PROTOCOL FOR: Post-Procedure Care: Interventional Radiology

POLICY:

1. Report will be communicated to the PACU or receiving floor nurse.
2. Patients being recovered in Radiology Holding Area will receive continued care as ordered by physician.
3. Discharge criteria will be met prior to discharge from the post-procedure care area.

4. Frequency of monitoring will be linked to patient acuity, procedure performed, and medications administered.

CLINICAL ASSESSMENT & CARE

Transferred Patients:

1. Report will be communicated between the IR nurse and the receiving nurse:
   a. general information: name, age, procedure
   b. intra-procedure management: medications received, blood loss, fluid intake, vital signs and level of pain.
   c. History: indication for procedure, pertinent medical/surgical history
   d. Intra-procedure course: response to procedure/medications, labs if performed
   e. Recovery plan of care: expected problems, suggested interventions, discharge plan

Patients Recovered in IR:

1. Continued vital sign monitoring as ordered or as the patient’s condition warrants.

2. Puncture site(s) will be monitored for unexpected bleeding or hematoma formation with each vital sign measurement, or per order.

3. Extremity distal to puncture site(s) will be assessed for changes in color, temperature, and sensation. Re-evaluate and document the pulse condition compared to pre-procedure.

4. Pain will be assessed with each vital sign measurement and a rating will be documented. FLACC scale will be used for patients unable to express a rating. Non-pharmacologic comfort measures will be offered, as appropriate, and documented.

5. Maintain bedrest and HOB elevation per orders.

5. Diet per orders.
6. Discharge per physicians orders when discharge criteria has been met.

DESIRED 1. The patient is free from signs and symptoms of

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PATIENT OUTCOMES: radiation injury.

2. The patient receives appropriate medication(s), safely administered during the post-procedure period.

3. The patient has wound/tissue perfusion consistent with or improved from baseline levels established pre-procedure.

4. The patient's fluid and electrolyte balance, cardiac status, respiratory status, and neurologic status are consistent with or improved from baseline levels established pre-procedure.

5. The patient demonstrates knowledge of the expected responses to the radiologic procedure.

6. The patient demonstrates or reports adequate pain control through the post-procedure period.

7. The patient verbalizes knowledge of pain management.

8. The patient verbalizes knowledge of medication management.

9. The patient verbalizes knowledge of wound healing.

10. All discharge instructions have been explained to the patient/family/caregiver and verbalized understanding.

11. Patient has ride home when sedation has been given.

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 10/92

REVISION DATE: 10/94, 7/00, 9/00, 10/03, 03/08