Fast Track Composite Resection Clinical Pathway*

Site Applicability

Vancouver General Hospital (VGH)

UBC Hospital

Pathway Patient Goals

Inclusion Criteria

Home Discharge Criteria

Instructions

1. Review pathway once per shift for patient care goals and expected outcomes
2. Do not document on this pathway, complete documentation in the Electronic Health Record (Cerner) or paper chart as per policy

*Previously titled “Clinical Pathway Head and Neck Reconstructive Surgery”

POST – OR Day	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Orient to unit & hospital routine • Reinforce pre-op teaching (ICOUGH protocol, early mobilization)) • Review pain scale • Patient and family understand outcome of surgery
Tests	• CXR to confirm entriflex placement prior to commencing tube feeds • Standing orders for enteral feeds • Standing orders for blood work
Consults	• Dietitian for initiating enteral tube feeds
Assessments/ Treatments	• NO circumferential or restricting ties around neck & face • Alert & oriented X3 • Vital signs as per postop protocol (R=12-20/min, HR= 60-100/min, SBP=90-150) • Chest auscultation q4h prn (breath sounds clear, resps easy & regular, no SOB, no resp distress) • Pulse oximeter q4h prn (FiO2 >93%, maintain with oxygen therapy) • Assess for minimal neck swelling (no airway obstruction/hematoma) • Assess neck incision, well approximated, no redness, no swelling, no cellulitis • Monitor/empty HMV drainage Q6h prn (no sanguinous/milky drainage) • Strip HMV drain Q6h prn • Staple remover, suture scissors and suction at bedside at all times (tape to HOB) • Capillary glucose monitoring X72h as per Insulin SS for TPN/TF patients • Assess IV site (free of redness, swelling and pain)
Airway	• RT aware of patient (RE: tracheostomy) • Emergency tracheostomy equipment at bedside/accompany patient at all times • Airway patent, can clear own secretions via NS instilling and coughing • RT to measure cuff pressure Q shift • Perform Tracheostomy care Q shift and PRN • Instill with NS prn (liquefy secretions) • Tracheostomy tube insitu & secure • Note tracheostomy tube size and type • Tracheostomy sign at the HOB • Cuff inflated • Document frequency of suctioning required on each shift

FLAP, FLAP DONOR SITE, STSG	• FLAP
	  ○ Note type of flap (external skin paddle, intra-oral skin paddle or no visible skin paddle)
	  ○ Monitor flap perfusion as ordered (assess CWMS, absence of venous congestion, flap edges approximated)
	  ○ Elevate HOB to 30 degrees
	  ○ Bair hugger X72h (setting at 38 degrees)
	  ○ NS oral rinses Q4h and prn while awake (if applicable i.e. oral flap)
	• FLAP DONOR SITE
	  ○ Note type of flap donor site (radial forearm, fibula, ALT, scapula, other)

	○ Note condition of flap donor site (covered with STSG or closed primarily) ○ Monitor NVS as ordered ○ Elevate flap donor site on pillow to prevent edema ○ Slab cast intact until POD 5 (if applicable) • STSG DONOR SITE ○ Note type of dressing (Tegaderm or Xerform) ○ See orders for care
Activity	• Elevate HOB 30 degrees • Bedrest • ICOUGH protocol followed • Avoid hyperflexion of flap donor site • See orders for head turn restrictions • PT to see for specific exercises, see orders (if applicable) • Plantar dorsi-flexion exercises Q1h while awake
Medications/ Pain	• POPS for analgesia (PCA) and antiemetics • Pain assessment as per protocol • Sedation level within norm • Apply Polysporin to incisions BID • ASA PR given in PACU
Nutrition	• NPO • Entriflex feeding tube insitu & secured • Enteral tube feeding as ordered • Assess abdominal status Q4h prn (soft, non distended, bowel sounds audible X4) • Absence of nausea and vomiting
Elimination	• Foley catheter to straight drainage as per CAUTI protocol, see orders for care
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes	• Airway patent; tracheostomy tube insitu, secretions clear • Vital signs within normal range • Flap, flap donor site, STSG donor site perfusing well and approximated • Drain output/colour within normal range • Patient states pain is controlled • Tolerates enteral feeds • Nausea controlled • Fluids & electrolytes balanced • IV site satisfactory and patent • Patient describes anxiety as acceptable

