

PROTOCOL FOR: Post-Cardiac Intervention Procedures

- INDICATIONS:
- Percutaneous Transluminal Coronary Angioplasty (PTCA)
 - Coronary Stent
 - Rotoblador

- POLICY:
1. Patients will be managed by the Interventional Cardiologist and/or Cardiology Service.
 2. Patients must be on cardiac monitor while arterial sheath is in place and for two hours after sheath is removed, unless otherwise ordered by MD.

DESIRED PATIENT
OUTCOME:

1. Patient will experience minimal/no complications related to Coronary Interventional Procedures, e.g., PTCA, Coronary Stent and/or Rotoblador.
2. Patient will maintain maximum level of comfort during post-procedure period.

CLINICAL
ASSESSMENT
AND CARE:

- A. Circulation
1. Assess BP, P, resp, every 15 minutes X 1 hour, then every 30 minutes X 2 hours, then every four hours. Monitor BP via arterial line if present.
 2. Monitor temperature every 4 hours while awake. If temperature is >101°F, monitor every 2 hours. If temperature is >102°F, notify HO/APRN.
 3. Assess circulation, sensation, motion and pulses to both feet every 15 minutes X 1 hour, then every 30 minutes X 2 hours, then every 1 hour. If patient is asleep, assess per unit protocol.
 4. Assess with sheath and/or closure device for bleeding or hematoma every 15 minutes X 1 hour, then every 30 minutes X 2 hours, then every 1 hour X 2 hours. If patient is asleep, assess every 2 hours after first five hours post-PTCA. Outline areas on dressing and time on all hematomas. Increase frequency of assessment to every 15 minutes if a hematoma is present and increasing in size.
 5. 12-Lead EKG should be performed on admission to the unit and in a.m. with copies on chart.
 6. Assess patient for recurrence of chest pain.
 7. Maintain Heparin, ReoPro, Integrilin and/or Research Study Drug Infusion per MD order. Monitor PTT and platelet count as ordered.

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8. Assess mentation and neuro status at 2-4 hours and prn.
9. The patient should remain on bedrest for 6 hours after the sheath is removed (HOB may be at 30°) unless otherwise ordered.
 - a. 6 hours after sheath is removed:
 - 1) Patient may turn in bed
 - 2) HOB may be elevated to 45°
 - 3) The affected lower extremity can be bent slightly
 - b. 6-18 hours post sheath:
 - 1) Continue bedrest primarily
 - 2) Patient may sit on edge of bed
 - 3) May use bedside commode with help
 - c. 18-24 hours post sheath:
 - 1) Ambulate in room
 - 2) Bathroom privileges and sit in bedside chair
 - d. 24-72 hours post sheath:
 - 1) Full ambulation
- B. If hematoma develops:
 1. Apply direct pressure just above arterial site if bleeding continues.
 2. Apply pressure dressing with Elastoplast and 51B sandbag. Apply "donut" around sheath site so pressure is not directly on sheath.
 3. Apply Femostop and/or c-clamp compression devices per protocol.
 4. Assess frequency for changes over time.
- C. Report any of the following to MD:
 1. Recurrence of chest pain.
 2. Suspected retroperitoneal bleeding.
 3. Symptomatic bradycardia or other arrhythmia occurs.
 4. Absent or diminished pulse in affected limb.
 5. Bleeding at sheath site or presence of a hematoma.
 6. Coagulation results outside of desired range.
 7. BP < 90 systolic or symptomatic hypotension occurs.
 8. Temperature >102°F.

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- PATIENT TEACHING:
1. Instruct patient/family re: need for frequent assessment, vital signs, etc. Instruct patient re: keeping affected extremity stabilized/straight. HOB will be no higher than 30°.
 2. Instruct patient to report any numbness, pain of affected limb, or right/left lower quadrant pain. Reinforce no bending of affected limb.
 3. Instruct patient about all anticoagulation medications (i.e., Plavix, ASA) and their potential adverse effects.
 4. Prior to discharge, instruct patient/family re: groin care:
 - leave dressing in place for 8 hours
 - no/minimal stairs
 - if bleeding starts and continues for >10 minutes, lie down, apply pressure, call 911
 5. Instruct patient to take only acetaminophen for aches and pains - no additional ASA.
 6. Instruct patient not to stop taking any prescribed medication without first checking with doctor.

- DOCUMENTATION:
1. Document assessment, findings and interventions on Post-Angioplasty Recovery Record.

APPROVAL: ICU Standards
Cardiac Step-Down Standards Committee
Nursing Standards Committee

EFFECTIVE DATE: 10/99

REVISION DATE(S): 8/02