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

Atrial Fibrillation

ESTIMATED LOS: 3 Days **Date placed on map:** _____

INCLUSIONARY CRITERIA:
Patients with documented diagnosis of Atrial Fibrillation / atrial flutter.

EXCLUSIONARY CRITERIA:
Patients with Chronic Atrial Fibrillation with controlled heart rate and / or on an oral anticoagulant.

Primary Diagnosis/Procedure: _____

Pertinent Past Medical History: _____

AF Risk Stratification: **Prior stroke / TIA or systemic embolus** _____ **Hx HTN** _____ **Age > 65** _____
Poor LV systolic function _____ **Mitral Valve Disease** _____ **Prosthetic Valve** _____

Social History: **Smoking** _____ **ETOH** _____

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: _____

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.

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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			

Problem/ Needs		D	E	N
Hemodynamic Instability	Vital Signs stable			
	Ventricular rate controlled HR 60 - 100			
	No neurological changes			
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			
	Verify prescription coverage for low molecular weight heparin (Lovenox), if applicable			

Patient Care Categories		D	E	N
Nutrition	* Diet: 2 gm Na or			
	% of diet consumed:			
	Breakfast _____%			
	Lunch _____ %			
	Dinner _____ %			
	Consider dietary consult			
	Educate on food / drug interactions			

** 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 as per unit protocol			
	Palpate peripheral pulses q shift and PRN			
	Pulse oximetry q shift and PRN			
	* O_2 (type):			
	Coumadin dose regimen prior to admission _____ Coumadin stopped prior to admission? If yes, why? _____			
	Vital signs q 8 hrs and PRN			
	No evidence of bleeding on anticoagulation			
	* Antiarrhythmics initiated: _____ Medication: IV _____ PO _____			
	Plan for DC cardioversion (if applicable)			
	* Anticoagulation Therapy initiated: _____ Medication: Heparin 25,000 units in 250 cc _____ @ _____ Low molecular weight heparin (Lovenox) _____ mg q _____ Coumadin _____ mg			
	Antiplatelet Therapy initiated: _____ Medication:			
	Collaborate with MD regarding candidate for low molecular weight Heparin (Lovenox) at home			
	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			
	Assess knowledge level and readiness to learn			
	Identify barriers to learning			
	Learning needs / teaching plan: - Explain schedule of events and tests - Instruct on medications			
	Instruct patient to inform nurse immediately of chest pain or shortness of breath, palpitations			
	AFIB Educational Tool Kit reviewed with patient / family			
	Videotapes on Coumadin and / or Lovenox Therapy viewed by patient / family (channel 69)			
	Explain option for self management using Low molecular weight Heparin			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated			
	* Tests / Procedures - if not done in ER - CBC - Chemistry, Mg - PT / PTT - Cardiac enzymes - U/A - EKG - Echo - TSH - Pregnancy Test (as appropriate) - Stool for occult blood X 1 _____			
	* Consider if applicable: - Digoxin level - ABG if pulse oximetry < 94			
Safety & Activity	Falls Protocol if indicated			
	Assist with ADL's as needed			
	* Activity level:			

University Medical Center

** indicates medical orders needed*

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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: - Anticoagulation plan - Etiology of Afib - Diagnostic tests - Meds / treatments			
Pain Management	Pain free or verbalizes relief after intervention			
	Respirations easy and unlabored			

Problem/ Needs		D	E	N
Hemodynamic Instability	Vital Signs stable			
	No neurological changes			
	Ventricular rate controlled HR 60 - 100			
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	Assessment of family / home support system by Discharge Planning complete			
	Social Services if indicated			
	Discharge plan identified: _____ Home with VNS _____ Home without VNS _____ Transfer to nursing facility			

Patient Care Categories		D	E	N
Nutrition	* Diet: 2 gm Na or			
	% of diet consumed: Breakfast _____% Lunch _____% Dinner _____%			
	Reinforce education on food/drug interactions			

* 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			
	Palpate peripheral pulses q shift or			
	Pulse oximetry check q shift and PRN			
	* Antiarrhythmics continued Medication:			
	Vital signs q 8 hrs and PRN			
	*Anticoagulation continued Medication:			
	*Antiplatelet therapy continued Medication:			
	If patient to be discharged on low molecular weight heparin (Lovenox), patient can demonstrate self injection			
	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			
	Learning needs / teaching plan: - Instruct on all medications: name and purpose - Early recognition signs and symptoms of bleeding - Purpose of Anticoagulation Therapy - Pulse Taking - Understands need for follow-up PT/INR labwork			
	Patient / family instructed on anticoagulation plan			
	Low molecular weight Heparin (Lovenox) instruction continued if indicated			
	Give Lovenox teaching box as applicable			
	Dietary Instruction related to Coumadin			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated			
	* Tests / Procedures Daily PT / INR _____ _____ _____ _____ _____			
Safety & Activity	Falls Protocol if indicated			
	* Activity level:			
	Consider PT evaluation if not progressing to baseline activity			
	Minimal assist with ADL's			

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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 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			
	* Telemetry discontinued if not done on Day 2			
	SpO_2 > 94% , or at baseline via pulse oximetry			
	Patient's rhythm stable			
Activity Intolerance	Tolerates increasing activity or back to baseline			
Patient Safety	Remains injury free in a safe environment			
	No evidence of bleeding on anticoagulation			
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 _____ Transfer to nursing facility			
	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 3 Date: _____	D	E	N
Assessment & Treatments	Assess respiratory / cardiac status q 8 hrs and PRN			
	* Antiarrhythmics continued Medication:			
	Vital signs q 8 hrs and PRN			
	*Anticoagulation continued Medication:			
	*Anitplatelet therapy continued Medication:			
	No evidence of bleeding on anticoagulation			
	Patient and or family member demonstrates correct administration of Low molecular weight Heparin (Lovenox)			
	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 - Early recognition signs and symptoms of bleeding - Purpose of Anticoagulation Therapy - Pulse Taking - Understands need for follow-up PT/INR labwork - State the dose of Coumadin, how and when to be taken			
	Patient has received written instructions related to their anticoagulation plan			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated			
	* Tests / Procedures PT / INR CBC _____ _____ _____ _____			
Safety & Activity	Falls protocol continued			
	* Activity level: Back to baseline			
	ADL's at baseline			