

PROTOCOL FOR: Flap Procedure: Care of the Post-Operative Patient

DESIRED PATIENT

OUTCOMES: 1. Patient will experience minimal/no complications from surgery.

CLINICAL  
ASSESSMENT

- AND CARE:
1. Circulation:
    - a. Monitor VS q 4° x 24°, then q 8° or as per M.D. order.
    - b. CSM checks per LIP order.
    - c. Monitor labs as ordered.
    - d. Monitor and record output from surgical drains as appropriate.
    - e. Doppler pulses as ordered
  2. Respiratory Assessment:
    - a. Assess lung sounds q 4° x 24°, then q 8° and prn.
    - b. Assess patient ability/compliance to cough, turn, deep breath and use IS q 1° while awake.
  3. Fluid Volume Status:
    - a. IV fluids as ordered. (Dextran 40 commonly used).
    - b. Monitor I+0 q 8 hours.
    - c. Assess skin turgor.
    - d. Monitor labs as ordered.
  4. Wound Care
    - a. Do not change dressing immediately post-op. Observe and document condition of dressing q 4° until first dressing change; notify LIP of ↑ drainage; reinforce dressing prn. LIP performs first dressing change, then change dressing as ordered.
    - b. Assess flap and donor site for adequate perfusion and signs and symptoms of infection/rejection: erythema, heat, swelling, discoloration and drainage (note color and odor).
    - c. Assess wound for bleeding.
    - d. Assess skin around incision line for irritation: redness and swelling (tape burns). Montgomery straps applied over skin barrier may decrease irritation with frequent dressing changes.

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- e. Administer antibiotics as ordered.
  - f. Maintain, and if appropriate, initiate bowel regimen to keep wound free of bowel incontinence.
  - g. If Split Thickness Skin Graft (STSG) also performed, monitor graft site for healing and signs of infection. Provide graft site care per M.D. order.
  - h. Reposition carefully as not to disrupt flap site.
  - i. Maintain patient on pressure relief mattress per LIP order.
5. Pain Management
- a. Assess and document patient report of pain on unit location, type, duration and severity. Use pain scale: 0-10 (0 = Ø pain. 10 = worst pain imaginable.)
  - b. Medicate for pain as needed, monitor and document patient response to medication regimen.
  - c. Premedicate as needed prior to dressing changes, ambulation per LIP order.
  - d. Institute comfort measures as needed: repositioning, relaxation and reassurance.

REPORTABLE  
CONDITIONS:

Notify House Officer if:

- 1. VS outside of M.D. parameters.
- 2. Wound shows signs of bleeding and/or infection.
- 3. Inadequate pain management.
- 4. Flap failure (Necrosis)

APPROVAL: Medical-Surgical Standards Review  
Nursing Standards Committee

EFFECTIVE DATE: 2/92

REVISION DATE: 12/97, 6/03, 9/03, 9/05