University Medical Center

Disclaimer: The is a suggested interdisciplinary plan of care. This is only a guideline. The patient problem, outcomes and interventions may be changed to meet the individual needs of the patient. Physician / Medical orders supersede all pre-printed interventions identified on the

ADDRESSOGRAPH

Coronary Catheterization / Interventional

☐ Coronary Cath Map ☐ Coronary Interventional Map

Estimated LOS: 12 hrs / 2 days Date placed on map: _____

Primary Diagnosis / Procedure: _____

Secondary Diagnosis / Procedure: _____

Allergies: _____

Code Status: _____

SIGNIFICANT PAST MEDICAL HSTORY (If taking Glucopahage, must be off 6 hrs. pre and 48 hrs. post procedure.)

☐ CHF ☐ PVD ☐ Renal Failure ☐ MI Date: _____ ☐ Hypercholesteriemia ☐ COPD

☐ Hypertension ☐ Obesity ☐ Family History ☐ Cerebrovascular Disease

☐ Diabetes ☐ Diet ☐ Insulin ☐ Oral

Smoker: ☐ Never ☐ Current (use of tobacco products within 1 month of this admission)

☐ Former (use of tobacco products greater than 1 month prior to admission)

PREVIOUS CARDIAC SURGERIES / CARDIAC PROCEDURES

	Date	Lesion
Cardiac Catheterization	_____	_____
Coronary Interventional Procedure:	_____	_____
Coronary Artery Bypass	_____	_____
Valve Surgery	_____	_____
Other: _____	_____	_____
_____	_____	_____

Instructions for Documentation:

OUTCOMES / INTERVENTIONS:

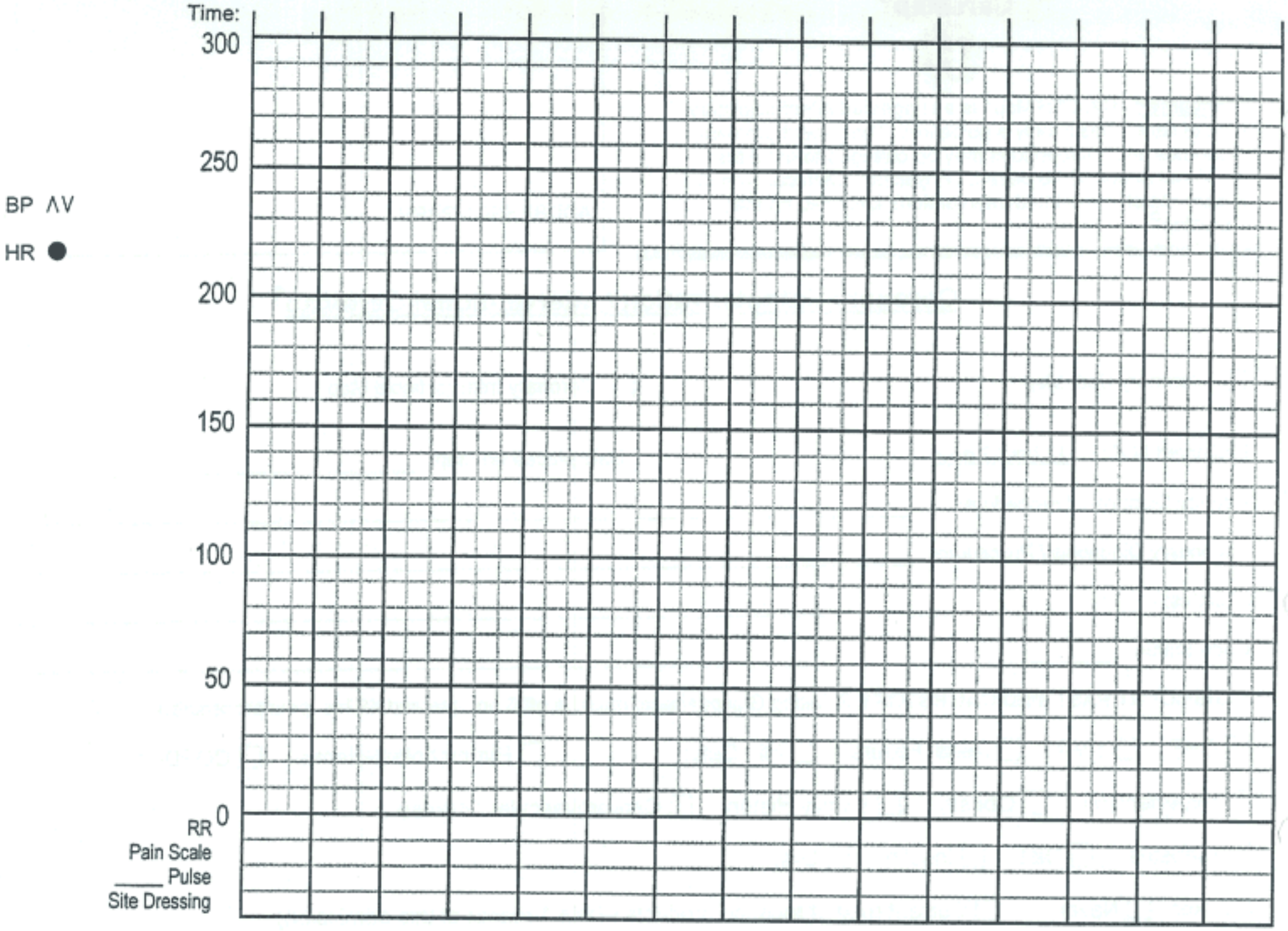
- Initial when met or completed
- Use notation N/A, if not applicable for the timeframe
- Initial and circle, if not met or completed

