Fast Track Total Laryngectomy 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

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Day of Surgery POD 0	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Orient to unit & hospital routine • Reinforce pre-op teaching (deep breathing, coughing and leg exercises) Review pain scale/management • Review feeding schedule • Patient and family understand outcome of surgery
Tests	• **Chest x-ray prior** to commencing tube feeds (confirm Entriflex placement) • Standing orders for blood work • Standing orders for enteral feeds
Consults	• Dietitian for initiating enteral tube feeds (type of formula, rate, flushes) • Speech Language Pathologist - notified re: patient admission and possible voice prosthesis insertion POD #5
Assessments, Treatments	• Vital signs and temp as per post-op protocol (R12-20 min, P60-100, BP 90-150) • Level of consciousness (alert & oriented x 3) • Chest auscultation Q4hrs prn (breath sounds clear, resps easy/regular, Ø SOB, Ø resp distress) • Pulse oximeter Q4hrs prn (>93%) - Maintain oxygen saturation levels with oxygen therapy • Assess for minimal neck swelling (**no airway obstruction/hematoma**) • Entriflex tube in situ & secured (**do not remove** - required for insertion of voice prosthesis) • Monitor and empty hemovac drainage Q6hrs prn (**no sanguineous drainage**) • **Strip hemovac drain** Q1hr x 4hrs then Q6hrs prn • Normal saline mouth rinses Q4hrs & prn • Assess abdominal status Q4hrs prn (soft, non-distended, bowel sounds audible x 4) • Assess IV site (free of pain, swelling & redness) • Capillary blood glucose monitoring QID x 72 hours • **Staple remover, suture scissors and suction at bedside at all times (tape to HOB)** • **Emergency trach equipment at bedside/accompany patient at all times**
Adequate Airway	• **RT aware of patient (re: trach/stoma)** • Airway patent, can clear own secretions via NS instilling and coughing • Suctioning required as ordered on days and nights • **Trach care Q shift and PRN (if applicable) or insert Lary Tube and HME** • Trach size and type noted • Measure cuff pressure Q shift (mmHg) • Note if cuff inflated/deflated • Stoma care Q shift and PRN. If Lary tube & HME inserted, clean Lary Tube Q shift & change HME daily & prn • Assess stoma (Size of "Quarter") • Monitor stoma (patent; Ø narrowing) • secretions (clear, thin, loose) • skin integrity (free of redness, swelling, stoma edges well approximated, Ø crusting) • Instill with NS PRN if no Lary Tube with HME
Activity, Rest	• **Elevate HOB 30°** • Encourage deep breathing, coughing and leg exercises Q1hr while awake

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	• ICOUGH protocol followed • Plantar dorsi-flexion exercises Q1hr while awake • Dangle at edge of bed • Mobilize up to chair (~ 2 hours)
Medications	• Patient Controlled Analgesia (PCA) • Analgesics prn • Antiemetic prn
Pain	• Pain assessment Q1hr until pain is controlled then Q4hrs prn (pain adequately controlled) • Sedation level within norm
Nutrition	• **NPO** • Enteral tube feeding (as per dietitian's recommendations) • Nausea controlled
Elimination	• Foley catheter to straight drainage (urine output > 30 mls/hr) • Voiding adequately (urine output > 30 mls/hr) • Passing flatus
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes **WNL - within normal limits**	• Airway patent • Trach in situ (if applicable) • Stoma patent & approximated • Secretions clear; able to clear with instilling/suctioning • Vital signs and temp stable within normal range/satisfactory • Drain output/colour within normal range/satisfactory • Patient states pain is at an acceptable level • Nausea controlled • Tolerates enteral feeds • Fluids & electrolytes balanced • IV patent (site free from pain, swelling or redness) • Patient describes anxiety as acceptable