Post-op Day 1	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Patient and family understand outcome of surgery • Reinforce deep breathing, coughing and leg exercises • Provide and review "Going Home After Head and Neck Reconstructive Surgery" pamphlet with patient and family • Review pain scale/management • Review feeding schedule • Patient and family understand emergency protocol for airway obstruction; importance of tracheostomy care
Tests	• Standing orders for enteral feeds • Standing orders for blood work
Consults	• Dietitian for initiating enteral tube feeds • Psychiatry if applicable (ETOH withdrawal/agitation etc)
Assessments/ Treatments	• NO circumferential or restricting ties around neck & face • Alert & oriented X3 • Vital signs as per postop protocol (R=12-20/min, HR= 60-100/min, SBP=90-150) • Chest auscultation q4h prn (breath sounds clear, resps easy & regular, no SOB, no resp distress) • Pulse oximeter q4h prn (FiO2 >93%, maintain with oxygen therapy) • Assess for minimal neck swelling (no airway obstruction/hematoma) • Assess neck incision, well approximated, no redness, no swelling, no cellulitis • Monitor/empty HMV drainage Q6h prn (no sanguinous/milky drainage) • Strip HMV drain Q6h prn • Staple remover, suture scissors and suction at bedside at all times (tape to HOB) • Capillary glucose monitoring X72h as per Insulin SS for TPN/TF patients • Assess IV site (free of redness, swelling and pain)
Airway	• RT following patient (RE: tracheostomy) • Emergency tracheostomy equipment at bedside/accompany patient at all times • Airway patent, can clear own secretions via NS instilling and coughing • Perform Tracheostomy care Q shift and PRN • Instill with NS prn (liquefy secretions) • Tracheostomy tube insitu & secure • Note tracheostomy tube size and type • Tracheostomy sign at the HOB • Cuff deflation trials (update Trach sign @ HOB) • Document frequency of suctioning required on each shift

FLAP, FLAP DONOR SITE, STSG	• FLAP
	  ○ Note type of flap (external skin paddle, intra-oral skin paddle or no visible skin paddle)
	  ○ Monitor flap perfusion as ordered (assess CWMS, absence of venous congestion, flap edges approximated)
	  ○ Elevate HOB to 30 degrees
	  ○ Bair hugger X72h (setting at 38 degrees)
	  ○ NS oral rinses Q4h and prn while awake (if applicable i.e. oral flap)

	• FLAP DONOR SITE
	  ○ Note type of flap donor site (Radial forearm, fibula, ALT, scapula, other)
	  ○ Note condition of flap donor site (covered with STSG or closed primarily)
	  ○ Monitor NVS as ordered
	  ○ Elevate flap donor site on pillow to prevent edema
	  ○ Slab cast intact until POD 5 (if applicable)
	• STSG DONOR SITE
	  ○ Note type of dressing (Tegaderm or Xeroform)
	  ○ See orders for care

Activity	• Elevate HOB 30 degrees • AAT • ICOUGH protocol followed • Avoid hyperflexion of flap donor site • See orders for head turn restrictions • PT to see for specific exercises, see orders (if applicable) • Plantar dorsi-flexion exercises Q1h while awake
Medications/ Pain	• POPS for analgesia (PCA), initiate weaning protocol • Provide analgesia via entriflex • Antiemetics prn • Pain assessment as per protocol • Sedation level within norm • Apply Polysporin to incisions BID • ASA PO/NG daily initiated
Nutrition	• NPO • Entriflex feeding tube insitu & secured • Enteral tube feeding as per dietitian orders • Assess abdominal status Q4h prn (soft, non distended, bowel sounds audible X4) • Absence of nausea and vomiting
Elimination	• Remove Foley catheter • Document if patient passing flatus • Note date of return of bowel function
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes	• Airway patent; tracheostomy tube insitu, secretions clear • Vital signs within normal range • Flap, flap donor site, STSG donor site perfusing well and approximated • Drain output/colour within normal range • Patient states pain is controlled • Tolerates enteral feeds • Nausea controlled • Fluids & electrolytes balanced • IV site satisfactory and patent • Ambulating as tolerated with assistance • Patient describes anxiety as acceptable

Post-op Day 2	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Reinforce deep breathing, coughing and leg exercises • Review "Going Home After Head and Neck Reconstructive Surgery" pamphlet with patient and family • Review pain scale/management • Review feeding schedule • Patient and family understand emergency protocol for airway obstruction; importance of tracheostomy care • Review tracheostomy care; process of cuff deflation trials
Tests	• Standing orders for enteral feeds • Standing orders for blood work
Consults	• Psychiatry if applicable (ETOH withdrawal/agitation, etc)
Assessments/ Treatments	• NO circumferential or restricting ties around neck & face • Alert & oriented X3 • Vital signs as per postop protocol (R=12-20/min, HR= 60-100/min, SBP=90-150) • Chest auscultation q4h prn (breath sounds clear, resps easy & regular, no SOB, no resp distress) • Pulse oximeter q4h prn (FiO2 >93%, maintain with oxygen therapy) • Assess for minimal neck swelling (no airway obstruction/hematoma) • Assess neck incision, well approximated, no redness, no swelling, no cellulitis • Monitor/empty HMV drainage Q6h prn (no sanguinous/milky drainage) • Strip HMV drain Q6h prn • Possible HMV removal, see MD orders • Staple remover, suture scissors and suction at bedside at all times (tape to HOB) • Capillary glucose monitoring X72h as per Insulin SS for TPN/TF patients • Assess IV site (free of redness, swelling and pain)
Airway	• RT following patient (RE: tracheostomy) • Emergency tracheostomy equipment at bedside/accompany patient at all times • Airway patent, can clear own secretions via NS instilling and coughing • Perform Tracheostomy care Q shift and PRN • Instill with NS prn (liquefy secretions) • Tracheostomy tube insitu & secure • Note tracheostomy tube size and type • Tracheostomy sign at the HOB • Cuff deflation trials (update Trach sign @ HOB) • Document frequency of suctioning required on each shift

