Diagnostic Cardiac Cath (Non-Intervention) Post Procedure [30400522]

Height_____________________
Weight_____________________ 
Allergies___________________

Consider the following order sets, if appropriate:
Hydration Orders for Reducing Risk of Radiocontrast Induced Nephrotoxicity Physician Order # 683
Glycemic Control - Subcutaneous Addendum Physician Order #825
Consider using, if appropriate, Heparin Infusion Titration-Weight Based (Not For Use In Stroke) Physician Order # 580

Level of Care
Level of Care (Single Response)
( ) Admit to Inpatient
Diagnosis: __________________________ (Required)
Expected length of stay (days) __________________________ (Required)
Certification: I reasonably expect the patient will require inpatient services that span a period of time over two-midnights. (See Rationale Section in the order for options) Additional documentation will be found in progress notes and admission history and physical. Must be completed by Physician for Inpatient Admissions:
Rationale for Inpatient Admission: __________________________ (Required)
Plans for post hospital care: See Discharge Summary/ Progress Note
Level of Care: __________________________ (Required)

( ) Refer to Observation
Diagnosis: __________________________ (Required)
Monitor for: __________________________ (Required)
Notify provider when: __________________________ (Required)
Level of Care: __________________________ (Required)

[ ] Other

General
Vital Signs
[X] Vital signs
Indication: Post Procedure
Q15 minutes x (# of occurrences): 4 __________________________
Q30 minutes x (# of occurrences): 2 __________________________
Q1 hour x (# of occurrences): 4 __________________________
Q2 hours x (# of occurrences): __________________________
Q4 hours x (# of occurrences): __________________________
Then: Per unit routine
Post-Procedure, Until discontinued, Starting today

[X] Notify physician
Routine, Until discontinued, Starting today
Pulse greater than: __________________________
Respiratory rate less than: __________________________
Respiratory rate greater than: __________________________
Temperature greater than (celsius): __________________________
Urine output less than (mL/hr): __________________________
Systolic BP greater than: __________________________
Systolic BP less than: __________________________
Diastolic BP greater than: __________________________
Diastolic BP less than: __________________________
Other: __________________________
Of any chest pain, hematoma, bleeding, decrease in pulses, arrhythmias, or unstable vital signs, Post-Procedure

[ ] Other

Date/Time __________________________ Provider Initial: __________________________
**Physician Orders**

### Patient Information

**Activity**

**[X]** Bed rest  
Routine, Until discontinued, Starting today, With leg straight for 4 hours, Post-Procedure  

**[X]** Patient may move side to side if no bleeding or hematoma  
Routine, Until discontinued, Starting today, Post-Procedure  

**[]** Activity as tolerated  
Routine, Until discontinued, Starting today, After 4 hours of bedrest is completed and Vital Signs are stable., Post-Procedure  

**[]** Other  

**Diet / Nutrition**

**[X]** Diet Cardiac  
Diet effective now, Starting today  
Select/Nonselect: ____________________ (Required)  
Additional Modifiers: Low Fat  
Viscosity/Liquids: ____________________  
Texture: ____________________  
Fluid Restriction / day: ____________________  
Supplements: ____________________  
Post-Procedure  

**[]** Diet General  
Diet effective now, Starting today  
Select/Nonselect: ____________________ (Required)  
Additional Modifiers: Low Fat  
Viscosity/Liquids: ____________________  
Texture: ____________________  
Fluid Restriction / day: ____________________  
Supplements: ____________________  
Post-Procedure  

**[]** Diet Diabetic  
Diet effective now, Starting today  
Diet, Diabetic: ____________________  
Select/Nonselect: ____________________ (Required)  
Additional Modifiers: Low Fat  
Viscosity/Liquids: ____________________  
Texture: ____________________  
Fluid Restriction / day: ____________________  
Supplements: ____________________  
Post-Procedure  

**[]** Other  

**Nursing Intervention**

**[]** Discontinue sheath(s) upon arrival to  
Routine, Until discontinued, Starting today  
Patient unit: ____________________  
Patient location (other): ____________________  
Post-Procedure  

**[]** Keep leg(s) straight  
Routine, Until discontinued, Starting today  
Leg choice: ____________________  
Length of time: ____________________  
Specify time, if femoral site present., Post-Procedure  

**[X]** Maintain hemostasis of puncture site(s)  
Routine, Until discontinued, Starting today, Per unit protocol. Notify Physician if bleeding persists., Post-Procedure  

