PATIENT POPULATION
This reference care plan is intended for pediatric patients who have received cleft lip and/or palate surgery.

DEFINITIONS
Normally in the first trimester of pregnancy, components that make up the lip and palate fuse. If these parts do not fuse properly, a space called a cleft result between the parts. Clefts can vary in type and severity. Clefts of the lip and palate are the most common types of birth defects, occurring in about one in 1000 births. Most babies with cleft lip or cleft palate are otherwise healthy with no other birth defects. Some babies who have clefts may also have other medical problems.

Cleft lip
Cleft lip is a separation in the upper lip. Cleft lip can occur if certain parts of the nose and upper jaw do not fuse properly during the early weeks of pregnancy. Cleft lip can vary in severity from a slight notch in the lip to a complete separation of the lip running up to the nose and back to the gum line.

Cleft palate
Cleft palate is a separation in the middle of the palate. Cleft palate can form if the roof of the mouth and the floor of the nasal cavity do not fuse properly in early pregnancy. Cleft palate can range in severity from a tiny opening at the back of the palate to a large gap in the roof of the mouth.

<table>
<thead>
<tr>
<th>Problem/Potential Problem</th>
<th>Objectives</th>
<th>Anticipatory/Therapeutic Nursing Interventions</th>
<th>Evidence-base/Rationale</th>
</tr>
</thead>
</table>
| Potential for airway obstruction due to edema related to surgical procedure | Respiration will remain easy, regular, quiet, and oxygen saturation will remain within normal range | • Assist in repositioning q2h and prn  
• Assess chest by auscultating qshift and prn  
• Monitor O2 saturation as ordered  
• Position sleeping patient to maximize open airway (e.g. avoid neck flexion and sleeping flat on back).  
• Administer oxygen prn as per physician’s orders.  
• Notify physician immediately if increasingly noisy breathing, respiratory distress, or if amount of oxygen required to maintain oxygen saturation is increasing. | To ensure patient is assessed thoroughly  
To ensure complications can be detected early and interventions can be initiated when required |
## Problem/Potential Problem

<table>
<thead>
<tr>
<th>Potential for bleeding related to surgical procedure</th>
<th>Surgical site will remain free from bleeding</th>
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### Objectives

- Assess skin colour, level of consciousness and vital signs (Temperature, Heart Rate, Respiratory Rate and Blood Pressure – TPR and BP) with transferring RN. Confirm patient status is unchanged or improved from PACU.
- If patient is stable, then MONITOR vital signs: hourly x 4, then every 2 hours x 2, then as per physicians order thereafter or as per unit routine.

#### FOR CLEFT PALATE

- Position with HOB elevated 45 degrees as per physician orders.

#### FOR CLEFT LIP

- Position patient on their back or as per physician orders.

- Discourage crying, coughing, frequent clearing of throat.
- Reassure parents/caregiver that normal crying will not cause wound to dehisce.

- Avoid hard objects in mouth i.e. popsicles on a stick, ice chips, do not feed with a straw or fork. Use a small spoon for feeding.

### Anticipatory/Therapeutic Nursing Interventions

- Bleeding may indicate wound dehiscence and requires assessment by a physician.
- Some children may need to be taken back to the Operating Room to control the bleeding.
- Positioning patient with HOB elevated will help decrease accumulation of oral secretions in the oral cavity and will help prevent potential for aspiration.
- Positioning patient on their back will help prevent any irritation to the suture line from being rubbed across the sheets/bedding.

### Evidence-base/Rationale

- Red liquids may be misinterpreted as blood if emesis.

