NEUROIR Post Angiogram [1542]

General

Nursing

Femoral - Sheath Removal

[ ] Closure Devices	
[ ] The physician must be notified for any signs of complications.	Routine, Until discontinued, Starting S, for abnormal vital signs, uncontrolled pain, absence of pulses/limb discoloration, bleeding, hematoma formation, or signs of complications., Post-op
[ ] Activity (Selection Required)	
[ ] Patient was treated with a closure device.	Routine, Until discontinued, Starting S Bedrest required minimum of *** hours. Keep affected leg straight., Post-op
[ ] Patient Education Prior to Sheath Removal and Hospital Discharge	
[ ] Patient education prior to post-sheath removal	Routine, Once, Starting S For 1 Occurrences Patient/Family: Patient Education for: Other (specify),Activity Specify: Patient education prior to post sheath removal. Sign and symptoms, Post-op
[ ] Patient education prior to discharge	Routine, Prior to discharge, Starting S Patient/Family: Patient Education for: Other (specify),Activity,Discharge,Smoking cessation counseling Specify: Patient education prior to discharge. Provide discharge instruction on emergent physician contact/symptom reporting due to bleeding/hematoma/swelling/pain/tenderness/numbness/tingling, Activity and Limitations and site care. Activity including Limiting movement in affected arm 6 hrs post procedure and keep wrist straight , refrain from lifting or pushing with the affected arm for 48 hrs., and site care., Post-op
[ ] Post Procedure Assessment	
[ ] Vital signs after sheath removal	Routine, Every 15 min For Until specified Assess/document vital signs Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
[ ] Assess post-sheath cath site	Routine, Every 15 min For Until specified Assess site for signs and symptoms of a hematoma or other vascular compromise distal to site Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
[ ] Site care	Routine, Once Site: catheter site Ensure complete hemostasis at catheter site, palpate for hematoma, apply appropriate dressing. At a minimum, cover site with 2X2 gauze and transparent dressing., Post-op
[ ] Assess for pulse distal to assess site post-sheath removal	Routine, Every 15 min For Until specified Pulses to assess: Distal Side: Assess and document Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q 4 hours x4 unless otherwise ordered by physician., Post-op
[ ] Neurological assessment after sheath removal	Routine, Every 15 min For Until specified Assessment to Perform: Assess/document neurological assessment Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
[ ] Manual Pressure	

[ ] The physician must be notified prior to sheath removal of a systolic blood if pressure >160mmHg.	Routine, Until discontinued, Starting S, prior to sheath removal if systolic blood pressure is >160mmHg., Post-op
[ ] Remove sheath	Routine, Once For 1 Occurrences when ACT less than 160 or within physician specified parameters. Sheath may be removed 2 hours after discontinuation of Angiomax (Bivalirudin) infusion unless otherwise specified by physician order., Post-op
[ ] The physician must be notified for any signs of complications.	Routine, Until discontinued, Starting S, for abnormal vital signs, uncontrolled pain, absence of pulses/limb discoloration, bleeding, hematoma formation, or signs of complications., Post-op

[ ] Activity (Selection Required)

[ ] Bed rest times following Procedure using femoral artery access are: (Must Select One) (Single Response) (Selection Required)

( ) Patient was treated with a 4 French catheter. Minimum 15 minutes of pressure at site/Bedrest required minimum of 2 hours.	Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
( ) Patient was treated with a 5 French catheter. Minimum 15 minutes of pressure at site/Bedrest required minimum of 3 hours.	Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
( ) Patient was treated with a 6 French catheter. Minimum 20 minutes for PCI/15 minutes of pressure at site for Diagnostic/Bedrest required minimum of 4 hours.	Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
( ) Patient was treated with a 7 French or greater catheter. Minimum 25 minutes of pressure at site/Bedrest required minimum of *** hours.	Routine, Until discontinued, Starting S Bedrest required minimum of *** hours. Keep affected leg straight. Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op