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Day of Surgery POD 1	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Patient and family understand outcome of surgery • Reinforce deep breathing, coughing and leg exercises • Review pain scale/management • **Review feeding schedule** • Patient and family understand emergency protocol for airway obstruction; importance of independence with stoma care • **Teaching of self stoma care initiated** • **Provide and review "Going Home After a Laryngectomy" pamphlet with patient/family**
Tests	• **Standing orders for blood work** • **Standing orders for enteral feeds**
Consults	• **Dietitian for** initiating enteral tube feeds (type of formula, rate, flushes) • Psychiatry (ETOH withdrawal/agitation etc.)
Assessments, Treatments	• Vital signs and temp as per post-op protocol (R12-20 min, P60-100, BP 90-150) • Level of consciousness (alert & oriented x 3) • Chest auscultation Q4hrs prn (breath sounds clear, resps easy/regular, Ø SOB, Ø resp distress) • Pulse oximeter Q4hrs prn (>93%) - Maintain oxygen saturation levels with oxygen therapy • Assess for minimal neck swelling (**no airway obstruction/hematoma**) • Entriflex tube in situ & secured (**do not remove** - required for insertion of voice prosthesis) • Monitor and empty hemovac drainage Q6hrs prn (**no sanguineous drainage**) • **Strip hemovac drain** Q1hr x 4hrs then Q6hrs prn • **Hemovac drain removed if approved by physician or senior resident** • Normal saline mouth rinses Q4hrs & prn • Assess abdominal status Q4hrs prn (soft, non-distended, bowel sounds audible x 4) • Assess IV site (free of pain, swelling & redness) • Capillary blood glucose monitoring QID x 72 hours • **Staple remover, suture scissors and suction at bedside at all times (tape to HOB)** • **Emergency trach equipment at bedside/accompany patient at all times**
Adequate Airway	• **RT following patient** • Airway patent, can clear own secretions via NS instilling and coughing • Suctioning required as ordered on days and nights • **Tracheostomy tube removed. Insert Lary Tube and HME** • **Stoma care Q shift and PRN. Lary tube cleaning Q shift and PRN. HME change daily/prn** • Assess stoma (Size of "Quarter") • Monitor stoma (patent; Ø narrowing) • secretions (clear, thin, loose) • skin integrity (free of redness, swelling, stoma edges well approximated, Ø crusting) • Instill with NS PRN if no Lary Tube with HME
Activity, Rest	• **Elevate HOB 30°** • Encourage deep breathing, coughing and leg exercises Q1hr while awake • ICOUGH protocol followed

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	• Dangle, sit in chair (~ 2 hours) • Assisting with am care • Ambulating with assistance
Medications	• Patient Controlled Analgesia (PCA) • Analgesics prn • Antiemetic prn • **Apply Polysporin BID to stoma edges** (promote healing & prevent crust formation)
Pain	• Pain assessment Q1hr until pain is controlled then Q4hrs prn (pain adequately controlled) • Sedation level within norm
Nutrition	• **NPO** • **Enteral tube feeding (as per dietitian's recommendations)** • **Nausea controlled**
Elimination	• Foley catheter to straight drainage (urine output > 30 mls/hr) • **Foley catheter removed** • Voiding adequately (urine output > 30 mls/hr) • Passing flatus
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes **WNL -** **within normal limits**	• Airway patent • Trach removed • Stoma patent & approximated • Secretions clear; able to clear with instilling/suctioning • Patient initiating self stoma care LaryTube insertion, cleaning & HME change • Vital signs and temp stable within normal range/satisfactory • Drain output/colour within normal range/satisfactory • Patient states pain is at an acceptable level • Nausea controlled • Tolerates enteral feeds • Fluids & electrolytes balanced • IV patent (site free from pain, swelling or redness) • Patient describes anxiety as acceptable • Ambulating with assistance

