Guidelines for the care and management of patients with a Ventricular Assist Device (VAD):

10 step pathway

V1.0

May 2013
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1. Introduction
1.1. Ventricular Assist Devices (VADs) are currently licenced in the UK for use as a bridge to transplant, providing mechanical support for the Left Ventricle in patients who have Left Ventricular Systolic Dysfunction. At the time of writing there are 3 patients in Cornwall who have one of these devices in situ, each of them have the Thoratec Heartmate II® in situ.

1.2. This version supersedes any previous versions of this document.

2. Purpose of this Procedure
2.1. A VAD is implanted in a patient to support their Left Ventricular function. This intervention is required because the patient’s intrinsic cardiac function can no longer meet their physiological needs. There are a number of important clinical idiosyncrasies for patients supported by a VAD. Incorrect management of these patients can lead to irreversible damage to the VAD and cessation of cardio-vascular support. This document provides information regarding the clinical management of these patients on admission to the Royal Cornwall Hospital NHS Trust (RCHT).

3. Scope
3.1. This procedure applies to any clinical area to which this group of patients may be admitted within RCHT

4. Definitions / Glossary
4.1. VAD  Ventricular Assist Device
4.2. LVAD  Left Ventricular Assist Device
4.3. LVSD  Left Ventricular Systolic Dysfunction
4.4. RCHT  Royal Cornwall Hospitals NHS Trust
4.5. CPR  Cardio Pulmonary Resuscitation

5. Ownership and Responsibilities

5.1. Role of the Medicine, ED and WCH Divisional Management Team
The Medicine, ED and WCH Divisional Management Team is responsible for:

- Ensuring this procedure is cascaded to relevant members of their team

5.2. Role of the Heart Failure MDT
The Heart Failure MDT is responsible for:

- Ensuring this document is up to date.

- Monitoring compliance and effectiveness of this procedure when a VAD patient is admitted to RCHT

Guidelines for the care and management of patients with a Ventricular Assist Device (VAD): 10 step pathway
- Ensuring any RCHT patient with a VAD in situ is ‘flagged’ in their medical notes and on PAS
- Ensure the list of implant centres and relevant contacts is kept up to date (held on the Coronary Care Unit)

5.3. Role of Admitting Physician
The admitting Physician (eg Surgical receiving unit, Medical Admissions Unit and Emergency Department) is responsible for:
- Ensuring the On Call Cardiologist is immediately informed of the admission.
- Ensuring the Heart Failure Specialist Nursing Team has been informed of the admission as soon as possible
- Initiating the 10 step ‘admission pathway’ (6.1) outlined in this document.

5.4. Role of On Call Cardiologist
The On Call Cardiologist is responsible for:
- Providing a Clinical and Nursing management plan, where appropriate
- Facilitating the rapid transfer of the patient to the Coronary Care Unit
- Ensuring this procedure is followed when a patient with a VAD is admitted to RCHT
- If the patient is admitted ‘out of hours’ and if necessary, inform the implanting centre of the admission. A list of contacts will be kept on the Coronary Care Unit
- Liaising with the Heart Failure Specialist Nursing team.

5.5. Role of Heart Failure Specialist Nursing team
The Heart Failure Specialist Nursing Team is responsible for:
- Providing a Clinical and Nursing management plan, where appropriate
- Facilitating the rapid transfer of the patient to the Coronary Care Unit
- Ensuring this procedure is followed when a patient with a VAD is admitted to RCHT
- Ensure the implanting centre has been informed of the patients admission during normal working hours. A list of contacts will be kept on the Coronary Care Unit
- Liaising with the On Call Cardiologist.
Facilitating the rapid transfer of the patient to the Coronary Care Unit

5.6. Role of Nurse in Charge of the Coronary Care Unit
The Nurse in charge of the Coronary Care Unit is responsible for:

- Facilitating the rapid transfer of the patient to the Coronary Care Unit
- Initiating the 10 step ‘following transfer to CCU pathway’ (6.2) outlined in this document

5.7. Role of the Duty Site Co-ordinator
The Duty Site Co-ordinator is responsible for:

- Facilitating the rapid transfer of the patient to the Coronary Care Unit

5.8. Role of the Clinical Leaders
Line managers (eg Ward Sisters/Charge Nurses and Consultant Speciality leads) are responsible for:

- Ensuring this procedure is cascaded to relevant members of their team
- Ensuring this procedure is followed when a patient with a VAD is admitted to RCHT

