

**University Medical Center
Generic CCU**

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

Generic Cardiac Care Unit

Estimated LOS: 3 Days Date placed on map: _____
Allergies: _____ Code Status: _____ Advanced Directive: _____
Primary Diagnosis / Procedure: _____
Secondary Diagnosis / Procedure: _____
Consulting Physicians: _____
Pertinent Past Medical / Surgical History: _____

Echo Date: _____ Results: _____
Cardiac Cath Date: _____ Results: _____
PTCA: _____ Stent: _____ for CABG: _____
Vascular: _____ CT Scan: _____ U/S: _____
Other procedures: _____
Medications: _____

INCLUSIONARY CRITERIA

All patients admitted / transferred to CCU that do not have a case specific _____ available.

Admission / Transfer Events: _____

Priority of Care issues: _____

Disciplines Involve / notified Discharge Planning: _____
Dietary: _____ Social Services: _____ Speech Therapy: _____
Physical Therapy: _____ Psychiatric: _____ Ostomy: _____
Transfer Order: _____
Emergency Contact: _____ Phone: _____
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 Interdisciplinary Progress Notes when an outcome or intervention is initialed and circled, indicating it was not met or completed as stated.

**University Medical Center
Transfer Summary Notes**

ADDRESSOGRAPH

Transfer Date: _____

Transfer to: _____

Allergies: _____

Lab Data: PT: _____ PTT: _____ Mg: _____ Bun: _____ Cr: _____

K: _____ WBC: _____ Hgb/Hct: _____ Cultures: _____

Vital Signs: Temp: _____ Apical Hr.: _____ RR: _____ BP: _____

Cardiac Rhythm: _____ Pulse Oximetry Saturation: _____

CV Status: Peripheral Pulse: _____ Edma: _____

Heart Sounds: _____

Condition of Skin: _____

Pulmonary

Status: Lung Sounds: _____ O₂ Therapy: _____

Secretion: _____ Chest Tube: _____

Neuro Status: Deficits: _____

Activity Level: _____ Safety Considerations: _____

GI Status: Bowel Sounds: _____ GI / Tubes: _____

Accuchecks: _____

Diet / Feedings: _____ Last BM: _____

GU Status: Urinary Output: _____ Voids / Foley: _____

Dialysis: _____

I/O Yesterday: _____ Today: _____

IV: PIV: Site: _____ Date Inserted: _____ Condition: _____ Drip: _____

PIV: Site: _____ Date Inserted: _____ Condition: _____ Drip: _____

Other type: _____ Site: _____ Date Inserted: _____ Condition: _____ Drip: _____

Pain / Symptom Management: _____

Risk for Falls: _____ Braden Scale: _____

Priority Issues: _____

Generic CCU

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	Problem/Needs	D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of need for critical care, anticipated plan of care and participates in decision making				Ineffective Airway / Clearance Impaired Gas Exchange	S _a O ₂ maintained greater than or equal to 92%		
						No evidence of respiratory distress		
Pain / Symptom Management	Pain free or verbalizes relief after intervention.				Discharge Plan	Discharge needs assessed / identified		
	Relief of symptoms							
Potential Infection	Afebrile				Patient Safety	Remains injury free in a safe environment.		
	No evidence of infection							
Immobility	Bedrest				Skin Integrity	No evidence of skin breakdown.		
	Moves all extremities on command							
Hemodynamic Status Impaired	Vital signs stable				Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care. Advanced Directive addressed		
	No cardiac arrhythmia							
Fluid / Electrolytes	Chest pain free							
	No extra heart sounds							
Fluid / Electrolytes	Urine output > 240 cc / 8 hours				Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care. Advanced Directive addressed		
	Labs within therapeutic range							

INTERVENTIONS (continued on back)

Patient Care Categories	D	E	N	Patient Care Categories	D	E	N
Discharge Plan	Assess need for Discharge Planning / Social Services based on nursing assessment of home environment / patient condition			Nutrition	* Diet:		
					Enteral Feeds: _____		
					% of diet consumed:		
					Breakfast _____ %		
					Lunch _____ %		
					Dinner _____ %		
					High risk nutritional assessment completed.		
					* Swallow evaluation		
					Daily Weight: _____		
					* Parental Feedings:		
					TPN / Lipids: _____		

