Cardiac Catheterization PCI Intervention - Outpatient [4845]

This outpatient post PCI order set is intended for patients discharging home. Medications in this order set include hospital medications and discharge prescriptions.

For PCI patients transferring to a unit, use the Cardiac Catheterization PCI Intervention - Inpatient order set.

4 new available Cath Lab order sets:

Discharge Post Procedure:

Cardiac Catheterization Post Procedure - Outpatient Cardiac Catheterization PCI Intervention - Outpatient

Admit/Transfer to Unit:

Cardiac Catheterization Post Procedure - Inpatient Cardiac Catheterization PCI Intervention - Inpatient

General

Discharge Order (Selection Required)

[X] Discharge when patient criteria met

Routine, Once For 1 Occurrences, Scheduling/ADT

Nursing - Post Procedure

Femoral - Sheath Removal

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 an Discharge	d Hospital
[] 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
post-sneath removal	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	Routine, Every 15 min For Until specified
removal	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	Routine, Until discontinued, Starting S, prior to sheath removal if systolic blood pressure is >160mmHg., Post-op
pressure >160mmHg.	blood pressure is >100mm ig., Fost-op
] Remove sheath	Routine, Once For 1 Occurrences
	when ACT less than 160 or within physician specified parameters. Sheat
	may be removed 2 hours after discontinuation of Angiomax (Bivalirudin) infusion unless otherwise specified by physician order., Post-op
1 The physician must be notified for any signs	
 The physician must be notified for any signs of complications. 	uncontrolled pain, absence of pulses/limb discoloration, bleeding,
of complications.	uncontrolled pain, absence of pulses/limb discoloration, bleeding, hematoma formation, or signs of complications., Post-op
of complications.] Activity (Selection Required)	hematoma formation, or signs of complications., Post-op
of complications. Activity (Selection Required)	hematoma formation, or signs of complications., Post-op emoral artery
of complications.] Activity (Selection Required)	hematoma formation, or signs of complications., Post-op emoral artery
of complications. 1 Activity (Selection Required) 1 Bed rest times following Procedure using for access are: (Must Select One) (Single Rese (Selection Required) 1 Patient was treated with a 4 French	hematoma formation, or signs of complications., Post-op emoral artery ponse) Routine, Until discontinued, Starting S
of complications. Activity (Selection Required) Bed rest times following Procedure using for access are: (Must Select One) (Single Researces) (Selection Required) () Patient was treated with a 4 French catheter. Minimum 15 minutes of pressure.	hematoma formation, or signs of complications., Post-op emoral artery ponse) Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed.,
of complications. 1 Activity (Selection Required) 1 Bed rest times following Procedure using for access are: (Must Select One) (Single Rese (Selection Required) 1 Patient was treated with a 4 French	hematoma formation, or signs of complications., Post-op emoral artery ponse) Routine, Until discontinued, Starting S
of complications. Activity (Selection Required) Bed rest times following Procedure using for access are: (Must Select One) (Single Rest (Selection Required) () Patient was treated with a 4 French catheter. Minimum 15 minutes of pressure at site/Bedrest required minimum of 2	hematoma formation, or signs of complications., Post-op emoral artery ponse) Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed.,
of complications. [] Activity (Selection Required) [] Bed rest times following Procedure using for access are: (Must Select One) (Single Rese (Selection Required) () Patient was treated with a 4 French catheter. Minimum 15 minutes of pressure at site/Bedrest required minimum of 2 hours. () Patient was treated with a 5 French catheter. Minimum 15 minutes of pressure.	hematoma formation, or signs of complications., Post-op emoral artery ponse) Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed.,
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of complications. Activity (Selection Required) Bed rest times following Procedure using for access are: (Must Select One) (Single Rest (Selection Required) Patient was treated with a 4 French catheter. Minimum 15 minutes of pressure at site/Bedrest required minimum of 2 hours. Patient was treated with a 5 French catheter. Minimum 15 minutes of pressure at site/Bedrest required minimum of 3 hours.	hematoma formation, or signs of complications., Post-op emoral artery ponse) Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
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of complications. [] Activity (Selection Required) [] Bed rest times following Procedure using for access are: (Must Select One) (Single Rest (Selection Required) () Patient was treated with a 4 French catheter. Minimum 15 minutes of pressure at site/Bedrest required minimum of 2 hours. () Patient was treated with a 5 French catheter. Minimum 15 minutes of pressure at site/Bedrest required minimum of 3 hours. () Patient was treated with a 6 French catheter. Minimum 20 minutes for PCI/15 minutes of pressure at site for	hematoma formation, or signs of complications., Post-op emoral artery ponse) Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
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of complications. Activity (Selection Required) Bed rest times following Procedure using for access are: (Must Select One) (Single Rest (Selection Required) Patient was treated with a 4 French catheter. Minimum 15 minutes of pressure at site/Bedrest required minimum of 2 hours. Patient was treated with a 5 French catheter. Minimum 15 minutes of pressure at site/Bedrest required minimum of 3 hours. 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. Patient was treated with a 7 French or greater catheter. Minimum 25 minutes of pressure at site/Bedrest required minimum of *** hours. Patient Education Prior to Sheath Removal Discharge	hematoma formation, or signs of complications., Post-op emoral artery ponse) Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op 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 and Hospital
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of complications. Activity (Selection Required) Bed rest times following Procedure using for access are: (Must Select One) (Single Rest (Selection Required) Patient was treated with a 4 French catheter. Minimum 15 minutes of pressure at site/Bedrest required minimum of 2 hours. Patient was treated with a 5 French catheter. Minimum 15 minutes of pressure at site/Bedrest required minimum of 3 hours. 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 hours. Patient was treated with a 7 French or greater catheter. Minimum 25 minutes of pressure at site/Bedrest required minimum of *** hours. Patient Education Prior to Sheath Removal Discharge Patient education prior to post-sheath	hematoma formation, or signs of complications., Post-op emoral artery ponse) Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op 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 Routine, Once, Starting S For 1 Occurrences Patient/Family: Patient

