UNIVERSITY MEDICAL CENTER INTERDISCIPLINARY

Disclaimer: The is a suggested interdisciplinary plan of care. This is only a guideline. The patient problem, outcomes and interventions may be changed to meet the individual needs of the patient. Physician/Medical orders supersede all pre-printed interventions identified on the

ADDRESSOGRAPH

Conges	tive Heart Failure (CHF)	
ESTIMATED LOS: 5 Days	Date placed on map:	
INCLUSIONARY CRITERIA: Patients with documented diagnos	is of Congestive Heart Failure.	
EXCLUSIONARY CRITERIA: Patients with Renal Failure, recent	t myocardial infarction (<7 days), and cardiac dysrhythmia (as primary	/ cause of CHF).
Primary Diagnosis/Procedure: _		
Pertinent Past Medical History:		
Allergies:		
Code Status:		
CONSULTS OR DISCIPLINES IN	VOLVED/NOTIFIED:	
1	Initials/Date/Time notified:	
2	Initials/Date/Time notified:	
3	Initials/Date/Time notified:	
4	Initials/Date/Time notified:	
5	Initials/Date/Time notified:	
SIGNIFICANT EVENTS THIS ADI	MISSION:	
Date/Event:		
Date/Event:		
Date/Event:		
RN Signature:	Date/Time:	
RN Signature:		
Instructions for Documentation: OUTCOMES/INTERVENTIONS:	- Initial when met or completed - Use notation N/A, if not applicable for the timeframe - Initial and circle, if not met or completed	

Supplemental Documentation is required on the Progress Record / Patient Focus Notes when an outcome or intervention is initialed and circled, indicating it was not met or completed as stated.