5.9. Role of Individual Staff
All staff members are responsible for:

- Ensuring they are up to date with this procedure
- Ensuring this procedure is followed when a patient with a VAD is admitted to RCHT
6. Standards and Practice

6.1. The Heart Failure MDT is responsible for ensuring any RCHT patient with a VAD in situ is ‘flagged’ in their medical notes and on PAS

6.2. If a patient with a VAD is admitted to RCHT; 10 step pathway. (Also see Appendix 3)

1. The patient may not have a palpable pulse (VAD flow is continuous not pulsatile).

2. CPR can dislodge the VAD cannulae (apical or aorta) so should only be commenced if all other possible causes of no flow are excluded (see appendix 4)

3. Obtaining a blood pressure is challenging due to the absence of pulsatile flow. Mean Arterial Pressure can be obtained using an electronic blood pressure monitor, or by utilising a manual sphygmomanometer and Doppler ultrasound.

4. The On Call Cardiologist Should be informed immediately (via RCHT switchboard)

5. **DO NOT** stop the patients anticoagulation unless requested by a consultant Cardiologist.

6. **Ensure the VAD is attached to a mains power source** (see Appendix 5)

7. The Heart Failure Specialist Nursing team should be informed as soon as possible (via RCHT switchboard)

8. The Nurse in charge of the Coronary Care Unit should be informed as soon as possible and a bed requested (Ext 2630 / 2648)

9. The Duty Site co-ordinator should be informed as soon as possible

10. The patient should be transferred to the Coronary Care Unit as a clinical priority, unless their presenting condition dictates management by critical care (for example patients requiring ventilation)
6.3. Following transfer to Coronary Care Unit; 10 step pathway. (Also see Appendix 3)

1. The patient may not have a palpable pulse (VAD flow is continuous not pulsatile).

2. CPR can dislodge the VAD cannulae (apical or aorta) so should only be commenced if all other possible causes of no flow are excluded (see appendix 4)

3. Obtaining a blood pressure is challenging due to the absence of pulsatile flow. Mean Arterial Pressure can be obtained using an electronic blood pressure monitor, or by utilising a manual sphygmomanometer and Doppler ultrasound.

4. The On Call Cardiologist Should be informed immediately (via RCHT switchboard)

5. **DO NOT** stop the patients anticoagulation unless requested by a consultant Cardiologist.

6. **Ensure the VAD is attached to a mains power source** (see Appendix 5)

7. Ensure the on call Cardiologist has been informed

8. Ensure the Heart Failure Specialist Nursing team has been informed.

9. Inform the implanting centre of the admission. During working hours the Heart Failure Specialist Nurse will liaise with implanting centre in the first instance. Out of hours, if necessary the On Call Cardiologist will liaise with the VAD implanting centre. A list of contacts will be kept on the Coronary Care Unit.

10. Commence VAD monitoring (see appendix 6)

7. **Dissemination and Implementation**

7.1. This document will be disseminated electronically to all relevant stakeholders once published. It will also be available via the RCHT document library. There are no previous versions of this document to archive.
8. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Whether this procedure is followed when a patient with a VAD presents non-electively to RCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>The Clinical Nurse Specialist, Heart Failure</td>
</tr>
<tr>
<td>Tool</td>
<td>‘Priorities of care for VAD patients’ mapping tool (appendix 6)</td>
</tr>
<tr>
<td>Frequency</td>
<td>This will be monitored each time a patient with a VAD is admitted to RCHT and a report compiled.</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>This report will be interrogated by the Cardiologist clinical lead for Heart Failure.</td>
</tr>
<tr>
<td></td>
<td>This report will be reviewed at the Cardiology Speciality meeting with arising actions minuted.</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>The heart failure multidisciplinary team will undertake subsequent recommendations and action planning for any or all deficiencies and recommendations within reasonable timeframes.</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified and action will commence within 1 week of report review. A lead member of the heart failure multidisciplinary team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders via the Cardiology speciality meeting.</td>
</tr>
</tbody>
</table>

9. Updating and Review

9.1. This document will be updated by the Clinical Nurse Specialist, Heart Failure every 3 years.

9.2. Currently the VAD of choice across the UK is the Thoratec Heartmate II®. Should this change, appendices 4 and 5 of this document will be updated earlier than 3 years to reflect differing user guides or monitoring values.