SUPPLEMENTAL DOCUMENTATION is required on the Interdisciplinary Progress Record when an outcome or intervention is initialed and circled, indicating it was not met or completed as stated.

RN Signature: _____ ***Date/Time:*** _____

RN Signature: _____ ***Date/Time:*** _____

MR # _____



Intravenous Solutions:

Solution	Amount	Start

Stent Sticker

ACT Parameters:
Baseline 120 – 196 sec
Therapeutic > 300 sec

IABP

Size: _____
Insertion Site _____ Time: _____
Timing: _____
Systolic: _____
Diastolic: _____
Augmentation: _____
Diastolic Dip: _____
Distal Pulses: Rt: _____ Lt: _____
Comments: _____

Transfer Summary

Vital Signs:
BP: _____ HR: _____ RR: _____
Cardiac Rhythm: _____
Puncture Site: _____
Distal Pulses: _____
Transfer to: _____ Time: _____
Accompanied by: _____

☐ Angioseal booklet ☐ Perclose booklet

Comments: _____

Coronary Catheterization_ Interventional

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

ADDRESSOGRAPH

DESIRED OUTCOMES — **D = DAYS E = EVENINGS N = NIGHTS**

Problem/ Needs	Pre-Admission/2 hrs. Pre-Procedure Date: _____	D	E	N
Knowledge Deficit related to plan of care	Verbalizes understanding of pre-procedure instructions			
Pain Management	Pain free or verbalizes pain relief after intervention.			
Alterations in ADL's due to: _____ _____ _____ _____ _____	Able to perform ADL's with (choose one): ____ assistance ____ independently			
Chest Pain	Chest pain free			
Unstable Cardiac Rhythm	Cardiac rhythm stable for patient			

Problem/ Needs		D	E	N
Unstable Vital Signs	Vital signs stable for patient			
	Patient awake,alert and oriented			
	Lungs clear to auscultation			
Pulses Present	Distal pulses palpable / audible			
Patient Safety	Remains injury free in a safe environment.			
Skin Integrity	No evidence of skin breakdown.			
Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan	Assess need for Discharge Planning / Social Service based on nursing assessment of home environment / patient condition.			

Patient Care Categories		D	E	N
Nutrition	* NPO 6 hrs. prior to procedure, except for medications			