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ADDRESSOGRAPH

Problem/	ETD	D	E	N	Problem/		D	E	TA
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Needs	Patient/family verbalizes understanding of	-	-		Needs	Vital signs stable.	_	-	╁
Knowledge	anticipated plan of care and participates				Hemodynamic	Vital signs stable.			l
Deficit related	in decision making.				Instability	No EKG changes as per MD.	+-	\vdash	t
to plan of care	Able to state signs & symptoms to report	-	-		motability	The Enter changes as per Mis.			١
to plan or care	immediately.					SpO ₂ > 94% via pulse oximetry.	+-	-	t
	ininodatoly.	\vdash				Opogravia via paloe eximitary.			l
						Bedrest - assistance with all ADL's.	+		ļ
		er et an	J. 177 - 187	1	Activity				ļ
	28 Mars 1 5 10 Mars 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	51751			Intolerance				
		Z. Do sa							
D-1-	Pain free or verbalizes relief after	Ī							ļ
Pain	intervention.	_	_	_					
Management	Respirations unlabored at rest.								
	Decreased anxiety.								
									ļ
	9/19/2000 9 1 10 1 N 7				Patient Safety	Remains injury free in a safe environment.			ı
Fig. 141 Value	Decreased respiratory distress.						\top		T
Fluid Volume Overload			_	_			4		╧
	Urine output > intake.				Skin Integrity	No evidence of skin breakdown.			
	Lung sounds improved from initial assessment.								İ
						Patient/family verbalizes satisfaction	T		Γ
	THE RESERVE TO SERVE THE RESERVE THE RESER				Patient/Family Satisfaction	with hospital stay/care.	+		H
Patient Care	INTERVE	NTI	ONS E	(cc	ntinued on bac Patient Care	(k)	TD	E	Т
Categories			-	l "	Categories		1	-	ľ
Discharge				1	Nutrition	* Diet: 2 gm Na or	\top		T
Plan						% of diet consumed:			i
						Breakfast%			Ī
						Lunch%			T
				1-		Dinner %			۲
						High risk nutritional assessment			Γ
						completed. * Fluid restriction:	+		+
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		D	E	N	Patient Care	Signature available available	D	Ε	Ν
Categories	Assess respiratory / cardiac status. Cardiac rhythm monitoring and Categories Categories Encourage verbalization of fears / concerns. Learning needs / teaching plan:								
	Assess respiratory / cardiac status.				- James of the second	Encourage verbalization of fears /			
Assessment					Teaching				
&					&	Learning needs / teaching plan:			
Assessment & Control of A violation					Psychosocial				
				1		- Instruct on medications			
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	Palpate peripheral pulses.								
	THE COSCINE A	_				I control of the cont			
	Strict I&O.	and a	23						
	* Foley if indicated.		(CA			The second section of the second	atg.	49	
	IV access obtained.	1000	0.45		1 1 m		12.000	95 9	
	* IV: ml/hr.				en vije sama		181 :s (5 : 0)		
	VS q 2 hrs. and PRN if stable.	\vdash				and the second			
	Pulse oximetry.	\vdash	_	-					
wodani di salah sa	IV diuretics begun.		11.000						
	Report urine output to ER MD.	- ,, -	p.A.	- {-		II ab / diagnostics results reviewed: MD			
	Ace inhibitor continued from home	\vdash	4	\vdash	Specimens				
	The same of the sa						_		\neg
	* O ₂ (type):	\vdash		-					- 1
	G2 (1) PO).				2.Lgcoco				- 1
andream sections	If patient diuresis < 200 cc, 1 hour		1 / 201	11.					- 1
				-)-					. 1
								01.70	1
				- 4		- U/A			- 1
						- BNP			- 1
						- Echo			- 1
in passage of the state	The state of the s	1100	- 192	s. d					- 1
	College Colleg					Consider if applicable:			\neg
area of the same and a same as	man of the second of the secon				entrates de Associate	- TSH		1770	
				- 1	1 1 1	- Digoxin level			
us processors from a	manufacture in region to religion participation in	200	res 15			- ABG if pulse oximetry < 90%		3.77	
			1 10			7			
and the same of the same						dedicate participation of the party			- 1
rack action through	Annick Communication Communication (Communication Communication Communic	- Chemistry - CXR - Cardiac enzymes q 8hr. X 3 - PT / PTT - U/A - BNP - Echo Consider if applicable: - TSH - Digoxin level - ABG if pulse oximetry < 90% Falls protocol initiated. Safety & Activity level: Bedrest - head of bed up greater than or							
	Contract Charles to the second								
had been been and the second			4.49			Falls protocol initiated			=
			1148		Safety	n and protocol lineated.			
						* Activity level:			\neg
particular and there is no a	property or the second of the								_
Percelinare Vision Complete	The second secon		100		Activity				- 1
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Andrew Same	Hygiene & Comfort Protocol								
	17								
	Peripheral IV Therapy Protocol								
	1. 11 1. 10 1.00 1.00 1.00 1.00 1.00 1.								
	Pressure Ulcer Prevention Protocol								
anger and area	* Respiratory Care provided.	\vdash							

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ADDRESSOGRAPH DESIRED OUTCOMES D = DAYS E = EVENINGS N = NIGHTSDay 1 E E Problem/ Problem/ Needs Date: Needs Patient/family verbalizes understanding of No dysrhythmias observed. Knowledge anticipated plan of care and participates Hemodynamic No EKG changes as per MD. Deficit related in decision making. Instability to plan of care Able to state signs & symptoms to report Vital signs stable. immediately. Oriented to unit. SpO₂ > 94% via pulse oximetry. Tolerates ADL's with assist. Activity Intolerance Pain free or verbalizes relief after Pain intervention. Respirations even and unlabored. Management Remains injury free in a safe Patient Safety environment. Decreased respiratory distress. Fluid Volume No evidence of skin breakdown. Overload Urine output > intake. Skin Integrity Lung sounds improved from initial Patient/family verbalizes satisfaction assessment. Patient/Family with hospital stay/care. Satisfaction INTERVENTIONS (continued on back) Patient Care Patient Care D E N Е Categories Categories Assess need for Discharge Planning / * Diet: 2 gm Na or Discharge Social Services based on admitting Nutrition Plan % of diet consumed: assessment and home environment. Breakfast _____ High risk nutritional assessment completed. * Fluid restriction: Consider dietary consult.