**[X]** Retention Catheter Panel  

**[X]** Insert Foley catheter  
Routine, As needed, Starting today, Insert as needed for inability to void or feelings of discomfort or distention.  
Initiate Medical Staff Approved Urinary Catheter Protocol, Post-Procedure  

**[X]** Urinalysis with culture, if indicated, upon insertion  
Daily, Starting today with First Occurrence Include Now For 2 Occurrences  
Obtain a UA-R upon insertion and repeat UA-R prior to 48 hours post-insertion., Post-Procedure
**Diagnostic Cardiac Cath (Non-Intervention) Post Procedure [30400522]**

**Physician Orders**

<table>
<thead>
<tr>
<th>Glucose Management</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>POCT glucose</td>
<td>Routine, 4 times daily after meals and at bedtime, Starting today, Post-Procedure</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Glucose Management</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Education</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco cessation education</td>
<td>Routine, Once, Starting today, Post-Procedure</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respiratory Intervention</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>May use home CPAP equipment</td>
<td>Routine, Until discontinued, Starting today, 1. Per CPAP – Patient Owned Medical Equipment Use Protocol # 908.00. 2. Home medical equipment waiver must be signed by the patient. 3. Respiratory Therapy/Nursing to assess patient ability to self administer CPAP.*, Post-Procedure</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician Consults</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient consult to Cardiothoracic Surgery</td>
<td>Reason for Consult? ___________________________ (Required) RN/Secretary to contact the consulting provider? ____ (Required)</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Labs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA PCR Screen</td>
<td>Once, Starting today Specimen SCR: ___________________________ (Required) Order contact precautions, if indicated for the MRSA PCR Screen, Post-Procedure</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Imaging</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Echocardiogram 2D complete</td>
<td>Routine, 1 time imaging, Starting today Provider Name: _____________________________ To be read by (specify provider)., Post-Procedure</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>VTE Prophylaxis</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Apply sequential compression device</td>
<td>Routine, Until discontinued, Starting today Apply sequential compression device: _____________________________ Ensure correct VTE choices, need mechanical VTE prophylaxis if no pharmacologic prophylaxis, please see SCIP guidelines, Post-Procedure</td>
</tr>
<tr>
<td>Place TED hose</td>
<td>Routine, Until discontinued, Starting today Stocking type: _____________________________ (Required) Leg choice: _____________________________ (Required)</td>
</tr>
<tr>
<td>Reason for No VTE Prophylaxis (Mech)</td>
<td>Reason for no VTE prophylaxis (mechanical): _____________________________ (Required) Note to provider: Reason required to be in compliance with CMS SCIP guidelines</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

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**Date/Time ___________________**

**Provider Initial:______________**

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**Franciscan Health System**

St. Joseph Medical Center  
St. Francis Hospital - St. Clare Hospital  
St. Elizabeth Hospital - St. Anthony Hospital  
Highline Medical Center  
Harrison Medical Center  
Franciscan Medical Group  
Harrison HealthPartners  
Regional Hospital

**PHYSICIAN ORDERS**

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Diagnostic Cardiac Cath (Non-Intervention) Post Procedure [30400522]
[ ] heparin (porcine) injection 5,000 units/mL 5,000 Units, SubCutaneous, Every 8 hours, Post-Procedure, Routine
[ ] enoxaparin (LOVENOX) injection 40 mg 40 mg, SubCutaneous, Daily, Post-Procedure, Routine
[ ] Reason for No VTE Prophylaxis (Pharm) Reason for no VTE prophylaxis (pharmacological): __________________________
[ ] Other

**Physician Orders**

**Patient Information**

**IV Fluids**

**IV Fluids**

- Saline Flush and Lock Panel
  - Sodium chloride 0.9% syringe 2 mL, IntraVenous, Every 8 hours, Post-Procedure, Routine
  - Saline lock IV Routine, Continuous, Starting today, Post-Procedure

- Sodium chloride 0.9% flush 10 mL, IntraCatheter, Every 8 hours, Post-Procedure, Routine
- Sodium chloride 0.45% (HALF SALINE) infusion 100 mL/hr, IntraVenous, Continuous, Post-Procedure, Routine
- Sodium chloride 0.9% (NS) infusion 100 mL/hr, IntraVenous, Continuous, Post-Procedure, Routine
- Dextrose 5% and sodium chloride 0.45% infusion 100 mL/hr, IntraVenous, Continuous, Post-Procedure, Routine

**Medications**

**Initiate Over the Counter Meds**

- Nurse may initiate OTC Pt Care Products Routine, As needed, Starting today, Post-Procedure
- Other

**IV Infusions**

- Nitroglycerin in D5W infusion 200 mcg/mL 10 mcg/min, IntraVenous, at 3 mL/hr, Continuous, Post-Procedure, Routine
  - Admin Instructions: (Required) Initial dose 5 mcg/min
  - Maxumum dose: Patient and indication specific
  - Titrate by 5 mcg/min increments every 3-5 minutes until hemodynamic goal is reached.