[]	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	
IJ	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
<u>[]</u>	Assist patient to void	Routine, Once For 1 Occurrences
ΙJ	Assist patient to void	Assist patient to void prior to sheath removal., Post-op
[]	Assess pre-sheath cath site	Routine, Once For 1 Occurrences
. 1	7,00000 pro oriodari catil olic	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	Routine, Until discontinued, Starting S
	for hematoma, distal pulses.	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
1	Doot Chooth Domoval	staff in the Cath Lab setting., Post-op
	Post-Sheath Removal	Douting Every 15 min For Until appoiling
IJ	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
<u> </u>	Assess post-sheath cath site	Routine, Every 15 min For Until specified
ΙJ	Assess posi-sileatii catti site	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 Q
		x4 unless otherwise ordered by the physician., Post-op
[]	Site care	Routine, Once
. 1		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
$\overline{1}$	Assess for pulse distal to assess site	Routine, Every 15 min For Until specified
	post-sheath removal	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	Routine, Every 15 min For Until specified
[]	_	Assessment to Perform:
[]	removal	
[]	removal	Assess/document neurological assessment Q 15 min x4, Q 30 min x4, C
[]	Temovai	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.,
[]	Temovai	

[] 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 Approa (Selection Required)	ıch
[] Bed rest times following Procedure using fem access are: (Must Select One) (Single Respo (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 Discharge 	d Hospital
[] 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

[] Ass	ess 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
[] Pati	ient transferred with sheaths left in place	Routine, Until discontinued, Starting S Patient transferred with Sheaths left in place., Post-op
[] App	bly hemostatic patch after assessment	Routine, Until discontinued, Starting S
	hematoma, distal pulses.	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
[] Anto	egrade 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	
[] Vita	al 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
[] Ass	ess 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
[] Sito	e care	Q4 x4 unless otherwise ordered by the physician., Post-op Routine, Once
[] Site	cale	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
	ess for pulse distal to assess site	Routine, Every 15 min For Until specified
pos	t-sheath removal	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
	urological assessment after sheath	Routine, Every 15 min For Until specified
rem	noval	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
() Femos	· · · · · · · · · · · · · · · · · · ·	
shea	physician must be notified prior to th removal of a systolic blood if sure >160mmHg.	Routine, Until discontinued, Starting S, prior to sheath removal of a systolic blood if pressure >160mmHg., Post-op
	ove 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 p	physician must be notified for any signs	Routine, Until discontinued, Starting S, capillary refill > 3 seconds,
	mplications.	cynosis, numbness and/or pain in affected extremity, bleeding, hematoma formation, or signs of complication., Post-op
	w Femostop manufacturer's guidelines	Routine, Until discontinued, Starting S, Post-op
[] Activ	ckage insert. ity Post Sheath Removal-Femoral Approa ection Required)	ch
[] Bed	d rest times following Procedure using femess are: (Must Select One) (Single Respo	
(Se	lection Required)	
` '	atient was treated with a 4 French	Routine, Until discontinued, Starting S
	theter. Minimum 15 minutes of pressure site/Bedrest required minimum of 2	Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
	ours.	. 55. 64

() 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 Discharge 	Hospital
[] 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

