about surgery.</td>
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<td>NOC Suggested Outcome. <strong>Knowledge:</strong> Extent of understanding conveyed about treatment regimen.</td>
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<td>▪ Teach about preoperative and postoperative events using appropriate developmental methods such as dolls, drawings, stories, and tours.</td>
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<td>▪ Reinforce information the family has received about the purpose of surgery.</td>
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<td>▪ Have the child demonstrate postoperative events that pertain to his or her case such as deep breathing, putting bandage on doll, taping intravenous line on doll, and pressing patient-controlled analgesia button.</td>
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<td>▪ Allow the parents and child to ask questions.</td>
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<td>2. Anxiety related to change in health status</td>
<td>NIC Priority Intervention: <strong>Anxiety Reduction:</strong> Minimizing apprehension, dread, foreboding, or uneasiness related to an unidentified source of anticipated danger.</td>
<td>Previous experiences can influence present anxiety level. Familiarity with the setting and people can decrease anxiety by removing unknown factors. Play can increase trust level and decrease anxiety. The child is more likely to trust caregivers if they are truthful and if parents are present. Questioning provides an opportunity to explain the unknown, which decreases anxiety.</td>
<td>The child and family demonstrate less anxiety. They verbalize understanding and comfort in hospital routines. Parents support the child for traumatic procedures.</td>
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<td>The child and family will show decreased behavior indicating anxiety.</td>
<td>▪ Question the child about expectations of hospitalization and previous experiences.</td>
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<td>NOC Suggested Outcome: <strong>Coping:</strong> Actions to manage stressors that tax an individual’s resources.</td>
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<td>▪ Orient the child to the hospital setting, routines, staff, and other patients.</td>
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<td>▪ Institute age-appropriate play and interactions with the child.</td>
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<td>▪ Explain procedures and prepare for those that might cause trauma.</td>
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<td>▪ Encourage parents to support the child.</td>
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<td>▪ Allow the parents and child to ask questions.</td>
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Nursing Considerations for the Hospitalized Child

### Nursing Care Plan: The Child Undergoing Surgery (continued)

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<tr>
<td>3. Risk for infection and injury related to exposure to nosocomial infection and use of preoperative medication</td>
<td>NIC Priority Intervention: Infection Control and Fall Prevention: Minimizing the acquisition and transmission of infectious agents, and instituting special precautions with patient at risk of falling.</td>
<td>Increase in vital sign levels, skin lesions, nasal drainage, or adventitious breath sounds can indicate signs of infection in the child. Symptoms are reported so surgery can be canceled if necessary. Preoperative medication can alter level of consciousness. NPO status prevents aspiration.</td>
<td>The child’s vital signs and assessment are within normal limits. The child is transported safely to the operating room.</td>
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**Postoperative Care**

4. Impaired skin integrity related to disruption of skin surface

| The child will be free of infection. | NIC Priority Intervention: Wound Care: Prevention of wound complications and promotion of wound healing. | Changes in vital signs, especially increased temperature and pulse, can indicate infection. Excess drainage may indicate infection. Wet dressing can allow organisms to come into contact with surgical wound. Intravenous lines may become infiltrated or cause thrombophlebitis. Parents report signs of infection and perform home care as needed. | The child shows no signs of infection. The surgical wound heals without infection. The intravenous line remains patent without signs of infection. The child continues to demonstrate no signs of infection at home. |

5. Risk for constipation related to surgical procedure and anesthetics

| The child will achieve and maintain normal bowel functioning by the fourth postoperative day. | NIC Priority Intervention: Constipation Management: Establishment and maintenance of regular bowel elimination | Restricting fluids avoids distention if peristalsis is not normal. Knowledge of bowel status ensures early identification of constipation. Fluids and roughage promote normal bowel functioning. Physical activity promotes peristalsis. | The child has bowel movement within 2 to 3 days after surgery with normal pattern by the fourth post-operative day. |
### Changes in vital signs, especially pulse or blood pressure

Can indicate fluid imbalance.