FLAP, FLAP DONOR SITE, STSG	• FLAP
	  ○ Note type of flap (external skin paddle, intra-oral skin paddle or no visible skin paddle)
	  ○ Monitor flap perfusion as ordered (assess CWMS, absence of venous congestion, flap edges approximated)
	  ○ Elevate HOB to 30 degrees
	  ○ Bair hugger X72h (setting at 38 degrees)

	○ NS oral rinses Q4h and prn while awake (if applicable i.e. oral flap) • FLAP DONOR SITE ○ Note type of flap donor site (Radial forearm, fibula, ALT, scapula, other) ○ Note condition of flap donor site (covered with STSG or closed primarily) ○ Monitor NVS as ordered ○ Elevate flap donor site on pillow to prevent edema ○ Slab cast intact until POD 5 (if applicable) • STSG DONOR SITE ○ Note type of dressing (Tegaderm or Xeroform) ○ See orders for care
Activity	• Elevate HOB 30 degrees • AAT • ICOUGH protocol followed • Avoid hyperflexion of flap donor site • See orders for head turn restrictions • PT to see for specific exercises, see orders (if applicable) • Plantar dorsi-flexion exercises Q1h while awake
Medications/ Pain	• POPS signed off • Provide analgesia via entriflex • Antiemetics prn • Pain assessment as per protocol • Sedation level within norm • Apply Polysporin to incisions BID
Nutrition	• NPO • Entriflex feeding tube insitu & secured • Enteral tube feeding as per dietitian orders • Assess abdominal status Q4h prn (soft, non distended, bowel sounds audible X4) • Absence of nausea and vomiting
Elimination	• Adequate urine output >30ml/h • Document if patient passing flatus • Note date, frequency, and quality of last BM (normal or diarrhea)
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes	• Airway patent; tracheostomy tube insitu, secretions clear • Vital signs within normal range • Flap, flap donor site, STSG donor site perfusing well and approximated • Drain output/colour within normal range • Patient states pain is controlled • Tolerates enteral feeds • Nausea controlled • Fluids & electrolytes balanced • IV site satisfactory and patent • Ambulating as tolerated with assistance • Patient describes anxiety as acceptable

Post-op Day 3	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Reinforce deep breathing, coughing and leg exercises • Review "Going Home After Head and Neck Reconstructive Surgery" pamphlet with patient and family • Review pain scale/management • Review feeding schedule • Encourage patient to participate in their own care • Review tracheostomy care, process of downsizing tracheostomy tube
Tests	• Standing orders for enteral feeds • Standing orders for blood work
Consults	
Assessments/ Treatments	• NO circumferential or restricting ties around neck & face • Alert & oriented X3 • Vital signs as per postop protocol (R=12-20/min, HR= 60-100/min, SBP=90-150) • Chest auscultation q4h prn (breath sounds clear, resps easy & regular, no SOB, no resp distress) • Pulse oximeter q6h prn, titrate oxygen for humidification only • Assess for minimal neck swelling (no airway obstruction/hematoma) • Assess neck incision, well approximated, no redness, no swelling, no cellulitis • Monitor/empty HMV drainage Q6h prn (no sanguinous/milky drainage) • Strip HMV drain Q6h prn • Possible HMV removal, see physician orders • Staple remover, suture scissors and suction at bedside at all times (tape to HOB) • Discontinue capillary blood glucose monitoring if normal or patient not diabetic • Assess IV site (free of redness, swelling and pain)
Airway	• RT following patient (RE: tracheostomy) • Emergency tracheostomy equipment at bedside/accompany patient at all times • Airway patent, can clear own secretions via NS instilling and coughing • Perform Tracheostomy care Q shift and PRN • Instill with NS prn (liquefy secretions) • Tracheostomy tube insitu & secure • Note tracheostomy tube size and type • Tracheostomy sign at the HOB • Physician to downsize tracheostomy tube (update Trach sign @ HOB) • Document frequency of suctioning required on each shift

FLAP, FLAP DONOR SITE, STSG	• FLAP
	  ○ Note type of flap (external skin paddle, intra-oral skin paddle or no visible skin paddle)
	  ○ Monitor flap perfusion as per orders (assess CWMS, absence of venous congestion, flap edges approximated)
	  ○ Elevate HOB to 30 degrees
	  ○ Discontinue Bair hugger
	  ○ NS oral rinses Q4h and prn while awake (if applicable i.e. oral flap)

	• FLAP DONOR SITE
	  ○ Note type of flap donor site (Radial forearm, fibula, ALT, scapula, other)
	  ○ Note condition of flap donor site (covered with STSG or closed primarily)
	  ○ Monitor NVS as per orders
	  ○ Elevate flap donor site on pillow to prevent edema
	  ○ Slab cast intact until POD 5 (if applicable)
	• STSG DONOR SITE
	  ○ Note type of dressing (Tegaderm or Xeroform)
	  ○ See orders for care