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[]	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
<u> </u>	Assess for pulse distal to assess site	Routine, Every 15 min For Until specified
[]		Pulses to assess: Distal
	post-sheath removal	Side:
		Assess and document Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q 4
	Nie velee 'eel een een een de foerel een	hours x4 unless otherwise ordered by physician., Post-op
[]	Neurological assessment after sheath	Routine, Every 15 min For Until specified
	removal	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
ładial -	Sheath Removal	
] Rad	lial Compression Device (Selection Required)	
	IOTIFY: The physician must be notified	Routine, Until discontinued, Starting S, prior to sheath removal if systolic
	rior to sheath removal of a systolic blood if	blood pressure is >160mmHg., Post-op
	ressure >160mmHg.	blood productions a roomining, it does op
	temove sheath	Routine, Once For 1 Occurrences
[] 1	demove sheath	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
	he physician must be notified for any signs	Routine, Until discontinued, Starting S, for abnormal vital signs,
01	f complications.	uncontrolled pain, absence of pulses/limb discoloration, bleeding,
		hematoma formation, or signs of complications., Post-op
	lace/Maintain Sequential Compression	Routine, Continuous
	Pevice following Manufacturer	Follow manufacturer insert/instructions for use, physician orders, or
In	nsert/instructions.	Dragragaiya Cuff Deflation instruction appoific to Diagnostic or
	isort in our doubles.	Progressive Cuff Deflation instruction specific to Diagnostic or
		Interventional Procedure performed. Radial Band, Post-op
	rogressive cuff deflation (Single Response) (Stequired)	Interventional Procedure performed. Radial Band, Post-op
R	rogressive cuff deflation (Single Response) (S	Interventional Procedure performed. Radial Band, Post-op Selection
(<u>)</u>	rogressive cuff deflation (Single Response) (Sequired)	Interventional Procedure performed. Radial Band, Post-op Selection ed) Routine, Until discontinued, Starting S
(<u>)</u>	rogressive cuff deflation (Single Response) (Stequired) Diagnostic Procedures only (Selection Require	Interventional Procedure performed. Radial Band, Post-op Selection ed)
(<u>)</u>	rogressive cuff deflation (Single Response) (Stequired) Diagnostic Procedures only (Selection Required) 30 minutes after Radial Compression	Interventional Procedure performed. Radial Band, Post-op Selection ed) Routine, Until discontinued, Starting S
(<u>)</u>	rogressive cuff deflation (Single Response) (Stequired) Diagnostic Procedures only (Selection Required) 30 minutes after Radial Compression	Interventional Procedure performed. Radial Band, Post-op Selection ed) Routine, Until discontinued, Starting S deflate 3cc of air from cuff. If no bleeding occurs from site, deflate 3cc
(<u>)</u>	rogressive cuff deflation (Single Response) (Stequired) Diagnostic Procedures only (Selection Required) 30 minutes after Radial Compression	Interventional Procedure performed. Radial Band, Post-op Selection ed) 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,
(<u>)</u>	rogressive cuff deflation (Single Response) (Stequired) Diagnostic Procedures only (Selection Required) 30 minutes after Radial Compression	Interventional Procedure performed. Radial Band, Post-op Selection ed) 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
(<u>)</u>	rogressive cuff deflation (Single Response) (Stequired) Diagnostic Procedures only (Selection Required) 30 minutes after Radial Compression	Interventional Procedure performed. Radial Band, Post-op Selection ed) 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
(<u>)</u>	rogressive cuff deflation (Single Response) (Stequired) Diagnostic Procedures only (Selection Required) 30 minutes after Radial Compression	Interventional Procedure performed. Radial Band, Post-op Selection 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
R () []	Progressive cuff deflation (Single Response) (Stequired) Diagnostic Procedures only (Selection Require 30 minutes after Radial Compression Device applied	Interventional Procedure performed. Radial Band, Post-op Selection 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
(<u>)</u>	Progressive cuff deflation (Single Response) (Stequired) Diagnostic Procedures only (Selection Required) 30 minutes after Radial Compression Device applied Monitor access site and extremity distal to	Interventional Procedure performed. Radial Band, Post-op Selection 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 Routine, Until discontinued, Starting S
R () []	Progressive cuff deflation (Single Response) (Stequired) Diagnostic Procedures only (Selection Require 30 minutes after Radial Compression Device applied	Interventional Procedure performed. Radial Band, Post-op Selection 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 Routine, Until discontinued, Starting S every 15 minutes until Radial Compression Device is removed.,
() []	Progressive cuff deflation (Single Response) (Stequired) Diagnostic Procedures only (Selection Required) 30 minutes after Radial Compression Device applied Monitor access site and extremity distal to puncture wound	Interventional Procedure performed. Radial Band, Post-op Selection 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 Routine, Until discontinued, Starting S every 15 minutes until Radial Compression Device is removed., Post-op
R () []	rogressive cuff deflation (Single Response) (Stequired) Diagnostic Procedures only (Selection Require 30 minutes after Radial Compression Device applied Monitor access site and extremity distal to puncture wound Assess for absence of ulnar pulse, caplilary	Interventional Procedure performed. Radial Band, Post-op Selection 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 Routine, Until discontinued, Starting S every 15 minutes until Radial Compression Device is removed., Post-op Routine, Until discontinued, Starting S, If any of these are present,
() []	rogressive cuff deflation (Single Response) (Stequired) Diagnostic Procedures only (Selection Required) 30 minutes after Radial Compression Device applied Monitor access site and extremity distal to puncture wound Assess for absence of ulnar pulse, caplilary refill greater than 3 seconds, cyanosis,	Interventional Procedure performed. Radial Band, Post-op Selection 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 Routine, Until discontinued, Starting S every 15 minutes until Radial Compression Device is removed., Post-op
