GUIDELINE

TITLE: Post Cardiac Catheterization and Peripheral Angioplasty Intervention FLOW SHEET GUIDELINE

PURPOSE: To provide a format to record post assessments for the patient undergoing a cardiac catheterization or peripheral angioplasty intervention.

NATURE OF FORM: Permanent

DEFINITIONS:

TARGETED PATIENT POPULATION: All patients post cardiac catheterization procedure or post peripheral angioplasty intervention

PLACEMENT: Patient Chart - Flow Sheet Section

INSTRUCTIONS:

1. Enter surgical site to be assessed
2. Enter extremity to be checked and laterality (i.e. right vs. left)
3. Enter the date on the first line of form horizontally. Enter time on subsequent lines of this column.
4. Enter status of extremity's color by placing a check (4) next to the appropriate assessment under the time and extremity side.
5. Enter temperature of extremity by placing a check (4) next to the appropriate assessment under the time and extremity side.
6. Enter status of all pulses that apply (brachial, radial, femoral, popliteal, posterior tibial and pedal). Use the legend at top of form. Use legend on back of form.
7. Enter status of extremity's edema by placing a check (4) next to the appropriate assessment under the time and extremity side. Use legend on back of form.
8. Enter capillary refill status by placing check (4) next to the appropriate assessment under the time and extremity side.
9. Enter status of extremity's sensation by placing a check (4) next to the appropriate assessment under the time and extremity side.
10. Record Vital signs, (Heart Rate, Rhythm, Blood Pressure, Respirations and o2 saturation) under the appropriate time frame.
11. Circle **"Y" (yes)** or **"N" (no)** to document patient's response to Pain related to procedure. Any other pain assessment should be documented in the nurse's notes. This section is only for pain related to the procedure.
12. Pain Level: If patient is having pain, document the numerical value the patient states.
13. Location: If patient is having pain, document the location the patient states.
14. Description: If patient is having pain and is able to describe it, enter information using key on the back of the form.
15. Intervention: If patient is having pain and an intervention was carried out, document using key on the back of the form.
16. Puncture site: Assess the puncture site for bleeding and hematoma. Circle **"Y" (yes)** or **"N" (no)** to document findings.
17. Enter initials
18. Comments: Narrative section to document and further assessments or expound on findings.
19. Enter signature and initials. This needs only to be done once per form.

Surgical/Procedural Site: 1 **Extremity to checked:** 2

Date: 3 **Time** 3

		Extremity Side	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Color		Flesh																												
		Pale	4																											
		Cyanotic																												
Temp		Warm																												
		Cool	5																											
		Cold																												
Pulse		Brachial																												
		Radial																												
		Femoral	6																											
		Popliteal																												
		Posterior Tibia																												
		Pedal																												
Edema	0	Absent																												
	1+	Trace																												
	2+	Mild	7																											
	3+	Moderate																												
	4+	Severe																												
Capillary Refill		Brisk = < 3 seconds	8																											
		Sluggish = > 3 seconds.																												
Sensation		Present																												
		Decreased	9																											
		Absent																												
		Tingling																												
Vital Signs and Pain Assessment Puncture Site		Heart Rate																												
		Rhythm	10																											
		Blood Pressure																												
		Respirations																												
		O2 sat																												
1		Pain related to procedure	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
		Pain level	12																											
		Location	13																											
		Description	14																											
		Intervention	15																											
		Puncture Site- Bleeding noted	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
16		Hematoma noted	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
		Initials	17																											

Comments: 18

Initials	Signature	Title	Initials	Signature	Title
	19				

Hackettstown Regional Medical Center

Post Cardiac Catheterization and Peripheral Angioplasty Intervention

Form #

LEGEND for PULSES		
1+ faintly palpable, weak and thready 2+ Palpable, normal pulse 3+ Bounding Hyperdynamic pulse D = Doppler A = Absent		
LEGEND for EDEMA SCALE		
Edema Scale	**Indentation Depth**	**Return to Baseline**
0- none present	none	
1- Trace	(0 -1/4) inch	Rapid
2- Mild	(1/4-1/2) inch	10-15 seconds
3- Moderate	(1/2-1) inch	1-2 minutes
4- Severe	Greater than 1 inch	2-5 minutes
LEGEND FOR PAIN		
Pain level : 0-10 per patient If using scale other than NRS, chart number followed by scale used. Wong scale/Facial face =W Behavioral scale =B Flacc scale =F	**Description** Aching = A Burning= B Dull = D Sharp =Sh Stabbing = St Throbbing= T Pressure =P	**Intervention** Relaxation = R Distraction = D Reposition = P Quiet = Q Medication = M (must chart drug, dose, route in comments.) Refuses intervention = R

Post Cardiac Catheterization Assessments:

- Q 15 minutes x4, Q30 min x2, Q1 hour x 5
- Initial assessments start immediately after procedure in the Cardiac Cath Lab. Follow time intervals as a continuation of assessments completed in Cath lab.
- This does not exclude unit routine assessments. Routine assessments are documented on the Nursing Flowsheet. If routine assessment includes information charted on the front of this form, no need to repeat documentation in Nurses Flowsheet. Only document what is assessed and not captured on this form.

Post Vascular (Peripheral Angioplasty Interventions):

- Q 15 minutes x4, Q30 min x4, Q1 hour x 4
- Initial assessments start immediately after procedure in the Vascular Suite. Follow time intervals as a continuation of assessments completed in Vascular Suite.
- This does not exclude unit routine assessments. Routine assessments are documented on the Nursing Flowsheet. If routine assessment includes information charted on the front of this form, no need to repeat documentation in Nurses Flowsheet. Only document what is assessed and not captured on this form.