Diagnost 1 - 1

GREENVILLE HOSPITAL NURSING SERVICES POLICY & PROCEDURE
ANGIOGRAM, CARE OF THE PATIENT PRE- AND POST-

PERSONNEL:

Registered Nurses
Licensed Practical Nurses
Student nurses under direct supervision of a Registered Nurse

DESIRED OUTCOME:

To prepare the patient physically and mentally for angiography. To detect and treat post angiography complications.

SUPPORTIVE DATA:

- GHS Policy Directive, S-50-31: Consents
- GHS Policy Directive, S-50-29: Sedation, Moderate and Deep

INFECTION CONTROL:

- Standard precautions
- Appropriate Personal Protective Equipment (PPE)

EQUIPMENT:

1. Teaching materials
2. Monitor
3. Micromedex
4. Doppler unit

Pre-Procedure:

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<th>STEPS</th>
<th>KEY POINTS</th>
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<td>1. Identify the patient and perform hand hygiene. Using patient teaching materials for angiogram, provide the patient with an explanation of the procedure.</td>
<td>1. To reduce anxiety and gain his/her cooperation.</td>
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<td>2. Follow the physician’s orders regarding labs, food, fluid, and preparation of the site prior to procedure. (See X-ray Prep Manual for guidelines.</td>
<td>2. Current PT, PTT, creatinine, and BUN should be on the patient record prior to procedure to screen for anticoagulants</td>
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3. Notify the physician performing the procedure if anticoagulants do not meet the following recommendation:

- **Warfarin/Coumadin**: discontinue 4 days, recheck INR prior to procedure
- **Clopidogrel/Plavis**: discontinue 7 days
- **Ticlopidine/Ticlid**: discontinue 14 days
- **GP IIb/IIIa inhibitors**:
  - **Abciximab/Reopro**: discontinue 24-48 hours
  - **Tirofiban/Aggrastat**: discontinue 8 hours
  - **Eptifibatide/Integrilin**: discontinue 8 hours
- **Low Molecular Weight Heparin or Lovenox** (restart in 24 hours)
- **Thromboprophylaxis** dose up to 40mg SubQ daily:
  - discontinue 12 hours. Treatment dose 1mg/kg every 12 hours: discontinue 24 hours
- **Unfractionated IV Heparin**: 2-4 hours, Heparin may be restarted without bolus in 1 hour post procedure
- **Arixtra**: discontinue 2 days

- No contraindication with Aspirin or NSAIDS.

4. Have patient dress in hospital gown only.  
4. To prevent soiling of patient’s clothing.

5. Assess for allergies to x-ray dye or iodine and notify the physician performing procedure of allergy.  
5. Prevent and reduce the risk of allergic reaction.

6. Document pre-medication taken by or given to the patient as relates to contrast allergy. (Refer to e-form M10377.)  
6. Indicates whether the patient can proceed with procedure. Clarification of pre-medications administered.

7. Take the patient’s temperature, pulse, respiration, oxygen saturation, pain level, and blood pressure and record. Document skin temperature, color, capillary refill, and pulse distal to the arterial site to be used. Mark pulses after identification.  
7. To provide baseline data for later assessment.

8. Send the medical record, MAR, and daily nurses notes (chart) to x-ray with patient.  
8. For reference during procedure.
Post – Procedure:

**STEPS**

1. Upon return from x-ray, assist the patient in transferring from stretcher to bed.

2. Check the patient’s temperature, pulse, respiration, and blood pressure per physician order (more often as the patient’s condition indicates) until vital signs are stable. Assess neurological symptoms such as motor or sensory alterations, reduced level of consciousness, speech disturbances, or blood pressure fluctuations. Follow the physician’s orders for post-procedure monitoring. Check for bleeding or hematoma at the puncture site. Check pulses distal to arterial stick. If non palpable, check with Doppler. If unable to obtain, notify the physician performing procedure.

3. Instruct and provide teaching pamphlet to patient and care provider on closure device.

4. Follow the physician’s orders regarding post-angiogram care. Notify the physician performing the procedure of changes in vital signs, bleeding, signs of hematoma, or other complications.

**KEY POINTS**

1. The patient may be sedated and need assistance in moving. Activity and extremity movement restricted to decrease risk of bleeding.

2. To detect changes which may indicate complications such as elevated blood pressure, loss of pulse distal to arterial stick, bleeding at puncture site, signs of compensating shock, neurological changes, etc.

3. To reduce anxiety and provide continuity of post-procedure care.

4. To provide prompt action in the event of complications.

**NOTES:**

1. If unable to palpate a pulse, use a Doppler to auscultate over the site.
2. Abnormal laboratory results are to be called to the primary/ordering physician and the physician performing the procedure.

**DOCUMENTATION:**

Document all observations and care of the patient on the appropriate record.

**REFERENCES:**
