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

Congestive Heart Failure (CHF)

ESTIMATED LOS: 5 Days ***Date placed on map:*** _____

INCLUSIONARY CRITERIA:
Patients with documented diagnosis of Congestive Heart Failure.

EXCLUSIONARY CRITERIA:
Patients with Renal Failure, recent 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 INVOLVED/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 ADMISSION:

Date/Event: _____

Date/Event: _____

Date/Event: _____

Date/Event: _____

RN Signature: _____ ***Date/Time:*** _____

RN Signature: _____ ***Date/Time:*** _____

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.

CHF

Signature		Title	Initial
Signature Requiring Co-Signature	**Date/Shift**	**Initial/Title**	

ADDRESSOGRAPH

DESIRED OUTCOMES **D = DAYS E = EVENINGS N = NIGHTS**

Problem/ Needs	ETD Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of anticipated plan of care and participates in decision making.			
	Able to state signs & symptoms to report immediately.			
Pain Management	Pain free or verbalizes relief after intervention.			
	Respirations unlabored at rest.			
	Decreased anxiety.			
Fluid Volume Overload	Decreased respiratory distress.			
	Urine output > intake.			
	Lung sounds improved from initial assessment.			

Problem/ Needs		D	E	N
Hemodynamic Instability	Vital signs stable.			
	No EKG changes as per MD.			
	SpO_2 > 94% via pulse oximetry.			
Activity Intolerance	Bedrest - assistance with all ADL's.			
Patient Safety	Remains injury free in a safe environment.			
Skin Integrity	No evidence of skin breakdown.			
Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan				

Patient Care Categories		D	E	N
Nutrition	* Diet: 2 gm Na or			
	% of diet consumed:			
	Breakfast _____%			
	Lunch _____ %			
	Dinner _____ %			
	High risk nutritional assessment completed.			
	* Fluid restriction:			

** indicates medical orders needed*

INTERVENTIONS (continued)

Patient Care Categories	ETD Date: _____	D	E	N
Assessment & Treatments	Assess respiratory / cardiac status.			
	Cardiac rhythm monitoring and documentation.			
	Assess edema and pressure of fluid volume reservoirs, i.e., ascites, sacral or scrotal edema, skin temperature and color.			
	Palpate peripheral pulses.			
	Strict I&O.			
	* Foley if indicated.			
	IV access obtained.			
	* IV: _____ ml/hr.			
	VS q 2 hrs. and PRN if stable.			
	Pulse oximetry.			
	IV diuretics begun.			
	Report urine output to ER MD.			
	Ace inhibitor continued from home.			
	* O_2 (type):			
	If patient diuresis < 200 cc, 1 hour post initial diuretic, reassess and notify MD.			
	Hygiene & Comfort Protocol			
	Peripheral IV Therapy Protocol			
	Pressure Ulcer Prevention Protocol			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Encourage verbalization of fears / concerns.			
	Learning needs / teaching plan: - Explain schedule of event and tests - Instruct on medications			
	Instruct patient to inform nurse immediately of chest pain or shortness of breath			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	* Tests / Procedures - CBC - 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%			
Safety & Activity	Falls protocol initiated.			
	* Activity level: Bedrest - head of bed up greater than or equal to 30 degrees			

CHF

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

ADDRESSOGRAPH

DESIRED OUTCOMES — **D = DAYS E = EVENINGS N = NIGHTS**

Problem/ Needs	Day 1 Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of anticipated plan of care and participates in decision making.			
	Able to state signs & symptoms to report immediately.			
	Oriented to unit.			
Pain Management	Pain free or verbalizes relief after intervention.			
	Respirations even and unlabored.			
Fluid Volume Overload	Decreased respiratory distress.			
	Urine output > intake.			
	Lung sounds improved from initial assessment.			