**Other**

**Analgesia**

**NOTE:** Number only those medications desired. The nurse will select #1 as the first medication to be given. If ineffective, #2 will be used next, and then #3, #4, etc. If orders chosen are not numbered, the nurse will contact the prescriber for clarification.

- Acetaminophen (TYLENOL) tablet 325-650 mg, Oral, Every 4 hours PRN, mild pain, Post-Procedure
  - Med choice: _____________________________ (# Required)
  - 325 mg 1-2 tablets PO every 4 hours PRN mild discomfort

- HYDROcodone-acetaminophen (VICODIN) tablet 5-325 mg 1-2 tablet, Oral, Every 4 hours PRN, moderate pain, Post-Procedure
  - Med choice: _____________________________ (# Required)
  - 5 mg with acetaminophen 325 mg (Vicodin) 1-2 tablets PO every 4 hours PRN pain (Not to exceed 9 tablets per 24 hours)
<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose/Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>oxyCODONE-acetaminophen (PERCOCET) tablet 5-325 mg</td>
<td>1-2 tablet, Oral, Every 4 hours PRN, moderate pain, Post-Procedure Med choice:</td>
</tr>
<tr>
<td></td>
<td>(Required)</td>
</tr>
<tr>
<td></td>
<td>5 mg with acetaminophen 325 mg (Percocet 5/325) 1-2 tablets PO every 4 hours PRN pain (Not to exceed 9 tablets per 24 hours) Routine</td>
</tr>
<tr>
<td>morphine injection</td>
<td>2-10 mg, IntraVENous, Every 1 hour PRN, pain, Post-Procedure Med choice:</td>
</tr>
<tr>
<td></td>
<td>(Required)</td>
</tr>
<tr>
<td></td>
<td>2-10 mg IV every 1 hour as needed for pain Avoid use in renal dysfunction (serum creatinine greater than 2 mg/dL or patient on dialysis) Routine</td>
</tr>
<tr>
<td>Other Nausea/Vomiting</td>
<td>4 mg, IntraVENous, Every 4 hours PRN, nausea, vomiting, Post-Procedure If ondansetron ineffective, discontinue ondansetron and give promethazine. Maximum dose is 24 mg in 24 hours Routine</td>
</tr>
<tr>
<td>ondansetron (ZOFRAN) injection 4 mg/2 mL</td>
<td>6.25-12.5 mg, IntraVENous, Every 4 hours PRN, nausea, vomiting, Post-Procedure Use 6.25-12.5 mg IV for patients age 65 and over. Give ondansetron first. If ineffective give promethazine Routine</td>
</tr>
<tr>
<td>promethazine (PHENERGAN) injection 25 mg/mL</td>
<td>12.5-25 mg, IntraVENous, Every 4 hours PRN, nausea, vomiting, Post-Procedure Use 6.25-12.5 mg IV for patients age 65 and over. Give ondansetron first. If ineffective give promethazine Routine</td>
</tr>
<tr>
<td>clopidogrel (PLAVIX) tablet</td>
<td>75 mg, Oral, Daily, Post-Procedure 75 mg PO daily. First dose tomorrow until discontinued. Routine</td>
</tr>
<tr>
<td>aspirin tablet</td>
<td>325 mg, Oral, Daily, Post-Procedure 325 mg PO daily First dose tomorrow until discontinued. Routine</td>
</tr>
<tr>
<td>aspirin chewable tablet 81 mg</td>
<td>81 mg, Oral, Daily, Post-Procedure 81 mg PO daily. First dose tomorrow until discontinued. Routine</td>
</tr>
<tr>
<td>temazepam (RESTORIL) capsule</td>
<td>15 mg, Oral, Nightly PRN, sleep, Post-Procedure, Routine Dose: __________________ mg (Required)</td>
</tr>
<tr>
<td>ALPRAZolam (XANAX) tablet</td>
<td>Oral, Every 6 hours PRN, anxiety, sedation/anxiety, Post-Procedure (Usual dose 0.25 – 0.5 mg) Routine</td>
</tr>
</tbody>
</table>
**PHYSICIAN ORDERS**

