CARDIOLOGY ROTATION HELPFUL HINTS

Teaching Rounds:
1. Morning Rounds – Patient Care Planning Room, 7:30 – run list, explore management, teaching case.
2. Cardiology Tuesday Noon Conference – Richardson Labs
3. Regular EKG teaching conference (Dr. Baranchuk)
4. Echo rounds/ gel rounds (Dr. Johri)

Sign-over

1- To ensure seamless patient care, please ensure that you sign over any pending patient care concerns to another member of the inpatient team if you are leaving post-call or for half-day, etc.
2- Every day, someone must hand over to the on-call residents covering the ward and CSU. If the CSU is following patients on the ward, don't forget to hand over to the R1 on call for the ward.
3- If patients are seen in the ER and admitted to cardiology – please tell the inpatient service about this patient.

Tips Regarding Medications (Work with the Cardiology Pharmacist!)

1- Plavix/Ticagrelor/Prasugrel:
    a. Any patient with a new stent must have the full one year prescription of anti-platelet therapy given to them upon discharge. The interventionalist usually writes a paper script – **You must ensure that the patient receives this script or that the full year is provided in the e-discharge script.**
    b. Remember limited use codes – 375 for plavix for ACS, 376 for plavix for stents. Prasugrel and ticagrelor both have programs offered by the drug companies to offset cost – please speak to the pharmacist prior to discharge.
2- Warfarin:
    a. Patients who are new to warfarin, who have had their warfarin interrupted or who have had changes in medication which may affect INR (i.e. amiodarone, abx, etc.) must have INR follow-up arranged upon discharge.
    b. **You should speak to the patient's GP or nurse practitioner directly to ensure proper follow-up is in place.**
    c. If you are unsure of what dose to discharge the patient on, please ask for assistance.
3- Amiodarone:
    a. For patients being discharged on amiodarone, ensure that the GP is aware of the monitoring recommendations
        i. ALT, AST, TSH, CXR annually
4- Titration of medications:
    a. Ensure that GPs are instructed to titrate medications and let the GP know what the target doses are

   b. Let the patients know that the family doctors should be titrating their meds.

5- Changes:
   a. Ensure that patients are aware of what medication changes have been made. Suggest that they bring the entire e-discharge summary to the pharmacy with the script so that the community pharmacist can see what meds you have changed.

6- Costs:
   a. Can the patient pay?
   b. Don't forget limited use codes if the patient is on ODB.
   c. If the patient can't pay and does not have ODB, please consult SW for information on other resources.

Tips for CHF patients:

1- Order (and review) daily weights – this is more accurate than ins and outs for ambulatory patients.
2- For new CHF patients, consider consulting Wendy Earle (CHF clinic RN) for beginning the education process re: daily weights, diet, etc. This also helps facilitate discharge follow-up.
3- Have the patients been referred to the CHF clinic upon discharge
   a. feel free to call the CHF clinic to set up the follow-up appt yourself – they can often accommodate patients within 2-3 weeks, and the clinic RNs will follow-up with the patient by phone after discharge if they are aware that the patient is going home.

Tips for Post-EP patients

1. If new ICD, pacemaker, are pts aware of restrictions needed?
   a. Primary prevention ICD: no driving for 1 month post implant
   b. Secondary prevention ICD with no reversible cause – report to Ministry of Transportation, 6 month driving restriction minimum
   c. PM: no driving x 1 week post implant
   d. Ask EP service if unsure
   e. Left arm (assuming left sided device) cannot be raised above 90 degrees x 6 weeks.
2. Follow-up will be automatically arranged with the rhythm device clinic for device checks but you have to decide if they require other cardiology follow-up.
3. Driving: For other EP and cardiology issues:

The Canadian Medical Association Driver's Guide 7th Edition: Determining Medical Fitness to Operate Motor Vehicles is a very useful resource for medical students and staff. Available on line: http://www.cma.ca then click on "CMA Drivers Guide" or http://www.cma.ca/determining-fitness-to-drive

Tips for ACS Patients:

1- If a stent is placed, the interventionalist will write a paper script for plavix (or prasugrel or ticagrelor). The patient must be given this script on discharge, or you must provide a full year's supply on the e-discharge. We cannot rely on another physician to refill this script due to the risk of stent thrombosis. **Remember the limited use codes.**

2- Consider all patients with ACS for cardiac rehab: Some patients are not suitable for mobility reasons (i.e wheelchair bound) or cognitive reasons (i.e. dementia) but most of the patients are suitable for referral.
3- Driving restrictions:
    a. Refer to the CCS/CMA guidelines for more details, but in general, all patients with STEMIs have a 1 month driving restriction
    b. If the patient is a commercial truck driver and has a STEMI, there is a 3 month driving restriction and you have to report them to the MOT.
    c. For NSTEMIs - it depends on where or not we stent them, and if there is significant LV damage - see the CMA guidelines for more details.
4- Any patient who gets cathed cannot lift more than 10 lbs for 1 week after the procedure.
5- Post cardiac cath instructions – the nurses have a booklet to give the patient.

Pre-procedure information (general guidelines only - may vary depending on the patient):

1- For Angiograms – check with cath lab if unsure
    a. The patient does not have to be NPO
    b. Enoxaparin must be held AM of the cath
    c. INR must be <1.5
    d. Pradax needs to be held x 24 hours minimum, 48 hours ideally pre-cath – check with cath lab if unsure
    e. Restarting anticoagulation post procedure – depends on the patient and should be discussed.
        i. If IV heparin needs to be restarted post-cath, it should be started no earlier than 4 hours post-sheath removal with no bolus
2- For Pacemakers/ICDS:
    a. The patient should be NPO after midnight.
    b. IV heparin must be held for at least 4 hours pre-procedure. Dalteparin must be held 24 hours pre-procedure. Enoxaparin must be held at least 12 hours pre-procedure.
    c. Liase with EP service regarding timing of restarting anticoagulation
    d. Coumadin does not need to be held for ICDs/Pacemakers if INR is between 2-3. Check with EP if patient is going for an ablation.
    e. Check with EP service if patient is on pradax

For patient who need CABG:

1- If they do not have a stent that requires plavix - please d/c plavix. Continue ASA.
2- If on enoxaparin, and they require ongoing anticoagulation, this should be switched to iv heparin. Check with the pharmacist about the best way to do this.
3- If your patient has an ICD or pacemaker, please ensure that EP is aware of the upcoming surgery for pre-operative reprogramming.
4- Surgeons and anesthesiologist will write the pre-op orders.

If your patient is going for a procedure and you are unsure about pre-procedure orders, please ask.

Tips for ECHO

1- Be clear on the requisition what you are looking for.
2- Is your patient having a TEE?
    a. Check with the echo lab about booking it so that you know the time and date
    b. the patient needs to be NPO after midnight including meds

Documentation:
When patients expire:
1- If the patient expired, does the eDischarge clearly reflect what happened? Was the Family Doctor called? Was the attending notified?
2- If the patient expired overnight – do not forget to do the edischarge summary (the on-call person likely did not do it)

Daily:
1- Physical Exam
2- Telemetry one-liner, assess the monitor and who needs it.