[ ] Patient Education Prior to Sheath Removal and Hospital Discharge

[ ] Patient education prior to post-sheath removal	Routine, Once, Starting S For 1 Occurrences Patient/Family: Patient Education for: Other (specify),Activity Specify: Patient education prior to post sheath removal. Provide patient post-sheath removal instructions to include reports of warmth, moistness, swelling, numbness or pain at insertion site., Post-op
[ ] Patient education prior to discharge	Routine, Prior to discharge, Starting S Patient/Family: Patient Education for: Other (specify),Activity,Discharge,Smoking cessation counseling Specify: Patient education prior to discharge. Provide discharge instruction on emergent physician contact/symptom reporting due to bleeding/hematoma/swelling/pain/tenderness/numbness/tingling, Activity and Limitations and site care. Activity including Limiting movement in affected arm 6 hrs post procedure and keep wrist straight , refrain from lifting or pushing with the affected arm for 48 hrs., and site care., Post-op

[ ] Pre-Sheath Removal

[ ] Vital signs prior to sheath removal	Routine, Every 15 min Vital signs prior to sheath removal - Obtain base line vital signs, include verified ACT results of less than 160 or within parameters ordered by physician, unless otherwise ordered by the physician. For Temp, check every 4 hours., Post-op
[ ] Assist patient to void	Routine, Once For 1 Occurrences Assist patient to void prior to sheath removal., Post-op

[ ] Assess pre-sheath cath site	Routine, Once For 1 Occurrences Assess for signs and symptoms of hematoma or other vascular compromise distal to site on arrival unless otherwise ordered by the physician. If hematoma is present, mark on skin surface and complete hematoma documentation., Post-op
[ ] Patient transferred with sheaths left in place	Routine, Until discontinued, Starting S Patient transferred with Sheaths left in place., Post-op
[ ] Apply hemostatic patch after assessment for hematoma, distal pulses.	Routine, Until discontinued, Starting S Apply pressure proximal to site, place patch over site, slowly remove sheath, allow blood to moisten patch. Apply direct pressure to site/proximal pressure for ½ allotted time. Slowly release proximal pressure, continue direct pressure over the site for a minimum of 20 minutes for PCI/10 minutes for diagnostic cath., Post-op
[ ] Antegrade sheaths present	Routine, Until discontinued, Starting S Antegrade sheath must be pulled by Physicians or appropriately trained staff in the Cath Lab setting., Post-op
[ ] Post-Sheath Removal	
[ ] Vital signs after sheath removal	Routine, Every 15 min For Until specified Assess/document vital signs Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
[ ] Assess post-sheath cath site	Routine, Every 15 min For Until specified Assess site for signs and symptoms of a hematoma or other vascular compromise distal to site Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
[ ] Site care	Routine, Once Site: catheter site Ensure complete hemostasis at catheter site, palpate for hematoma, apply appropriate dressing. At a minimum, cover site with 2X2 gauze and transparent dressing., Post-op
[ ] Assess for pulse distal to assess site post-sheath removal	Routine, Every 15 min For Until specified Pulses to assess: Distal Side: Assess and document Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q 4 hours x4 unless otherwise ordered by physician., Post-op
[ ] Neurological assessment after sheath removal	Routine, Every 15 min For Until specified Assessment to Perform: Assess/document neurological assessment Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
[ ] Compression Systems (Single Response)	
( ) C-clamp (Selection Required)	
[ ] The physician must be notified prior to sheath removal of a systolic blood if pressure >160mmHg.	Routine, Until discontinued, Starting S, prior to sheath removal of a systolic blood if pressure >160mmHg., Post-op
[ ] Remove sheath	Routine, Once For 1 Occurrences when ACT less than 160 or within physician specified parameters. Sheath may be removed 2 hours after discontinuation of Angiomax (Bivalirudin) infusion unless otherwise specified by physician order., Post-op
[ ] The physician must be notified for any signs of complications.	Routine, Until discontinued, Starting S, for abnormal vital signs, uncontrolled pain, absence of pulses/limb discoloration, bleeding, hematoma formation, or signs of complications., Post-op
[ ] Activity Post Sheath Removal-Femoral Approach (Selection Required)	
[ ] Bed rest times following Procedure using femoral artery access are: (Must Select One) (Single Response) (Selection Required)	