9.3. Revisions can be made ahead of the review date when the procedural document requires updating. Where the revisions are significant and the overall policy is changed, the author should ensure the revised document is taken through the standard consultation, approval and dissemination processes.

9.4. Where the revisions are minor, e.g. amended job titles or changes in the organisational structure, approval can be sought from the Executive Director responsible for signatory approval, and can be re-published accordingly without having gone through the full consultation and ratification process.

9.5. Any revision activity is to be recorded in the Version Control Table as part of the document control process.

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10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement.

10.2. **Equality Impact Assessment**

10.3. The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Priorities of care for the management of patients with a Ventricular Assist Device (VAD)</th>
</tr>
</thead>
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<td>Date Issued/Approved:</td>
<td>29 Jul 13</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>9 Jul 13</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>9 Jul 16</td>
</tr>
</tbody>
</table>
| Directorate / Department responsible (author/owner): | Cardiology Speciality  
Joanna Davies  
Clinical Nurse Specialist, Heart Failure |
| Contact details: | 01872 253018  
Joanna.davies@rcht.cornwall.nhs.uk |
| Brief summary of contents | 10 step pathway for clinical management of Ventricular Assist Devices on admission to the Royal Cornwall Hospital |
| Suggested Keywords: | Cardiology  
Heart Failure  
Left Ventricular Systolic Dysfunction (LVSD)  
Ventricular Assist Device (VAD)  
Heart Transplant |
| Target Audience | RCHT  
PCT  
CFT  
| Execuitive Director responsible for Policy: | Medical Director |
| Date revised: | Not applicable |
| This document replaces (exact title of previous version): | New Document |
| Approval route (names of committees)/consultation: | Cardiology Speciality Group  
Divisional Management Team |
| Divisional Manager confirming approval processes | Dr Duncan Browne, Divisional Director |
| Name and Post Title of additional signatories | Not Required |
| Signature of Executive Director giving approval | {Original Copy Signed} |
| Publication Location (refer to Policy on Policies – Approvals and Ratification): | Internet & Intranet  
[✓] Intranet Only |
| Document Library Folder/Sub Folder | Clinical / Cardiology |
| Links to key external standards | None |

Guidelines for the care and management of patients with a Ventricular Assist Device (VAD): 10 step pathway
Related Documents: Heartmate II user guide: operating manual can be accessed via the Internet – search for ‘Heatmate ii manual’.

Training Need Identified? No, all relevant information pertaining to the device is included within this document.

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/05/13</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Joanna Davies Clinical Nurse Specialist, Heart Failure</td>
</tr>
<tr>
<td></td>
<td>V2.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>V3.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
### Appendix 2. Initial Equality Impact Assessment Screening Form

| Priorities of care for the management of patients with a Ventricular Assist Device (VAD) |
|---|---|
| **Directorate and service area:** Medicine, ED & WCH, Cardiology speciality | **Is this a new or existing Procedure?** New |
| **Name of individual completing assessment:** Joanna Davies | **Telephone:** 01872 253018 |
| 1. **Policy Aim** | To improve the clinical management of patients with a VAD who are acutely admitted to the Royal Cornwall Hospital, reducing the risk of adverse events for this group of patients who have complex clinical management requirements. |
| 2. **Policy Objectives** | To provide a clear, speciality agreed, pathway for the initial clinical management of patients with a Ventricular Assist Device on admission to the Royal Cornwall Hospital |
| 3. **Policy – intended Outcomes** | Availability of a robust, measureable, Speciality agreed pathway for the initial management of patients with a VAD. |
| 4. **How will you measure the outcome?** | Outlined in section 8 of this document. Utilising Appendix 7 ‘Priorities of care for VAD patients’ mapping tool |
| 5. **Who is intended to benefit from the Policy?** | Patients with a VAD, acutely admitted to RCHT and those members of the MDT caring for them. |
| 6a. **Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?** | Yes, Workforce |
| b. **If yes, have these groups been consulted?** | All Consultant Cardiologists Ward Sister Coronary Care Unit Medical Admissions Unit Consultant Physicians and Unit Clinical Matron, Medicine Cardiology Speciality Group |
| c. **Please list any groups who have been consulted about this procedure.** | |

#### 7. The Impact

Please complete the following table using ticks. You should refer to the EA guidance notes for areas of possible impact and also the Glossary if needed.

- Where you think that the policy could have a positive impact on any of the equality group(s) like promoting equality and equal opportunities or improving relations within equality groups, tick the ‘Positive impact’ box.