Patient Care	Day 1	D	E	N	Patient Care	STREET, 1	D	E	N
Categories	Date:				Categories		1	Prince of the last	
	Assess respiratory / cardiac status					Encourage verbalization of fears /	$\overline{}$		
Assessment	q 4 hrs. and PRN.				Teaching	concerns.	-		-
.8	Telemetry monitoring and documentation.				&	Learning needs / teaching plan:	1		\vdash
Treatments					Psychosocial				1
	Assess edema and pressure of fluid					- Signs of heart failure exacerbation			
	volume reservoirs, i.e., ascites, sacral					- Medications at home			
	or scrotal edema, skin temperature					- Treatment Goals			
	and color.	_			1				
	Palpate peripheral pulses q shift and PRN.						-		
1975		_	_			Assess patient / family's perception of			
Julian many	* Pulse oximetry q shift and PRN.					CHF diagnosis.	-		-
	O ₂ (type):	100		-	- 2 0	Assess knowledge level and readiness			
	02 (1900).		1			to learn.	-		_
	* Strict I&O.	-		-					1
	WO 125 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -				3 1	Charles and the management of the		10.1	
	Obtain weight:					and the same of the same of			
	Profit of the Control						0.0	11.0	-
	* ACE Inhibitor ordered if no fluid overload				engline per est en	ADVISOR*			
	If not, why:					Land Markey C			
				- 4					
water bearing	* IV diuretic:								
	* IV: ml/hr.			_					
	TV munr.	2-3	20			I ab / discount and the	-	_	
	Vital signs q 4 hrs and PRN.		_	\dashv	Specimens	Lab / diagnostics results reviewed; MD notified if indicated.	H		
	Vital biglis q 4 ilis alid P Kit.		- 1		&	* Tests / Procedures - if not done in ER	\vdash		\vdash
	* O ₂ (type):	\vdash		\neg	Diagnostics	- CBC		ı	
	-2 (3)-3)			- 1	Diagnostics	- Chemistry			
						- PT / PTT			
				- 1		- Cardiac enzymes	1 1	- 1	
				- 1		- U/A			
				- 1		- EKG	1 1		
				- 1		- Echo	1 1		
na hare in the	NATIONAL CONTRACTOR CONTRACTOR			- 1		- ABG if pulse oximetry <94		- 1	
			- 1	- 1		- BNP			
			- 1	- 1		Consider if annihable:	\vdash	-	-
				- 1		Consider if applicable: - TSH			
A ROTE THE STREET						- Digoxin level			- 77
						- Digoxiii iovoi	- 4	500	
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and the second second				- 1				- 1	- 1
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and hard yet (Barrie) or 1 to the miles of	er en etc. I a seu a seu sel est est a company	×	- 1		& Activity	* Activity level: Bed rest or:			
and the second	and the second s			- 1	Acuvity	N. A.			- 1
		7 -4	124	- 1		Assist with all ADL's.			\neg
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1	Hygiene & Comfort Protocol								
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	Peripheral IV Therapy Protocol								
	Pressure Ulcer Prevention Protocol	-	-	\dashv					
	Pressure Older Prevention Protocol								
	* Respiratory Care provided.	-	-	\dashv					
	(See Respiratory Care Record)								

Signature		Title	Initial
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Signature Requiring Co-Signature	Date/Shift	Initial/	Title
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ADDRESSOGRAPH D = DAYS E = EVENINGS N = NIGHTS**DESIRED OUTCOMES** DEN E Problem/ Problem/ Day 2 Needs Needs Date: No dysrhythmias observed. Patient/family verbalizes understanding of Hemodynamic anticipated plan of care and participates Knowledge No EKG changes as per MD. in decision making. Instability Deficit related to plan of care Verbalizes: Vital signs stable. Etilogy of heart failure diagnostic test SpO₂ > 94% via pulse oximetry. Meds / treatments Tolerates OOB to chair, begins to resume pre-admit activity level. Activity Intolerance Pain free or verbalizes relief after Pain intervention. Management Respirations easy and unlabored. Remains injury free in a safe Patient Safety environment. Urine output > intake. No evidence of skin breakdown. Fluid Volume Lung sounds improved from Day 1, if not Skin Integrity Overload notify MD. Weight loss from Day 1, if no decrease Patient/family verbalizes satisfaction notify MD. Patient/Family with hospital stay/care. Decrease in edema from admission. Satisfaction INTERVENTIONS (continued on back) Patient Care Patient Care Ε E N Categories Categories If patient is not progressing, call HF Diet: 2 gm Na or Nutrition Discharge Program 4849. Assessment of family / home support % of diet consumed: Plan Breakfast _____ system by Discharge Planning Consider Heart Failure Homecare Team Lunch _____ Program or telephone follow-up. Dinner ___ Social Services if indicated. High risk nutritional assessment completed. * Fluid restriction:

Dationt Com		IN VE	_	T	(continued)			F	-
	Day 2	0	E	N	Patient Care	A second of	D	E	1
Categories	Date:	-	-	-	Categories	Encourage we shall retire of feers /		_	+
Access	Assess respiratory / cardiac status				Tanakina	Encourage verbalization of fears /		**	
Assessment	q 4 hrs. and PRN.	-	-	-	Teaching	concerns.	\vdash	-	╀
Ğı	* Discontinue telemetry if arrhythmia free.				6	Learning needs / teaching plan:			1
Treatments	Designant adams (leasting design) if not	-	-	\vdash	Psychosocial	- Instruct on all medications: name			ı
	Document edema (location, degree), if not			1 1		and purpose.			ŀ
	improved notify MD.	-	-	-		- Assess ability to self administer	- 1		l
	Palpate peripheral pulses q shift or			1 1	2.00	medications once home. If patient is			ı
		-	<u></u>	-		not able or may have problems, notify			L
	Pulse oximetry check q shift and PRN and	-				discharge planner or heart failure			ı
	with activity.	_	_	ш		team.		_	╀
	* Titrating down O ₂ if SPO ₂ > 94%. O ₂ :			H		Reinforce what heart failure is (disease			l
				Ш		process).	7.1		L
	* Strict I&O.					Give book: "A Stronger Pump"	100		ı
		_	_	_					╀
	Obtain weight before breakfast. If patient		. 11			Instruct on:			1
	has not lost 4-5% of total body weight		1			- Decreased sodium diet			l
	notify MD.					- Medications			ı
	* Ace Inhibitor continued or increased.					- Follow-up plan to avoid exacerbation			l
						- Actions to take if S/S reoccur			
	Obtain ECHO report, if EF < 40 (systolic					- Discharge Recovery			
	dysfunction) is patient on an ACEI?			1 1					
	If not, collaborate with MD as to why.		1						Г
	The second secon	7. 1	75						
	* IV diuretic if fluid overload continues/								L
	IV: ml/Hr.					Lab / diagnostics results reviewed; MD			Т
	Vital signs q 4 hrs and PRN.				Specimens	notified if indicated.			L
	100				&	* Tests / Procedures			Г
					Diagnostics				l
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					Safety	Autivity levely ambulation is access	-	_	+
		1			8	* Activity level: ambulating in room.			
		1,00	Ln'		Activity	Occasion DT control of the Control		-	+
			-		15 5 7	Consider PT evaluation if not progressing			
						to baseline activity.		_	+
						Minimal assist with ADL's.	JE		
		100						_	+
	The second secon			-		27 27 27 27 27 27 27 27 27 27 27 27 27 2			
						100 000 000 000 000 000 000 000 000 000			
	Hygiene & Comfort Protocol					1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
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	Peripheral IV Therapy Protocol				1				16
	Peripheral IV Therapy Protocol			1					
	Peripheral IV Therapy Protocol Pressure Ulcer Prevention Protocol								
	Pressure Ulcer Prevention Protocol		-						

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Signature Requiring Co-Signature	Date/Shift	Initial/1	Title.