Activity	• Elevate HOB 30 degrees • AAT • ICOUGH protocol followed • Avoid hyperflexion of flap donor site • See orders for head turn restrictions • PT to see for specific exercises, see orders (if applicable) • Plantar dorsi-flexion exercises Q1h while awake
Medications/ Pain	• Analgesia prn • Antiemetics prn • Pain assessment as per protocol • Sedation level within norm • Apply Polysporin to incisions BID
Nutrition	• NPO • Entriflex feeding tube insitu & secured • Enteral tube feeding as per dietitian orders • Assess abdominal status Q4h prn (soft, non distended, bowel sounds audible X4) • Absence of nausea and vomiting
Elimination	• Adequate urine output >30ml/h • Document if patient passing flatus • Note date, frequency, and quality of last BM (normal or diarrhea)
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes	• Airway patent; tracheostomy tube insitu, secretions clear • Vital signs within normal range • Flap, flap donor site, STSG donor site perfusing well and approximated • Drain output/colour within normal range • Patient states pain is controlled • Tolerates enteral feeds • Nausea controlled • Fluids & electrolytes balanced • IV site satisfactory and patent • Ambulating as tolerated with assistance • Patient describes anxiety as acceptable

Post-op Day 4	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Reinforce deep breathing, coughing and leg exercises • Review "Going Home After Head and Neck Reconstructive Surgery" pamphlet with patient and family • Review pain scale/management • Review feeding schedule • Encourage patient to participate in their own care • Review tracheostomy care, process of downsizing tracheostomy tube
Tests	• Standing orders for enteral feeds • Standing orders for blood work
Consults	
Assessments/ Treatments	• NO circumferential or restricting ties around neck & face • Alert & oriented X3 • Vital signs as per postop protocol (R=12-20/min, HR= 60-100/min, SBP=90-150) • Chest auscultation q4h prn (breath sounds clear, resps easy & regular, no SOB, no resp distress) • Pulse oximeter q6h prn, titrate oxygen for humidification only • Assess for minimal neck swelling (no airway obstruction/hematoma) • Assess neck incision, well approximated, no redness, no swelling, no cellulitis • Staple remover, suture scissors and suction at bedside at all times (tape to HOB) • Assess IV site (free of redness, swelling and pain)
Airway	• RT following patient (RE: tracheostomy) • Emergency tracheostomy equipment at bedside/accompany patient at all times • Airway patent, can clear own secretions • Perform Tracheostomy care Q shift and PRN • Tracheostomy tube insitu & secure • Note tracheostomy tube size and type • Tracheostomy sign at the HOB • Corking trials

FLAP, FLAP DONOR SITE, STSG	• FLAP
	  ○ Note type of flap (external skin paddle, intra-oral skin paddle or no visible skin paddle)
	  ○ Monitor flap perfusion as per orders (assess CWMS, absence of venous congestion, flap edges approximated)
	  ○ Elevate HOB to 30 degrees
	  ○ NS oral rinses Q4h and prn while awake (if applicable i.e. oral flap)
	• FLAP DONOR SITE
	  ○ Note type of flap donor site (Radial forearm, fibula, ALT, scapula, other)
	  ○ Note condition of flap donor site (covered with STSG or closed primarily)
	  ○ Monitor NVS as per orders
	  ○ Elevate flap donor site on pillow to prevent edema
	  ○ Slab cast intact until POD 5 (if applicable)

	• STSG DONOR SITE
	  ○ Note type of dressing (Tegaderm or Xeroform)
	  ○ See orders for care

Activity	• Elevate HOB 30 degrees • AAT • ICOUGH protocol followed • Avoid hyperflexion of flap donor site • See orders for head turn restrictions • PT to see for specific exercises, see orders (if applicable) • Plantar dorsi-flexion exercises Q1h while awake
Medications/ Pain	• Analgesia prn • Antiemetics prn • Pain assessment as per protocol • Sedation level within norm • Apply Polysporin to incisions BID
Nutrition	• NPO • Entriflex feeding tube insitu & secured • Enteral tube feeding as per dietitian orders • Assess abdominal status Q4h prn (soft, non distended, bowel sounds audible X4) • Absence of nausea and vomiting
Elimination	• Adequate urine output >30ml/h • Document if patient passing flatus • Note date, frequency, and quality of last BM (normal or diarrhea)
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes	• Airway patent; tracheostomy tube insitu, secretions clear • Vital signs within normal range • Flap, flap donor site, STSG donor site perfusing well and approximated • Patient states pain is controlled • Tolerates enteral feeds • Nausea controlled • Fluids & electrolytes balanced • IV site satisfactory and patent • Ambulating as tolerated with assistance • Patient describes anxiety as acceptable

Post-op Day 5	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Reinforce deep breathing, coughing and leg exercises • Review "Going Home After Head and Neck Reconstructive Surgery" pamphlet with patient and family • Review pain scale/management • Review feeding schedule • Encourage patient to participate in their own care • Review tracheostomy care, process of downsizing tracheostomy tube
Tests	• Standing orders for enteral feeds
Consults	
Assessments/ Treatments	• NO circumferential or restricting ties around neck & face • Alert & oriented X3 • Vital signs as per postop protocol (R=12-20/min, HR= 60-100/min, SBP=90-150) • Chest auscultation q4h prn (breath sounds clear, resps easy & regular, no SOB, no resp distress) • Pulse oximeter q6h prn, titrate oxygen for humidification only • Assess for minimal neck swelling (no airway obstruction/hematoma) • Assess neck incision, well approximated, no redness, no swelling, no cellulitis • Staple remover, suture scissors and suction at bedside at all times (tape to HOB) • Assess IV site (free of redness, swelling and pain)
Airway	• RT following patient (RE: tracheostomy) • Emergency tracheostomy equipment at bedside/accompany patient at all times • Airway patent, can clear own secretions • Note tracheostomy tube size and type • Tracheostomy sign at the HOB • Physician to decannulate +/- suture trach site (update Trach sign @ HOB)