Problem/ Needs		D	E	N
Hemodynamic Instability	No dysrhythmias observed.			
	No EKG changes as per MD.			
	Vital signs stable.			
	SpO_2 > 94% via pulse oximetry.			
Activity Intolerance	Tolerates ADL's with assist.			
Patient Safety	Remains injury free in a safe environment.			
Skin Integrity	No evidence of skin breakdown.			
Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan	Assess need for Discharge Planning / Social Services based on admitting assessment and home environment.			

Patient Care Categories		D	E	N
Nutrition	* Diet: 2 gm Na or			
	% of diet consumed:			
	Breakfast _____%			
	Lunch _____ %			
	Dinner _____ %			
	High risk nutritional assessment completed.			
	* Fluid restriction:			
	Consider dietary consult.			

** indicates medical orders needed*

INTERVENTIONS (continued)

Patient Care Categories	Day 1 Date: _____	D	E	N
Assessment & Treatments	Assess respiratory / cardiac status q 4 hrs. and PRN.			
	Telemetry monitoring and documentation.			
	Assess edema and pressure of fluid volume reservoirs, i.e., ascites, sacral or scrotal edema, skin temperature and color.			
	Palpate peripheral pulses q shift and PRN.			
	* Pulse oximetry q shift and PRN.			
	O_2 (type):			
	* Strict I&O.			
	Obtain weight:			
	* ACE Inhibitor ordered if no fluid overload If not, why:			
	* IV diuretic:			
	* IV: _____ ml/hr.			
	Vital signs q 4 hrs and PRN.			
	* O_2 (type):			
	Hygiene & Comfort Protocol			
	Peripheral IV Therapy Protocol			
	Pressure Ulcer Prevention Protocol			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Encourage verbalization of fears / concerns.			
	Learning needs / teaching plan: - Signs of heart failure exacerbation			
	- Medications at home			
	- Treatment Goals			
	Assess patient / family's perception of CHF diagnosis.			
	Assess knowledge level and readiness to learn.			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	* Tests / Procedures - if not done in ER - CBC - Chemistry - PT / PTT - Cardiac enzymes - U/A - EKG - Echo - ABG if pulse oximetry <94 - BNP			
	Consider if applicable: - TSH - Digoxin level			
Safety & Activity	Falls protocol continued.			
	* Activity level: Bed rest or:			
	Assist with all ADL's.			

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** indicates medical orders needed*

CHF

Signature	Title	Initial

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ADDRESSOGRAPH

DESIRED OUTCOMES **D = DAYS E = EVENINGS N = NIGHTS**

Problem/ Needs	Day 2 Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of anticipated plan of care and participates in decision making.			
	Verbalizes: - Etilogy of heart failure - diagnostic test - Meds / treatments			
Pain Management	Pain free or verbalizes relief after intervention.			
	Respirations easy and unlabored.			
Fluid Volume Overload	Urine output > intake.			
	Lung sounds improved from Day 1, if not notify MD.			
	Weight loss from Day 1, if no decrease notify MD.			
	Decrease in edema from admission.			

Problem/ Needs		D	E	N
Hemodynamic Instability	No dysrhythmias observed.			
	No EKG changes as per MD.			
	Vital signs stable.			
	SpO_2 > 94% via pulse oximetry.			
Activity Intolerance	Tolerates OOB to chair, begins to resume pre-admit activity level.			
Patient Safety	Remains injury free in a safe environment.			
Skin Integrity	No evidence of skin breakdown.			
Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan	If patient is not progressing, call HF Program 4849.			
	Assessment of family / home support system by Discharge Planning			
	Consider Heart Failure Homecare Team Program or telephone follow-up.			
	Social Services if indicated.			