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Page 2 of 8
<table>
<thead>
<tr>
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<td></td>
<td></td>
<td>• Avoid sucking (i.e. straws, soother)</td>
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<td>• No red liquids, popsicles, Jello, or foods with red sauce i.e. Spaghetti sauce.</td>
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<td>• Follow physician orders regarding arm restraints, soothers.</td>
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<td>• Remove splints/restraints q1-2h for passive ROM</td>
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<td>• Treat post-operative vomiting promptly</td>
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<td>• Observe for increased swallowing, vomiting of large amounts of blood and/or profuse bloody discharge from nose or mouth</td>
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<td>• Suctioning is contraindicated unless absolutely necessary. Suction away from suture line if suctioning necessary</td>
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<td>• Notify the physician immediately if any bleeding is noted</td>
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<tr>
<td>Potential for delayed healing related to inadequate or absent mouth care</td>
<td>Mouth will be cleansed regularly during hospital stay</td>
<td>• Give sips of water to cleanse mouth after meals once baby is on a pureed diet.</td>
<td>Prevents infection and improves healing</td>
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<td>• Reassure parents that a small amount of blood-tinged discharge from mouth and nares is normal for the first 24-48 hours.</td>
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<td>• Keep area around mouth clean and dry to avoid skin irritation</td>
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<tr>
<td></td>
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<td>• Put nothing in the mouth except nipple, spoon or soother.</td>
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| Surgical site will remain free of infection | • Assess and document surgical site  
• Assess and document vital signs as ordered and prn  
• Administer antibiotics if prescribed  
• Assist child in maintaining good oral hygiene (brush teeth but no gargling)  
• Report signs of infection (i.e. increased pain, lethargy, general deterioration of condition) to Physician. The patient may have a smell to their breath post-op. If the breath smell gets stronger after they are discharged then they should notify the physician. | • Use cotton tipped swabs with sterile water to clean incision line. Gently roll the swab up and down beside the incision line – **do not** roll swab on incision line. Use a clean swab each time. Try to avoid hard crusting along incision line. If hard crusting is present, soak the crust off during cleaning and monitor patient closely afterwards. | Provides thorough assessment of patients clinical status including vitals, surgical wound, and comfort to ensure complications can be detected early and immediate interventions can be initiated |
| Patient will remain comfortable post-op | • Assess and document pain q4h and PRN using an age and developmentally appropriate pain scale.  
• Administer analgesic as ordered PRN. Consider providing patient with **regular analgesia** for the | Establishing a pain-management plan based on the findings from the assessment and incorporating the person’s beliefs and goals is important |
**Problem/Potential Problem** | **Objectives** | **Anticipatory/Therapeutic Nursing Interventions** | **Evidence-base/Rationale**
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Potential for inadequate nutritional intake/hydration related to post-op discomfort and nausea | Will receive adequate nutrition/hydration for age/wt. | • Measure intake and output. Note colour of urine indicating concentration/dilution.  
• Offer preferred fluids and soft/frozen foods at regular interval  
• Maintain IV access and rate as per physician’s orders  
• Reinforce importance and benefits of maintaining adequate fluid intake to patient and family  
• Follow physician specific orders regarding progression of diet  
• Offer small frequent feeds  
• Offer bottle/cup 30 minutes after analgesia is given.  
• Use nipple and bottle that the baby is used to i.e. Dr. Brown specialty cleft nurser.  
• Use dropper, syringe, sipper cup or spoon for feeding prn.  
• Encourage thicker fluids/foods i.e. yogurt, runny cereal, ice cream, etc. | Optimal fluid balance is important to facilitate regulation of body function and wound healing  
Fluid imbalances lead to imbalance of electrolyte and decrease the body’s ability to function properly  
Educates family on importance of performing the hourly site assessments and engages them in the process of care  
Thicker foods are more easily swallowed.

For the first 24-48 hours post-operatively:  
• Give analgesia 30 minutes prior to feeding.  
• Assess effectiveness of analgesic 30-45 minutes post administration.  
• If ordered analgesic is ineffective, contact physician  
• Encourage parents/caregiver to hold, cuddle, speak to and play with baby.  
• Follow physician orders regarding arm restraints, soothers.  

for minimizing pain and distress.
## Problem/Potential Problem

### Anxiety and disturbance of self-concept due to hospitalization and diagnosis

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| Patient/family will demonstrate positive coping skills in response to their condition and hospitalization prior to discharge | - Monitor IV site q1h and PRN  
- Assess IV site using Touch Look Compare  
- Teach and support families to assess IV site. | Provides thorough assessment of infusion system so complications can be detected early and immediate interventions can be provided in a timely manner. |

- Explain to parents: the feeding routine post-op, careful hand washing, the purpose of arm restraints, removing small objects from the patients surrounding area, why decreasing crying to minimize stress on the suture line, and that sutures are absorbable and do not need removal.  
- Orient patient/family to hospital and unit routines  
- Involve patient/family in establishing the nursing care plan on admission. Review any changes with them as they occur.  
- Promote autonomy and control by structuring the plan of care with the patient/family at the beginning of each shift.  
- Encourage discussion and questions of fears and anxieties  
- Encourage the use of the whiteboard for questions with their Core Care Team  
- Prepare patient/family prior to all tests and procedures utilizing teaching pamphlets as applicable.  

Having open, reliable and timely information available regarding the plan of care for family members and caregivers increases families’ satisfaction with the hospital experience.
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| Patient/Family discharge teaching              | Patient and family will state an understanding of information relevant to post-op recovery and will express realistic plans for home care by discharge | • Review and ensure that the patient/family have a copy of appropriate discharge pamphlet 'Caring for your Child After Cleft Palate Surgery'  
• Ensure patient/family has the contact information for Cleft Palate/Craniofacial Program Clinic Nurse Clinician Sandra Robertson 604-875-2345 ext 7057 | To ensure the family understands and is prepared to care for the child at home with the necessary equipment and prescriptions as required |

### CROSS-REFERENCES

- Caring for Your Child After Cleft Palate Surgery  

- Nursing Assessment and Documentation  
  [http://policyandorders.cw.bc.ca/resource-gallery/Documents/BC%20Children's%20Hospital/Nursing%20Assessment%20and%20Documentation-CC.03.01-Feb-01-2017.pdf](http://policyandorders.cw.bc.ca/resource-gallery/Documents/BC%20Children's%20Hospital/Nursing%20Assessment%20and%20Documentation-CC.03.01-Feb-01-2017.pdf)

- Pre and Post-Operative Care  

- Guidelines for Maintaining Infusion Therapy  
  [http://policyandorders.cw.bc.ca/resource-gallery/Documents/BC%20Children's%20Hospital/CV.01.01%20(PT003)%20Maintaining%20Infusion%20Therapy.FINAL.14Jan16[6246][8629].pdf](http://policyandorders.cw.bc.ca/resource-gallery/Documents/BC%20Children's%20Hospital/CV.01.01%20(PT003)%20Maintaining%20Infusion%20Therapy.FINAL.14Jan16[6246][8629].pdf)
REFERENCES


https://www.cincinnatichildrens.org/health/c/cleft-palate-repair

https://www.cincinnatichildrens.org/health/c/cleft-lip-repair