( ) Patient was treated with a 4 French catheter. Minimum 15 minutes of pressure at site/Bedrest required minimum of 2 hours.	Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
( ) Patient was treated with a 5 French catheter. Minimum 15 minutes of pressure at site/Bedrest required minimum of 3 hours.	Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
( ) Patient was treated with a 6 French catheter. Minimum 20 minutes for PCI/15 minutes of pressure at site for Diagnostic/Bedrest required minimum of 4 hours.	Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
( ) Patient was treated with a 7 French or greater catheter. Minimum 25 minutes of pressure at site/Bedrest required minimum of *** hours.	Routine, Until discontinued, Starting S Bedrest required minimum of *** hours. Keep affected leg straight. Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op

[ ] Patient Education Prior to Sheath Removal and Hospital Discharge

[ ] Patient education prior to post-sheath removal	Routine, Once, Starting S For 1 Occurrences Patient/Family: Patient Education for: Other (specify),Activity Specify: Patient education prior to post sheath removal. Provide patient post-sheath removal instructions to include reports of warmth, moistness, swelling, numbness or pain at insertion site., Post-op
[ ] Patient education prior to discharge	Routine, Prior to discharge, Starting S Patient/Family: Patient Education for: Other (specify),Activity,Discharge,Smoking cessation counseling Specify: Patient education prior to discharge. Provide discharge instruction on emergent physician contact/symptom reporting due to bleeding/hematoma/swelling/pain/tenderness/numbness/tingling, Activity and Limitations and site care. Activity including Limiting movement in affected arm 6 hrs post procedure and keep wrist straight , refrain from lifting or pushing with the affected arm for 48 hrs., and site care., Post-op

[ ] Pre-Sheath Removal

[ ] Vital signs prior to sheath removal	Routine, Every 15 min Vital signs prior to sheath removal - Obtain base line vital signs, include verified ACT results of less than 160 or within parameters ordered by physician, unless otherwise ordered by the physician. For Temp, check every 4 hours., Post-op
[ ] Assist patient to void	Routine, Once For 1 Occurrences Assist patient to void prior to sheath removal., Post-op
[ ] Assess pre-sheath cath site	Routine, Once For 1 Occurrences Assess for signs and symptoms of hematoma or other vascular compromise distal to site on arrival unless otherwise ordered by the physician. If hematoma is present, mark on skin surface and complete hematoma documentation., Post-op
[ ] Patient transferred with sheaths left in place	Routine, Until discontinued, Starting S Patient transferred with Sheaths left in place., Post-op
[ ] Apply hemostatic patch after assessment for hematoma, distal pulses.	Routine, Until discontinued, Starting S Apply pressure proximal to site, place patch over site, slowly remove sheath, allow blood to moisten patch. Apply direct pressure to site/proximal pressure for ½ allotted time. Slowly release proximal pressure, continue direct pressure over the site for a minimum of 20 minutes for PCI/10 minutes for diagnostic cath., Post-op