[]	Progressive cuff deflation (Single Response) (Stequired) Diagnostic Procedures only (Selection Required) 30 minutes after Radial Compression Device applied Monitor access site and extremity distal to puncture wound Assess for absence of ulnar pulse, caplilary refill greater than 3 seconds, cyanosis, numbness and/or pain in affected extremity.	Interventional Procedure performed. Radial Band, Post-op Selection 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 Routine, Until discontinued, Starting S every 15 minutes until Radial Compression Device is removed., Post-op Routine, Until discontinued, Starting S, If any of these are present, notify the procedural Cardiologist.
() R ()	Progressive cuff deflation (Single Response) (Stequired) Diagnostic Procedures only (Selection Required) 30 minutes after Radial Compression Device applied Monitor access site and extremity distal to puncture wound Assess for absence of ulnar pulse, caplilary refill greater than 3 seconds, cyanosis, numbness and/or pain in affected extremity. Interventional Procedures only (Selection Register)	Interventional Procedure performed. Radial Band, Post-op Selection 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 Routine, Until discontinued, Starting S every 15 minutes until Radial Compression Device is removed., Post-op Routine, Until discontinued, Starting S, If any of these are present, notify the procedural Cardiologist.
[]	Progressive cuff deflation (Single Response) (Stequired) Diagnostic Procedures only (Selection Required) 30 minutes after Radial Compression Device applied Monitor access site and extremity distal to puncture wound Assess for absence of ulnar pulse, caplilary refill greater than 3 seconds, cyanosis, numbness and/or pain in affected extremity. Interventional Procedures only (Selection Regions) 2 hours after Radial Compression Device	Interventional Procedure performed. Radial Band, Post-op Selection ed) 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 Routine, Until discontinued, Starting S every 15 minutes until Radial Compression Device is removed., Post-op Routine, Until discontinued, Starting S, If any of these are present, notify the procedural Cardiologist.
() R ()	Progressive cuff deflation (Single Response) (Stequired) Diagnostic Procedures only (Selection Required) 30 minutes after Radial Compression Device applied Monitor access site and extremity distal to puncture wound Assess for absence of ulnar pulse, caplilary refill greater than 3 seconds, cyanosis, numbness and/or pain in affected extremity. Interventional Procedures only (Selection Register)	Interventional Procedure performed. Radial Band, Post-op Selection ed) 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 Routine, Until discontinued, Starting S every 15 minutes until Radial Compression Device is removed., Post-op Routine, Until discontinued, Starting S, If any of these are present, notify the procedural Cardiologist. [uired) Routine, Until discontinued, Starting S if no bleeding at site, deflate 3cc every 10 min until all air removed from
() R ()	Progressive cuff deflation (Single Response) (Stequired) Diagnostic Procedures only (Selection Required) 30 minutes after Radial Compression Device applied Monitor access site and extremity distal to puncture wound Assess for absence of ulnar pulse, caplilary refill greater than 3 seconds, cyanosis, numbness and/or pain in affected extremity. Interventional Procedures only (Selection Regions) 2 hours after Radial Compression Device	Interventional Procedure performed. Radial Band, Post-op Selection ed) 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 Routine, Until discontinued, Starting S every 15 minutes until Radial Compression Device is removed., Post-op Routine, Until discontinued, Starting S, If any of these are present, notify the procedural Cardiologist. guired) 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
() R ()	Progressive cuff deflation (Single Response) (Stequired) Diagnostic Procedures only (Selection Required) 30 minutes after Radial Compression Device applied Monitor access site and extremity distal to puncture wound Assess for absence of ulnar pulse, caplilary refill greater than 3 seconds, cyanosis, numbness and/or pain in affected extremity. Interventional Procedures only (Selection Regions) 2 hours after Radial Compression Device	Interventional Procedure performed. Radial Band, Post-op Selection 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 Routine, Until discontinued, Starting S every 15 minutes until Radial Compression Device is removed., Post-op Routine, Until discontinued, Starting S, If any of these are present, notify the procedural Cardiologist. Juired) 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
() R ()	Progressive cuff deflation (Single Response) (Stequired) Diagnostic Procedures only (Selection Required) 30 minutes after Radial Compression Device applied Monitor access site and extremity distal to puncture wound Assess for absence of ulnar pulse, caplilary refill greater than 3 seconds, cyanosis, numbness and/or pain in affected extremity. Interventional Procedures only (Selection Regions) 2 hours after Radial Compression Device	Interventional Procedure performed. Radial Band, Post-op Selection ed) 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 Routine, Until discontinued, Starting S every 15 minutes until Radial Compression Device is removed., Post-op Routine, Until discontinued, Starting S, If any of these are present, notify the procedural Cardiologist. guired) 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
() R ()	Progressive cuff deflation (Single Response) (Stequired) Diagnostic Procedures only (Selection Required) 30 minutes after Radial Compression Device applied Monitor access site and extremity distal to puncture wound Assess for absence of ulnar pulse, caplilary refill greater than 3 seconds, cyanosis, numbness and/or pain in affected extremity. Interventional Procedures only (Selection Regions) 2 hours after Radial Compression Device	Interventional Procedure performed. Radial Band, Post-op Selection 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 Routine, Until discontinued, Starting S every 15 minutes until Radial Compression Device is removed., Post-op Routine, Until discontinued, Starting S, If any of these are present, notify the procedural Cardiologist. Juired 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