FLAP, FLAP DONOR SITE, STSG	• FLAP
	  ○ Note type of flap (external skin paddle, intra-oral skin paddle or no visible skin paddle)
	  ○ Monitor flap perfusion as per orders (assess CWMS, absence of venous congestion, flap edges approximated)
	  ○ Elevate HOB to 30 degrees
	  ○ NS oral rinses Q4h and prn while awake (if applicable i.e. oral flap)
	• FLAP DONOR SITE
	  ○ Note type of flap donor site (Radial forearm, fibula, ALT, scapula, other)
	  ○ Note condition of flap donor site (covered with STSG or closed primarily)
	  ○ Monitor NVS as per orders
	  ○ Elevate flap donor site on pillow to prevent edema
	  ○ Slab cast removed by physician
	  ○ Primary closure-leave open to air

	○ Covered with STSG-clean with NS, apply jelonet dressing, abdominal pad and kling • STSG DONOR SITE ○ Note type of dressing (Tegaderm or Xeroform) ○ See orders for care
Activity	• Elevate HOB 30 degrees • AAT • ICOUGH protocol followed • Avoid hyperflexion of flap donor site • See orders for head turn restrictions • PT to see for specific exercises, see orders (if applicable) • Independent with personal care • Mobilizing independently
Medications/ Pain	• Analgesia prn • Antiemetics prn • Pain assessment as per protocol • Sedation level within norm • Apply Polysporin to incisions BID
Nutrition	• NPO • Entriflex feeding tube insitu & secured • Enteral tube feeding as per dietitian orders • Assess abdominal status Q4h prn (soft, non distended, bowel sounds audible X4) • Absence of nausea and vomiting
Elimination	• Adequate urine output >30ml/h • Document if patient passing flatus • Note date, frequency, and quality of last BM (normal or diarrhea)
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes	• Airway patent; patient decannulated • Vital signs within normal range • Flap, flap donor site, STSG donor site perfusing well and approximated • Patient states pain is controlled • Tolerates enteral feeds • Nausea controlled • Fluids & electrolytes balanced • IV site satisfactory and patent • Patient returning to baseline level of function • Patient describes anxiety as acceptable

Post-op Day 6	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Review "Going Home After Head and Neck Reconstructive Surgery" pamphlet with patient and family • Review pain scale/management • Review feeding schedule • Encourage patient to participate in their own care • Review importance of mouth/flap care • Discuss potential needs upon discharge (PT/OT assessments for home supports and home care nursing if applicable)
Tests	• Standing orders for enteral feeds
Consults	• SLP consult for swallowing if required (see orders)
Assessments/ Treatments	• NO circumferential or restricting ties around neck & face • Alert & oriented X3 • Vital signs as per postop protocol (R=12-20/min, HR= 60-100/min, SBP=90-150) • Chest auscultation q4h prn (breath sounds clear, resps easy & regular, no SOB, no resp distress) • Pulse oximeter q6h prn, wean oxygen, on room air • Assess for minimal neck swelling (no airway obstruction/hematoma) • Assess neck incision, well approximated, no redness, no swelling, no cellulitis • Staple remover, suture scissors and suction at bedside at all times (tape to HOB) • Assess IV site (free of redness, swelling and pain)
Airway	• Emergency tracheostomy equipment at bedside/accompany patient at all times • Airway patent, can clear own secretions • Instruct patient to apply firm pressure to trach site (when coughing/speaking)-helps seal/close trach site

FLAP, FLAP DONOR SITE, STSG	• FLAP
	  ○ Note type of flap (external skin paddle, intra-oral skin paddle or no visible skin paddle)
	  ○ Monitor flap perfusion as per orders (assess CWMS, absence of venous congestion, flap edges approximated)
	  ○ Elevate HOB to 30 degrees
	  ○ NS oral rinses Q4h and prn while awake (if applicable i.e. oral flap)
	• FLAP DONOR SITE
	  ○ Note type of flap donor site (Radial forearm, fibula, ALT, scapula, other)
	  ○ Note condition of flap donor site (covered with STSG or closed primarily)
	  ○ Monitor NVS as per orders
	  ○ Elevate flap donor site on pillow to prevent edema
	  ○ Primary closure- leave open to air
	  ○ Covered with STSG- clean with NS, apply jelonet dressing, abdominal pad and kling
	• STSG DONOR SITE
	  ○ Note type of dressing (Tegaderm or Xeroform)
	  ○ See orders for care

