AFIB

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			

Problem/ Needs		D	E	N
Hemodynamic Instability	Vital signs stable			
	SpO_2 > 94% via pulse oximetry			
	Rhythm returned to sinus rhythm or ventricular rate controlled			
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 _____ %			

* 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			
	* Discharge on Anticoagulation Therapy If not, reason why:			
	* Discharge on Antiplatelet Therapy If not, reason why:			
	* Discharged on Antiarrhythmic therapy If not, reason why:			
	Vital signs q 8 hrs and PRN			
	No evidence of bleeding on anticoagulation			
	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 of bleeding occur at home - Activity guideline - All medications and indication for taking them - Follow-up care - Smoking cessation plan if applicable - Medication information sheets given: _____ _____ _____ _____ _____			
	Prescription for follow up lab work (PT / INR) given			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated			
	* Tests / Procedures PT / INR _____ _____ _____ _____ _____			
Safety & Activity	Falls protocol continued			
	* Activity level:			

University Medical Center ** indicates medical orders needed*