
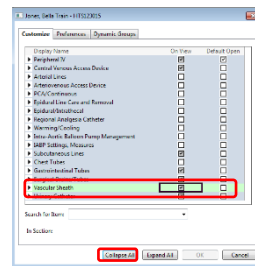




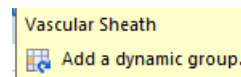
## EMR Quick Reference Guide

### Angiogram/PCI/EP Observations

1. Document standard observations as normal in the **Observation Chart** and document any relevant additional comments.
2. Go to the table of contents to select **Interactive View and Fluid Balance**, select **Adult Lines and Devices** and then **Vascular Sheath**.
3. If Vascular Sheath not visible go to Customize View 
4. **Collapse All** and select **Vascular Sheath**.



5. Identify the Vascular Sheath site by adding a dynamic group.



6. Enter the following Vascular Sheath information:
  - o Activity
  - o Site condition
  - o Site Care
  - o Closure Device in Place (if required)
  - o Dressing
  - o Activated Clotting time (if required)
  - o Removal (if required)
  - o Direct pressure Method/Device (if required)
  - o Direct Pressure Duration (if required)
  - o Complications (if applicable)

Vascular Sheath		
- Femoral artery Left Arterial -		
Activity		Assessment
Site Condition		Bleeding
Site Care		Direct pressure ap...
Closure Device in Place		Collagen plug
Dressing		Transparent/Occlus...
Activated Clotting Time	sec(s)	
Removal		
Direct Pressure Method/Device		Manual
Direct Pressure Duration	min(s)	5
Patient Indicated Response		
Complications		

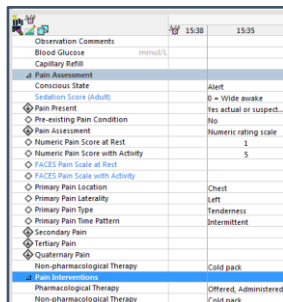
7. Document the **Neurovascular Observations**.

- o Go to the Table of Contents, select **Interactive View and Fluid Balance**.
- o Select **Adult Systems Assessment** and then **Neurovascular Observations**.
- o Enter the following Neurovascular Observations:
  - o Select appropriate Limb Obs
  - o Skin Colour
  - o Limb Warmth
  - o Movement
  - o Sensation
  - o Swelling
  - o Pulse Type
  - o Pulses
  - o Capillary Refill
  - o Capillary Refill Comment/Comments (as required)

Neurovascular Observations		15:54	15:51
- Left Upper Limb Neurovascular Obs			
Skin Colour			Usual for ethnicity
Left Upper Limb Warmth			Warm
Movement			Full
Sensation			Full
Swelling			Mild
Pulse Type			Radial
Pulses			Strong
Capillary Refill			Brisk 1-2 seconds
Capillary Refill Comment			
Comments			

**8. Document the Pain Assessment.**

- Go to the Table of Contents, select **Interactive View and Fluid Balance**.
- Select **Adult Systems Assessment** and then **Pain Assessment**.
- Enter the following Pain Assessment fields:
  - Conscious State
  - Sedation Score
  - Pain Present
  - If Pain Present, complete the conditional logic and use the Numeric Pain Assessment.



	15:38	15:35
Observation Comments		
Blood Glucose	mmol/L	
Capillary Refill		
<b>Pain Assessment</b>		
Conscious State	Alert	
Sedation Score (Adult)	D = Wide awake	
Pain Present	Yes actual or suspected	
Pre-existing Pain Condition	No	
Pain Assessment	Numeric rating scale	
Numeric Pain Score at Rest	1	
Numeric Pain Score with Activity	5	
FACES Pain Scale at Rest		
FACES Pain Scale with Activity		
Primary Pain Location	Chest	
Primary Pain Laterality	Left	
Primary Pain Type	Tenderness	
Primary Pain Time Pattern	Intermittent	
Secondary Pain		
Tertiary Pain		
Quaternary Pain		
<b>Pain Interventions</b>		
Non-pharmacological Therapy	Cold pack	
Pharmacological Therapy	Offered, Administered	
Non-pharmacological Therapy	Cold pack	

**9. If additional information is required for any of the above fields, enter comments into the Nursing Shift Notes.**