Patient Care Categories		D	E	N
Nutrition	* Diet: 2 gm Na or			
	% of diet consumed:			
	Breakfast _____%			
	Lunch _____ %			
	Dinner _____ %			
	High risk nutritional assessment completed.			
	* Fluid restriction:			

** indicates medical orders needed*

INTERVENTIONS (continued)

Patient Care Categories	Day 2 Date: _____	D	E	N
Assessment & Treatments	Assess respiratory / cardiac status q 4 hrs. and PRN.			
	* Discontinue telemetry if arrhythmia free.			
	Document edema (location, degree), if not improved notify MD.			
	Palpate peripheral pulses q shift or			
	Pulse oximetry check q shift and PRN and with activity.			
	* Titrating down O_2 if SPO_2 > 94%. O_2:			
	* Strict I&O.			
	Obtain weight before breakfast. If patient has not lost 4-5% of total body weight notify MD.			
	* Ace Inhibitor continued or increased.			
	Obtain ECHO report, if EF < 40 (systolic dysfunction) is patient on an ACEI? If not, collaborate with MD as to why.			
	* IV diuretic if fluid overload continues/ IV: _____ ml/Hr.			
	Vital signs q 4 hrs and PRN.			
	Hygiene & Comfort Protocol			
	Peripheral IV Therapy Protocol			
	Pressure Ulcer Prevention Protocol			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Encourage verbalization of fears / concerns.			
	Learning needs / teaching plan: - Instruct on all medications: name and purpose. - Assess ability to self administer medications once home. If patient is not able or may have problems, notify discharge planner or heart failure team.			
	Reinforce what heart failure is (disease process).			
	Give book: "A Stronger Pump"			
	Instruct on: - Decreased sodium diet - Medications - Follow-up plan to avoid exacerbation - Actions to take if S/S reoccur - Discharge Recovery			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	* Tests / Procedures _____ _____ _____ _____ _____			
Safety & Activity	Falls protocol initiated.			
	* Activity level: ambulating in room.			
	Consider PT evaluation if not progressing to baseline activity.			
	Minimal assist with ADL's.			

CHF

Signature		Title	Initial
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ADDRESSOGRAPH

DESIRED OUTCOMES **D = DAYS E = EVENINGS N = NIGHTS**

Problem/ Needs	Day 3 Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of anticipated plan of care and participates in decision making.			
	Verbalizes understanding of: - Low Sodium diet - Medications - Follow-up plan to avoid future exacerbations - Discharge recovery plan - Action to take if CHF signs and symptoms occur at home			
Pain Management	Pain free or verbalizes relief after intervention.			
	Respirations easy and unlabored.			
Fluid Volume Overload	Urine output > intake.			
	Lungs clear or at baseline status.			
	At or near dry weight (euvolemic), if not notify MD.			
	No edema noted.			
	BNP trending down, switch to P.O. diuretics.			

Problem/ Needs		D	E	N
Hemodynamic Instability	Vital signs stable.			
	If EKG ordered, no changes as per MD.			
	* Telemetry discontinued if not done on Day 2.			
	SpO_2 > 94% , or at baseline via pulse oximetry.			
Activity Intolerance	Tolerates increasing activity or back to baseline.			
Patient Safety	Remains injury free in a safe environment.			
Skin Integrity	No evidence of skin breakdown.			
Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan	Discharge plan confirmed: _____ Home with VNS _____ Home without VNS _____ Home with telephone follow-up _____ Transfer to nursing facility			
	Cardiac rehab referral if indicated.			
	Patient / family verbalizes readiness for discharge.			

Patient Care Categories		D	E	N
Nutrition	* Diet: 2 gm Na or			
	% of diet consumed: Breakfast _____% Lunch _____ % Dinner _____ %			
	High risk nutritional assessment completed.			
	* Fluid restriction:			

** indicates medical orders needed*

INTERVENTIONS (continued)

Patient Care Categories	*Day 3* *Date:* _____	*D*	*E*	*N*
Assessment & Treatments	Assess respiratory / cardiac status q 8 hrs. and PRN.			
	Document pressure of edema (location, degree).			
	Palpate peripheral pulses q shift			
	Pulse oximetry check q shift and PRN.			
	* Discontinue O_2 or:			
	* Strict I&O.			
	Obtain weight before breakfast, if weight gain notify MD.			
	* 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			
	Vital signs q 8 hrs and PRN (or unit routine).			
	Hygiene & Comfort Protocol			
	Peripheral IV Therapy Protocol			
	Pressure Ulcer Prevention Protocol			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		*D*	*E*	*N*
Teaching & Psychosocial	Encourage verbalization of fears / concerns.			
	Learning needs / teaching plan: - Diet: 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 & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	* Tests / Procedures BNP Assay _____ _____ _____ _____ _____			
Safety & Activity	Falls protocol continued.			
	* Activity level: Back to baseline.			
	Physical therapy evaluation if not at baseline.			