[] Evaluate access site for bleeding as follows:	Routine, Until discontinued, Starting S
[] Evaluate decess site for pieculing as follows.	every 15 minutes x 4; every 30 minutes x2; and every hour x2., Post-op
[] Patient Education Prior to Sheath Removal and Discharge	Hospital
[] 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	Routine, Until discontinued, Starting S
for hematoma, distal pulses.	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	Routine, Every 15 min
access site	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
	and transparent discounting, i out op

Continued Cont		
Patient may ambulate 30 minutes after arrival in recovery area. Routine, Until discontinued, Starting S Specily: Other activity (specily) Other. Patient may ambulate 30 minutes after arrival in recovery area. Routine, Until discontinued, Starting S Specily: Other activity (specily) Other. Patient may ambulate 30 minutes after arrival in recovery area. Post-op Patient may ambulate 30 minutes after arrival in recovery area. Post-op Patient may ambulate 30 minutes after arrival in recovery area. Post-op Patient may ambulate 30 minutes after arrival in recovery area. Post-op Patient may ambulate 30 minutes after arrival in recovery area. Post-op Patient may ambulate 30 minutes after arrival in recovery area. Post-op Patient may ambulate 30 minutes after arrival in recovery area. Post-op Patient may ambulate 30 minutes after arrival in recovery area. Post-op Patient may ambulate 30 minutes after arrival in recovery area. Post-op Patient may ambulate 30 minutes after arrival in recovery area. Post-op Patient may ambulate 30 minutes after arrival in recovery area. Post-op Patient		No blood pressure readings, lab draws, or IV access in the affected arm
arrival in recovery area. Specify: Other Patient may ambulate 30 minutes after arrival in recovery area. Post-op Post-op Post-op Post-op 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 Pulses to assess: Distal Side: Assess and document Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q 4 Pulses to assess: Distal Side: Assess and document Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q 4 Pulses to assess: Distal Side: Assess and document Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q 4 Pulses to assess: Distal Side: Assessine to Perform: Assess/document neurological assessment Q 15 min x4, Q 30 min x4, 1 hour x4, and Q4 x4 unless otherwise ordered by physician. Post-op Post-op Post-op Post-op Post-op The physician must be notified prior to sheath removal of a systolic blood if pressure > 160mmHg. Post-op Post-op The physician must be notified prior to sheath removal of a systolic blood if pressure > 160mmHg. Post-op Post-op The physician - for abnormal vital signs, uncontrolled pain, absence of pulses/limb discoloration, bleeding, hematoma formation, or signs of complications. Patient Education Prior to Sheath Removal and Hospital Discharge Patient education prior to post-sheath removal Patient education prior to discharge Post-op P		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.,
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 Routine, Every 15 min For Until specified Assessment or Perform: Assess/document neurological assessment Q 15 min x4, Q 30 min x4, Q 10 min x4, Q 30 min x4, 1 hour x4, and Q 4 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., Post-op Routine, Once For 1 Occurrences When ACT less than 160 or within physician specified parameters. She may be removed 2 hours after discontinuation of Angiomax (Bivalirudin) infusion unless otherwise specified by physician order., Post-op Post-op Notify physician - for abnormal vital signs, uncontrolled pain, absence of pulses/limb discoloration, bleeding, hematoma formation, or signs of complications. Patient Education Prior to Sheath Removal and Hospital Discharge Patient Education Prior to Sheath Removal and Hospital Discharge Patient Education prior to post-sheath removal Patient Education prior to discharge Patient/Family: Patient Education prior to discharge Patient/Family: Patient Education prior to discharge. Provide patient post-sheath removal instructions to include reports of warmth, moistness, swelling, numbness or pain at insertion site., Post-op varmth, moistness, swelling, numbness or pain at insertion site., Post-op Provide discharge instruction on emergent physician contact/symptom reporting due to bleeding/hematoma/swelling/pain/tendermess/numbness/tingling, Activand 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 fo 4 brs., and 5 brs., and 5 brs., and 5 brs., and 5 brs., post-op Provide discharge instruction on emergent physician contact/symptom reporting due to bleed		Specify: Other activity (specify) Other: Patient may ambulate 30 minutes after arrival in recovery area.
Routine, Every 15 min For Until specified Assessment 16 Perform: Assess/document neurological assessment Q 15 min x4, Q 30 min x4, 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. Remove sheath Routine, Once For 1 Occurrences when ACT less than 160 or within physician specified parameters. Sheam and be removed 2 hours after discontinuation of Angiomax (Bivalirudin) infusion unless otherwise specified by physician order., Post-op Routine, Until discontinued, Starting S, prior to sheath removal of a systolic blood if pressure > 160mmHg. Notify physician - for abnormal vital signs, uncontrolled pain, absence of pulses/limb discoloration, bleeding, hematoma formation, or signs of complications. Patient Education Prior to Sheath Removal and Hospital Discharge Patient Education Prior to Sheath Removal and Hospital Discharge Patient/Family: 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 and Courseling Specify: 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 including Limiting movement in affected am 6 hrs post procedure and keep wrist straight, refrain from lifting or pushing with the affected arm for 48 hrs., and site care. Activity including Limiting movement in affected am 6 hrs post procedure and keep wrist straight, refrain from lifting or pushing with the affected am for 48 hrs., and site care. Act		Pulses to assess: Distal Side: Assess and document Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q 4
Routine, Until discontinued, Starting S, prior to sheath removal of a systolic blood if pressure >160mmHg.	removal	Routine, Every 15 min For Until specified Assessment to Perform: Assess/document neurological assessment Q 15 min x4, Q 30 min x4, C 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
sheath removal of a systolic blood if pressure >160mmHg., Post-op pressure >160mmHg. Remove sheath Routine, Once For 1 Occurrences when ACT less than 160 or within physician specified parameters. Shea may be removed 2 hours after discontinuation of Angiomax (Bivalirudin) infusion unless otherwise specified by physician order., Post-op service and post post post post post post post post	•	
when ACT less than 160 or within physician specified parameters. Shea may be removed 2 hours after discontinuation of Angiomax (Bivalirudin) infusion unless otherwise specified by physician order., Post-op Notify physician - for abnormal vital signs, uncontrolled pain, absence of pulses/limb discoloration, bleeding, hematoma formation, or signs of complications. 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 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 formation, or signs of complications. 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 for the 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/tendemess/numbness/tingling, Activ 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 Provide darm for 48 hrs., and site care., Post-op Routine, Every 15 min Vital signs prior to sheath removal - Obtain base line vital signs, includiverfied ACT results of less than 160 or within parameters ordered by physician, unless otherwise ordered by the physician. For Temp, checkevery 4 hours., Post-op	sheath removal of a systolic blood if pressure >160mmHg.	
uncontrolled pain, absence of pulses/limb discoloration, bleeding, hematoma formation, or signs of complications. Patient Education Prior to Sheath Removal and Hospital Discharge Patient education prior to post-sheath removal Patient/Family: 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-Routine, Prior to discharge, Starting S Patient/Family: Patient Education prior to discharge, Starting S Patient/Family: Patient Education prior to 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, Activ 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 Pre-Sheath Removal Routine, Every 15 min Vital signs prior to sheath removal - Obtain base line vital signs, includiverified ACT results of less than 160 or within parameters ordered by physician, unless otherwise ordered by the physician. For Temp, checkevery 4 hours., Post-op Routine, Once For 1 Occurrences	[] Remove sheath	when ACT less than 160 or within physician specified parameters. Sheath may be removed 2 hours after discontinuation of Angiomax (Bivalirudin)
Discharge [] Patient education prior to post-sheath removal Patient education prior to post-sheath removal Patient/Family: Patient	uncontrolled pain, absence of pulses/limb discoloration, bleeding, hematoma	uncontrolled pain, absence of pulses/limb discoloration, bleeding,
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- 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, Activ 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 Soutine, Every 15 min Vital signs prior to sheath removal - Obtain base line vital signs, includiverified 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		nd Hospital
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, Activ 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, includiverified 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	[] Patient education prior to post-sheath	Patient/Family: Patient Education for: Other (specify), Activity Specify: Patient education prior to post sheath removal.
[] 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	[] Patient education prior to discharge	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
[] 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, 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 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 Routine, Every 15 min	[] Pre-Sheath Removal	2 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
[] Assist patient to void Routine, Once For 1 Occurrences	• •	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
	[] Assist patient to void	Routine, Once For 1 Occurrences

[]	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
[] F	Post-Sheath Removal	5 / I
[]	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
e-sh	eath(s) Removal Diet	
Die	et Clear Liquids	Diet effective now, Starting S Diet(s): Clear Liquids Advance Diet as Tolerated? No IDDSI Liquid Consistency: Fluid Restriction: Foods to Avoid:

[X] Nurse to provide discharge education	Routine, Once Patient/Family: Both Education for: Other (specify) Specify: Nurse to provide patient education Post-op
[] Nurse to provide tobacco cessation education	Routine, Once Patient/Family: Both Education for: Other (specify) Specify: Nurse to provide tobacco cessation education Post-op
Discontinue IV	
[X] Discontinue IV	Routine, Once When IV Fluids completed, Post-op
Hydration Protocol - Prevention of Co	ntrast Induced Nephropathy
IV Fluids	
[] sodium chloride 0.9 % infusion	150 mL/hr, intravenous, continuous, Post-op
IV Hydration - Prevention of Contrast Induced Ne	ephropathy (Single Response)
(X) Outpatient (Single Response)	
() Patients with EF LESS than 40% or with evidence of fluid overload	0.5 mL/kg/hr, intravenous, continuous, Post-op Infuse for 6 hours Post-Procedure or until discharge, whichever come first.
() Patients with EF GREATER than 40% or no evidence of fluid overload	1 mL/kg/hr, intravenous, continuous, Post-op Infuse for 6 hours Post-Procedure or until discharge, whichever come

Medications - Post Procedure **Beta-Blockers (Single Response)** () metoprolol tartrate (LOPRESSOR) tablet 25 mg, oral, 2 times daily at 0600, 1800, Post-op BP & HR HOLD parameters for this order: Contact Physician if: () metoprolol succinate XL (TOPROL-XL) 24 hr tablet 25 mg, oral, daily, Post-op BP & HR HOLD parameters for this order: Contact Physician if: () carvedilol (COREG) tablet 3.125 mg, oral, 2 times daily at 0600, 1800, Post-op BP & HR HOLD parameters for this order: Contact Physician if: **Nitrates** nitroglycerin infusion 5-200 mcg/min, intravenous, continuous, Post-op [] isosorbide mononitrate (ISMO,MONOKET) tablet 20 mg, oral, 2 times daily at 0900, 1600, Post-op Post-Op BP HOLD parameters for this order: Contact Physician if: [] isosorbide mononitrate (IMDUR) 24 hr tablet oral, daily, Post-op Post-Op BP HOLD parameters for this order: Contact Physician if: nitroglycerin (NITRODUR) 24 hr patch transdermal, Administer over: 12 Hours, daily, Post-op Post-Op 1 inch, Topical, every 6 hours scheduled, Post-op

Post-Op, Apply to chest wall

Post-Op. Call provider after third dose.

Post-op

0.4 mg, sublingual, every 5 min PRN, chest pain, For 3 Doses,

first.

Antiplatelet Agents - ONE MUST BE SELECTED (Single Response) (Selection Required)

nitroglycerin (NITROSTAT) 2% ointment

nitroglycerin (NITROSTAT) SL tablet

() Loading Dose Followed By Maintenance			
[] Loading Dose (Single Response)			
() clopidogreL (PLAVIX) tablet	300 mg, oral, once, For 1 Doses Loading Dose		
() ticagrelor (BRILINTA) tablet	180 mg, oral, once, For 1 Doses Loading Dose		
() prasugreL (EFFIENT) tablet	60 mg, oral, once, For 1 Doses Loading Dose		
[] Maintenance Doses Only (Single Response)	5		
() clopidogrel (PLAVIX) 75 mg Maintenance Dose	e and		
aspirin EC 81 mg tablet - Start Tomorrow			
[] clopidogreL (PLAVIX) 75 mg tablet	Normal, 30 tablet, 3		
[] aspirin (ECOTRIN) 81 MG enteric coated tablet	Normal, 30 tablet, 3		
() ticagrelor (BRILINTA) 90 mg Maintenance Dos	e and		
aspirin EC 81 mg tablet - Start 12 Hours from N			
[] ticagrelor (BRILINTA) 90 mg tablet	Normal, 60 tablet, 3		
[] aspirin (ECOTRIN) 81 MG enteric coated	Normal, 30 tablet, 3		
tablet			
() prasugrel (EFFIENT) 10 mg Maintenance Dose	e and		
aspirin EC 81 mg tablet - Start Tomorrow	Name of 20 tablet 2		
[] prasugreL (EFFIENT) 10 mg tablet	Normal, 30 tablet, 3		
[] aspirin (ECOTRIN) 81 MG enteric coated tablet	Normal, 30 tablet, 3		
() Maintenance Doses Only (Single Response)			
() clopidogrel (PLAVIX) 75 mg Maintenance Dose	and		
aspirin EC 81 mg tablet - Start Tomorrow			
[] clopidogreL (PLAVIX) 75 mg tablet	Normal, 30 tablet, 3		
[] aspirin (ECOTRIN) 81 MG enteric coated tablet	Normal, 30 tablet, 3		
() ticagrelor (BRILINTA) 90 mg Maintenance Dose	and		
aspirin EC 81 mg tablet - Start 12 Hours from No	OW CONTRACTOR OF THE CONTRACTO		
[] ticagrelor (BRILINTA) 90 mg tablet	Normal, 60 tablet, 3		
[] aspirin (ECOTRIN) 81 MG enteric coated tablet	Normal, 30 tablet, 3		
() prasugrel (EFFIENT) 10 mg Maintenance Dose	and		
aspirin EC 81 mg tablet - Start Tomorrow			
prasugreL (EFFIENT) 10 mg tablet	Normal, 30 tablet, 3		
aspirin (ECOTRIN) 81 MG enteric coated	Normal, 30 tablet, 3		
tablet			
() Patient already on antiplatelet therapy	Routine, Until discontinued, Starting S		
Antihyperlipidemic Agents - ONE MUST BE SELEC	TED (Single Response) (Selection Required)		
() Statin - Moderate Intensity (Single Response)			
Discharge medication prescription			
Discharge medication prescription			
() atorvastatin (Lipitor) 10 mg tablet	Normal, 30 tablet, 3		
	Normal, 30 tablet, 3		
<u>, , , , , , , , , , , , , , , , , , , </u>	Normal, 30 tablet, 3		
() Statin - High Intensity (Single Response)	,, -		
Discharge medication prescription			
() atorvastatin (Lipitor) 40 mg tablet	Normal, 30 tablet, 3		
<u>, , , , , , , , , , , , , , , , , , , </u>	Normal, 30 tablet, 3		
	Normal, 30 tablet, 3		
() The patient is currently on a statin	Details		
() The patient is currently of a statin () The patient is not on a statin due to contraindicatio			
() The patient is not on a statin due to contraindicatio	Other: contraindication		