** indicates medical orders needed*

MR# _____ **INTERVENTIONS (continued)**

Patient Care Categories	Pre-Admission/2 hrs. Pre-Procedure Date: _____	D	E	N
Assessment & Treatments	* History / Physical completed			
	Initial assessment completed			
	* Consent # 1 obtained			
	* Consent # 2 obtained			
	* If allergic to iodine / shell fish / contrast discuss need for Solucortef. MD notified at _____ am/pm			
	* Shave and prep @ _____ am/pm _____ Right _____ Left Groin _____ Right _____ Left Arm			
	Assess and document distal pulses: Dorsalis Pedis Lt: _____ Rt: _____ Posterior Tibial Lt: _____ Rt: _____			
	Assess lung sounds			
	Assess LOC			
	Encourage patient to void on call to Cath Lab			
	PIID lock site: _____ Inserted by: _____			
	* Heparin Drip (25,000u in 250cc D_5W) D/C on call to Cath Lab _____ am/pm or continue Heparin _____ cc/hr			
	* Administer pre-medication if ordered			
	* Transfer to Cath Lab: _____ am/pm			
	Hygiene & Comfort Protocol			
	Peripheral IV Therapy Protocol			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Assess patient/family satisfaction.			
	Encourage verbalization of fears / concerns.			
	Assess knowledge level and readiness to learn.			
	Instruct patient to anticipate: - EKG to monitor heart rate - Sensation of heat as dye is injected - Coughing and deep breathing during procedure - Inform MD if chest pain or difficulty in breathing occurs			
	Review with patient "Take Care of the Heart You Have" booklet if indicated			
Specimens & Diagnostics	* Tests / Procedures _____ _____ _____ _____ _____ _____			
	Assess lab results: CXR, CBC, Platelets, SMA - 7, PTT, PT, INR, EKG (on chart to Cath Lab) MD notified if indicated			
Safety & Activity	Falls protocol initiated.			
	* Activity level: * Bedrest maintained after pre-medications			
	Patient Identification bracelet confirmed			

Coronary Catheterization_ Interventional

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

ADDRESSOGRAPH

DESIRED OUTCOMES **D = DAYS E = EVENINGS N = NIGHTS**

Problem/ Needs	Intra Procedure Date: _____	D	E	N
Knowledge Deficit related to plan of care	Verbalizes understanding of procedural events			
Pain Management	Pain free or verbalizes pain relief after intervention.			
Alterations in ADL's due to: _____ _____ _____ _____				
Chest Pain	Chest pain free			
Unstable Cardiac Rhythm	Cardiac rhythm stable for patient			

Problem/ Needs		D	E	N
Unstable Vital Signs	Vital signs stable for patient			
	Patient awake,alert and oriented			
	Hemodynamic status stable for patient			
Bleeding from Cath Site	Procedure site intact			
	No hematoma noted > 2 inches			
Pulses Present	Distal pulses palpable / audible			
Patient Safety	Remains injury free in a safe environment.			
Skin Integrity	No evidence of skin breakdown.			
Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan				

Patient Care Categories		D	E	N
Nutrition	* Diet: NPO			

** indicates medical orders needed*

MR# _____ **INTERVENTIONS (continued)**

Patient Care Categories	Intra Procedure Date: _____	D	E	N
Assessment & Treatments	Review completed assessment prior to starting procedure			
	* IV 0.9% normal saline with 8,000u Heparin for intra arterial flush			
	Assess and document distal pulses: Dorsalis Pedis Lt: _____ Rt: _____ Posterior Tibial Lt: _____ Rt: _____			
	* Patient prepped and sterile drape applied			
	* Procedure start time: _____			
	* Physician performing: _____			
	* Procedure performed: _____			
	* Continuous monitoring of arterial pressure, heart rate, & cardiac rhythm: _____			
	* 2% Lidocaine: _____ groin/arm Injected by Dr. _____			
	Arterial sheath: _____ FR Venous sheath: _____ FR Inserted by Dr. _____			
	During conscious sedation, vital signs & oxygen saturation monitored and recorded q5min			
	* IV - see flowsheet			
	* Administer 0.9% normal saline at: _____ cc/hr			
	Hygiene & Comfort Protocol			
	Peripheral IV Therapy Protocol			
	*0_2 3L / min via nasal canula			
	For Cardiac Cath only: Procedure complete _____ am/pm Patient transferred to recovery room: _____ am/pm **See Recovery Phase**			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Assess patient/family satisfaction.			
	Encourage verbalization of fears / concerns.			
	Assess knowledge level and readiness to learn.			
	Reinforce pre-procedure teaching			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	* Tests / Procedures _____			
Safety & Activity	Falls protocol initiated.			
	* Activity level: * Bedrest: Leg: _____ Arm: _____ immobolized			
	Patient Identification bracelet confirmed			