Guidelines for the care and management of patients with a Ventricular Assist Device (VAD): 10 step pathway
Where you think that the policy could have a negative impact on any of the equality group(s) i.e. it could disadvantage them, tick the ‘Negative impact’ box.

Where you think that the policy has no impact on any of the equality group(s) listed below i.e. it has no effect currently on equality groups, tick the ‘No impact’ box.

<table>
<thead>
<tr>
<th>Equality Group</th>
<th>Positive Impact</th>
<th>Negative Impact</th>
<th>No Impact</th>
<th>Reasons for decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Religion or belief</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Transgender</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Pregnancy/Maternity</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Marriage/Civil Partnership</td>
<td></td>
<td></td>
<td>√</td>
<td></td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- A negative impact
- No consultation (this excludes any policies which have been identified as not requiring consultation).

8. If there is no evidence that the policy promotes equality, equal opportunities or improved relations - could it be adapted so that it does? How?

Full statement of commitment to policy of equal opportunities is included in the policy

Please sign and date this form.

Keep one copy and send a copy to Matron, Equality, Diversity and Human Rights, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Chyvean House, Penventinnie Lane, Truro, Cornwall, TR1 3LJ

A summary of the results will be published on the Trust’s web site.

Signed

Date

Guidelines for the care and management of patients with a Ventricular Assist Device (VAD): 10 step pathway
Appendix 3. Patient journey

**Patient with a Ventricular Assist Device (VAD) admitted to RCHT.**

1. The patient may not have a palpable pulse (VAD flow is continuous not pulsatile).
2. Obtaining a blood pressure is challenging due to the absence of pulsatile flow. Mean Arterial Pressure can be obtained using an electronic blood pressure monitor, or by utilising a manual sphygmomanometer and Doppler ultrasound.

**3. Do Not commence CPR**

CPR can dislodge the VAD cannulae (apical or aorta) so should only be commenced if all other possible causes of no flow are excluded (see appendix 4).

**4. Inform the On Call Cardiologist about the admission immediately**

via RCHT switchboard

**5. Do Not stop anticoagulation**

unless requested to do so by a Consultant Cardiologist.

If the patient is not anticoagulated the VAD can fill with clot leading to irreversible damage to the VAD and cessation of cardio-vascular support.

**6. Ensure the VAD is attached to a mains power source**

See Appendix 5.

**7. Inform the Heart Failure Specialist Nursing team**

As soon as possible via RCHT switchboard

**Arrange Transfer to Coronary Care Unit**

Contact the Nurse in charge of the Coronary Care Unit, to request a bed, via extension 2630 / 2648.

Inform the Duty Site co-ordinator, to facilitate transfer to Coronary Care, via RCHT switchboard

**Transfer to the Coronary Care Unit as a clinical priority**

unless their presenting condition dictates management by critical care (for example patients requiring ventilation)
Following Transfer to Coronary Care

Review steps 1 to 7

Inform the implanting centre of the admission
(A list of contacts will be kept on the Coronary Care Unit)

During working hours the Heart Failure Specialist Nurse will liaise with implanting centre in the first instance. Out of hours, if necessary the On Call Cardiologist will liaise with the VAD implanting centre.

Commence VAD monitoring

see appendix 6
Appendix 4. VAD Resuscitation guidelines

VAD PATIENTS DO NOT ALWAYS HAVE A PULSE, DO NOT IMMEDIATELY DO CARDIAC MASSAGE, FOLLOW THESE GUIDELINES:

Contact the Transplantation Emergency Line for guidance 07850 233730

Low Flow

URGENT

ASSESS PATIENT
- ABCDE
- Auscultate over pump pocket if running
- Doppler BP

POWER
- reading > 10 or a sudden increase of > 2 from usual amount

Investigation needed for thrombus. Contact QE Hospital Birmingham

FLUID
- Give colloid in 100ml increments. Contact QEHB

DEFIBRILLATE as per Resus Councils Guidelines

VT / VF

No Flow

EMERGENCY

ASSESS PATIENT
- ABCDE
- Auscultate over pump pocket if running
- Doppler BP

VT / VF

CHECK PUMP
- X2 viable power sources attached
- Drive Line lead attached/ damaged RECTIFY

Still No Flow

CHANGE system controller (follow emergency controller change)

NO FLOW

CARDIAC MASSAGE
If no cardiac output

LVAD cannulae can be dislodged during CPR, commence only when it is certain there is no signs of perfusion

Guidelines for the care and management of patients with a Ventricular Assist Device (VAD): 10 step pathway
Appendix 5. Attaching a VAD to a mains power supply
(Heartmate II®)

The VAD is implanted in the patient. All that is visible is the driveline, which usually exits the abdomen on the patients’ left hand side.