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** indicates medical orders needed*

CHF

Signature	Title	Initial

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ADDRESSOGRAPH

DESIRED OUTCOMES — **D = DAYS E = EVENINGS N = NIGHTS**

Problem/ Needs	Day 4 Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of anticipated plan of care and participates in decision making.			
	Verbalizes understanding of: - Low Sodium diet - Medications - Follow-up plan to avoid future exacerbations - Discharge recovery plan - Action to take if CHF signs and symptoms occur at home			
Pain Management	Pain free or verbalizes relief after intervention.			
	Respirations easy and unlabored.			
Fluid Volume Overload	Urine output > intake.			
	Lungs clear or at baseline status.			
	No weight increase.			
	Absence of edema / baseline.			

Problem/ Needs		D	E	N
Hemodynamic Instability	Vital signs stable.			
	SpO_2 > 94% via pulse oximetry.			
Activity Intolerance	Activity at baseline.			
	ADL's at baseline.			
Patient Safety	Remains injury free in a safe environment.			
Skin Integrity	No evidence of skin breakdown.			
Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan	Patient discharged to _____			

Patient Care Categories		D	E	N
Nutrition	* Diet: 2 gm Na or			
	% of diet consumed: Breakfast _____% Lunch _____ % Dinner _____ %			
	High risk nutritional assessment completed.			
	* Fluid restriction:			

** indicates medical orders needed*

INTERVENTIONS (continued)

Patient Care Categories	Day 4 Date: _____	D	E	N	Patient Care Categories		D	E	N
Assessment & Treatments	Assess respiratory / cardiac status q 8 hrs. and PRN.				*Teaching & Psychosocial*	Encourage verbalization of fears / concerns.			
	Document edema (location, degree) if still present.					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.			
	Palpate peripheral pulses q shift								
	* Discontinue O_2 or:								
	Obtain weight before breakfast.								
	* Ace Inhibitor continued.								
	* PO diuretic continued.								
	Vital signs q 8 hrs and PRN (or unit routine).								
					Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
						* Tests / Procedures _____ _____ _____ _____ _____ _____			
					Safety & Activity	Falls protocol continued.			
						* Activity level: At baseline.			
						ADL's at baseline.			
	Hygiene & Comfort Protocol								
	Peripheral IV Therapy Protocol								
	Pressure Ulcer Prevention Protocol								
	* Respiratory Care provided. (See Respiratory Care Record)								

CHF

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

ADDRESSOGRAPH

DESIRED OUTCOMES — **D = DAYS E = EVENINGS N = NIGHTS**

Problem/ Needs	Day 5 Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of anticipated plan of care and participates in decision making.			
	Understands discharge instructions and when to call MD.			
Pain Management	Pain free or verbalizes relief after intervention.			
	Respirations easy and unlabored.			
Fluid Volume Overload	Urine output > intake or intake = output.			
	Lungs clear or at baseline status.			
	At or below dry weight.			
	Absence of edema / baseline.			

Problem/ Needs		D	E	N
Hemodynamic Instability	Vital signs stable.			
	SpO_2 > 94% via pulse oximetry.			
Activity Intolerance	Able to perform all ADL's at pre-admit level.			
Patient Safety	Remains injury free in a safe environment.			
Skin Integrity	No evidence of skin breakdown.			
Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan	Patient discharged to:			
	If patient not ready for discharge, document reason.			