ADDRESSOGRAPH DESIRED OUTCOMES D = DAYS E = EVENINGS N = NIGHTSProblem/ Day 3 DEN Problem/ DEN Needs Date: Needs Patient/family verbalizes understanding of Vital signs stable. anticipated plan of care and participates Knowledge Hemodynamic Deficit related in decision making. Instability If EKG ordered, no changes as per MD. to plan of care Verbalizes understanding of: - Low Sodium diet * Telemetry discontinued if not done Medications on Day 2. - Follow-up plan to avoid future SpO₂ > 94%, or at baseline via exacerbations pulse oximetry. Discharge recovery plan - Action to take if CHF signs and symptoms occur at home Tolerates increasing activity or back to Activity baseline. Intolerance Pain free or verbalizes relief after Pain intervention. Management Respirations easy and unlabored. Remains injury free in a safe Patient Safety environment. Urine output > intake. Fluid Volume No evidence of skin breakdown. Overload Lungs clear or at baseline status. Skin Integrity At or near dry weight (euvolemic), if not notify MD. Patient/family verbalizes satisfaction No edema noted. Patient/Family with hospital stay/care. BNP trending down, switch to P.O. Satisfaction diuretics. INTERVENTIONS (continued on back) Patient Care E Patient Care E N Categories Categories Discharge plan confirmed: * Diet: 2 gm Na or Discharge Home with VNS Nutrition Plan Home without VNS % of diet consumed: Breakfast _____ Home with telephone follow-up Lunch ______ % Transfer to nursing facility Cardiac rehab referral if indicated. Dinner ______ % High risk nutritional assessment Patient / family verbalizes readiness for completed. discharge. * Fluid restriction:

Patient Care		D	E	N	Patient Care	100011 0001(100)(10	D	Ε	1
Assessment & G. K. P.	Date:	1	-		Categories	and the same of th			
	Assess respiratory / cardiac status	Categories Teaching & Concerns. Learning needs / teaching plan: Dulses q shift pulses q shift ck q shift and PRN. Teaching a but sodium restrictions Psychosocial Psychosocial Psychosocial Psychosocial Teaching Concerns. Learning needs / teaching plan: Debt sodium restrictions Purpose of obtaining daily weights at home Signs and symptoms of worsening heart failure. When to call the doctor Smoking cessation if applicable Activity levels Specimens BNP Assay Falls protocol continued. Safety Activity Falls protocol continued. *Activity level: Back to baseline. Physical therapy evaluation if not at baseline. Physical therapy evaluation if not at baseline. Physical therapy evaluation if not at baseline.		T					
	q 8 hrs. and PRN.		_	Ш			-		1
_	Document pressure of edema				-	-	-		
Treatments	(location, degree). Palpate peripheral pulses q shift	+	-		Psychosocial	- Purpose of obtaining daily weights			
	Pulse oximetry check q shift and PRN.	\dagger				- Signs and symptoms of worsening			
	* Discontinue O ₂ or:				F 2	- When to call the doctor			
	* Strict I&O.					- Activity levels			
1 t	Obtain weight before breakfast, if weight gain notify MD.				- 2				
	* Ace Inhibitor continued or increased.								
	If ACE Inhibitor discontinued, reason why:								
	* Collaborate with MD if patient is eligible	-							
	to switch to PO diuretic. Maintain Heparin lock	+	_	H					
	Vital signs q 8 hrs and PRN (or unit	+	_	Н					
	routine).			Ш		-	T		Ť
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					Safety	Falls protocol continued.			Ī
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	Hygiene & Comfort Protocol								
	Peripheral IV Therapy Protocol								
	Pressure Ulcer Prevention Protocol								
	* Respiratory Care provided. (See Respiratory Care Record)								

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ADDRESSOGRAPH D = DAYS E = EVENINGS N = NIGHTSDESIRED OUTCOMES E E N Problem/ Problem/ Day 4 Needs Date: Needs Vital signs stable. Patient/family verbalizes understanding of Hemodynamic Knowledge anticipated plan of care and participates SpO₂ > 94% via pulse oximetry. Instability Deficit related in decision making. to plan of care Verbalizes understanding of: - Low Sodium diet Medications - Follow-up plan to avoid future exacerbations Discharge recovery plan - Action to take if CHF signs and Activity at baseline. symptoms occur at home Activity ADL's at baseline. Intolerance Pain free or verbalizes relief after Pain intervention. Respirations easy and unlabored. Management Remains injury free in a safe Patient Safety environment. Urine output > intake. No evidence of skin breakdown. Fluid Volume Skin Integrity Overload Lungs clear or at baseline status. No weight increase. Patient/family verbalizes satisfaction Absence of edema / baseline. Patient/Family with hospital stay/care. Satisfaction INTERVENTIONS (continued on back) E Patient Care E Patient Care D Categories Categories * Diet: 2 gm Na or Patient discharged to Discharge Nutrition % of diet consumed: Plan Breakfast _____ Dinner _____ % High risk nutritional assessment completed. * Fluid restriction:

Patient Care			-			70,900	D	F	N
	1 *		-	"	Teaching & Encourage verbalization of fears / concerns. Learning needs / teaching plan: Instruct / review: - What heart failure is (disease process) Diet - sodium restrictions Activity progression or restrictions Medications: Purpose, dosage, adverse reactions Purpose of obtaining daily weights Action to be taken if signs / symptoms worsen at home. Specimens & Diagnostics - Tests / Procedures Lab / diagnostics results reviewed; MD notified if indicated Tests / Procedures Falls protocol continued Activity - Activity level: At baseline. ADL's at baseline.	-	-	1"	
	Assess respiratory / cardiac status	_	_		Jategories	Encourage verbalization of fears /	oms		
Assessment	Assess respiratory / cardiac status Assess respiratory / cardiac s								
Patient Care Day 4 D E N Patient Care Categories									
	Palpate peripheral pulses q shift						100		
	* Discontinue O ₂ or:				1				
	Obtain weight before breakfast.					adverse reactions.			
	* Ace Inhibitor continued.					- Action to be taken if signs / symptoms			
	* PO diuretic continued.								
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					Safety	Falls protocol continued.			
					&	* Activity level: At baseline.			
						ADL's at baseline.	-		
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	Hygiene & Comfort Protocol			\Box					
	Peripheral IV Therapy Protocol								
	Pressure Ulcer Prevention Protocol								
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	iversity Medical Center		* ir	rdicat	tes medical orders	needed			