Intake and output are roughly equivalent. Urinary retention sometimes occurs postoperatively as a result of anesthesia. Fluid status can be assessed by skin and mucous membrane hydration.

- Increased hematocrit and hemoglobin can indicate hemoconcentration and underhydration. Decreased serum values can indicate hemodilution or overhydration.
- Vomiting can cause fluid loss.
- Early identification of respiratory difficulty aids early treatment.
- Analgesics, especially morphine, may slow respiratory rate.
- Oxygen may facilitate breathing status postoperatively.
- Repositioning ensures expansion of all lung fields.
- All areas of the lungs must be expanded. Mucus is expectorated.
- Balanced fluid status ensures liquification of secretions and prevents excess fluid accumulation.
- Behavior of preverbal children provides clues to pain experience.
- Pain scales allow children to quantify the amount of pain (see Chap. 9).

### NIC Priority Intervention: Fluid Management

- Promotion of fluid balance and prevention of imbalance complications.
- Changes in vital signs, especially pulse or blood pressure, can indicate fluid imbalance.
- Intake and output are roughly equivalent. Urinary retention sometimes occurs postoperatively as a result of anesthesia. Fluid status can be assessed by skin and mucous membrane hydration.
- Increased hematocrit and hemoglobin can indicate hemoconcentration and underhydration. Decreased serum values can indicate hemodilution or overhydration.
- Vomiting can cause fluid loss.

### NIC Priority Intervention: Airway Management

- Facilitation of patency of air passages.
- Early identification of respiratory difficulty aids early treatment. Analgesics, especially morphine, may slow respiratory rate.
- Oxygen may facilitate breathing status postoperatively.
- Repositioning ensures expansion of all lung fields.
- All areas of the lungs must be expanded. Mucus is expectorated.
- Balanced fluid status ensures liquification of secretions and prevents excess fluid accumulation.

### NIC Priority Intervention: Pain Management

- Alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the patient.
- Behavior of preverbal children provides clues to pain experience.
- Pain scales allow children to quantify the amount of pain (see Chap. 9).
- Narcotics and nonnarcotic analgesics alter pain perception.
- Nonpharmacologic interventions interfere with pain perception.

### Goal: 6. Risk for fluid volume imbalance related to intravenous infusion and NPO status

The child will achieve and maintain proper circulating volume.

The child will tolerate oral intake when started, with no nausea, vomiting, or dehydration present.

- Monitor vital signs per hospital routines.
- Record intake and output. Be alert for fluid loss via dressings or watery stools. Evaluate hydration status by skin turgor and mucous membranes.
- Monitor laboratory values of hematocrit and hemoglobin.
- Begin oral intake after assessment of bowel sounds. Record vomiting. Administer antiemetics if indicated.

### Rationale: 6. Risk for fluid volume imbalance related to intravenous infusion and NPO status

- Changes in vital signs, especially pulse or blood pressure, can indicate fluid imbalance.
- Intake and output are roughly equivalent. Urinary retention sometimes occurs postoperatively as a result of anesthesia. Fluid status can be assessed by skin and mucous membrane hydration.
- Increased hematocrit and hemoglobin can indicate hemoconcentration and underhydration. Decreased serum values can indicate hemodilution or overhydration.
- Vomiting can cause fluid loss.

### Expected Outcome: 6. Risk for fluid volume imbalance related to intravenous infusion and NPO status

The child remains in fluid balance with no vomiting in postoperative period.

### Goal: 7. Impaired gas exchange related to anesthetics and pain

The child will maintain adequate ventilation with no respiratory impairment.

- Auscultate lungs every 2 hours. Record rate, rhythm, and quality of respiration. Evaluate respiratory rate after analgesics.
- Administer oxygen if ordered.
- Reposition the child every 2 hours.
- Encourage deep breathing and coughing every 2 hours. Use incentive spirometer, pinwheels, or other blow toys appropriate for the development level of the child.
- Ensure proper intake and output.

