

## Supplementary Material to “Nursing protocol in transcatheter aortic valve implantation: care guideline”

POST TAVI NURSING CARE PROTOCOL									
<b>VITAL SIGNS ASSESSMENT:</b>									
<input type="checkbox"/> Blood Pressure		<input type="checkbox"/> Heart rate		<input type="checkbox"/> Respiratory rate			<input type="checkbox"/> Temperature		
<b>1<sup>st</sup> hour</b> (every 15 min)	<b>2<sup>nd</sup> hour</b> (every 30 min)	After 2 <sup>nd</sup> hour (Assess every hour)							
<input type="checkbox"/> 0 hours	<input type="checkbox"/> 1h:30 min	<input type="checkbox"/> 3 <sup>rd</sup> hour	<input type="checkbox"/> 8 <sup>th</sup> hour	<input type="checkbox"/> 13 <sup>th</sup> hour	<input type="checkbox"/> 18 <sup>th</sup> hour	<input type="checkbox"/> 23 <sup>rd</sup> hour	<input type="checkbox"/> 15 min	<input type="checkbox"/> 4 <sup>th</sup> hour	<input type="checkbox"/> 9 <sup>th</sup> hour
<input type="checkbox"/> 30 min	<input type="checkbox"/> 2 <sup>nd</sup> hour	<input type="checkbox"/> 5 <sup>th</sup> hour	<input type="checkbox"/> 10 <sup>th</sup> hour	<input type="checkbox"/> 14 <sup>th</sup> hour	<input type="checkbox"/> 19 <sup>th</sup> hour	<input type="checkbox"/> 24 <sup>th</sup> hour	<input type="checkbox"/> 45 min	<input type="checkbox"/> 6 <sup>th</sup> hour	<input type="checkbox"/> 11 <sup>th</sup> hour
<input type="checkbox"/> 1 hour		<input type="checkbox"/> 7 <sup>th</sup> hour	<input type="checkbox"/> 12 <sup>th</sup> hour	<input type="checkbox"/> 15 <sup>th</sup> hour	<input type="checkbox"/> 20 <sup>th</sup> hour		<input type="checkbox"/> 16 <sup>th</sup> hour	<input type="checkbox"/> 21 <sup>st</sup> hour	<input type="checkbox"/> 17 <sup>th</sup> hour
				<input type="checkbox"/> 22 <sup>nd</sup> hour					
<b>NEUROLOGICAL ASSESSMENT:</b>									
<b>LEVEL OF CONSCIOUSNESS</b>		<b>PUPIL ASSESSMENT:</b>		<b>SUDDEN SIGNS OF STROKE:</b>			<b>SLEEP PATTERN:</b> (After first night postoperative)		
<input type="checkbox"/> Alert <input type="checkbox"/> Sleepy <input type="checkbox"/> Torpor <input type="checkbox"/> Comatose <input type="checkbox"/> Sedated		<input type="checkbox"/> Reactive <input type="checkbox"/> Isochoric <input type="checkbox"/> Mydriasis <input type="checkbox"/> Myosis <input type="checkbox"/> Normal		<input type="checkbox"/> Sudden change in consciousness <input type="checkbox"/> Facial asymmetry <input type="checkbox"/> Changes in speech Sensitiveness is preserved? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Motor strength preserved? <input type="checkbox"/> Yes <input type="checkbox"/> No _____			<input type="checkbox"/> Satisfactory in the first 24 hrs. <input type="checkbox"/> Insomnia <input type="checkbox"/> Other changes _____		
➡ Apply Glasgow scale every 4 hours; ➡ If sedated, apply Ramsay scale.									
<b>ASSESSMENT OF RESPIRATORY FUNCTION:</b>									
<input type="checkbox"/> Eupnea <input type="checkbox"/> Tachypnea <input type="checkbox"/> Bradypnea <input type="checkbox"/> Dyspnea		<input type="checkbox"/> Mechanical ventilation <input type="checkbox"/> OTT <input type="checkbox"/> TQT Mode of Ventilation: _____ No. OTT: _____ No. Lip commissure: _____ PEEP: _____ FiO2: _____ Tidal Volum: _____			<input type="checkbox"/> Subglottic aspiration <input type="checkbox"/> Assess Cuff pressure(18 to 22mmhg) <input type="checkbox"/> Raised heaboard from 30 to 45 graus  <input type="checkbox"/> Thoracic drain Type of oscilation _____ Drained volume (every 24hs) ____/____				
<input type="checkbox"/> Ventilação espontânea; <input type="checkbox"/> Oxigenoterapia L/min: _____ <input type="checkbox"/> Máscara de Venturi <input type="checkbox"/> Cateter óculos <input type="checkbox"/> Máscara de Hudson <input type="checkbox"/> Outros									
<b>ASSESSMENT OF CARDIOLOGICAL FUNCTION:</b>									
<input type="checkbox"/> Continous cardiac monitoring <input type="checkbox"/> Presence of disturbances in conduction and/or rhythm? List: _____ <input type="checkbox"/> ECG after the procedure? <input type="checkbox"/> ECG every 12 hours <input type="checkbox"/> 12 hr <input type="checkbox"/> 24hr <input type="checkbox"/> Is there pain? <input type="checkbox"/> ECG when in pain				<input type="checkbox"/> Cardiac enzymes – Troponin, CK-MB (Monitor every 6 hs) <input type="checkbox"/> 6hrs <input type="checkbox"/> 12 hrs <input type="checkbox"/> 18 hrs <input type="checkbox"/> 24hrs <input type="checkbox"/> Presence of cardiac arrest after the procedure? <input type="checkbox"/> Shockable rhythm <input type="checkbox"/> Non-schockable rhythm <input type="checkbox"/> Use transvenous pacemaker Time of conection: _____ Dependency : <input type="checkbox"/> Yes <input type="checkbox"/> No ➡ Attempt to mobilize the patient (risk of dislodgement )					