[ ] Antegrade sheaths present	Routine, Until discontinued, Starting S Antegrade sheath must be pulled by Physicians or appropriately trained staff in the Cath Lab setting., Post-op
[ ] Post-Sheath Removal	
[ ] Vital signs after sheath removal	Routine, Every 15 min For Until specified Assess/document vital signs Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
[ ] Assess post-sheath cath site	Routine, Every 15 min For Until specified Assess site for signs and symptoms of a hematoma or other vascular compromise distal to site Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
[ ] Site care	Routine, Once Site: catheter site Ensure complete hemostasis at catheter site, palpate for hematoma, apply appropriate dressing. At a minimum, cover site with 2X2 gauze and transparent dressing., Post-op
[ ] Assess for pulse distal to assess site post-sheath removal	Routine, Every 15 min For Until specified Pulses to assess: Distal Side: Assess and document Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q 4 hours x4 unless otherwise ordered by physician., Post-op
[ ] Neurological assessment after sheath removal	Routine, Every 15 min For Until specified Assessment to Perform: Assess/document neurological assessment Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
( ) Femostop	
[ ] The physician must be notified prior to sheath removal of a systolic blood if pressure >160mmHg.	Routine, Until discontinued, Starting S, prior to sheath removal of a systolic blood if pressure >160mmHg., Post-op
[ ] Remove sheath	Routine, Once For 1 Occurrences when ACT less than 160 or within physician specified parameters. Sheath may be removed 2 hours after discontinuation of Angiomax (Bivalirudin) infusion unless otherwise specified by physician order., Post-op
[ ] The physician must be notified for any signs of complications.	Routine, Until discontinued, Starting S, capillary refill > 3 seconds, cynosis, numbness and/or pain in affected extremity, bleeding, hematoma formation, or signs of complication., Post-op
[ ] Follow Femostop manufacturer's guidelines in package insert.	Routine, Until discontinued, Starting S, Post-op
[ ] Activity Post Sheath Removal-Femoral Approach (Selection Required)	
[ ] Bed rest times following Procedure using femoral artery access are: (Must Select One) (Single Response) (Selection Required)	
( ) Patient was treated with a 4 French catheter. Minimum 15 minutes of pressure at site/Bedrest required minimum of 2 hours.	Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
( ) Patient was treated with a 5 French catheter. Minimum 15 minutes of pressure at site/Bedrest required minimum of 3 hours.	Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
( ) Patient was treated with a 6 French catheter. Minimum 20 minutes for PCI/15 minutes of pressure at site for Diagnostic/Bedrest required minimum of 4 hours.	Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op

( ) Patient was treated with a 7 French or greater catheter. Minimum 25 minutes of pressure at site/Bedrest required minimum of *** hours.	Routine, Until discontinued, Starting S Bedrest required minimum of *** hours. Keep affected leg straight. Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
[ ] Patient Education Prior to Sheath Removal and Hospital Discharge	
[ ] Patient education prior to post-sheath removal	Routine, Once, Starting S For 1 Occurrences Patient/Family: Patient Education for: Other (specify),Activity Specify: Patient education prior to post sheath removal. Provide patient post-sheath removal instructions to include reports of warmth, moistness, swelling, numbness or pain at insertion site., Post-op
[ ] Patient education prior to discharge	Routine, Prior to discharge, Starting S Patient/Family: Patient Education for: Other (specify),Activity,Discharge,Smoking cessation counseling Specify: Patient education prior to discharge. Provide discharge instruction on emergent physician contact/symptom reporting due to bleeding/hematoma/swelling/pain/tenderness/numbness/tingling, Activity and Limitations and site care. Activity including Limiting movement in affected arm 6 hrs post procedure and keep wrist straight , refrain from lifting or pushing with the affected arm for 48 hrs., and site care., Post-op
[ ] Pre-Sheath Removal	
[ ] Vital signs prior to sheath removal	Routine, Every 15 min Vital signs prior to sheath removal - Obtain base line vital signs, include verified ACT results of less than 160 or within parameters ordered by physician, unless otherwise ordered by the physician. For Temp, check every 4 hours., Post-op
[ ] Assist patient to void	Routine, Once For 1 Occurrences Assist patient to void prior to sheath removal., Post-op
[ ] Assess pre-sheath cath site	Routine, Once For 1 Occurrences Assess for signs and symptoms of hematoma or other vascular compromise distal to site on arrival unless otherwise ordered by the physician. If hematoma is present, mark on skin surface and complete hematoma documentation., Post-op
[ ] Patient transferred with sheaths left in place	Routine, Until discontinued, Starting S Patient transferred with Sheaths left in place., Post-op
[ ] Apply hemostatic patch after assessment for hematoma, distal pulses.	Routine, Until discontinued, Starting S Apply pressure proximal to site, place patch over site, slowly remove sheath, allow blood to moisten patch. Apply direct pressure to site/proximal pressure for ½ allotted time. Slowly release proximal pressure, continue direct pressure over the site for a minimum of 20 minutes for PCI/10 minutes for diagnostic cath., Post-op
[ ] Antegrade sheaths present	Routine, Until discontinued, Starting S Antegrade sheath must be pulled by Physicians or appropriately trained staff in the Cath Lab setting., Post-op
[ ] Post-Sheath Removal	
[ ] Vital signs after sheath removal	Routine, Every 15 min For Until specified Assess/document vital signs Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
[ ] Assess post-sheath cath site	Routine, Every 15 min For Until specified Assess site for signs and symptoms of a hematoma or other vascular compromise distal to site Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op