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Day of Surgery POD 2	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Reinforce deep breathing, coughing and leg exercises • Review pain scale/management • **Review feeding schedule** • Patient and family understand emergency protocol for airway obstruction**; importance of self stoma care** • **Self stoma care teaching in progress** • **Provide and review "Going Home After a Laryngectomy" pamphlet with patient/family**
Tests	• Standing orders for blood work • Standing orders for enteral feeds
Consults	• Psychiatry (ETOH withdrawal/agitation etc.)
Assessments, Treatments	• Vital signs and temp as per post-op protocol (R12-20 min, P60-100, BP 90-150) • Level of consciousness (alert & oriented x 3) • Chest auscultation Q4hrs prn (breath sounds clear, resps easy/regular, Ø SOB, Ø resp distress) • Pulse oximeter Q4hrs prn (>93%) - Maintain oxygen saturation levels with oxygen therapy • Assess for minimal neck swelling (**no airway obstruction/hematoma**) • Entriflex tube in situ & secured (**do not remove** - required for insertion of voice prosthesis) • Monitor and empty hemovac drainage Q6hrs prn (**no sanguineous drainage**) • **Strip hemovac drain** Q1hr x 4hrs then Q6hrs prn • **Hemovac drain removed if approved by physician or senior resident** • Normal saline mouth rinses Q4hrs & prn • Assess abdominal status Q4hrs prn (soft, non-distended, bowel sounds audible x 4) • Assess IV site (free of pain, swelling & redness) • Capillary blood glucose monitoring QID x 72 hours • **Staple remover, suture scissors and suction at bedside at all times (tape to HOB)** • **Emergency trach equipment at bedside/accompany patient at all times**
Adequate Airway	• Airway patent, can clear own secretions • **Stoma care Q shift and PRN. Lary tube cleaning Q shift and PRN. HME change daily/prn** • Monitor stoma (patent; Ø narrowing) • secretions (clear, thin, loose) • skin integrity (free of redness, swelling, stoma edges well approximated, Ø crusting) • Assess stoma (Size of "Quarter") • Instill with NS PRN if no Lary Tube with HME
Activity, Rest	• **Elevate HOB 30°** • Encourage deep breathing, coughing and leg exercises Q4hr while awake • ICOUGH protocol followed • Sit in chair(2-3 times/day) • Assisting with am care • Ambulating with assistance
Medications	• Patient Controlled Analgesia (PCA)

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	• Analgesics prn • Antiemetic prn • **Apply Polysporin BID to stoma edges** (promote healing & prevent crust formation)
Pain	• Pain assessment Q1hr until pain is controlled then Q4hrs prn (pain adequately controlled) • Sedation level within norm
Nutrition	• **NPO** • Enteral tube feeding (as per dietitian's recommendations) • Nausea controlled
Elimination	• Voiding adequately (urine output > 30 mls/hr) • Passing flatus • Note any normal BM • Note any diarrhea
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes **WNL -** **within normal limits**	• Airway patent • Stoma patent & approximated • Secretions clear; able to clear with instilling/suctioning • Patient assisting with self stoma care Lary Tube insertion, cleaning & HME change • Vital signs and temp stable within normal range/satisfactory • Drain output/colour within normal range/satisfactory • Patient states pain is at an acceptable level • Nausea controlled • Fluids & electrolytes balanced • IV patent (site free from pain, swelling or redness) • Patient describes anxiety as acceptable • Ambulating with assistance

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Day of Surgery POD 3	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Patient and family understand emergency protocol for airway obstruction**; importance of self stoma care** • Review feeding schedule • **Self stoma care teaching in progress** • **Review "Going Home After a Laryngectomy" pamphlet with patient/family** • Discuss potential needs upon discharge (home support/home care nursing) • **Discuss potential discharge plans in 2-3 days**
Tests	• Standing orders for blood work • Standing orders for enteral feeds
Consults	• Home Care Nursing notified re: stoma management
Assessments, Treatments	• Vital signs and temp as per post-op protocol (R12-20 min, P60-100, BP 90-150) • Level of consciousness (alert & oriented x 3) • Chest auscultation Q4hrs prn (breath sounds clear, resps easy/regular, Ø SOB, Ø resp distress) • Pulse oximeter Q4hrs prn (>93%) - Maintain oxygen saturation levels with oxygen therapy • **Wean to humidified air** • Assess for minimal neck swelling (**no airway obstruction/hematoma/cellulitis**) • Entriflex tube in situ & secured (**do not remove** - required for insertion of voice prosthesis) • Normal saline mouth rinses Q4hrs & prn • Assess abdominal status Q4hrs prn (soft, non-distended, bowel sounds audible x 4) • Assess IV site (free of pain, swelling & redness) • Capillary blood glucose monitoring QID x 72 hours • **Staple remover, suture scissors and suction at bedside at all times (tape to HOB)** • **Emergency trach equipment at bedside/accompany patient at all times**
Adequate Airway	• Airway patent, can clear own secretions • **Stoma care Q shift and PRN. Lary tube cleaning Q shift and PRN. HME change daily/prn** • Monitor stoma (patent; Ø narrowing) • secretions (clear, thin, loose) • skin integrity (free of redness, swelling, stoma edges well approximated, Ø crusting) • Assess stoma (Size of "Quarter") • Instill with NS PRN if no Lary Tube with HME
Activity, Rest	• Elevate HOB 30° • Encourage deep breathing, coughing and leg exercises Q4hr while awake • ICOUGH protocol followed • Up to chair (2-3 times/day) • Perform self care independently • Mobilizing independently
Medications	• Patient Controlled Analgesia (PCA) • Wean Patient Controlled Analgesia • Analgesics prn

