

Guidelines for management of CSF drain in CVICU (Nursing responsibilities)

1. Upon arrival to CVICU
 - ❖ Obtain sign out from attending anesthesiologist
 - ❖ Inspect the site of catheter placement.
 - ❖ Zero the transducer at the level of Right Atrium. Do not connect saline flush or pressure bag to transducer
 - ❖ Check for drainage/flow of CSF.
2. Keep the HOB < 15-20° at all times till CSF drain is in place.
3. Monitor CSF pressure continuously.
4. Standard neuro Checks every 1 hour including
 - ❖ If patient is unresponsive/sedated :
 - Check for deviation of eye medially (6th Nerve Palsy).
 - Deep tendon reflexes.
 - ❖ If patient is responsive:
 - Motor strength in extremities.
 - Check for deviation of eye medially (6th Nerve Palsy).
5. Examine the catheter and its insertion site every 4 hours and at every changeover.
6. Drain CSF to keep CSF pressure <= 10 mm of Hg up to 15 ml/ hr in aliquots of 5 ml while checking CSF pressure in between.
7. Hold anticoagulation until further orders.
8. Keep Mean Arterial Pressure (MAP) >= 70 mm of Hg.
9. Call CV surgical PA/MLP if:
 - CSF pressure > 15 mm Hg and drainage of 15 ml or above has been achieved for that hour.
 - CSF drainage stops and/or CSF pressure > 15 mm Hg.
 - CSF drainage is blood tinged or frank blood is seen.
 - Loss of CSF waveform
10. Call CV surgeon/Anesthesiologist on call if there is sudden change in neurological status or if the PA/MLP cannot troubleshoot the problem.
11. CT scan of head, neck and whole spine if patient continues to fail neuro checks as per the order protocol. CSF drainage and monitoring should be off during transport

12. After 36 hours:

- ❖ **Check PT/INR, aPTT and platelet counts**
- ❖ **Call attending anesthesiologist after consultation with CV surgeon for removal of CSF drain after the Lab results are available.**
- ❖ **Patient remains flat for 1 hour post removal of CSF drain.**
- ❖ **Save catheter tip till MD asks to dispose**