[ ] Site care	Routine, Once Site: catheter site Ensure complete hemostasis at catheter site, palpate for hematoma, apply appropriate dressing. At a minimum, cover site with 2X2 gauze and transparent dressing., Post-op
[ ] Assess for pulse distal to assess site post-sheath removal	Routine, Every 15 min For Until specified Pulses to assess: Distal Side: Assess and document Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q 4 hours x4 unless otherwise ordered by physician., Post-op
[ ] Neurological assessment after sheath removal	Routine, Every 15 min For Until specified Assessment to Perform: Assess/document neurological assessment Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op

Radial - Sheath Removal

[ ] Radial Compression Device (Selection Required)

[ ] NOTIFY: The physician must be notified prior to sheath removal of a systolic blood if pressure >160mmHg.	Routine, Until discontinued, Starting S, prior to sheath removal if systolic blood pressure is >160mmHg., Post-op
[ ] Remove sheath	Routine, Once For 1 Occurrences when ACT less than 160 or within physician specified parameters. Sheath may be removed 2 hours after discontinuation of Angiomax (Bivalirudin) infusion unless otherwise specified by physician order., Post-op
[ ] The physician must be notified for any signs of complications.	Routine, Until discontinued, Starting S, for abnormal vital signs, uncontrolled pain, absence of pulses/limb discoloration, bleeding, hematoma formation, or signs of complications., Post-op
[ ] Place/Maintain Sequential Compression Device following Manufacturer Insert/instructions.	Routine, Continuous Follow manufacturer insert/instructions for use, physician orders, or Progressive Cuff Deflation instruction specific to Diagnostic or Interventional Procedure performed. Radial Band, Post-op

[ ] Progressive cuff deflation (Single Response) (Selection Required)

( ) Diagnostic Procedures only (Selection Required)

[ ] 30 minutes after Radial Compression Device applied	Routine, Until discontinued, Starting S deflate 3cc of air from cuff. If no bleeding occurs from site, deflate 3cc of air from the Radial Compression Device every 5 minutes until all air is completely removed. If bleeding occurs when 3cc of air is removed, re-inflate with 3cc of air. Wait 15 minutes, then restart releasing 3cc of air every 5 minutes until all air is completely removed. If site remains free of bleeding/hematoma after 5 min, remove TR band, apply dressing., Post-op
[ ] Monitor access site and extremity distal to puncture wound	Routine, Until discontinued, Starting S every 15 minutes until Radial Compression Device is removed., Post-op
[ ] Assess for absence of ulnar pulse, caplilary refill greater than 3 seconds, cyanosis, numbness and/or pain in affected extremity.	Routine, Until discontinued, Starting S, If any of these are present, notify the procedural Cardiologist.