Activity	• Elevate HOB 30 degrees • AAT • ICOUGH protocol followed • Avoid hyperflexion of flap donor site • See orders for head turning restrictions • PT to see for specific exercises, see orders (if applicable) • Independent with personal care • Mobilizing independently
Medications/ Pain	• Analgesia prn • Antiemetics prn • Pain assessment as per protocol • Sedation level within norm • Apply Polysporin to incisions BID
Nutrition	• SLP (if required) • Start oral feeds, as per physician orders • Start calorie counts X 3 days • Entriflex feeding tube insitu & secured • Enteral tube feeding as per dietitian orders • Assess abdominal status Q4h prn (soft, non distended, bowel sounds audible X4) • Absence of nausea and vomiting
Elimination	• Adequate urine output >30ml/h • Document if patient passing flatus • Note date, frequency, and quality of last BM (normal or diarrhea)
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes	• Airway patent • Vital signs within normal range • Flap, flap donor site, STSG donor site perfusing well and approximated • Patient states pain is controlled • Tolerating oral diet • Tolerates enteral feeds • Nausea controlled • Fluids & electrolytes balanced • IV site satisfactory and patent • Patient returning to baseline level of function • Patient describes anxiety as acceptable

Post-op Day 7	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Review "Going Home After Head and Neck Reconstructive Surgery" pamphlet with patient and family • Explain swallowing process i.e. if SLP assessment required • Review importance of flap/ mouth care • Discuss potential needs upon discharge (PT/OT assessments for home supports and home care nursing if applicable) • Plan home in 24-72 hours
Tests	• Standing orders for enteral feeds, if still required
Consults	• SLP consult for swallowing if required (see orders)
Assessments/ Treatments	• NO circumferential or restricting ties around neck & face • Alert & oriented X3 • Vital signs as per postop protocol (R=12-20/min, HR= 60-100/min, SBP=90-150) • Chest auscultation q6h prn (breath sounds clear, resps easy & regular, no SOB, no resp distress) • Pulse oximeter q6h prn, on room air • Assess for minimal neck swelling (no airway obstruction/hematoma) • Assess neck incision, well approximated, no redness, no swelling, no cellulitis • For non-radiated patients, discontinue all staples, if approved by physician • Staple remover, suture scissors and suction at bedside at all times (tape to HOB) • Assess IV site (free of redness, swelling and pain)
Airway	• Emergency tracheostomy equipment at bedside/accompany patient at all times • Airway patent, can clear own secretions • Instruct patient to apply firm pressure to trach site (when coughing/speaking)-helps seal/close trach site

FLAP, FLAP DONOR SITE, STSG	• FLAP
	  ○ Note type of flap (external skin paddle, intra-oral skin paddle or no visible skin paddle)
	  ○ Monitor flap perfusion as per orders (assess CWMS, absence of venous congestion, flap edges approximated)
	  ○ Elevate HOB to 30 degrees
	  ○ NS oral rinses Q4h and prn while awake (if applicable i.e. oral flap)
	• FLAP DONOR SITE
	  ○ Note type of flap donor site (Radial forearm, fibula, ALT, scapula, other)
	  ○ Note condition of flap donor site (covered with STSG or closed primarily)
	  ○ Monitor NVS as per orders
	  ○ Elevate flap donor site on pillow to prevent edema
	  ○ Primary closure- leave open to air
	  ○ Covered with STSG- clean with NS, apply jelonet dressing, abdominal pad and kling

	• STSG DONOR SITE
	  ○ Note type of dressing (Tegaderm or Xeroform)
	  ○ Remove Tegaderm (if applicable), leave exposed, cover with “save a day tray” to avoid contact with linen.
	  ○ See orders for care

Activity	• Elevate HOB 30 degrees • AAT • ICOUGH protocol followed • Avoid hyperflexion of flap donor site • See orders for head turn restrictions • PT to see for specific exercises, see orders (if applicable) • Independent with personal care • Mobilizing independently
Medications/ Pain	• Analgesia prn • Antiemetics prn • Pain assessment as per protocol • Sedation level within norm • Apply Polysporin to incisions BID
Nutrition	• SLP (if required) • Start oral feeds, as per physician orders • Start calorie counts X 3 days • Entriflex feeding tube insitu & secured • Enteral tube feeding as per dietitian orders • Assess abdominal status Q4h prn (soft, non distended, bowel sounds audible X4) • Absence of nausea and vomiting
Elimination	• Adequate urine output >30ml/h • Document if patient passing flatus • Note date, frequency, and quality of last BM (normal or diarrhea)
Anxiety/Fear	• Nurse will anticipate and discuss patient’s/families concerns and fears related to surgery • Information needs met
Desired Outcomes	• Airway patent • Vital signs within normal range • Flap, flap donor site, STSG donor site perfusing well and approximated • Patient states pain is controlled • Tolerating oral diet • Tolerates enteral feeds if applicable • Nausea controlled • Fluids & electrolytes balanced • IV site satisfactory and patent • Patient returning to baseline level of function • Patient describes anxiety as acceptable

