



TAVR Clinical Pathway Protocol



Transfemoral Approach

July 2016

Timeframe (Post-Op)	Clinical Action
0-4 Hours	<p>NO Narcotics OR Sedatives</p> <ul style="list-style-type: none">• Extubate within 1 hour• Wean off all drips within 1 hour of arrival<ul style="list-style-type: none">▪ Saline lock all IVs except renal protection protocol fluids▪ Continue for 6 hours post-op (if ordered)• Remove PA catheter within 1 hours if present and continue central line• Remove arterial line within 2 hours• OOB to chair after 4 hours of bed rest• Discontinue Foley Catheter once patient has been OOB• Discontinue oxygen within 4 hours <u>if</u> O2 saturation \geq 90%

4-12 Hours	<p>NO Narcotics OR Sedatives</p> <ul style="list-style-type: none"> • Restart oral antihypertensive medications in 4 hours and, if able to, take PO <ul style="list-style-type: none"> ▪ Hold if SBP < 100 ▪ Do not give beta blockers if bradycardia and heart rate < 60 • Restart BPH medications in 4 - 6 hours <ul style="list-style-type: none"> ▪ Double dose for 1st dose • Begin incentive spirometry, cough, and deep breathe Q2 hours • RN bedside evaluation for dysphagia <ul style="list-style-type: none"> ▪ ST consult on POD if #1 fails • Begin ice chips <ul style="list-style-type: none"> ▪ Advance to clear liquids ▪ Advance to regular diet (if passed bedside evaluation) • Walk within 8 hours by RN • Reinforce early ambulation with family <ul style="list-style-type: none"> ▪ Educate family on how to mobilize patient
Post-Op Day 1	<p>NO Narcotics OR Sedatives</p> <ul style="list-style-type: none"> • Aggressive blood sugar control per individual hospital policy • Antiplatelets: <ul style="list-style-type: none"> ▪ Begin ASA 325 mg/day if not started pre-op ▪ Begin Plavix 75 mg/day unless contraindicated • Anticoagulation: <ul style="list-style-type: none"> ▪ Begin Coumadin at 1700 if patient was taking pre-op • Insert peripheral IV and remove central line POD #1
	<ul style="list-style-type: none"> • PT consult <ul style="list-style-type: none"> ▪ Ambulate x6 ▪ Encourage all meals OOB • Social work consult if needed • Discharge if criteria met on POD #1-3

TAVR Discharge Information

Discharge Criteria	<ul style="list-style-type: none"> • Discharge studies complete: TTE, CXR, EKG, BMP, BNP, PT, PTT • Baseline neurological function • Stable heart rhythm and has not required pacing within 24 hours • Vital signs stable <ul style="list-style-type: none"> ▪ Heart rate: 60 - 90 ▪ Systolic BP: 90 - 140 (or at baseline) • Voiding without difficulty; emptying bladder <ul style="list-style-type: none"> ▪ If discharged with Foley catheter, urology follow-up appointment is scheduled • Blood sugar < 150 • Creatinine ≤ baseline • O2 weaned off <ul style="list-style-type: none"> ▪ O2 saturation ≥ 90% ▪ Effective cough and airway clearance • Effective pain control on oral medications, no narcotics or sedatives • Independent in ADLs and ambulation or patient has appropriate assistance and devices • Able to ambulate 200 feet (or baseline) • Groin without bleed or hematoma • Patient and family voice appropriate understanding of post TAVR discharge instructions
Discharge & Follow Up	<ul style="list-style-type: none"> • Consider discharge to hotel for 1 - 2 days prior to returning home if the patient is from out of town • Return to Valve Clinic the first Friday after discharge for an office visit <ul style="list-style-type: none"> ▪ Provide patient with date and time • Return to Valve Clinic for 30 day studies <ul style="list-style-type: none"> ▪ Provide patient with date and time • Studies to be completed by/at 30 day Valve Clinic appointment <ul style="list-style-type: none"> ▪ Five Meter Walk ▪ 12 Lead ECG ▪ KCCQ-12 ▪ Echocardiogram <ul style="list-style-type: none"> • Aortic insufficiency addressing paravalvular severity • LVEF • Mean gradient <ul style="list-style-type: none"> ▪ Evidence of elevated gradient on follow-up echocardiogram compared to pre-discharge TTE should consider subclinical leaflet thrombosis. ▪ Further evaluation with Four-dimensional CT with a

volume-rendered imaging protocol to assess for subclinical leaflet thrombosis.

Meduri, Christopher U., Potter, Brian J. (2015). Post - TAVR Optimization (Version 2.0). [Mobile application software]