

# York/Simcoe/Muskoka Regional Cardiac Standards Angioplasty PCI Post- Procedure Care

<b>Allergies</b> <input type="checkbox"/> Environmental <input type="checkbox"/> Foods <input type="checkbox"/> Latex <input type="checkbox"/> Drugs (specify) _____ <input type="checkbox"/> No Known Allergy	Date ____/____/____    Wt. _____ kg
<b>1. Receiving MD</b> _____ Transfer/Admit to <input type="checkbox"/> Critical/Coronary Care <input type="checkbox"/> Medicine <input type="checkbox"/> With Telemetry <b>2. Procedure</b> _____ <input type="checkbox"/> Femoral <input type="checkbox"/> Radial <input type="checkbox"/> Brachial <b>3. Transfer Diagnosis</b> <input type="checkbox"/> MI with Primary PCI <input type="checkbox"/> MI with Fibrinolytics + PCI <input type="checkbox"/> ACS <input type="checkbox"/> Other _____    See PCI Documentation from SRHC <b>4. Diet</b> <input type="checkbox"/> Healthy Heart Diet <input type="checkbox"/> Other _____ <input type="checkbox"/> Saline Lock(s) with routine flush <input type="checkbox"/> IV _____ @ _____ until _____ hrs	
<b>5. Recommended Physician's Orders – Antithrombotic Therapy</b> <b>Continue</b> <input type="checkbox"/> IV Heparin _____ Start Date, refer to standard heparin orders <input type="checkbox"/> Warfarin _____ Start Date <input type="checkbox"/> Continue Eptifibatide, <a href="#">refer to Eptifibatide orders</a> (CCU Only)	
<b>6. Medications</b> <input type="checkbox"/> O <sub>2</sub> prn for chest pain, per hospital policy <input type="checkbox"/> ECASA ___ mg daily po start date _____ <input type="checkbox"/> Beta Blocker _____ <input type="checkbox"/> ACE Inhibitor _____ <input type="checkbox"/> Cholesterol Lowering Agent _____ <input type="checkbox"/> Clopidogrel 75 mg po daily <input type="checkbox"/> Hold <a href="#">Metformin</a> 48 hrs after the procedure <b>Patient Routine Medications</b> _____ _____ _____	<input type="checkbox"/> Morphine _____ mg IV prn, max ____4hrs <input type="checkbox"/> Docusate Sodium 100 mg po daily prn <input type="checkbox"/> Laxative of choice, per hospital policy <input type="checkbox"/> Acetaminophen 325mg to _____ po q4h prn <input type="checkbox"/> Lorazepam _____ mg po/SL _____ prn <input type="checkbox"/> Dimenhydrinate _____ IV q4h prn <input type="checkbox"/> Nitroglycerin 0.3 mg tablet S/L prn <input type="checkbox"/> Nitroglycerin 0.4 mg S/L Spray
<b>7. Procedures</b> <input type="checkbox"/> 12 lead ECG daily X ___ days & prn with chest pain <input type="checkbox"/> Portable CXR unless done within last 24 hrs <input type="checkbox"/> CBC, Diff <input type="checkbox"/> BS, BUN, Creatinine, Lytes <input type="checkbox"/> PTT and INR next a.m. after procedure <input type="checkbox"/> Ck Total <input type="checkbox"/> Troponin at _____ Repeat at _____ <input type="checkbox"/> Lipid Profile: Total Cholesterol, HDL, LDL (if not done within past 3 months) <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> Referral for cardiac rehab per institutional policy	<b>8. Assessment Post PCI</b> <ul style="list-style-type: none"> <li>● V/S q4h and prn, assess color, warmth, movement, sensation and pulse of affected extremity q4h and prn.</li> <li>● Check site for hematoma/bleeding, q4hr and prn</li> <li>● Pressure drsg post hemostasis until next a.m.</li> <li>● Assess patient for chest pain and do stat 12 Lead ECG if indicated, <b>Notify physician of any increase in chest pain &amp; Consider contacting Interventionalist at SRHC</b></li> <li>● Ice bag prn if wrist pain for radial approach</li> </ul> <b>9. Site Bleeding</b> <ul style="list-style-type: none"> <li>● Apply manual pressure over insertion site until bleeding stops</li> <li>● Notify physician of any bleeding or increase in hematoma size</li> <li>● Advise PCI Coordinator@ 1-905-895-4521, ext 2707</li> </ul>
<b>10. Mobilization</b> <input type="checkbox"/> Radial Approach- AAT if able 2 hours post hemostasis <input type="checkbox"/> Femoral Approach - AAT if able _____ hours post hemostasis	<b>11. Upon Discharge</b> <ul style="list-style-type: none"> <li>● Review and send home with pt discharge information</li> </ul>

Date \_\_\_\_\_ Time \_\_\_\_\_ Physician's Signature \_\_\_\_\_ **FAXED TO PHARMACY** \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_ Transcriber's Signature \_\_\_\_\_ Checked by \_\_\_\_\_