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

MYOCARDIAL INFARCTION - UNCOMPLICATED

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

EKG DIAGNOSTIC FOR AMI: YES _____ NO _____
ECHO DATE: _____ **Result:** _____
CARDIAC CATH DATE: _____ **Result:** _____

INCLUSIONARY CRITERIA:

All patients diagnosed with a Myocardial Infarction (diagnostic EKG and/or positive enzymes) will be placed on the MI except those patients who are diagnosed with a Myocardial Infarction post-operatively, i.e., CABG or any surgical procedure will not be placed on this

CRITERIA FOR REMOVING PATIENTS FROM CAREMAP®

Patients will be removed from the MI who:

1. 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.
4. Are diagnosed with a G.I. bleed as the primary diagnosis and M.I. is secondary.

Primary Diagnosis/Procedure: _____
Secondary Diagnosis/Procedure: _____
Allergies: _____
Pre-op Medications: _____
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 **Interdisciplinary Progress Record** when an outcome or intervention is initialed and circled, indicating it was not met or completed as stated.

S-10

EMERGENCY TRAUMA DEPARTMENT
TRANSFER RECORD

Transfer Date: _____

Transfer Time: _____

Transferred Via: _____ Stretcher _____ Wheelchair _____ Bed

Accompanied by: _____ Transferred to: _____

Vital Signs: Temp: _____ Pulse: _____ Resp: _____ BP: _____ Ap: _____

Cardiac Rhythm: _____

Skin Color: _____ Normal _____ Mottled _____ Pale _____ Jaundiced _____ Cyanotic

Lung sounds/Respiration:

_____ Normal _____ Wheezing _____ Tachypnea _____ Stridor _____ Dyspnea

_____ Labored

Skin: _____ Warm _____ Cool Other: _____

_____ Dry _____ Moist Edema of: _____

Other: _____

Oxygen Therapy:

_____ None _____ PRN _____ Continuous _____ 100% Mask

_____ Nasal Cannula _____ Ventimask _____ %

Ventilator: _____ Resp. Assit. _____ Oxygen

Tidal Volume: _____ Rate: _____ Other: _____

Neuro/Mental Status:

_____ Alert _____ Oriented _____ Comatose

Disoriented to:

_____ Time _____ Place _____ Person

Paresis of: _____ Paralysis of: _____

Tubes/Drains:

_____ Foley Catheter _____ Chest Tube (R) (L) _____ Ostomy

_____ Naso-gastric Tube Other: _____

I.V. Infusions: (1) _____ at _____ ml/hr

(2) _____ at _____ ml/hr

(3) _____ at _____ ml/hr

Other Pertinent Information: _____

Immediate Needs on Arrival to Unit: _____

(Signature of R.N.)

Myocardial Infarction

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.			
	Oriented to unit			
	Able to state symptoms to report immediately; i.e., chest pain, SOB			
Chest Pain	Chest pain free.			
Pain Management	Pain free or verbalizes relief after intervention.			
VS Unstable	Vital signs stable for patient.			

Problem/ Needs		D	E	N
Cardiac Dysrhythmias CHF	No dysrhythmias observed.			
	Lungs clear.			
Activity Intolerance	Bedrest Assistance with all ADLs			
	Side rails up X 2, while in bed			
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: _____			
	Assess tolerance to diet			
	Assess patient previous dietary restrictions			
	% of diet consumed: Breakfast _____% Lunch _____ % Dinner _____ %			
	High risk nutritional assessment completed.			