Post-op Day 8	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Review "Going Home After Head and Neck Reconstructive Surgery" pamphlet with patient and family • Explain swallowing process i.e. if SLP assessment required • Explain process of nutritional intake • Review importance of flap/ mouth care • Reinforce importance of tracheostomy site closure • Discuss potential needs upon discharge (PT/OT assessments for home supports and home care nursing if applicable) • Plan home in 24-48 hours
Tests	• Standing orders for enteral feeds, if still required
Consults	• SLP consult for swallowing if required (see orders)
Assessments/ Treatments	• NO circumferential or restricting ties around neck & face • Alert & oriented X3 • Vital signs as per postop protocol (R=12-20/min, HR= 60-100/min, SBP=90-150) • Chest auscultation q6h prn (breath sounds clear, resps easy & regular, no SOB, no resp distress) • Pulse oximeter q6h prn, on room air • Assess for minimal neck swelling (no airway obstruction/hematoma) • Assess neck incision, well approximated, no redness, no swelling, no cellulitis • Staple remover, suture scissors and suction at bedside at all times (tape to HOB) • Assess IV site (free of redness, swelling and pain) • Saline lock IV
Airway	• Emergency tracheostomy equipment at bedside/accompany patient at all times • Airway patent, can clear own secretions • Trach site sealed and healing • Instruct patient to apply firm pressure to trach site (when coughing/speaking) – helps seal/close trach site • Trach site sutured by surgical team (if necessary)

FLAP, FLAP DONOR SITE, STSG	• FLAP
	  ○ Note type of flap (external skin paddle, intra-oral skin paddle or no visible skin paddle)
	  ○ Monitor flap perfusion as per orders (assess CWMS, absence of venous congestion, flap edges approximated)
	  ○ Elevate HOB to 30 degrees
	  ○ Patient independent NS oral rinses Q4h and prn while awake (if applicable i.e. oral flap)
	• FLAP DONOR SITE
	  ○ Note type of flap donor site (Radial forearm, fibula, ALT, scapula, other)

	○ Note condition of flap donor site (covered with STSG or closed primarily) ○ Monitor NVS as per orders ○ Elevate flap donor site on pillow to prevent edema ○ Primary closure- leave open to air ○ Covered with STSG- clean with NS, apply jelonet dressing, abdominal pad and kling. Open to air if dry. • STSG DONOR SITE ○ Note type of dressing (Tegaderm or Xeroform) ○ See orders for care
Activity	• Elevate HOB 30 degrees • AAT • ICOUGH protocol followed • Avoid hyperflexion of flap donor site • See orders for head turn restrictions • PT to see for specific exercises, see orders (if applicable) • Independent with personal care • Mobilizing independently
Medications/ Pain	• Analgesia prn • Antiemetics prn • Pain assessment as per protocol • Apply Polysporin to incisions BID
Nutrition	• SLP (if required) • Start oral feeds, as per physician orders • Start calorie counts X 3 days • Enteral tube feeds discontinued if patient eating well • Entriflex tube removed, as per physician orders • Assess abdominal status Q4h prn (soft, non distended, bowel sounds audible X4) • Absence of nausea and vomiting
Elimination	• Adequate urine output >30ml/h • Document if patient passing flatus • Note date, frequency, and quality of last BM (normal or diarrhea)
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes	• Airway patent • Vital signs within normal range • Flap, flap donor site, STSG donor site perfusing well and approximated • Patient states pain is controlled • Tolerating oral diet if applicable • Nausea controlled • Fluids & electrolytes balanced • IV site satisfactory and patent • Mobilizing independently- at baseline level of function • Patient describes anxiety as acceptable

Post-op Day 9	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Review "Going Home After Head and Neck Reconstructive Surgery" pamphlet with patient and family • Reinforce importance of nutritional intake • Patient and family aware of home tube feeding protocol (if applicable) • Provide home tube feed teaching (if applicable) • Review importance of flap/ mouth care • Plan home today or tomorrow • Inform patient/family of all resources arranged upon discharge • Meets discharge criteria: safe with ADLs/ mobility; has adequate oral intake, flap, flap donor site, STSG donor site healing well. Home care arranged if applicable
Tests	
Consults	
Assessments/ Treatments	• NO circumferential or restricting ties around neck & face • Alert & oriented X3 • Vital signs as per postop protocol (R=12-20/min, HR= 60-100/min, SBP=90-150) • Chest auscultation q6h prn (breath sounds clear, resps easy & regular, no SOB, no resp distress) • Pulse oximeter q6h prn, on room air • Assess for minimal neck swelling (no airway obstruction/hematoma) • Assess neck incision, well approximated, no redness, no swelling, no cellulitis • Staple remover, suture scissors and suction at bedside at all times (tape to HOB) • Assess IV site (free of redness, swelling and pain) • Saline lock IV removed
Airway	• Emergency tracheostomy equipment at bedside/accompany patient at all times • Airway patent, can clear own secretions • Trach site sealed and healing • Trach site sutured by surgical team (if necessary)

FLAP, FLAP DONOR SITE, STSG	• FLAP
	  ○ Note type of flap (external skin paddle, intra-oral skin paddle or no visible skin paddle)
	  ○ Monitor flap perfusion as per orders (assess CWMS, absence of venous congestion, flap edges approximated)
	  ○ Elevate HOB to 30 degrees
	  ○ Patient independent NS oral rinses Q4h and prn while awake (if applicable i.e. oral flap)
	• FLAP DONOR SITE
	  ○ Note type of flap donor site (Radial forearm, fibula, ALT, scapula, other)
	  ○ Note condition of flap donor site (covered with STSG or closed primarily)