Surgical access site:		<input type="checkbox"/> RLL	<input type="checkbox"/> LLL	<input type="checkbox"/> Thoracotomy	<input type="checkbox"/> Sternotomy	<input type="checkbox"/> left subclavian/axillary
<b>Assess:</b> - Pulso <input type="checkbox"/> Preserved <input type="checkbox"/> Diminished <input type="checkbox"/> Absent - Perfusion <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory - Hematoma <input type="checkbox"/> Yes <input type="checkbox"/> No Site: _____ - Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No - Limb coloration <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory - Limbs tempearture <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory		1 <sup>st</sup> hour (every 15 min) <input type="checkbox"/> 0 hours <input type="checkbox"/> 15 min <input type="checkbox"/> 30 min <input type="checkbox"/> 45 min <input type="checkbox"/> 1 hour	2 <sup>nd</sup> hour (every 30 min) <input type="checkbox"/> 1h:30 min  <input type="checkbox"/> 2 <sup>nd</sup> hour	3 <sup>rd</sup> hour (every hour) <input type="checkbox"/> 3 <sup>rd</sup> hour <input type="checkbox"/> 14 <sup>th</sup> hour <input type="checkbox"/> 4 <sup>th</sup> hour <input type="checkbox"/> 15 <sup>th</sup> hour <input type="checkbox"/> 5 <sup>th</sup> hour <input type="checkbox"/> 16 <sup>th</sup> hour <input type="checkbox"/> 6 <sup>th</sup> hour <input type="checkbox"/> 17 <sup>th</sup> hour <input type="checkbox"/> 7 <sup>th</sup> hour <input type="checkbox"/> 18 <sup>th</sup> hour <input type="checkbox"/> 8 <sup>th</sup> hour <input type="checkbox"/> 19 <sup>th</sup> hour <input type="checkbox"/> 9 <sup>th</sup> hour <input type="checkbox"/> 20 <sup>th</sup> hour <input type="checkbox"/> 10 <sup>th</sup> hour <input type="checkbox"/> 21 <sup>st</sup> hour <input type="checkbox"/> 11 <sup>th</sup> hour <input type="checkbox"/> 22 <sup>nd</sup> hour <input type="checkbox"/> 12 <sup>th</sup> hour <input type="checkbox"/> 23 <sup>rd</sup> hour <input type="checkbox"/> 13 <sup>th</sup> hour <input type="checkbox"/> 24 <sup>th</sup> hour		
<input type="checkbox"/> Presence of hematoma? <input type="checkbox"/> Yes <input type="checkbox"/> No – If yes, delineate the extent of the hematoma with a surgical pen. - Serum hemoglobin values _____, hematocrit _____ and platelets _____. <input type="checkbox"/> Collection of pre-transfusion samples (in case of anemia or important bleeding during procedure). Needed blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No No. of bags: _____ <b>Presence of bleeding:</b> <input type="checkbox"/> oral mucosa <input type="checkbox"/> urine <input type="checkbox"/> feces <input type="checkbox"/> bruises <input type="checkbox"/> Limb extended and rested during 12 hours after the procedure						

☐ Assess every 4 hours

☐ Pain? Site: \_\_\_\_\_ characteristic: \_\_\_\_\_ Intensity (0 to 10): \_\_\_\_\_ Start: \_\_\_\_\_ Duration: \_\_\_\_\_

☐ Sudden pain in the following sites: flank, back and groin. \_\_\_\_\_

☐ Analgesic medication ( Reassess after 1 hour)    ☐ Reassessment.

- ☐ Change decubitus every 2 hours;
- ☐ HGT every 4 hours;
- ☐ Bed rest in the first 24 to 48 hours;
- ☐ Prophylactic antibiotic therapy after 6 hours of arrival at the unit.
- ☐ Antiplatelet agent

<b><i>OBSERVATIONS:</i></b>	
<b>Nurse:</b> _____ <b>Date:</b> __/__/__.	