Patient Care Categories		D	E	N
Nutrition	* Diet: 2 gm Na or			
	% of diet consumed:			
	Breakfast _____%			
	Lunch _____ %			
	Dinner _____ %			
	High risk nutritional assessment completed.			
	* Fluid restriction:			

** indicates medical orders needed*

INTERVENTIONS (continued)

Patient Care Categories	Day 5 Date: _____	D	E	N
Assessment & Treatments	Assess respiratory / cardiac status q 8 hrs. and PRN.			
	Document edema (location, degree) if still present.			
	Palpate peripheral pulses q shift			
	SpO_2 > 94% on room air.			
	Obtain weight before breakfast.			
	* Discharge on an ACE Inhibitor. If not, reason why:			
	* Discharged on diuretic therapy.			
	Vital signs q 8 hrs and PRN (or unit routine).			
	Hygiene & Comfort Protocol			
	Peripheral IV Therapy Protocol			
	Pressure Ulcer Prevention Protocol			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Encourage verbalization of fears / concerns.			
	Patient / family able to verbalize: - Action to take if signs / symptoms occur at home. - Sodium restrictions / fluid restrictions and diet: - Daily weight monitoring and its purpose. - Activity guideline. - All medications and indication for taking them. - Follow-up care. - Smoking cessation plan if applicable. - Medication information sheets given: _____ _____ _____ _____ _____ _____ _____			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	* Tests / Procedures _____ _____ _____ _____ _____ _____			
Safety & Activity	Falls protocol continued.			
	* Activity level: At baseline.			
	ADL's at baseline.			

CHF

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

ADDRESSOGRAPH

DESIRED OUTCOMES — **D = DAYS E = EVENINGS N = NIGHTS**

Problem/ Needs	Day _____ Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of anticipated plan of care and participates in decision making.			
	Understands discharge instructions and when to call MD.			
Pain Management	Pain free or verbalizes relief after intervention.			
	Respirations easy and unlabored.			
Fluid Volume Overload	Urine output > intake or intake = output.			
	Lungs clear or at baseline status.			
	At or below dry weight.			
	Absence of edema / baseline.			

Problem/ Needs		D	E	N
Hemodynamic Instability	Vital signs stable.			
	SpO_2 > 94% via pulse oximetry.			
Activity Intolerance	Able to perform all ADL's at pre-admit level.			
Patient Safety	Remains injury free in a safe environment.			
Skin Integrity	No evidence of skin breakdown.			
Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan	Patient discharged to:			

Patient Care Categories		D	E	N
Nutrition	* Diet: 2 gm Na or			
	% of diet consumed:			
	Breakfast _____%			
	Lunch _____ %			
	Dinner _____ %			
	High risk nutritional assessment completed.			
	* Fluid restriction:			

** indicates medical orders needed*

INTERVENTIONS (continued)

Patient Care Categories	Day _____ Date: _____	D	E	N
Assessment & Treatments	Assess respiratory / cardiac status q 8 hrs. and PRN.			
	Document edema (location, degree) if still present.			
	Palpate peripheral pulses q shift			
	SpO_2 > 94% on room air.			
	Obtain weight before breakfast.			
	* Discharge on an ACE Inhibitor. If not, reason why:			
	* Discharged on diuretic therapy.			
	Vital signs q 8 hrs and PRN (or unit routine).			
	Hygiene & Comfort Protocol			
	Peripheral IV Therapy Protocol			
	Pressure Ulcer Prevention Protocol			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Encourage verbalization of fears / concerns.			
	Patient / family able to verbalize: - Action to take if signs / symptoms occur at home. - Sodium restrictions / fluid restrictions and diet: - Daily weight monitoring and its purpose. - Activity guideline. - All medications and indication for taking them. - Follow-up care. - Smoking cessation plan if applicable. - Medication information sheets given: _____ _____ _____ _____ _____ _____ _____			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	* Tests / Procedures _____ _____ _____ _____ _____ _____ _____			
Safety & Activity	Falls protocol continued.			
	* Activity level: At baseline.			
	ADL's at baseline.			

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** indicates medical orders needed*