( ) Interventional Procedures only (Selection Required)

[ ] 2 hours after Radial Compression Device applied deflate 3cc	Routine, Until discontinued, Starting S if no bleeding at site, deflate 3cc every 10 min until all air removed from cuff. If bleeding occurs when 3cc of air is removed, re-inflate with 3cc of air. Wait 30 minutes then restart releasing 3cc of air every 10 minutes until all air has been removed. If site remains free of bleeding/hematoma after 5 min, remove TR band, apply dressing., Post-op
[ ] Evaluate access site for bleeding as follows:	Routine, Until discontinued, Starting S every 15 minutes x 4; every 30 minutes x2; and every hour x2., Post-op

[ ] Patient Education Prior to Sheath Removal and Hospital Discharge	
[ ] Patient education prior to post-sheath removal	Routine, Once, Starting S For 1 Occurrences Patient/Family: Patient Education for: Other (specify),Activity Specify: Patient education prior to post sheath removal. Provide patient post-sheath removal instructions to include reports of warmth, moistness, swelling, numbness or pain at insertion site., Post-op
[ ] Patient education prior to discharge	Routine, Prior to discharge, Starting S Patient/Family: Patient Education for: Other (specify),Activity,Discharge,Smoking cessation counseling Specify: Patient education prior to discharge. Provide discharge instruction on emergent physician contact/symptom reporting due to bleeding/hematoma/swelling/pain/tenderness/numbness/tingling, Activity and Limitations and site care. Activity including Limiting movement in affected arm 6 hrs post procedure and keep wrist straight , refrain from lifting or pushing with the affected arm for 48 hrs., and site care., Post-op
[ ] Pre-Sheath Removal	
[ ] Vital signs prior to sheath removal	Routine, Every 15 min Vital signs prior to sheath removal - Obtain base line vital signs, include verified ACT results of less than 160 or within parameters ordered by physician, unless otherwise ordered by the physician. For Temp, check every 4 hours., Post-op
[ ] Assist patient to void	Routine, Once For 1 Occurrences Assist patient to void prior to sheath removal., Post-op
[ ] Assess pre-sheath cath site	Routine, Once For 1 Occurrences Assess for signs and symptoms of hematoma or other vascular compromise distal to site on arrival unless otherwise ordered by the physician. If hematoma is present, mark on skin surface and complete hematoma documentation., Post-op
[ ] Patient transferred with sheaths left in place	Routine, Until discontinued, Starting S Patient transferred with Sheaths left in place., Post-op
[ ] Apply hemostatic patch after assessment for hematoma, distal pulses.	Routine, Until discontinued, Starting S Apply pressure proximal to site, place patch over site, slowly remove sheath, allow blood to moisten patch. Apply direct pressure to site/proximal pressure for ½ allotted time. Slowly release proximal pressure, continue direct pressure over the site for a minimum of 20 minutes for PCI/10 minutes for diagnostic cath., Post-op
[ ] Antegrade sheaths present	Routine, Until discontinued, Starting S Antegrade sheath must be pulled by Physicians or appropriately trained staff in the Cath Lab setting., Post-op
[ ] Post-Sheath Removal (Selection Required)	
[ ] Vital signs after sheath removal	Routine, Every 15 min For Until specified Assess/document vital signs Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
[ ] Peripheral vascular assessment - Monitor access site	Routine, Every 15 min Monitor access site, extremity distal to puncture every 15 min until Radial approach cath band removed., Post-op
[ ] Notify physician of bleeding and/or loss of pulses.	Routine, Until discontinued, Starting S, Notify physician of bleeding and/or loss of pulses., Post-op
[ ] Site care	Routine, Once Site: catheter site Ensure complete hemostasis at catheter site, palpate for hematoma, apply appropriate dressing. At a minimum, cover site with 2X2 gauze and transparent dressing., Post-op

[ ] No blood pressure readings, lab draws, or IV access	Routine, Until discontinued, Starting S No blood pressure readings, lab draws, or IV access in the affected arm for 24 hours., Post-op
[ ] Limit movement in affected arm 6 hrs post procedure	Routine, Until discontinued, Starting S keep wrist straight , refrain from lifting or pushing with the affected arm for 48 hrs. If needed, place wrist on arm board to restrict movement., Post-op
[ ] Patient may ambulate 30 minutes after arrival in recovery area.	Routine, Until discontinued, Starting S Specify: Other activity (specify) Other: Patient may ambulate 30 minutes after arrival in recovery area. Post-op
[ ] Assess for pulse distal to assess site post-sheath removal	Routine, Every 15 min For Until specified Pulses to assess: Distal Side: Assess and document Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q 4 hours x4 unless otherwise ordered by physician., Post-op
[ ] Neurological assessment after sheath removal	Routine, Every 15 min For Until specified Assessment to Perform: Assess/document neurological assessment Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op