** indicates medical orders needed*

MR # _____ **INTERVENTIONS (continued)**

Patient Care Categories	ETD Date: _____	D	E	N
Assessment & Treatments	Patient arrived in ETD: _____ am / pm			
	* EKG; Time obtained _____ am / pm			
	* VS q 15 min until stable, then q 30 min X 2; then q 1 hr.; then q 4 hrs.			
	* Assess / document cardiac rhythm			
	* Assess chest pain / notify MD			
	* EKG for chest pain or associated anginal symptoms			
	Interventional Therapy: - Time Rx decision determined: _____ am / pm			
	Direct PTCA: - Time sent to Cath Lab: _____ am / pm			
	* **Thrombolysis:** _____ - Time initiated in ETD: _____ am / pm			
	- * EKG when fibrinolytic completed			
	Medical Management: * **Catherization / CABG:** - Time Rx decision _____ am / pm			
	O_2 therapy _____ * If PaO_2 < 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 _____ - If no, reason why: _____ * Beta blockers: _____ - If no, reason why: _____			
	* Nitrates IV - If no, reason why: _____			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Encourage verbalization of fears / concerns.			
	Assess patient / family's perception of diagnosis			
	Explain schedule of events / rationale for treatment plan			
	Instruct patient to inform nurse of chest pain / related anginal symptoms, SOB			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	* EKG within 10 min.			
	* CXR within 30 min.			
	* Chemscreen with Stat Mini, PT, PTT, CBC			
	* Urine routine			
	* Schedule Echo for Day 2			
	* Thyroid function tests if in atrial fibrillation			
	Total CK, Troponin & MB stat, q 8h X3			
	* Lipid profile: Cholesterol, HDL, LDL & triglycerides			
Safety & Activity	Falls Protocol, if indicated			
	* Bedrest			

** indicates medical orders needed*

Myocardial Infarction

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.			
	Oriented to unit routine			
	Verbalizes understanding of treatment plan			
Chest Pain	Chest pain free.			
Pain Management	Pain free or verbalizes relief after intervention.			
VS Unstable	Vital signs stable for patient.			

Problem/ Needs		D	E	N
Cardiac Dysrhythmias CHF	No dysrhythmias observed.			
	Lungs clear.			
Activity Intolerance	Bedrest Tolerates commode privileges			
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 based on initial assessment of home environment / patient condition			
	Notify Discharge Planning / Social Services if needed			

Patient Care Categories		D	E	N
Nutrition	* Diet:			
	Assess tolerance of diet			
	% of diet consumed: Breakfast _____% Lunch _____ % Dinner _____ %			
	High risk nutritional assessment completed.			

** indicates medical orders needed*

MR # _____ INTERVENTIONS (continued)

Patient Care Categories	Day 1 Date: _____	D	E	N
Assessment & Treatments	* VS q 15 min until stable, then q 30 min X 2; then q 1 hr.; then q 4 hrs.			
	* Assess / document cardiac rhythm q 4 hr.			
	* Assess chest pain / notify MD			
	* EKG for chest pain or associated anginal symptoms			
	Assess for extra heart sounds			
	Assess lungs q 4 hrs.			
	Neuro checks q 4 hrs.			
	Assess abdomen for distension, tenderness, and bowel sounds			
	Palpate peripheral pulses q 4 hrs.			
	Assess need for continued *O_2 therapy, if SaO_2 > 90% D/C pulse oximetry D/C O_2			
	Assess for bleeding			
	* I&O q 2 hr. if foley present; q 8 hr. if voiding spontaneously			
	* Weight: _____ lbs./kg			
	* ASA continued			
	* Heparin continued			
	* Beta blockers continued			
	* ACE inhibitors started, if no, reason why _____			
	* IV: _____ ml. hr. Site: _____			
	* IV: _____ ml. hr. Site: _____			
	* IV: _____ ml. hr. Site: _____			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Assess patient / family satisfaction			
	Assess patient / family's perception of diagnosis			
	Encourage verbalization of fears / concerns			
	Information booklet for "Families / Patients in Critical Care Units"			
	Identify barriers to learning			
	Learning needs / teaching plan: - Schedule of events / treatment plan - MI / Heart Attack / Tissue Damage - Activity restrictions / progression - Symptoms to report immediately, i.e., chest pain, SOB or related anginal symptoms, risk factors			
Specimens & Diagnostics	Lab / diagnostics results reviewed, MD notified, if abnormal			
	* PTT (heparin Nomogram) if using IV heparin			
	EKG daily Total CK, Troponin & MB q 8h until downward trend			
	Evaluate lipid profile results, consider: Diet modification / drug treatment if abnormal			
Safety & Activity	Falls Protocol, if indicated			
	* Bedrest			
	Bed Bath: Self ____ Assisted ____			
	* Commode for BM if no chest pain; instruct patient to ask for assist			

** indicates medical orders needed*

Myocardial Infarction

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
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of anticipated plan of care and participates in decision making.			
	Verbalizes understanding of: - Diagnostic tests			
	- Medications and treatments			
	- Modifiable risk factors contributing to coronary artery disease identified			
	- List patient's risk factors and document teaching on progress record			
Chest Pain	Chest pain free.			
Pain Management	Pain free or verbalizes relief after intervention.			
VS Unstable	Vital signs stable for patient.			

Problem/ Needs		D	E	N
Cardiac Dysrhythmias CHF	No dysrhythmias observed.			
	Lungs clear.			
Activity Intolerance	OOB to chair			
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:			
	Assess tolerance to diet			
	% of diet consumed: Breakfast _____% Lunch _____ % Dinner _____ %			
	High risk nutritional assessment completed.			
	Notify RD if: -Prescribed diet protein restricted or ADA -Intake < 50% or abnormal fat lipid profile			

** indicates medical orders needed*

MR # _____ **INTERVENTIONS (continued)**

Patient Care Categories	Day 2 Date: _____	D	E	N	Patient Care Categories		D	E	N
Assessment & Treatments	VS q 4 hr. or per unit protocol				*Teaching & Psychosocial*	Encourage verbalization of fears / concerns			
	* Assess / document cardiac rhythm q 4 hr.					Reinforce MI teaching. Provide patient with "Take Care of the Heart You Have" booklet			
	* Assess chest pain / notify MD EKG for chest pain or associated anginal symptoms					Instruct patient to view channel 6: "Understanding Heart Disease", "Recovering from a Heart Attack"			
	Assess for extra heart sounds					Learning needs / teaching plan: - Diagnostic Tests - List current medications reviewed: _____ _____ _____ - Interventional Therapy: instruct on modifiable risk factors of heart disease & follow up plan to decrease risk. Identify modifiable risk factors with a check mark ___ Smoking ___ Diabetes ___ Overweight ___ Stress ___ High Blood Pressure ___ High Cholesterol ___ Sedentary Life Style			
	Assess lungs q 4 hrs.								
	Assess abdomen for distension, tenderness, and bowel sounds								
	Palpate peripheral pulses q 4 hrs.								
	Assess need for continued *O_2 therapy, if SaO_2 > 90% D/C pulse oximetry D/C O_2								
	Assess for bleeding								
	* I & O q 8hrs.								
	* Weight: _____ lbs./kg								
	* ASA continued								
	* Heparin continued								
	* Beta blockers continued and increased								
	* ACE inhibitors started, if no, reason why _____								
	* IV: _____ ml. hr. Site: _____				*Specimens & Diagnostics*	Lab / diagnostics results reviewed, MD notified, if abnormal			
	* IV: _____ ml. hr. Site: _____					* EKG			
						* CBC, SMA 7, Mg, Calcium, Phosphorus			
						* PTT: _____ sec. (60-85) PT _____ if on coumadin			
						* Recycle cardiac enzymes X 2, if no downward trend			
						* Schedule Cardiac Cath.			
						Evaluate lipid profile results, Diet modification / drug treatment if abnormal			
	* Respiratory Care provided. (See Respiratory Care Record)				*Safety & Activity*	Falls Protocol, if indicated			
						* OOB to chair with assistance * BRP Assess activity tolerance			

** indicates medical orders needed*

Myocardial Infarction

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

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 Recovery Plan			
	- Diet			
	- Medications			
	- Activity Limitations			
	- Follow-up plan to eliminate / avoid risk factors for CAD			
	- Action to take if chest pain or SOB occurs			
Chest Pain	Chest pain free.			
Pain Management	Pain free or verbalizes relief after intervention.			
VS Unstable	Vital signs stable for patient.			

Problem/ Needs		D	E	N
Cardiac Dysrhythmias CHF	No dysrhythmias observed.			
	Lungs clear.			
Activity Intolerance	Tolerates ambulation in room			
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	Initial assessment of family / home support system by Discharge Planning / Social Services if indicated			

Patient Care Categories		D	E	N
Nutrition	* Diet:			
	Assess tolerance to diet			
	% of diet consumed: Breakfast _____ % Lunch _____ % Dinner _____ %			

* indicates medical orders needed

MR # _____ **INTERVENTIONS (continued)**

Patient Care Categories	Day 3 Date: _____	D	E	N
Assessment & Treatments	* VS q 4 hr. or per unit protocol			
	* Assess / document cardiac rhythm q 4 hr.			
	* Assess chest pain / notify MD EKG for chest pain or associated anginal symptoms			
	Assess for extra heart sounds			
	Assess lung sounds q shift			
	Palpate peripheral pulses q shift			
	Assess for bleeding			
	* Weight: _____ lbs./kg			
	* I&O q 8 hr.			
	* 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 not done			
	* Beta blockers continued and increased, if not, reason why _____ _____			
	* ACE inhibitors increased, if not, reason why _____ _____			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Encourage verbalization of fears / concerns			
	Instruct patient to view channel 6: "Cardiac Rehabilitation"			
	Learning needs / teaching plan: - Diagnostic Tests - Current Medications - Interventional Therapy			
	Refer to Cardiac Prevention Rehab Outpatient Center; give patient brochure / handout for referral.			
	Risk Factor Modification: - Smoking cessation counseling - HTN - Elevated Lipid Profile - Weight reduction - Diabetes Control - Sedentary Life Style			
Specimens & Diagnostics	Lab / diagnostics results reviewed, MD notified, if abnormal			
	* EKG			
	* CBC, SMA 7, Mg, Calcium, Phosphorus			
	* PT: _____ sec. (if on coumadin) PTT _____ if on IV heparin			
Safety & Activity	Falls Protocol, if indicated			
	* OOB to chair with assistance * BRP Assess activity tolerance			

** indicates medical orders needed*

Myocardial Infarction

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

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: - Discharge Recovery Plan			
	- Diet			
	- Medications			
	- Activity Limitations			
	- Follow-up plan to eliminate / avoid risk factors for CAD documented in progress record			
	- Action to take if chest pain or SOB occurs			
Chest Pain	Chest pain free.			
Pain Management	Pain free or verbalizes relief after intervention.			
VS Unstable	Vital signs stable for patient.			

Problem/ Needs		D	E	N
Cardiac Dysrhythmias CHF	No dysrhythmias observed.			
	Lungs clear.			
Activity Intolerance	Tolerates hall ambulation 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	Discharge plan identified: - Home with VNS _____ - Home - no VNS needed _____			
	Complete Cardiac Rehab Referral			

Patient Care Categories		D	E	N
Nutrition	* Diet:			
	Assess tolerance to diet			
	% of diet consumed: Breakfast _____% Lunch _____ % Dinner _____ %			
	Instruct: fat, sodium, cholesterol restrictions			