The system controller is connected to the VAD via the driveline.

There are 2 power source options for the VAD, either of which can be connected to the VAD via the system controller:

**Batteries:**
These batteries will last 8-10 hours depending on RPM setting.

**Or mains power via the power module:**
The power module has a built in battery which will last for 30 minutes if the mains power supply is interrupted.

Ensure the power module is plugged into the mains and connected to the patient’s system controller as soon as possible

A full, up to date operating manual can be accessed via the Internet – search for ‘Heartmate ii manual’.

Guidelines for the care and management of patients with a Ventricular Assist Device (VAD): 10 step pathway
Appendix 6. VAD monitoring (Heartmate II®)

VAD monitoring checklist

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>RPM</th>
<th>Flow</th>
<th>Pulse Index</th>
<th>Power</th>
</tr>
</thead>
</table>

**Daily Checks**

| Power module self test | System controller self test | INR (target range 1.5 to 2.5) | Dressing Check | Dressing Change |

Please note:

To reduce the risk of driveline infection, only the patient or their NOK (who has been trained by the implanting centre) should change drive-line dressings.
Daily checks:

Power Module Self-Test

1. Press and hold the Power Module's (PM’s) Silence Alarm Button for five seconds.

2. Listen for 3 beeps to sound and watch the front of the PM to see if all the lights come on in sequence (i.e., one-at-a-time; not all at once).

3. If any of the following occurs, there may be a problem with the PM and you should change to battery power and contact Inplanting centre/Thoratec immediately:
   - No sound
   - Anything other than 3 beeps (such as continuous beeping or a broken tone)
   - All the lights come on at once
   - All the lights remain off
   - One of the lights does not come on

System Controller Self-Test

1. Press and hold the Test Select Button for three seconds.

   After three seconds, the Red Heart, Red and Yellow Battery, Yellow Controller Cell Symbol, and Fuel Gauge lights will come on, along with a CONTINUOUS AUDIO TONE.
Note: Pressing the Test Select Button will have no effect when an alarm is active. A self-test can be performed only when there are no active alarms.

2. Look closely at the System Controller display panel. Make sure that all of the lights are on and the alarm is making a CONTINUOUS AUDIO TONE. If there is a problem with the audio alarm, it will beep once every two seconds instead of a continuous or steady tone.

3. Release the Test Select Button.
   All the lights should remain on and the alarm should sound a CONTINUOUS AUDIO TONE for an additional five seconds.

4. If all the alarms and lights come on as described above and then turn off five seconds after releasing the button, the System Controller has passed the self-test.

IF IT DOES NOT PASS THE SELF TEST, CONTACT implanting hospital / THORATEC IMMEDIATELY
### Appendix 7. ‘Priorities of care for VAD patients’ mapping tool

<table>
<thead>
<tr>
<th>Affix Patient ID label</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date / Time of admission</td>
<td></td>
</tr>
<tr>
<td>Was the On call Cardiologist Informed of admission?</td>
<td>Yes</td>
</tr>
<tr>
<td>Was anticoagulation withheld/altered?</td>
<td>Yes</td>
</tr>
<tr>
<td>Was the VAD connected to a mains power source?</td>
<td>Yes</td>
</tr>
<tr>
<td>Was the Heart Failure Specialist Nursing team informed of the patients admission?</td>
<td>Yes</td>
</tr>
<tr>
<td>Was the Nurse in charge of the Coronary Care Unit informed of the patients admission?</td>
<td>Yes</td>
</tr>
<tr>
<td>Was the Duty Site co-ordinator should be informed of the patients admission?</td>
<td>Yes</td>
</tr>
<tr>
<td>Was the patient transferred to the Coronary Care Unit / critical care as a clinical priority?</td>
<td>Yes</td>
</tr>
<tr>
<td>Date/Time of transfer to CCU/ critical care</td>
<td></td>
</tr>
<tr>
<td>Was CPR carried out on the patient at any time during their admission episode?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Mapping completed by (name and Job title).............................................................................................................

Date of completion....................................................................................................................................................

Guidelines for the care and management of patients with a Ventricular Assist Device (VAD): 10 step pathway