Coronary Catheterization_ Interventional *Diagnosis/Procedures*

Signature	Title	Initial

Signature Requiring Co-Signature		
Signature	**Date/Shift**	**Initial /Title**

Addressograph

INTERVENTIONS

PTCA/STENT ☐ Post-Roto ☐ Post Angiojet	RN Init	PTCA/STENT ☐ Post-Roto ☐ Post Angiojet	RN Init	PTCA/STENT ☐ Post-Roto ☐ Post Angiojet	RN Init
Lesion # _____		Lesion # _____		Lesion # _____	
Lesion visualized		Lesion visualized		Lesion visualized	
Wire advanced to lesion Type: _____		Wire advanced to lesion Type: _____		Wire advanced to lesion Type: _____	
Balloon advanced over guide wire Type: _____ Location: _____ Type: _____ Location: _____		Balloon advanced over guide wire Type: _____ Location: _____ Type: _____ Location: _____		Balloon advanced over guide wire Type: _____ Location: _____ Type: _____ Location: _____	
Cutting balloon advanced: Type: _____ Location: _____		Cutting balloon advanced: Type: _____ Location: _____		Cutting balloon advanced: Type: _____ Location: _____	
Balloon inflation: ST's : ☐ Baseline ☐ Increased ☐ Decreased Chest pain ☐ Yes ☐ No		Balloon inflation: ST's : ☐ Baseline ☐ Increased ☐ Decreased Chest pain ☐ Yes ☐ No		Balloon inflation: ST's : ☐ Baseline ☐ Increased ☐ Decreased Chest pain ☐ Yes ☐ No	
Balloon deflation: ST's : Baseline ☐ Yes ☐ No Chest pain relieved ☐ Yes ☐ No		Balloon deflation: ST's : Baseline ☐ Yes ☐ No Chest pain relieved ☐ Yes ☐ No		Balloon deflation: ST's : Baseline ☐ Yes ☐ No Chest pain relieved ☐ Yes ☐ No	
ACT: Time: _____ ACT: _____ Time: _____ ACT: _____		ACT: Time: _____ ACT: _____ Time: _____ ACT: _____		ACT: Time: _____ ACT: _____ Time: _____ ACT: _____	
Stent deployed: Type: _____ Location: _____ Type: _____ Location: _____		Stent deployed: Type: _____ Location: _____ Type: _____ Location: _____		Stent deployed: Type: _____ Location: _____ Type: _____ Location: _____	
Inflation of Stent balloon: ST's : ☐ Baseline ☐ Increased ☐ Decreased Chest pain ☐ Yes ☐ No		Inflation of Stent balloon: ST's : ☐ Baseline ☐ Increased ☐ Decreased Chest pain ☐ Yes ☐ No		Inflation of Stent balloon: ST's : ☐ Baseline ☐ Increased ☐ Decreased Chest pain ☐ Yes ☐ No	
Deflation of stent balloon ST's : Baseline ☐ Yes ☐ No Chest pain relieved ☐ Yes ☐ No		Deflation of stent balloon ST's : Baseline ☐ Yes ☐ No Chest pain relieved ☐ Yes ☐ No		Deflation of stent balloon ST's : Baseline ☐ Yes ☐ No Chest pain relieved ☐ Yes ☐ No	
II B / III A Bolus given ☐ Infusion Started ☐ _____ am / pm		II B / III A Bolus given ☐ Infusion Started ☐ _____ am / pm		II B / III A Bolus given ☐ Infusion Started ☐ _____ am / pm	
Procedure Completed _____ am / pm		Procedure Completed _____ am / pm		Procedure Completed _____ am / pm	
Arterial Sheath: Sutured in place _____ am/pm Angioseal deployed _____ am/pm Perclose deployed _____ am/pm		Arterial Sheath: Sutured in place _____ am/pm Angioseal deployed _____ am/pm Perclose deployed _____ am/pm		Arterial Sheath: Sutured in place _____ am/pm Angioseal deployed _____ am/pm Perclose deployed _____ am/pm	
Total Contrast _____ cc		Total Contrast _____ cc		Total Contrast _____ cc	
Transferred to Recovery Room _____ am / pm		Transferred to Recovery Room _____ am / pm		Transferred to Recovery Room _____ am / pm	