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	• Antiemetic prn • **Apply Polysporin BID to stoma edges** (promote healing & prevent crust formation)
Pain	• Pain assessment Q1hr until pain is controlled then Q4hrs prn (pain adequately controlled) • Sedation level within norm
Nutrition	• **NPO** • Enteral tube feeding (as per dietitian's recommendations) • Nausea controlled
Elimination	• Voiding adequately (urine output > 30 mls/hr) • Passing flatus • Note any normal BM • Note any diarrhea
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes **WNL -** **within normal limits**	• Airway patent • Vital signs and temp stable within normal range/satisfactory • Stoma edges approximated • Patient assisting with self stoma care Lary Tube insertion, cleaning & HME change • Patient states pain is at an acceptable level • Nausea controlled • Fluids & electrolytes balanced • IV patent (site free from pain, swelling or redness) • Patient describes anxiety as acceptable • Ambulating independently – returning to baseline level of function

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Day of Surgery POD 4	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Patient and family understand emergency protocol for airway obstruction**; importance of self stoma care** • Review feeding schedule • **Self stoma care teaching in progress** • **Review "Going Home After a Laryngectomy" pamphlet with patient/family** • Discuss potential needs upon discharge (home support/home care nursing) • **Discuss potential discharge plans in 1-2 days**
Tests	• Standing orders for enteral feeds
Consults	• Home Care Nursing notified re: stoma management • Remind speech language pathologist to see patient tomorrow (re: voice prosthesis information/insertion)
Assessments, Treatments	• Vital signs and temp as per post-op protocol (R12-20 min, P60-100, BP 90-150) • Level of consciousness (alert & oriented x 3) • Chest auscultation Q4hrs prn (breath sounds clear, resps easy/regular, Ø SOB, Ø resp distress) • Pulse oximeter Q4hrs prn (>93%) - Maintain oxygen saturation levels with oxygen therapy • Assess for minimal neck swelling (**no airway obstruction/hematoma/cellulitis**) • Entriflex tube in situ & secured (do not remove - required for insertion of voice prosthesis) • Normal saline mouth rinses Q4hrs & prn • Assess abdominal status Q4hrs prn (soft, non-distended, bowel sounds audible x 4) • Assess IV site (free of pain, swelling & redness) • **Saline lock IV** • **Staple remover, suture scissors and suction at bedside at all times (tape to HOB)** • **Emergency trach equipment at bedside/accompany patient at all times**
Adequate Airway	• Airway patent, can clear own secretions • **Stoma care Q shift and PRN. Lary tube cleaning Q shift and PRN. HME change daily/prn** • Monitor stoma (patent; Ø narrowing) • secretions (clear, thin, loose) • skin integrity (free of redness, swelling, stoma edges well approximated, Ø crusting) • Assess stoma (Size of "Quarter") • **Independent with stoma care, Lary Tube insertion, cleaning BID & HME change daily/prn**
Activity, Rest	• **Elevate HOB 30°** • Encourage deep breathing, coughing and leg exercises Q4hr while awake • ICOUGH protocol followed • Up to chair (2-3 times/day) • Perform self care independently • Mobilizing independently
Medications	• Analgesics prn • Antiemetic prn

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	• **Apply Polysporin BID to stoma edges** (promote healing & prevent crust formation)
Pain	• Pain assessment Q1hr until pain is controlled then Q4hrs prn (pain adequately controlled) • Sedation level within norm
Nutrition	• **Sips of clear fluids only – NO straw/NO Jello** • Enteral tube feeding (as per dietitian's recommendations) • Nausea controlled
Elimination	• Voiding adequately (urine output > 30 mls/hr) • Passing flatus • Note any normal BM • Note any diarrhea
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes **WNL -** **within normal limits**	• Airway patent • Stoma patent and approximated • Secretions clear, able to clear with instilling • Vital signs and temp stable within normal range/satisfactory • Stoma edges approximated • Patient assisting with self stoma care Lary Tube insertion, cleaning & HME change • Patient states pain is at an acceptable level • Nausea controlled • Tolerating enteral feedings • Fluids & electrolytes balanced • Patient describes anxiety as acceptable • Mobilizing independently – returning to baseline level of function

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Day of Surgery POD 5	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Patient and family understand emergency protocol for airway obstruction**; importance of self stoma care** • **Patient and family able to demonstrate management & self care of stoma** • **Review "Going Home After a Laryngectomy" pamphlet with patient/family** • **Review feeding schedule** • **Seen by SLP** (Voice prosthesis information provided/inserted) • Seen by SLP (teaching done re: maintenance around voice prosthesis, how to insert red rubber catheter, medical alert bracelet) • **Plan discharge home today/tomorrow** • **Meets discharge criteria**: independent with stoma care, safe with ADL's/mobility, has adequate oral intake, seen by SLP and home care arranged
Tests	• Standing orders for enteral feeds
Consults	• Speech language pathologist (re: voice prosthesis information/insertion)
Assessments, Treatments	• Vital signs and temp as per post-op protocol (R12-20 min, P60-100, BP 90-150) • Level of consciousness (alert & oriented x 3) • Chest auscultation Q4hrs prn (breath sounds clear, resps easy/regular, Ø SOB, Ø resp distress) • Pulse oximeter Q4hrs prn (>93%) - Maintain oxygen saturation levels with oxygen therapy • Assess for minimal neck swelling (**no airway obstruction/hematoma/cellulitis**) • Entriflex tube in situ & secured (do not remove - required for insertion of voice prosthesis) • Normal saline mouth rinses Q4hrs & prn • Assess abdominal status Q4hrs prn (soft, non-distended, bowel sounds audible x 4) • Assess IV site (free of pain, swelling & redness) • **Saline lock IV** • **Saline lock removed** • **Staple remover, suture scissors and suction at bedside at all times (tape to HOB)** • **Emergency trach equipment at bedside/accompany patient at all times**
Adequate Airway	• Airway patent, can clear own secretions • **Stoma care Q shift and PRN. Lary tube cleaning Q shift and PRN. HME change daily/prn** • Monitor stoma (patent; Ø narrowing) • secretions (clear, thin, loose) • skin integrity (free of redness, swelling, stoma edges well approximated, Ø crusting) • Assess stoma (Size of "Quarter") • **Independent with stoma care, Lary Tube insertion, cleaning BID & HME change daily/prn**
Activity, Rest	• **Elevate HOB 30°** • Encourage deep breathing, coughing and leg exercises Q4hr while awake • ICOUGH protocol followed • Up to chair (2-3 times/day) • Perform self care independently

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	• Mobilizing independently
Medications	• Analgesics prn • Antiemetic prn • **Apply Polysporin BID to stoma edges** (promote healing & prevent crust formation)
Pain	• Pain assessment Q1hr until pain is controlled then Q4hrs prn (pain adequately controlled) • Sedation level within norm
Nutrition	• **Clear fluids with Resource 2.0/Boost (do not advance) – NO straw/NO Jello** • Enteral tube feeding (as per dietitian's recommendations) • Enteral feed discontinued as per MD/dietician • Nausea controlled
Elimination	• Voiding adequately (urine output > 30 mls/hr) • Passing flatus • Note any normal BM • Note any diarrhea
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes **WNL - within normal limits**	• Airway patent • Stoma patent and approximated • Secretions clear, able to clear with instilling • Vital signs and temp stable within normal range/satisfactory • Patient performing stoma care independently Lary Tube insertion, cleaning & HME change • Patient states pain is at an acceptable level • Nausea controlled • Tolerating enteral feedings • Fluids & electrolytes balanced • Patient describes anxiety as acceptable • Patient at baseline level of function

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Day of Surgery POD 6	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Patient and family understand emergency protocol for airway obstruction**; importance of self stoma care** • **Patient and family able to demonstrate management & self care of stoma** • **Review "Going Home After a Laryngectomy" pamphlet with patient/family** • **Review feeding schedule** • **Seen by SLP** (Voice prosthesis information provided/inserted) • Seen by SLP (teaching done re: maintenance around voice prosthesis, how to insert red rubber catheter, medical alert bracelet) • **Plan discharge home today/tomorrow** • **Meets discharge criteria**: independent with stoma care, safe with ADL's/mobility, has adequate oral intake, seen by SLP and home care arranged
Tests	• Standing orders for enteral feeds
Consults	• Speech language pathologist (re: voice prosthesis information/insertion)
Assessments, Treatments	• Vital signs and temp as per post-op protocol (R12-20 min, P60-100, BP 90-150) • Level of consciousness (alert & oriented x 3) • Chest auscultation Q4hrs prn (breath sounds clear, resps easy/regular, Ø SOB, Ø resp distress) • Pulse oximeter Q4hrs prn (>93%) - Maintain oxygen saturation levels with oxygen therapy • Assess for minimal neck swelling (**no airway obstruction/hematoma/cellulitis**) • Entriflex tube in situ & secured (do not remove - required for insertion of voice prosthesis) • Normal saline mouth rinses Q4hrs & prn • Assess abdominal status Q4hrs prn (soft, non-distended, bowel sounds audible x 4) • Assess IV site (free of pain, swelling & redness) • Saline lock IV • **Saline lock removed** • **Staple remover, suture scissors and suction at bedside at all times (tape to HOB)** • **Emergency trach equipment at bedside/accompany patient at all times**
Adequate Airway	• Airway patent, can clear own secretions • **Stoma care Q shift and PRN. Lary tube cleaning Q shift and PRN. HME change daily/prn** • Monitor stoma (patent; Ø narrowing) • secretions (clear, thin, loose) • skin integrity (free of redness, swelling, stoma edges well approximated, Ø crusting) • Assess stoma (Size of "Quarter") • **Independent with stoma care, Lary Tube insertion, cleaning BID & HME change daily/prn**
Activity, Rest	• Elevate HOB 30° • Encourage deep breathing, coughing and leg exercises Q4hr while awake • ICOUGH protocol followed • Up to chair (2-3 times/day) • Perform self care independently

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	• Mobilizing independently
Medications	• Analgesics prn • Antiemetic prn • **Apply Polysporin BID to stoma edges** (promote healing & prevent crust formation)
Pain	• Pain assessment Q1hr until pain is controlled then Q4hrs prn (pain adequately controlled) • Sedation level within norm
Nutrition	• **Clear fluids with Resource 2.0/Boost (do not advance) – NO straw/NO Jello** • Enteral tube feeding (as per dietitian's recommendations) • Enteral feed discontinued as per MD/dietician • Nausea controlled
Elimination	• Voiding adequately (urine output > 30 mls/hr) • Passing flatus • Note any normal BM • Note any diarrhea
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes **WNL - within normal limits**	• Airway patent • Stoma patent and approximated • Secretions clear, able to clear with instilling • Vital signs and temp stable within normal range/satisfactory • Patient performing stoma care independently, Lary Tube insertion, cleaning & HME change • Patient states pain is at an acceptable level • Nausea controlled • Tolerating enteral feedings • Fluids & electrolytes balanced • Patient describes anxiety as acceptable • Mobilizing independently - at baseline level of function

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Developed By

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

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