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ADDRESSOGRAPH

DESIRED OUTCOMES D = DAYS E = EVENINGS N = NIGHTS

	DESI	RED	OU	TCC	OMES	D = DAYS E = EVENINGS N = NIC	GHTS		-
Problem/	Day 5	D	Ε	N	Problem/		D	E	N
Needs	Date:				Needs				
740003	Patient/family verbalizes understanding of					Vital signs stable.			
Knowledge	anticipated plan of care and participates				Hemodynamic	A Comment of the Comm			
Deficit related	in decision making.				Instability	SpO ₂ > 94% via pulse oximetry.			
	Understands discharge instructions and								
to plan or care	when to call MD.				1				
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						Able to perform all ADL's at pre-admit	+		-
					Activity	level.	-		-
					Intolerance		-		
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	Pain free or verbalizes relief after	T							_
Pain	intervention.								
Management	Respirations easy and unlabored.				1				
marragerrion	Trooping on the contract of				1				
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		1			1				1
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						Remains injury free in a safe	T	i -	T
		1			Patient Safety	environment.			1
		1			Patient Salety	environment.		-	+-
		-	<u> </u>	-	4				
	Urine output > intake or intake = output.		1			No evidence of skin breakdown.	+	+-	+
Fluid Volume		-	-	₩		No evidence of skin breakdown.			
Overload	Lungs clear or at baseline status.	1		1	Skin Integrity		-	-	+
		<u> </u>	<u> </u>	_	1			1	
	At or below dry weight.						_	-	+
						Patient/family verbalizes satisfaction			
	Absence of edema / baseline.	T		П	Patient/Family	with hospital stay/care.		_	╄
		1			Satisfaction			1	
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									_
	INTERVI	ENTI	ONS	S (co	ontinued on ba	ck)			
Patient Care		TD	E	_			D	E	N
		1	-	1.	Categories				
Categories		+-	⊢	+-	Categories	* Diet: 2 am No or	-	+-	+
	Patient discharged to:				Montaldian	* Diet: 2 gm Na or			
Discharge		+	-	+	Nutrition	O/ of disk sensureddi	10000		
Plan	If patient not ready for discharge,				1	% of diet consumed:			-
	document reason.				1	Breakfast%			
					1	Lunch %	121717	-	
					1	Dinner %			+
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	Day 5	D	E	N	Patient Care	The state of the s	D	E	^
Categories	Date:		_	\vdash	Categories	E	-	_	╀
Assessment	Assess respiratory / cardiac status				Tacables	Encourage verbalization of fears /			
_	q 8 hrs. and PRN.		-	\vdash	Teaching	Concerns.	+-	-	╫
& Treatments	Document edema (location, degree) if				G. Devohosesisi	Patient / family able to verbalize:			
reatments	still present. Palpate peripheral pulses q shift		-	┼	Psychosocial	Action to take if signs / symptoms occur at home.			
	Palpate peripheral pulses q shift					- Sodium restrictions / fluid restrictions			
	SpO ₂ > 94% on room air.		\vdash	+-		and diet:			
	SpO ₂ > 94% on room air.					and diet.			
	Obtain weight before breakfast.		\vdash	+-		- Daily weight monitoring and its	- 2		
	Obtain weight before breaklast.					purpose.	1		
	* Discharge on an ACE Inhibitor. If not,	_	-	+		- Activity guideline.			
	reason why:			1 1		- All medications and indication for			
	l leason wily.		1			taking them.	1 - 1		1
						- Follow-up care.			1
	* Discharged on diuretic therapy.	_	\vdash	+		- Smoking cessation plan if applicable.			1
	Discharged on didietic dierapy.					- Medication information sheets given:			1
	Vital signs q 8 hrs and PRN (or unit	-	-			- Medication information sheets given.			
	routine).			1 1			1		1
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						Lab / diagnostics results reviewed; MD	†		亡
					Specimens	notified if indicated.			
				1 1	8	* Tests / Procedures	+		$^{+}$
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						Falls protocol continued.	T		T
					Safety				
					.8	* Activity level: At baseline.			
					Activity		- 1	1	1
						ADL's at baseline.		٠,	
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	Hygiene & Comfort Protocol								
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	Pressure Ulcer Prevention Protocol								
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	* Respiratory Care provided.				l				
	(See Respiratory Care Record)				1				
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Signature	Title	Initial		
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Signature Requiring Co-Signature	Date/Shift	Initial/	ritle	

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	Patient/family v						l	Vital signs st	able.			
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Overroad	Lungs clear or	at basonilo ste	itus.				On mogney			+-	-	\vdash
1	At or below dry	weight.		-	\vdash		1					
1	, , ,							Patient/famil	y verbalizes satisfaction	$\overline{}$	$\overline{}$	\vdash
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	10001100 01 00	orna / basoniio					Satisfaction	The state of the s		+	\vdash	
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Categories	Patient dischar	ned to:		\vdash	-	-	Categories	* Diet: 2 gm	Na or	+-	┼─	\vdash
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Categories	Date:			1	Categories				
	Assess respiratory / cardiac status					Encourage verbalization of fears /			
Assessment	q 8 hrs. and PRN.				Teaching	concerns.			
&	Document edema (location, degree) if				8	Patient / family able to verbalize:			
Treatments	still present.				Psychosocial	- Action to take if signs / symptoms			
	Palpate peripheral pulses q shift					occur at home Sodium restrictions / fluid restrictions			
,	SpO ₂ > 94% on room air.					and diet:			
	Obtain weight before breakfast.					Daily weight monitoring and its purpose.			
	* Discharge on an ACE Inhibitor. If not,	-				- Activity guideline.			
	reason why:					- All medications and indication for			
						taking them.			
						- Follow-up care.			
	* Discharged on diuretic therapy.				1	- Smoking cessation plan if applicable.			
					1	- Medication information sheets given:			
	Vital signs q 8 hrs and PRN (or unit								
	routine).			1					
						Dah / diagnostics socults soviewed: MD	_	_	_
		- 4			Specimens	Lab / diagnostics results reviewed; MD notified if indicated.			
					&	* Tests / Procedures		-	
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					Safety	Falls protocol continued.			
					& Activity	* Activity level: At baseline.			
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	Hygiene & Comfort Protocol								
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	Pressure Ulcer Prevention Protocol			7	1				
	* Respiratory Care provided.				1				
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