Coronary Interventional CareMap® Diagnosis/Procedures MR# _____

Procedure ROTATIONAL ARTHRECTOMY	RN Init	Procedure BRACHY THERAPY	RN Init	Procedure ANGIOJET	RN Init
Arterial sheath upsize _____ fr		Angioplasty complete _____ am / pm		Lesion visualized: _____	
TVP inserted by: _____		Arterial sheath upsized _____ fr.		Angiojet system prepped & purged	
TVP Settings: Rate: _____ MA: _____ Mode: _____		Radiation therapy catheter advanced & delivered across lesion by cardiologist		Angiojet cath advanced to lesion	
TVP removed at end of procedure by MD		Radiation oncologist delivered radioactive source		Angiojet in progress ST's ☐ increased ☐ decreased Chest pain ☐ Yes ☐ No Heart Rate: ☐ increased ☐ decreased Blood Pressure: ☐ increased ☐ decreased # passes _____	
Lesion visualized		Dwell in place for: _____ minutes _____ seconds ST's ☐ increased ☐ decreased Chest pain ☐ Yes ☐ No			
Roto wire advanced Type: _____					
Burr advanced to lesion burr size _____ lesion _____ burr size _____ lesion _____ burr size _____ lesion _____		Radiation source returned into device by radiation oncologist		Angiojet complete ST's baseline ☐ Yes ☐ No Chest pain relieved ☐ Yes ☐ No HR / BP stable ☐ Yes ☐ No	
		Radiation delivery catheter removed by cardiologist			
		Room & patient surveyed by physicist with negative results		ACT: Time: _____ ACT: _____ Time: _____ ACT: _____ Time: _____ ACT: _____	
Roto in progress ST's ☐ increased ☐ decreased Chest pain ☐ Yes ☐ No Heart Rate: ☐ increased ☐ decreased Pacing ☐ Yes ☐ No Blood Pressure: ☐ increased ☐ decreased		Procedure complete _____ am / pm see immediate post - procedure intervention			
		Arterial sheath: Sutured in place _____ am/pm Perclose deployed _____ am/pm Angioseal deployed ___ am/pm		Balloon advanced: See PTCA / Stent interventions	
		Brachy therapy consent on chart			
Roto completed ST's baseline ☐ Yes ☐ No HR / BP stable ☐ Yes ☐ No Chest pain relieved ☐ Yes ☐ No					

ACT: Time: _____ ACT: _____ Time: _____ ACT: _____ Time: _____ ACT: _____		PROCEDURE INTRAVASCULAR ULTRASOUND	RN Init	PROCEDURE PRESSURE WAVE WIRE	RN Init
Balloon advanced. See PTCA / Stent interventions.		Vessel visualized: _____		Vessel visualized: _____	
Procedure complete _____ am/pm See immediate post-procedure interventions		Wire advanced to vessel		Wave wire prepped, zeroed & normalized	
		Intravascular Ultrasound cath prepped & advanced to vessel		Wave wire advanced to lesion proximal / distal	
Arterial sheath: Sutured in place _____ am/pm Perclose deployed _____ am/pm Angioseal deployed ___ am/pm		Intravascular Ultrasound in progress ST's baseline ☐ Yes ☐ No Chest pain ☐ Yes ☐ No		Administer _____ as per protocol	
				Flow rates _____ Flow rates _____	
		Intravascular Ultrasound Complete: _____ am/pm See PTCA / Stent or immediate post-procedure		Wave wire removed See PTCA / Stent or immediate post-procedure	

Coronary Catheterization_ Interventional

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

ADDRESSOGRAPH

DESIRED OUTCOMES **D = DAYS E = EVENINGS N = NIGHTS**

Problem/ Needs	Recovery Phase Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of post instructions, including rationale			
Pain Management	Pain free or verbalizes relief after intervention.			
Chest Pain	Chest pain free or verbalized relief after intervention			
Unstable Cardiac Rhythm	Cardiac rhythm stable for patient			
Unstable Vital Signs	Vital signs stable for patient			
	Patient awake, alert and oriented			
	Hemodynamic status stable for patient			

Problem/ Needs		D	E	N
Bleeding from Cath site	Hemostasis obtained			
	No hematoma noted > 2 inches			
Pulses Present	Distal pulses palpable / audible			
Patient Safety	Remains injury free in a safe environment.			
Skin Integrity	No evidence of skin breakdown.			
Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan				

Patient Care Categories		D	E	N
Nutrition	* Encourage fluid intake			
	% of diet consumed:			
	Breakfast _____ %			
	Lunch _____ %			
	Dinner _____ %			