Discharge medication prescription - evolocumab (REPATHA) subcutaneous pen or wearable injector (Single Response)	
() evolocumab (Repatha SureClick) 140 No mg/mL pen injector injection	ormal, 2 mL, 0
	ormal, 3.5 mL, 0
Anti-Anginal	
[] ranolazine (RANEXA) 12 hr tablet	500 mg, oral, 2 times daily, Post-op
For Sheath(s) Pull ONLY	
[] atropine injection	0.5 mg, intravenous, once PRN, for heart rate LESS than 55 beats per minute, Post-op
[] diazepam (VALIUM) injection	1 mg, intravenous, once PRN, sedation, Post-op Indication(s): Sedation
[] MIDAZolam (VERSED) injection	1 mg, intravenous, once PRN, sedation, Post-op Indication(s): Sedation
[] fentaNYL (SUBLIMAZE) injection	25 mcg, intravenous, once PRN, severe pain (score 7-10), sheath pull, Post-op Allowance for Patient Preference:
[] morPHINE injection	1 mg, intravenous, once PRN, sheath pull, Post-op Allowance for Patient Preference:
Other Studies	
ECG	
[X] ECG Pre/Post Op (PRN)	Routine, Once, Starting S For 1 Occurrences Clinical Indications: Chest Pain Interpreting Physician: Post-op
[] ECG Pre/Post Op (STAT)	STAT, Once Clinical Indications: Post-Op Surgery Interpreting Physician: Ordering cardiologist to interpret EKG, Post-op
Discharge Instructions - Will print on Pati	ient AVS
Diet - REQUIRED (Single Response)	
(X) Discharge Diet - Heart Healthy	Routine, Normal, Scheduling/ADT
() Discharge Diet- Regular	Discharge Diet: Heart Healthy Routine, Normal, Scheduling/ADT Discharge Diet: Regular
Activity - REQUIRED (Selection Required)	
[] Activity as tolerated	Routine, Normal, Scheduling/ADT
[] Ambulate with assistance or assistive device	Routine, Normal, Scheduling/ADT
[] Lifting restrictions	Routine, Normal, Scheduling/ADT, No lifting over 10 pounds.
[] Weight bearing restrictions (specify)	Routine, Normal, Scheduling/ADT Weight Bearing Status: Extremity:

[] Moderate bedrest with complete pelvic rest (no tampo douching, sex)	
[] Complete pelvic rest (no tampons, douching, sex)	Routine, Normal, Scheduling/ADT
[] No driving for 2 days	Routine, Normal, Scheduling/ADT
[] Shower instructions:	Routine, Normal, Scheduling/ADT, ***
Discharge activity Other restrictions (specify):	Routine, Normal, Scheduling/ADT Routine, Normal, Scheduling/ADT, ***
[] Outor resultations (specify).	Modulie, Molitiai, Joliedailing/ADT,

