

PROTOCOL FOR: Head and Neck: Neck Dissection, Care of the Patient

SUPPORTIVE DATA: A neck dissection is performed to detect the spread of malignant tumors of the head and neck or to treat existing cervical metastasis. Depending on the location and extent of the tumor, the type of neck dissection performed may be either radical or modified and either unilateral or bilateral. A radical neck dissection involves the removal of cervical lymph nodes, the sternocleidomastoid and omohyoid muscles, jugular vein and the spinal accessory nerve. A modified neck dissection preserves the spinal accessory nerve, the sternocleidomastoid muscle, and in some cases, the jugular vein.

DESIRED
PATIENT OUTCOMES:

1. The patient will have minimal/no post-operative complications.
2. The patient will have adequate pain control.
3. The patient's nutritional status will be maintained or improved.

CLINICAL
ASSESSMENT
AND CARE:

- A. Respiratory
 1. Assess airway patency and monitor for any signs or symptoms of respiratory distress.
 2. Administer oxygen therapy as ordered.
 3. Assess lung sounds every eight hours for 24 hours, and prn.
 4. Encourage coughing and deep breathing and/or use of
 5. Incentive spirometer every hour while awake.
- B. General Post-Operative Management
 1. Assess vital signs every four hours for 24 hours. Advance to every eight hours when stable.
 2. Maintain the head of the bed at 30° or higher to promote respiratory function and to prevent or lessen edema.
 3. Assess the patient's pain level on a scale of zero to ten at least every four hours. Medicate as ordered for pain and assess the patient's response to analgesia.
 4. Assess the patient's nutritional status. Administer diet as ordered and assess the patient's response to the diet.
 5. Encourage the patient to be out of bed to the chair and ambulating (with assistance as needed) two times on post-operative day one and three times a day thereafter.
 6. Assess the function and range of motion of the affected upper extremity. As needed, consult with the physician regarding the patient's need for physical therapy.
 7. Consult with the physician and unit case manager regarding the need for community nursing services.
 8. Provide the patient and family with emotional support and explain the rationale for interventions.
 9. Notify the physician for:
 - a) any signs or symptoms of respiratory distress.
 - b) changes in baseline vital signs.

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- c) inadequate pain control.
- d) any signs or symptoms of hemorrhage, hematoma, wound dehiscence, necrosis, infection, fistula or chyle leak.
- e) problems with wound drainage system.
- f) increased edema.
- g) poor tolerance to diet or inadequate fluid intake.

C. Wound Care

1. Drain(s)

- a. Assess that the drain is functioning as evidenced by maintenance of suction and draining of fluid into the drain reservoir.
- b. Assess the area surrounding the drain insertion site for edema, drainage and/or signs of infection.
- c. Empty, measure and record drain output every eight hours.
- d. Assess amount and character of drainage.

2. Incisions

- a. Assess incisions for signs of hemorrhage, hematoma, dehiscence, necrosis, infection or fistula.
- b. Assess amount and type of drainage if drainage is present.
- c. As ordered, every eight hours cleanse the incisions (and the drain insertion sites) with a solution of half-strength hydrogen peroxide and normal saline. Rinse with normal saline and apply a light application of bacitracin ointment. Use cotton-tipped applicators or gauze to provide wound care.
- d. Make sure that no pressure is exerted on the incisions (such as by the oxygen mask or collar which may contribute to skin breakdown).

PATIENT
EDUCATION:

- 1. If the patient is discharged with the drain in place, instruct the patient and family in emptying, measuring and recording drain output.
- 2. Instruct the patient and family in the signs and symptoms of wound complications and infection.
- 3. Instruct the patient and family in the importance of maintaining adequate nutritional and fluid intake after discharge.
- 4. As applicable, discourage smoking and/or heavy alcohol consumption. Provide the patient with information regarding community services as needed.

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 12/01

REVISION DATE(S): 10/03