** indicates medical orders needed*

MR# _____ INTERVENTIONS

Patient Care Categories	Recovery Phase Date: _____	D	E	N
Assessment & Treatments	* Monitor cardiac rhythm continuously			
	* Monitor VS continuously and record q15min until discharged from recovery			
	ACT = _____ @ _____ am/pm			
	* Arterial/Venous sheaths removed according to established guideline: ____ am/pm by: _____			
	* Apply manual pressure to site until hemostasis obtained: _____ am/pm			
	Topical patch applied _____ @ _____ am/pm			
	Assess and document distal pulses: Dorsalis Pedis Lt: _____ Rt: _____ Posterior Tibial Lt: _____ Rt: _____			
	DSD applied: _____ groin			
	Report given to _____ RN			
	Initial voiding: _____ cc			
	* Transfer to: _____ unit _____ am/pm. Instable condition			
	* IV - see flowsheet Condition: _____ Site: _____			
	Hygiene and Comfort Protocol implemented			
	Peripheral IV Therapy Protocol implemented			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Post-procedure teaching Instruct: • Rationale for bedrest/HOB 30 degrees; immobilization of affected extremity. • Inform nurse of numbness or tingling of affected extremity, or bleeding from cath site. • Apply pressure to area when coughing or sneezing. • Inform nurse of any chest pain or difficulty breathing. • Increase fluid intake.			
	If Vascular Hemstatis Device utilized, give patient **"VHD Information"** booklet.			
	Stentcard reviewed with patient - placed on chart / given to patient			
Specimens & Diagnostics	EKG complete			
Safety & Activity	Falls protocol initiated.			
	* Bedrest with immobilization of affected extremity _____ hrs.			
	* 5 lb. Sandbag applied to _____ groin for _____ hrs. if ordered.			

Coronary Catheterization_ Interventional

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

CATHETERIZATION ONLY

ADDRESSOGRAPH

DESIRED OUTCOMES **D = DAYS E = EVENINGS N = NIGHTS**

Problem/ Needs	Post Procedures 1 - 4 hours Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of anticipated plan of care and participates in decision making.			
Pain Management	Pain free or verbalizes relief after intervention.			
	Chest pain free			
Unstable Cardiac Rhythm	Cardiac rhythm stable for patient			
Unstable Vital Signs	Vital signs stable for patient			
	Patient awake, alert and oriented			
	Lungs clear to ausculation			
Bleeding From Cath Site	Hemostasis maintained			
	No hematoma noted > 2 inches			
Diminshed Pulses	Distal pulses palpable / audible			

Problem/ Needs		D	E	N
Patient Safety	Remains injury free in a safe environment.			
Skin Integrity	No evidence of skin breakdown.			
Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan				

Patient Care Categories		D	E	N
Nutrition	* Diet: Resume diet: _____			
	% of diet consumed: Breakfast _____% Lunch _____ % Dinner _____ %			
	Encourage fluid intake			

** indicates medical orders needed*

MR # _____ INTERVENTIONS

Patient Care Categories	Post Procedure 1 - 4 Hours Date: _____	D	E	N	Patient Care Categories		D	E	N
Assessment & Treatments	VS q 15 mins X 4; q 30 min X 2 and q 1 hr X 4 and PRN				Teaching & Psychosocial	Encourage verbalization of fears / concerns.			
	Monitor site for bleeding, tenderness, and hematoma q 15 min X 4, q 30 min X 2, q 1hr X 4 and PRN					Learning needs / teaching plan: - Rationale for bedrest and immobilization of affected extremity - Inform nurses of numbness or tingling of affected extremity or bleeding from cath site - Apply pressure to area when coughing or sneezing			
	Assess lung sounds								
	Initial voiding _____ cc								
	Distal pulse assessment q 15 min X 4, q 30 min X 2, q 1 hr X 4 and PRN								
	Document distal pulses: Dorsalis Pedis: Lt: _____ Rt: _____ Posterior Tibial: Lt: _____ Rt: _____								
	IV: See Flowsheet Site: _____ Condition: _____								
	Assess and document for bruit q 1hr X _____ hrs								
					Specimens & Diagnostics				
					Safety & Activity	Falls protocol initiated.			
						* Activity level: Keep leg immobile. Complete bedrest for _____ hr			
						HOB elevated 30 degrees			
						5 lb. Sandbag to _____ groin for _____ hrs			
						Brachial Technique: Bedrest for 2 hrs. Keep arm straight for 4 hrs.			
						OOB after 3 hrs if VHD			
	* Respiratory Care provided.								