### Rationale: 7. Impaired gas exchange related to anesthetics and pain

- Early identification of respiratory difficulty aids early treatment. Analgesics, especially morphine, may slow respiratory rate.
- Oxygen may facilitate breathing status postoperatively.
- Repositioning ensures expansion of all lung fields.
- All areas of the lungs must be expanded. Mucus is expectorated.

### Expected Outcome: 7. Impaired gas exchange related to anesthetics and pain

The child moves adequate air in and out of lungs.

### Goal: 8. Pain related to surgical procedure

The child will maintain an adequate comfort level.

- Assess behavioral cues (e.g., crying, movement, guarding).
- Use an appropriate pain scale with verbal children.
- Administer prescribed pain medications on a regular basis.
- Use age-appropriate non-pharmacologic methods of pain control (e.g., distraction, repositioning).

### Rationale: 8. Pain related to surgical procedure

- Behavior of preverbal children provides clues to pain experience.
- Pain scales allow children to quantify the amount of pain (see Chap. 9).
- Narcotics and nonnarcotic analgesics alter pain perception.
- Nonpharmacologic interventions interfere with pain perception.

### Expected Outcome: 8. Pain related to surgical procedure

The child’s pain is controlled as demonstrated by a low number on the pain control scale (behavioral or verbal).
### NURSING CARE PLAN  The Child Undergoing Surgery (continued)

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<td>9. Risk for impaired skin integrity related to limited mobility after surgery</td>
<td>NIC Priority Intervention: <strong>Skin Surveillance and Pressure Management</strong>: Collection and analysis of patient data to maintain skin integrity and minimizing pressure to body parts.</td>
<td>Repositioning takes pressure off the skin and allows increased circulation. Clean linen decreases the chance of skin break-down. Rubbing increases circulation. Movement decreases pressure on skin. Early identification of infection or problems with wound healing can ensure fast treatment.</td>
<td>The child develops no pressure areas. The wound heals without complication.</td>
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<tr>
<td>The child's skin will remain intact.</td>
<td>Turn and reposition the child every 2 hours. Keep linens clean and dry. Check pressure areas when turning and rub erythematous areas with lotion. Get the child up and ambulating when ordered. Check the incision for drainage, redness, and intactness of staples or stitches every 4–8 hours.</td>
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<td>10. Anxiety (child and family) related to equipment and surgical outcome</td>
<td>NIC Priority Intervention: <strong>Anxiety Reduction</strong>: Minimizing apprehension, dread, foreboding, or uneasiness related to an unidentified source of danger.</td>
<td>Knowledge of purpose decreases anxiety. Knowledge of what is expected decreases anxiety. The child's anxiety decreases with parental presence. Effective communication reassures child and family.</td>
<td>The child and family demonstrate coping skills to deal with hospitalization.</td>
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<tr>
<td>The child and family will verbalize comfort with postoperative care and outcome.</td>
<td>Explain monitors, drainage dressings, intravenous lines, and procedures. Reassure the child and family that anxiety is a normal response to the stressful event of surgery. Encourage parental presence and care of the child. Use touch and other nonverbal and verbal communication with the child and family</td>
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<td>11. Knowledge deficit (child and family) related to needed home care</td>
<td>NIC Priority Intervention: <strong>Teaching, Postoperative</strong>: Health System Guidance: Facilitating a patient’s location and use of appropriate health services.</td>
<td>Teaching regarding home care is necessary early in hospitalization. Parents need to know emergency information and that follow-up care is required.</td>
<td>The child and family demonstrate skills needed for home care following discharge. They verbalize plans for future care.</td>
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<td>The child and family will verbalize self-care required at home.</td>
<td>Provide oral and written home care instructions regarding surgical wound care, medications, activities, and diet. Provide a number to call for questions or concerns. Instruct on follow-up visits.</td>
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NOC Suggested Outcome: **Risk Control**: Actions to eliminate or reduce actual personal and modifiable health threats.

NOC Suggested Outcome: **Coping**: Actions to manage stressors that tax an individuals’ resources.

NOC Suggested Outcome: **Knowledge**: Home Care Extent of understanding conveyed about home care.