Patient Name:_____

Order Set Directions:
➢ (√)- Check orders to activate; Orders with pre-checked box ☑ will be followed unless lined out.
➢ Initial each place in the pre-printed order set where changes such as additions, deletions or line outs have been made
➢ Initial each page and Sign/Date/Time last page

Diagnosis: _____

Allergies with reaction type: _____

Transesophageal Echocardiogram - Postprocedure   Version 1 11/10/2014

General
● Use for patients who have received moderate sedation

Activity
☑ Bed rest then up with assistance when awake and stable

Nursing Orders
☑ Vital signs-post procedure Q 15 min x 2, Q 30 min x2, Q1H x2 then per unit standard
☑ Cardiac monitor until discharge or per unit standard
☐ Discharge Instructions: Patient to avoid alcohol, working with machinery, making important decisions and driving for at least 24 hours
☐ Discharge after 2 hours if stable and all criteria are met [Medication Reconciliation must be completed prior to discharge] Discharge with a responsible person (someone who can receive and understand instructions, stay with the patient and call for assistance as instructed)
☐ Discharge criteria:
Patient is easily awakened by normal or softly spoken verbal communication;
Patient is oriented when awake as appropriate for age;
Vital signs within pre-procedure levels and cardiac rhythm stable;
There is no significant risk of losing protective reflexes;
Patent is able to maintain pre-procedure mobility;
Pain is controlled
☐ Arrange follow up appointment with _____

Respiratory
☑ Oxygen Delivery RN/RT to Determine Titrate to maintain Oxygen saturation greater than 94%
☑ Pulse oximetry , continuous until awake and alert and oxygen saturation remains > 94 % then pulse oximetry per unit standard of care

Diet
☑ NPO for 2 hours then advance diet as tolerated to cardiac (heart healthy)

IV Fluids
Sodium Chloride 0.9% IV
☐ _____ milliliter/hour continuous intravenous infusion until discharge; discontinue IV before discharge
☐ _____ milliliter/hour continuous intravenous infusion for _____ hours then convert to IV to saline lock

Provider Signature:_____Date:_____Time:_____