	○ Monitor NVS as per orders ○ Elevate flap donor site on pillow to prevent edema ○ Primary closure- leave open to air ○ Covered with STSG- clean with NS, apply jelonet dressing, abdominal pad and kling. Exposed to air if dry. • STSG DONOR SITE ○ Note type of dressing (Tegaderm or Xeroform) ○ See orders for care
Activity	• Elevate HOB 30 degrees • AAT • ICOUGH protocol followed • Avoid hyperflexion of flap donor site • See PPO for head turning restrictions • PT to see for specific exercises, see PPO (if applicable) • Independent with personal care • Mobilizing independently
Medications/ Pain	• Analgesics prn • Antiemetics prn • Pain assessment as per protocol • Apply Polysporin to incisions BID
Nutrition	• Tolerating oral feeds, as per physician orders • Assess abdominal status Q4h prn (soft, non distended, bowel sounds audible X4) • Absence of nausea and vomiting
Elimination	• Adequate urine output >30ml/h • Document if patient passing flatus • Note date, frequency, and quality of last BM (normal or diarrhea)
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes	• Airway patent • Vital signs within normal range • Flap, flap donor site, STSG donor site perfusing well and approximated • Patient states pain is controlled • Tolerating oral diet if applicable • Nausea controlled • Fluids & electrolytes balanced • IV site satisfactory and patent • Mobilizing independently- at baseline level of function

Post-op Day 10	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Review "Going Home After Head and Neck Reconstructive Surgery" pamphlet with patient and family • Reinforce importance of nutritional intake • Patient and family aware of home tube feeding protocol (if applicable) • Provide home tube feed teaching (if applicable) • Review importance of flap/ mouth care • Plan home today • Inform patient/family of all resources arranged upon discharge • Meets discharge criteria: safe with ADLs/ mobility; has adequate oral intake, flap, flap donor site, STSG donor site healing well. Home care arranged if applicable
Tests	
Consults	
Assessments/ Treatments	• NO circumferential or restricting ties around neck & face • Alert & oriented X3 • Vital signs as per postop protocol (R=12-20/min, HR= 60-100/min, SBP=90-150) • Chest auscultation q6h prn (breath sounds clear, resps easy & regular, no SOB, no resp distress) • Pulse oximeter q6h prn, on room air • Assess for minimal neck swelling (no airway obstruction/hematoma) • Assess neck incision, well approximated, no redness, no swelling, no cellulitis • Remove all staples, if approved by physician • Staple remover, suture scissors and suction at bedside at all times (tape to HOB) • Assess IV site (free of redness, swelling and pain) • Saline lock IV removed
Airway	• Emergency tracheostomy equipment at bedside/accompany patient at all times • Airway patent, can clear own secretions • Trach site sealed and healing • Trach site sutured by surgical team (if necessary)

FLAP, FLAP DONOR SITE, STSG	• FLAP
	  ○ Note type of flap (external skin paddle, intra-oral skin paddle or no visible skin paddle)
	  ○ Monitor flap perfusion as per orders (assess CWMS, absence of venous congestion, flap edges approximated)
	  ○ Elevate HOB to 30 degrees
	  ○ Patient independent NS oral rinses Q4h and prn while awake (if applicable i.e. oral flap)
	• FLAP DONOR SITE
	  ○ Note type of flap donor site (Radial forearm, fibula, ALT, scapula, other)
	  ○ Note condition of flap donor site (covered with STSG or closed primarily)
	  ○ Monitor NVS as per orders
	  ○ Elevate flap donor site on pillow to prevent edema

	○ Primary closure- leave open to air ○ Covered with STSG- clean with NS, apply jelonet dressing, abdominal pad and kling. Exposed to air if dry. • STSG DONOR SITE ○ Note type of dressing (Tegaderm or Xeroform) ○ See orders for care
Activity	• Elevate HOB 30 degrees • AAT • ICOUGH protocol followed • Avoid hyperflexion of flap donor site • See PPO for head turning restrictions • PT to see for specific exercises, see orders (if applicable) • Independent with personal care • Mobilizing independently
Medications/ Pain	• Analgesics prn • Antiemetics prn • Pain assessment as per protocol • Apply Polysporin to incisions BID
Nutrition	• Tolerating oral feeds, as per physician orders • Assess abdominal status Q4h prn (soft, non distended, bowel sounds audible X4) • Absence of nausea and vomiting
Elimination	• Adequate urine output >30ml/h • Document if patient passing flatus • Note date, frequency, and quality of last BM (normal or diarrhea)
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes	• Airway patent • Vital signs within normal range • Flap, flap donor site, STSG donor site perfusing well and approximated • Patient states pain is controlled • Tolerating oral diet if applicable • Nausea controlled • Fluids & electrolytes balanced • IV site satisfactory and patent • Mobilizing independently- at baseline level of function

Developed By

Effective Date:	
Posted Date:	
Last Revised:	
Last Reviewed:	
Approved By:	
	Endorsed By: **Final Sign Off:**
Owners:	VGH
	Developer Lead(s): • Clinical Nurse Educator, General/Vascular Surgery, OTL-HNS, GI Medicine, VGH