Coronary Catheterization_ Interventional

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

CATHETERIZATION ONLY

ADDRESSOGRAPH

DESIRED OUTCOMES **D = DAYS E = EVENINGS N = NIGHTS**

Problem/ Needs	Post Procedures 5 - 12 hours Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of anticipated plan of care and participates in decision making.			
Pain Management	Pain free or verbalizes relief after intervention.			
	Chest pain free			
Unstable Cardiac Rhythm	Cardiac rhythm stable for patient			
Unstable Vital Signs	Vital signs stable for patient			
	Patient awake, alert and oriented			
	Lungs clear to ausculation			
Bleeding From Cath Site	Hemostatis maintained			
	No hematoma noted > 2 inches			
Diminshed Pulses	Distal pulses palpable / audible			

Problem/ Needs		D	E	N
Patient Safety	Remains injury free in a safe environment.			
Skin Integrity	No evidence of skin breakdown.			
Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan	Discharge to: Home: _____ Admit: _____			

Patient Care Categories		D	E	N
Nutrition	* Diet:			
	% of diet consumed:			
	Breakfast _____%			
	Lunch _____ %			
	Dinner _____ %			
	Encourage fluid intake			

** indicates medical orders needed*

MR # _____ **INTERVENTIONS**

Patient Care Categories	Post Procedures 5 - 12 hours Date: _____	D	E	N
Assessment & Treatments	VS q 4 hrs until discharge			
	Assess site for bleeding, tenderness and hematoma			
	Pulse q 1 hr until discharge			
	Assess and document distal pulses on Flowsheet Left _____ Right _____			
	PIID lock removed			
	Voided _____ cc			
	No bruit present			
	* Respiratory Care provided.			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Encourage verbalization of fears / concerns.			
	Learning needs / teaching plan: - Instruct activity program - Inform nurses of numbness or tingling of affected extremity or bleeding from cath site - Apply pressure to area when coughing or sneezing			
	Instruct patient/family on care: - Action to take if chest pain occurs - Cath site care, including signs and symptoms of infection and action to take if bleeding - Follow-up appointment with MD			
	- Fluids, diet, meds and new Rx if any			
Specimens & Diagnostics				
Safety & Activity	Falls protocol initiated.			
	* Activity level: Ambulating ad lib			

Coronary Catheterization_ Interventional

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

INTERVENTIONAL ONLY

ADDRESSOGRAPH

DESIRED OUTCOMES **D = DAYS E = EVENINGS N = NIGHTS**

Problem/ Needs	Post Procedure Day 1 Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of diagnosis and plan of care, participates in decision making.			
	Orient to telemetry unit, call bell system, TV, & bed controls, post procedure care			
	Patient/family verbalizes understanding of post-procedure instructions.			
Pain Management	Pain free or verbalizes pain relief after intervention.			
	Remains free of chest pain, SOB, groin or back discomfort			
Alterations in ADL's due to: Bedrest Sheath Placement	Able to perform ADL's with (choose one): _____ assistance _____ independently			
Sheath Access Site	Remains free of bleed, hematoma, bruit, signs and symptoms of infection, ecchymosis			
Tissue Perfussion	Will have (+) peripheral pulses; extremities warm bilateral; (-) numbness / tingling			

Problem/ Needs		D	E	N
Telemetry	Remains WNL for patient			
Unstable Vital Signs	Vital Signs stable for patient.			
	Patient awake, alert and oriented.			
	Hemodynamic status stable for patient.			
Patient Safety	Remains injury free in a safe environment.			
Skin Integrity	No evidence of skin breakdown.			
Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan	Assess need for Discharge Planning / Social Service based on nursing assessment of home environment / patient condition.			
	Insurance:			

Patient Care Categories		D	E	N
Nutrition	% of diet consumed: Breakfast _____% Lunch _____ % Dinner _____ %			
	Encourage P.O. fluids			

MR# _____ INTERVENTIONS (continued)