[ ] Manual Pressure - without Radial Compression Device

[ ] The physician must be notified prior to sheath removal of a systolic blood if pressure >160mmHg.	Routine, Until discontinued, Starting S, prior to sheath removal of a systolic blood if pressure >160mmHg., Post-op
[ ] Remove sheath	Routine, Once For 1 Occurrences when ACT less than 160 or within physician specified parameters. Sheath may be removed 2 hours after discontinuation of Angiomax (Bivalirudin) infusion unless otherwise specified by physician order., Post-op
[ ] The physician must be notified for any signs of complications.	Routine, Until discontinued, Starting S, for abnormal vital signs, uncontrolled pain, absence of pulses/limb discoloration, bleeding, hematoma formation, or signs of complications., Post-op

[ ] Patient Education Prior to Sheath Removal and Hospital Discharge

[ ] Patient education prior to post-sheath removal	Routine, Once, Starting S For 1 Occurrences Patient/Family: Patient Education for: Other (specify),Activity Specify: Patient education prior to post sheath removal. Provide patient post-sheath removal instructions to include reports of warmth, moistness, swelling, numbness or pain at insertion site., Post-op
[ ] Patient education prior to discharge	Routine, Prior to discharge, Starting S Patient/Family: Patient Education for: Other (specify),Activity,Discharge,Smoking cessation counseling Specify: Patient education prior to discharge. Provide discharge instruction on emergent physician contact/symptom reporting due to bleeding/hematoma/swelling/pain/tenderness/numbness/tingling, Activity and Limitations and site care. Activity including Limiting movement in affected arm 6 hrs post procedure and keep wrist straight , refrain from lifting or pushing with the affected arm for 48 hrs., and site care., Post-op

[ ] Pre-Sheath Removal

[ ] Vital signs prior to sheath removal	Routine, Every 15 min Vital signs prior to sheath removal - Obtain base line vital signs, include verified ACT results of less than 160 or within parameters ordered by physician, unless otherwise ordered by the physician. For Temp, check every 4 hours., Post-op
[ ] Assist patient to void	Routine, Once For 1 Occurrences Assist patient to void prior to sheath removal., Post-op

[ ] Assess pre-sheath cath site	Routine, Once For 1 Occurrences Assess for signs and symptoms of hematoma or other vascular compromise distal to site on arrival unless otherwise ordered by the physician. If hematoma is present, mark on skin surface and complete hematoma documentation., Post-op
[ ] Patient transferred with sheaths left in place	Routine, Until discontinued, Starting S Patient transferred with Sheaths left in place., Post-op
[ ] Apply hemostatic patch after assessment for hematoma, distal pulses.	Routine, Until discontinued, Starting S Apply pressure proximal to site, place patch over site, slowly remove sheath, allow blood to moisten patch. Apply direct pressure to site/proximal pressure for ½ allotted time. Slowly release proximal pressure, continue direct pressure over the site for a minimum of 20 minutes for PCI/10 minutes for diagnostic cath., Post-op
[ ] Antegrade sheaths present	Routine, Until discontinued, Starting S Antegrade sheath must be pulled by Physicians or appropriately trained staff in the Cath Lab setting., Post-op
[ ] Post-Sheath Removal	
[ ] Vital signs after sheath removal	Routine, Every 15 min For Until specified Assess/document vital signs Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
[ ] Notify physician of bleeding and/or loss of pulses.	Routine, Until discontinued, Starting S, Notify physician of bleeding and/or loss of pulses., Post-op
[ ] Site care	Routine, Once Site: catheter site Ensure complete hemostasis at catheter site, palpate for hematoma, apply appropriate dressing. At a minimum, cover site with 2X2 gauze and transparent dressing., Post-op
[ ] No blood pressure readings, lab draws, or IV access	Routine, Until discontinued, Starting S No blood pressure readings, lab draws, or IV access in the affected arm for 24 hours., Post-op
[ ] Limit movement in affected arm 6 hrs post procedure	Routine, Until discontinued, Starting S keep wrist straight , refrain from lifting or pushing with the affected arm for 48 hrs. If needed, place wrist on arm board to restrict movement., Post-op
[ ] Patient may ambulate 30 minutes after arrival in recovery area.	Routine, Until discontinued, Starting S Specify: Other activity (specify) Other: Patient may ambulate 30 minutes after arrival in recovery area. Post-op
[ ] Assess for pulse distal to assess site post-sheath removal	Routine, Every 15 min For Until specified Pulses to assess: Distal Side: Assess and document Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q 4 hours x4 unless otherwise ordered by physician., Post-op
[ ] Neurological assessment after sheath removal	Routine, Every 15 min For Until specified Assessment to Perform: Assess/document neurological assessment Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op

