

MASSACHUSETTS EYE AND EAR INFIRMARY

Department of Nursing -- 11th Floor

DRG: FREE FLAP

Primary Nurse/Case Manager: _____ Patient: _____

Physician/Resident: _____ Admission Date: _____

	Pre-Operative	Day 1 IMCU	Day 2 IMCU	Day 3 IMCU
Assessments/ Evaluations	<ul style="list-style-type: none"> • Complete pre-operative assessment • Pre-Op tour 	<ul style="list-style-type: none"> • Check flap every 1 hour • Check Doppler every 1 hour • Check skin graft donor site every shift 	<ul style="list-style-type: none"> • Check flap every 2 hours • Check Doppler every 2 hours • Check skin graft donor site every shift 	<ul style="list-style-type: none"> • Check flap every 2 hours • Check Doppler every 2 hours • Check skin graft donor site every shift
Diagnostics	<ul style="list-style-type: none"> • Order type/cross 4 units red packed cells • Insert central line, complete chest x-ray for position • Order pt/ptt, CBC 	<ul style="list-style-type: none"> • Order CBC, Chem 7 	<ul style="list-style-type: none"> • Order CBC, Chem 7 	<ul style="list-style-type: none"> • Order CBC, Chem 7
Treatment	<ul style="list-style-type: none"> • Take standing weight • Take pre-operative weight on IMCU bed 	<ul style="list-style-type: none"> • Maintain patent airway. (tracheostomy care when indicated) • Take vital signs every hour • Patient to remain on ventilator overnight and weened in AM • Begin chest physical therapy every 4 hours • Take and record daily weight • Apply Bacitracin to wounds • Connect drains to wall suction • Provide wound care every 6 hours 	<ul style="list-style-type: none"> • Take vital signs every hour • Continue oxygen, titrate to patient's oxygen saturation level • Continue chest physical therapy every 4 hours • Take and record daily weight • Apply Bacitracin to wounds • Check drains to wall suction • Continue wound care every 6 hours 	<ul style="list-style-type: none"> • Take vital signs every hour • Continue oxygen, titrate to patient's oxygen saturation level • Continue chest physical therapy every 4 hours • Take and record daily weight • Apply Bacitracin to wounds • Check drains to wall suction • Continue wound care every 6 hours
Diet/ Fluids	<ul style="list-style-type: none"> • Maintain NPO after midnight • Start IV as ordered 	<ul style="list-style-type: none"> • Continue Rheomacrodex at 25cc per hour • Check nasogastric tube to low wall suction • Connect Foley catheter to gravity drainage • Continue IV fluids as ordered 	<ul style="list-style-type: none"> • Continue Rheomacrodex at 25 cc per hour • Give Promit at 50 cc IV push • Clamp nasogastric tube • Check bowel sounds • Check stomach contents • Start tube feeding protocol when appropriate • Maintain Foley catheter to gravity drainage 	<ul style="list-style-type: none"> • Continue Rheomacrodex at 25 cc • Give IV fluids as ordered • Increase tube feeding • Decrease IV fluids • Maintain Foley catheter to gravity drainage
Activity/ Safety		<ul style="list-style-type: none"> • Continue pneumoboots • Assist patient to turn, cough, and deep breath every 2 hours • Gently restrain wrists for safety 	<ul style="list-style-type: none"> • Ambulate patient out of bed to chair TID • Ambulate patient BID in room • Remove compression boots 	<ul style="list-style-type: none"> • Ambulate patient out of bed to chair TID • Ambulate patient BID in room
Consults	<ul style="list-style-type: none"> • Consult Social Service, Medicine, Anesthesia, Continuing Care Nurse 	<ul style="list-style-type: none"> • Consult MGH Chest Physical Therapy for initial evaluation 	<ul style="list-style-type: none"> • Continue with MGH Chest Physical Therapy 	<ul style="list-style-type: none"> • Continue with MGH Chest Physical Therapy
Discharge Planning			<ul style="list-style-type: none"> • Develop discharge plan with the Continuing Care and Primary Nurses 	
Patient Education	<ul style="list-style-type: none"> • Begin pre-operative teaching 	<ul style="list-style-type: none"> • Initiate teaching standards 		<ul style="list-style-type: none"> • Require patient to view tube feeding video

	Day 4 IMCU	Day 5 Floor	Day 6 Floor	Day 7 Floor
Assessments/ Evaluations	<ul style="list-style-type: none"> • Check flap every 2 hours • Check Doppler every 2 hours • Check skin graft donor site every shift 	<ul style="list-style-type: none"> • Check flap every 4 hours • Check Doppler every 4 hours 	<ul style="list-style-type: none"> • Check flap and Doppler every shift 	<ul style="list-style-type: none"> • Check flap and Doppler every shift
Diagnostics	<ul style="list-style-type: none"> • Order CBC, Chem 7 	<ul style="list-style-type: none"> • Order CBC 	<ul style="list-style-type: none"> • Order CBC 	
Treatment	<ul style="list-style-type: none"> • Take vital signs every 4 hours • Continue oxygen, titrate to patient's oxygen saturation level • Continue chest physical therapy every 4 hours • Take and record daily weight • Apply Bacitracin to wounds • Check drains to wall suction • Continue wound care every 6 hours 	<ul style="list-style-type: none"> • Take vital signs every 4 hours • Decrease oxygen if saturation is >95% • Continue chest physical therapy • Take and record daily weight • Apply Bacitracin to wounds • Continue wound care every 6 hours • Check drains to bulb suction 	<ul style="list-style-type: none"> • Take vital signs every 4 hours • Decrease oxygen if saturation is >95% • Take and record daily weight • Apply Bacitracin to wounds • Continue wound care every 6 hours • Check drains to bulb suction 	<ul style="list-style-type: none"> • Take vital signs every 4 hours • Decrease oxygen if saturation is >95% • Take and record daily weight • Apply Bacitracin to wounds • Continue wound care every 6 hours • Check drains for discharge
Diet/ Fluids	<ul style="list-style-type: none"> • Continue Rheomacrodex at 25 cc • Give Promit at 50 cc IV push • Continue tube feeding as tolerated • Discontinue Foley catheter • Check urine output in 8 hours 	<ul style="list-style-type: none"> • Continue Rheomacrodex at 25 cc • Increase tube feeding to 240 cc for 6 feedings per day • Monitor urine output 	<ul style="list-style-type: none"> • Discontinue Rheomacrodex • Continue tube feedings at 240 cc for 6 feedings per day • Monitor urine output 	<ul style="list-style-type: none"> • Increase tube feedings to 360 cc for 6 feedings per day, or as recommended by nutritionist • Monitor urine output
Activity/ Safety	<ul style="list-style-type: none"> • Ambulate patient out of bed to chair TID • Ambulate patient BID in room 	<ul style="list-style-type: none"> • Ambulate patient, ad lib, a minimum of TID in corridor 	<ul style="list-style-type: none"> • Begin self activity 	<ul style="list-style-type: none"> • Continue self activity
Consults	<ul style="list-style-type: none"> • Continue with MGH Chest Physical Therapy 	<ul style="list-style-type: none"> • Continue with MGH Chest Physical Therapy 		
Discharge Planning	<ul style="list-style-type: none"> • Begin discharge teaching 			<ul style="list-style-type: none"> • Discuss discharge plan with patient, and begin Visiting Nursing Association referral if needed
Patient Education	<ul style="list-style-type: none"> • Require patient to view tube feeding video (if not viewed on Day 3) 	<ul style="list-style-type: none"> • Have patient perform return demonstration of tube feeding 	<ul style="list-style-type: none"> • Discuss patient education needs and finalize plan with patient 	

	Day 8 Floor	Day 9 Floor	Day 10 Floor	Day 11 Floor	Day 12 Floor
Assessments/ Evaluations	<ul style="list-style-type: none"> • Check flap and Doppler every shift 	<ul style="list-style-type: none"> • Check flap and Doppler every shift 	<ul style="list-style-type: none"> • Check flap and Doppler every shift 	<ul style="list-style-type: none"> • Check flap and Doppler every shift 	<ul style="list-style-type: none"> • Check flap and Doppler before discharge home
Diagnostics					
Treatment	<ul style="list-style-type: none"> • Take vital signs every 4 hours. • Take and record daily weight. • Continue wound care every 6 hours. • Apply Bacitracin • Check drains for discharge. 	<ul style="list-style-type: none"> • Take vital signs every 4 hours. • Take and record daily weight. • Continue wound care every 6 hours. • Apply Bacitracin. 	<ul style="list-style-type: none"> • Take vital signs every 4 hours. • Discontinue daily weight. • Continue wound care every 6 hours. • Apply Bacitracin. 	<ul style="list-style-type: none"> • Take vital signs every shift. • Continue wound care every 6 hours. • Apply Bacitracin. • Discontinue I & O. 	<ul style="list-style-type: none"> • Take vital signs every shift. • Continue wound care every 6 hours. • Apply Bacitracin.
Diet/ Fluids	<ul style="list-style-type: none"> • Continue tube feeding as recommended. 	<ul style="list-style-type: none"> • Complete Barium Swallow early in day. • Call Radiology for results. 	<ul style="list-style-type: none"> • Advance to soft diet as tolerated. 	<ul style="list-style-type: none"> • Advance to soft diet as tolerated. 	<ul style="list-style-type: none"> • Advance to soft diet as tolerated.
Activity/ Safety	<ul style="list-style-type: none"> • Continue self activity. 	<ul style="list-style-type: none"> • Continue self activity 	<ul style="list-style-type: none"> • Continue self activity 	<ul style="list-style-type: none"> • Continue self activity. 	<ul style="list-style-type: none"> • Continue self activity.
Consults					
Discharge Planning					<ul style="list-style-type: none"> • Continue Visiting Nurse Association with referral if needed.
Patient Education		<ul style="list-style-type: none"> • Review wound care with patient and have patient perform return demonstration. 	<ul style="list-style-type: none"> • Review and finalize discharge plan with patient. 		