### PATIENT INFORMATION

**Diagnostic Cardiac Cath (Non-Intervention) Post Procedure [30400522]**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage</th>
<th>Route</th>
<th>Frequency</th>
<th>Notes</th>
</tr>
</thead>
</table>
| **[X] atropine syringe 0.1 mg/mL**        | 0.5 mg, IntraVENous, As needed, symptomatic bradycardia, For 2 Doses, Post-Procedure  
May repeat times 1. Notify Physician if additional dose required Routine | [ ] Other | | |
| **[X] nitroglycerin (NITROSTAT) SL tablet** | 0.4 mg, SubLINgual, Every 5 min PRN, chest pain, For 3 Doses, Post-Procedure  
PRN for chest pain. May repeat every 5 minutes times 3 providing systolic BP greater than 90 mmHg and notify Physician. Routine | [ ] Other | | |

**Nicotine Replacement Therapy**

Nicotine Replacement therapy will be avoided if possible in patient with unstable acute coronary syndrome for 72 hours. After 72 hours if chest pain, arrhythmias, and/or blood pressure have stabilized, Nicotine replacement may be considered at ONE STEP below the calculated replacement dose. NOTE: 1/2 pack = 10 cigarettes

The nicotine products listed below may be used as monotherapy or in combination therapy. Combination therapy should include a nicotine patch plus either nicotine gum or nicotine lozenges.

<table>
<thead>
<tr>
<th>Smoking History</th>
<th>Recommended Starting Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step down therapy after initial nicotine Replacement for 6-7 weeks Nicotine patch, 7mg</td>
<td></td>
</tr>
<tr>
<td>10 Cigarettes per Day or less, past history Of cardiovascular disease, or weight under 45 kg Nicotine patch, 14 mg</td>
<td></td>
</tr>
<tr>
<td>Heavy smokers (More than 10 cigarettes/day) Nicotine patch, 21 mg</td>
<td></td>
</tr>
<tr>
<td>Smokeless tobacco users, pipe Smokers or at patient request Nicotine Gum, 2mg</td>
<td></td>
</tr>
</tbody>
</table>

Note to provider: Insulin requirements may change - monitor blood sugars. Topical Steroids and oral antihistamines may be recommended to treat less severe skin irritations.

<table>
<thead>
<tr>
<th>No Smoking while on nicotine replacement therapy</th>
<th>Routine, Until discontinued, Starting today, Post-op</th>
</tr>
</thead>
</table>
| [ ] nicotine (NICODERM CQ) patch 7 mg           | 1 patch, TransDermal, for 24 Hours, Daily, Post-op  
Change skin site daily and do not reuse for one week. Discontinue patch and notify prescriber if patient develops severe rash, chest pain, irregular heartbeat, palpitations, nausea, or vomiting. If severe rash develops, contact pharmacist with order to change to nicotine (Nicorette) gum. Routine |
| [ ] nicotine (NICODERM CQ) patch 14 mg/24 hr    | 1 patch, TransDermal, for 24 Hours, Daily, Post-op  
Change skin site daily and do not reuse for one week. Discontinue patch and notify prescriber if patient develops severe rash, chest pain, irregular heartbeat, palpitations, nausea, or vomiting. If severe rash develops, contact pharmacist with order to change to nicotine (Nicorette) gum. Routine |
[ ] **nicotine (NICODERM CQ) patch 21 mg/24 hr**

1 patch, TransDermal, for 24 Hours. Daily, Post-op

Change skin site daily and do not reuse for one week. Discontinue patch and notify prescriber if patient develops severe rash, chest pain, irregular heartbeat, palpitations, nausea, or vomiting. If severe rash develops, contact pharmacist with order to change to nicotine (Nicorette) gum.

Routine

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[ ] **nicotine polacrilex (NICORETTE) gum 2 mg**

2 mg, Buccal, As needed, smoking cessation, Post-op

Maximum = 24 pieces/24 hours

Routine

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[ ] **Other**

---

**Date/Time:** __________________________

**Printed Name of Ordering Provider:** __________________________

**Provider Signature:** __________________________

**Date/Time:** ________________

**RN Acknowledged:** __________________________