Medications

VTE

Labs

Cardiology

Imaging

Other Studies

Respiratory

Rehab

Consults

For Physician Consult orders use sidebar

Additional Orders

Discharge

Discharge Order (Single Response)

( ) Discharge patient when criteria met	Routine, Once Discharge Criteria: Clearing specialty: Scheduling/ADT

Discontinue tubes/drains

[ ] Discontinue Foley catheter	Routine, Once, Scheduling/ADT
[ ] Discharge home with Foley catheter	Routine, Once, Scheduling/ADT
[ ] Discontinue IV	Routine, Once For 1 Occurrences, Scheduling/ADT
[ ] Deaccess port	
[ ] Deaccess Port-a-cath	Routine, Once, Scheduling/ADT
[ ] heparin, porcine (PF) 100 unit/mL injection	intra-catheter, once, Scheduling/ADT

Discharge Activity

[ ] Activity as tolerated	Routine, Normal, Scheduling/ADT
[ ] Lifting restrictions	Routine, Normal, Scheduling/ADT, No lifting over 10 pounds.
[ ] Shower instructions:	Routine, Normal, Scheduling/ADT, May remove large dressing and shower the day after procedure/do not remove Steri-strips. ***
[ ] Discharge activity	Routine, Normal, Scheduling/ADT
[ ] Other restrictions (specify):	Routine, Normal, Scheduling/ADT, ***

Wound/Incision Care

[ ] Discharge wound care	Routine, Normal, Scheduling/ADT, May remove large dressing the day after procedure/do not remove Steri-strips. ***

Discharge Diet - REQUIRED

[ ] Discharge Diet	Routine, Normal, Scheduling/ADT Discharge Diet:

Patient to notify physician

[ ] Call physician for:	Routine, Normal, Scheduling/ADT, Temperature greater than 100.5
[ ] Call physician for: Persistent nausea or vomiting	Routine, Normal, Scheduling/ADT
[ ] Call physician for: severe uncontrolled pain	Routine, Normal, Scheduling/ADT
[ ] Call physician for: redness, tenderness, or signs of infection (pain, swelling, redness, odor or green/yellow discharge from affected area)	Routine, Normal, Scheduling/ADT
[ ] Call physician for difficulty breathing, chest pain, persistent dizziness or light-headedness	Routine, Normal, Scheduling/ADT

Discharge Education

[ ] Nurse to provide discharge education	Routine, Once Patient/Family: Both Education for: Other (specify) Specify: Nurse to provide patient education Scheduling/ADT

Discharge Instructions

[ ] Additional discharge instructions for Patient	Routine, Normal, Scheduling/ADT, ***
[ ] Discharge instructions for Nursing- Will not show on AVS	Routine, Once ***, Scheduling/ADT

Place Follow-Up Order

[ ] Follow-up with me	Follow up with me: Clinic Contact: Follow up in: On date: Appointment Time: