UNIVERSITY MEDICAL CENTER INTERDISCIPLINARY

<u>Disclaimer:</u> 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

interventions identified on the	ADDRESSOGRAPH NCOMPLICATED
MYOCARDIAL INFARCTION - UN ESTIMATED LOS: <u>5 Days</u>	Date placed on map:
Pake Cyanobo	Star Color Morena Morelad
EKG DIAGNOSTIC FOR AMI: YES NO	
ECHO DATE: Result:	
CARDIAC CATH DATE:Result:	rotanda lament
NCLUSIONARY CRITERIA:	
All patients diagnosed with a Myocardial Infarction (diagnostic EKC	G and/or positive enzymes) will be placed on the MI except
those patients who are diagnosed with a Myocardial Infarction pos	t-operatively, i.e., CABG or any surgical procedure will not be
laced on this	
CRITERIA FOR REMOVING PATIENTS FROM CAREMAN	e°
Patients will be removed from the MI who:	mane i name
Cardiac arrest 12 hours or greater after admission.	
2. Are not extubated within 36 hours.	
3. Are requiring 100mgm lasix in a 24 hour period.	A.I. is secondary.
. Are diagnosed with a G.I. bleed as the primary diagnosis and w	n.i. is secondary.
Primary Diagnosis/Procedure:	
Secondary Diagnosis/Procedure:	paralle incommen
Allergies:	Alast Opported
Pre-op Medications:	
Code Status:	
CONSULTS OR DISCIPLINES INVOLVED/NOTIFIED:	
1 ec	Initials/Date/Time notified:
2	Initials/Date/Time notified:
	Initials/Date/Time notified:
3, 1650mm 16	Initials/Date/Time notified:
4.	Initials/Date/Time notified:
5	Initials/Date/Time notified:
	The language a section is seen to
SIGNIFICANT EVENTS THIS ADMISSION:	
Date/Event:	
Date/Event:	
Date/Event:	
RN Signature:	Date/Time:
RN Signature:	Date/Time:
OUTCOMES/INTERVENTIONS: - Initial when met or co Use notation N/A, if n	ompleted not applicable for the timeframe

and circled, indicating it was not met or completed as stated.

Myocardial Infarction Uncomp - Cover

Medical Record

SUPPLEMENTAL DOCUMENTATION is required on the Interdisciplinary Progress Record when an outcome or intervention is initialed

Initial and circle, if not met or completed

Rev. 4/18/02

EMERGENCY TRAUMA DEPARTMENT TRANSFER RECORD Transfer Date: Transfer Time: _ Stretcher Wheelchair Transferred Via: Transferred to: Accompanied by: Pulse: ___ Resp: __ Vital Signs: Temp: ____ Cardiac Rhythm: Jaundiced Mottled Pale Skin Color: Normal Lung sounds/Respiration: Stridor Dyspnea Tachypnea Wheezing Normal Labored Other:___ Cool Skin: , Warm Edema of:_ Moist Dry Other: -Oxygen Therapy: PRN Continuous 100% Mask None Ventimask Nasal Cannula __ Resp. Assit. ___ Oxygen Ventilator: Other: Rate: __ Tidal Volume: __ Neuro/Mental Status: Oriented Comatose Alert Disoriented to: _ Place Person Time Paralysis of:_ Paresis of:_ Tubes/Drains: _ Chest Tube (R) (L) Ostomy Foley Catheter Naso-gastric Tube Other: ___ ml/hr I.V. Infusions: (1)_ at_ ml/hr $(2)_{-}$ ml/hr Other Pertinent Information: Immediate Needs on Arrival to Unit:

(Signature of R.N.)

S-10

Initial Signature Title Date/Shift Initial/Title Signature Requiring Co-Signature **ADDRESSOGRAPH** D = DAYS E = EVENINGS N = NIGHTS**DESIRED OUTCOMES** D E DEN Problem/ Problem/ ETD Needs Needs Date: No dysrhythmias observed. Patient/family verbalizes understanding of Cardiac anticipated plan of care and participates Knowledge Dysrhythmias Lungs clear. Deficit related in decision making. CHF Oriented to unit to plan of care Able to state symptoms to report Bedrest immediately; i.e., chest pain, SOB Assistance with all ADLs Activity Side rails up X 2, while in bed Intolerance Chest pain free. Chest Pain Pain free or verbalizes relief after Pain intervention. Remains injury free in a safe Management Patient Safety environment. No evidence of skin breakdown. Vital signs stable for patient. Skin Integrity VS Unstable Patient/family verbalizes satisfaction Patient/Family with hospital stay/care. Satisfaction INTERVENTIONS (continued on back) Patient Care EN Patient Care E Categories Categories Diet: Nutrition Discharge Plan Assess tolerance to diet Assess patient previous dietary restrictions % of diet consumed: Breakfast _____% Lunch ____ Dinner _____ % High risk nutritional assessment completed.

Myocardial Infarction

MR #	INTE	RVE	NTI	ONS	(continued)				
	ETD	D	E	N	Patient Care		D	E	N
Categories	Date:				Categories				
Assessment	Patient arrived in ETD: am / pm				Teaching	Encourage verbalization of fears / concerns.			
& Treatments	* EKG; Time obtained am / pm				& Psychosocial	Assess patient / family's perception of diagnosis			
	* VS q 15 min until stable, then q 30 min		10 5			Explain schedule of events / rationale			
	X 2; then q 1 hr.; then q 4 hrs.					for treatment plan			
	* Assess / document cardiac rhythm					Instruct patient to inform nurse of chest pain / related anginal symptoms, SOB			
	* Assess chest pain / notify MD					Account to the first section in the first section i		and the same	77
	* EKG for chest pain or associated anginal symptoms		119	er c					
	Interventional Therapy:					1	100		maning .
	- Time Rx decision determined: am / pm						200	196	
	Direct PTCA:					1			
	- Time sent to Cath Lab: am / pm			. 1		1	(Institu	1210	
	* Thrombolysis:	746				1		270	
	- Time initiated in ETD: am / pm - * EKG when fibrinolytic completed						39.4		
	Medical Management:			\dashv					
	* Catherization / CABG: - Time Rx decision am / pm								
	O ₂ therapy			П					
	f PaO < 90% or pulmonary congestion present								
	*/SaO ₂ /q 4 hrs.								
	* Soluble Aspirin								
	Time administered in ETD:								
	- If no, reason why:								
	* Heparin drip - time started in ETD			+					
						Lab / diagnostics results reviewed; MD			
	- If no, reason why:				Specimens &	notified if indicated. * EKG within 10 min.			
	* Beta blockers:				Diagnostics	Erro William To Halli.	1		
	- If no, reason why:			1		* CXR within 30 min.	uksa		
	* Nitrates IV		and a			* Chemscreen with Stat Mini, PT, PTT,		-	
	- If no, reason why:					CBC			
		Т		+		* Urine routine			
		110	bre i	П		* Schedule Echo for Day 2	IN CORN		-
				1		* Thyroid function tests if in atrial fibrillation			
						Total CK, Troponin & MB stat, q 8h X3			
		10	12			* Linid profile:	-		
				ч		* Lipid profile: Cholesterol, HDL, LDL & triglycerides			
		100				Onotation, Tibe, Ebe a trigiyeerides			
							100		
						Falls Protocol, if indicated			
					Safety &	* Bedrest			
					Activity	5501050			
	Activity								
	* Respiratory Care provided.	-	-	\dashv					
	(See Respiratory Care Record)								

Signature Initial/Title Date/Shift Signature Requiring Co-Signature **ADDRESSOGRAPH** DESIRED OUTCOMES D = DAYS E = EVENINGS N = NIGHTSЕ E N Problem/ Day 1 Problem/ Needs Needs Date: No dysrhythmias observed. Patient/family verbalizes understanding of anticipated plan of care and participates Cardiac Knowledge Dysrhythmias Lungs clear. Deficit related in decision making. CHF Oriented to unit routine to plan of care Verbalizes understanding of treatment Bedrest plan Tolerates commode privileges Activity Intolerance Chest pain free. Chest Pain Pain free or verbalizes relief after intervention. Pain Remains injury free in a safe Management environment. Patient Safety No evidence of skin breakdown. Vital signs stable for patient. Skin Integrity VS Unstable Patient/family verbalizes satisfaction Patient/Family with hospital stay/care. Satisfaction INTERVENTIONS (continued on back) Patient Care E D Ε N Patient Care Categories Categories Assess need for discharge planning Diet: Discharge based on initial assessment of home Nutrition Assess tolerance of diet environment / patient condition Plan Notify Discharge Planning / Social Services if needed % of diet consumed: Breakfast _____% Lunch _____ % High risk nutritional assessment completed.

Initial

Title

Myocardial Infarction

MR #	INIE	RV	ENII	ONS	(continued)			_	
Patient Care	Day 1	D	E	N	Patient Care	Spiriting Spirit	D	E	N
Categories	Date:				Categories				
	* VS q 15 min until stable, then q 30 min					Assess patient / family satisfaction			
Assessment	X 2; then q 1 hr.; then q 4 hrs.				Teaching		_		
&	* Assess / document cardiac rhythm				&	Assess patient / family's perception of			
Treatments	q 4 hr.				Psychosocial	diagnosis			
	* Assess chest pain / notify MD					Encourage verbalization of fears /			
	* EKG for chest pain or associated					concerns	_		
	anginal symptoms					Information booklet for "Families /			
	Assess for extra heart sounds				927.03	Patients in Critical Care Units"			
	and the second s			1		Identify barriers to learning			
	Assess lungs q 4 hrs.					Lacroine and Atachine plan	+	\vdash	_
	No. of the last the	-		_	TUO 037423	Learning needs / teaching plan:			
	Neuro checks q 4 hrs.	1010	2015		A 3 0	Schedule of events / treatment plan MI / Heart Attack / Tissue Damage			7
	A		-	-			la la sun		- 1
	Assess abdomen for distension,				I IC p	- Activity restrictions / progression - Symptoms to report immediately, i.e.,			
	tenderness, and bowel sounds	-		_	1 10	the state of the s		0.00	
	Palpate peripheral pulses q 4 hrs.	udgy	male:			chest pain, SOB or related anginal symptoms, risk factors	in their	- 20	a l
	Assess need for continued *O ₂ therapy,			_			61 10		
	if SaO ₂ > 90% D/C pulse oximetry	1							
	D/C O ₂	0.000				ternis in he garantalism in rest sons?			
	constitute about par patrons.	Carrie	- 6	-		- Call			
	Assess for bleeding	1557(5)	0110	1					
	100 01 W/1 0 b - W	-	\vdash	_	1				
	* I&O q 2 hr. if foley present; q 8 hr. if	1	1 1						
	voiding spontaneously	├-							
	* Weight: lbs./kg								
	* ASA continued	-		-					
	, tort contained								
	* Heparin continued						1		
	CARL SECTION OF THE PARTY OF TH	0000		mila	and the second second	and the second of the second o	200	10000	
	* Beta blockers continued			1		100 100 100 100		oxdot	
						Lab / diagnostics results reviewed,			- [-]
	* ACE inhibitors started, if no, reason				Specimens	MD notified, if abnormal	1000		
	why				&	* PTT (heparin Nomogram) if using			
	* IV: ml. hr.			1225	Diagnostics	IV heparin			
	Site:					EKG daily Total CK, Troponin & MB q 8h until downward trend Evaluate lipid profile results, consider: Diet modification / drug treatment if	100		
	* IV: ml. hr.	-		7					
	Site:	9.00							Ц.
	* IV: ml. hr.								
	Site:	_							
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						With and as heart and will be use a server	136	-	4
		mhu				STOCK TO PROPERTY INSTERNATION OF	and the		
						Falls Protocol, if indicated		1	
					Safety	Is a suppose of a condition of			
					&	* Bedrest	\top	\top	
		1			Activity				
					-	Bed Bath: Self Assisted			
								1	1
			Ш			* Commode for BM if no chest pain;			
	* Respiratory Care provided.					instruct patient to ask for assist			_
	(See Respiratory Care Record)								
	March 1 and	1	1	1					

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Problem/	Day 2			D	E	N	Problem/		D	E	N
Needs	Date:					1	Needs				
Needs Date:	1										
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to plan of care	Children, Burgar, 1887.					1	CHF	Continue b	-	-	⊢
	- Diagnostic te	ALS MISSES AND						1			
	- Medications a	and treatment	s	+	_	1		IOOB to chair			+
	0 00	Mgsawn;	-			1	Activity				
	- Modifiable ris	k factors cont	ributing	\vdash			4				
						1		I			1
	- List patient's risk factors and document					T.	1				
	teaching on progress record				1	l					
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	Pain free or ver	balizes relief	after	-	-	L					
Pain	intervention.	SMA 7, 2002.	080 1			1					
Management	151 . 252 TEQ			3		Remains injury free in a safe					
		1		13	Patient Safety	environment.					
						1			-		
	a G. S. X. assessment										느
				-	-	-	Chin Indonesia	No evidence of skin breakdown.			
VS IInetable	Vital signs stabi	e for patient.		1		1	Skin integrity		-		⊢
vo onstable				-	-	1					
	BMCL (Afficial)					1		Patient/family verbalizes satisfaction			-
	rice h in subset					3	Patient/Family				
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						1					
			INTERVE	_		(co		:k)			
				D	E	N			D	E	N
Categories						3	Categories				1
								* Diet:			
						1	Nutrition				
Plan	hates.				1000000	1		Assess tolerance to diet			
	N 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			rhs à				0/ of dist as a second	1	-	-
	80/46719 (23)			3 .							
				ris 5)		9					
	197.038%										-
								Notify RD if:			
								-Prescribed diet protein restricted or ADA		1	1
				GHIGH	a division			-Intake < 50% or abnormal fat lipid profile			

Myocardial Infarction

Title

Initial

Signature

MR #	INTE	ERVE	ENT	IONS	S (continued)				
Patient Care		D	E	N	Patient Care	1	D	E	N
Categories	Date:				Categories	I	-		-
Assessment	VS q 4 hr. or per unit protocol				Teaching	Encourage verbalization of fears / concerns			
8	* Assess / document cardiac rhythm	+-	1		8	Reinforce MI teaching. Provide patient	_	-	-
Treatments	q 4 hr.				Psychosocial	with "Take Care of the Heart You Have"			-
	* Assess chest pain / notify MD	\Box				booklet			
	EKG for chest pain or associated			1		Instruct patient to view channel 6:			
	anginal symptoms	\perp				"Understanding Heart Disease",			
	Assess for extra heart sounds					"Recovering from a Heart Attack"		_	
	Access home & 4 has	-	-			Learning needs / teaching plan:			
	Assess lungs q 4 hrs.		813	100		Diagnostic Tests List current medications reviewed:			
	Assess abdomen for distension,	1976	100			The second control of the second control of the property of the second control of the se	100		-
	tenderness, and bowel sounds						2450	alid.	
	Palpate peripheral pulses q 4 hrs.					International Theorem instruction			
	Assess need for continued to thereou	13.00				- Interventional Therapy: instruct on	logis	100)	
	Assess need for continued *O ₂ therapy, if SaO ₂ > 90% D/C pulse oximetry D/C O ₂	PRE .				modifiable risk factors of heart disease & follow up plan to decrease risk. Identify modifiable risk factors with	sion To	toff;	
	Assess for bleeding	\vdash				a check mark			
	Assess for bleeding	10000	100 p. (31)			Smoking Diabetes			
A A EP A FDA	* I & O q 8hrs.	10.70	50			Overweight Stress High Blood Pressure			
	* Weight: lbs./kg					High Cholesterol Sedentary Life Style			
	* ASA continued			1		- Local State of the State of t			
	* Heparin continued								
	* Beta blockers continued and increased			T					
	* ACE inhibitors started, if no, reason why					The second secon	67013	SCHOOL	
	* IV: ml. hr.	\vdash				Lab / diagnostics results reviewed,			_
	Site:				Specimens	MD notified, if abnormal	511/05		
	* IV: ml. hr.	Н			&	* EKG			
	Site:	Ш		100	Diagnostics	The second secon	e Consulta	rod (c	
						* CBC, SMA 7, Mg, Calcium, Phosphorus	History		
						* PTT: sec. (60-85)			
						PT			
						if on coumadin			
		1 1				* Recycle cardiac enzymes X 2, if no			
				1		downward trend		52202T	
		1 1				* Schedule Cardiac Cath.	16.00		
		1 1				Fredrick Seid and Inc. Diet	_		_
						Evaluate lipid profile results, Diet			
						modification / drug treatment if abnormal			
					ZECHTYCK SE	1913 1913		-	j
					3 3		lava		
							2532	5.00 4.0	
						Falls Protocol, if indicated		ACC.	
					Safety &	* OOB to chair with assistance			_
					Activity	* BRP Assess activity tolerance			
	* Respiratory Care provided.			Н					
	(See Respiratory Care Record)								

Signature Requiring Co-Signature Date/Shift Initial/Title ADDRESSOGRAPH DESIRED OUTCOMES D = DAYS E = EVENINGS N = NIGHTSE Problem/ Day 3 E Problem/ D N Needs Needs Patient/family verbalizes understanding of No dysrhythmias observed. Knowledge anticipated plan of care and participates Cardiac Deficit related Dysrhythmias in decision making. Lungs clear. CHF to plan of care Verbalizes understanding of: Discharge Recovery Plan Diet Tolerates ambulation in room Activity Intolerance Medications Activity Limitations Follow-up plan to eliminate / avoid risk factors for CAD Action to take if chest pain or SOB occurs Chest pain free. Chest Pain Pain free or verbalizes relief after Pain intervention. Management Remains injury free in a safe Patient Safety environment. No evidence of skin breakdown. Vital signs stable for patient. Skin Integrity VS Unstable Patient/family verbalizes satisfaction Patient/Family with hospital stay/care. Satisfaction INTERVENTIONS (continued on back) Patient Care D E Patient Care N E Categories Categories Initial assessment of family / home Diet: Discharge support system by Discharge Planning / Nutrition Plan Social Services if indicated Assess tolerance to diet % of diet consumed: Breakfast ____ Lunch ______ % Dinner ___

Myocardial Infarction

Title

Initial

Signature

MR# INTERVENTIONS (continued) Patient Care Day 3 EN Patient Care E Categories Date: Categories * VS q 4 hr. or per unit protocol Encourage verbalization of fears / Assessment Teaching concerns * Assess / document cardiac rhythm Instruct patient to view channel 6: Treatments q 4 hr. Psychosocial "Cardiac Rehabilitation" Assess chest pain / notify MD Learning needs / teaching plan: EKG for chest pain or associated Diagnostic Tests anginal symptoms Current Medications Assess for extra heart sounds Interventional Therapy Refer to Cardiac Prevention Rehab Assess lung sounds q shift Outpatient Center; give patient brochure / handout for referral. Palpate peripheral pulses q shift Risk Factor Modification: Smoking cessation counseling Assess for bleeding Elevated Lipid Profile * Weight: lbs./kg Weight reduction Diabetes Control * 1&O q 8 hr. Sedentary Life Style * ASA continued Transfer to telemetry Interventional therapy: * Initiate pre / post procedure caremap / protocol (refer to Cardiac Education Manual) * Consider discontinuing IV NTG and converting to oral form if needed * Convert IV's to 2 PIID lines * Heparin continued if intervention Lab / diagnostics results reviewed, Specimens MD notified, if abnormal * EKG * Beta blockers continued and increased. Diagnostics if not, reason why ___ * CBC, SMA 7, Mg, Calcium, Phosphorus * ACE inhibitors increased, if not, reason * PT: ____ why _____ (if on coumadin) PTT _ if on IV heparin Falls Protocol, if indicated Safety OOB to chair with assistance Activity * BRP Assess activity tolerance * Respiratory Care provided. (See Respiratory Care Record)

Medical Record

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	Day 4			D	E	N	Problem/ Needs		D	=	N
Needs	Date: Patient/family	verhalizes und	lerstanding of	-		1	Needs	No dysrhythmias observed.	+	-	
Knowledge	anticipated pla						Cardiac	Weight 1			
	in decision ma	king.	market) -				Dysrhythmias	Lungs clear.			
to plan of care	Verbalizes und						CHF		-	-	
	- Discharge R	ecovery Plan									
1	- Diet	HIGH HEREO GO	VICTOR :					Tolerates hall ambulation with assist	T		
			MIN -	_			Activity	(Interventional Therapy	+	_	-
ł	- Medications						Intolerance				
	- Activity Limit	tations	100200	_		1	1				
		अधिक श्रीम १५६३	Rebeil -]				
		an to eliminate or CAD docum									
	progress rec		iented in			1	1				13
		e if chest pain	or SOB			1	1				11
	occurs			<u></u>					-		-
Chast	Chest pain free	e.									1
Pain				-			1				
					308	1					1 3
Do to	Pain free or ve	erbalizes relief	after	- 80			1				
	intervention.	1,111,111					1				
								Remains injury free in a safe	T		T
							Patient Safety	environment.	_	_	-
						1		No evidence of skin breakdown.	+		
	Vital signs stat	ble for patient.		T			Skin Integrity				
VS Unstable				-	_						
								Patient/family verbalizes satisfaction	+	1	E N
						1	Patient/Family	with hospital stay/care.			
							Satisfaction				
			INTERVE	NTI	ONS	(00	ntinued on bac	(k)			
Patient Care	T		VL	D	E	N	Patient Care		TD	E	N
				-	-	I	Categories		-	_	1
	Discharge plan							* Diet:			
Discharge	- Home with V						Nutrition	A	-	-	-
Needs Dan Needs Park Nowledge Deficit related in to plan of care Version Pain Pain Pain Management Visual V	- Home - no Vi Complete Card		eferral				1	Assess tolerance to diet			100
	Complete care	alao Horiab I to	, ioirai	100	3	1		% of diet consumed:			
				100			l	Breakfast%			
								Lunch % Dinner %	100000	-	
								Dinner % Instruct:		-	1
						1		fat, sodium, cholesterol restrictions			
								1			

Myocardial Infarction

MR #	INTE	RVE	ENT	ONS	(continued)				
Patient Care	Day 4	D	E	N	Patient Care		D	E	N
Categories	Date:				Categories				
Assessment	* VS q 8 hr. or per unit protocol				Teaching	Encourage verbalization of fears / concerns			
8	* Assess / document cardiac rhythm				8	Learning needs / teaching plan:			
Treatments	per unit protocol			· - E	Psychosocial	- MI disease process			
	* Assess chest pain / notify MD			1		- Dietary fat / cholesterol restrictions			
	EKG for chest pain or associated			1		- Activity restrictions	-		
	anginal symptoms	_	_		1	- Discharge medication			11/10/2004
	Palpate peripheral pulses q shift					List:	1075	1010	1131
	* D/C telemetry if patient able to progress activity without chest pain, SOB or					including aspiring or alternative (purpose, dosage, frequency, adverse reactions, food / drug interactions)			
	dysrhythmias					- Weight reduction	Sel	375	
	Assess for bleeding	100	195			- Radial pulse taking if indicated	ec'os	200	
	the contraction and a second			T		- Action to take if chest pain / SOB	-		
	* Weight: lbs./kg		na) man			- Utilizing appropriate learning materials,	rices Blen	roni Noile	
	* I&O q 8 hr.	381				discuss risk factors and follow-up plan to decrease risk	10	sst q	
	* ASA continued					Risk Factor Modification: - Smoking cessation counseling			
	Interventional therapy:					- HTN - Elevated Lipid Profile			
	 * Initiate pre / post procedure caremap / protocol (refer to Cardiac Education 					- Weight reduction - Diabetes Control			
	Manual)					- Sedentary Life Style			
	* Initiate oral anticoagulant if indicated.				1				
	Consider discontinuing heparin.	_			1		1		
	* Consider discontinuing IV NTG and			1.			-	_	- 1
	converting to oral form if needed	_	_						
					Specimens	Lab / diagnostics results reviewed, MD notified, if abnormal	nig	e e	
					specimens 2	* PT:sec.			-
	1				Diagnostics	(if on coumadin)			
	Į.					PTT		_	
							15:00	3 34	
									-
					l	1			
			1	1	l		00	260	
						Falls Protocol, if indicated	H		
					Safety	services are selected and services field of the services.			
					& Activity	* Ambulate in hallway 5-10 min. BID Assess activity tolerance Shower with seat			
	* Respiratory Care provided.				1				
	(See Respiratory Care Record)								

MR#

Signature Requiring Co-Signature Date/Shift Initial/Title ADDRESSOGRAPH DESIRED OUTCOMES D = DAYS E = EVENINGS N = NIGHTSProblem/ EN Day 5 Problem/ EN Needs Needs Date: Patient/family verbalizes understanding of No dysrhythmias observed. anticipated discharge and participates Knowledge Cardiac Deficit related in decision making. Dysrhythmias Lungs clear. CHF to plan of care Verbalizes understanding of: Discharge Recovery Plan Tolerates hall ambulation without assist Diet Activity Medications Intolerance Activity Limitations Follow-up plan to eliminate / avoid risk factors for CAD Action to take if chest pain or SOB occurs Chest pain free. Chest Pain Pain free or verbalizes relief after Pain intervention. Management Remains injury free in a safe Patient Safety environment. No evidence of skin breakdown. Vital signs stable for patient. Skin Integrity VS Unstable Patient/family verbalizes satisfaction Patient/Family with hospital stay/care. Satisfaction INTERVENTIONS (continued on back) Patient Care DEN Patient Care DE Categories Categories * Diet: Discharge Nutrition Plan Assess tolerance to diet % of diet consumed: Breakfast _ Lunch Dinner Instruct: fat, sodium, cholesterol restrictions

Myocardial Infarction

Title

Initial

Signature

Patient Care	Day 5	D	E	N	Patient Care		D	E	٨
Categories	Date:				Categories				
Assessment	* VS q 8 hr. or per unit protocol	43		3	Teaching	Encourage verbalization of fears / concerns			
&	* Assess chest pain / notify MD				8	Learning needs / teaching plan:			
Treatments	EKG for chest pain or associated				Psychosocial	- MI disease process			
	anginal symptoms * D/C Heparin, if not previously done		-			Dietary fat / cholesterol restrictions Activity restrictions			
						- Discharge medication			-
	Assess for bleeding					List:including aspiring or alternative	100.1		9
	* Weight: lbs./kg					(purpose, dosage, frequency, adverse reactions, food / drug interactions)			
	* Consider D/C I&O		OF STREET			Weight reduction Radial pulse taking if indicated	rieli	ion ^a	
	* ASA continued					- Action to take if chest pain / SOB occurs		ev.	
	* Initiate oral anticoagulant if indicated	100		01		Instruct post discharge activity:	took	erni Mark	
	Consider discontinuing heparin					- Activity limitations / restrictions		ESCENT Market	
	* Consider discontinuing IV NTG and converting to oral form if not previously					- Valsalva - Bursts of Activity			
	done.		100			- Sexual Activity			
	* Discontinue all PIID devices except one	AVA.				- Aerobics / Isometrics			L
		-				Discuss home exercise options, i.e.,			
		3				home walking program, cardiac rehabilitation program			
						Risk Factor Education:	-	-	h
						- Smoking cessation counseling			
						- HTN			
						- High Lipid Profile			
						- Weight reduction			
						- Diabetes Control - Sedentary Life Style			
						Sedentary Life Style		20,00	
					Canalanana	Lab / diagnostics results reviewed,	Ass		_
					Specimens & Diagnostics	MD notified, if indicated * PT:sec.	\vdash	_	_
						if on Coumadin			
					200	* Schedule EKG for day of discharge,			
						Day 6	1000		
						* Submaximal stress test scheduled			
						for a.m. if appropriate			Γ
						Falls Protocol, if indicated			
					Safety	T and P TOLOGOI, II IIIU/GREGO			
					8	* Ambulate in hallway 5-10 min.	1		ſ
					Activity	Assess activity tolerance Shower with seat			
	* Respiratory Care provided.								
	(See Respiratory Care Record)		6		Total Inc.				1

Initial/Title Signature Requiring Co-Signature Date/Shift **ADDRESSOGRAPH** D = DAYS E = EVENINGS N = NIGHTSDESIRED OUTCOMES DEN Problem/ D E N Problem/ Day 6 Needs Needs Date: No dysrhythmias observed. Patient/family verbalizes understanding of Cardiac anticipated plan of care and participates Knowledge Dysrhythmias Lungs clear. Deficit related in decision making. CHF to plan of care Verbalizes understanding of: Discharge Recovery Plan Tolerates hall ambulation without assist Diet Activity Intolerance Medications Activity Limitations Follow-up plan to eliminate / avoid risk factors for CAD Action to take if chest pain or SOB occurs Chest pain free. Chest Pain Pain free or verbalizes relief after Pain intervention. Remains injury free in a safe Management Patient Safety environment. No evidence of skin breakdown. Skin Integrity Vital signs stable for patient. VS Unstable Patient/family verbalizes satisfaction Patient/Family with hospital stay/care. Satisfaction INTERVENTIONS (continued on back) E Patient Care E D N Patient Care Categories Categories Diet: Nutrition Discharge Plan Assess tolerance to diet % of diet consumed: Breakfast Lunch ____ Dinner Instruct: fat, sodium, cholesterol restrictions

Myocardial Infarction

Signature

Title

Initial

Patient Care	Day 6	D	Ε	Ν	Patient Care		D	E	N
Categories	Date:				Categories		-		
	* VS q 8 hr. or per unit protocol					Encourage verbalization of fears /			
Assessment					Teaching	concerns			-
R	* Assess chest pain / notify MD	-			8	Learning needs / teaching plan:			
Treatments	EKG for chest pain or associated				Psychosocial	- MI disease process	-		
rreatments	anginal symptoms				rsychosocial	- Dietary fat / cholesterol restrictions			
		_		-	-	- Activity restrictions			
	Assess for bleeding					Name of the second seco			
						- Discharge medication			
	* Weight: lbs./kg					List:	000	recte	1012
						including aspiring or alternative			-
	* ASA continued					(purpose, dosage, frequency, adverse			
	可谓、这句情情是好到本品,但没有在本意		70	18.00		reactions, food / drug interactions)	-		
	* Initiate oral anticoagulant if indicated					- Weight reduction		(Section)	
	Consider discontinuing heparin					- Radial pulse taking if indicated	TO ST	CON	
	* Discontinue all PIID devices except one	i mai		-	1	- Action to take if chest pain / SOB	809	180	
						occurs			
	1	Stella .	The same	. 3		Instruct post discharge activity:	1000	eon)	
					1	- Activity limitations / restrictions	nd on	1908	0.1
						- Valsalva	0.10	resid	er i
						- Bursts of Activity			
					l	- Sexual Activity			
	1					- Aerobics / Isometrics	1 1		
					1		+		_
					1	Discuss home exercise options, i.e.,			- 8
					1	home walking program, cardiac			
						rehabilitation program			
					1	Risk Factor Reduction:			
						- Smoking			- 1
						- HTN	1 1		
						- High Lipid Profile			
					1	- Weight reduction	1 1		- 8
					1	- Diabetes Control			
						- Sedentary Life Style			
						Codemary Ene Cipie			3
						Lab / diagnostics results reviewed,	1	_	-
	1				Cassimone		Diser		
				Specimens	MD notified, if indicated * PT: sec.	-		-	
				&	* PT: sec.				
					Diagnostics		-		
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						Falls Protocol, if indicated	T		
					Safety	The state of the s			1
					& &	* Ambulate in hallway 5-10 min.	+		
				FIES	Activity	Assess activity tolerance			
						Shower with seat			-
	1								
									0
	* Respiratory Care provided.								
	(See Respiratory Care Record)								
		1							