Wound/Incision Care	
[] Discharge wound care	Routine, Normal, Scheduling/ADT, ***
[] Discharge incision care	Routine, Normal, Scheduling/ADT, ***
[] Discharge dressing	Routine, Normal, Scheduling/ADT, ***
Notify Physician	
[X] Call physician for:	Routine, Normal, Scheduling/ADT, Temperature greater that 100.5
	Persistent nausea or vomiting
	Severe uncontrolled pain
	Redness, tenderness, or signs of infection (pain, swelling,
	redness, odor or green/yellow discharge from affected area)
	Difficulty breathing, chest pain, persistent dizziness or light-headedness
[] Call physician for:	Routine, Normal, Scheduling/ADT, ***
[] Can proceedings	
Referrals and Follow Ups - Will Print on Patie	
Referral to Cardiac Rehabilitation Phase II (Single Respons	se) (Selection Required) eferral to Cardiac Rehab Phase II and select the order: "The
Referral to Cardiac Rehabilitation Phase II (Single Responsible Please unselect if patient does not meet requirements for Repatient will not be referred to cardiac rehab due to:" (a reasonable patient will not be referred to cardiac rehab due to:	se) (Selection Required) eferral to Cardiac Rehab Phase II and select the order: "The on is required on this order).
Referral to Cardiac Rehabilitation Phase II (Single Responsible Please unselect if patient does not meet requirements for Re	se) (Selection Required) eferral to Cardiac Rehab Phase II and select the order: "The
Referral to Cardiac Rehabilitation Phase II (Single Responsible Please unselect if patient does not meet requirements for Repatient will not be referred to cardiac rehab due to:" (a reasonable patient will not be referred to cardiac rehab due to:	se) (Selection Required) eferral to Cardiac Rehab Phase II and select the order: "The on is required on this order). Internal Referral, Scheduling/ADT I am referring my patient to outpatient Cardiac Rehabilitation for: Initial, Phase II (36 Sessions) prescription for Cardiac
Referral to Cardiac Rehabilitation Phase II (Single Responsible Please unselect if patient does not meet requirements for Repatient will not be referred to cardiac rehab due to:" (a reasonable patient will not be referred to cardiac rehab due to:	se) (Selection Required) eferral to Cardiac Rehab Phase II and select the order: "The on is required on this order). Internal Referral, Scheduling/ADT I am referring my patient to outpatient Cardiac Rehabilitation for: Initial, Phase II (36 Sessions) prescription for Cardiac Rehabilitation.
Referral to Cardiac Rehabilitation Phase II (Single Responsible Please unselect if patient does not meet requirements for Repatient will not be referred to cardiac rehab due to:" (a reasonable patient will not be referred to cardiac rehab due to:	se) (Selection Required) eferral to Cardiac Rehab Phase II and select the order: "The on is required on this order). Internal Referral, Scheduling/ADT I am referring my patient to outpatient Cardiac Rehabilitation for: Initial, Phase II (36 Sessions) prescription for Cardiac Rehabilitation. Medical justification required: s/p MI (last 12 months)
Referral to Cardiac Rehabilitation Phase II (Single Response Please unselect if patient does not meet requirements for Repatient will not be referred to cardiac rehab due to:" (a reason) (X) Referral to Cardiac Rehab Phase 2	se) (Selection Required) eferral to Cardiac Rehab Phase II and select the order: "The on is required on this order). Internal Referral, Scheduling/ADT I am referring my patient to outpatient Cardiac Rehabilitation for: Initial, Phase II (36 Sessions) prescription for Cardiac Rehabilitation.
Referral to Cardiac Rehabilitation Phase II (Single Response Please unselect if patient does not meet requirements for Repatient will not be referred to cardiac rehab due to:" (a reason) (X) Referral to Cardiac Rehab Phase 2 () The patient will not be referred to cardiac rehab due to:	se) (Selection Required) eferral to Cardiac Rehab Phase II and select the order: "The on is required on this order). Internal Referral, Scheduling/ADT I am referring my patient to outpatient Cardiac Rehabilitation for: Initial, Phase II (36 Sessions) prescription for Cardiac Rehabilitation. Medical justification required: s/p MI (last 12 months) s/p MI (last 12 mos) Date:
Referral to Cardiac Rehabilitation Phase II (Single Response Please unselect if patient does not meet requirements for Repatient will not be referred to cardiac rehab due to:" (a reason) (X) Referral to Cardiac Rehab Phase 2 () The patient will not be referred to cardiac rehab due to: Place Follow-Up Order	se) (Selection Required) eferral to Cardiac Rehab Phase II and select the order: "The on is required on this order). Internal Referral, Scheduling/ADT I am referring my patient to outpatient Cardiac Rehabilitation for: Initial, Phase II (36 Sessions) prescription for Cardiac Rehabilitation. Medical justification required: s/p MI (last 12 months) s/p MI (last 12 mos) Date:
Referral to Cardiac Rehabilitation Phase II (Single Response Please unselect if patient does not meet requirements for Repatient will not be referred to cardiac rehab due to:" (a reason) (X) Referral to Cardiac Rehab Phase 2 () The patient will not be referred to cardiac rehab due to: Place Follow-Up Order	se) (Selection Required) eferral to Cardiac Rehab Phase II and select the order: "The on is required on this order). Internal Referral, Scheduling/ADT I am referring my patient to outpatient Cardiac Rehabilitation for: Initial, Phase II (36 Sessions) prescription for Cardiac Rehabilitation. Medical justification required: s/p MI (last 12 months) s/p MI (last 12 mos) Date: The patient will not be referred to cardiac rehab due to:
Referral to Cardiac Rehabilitation Phase II (Single Response Please unselect if patient does not meet requirements for Repatient will not be referred to cardiac rehab due to:" (a reason) (X) Referral to Cardiac Rehab Phase 2 () The patient will not be referred to cardiac rehab due to: Place Follow-Up Order	se) (Selection Required) eferral to Cardiac Rehab Phase II and select the order: "The on is required on this order). Internal Referral, Scheduling/ADT I am referring my patient to outpatient Cardiac Rehabilitation for: Initial, Phase II (36 Sessions) prescription for Cardiac Rehabilitation. Medical justification required: s/p MI (last 12 months) s/p MI (last 12 mos) Date: The patient will not be referred to cardiac rehab due to: Follow up with me:
Referral to Cardiac Rehabilitation Phase II (Single Response Please unselect if patient does not meet requirements for Repatient will not be referred to cardiac rehab due to:" (a reason) (X) Referral to Cardiac Rehab Phase 2 () The patient will not be referred to cardiac rehab due to: Place Follow-Up Order	se) (Selection Required) eferral to Cardiac Rehab Phase II and select the order: "The on is required on this order). Internal Referral, Scheduling/ADT I am referring my patient to outpatient Cardiac Rehabilitation for: Initial, Phase II (36 Sessions) prescription for Cardiac Rehabilitation. Medical justification required: s/p MI (last 12 months) s/p MI (last 12 mos) Date: The patient will not be referred to cardiac rehab due to: Follow up with me: Clinic Contact: Follow up in: On date:
Referral to Cardiac Rehabilitation Phase II (Single Response Please unselect if patient does not meet requirements for Repatient will not be referred to cardiac rehab due to:" (a reason) (X) Referral to Cardiac Rehab Phase 2 () The patient will not be referred to cardiac rehab due to: Place Follow-Up Order [X] Follow-up with me	se) (Selection Required) eferral to Cardiac Rehab Phase II and select the order: "The on is required on this order). Internal Referral, Scheduling/ADT I am referring my patient to outpatient Cardiac Rehabilitation for: Initial, Phase II (36 Sessions) prescription for Cardiac Rehabilitation. Medical justification required: s/p MI (last 12 months) s/p MI (last 12 mos) Date: The patient will not be referred to cardiac rehab due to: Follow up with me: Clinic Contact: Follow up in: On date: Appointment Time:
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