Patient Care Categories	Post Procedure Day 1 Date: _____	D	E	N
Assessment & Treatments	Monitor and record vital signs, distal pulses, sheath access site every 15 mins. X 1 hr., every 30 mins. X 2 hrs., every 1 hr. x 4 hrs. post procedure and post sheath removal.			
	I & O q 8 hrs.			
	* Telemetry #			
	* O_2: 3 liters nasal cannula prn chest pain			
	Change sheath dressing PRN sterile technique			
	MD notified of variances per protocol Yes _____ No _____			
	Arterial / venous sheath removed and documented in progress notes according to protocol			
	Notify MD of significant changes in vital signs, dimished distal pulses, persistant bleeding or hematoma > 2 cms.			
	Notify MD if ckmb > 8.			
	Apply pressure dessing and additional manual pressure if bleeding or oozing persists.			
	IV: _____ @ ____ cc/hr. Discontinue @ _____			
	IV: _____ @ ____ cc/hr. Discontinue @ _____			
	Hygiene & Comfort Protocol			
	Peripheral IV Therapy Protocol			
	Pressure Ulcer Prevention Protocol			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Assess patient/family satisfaction.			
	Encourage verbalization of fears / concerns.			
	Assess knowledge level and readiness to learn.			
	Inform patient of possible discharge in a.m.			
	Provide patient with procedural and educational materials.			
	Instruct patient to maintain bedrest with alignment of limb.			
	Instruct patient to inform the RN of numbness, tingling of leg and bleeding from groin.			
	Instruct patient to notify RN if having chest discomfort or SOB			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	* Tests / Procedures CBC _____ 4 hours post CKMB _____ 8 hours post EKG _____ stat post _____ _____ _____			
Safety & Activity	Falls protocol initiated.			
	* Activity level: Bedrest x _____ hrs. after sheath removal			
	Assess need for functional evaluation by rehab.			
	Follow post interventional orders regarding activity			
	Hemostatis obtained @ _____			
	HOB limited to < 30 degress during bed rest period.			
	Immobilize involved extremity for _____ hrs.			
	Apply leg or arm immbilizer prn.			
	May apply sandbag to access site.			

Coronary Catheterization_ Interventional

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

ADDRESSOGRAPH

DESIRED OUTCOMES

D = DAYS E = EVENINGS N = NIGHTS

Problem/ Needs	Day 2 Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of diagnosis and plan of care, participates in decision making.			
Pain Management	Pain free or verbalizes pain relief after intervention.			
	Remains free of chest pain, SOB, groin or back discomfort			
Alterations in ADL's due to: _____ _____ _____ _____	Able to perform ADL's with (choose one): ____ assistance ____ independently			
	Patient ambulatory ad lib without difficulty			
Sheath Access Site	Remains free of bleed, hematoma, bruit, ecchymosis, signs and symptoms of infection			
Tissue Perfussion	Will have (+) peripheral pulses and affected extremity warm bilateral (-) numbness / tingling			

Problem/ Needs		D	E	N
Telemetry	Remains WNL for patient			
Unstable Vital Signs	Vital Signs stable for patient.			
	Patient awake, alert and oriented.			
	Hemodynamic status stable for patient.			
Patient Safety	Remains injury free in a safe environment.			
Skin Integrity	No evidence of skin breakdown.			
Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan	Patient will be discharged in a.m.			

Patient Care Categories		D	E	N
Nutrition	* Diet:			
	% of diet consumed:			
	Breakfast _____%			
	Lunch _____ %			
	Dinner _____ %			
	Encourage P.O fluids Yes _____ No _____			

* indicates medical orders needed

MR# _____ INTERVENTIONS (continued)

Patient Care Categories	Day 2 Date: _____	D	E	N	Patient Care Categories		D	E	N
Assessment & Treatments	Vital signs q ____ hrs. as per post interventional orders				Teaching & Psychosocial	Assess patient/family satisfaction.			
	I & O q _____ hrs.					Encourage verbalization of fears / concerns.			
	* Telemetry					Discharge teaching completed, see discharge summary			
	* O_2:								
	Change sheath dressing prn sterile tech								
	Final groin assessment and dressing change done prior to discharge and documented								
	Discontinue PIID with catheter intact								
					Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
						* Tests / Procedures CBC _____ a.m. EKG _____ a.m. _____ _____ _____ _____			
					Safety & Activity	Falls protocol maintained.			
						* Activity level: Ambulatory ad lib			
	Hygiene & Comfort Protocol								
	Peripheral IV Therapy Protocol								
	Pressure Ulcer Prevention Protocol								
	* Respiratory Care provided. (See Respiratory Care Record)								