INTERVENTIONS

Patient Care Categories	Day 1 Date: _____	D	E	N	Patient Care Categories	D	E	N		
Assessment & Treatments	Cardiac monitor alarm parameters set				Teaching & Psychosocial	Encourage verbalization of fears / concerns.				
	Admission assessment completed / reviewed					Assess patient's readiness to learn, learning needs and barriers to learning				
	Assessment completed per unit standards					Learning needs / teaching plan: - Orientation to CCU, visiting hours / policies, environment / equipment - Tests / procedures - Disease process - Medications - Diet - Activity limitations - Smoking cessation				
	I & O measured per unit standard					Assess patient / family satisfaction				
	* Foley catheter: size: _____ Date inserted: _____					Daily discussion with patient / family on current status / issues (document details in progress record)				
	FIO ₂ _____ % Mode: N/C _____ FM _____ CPAP _____ Ventilator: ETT size _____ Trach size _____ Date intubated: _____									
	Cough and deep breath q4 hrs									
	Peripheral IV Therapy Management Protocol followed									
	* Hemodynamic monitoring / invasive line care per unit standard									
	* IV fluids as ordered					Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	* Heparin nomogram Cardiac _____ Thromboembolic _____				* Tests / Procedures _____ _____ _____ _____ _____					
	* Vasopressor / Inotropic Therapy				* Blood sugar q _____ * Cover per sliding scale as ordered					
	* GI Prophylaxis									
	* DVT Prophylaxis Thigh / knee high Teds _____ Venodyne _____									
	Hygiene / comfort management protocol followed									
	* Respiratory care provided (see respiratory care record)									
	Pain Management Protocol followed				Safety & Activity		Assess patient risk for falls per protocol, initiate falls protocol if needed			
	Palliative care rendered						* Activity level: _____ _____			
							Pressure ulcer prevention management protocol followed			
						Physical restraint management protocol followed				
				* Rehab Therapy PT _____ OT _____						
				Patient's environment is safe						

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* indicates medical orders needed

Generic CCU

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

ADDRESSOGRAPH

DESIRED OUTCOMES

D = DAYS E = EVENINGS N = NIGHTS

Problem/Needs	Day 2 Date:	D	E	N	Problem/Needs	D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of anticipated transfer out of critical care and continued plan of care, participates in decision making				Ineffective Airway / Clearance Impaired Gas Exchange	S _a O ₂ maintained greater than or equal to 92%		
						No evidence of respiratory distress		
Pain / Symptom Management	Pain free or verbalizes relief after intervention.				Discharge Plan	Transfer out of CCU		
	Relief of symptoms							
Potential Infection	Afebrile							
	No evidence of infection							
Immobility	OOB				Patient Safety	Remains injury free in a safe environment.		
	Performs ADL's independently							
Hemodynamic Status Impaired	Vital signs stable				Skin Integrity	No evidence of skin breakdown.		
	No cardiac arrhythmia							
Fluid / Electrolytes	Chest pain free				Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care.		
	No extra heart sounds						Advanced Directive addressed	
	Urine output > intake							
	Labs within therapeutic range							

INTERVENTIONS (continued on back)

Patient Care Categories	D	E	N	Patient Care Categories	D	E	N
Discharge Plan				Nutrition	* Diet:		
					Enteral Feeds: _____		
					% of diet consumed:		
					Breakfast _____ %		
					Lunch _____ %		
					Dinner _____ %		
					High risk nutritional assessment completed.		
					Daily Weight: _____		
					* Parental Feedings:		
					TPN / Lipids: _____		

INTERVENTIONS

Patient Care Categories	Day 2 Date:	D	E	N	Patient Care Categories	D	E	N	
Assessment & Treatments	Cardiac monitor alarm parameters set				Teaching & Psychosocial	Encourage verbalization of fears / concerns.			
	Admission assessment reviewed / updated					Assess patient / family satisfaction			
	Assessment completed per unit standards					Learning needs / teaching plan: - Medication:			
	I & O measured per unit standard					Activity:			
	Assess need for foley d/c if possible					Diet:			
	FIO ₂ _____ %					Modifiable Risk Factors:			
	Mode: N/C _____ FM _____					Smoking cessation:			
	CPAP _____					Daily discussion with patient / family on current status / issues (document details in progress record)			
	Ventilator: ETT size _____								
	Trach size _____								
	Date intubated: _____								
	Attempt weaning: _____								
	Cough and deep breath q4 hrs				Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	Peripheral IV Therapy Management Protocol followed					* Tests / Procedures			
	* IV fluids as ordered								
	* Heparin nomogram								
	Cardiac _____								
	Thromboembolic _____								
	* GI Prophylaxis								
	* DVT Prophylaxis								
Teds _____									
Venodyne _____									
Hygiene / comfort management protocol followed					* Cover per sliding scale as ordered				
* Respiratory care provided (see respiratory care record)									
Pain Management Protocol followed				Safety & Activity	Falls protocol maintained				
D/C invasive lines if applicable					* Activity level:				
Palliative care rendered					Pressure ulcer prevention management protocol followed				
					Physical restraint management protocol followed				
					* Rehab Therapy PT _____ OT _____				
					Patient's environment is safe				