** indicates medical orders needed*

MR # _____ **INTERVENTIONS (continued)**

Patient Care Categories	Day 4 Date: _____	D	E	N
Assessment & Treatments	* VS q 8 hr. or per unit protocol			
	* Assess / document cardiac rhythm per unit protocol			
	* Assess chest pain / notify MD EKG for chest pain or associated anginal symptoms			
	Palpate peripheral pulses q shift			
	* D/C telemetry if patient able to progress activity without chest pain, SOB or dysrhythmias			
	Assess for bleeding			
	* Weight: _____ lbs./kg			
	* I&O q 8 hr.			
	* ASA continued			
	Interventional therapy: _____ - * Initiate pre / post procedure caremap / protocol (refer to Cardiac Education Manual)			
	* Initiate oral anticoagulant if indicated. Consider discontinuing heparin.			
	* Consider discontinuing IV NTG and converting to oral form if needed			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Encourage verbalization of fears / concerns			
	Learning needs / teaching plan: - MI disease process - Dietary fat / cholesterol restrictions - Activity restrictions - Discharge medication List: _____ including aspiring or alternative (purpose, dosage, frequency, adverse reactions, food / drug interactions) - Weight reduction - Radial pulse taking if indicated - Action to take if chest pain / SOB occurs - Utilizing appropriate learning materials, discuss risk factors and follow-up plan to decrease risk			
	Risk Factor Modification: - Smoking cessation counseling - HTN - Elevated Lipid Profile - Weight reduction - Diabetes Control - Sedentary Life Style			
Specimens & Diagnostics	Lab / diagnostics results reviewed, MD notified, if abnormal			
	* PT: _____ sec. (if on coumadin) PTT _____			
Safety & Activity	Falls Protocol, if indicated			
	* Ambulate in hallway 5-10 min. BID Assess activity tolerance Shower with seat			

** indicates medical orders needed*

Myocardial Infarction

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 discharge and participates in decision making.			
	Verbalizes understanding of: - Discharge Recovery Plan			
	- Diet			
	- Medications			
	- Activity Limitations			
	- Follow-up plan to eliminate / avoid risk factors for CAD			
	- Action to take if chest pain or SOB occurs			
Chest Pain	Chest pain free.			
Pain Management	Pain free or verbalizes relief after intervention.			
VS Unstable	Vital signs stable for patient.			

Problem/ Needs		D	E	N
Cardiac Dysrhythmias CHF	No dysrhythmias observed.			
	Lungs clear.			
Activity Intolerance	Tolerates hall ambulation without 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				

Patient Care Categories		D	E	N
Nutrition	* Diet:			
	Assess tolerance to diet			
	% of diet consumed: Breakfast _____% Lunch _____ % Dinner _____ %			
	Instruct: fat, sodium, cholesterol restrictions			

** indicates medical orders needed*

MR # _____ **INTERVENTIONS (continued)**

Patient Care Categories	Day 5 Date: _____	D	E	N
Assessment & Treatments	* VS q 8 hr. or per unit protocol			
	* Assess chest pain / notify MD EKG for chest pain or associated anginal symptoms			
	* D/C Heparin, if not previously done			
	Assess for bleeding			
	* Weight: _____ lbs./kg			
	* Consider D/C I&O			
	* ASA continued			
	* Initiate oral anticoagulant if indicated Consider discontinuing heparin			
	* Consider discontinuing IV NTG and converting to oral form if not previously done.			
	* Discontinue all PIID devices except one			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Encourage verbalization of fears / concerns			
	Learning needs / teaching plan: - MI disease process - Dietary fat / cholesterol restrictions - Activity restrictions - Discharge medication List: _____ including aspiring or alternative (purpose, dosage, frequency, adverse reactions, food / drug interactions) - Weight reduction - Radial pulse taking if indicated - Action to take if chest pain / SOB occurs			
	Instruct post discharge activity: - Activity limitations / restrictions - Valsalva - Bursts of Activity - Sexual Activity - Aerobics / Isometrics			
	Discuss home exercise options, i.e., home walking program, cardiac rehabilitation program			
	Risk Factor Education: - Smoking cessation counseling - HTN - High Lipid Profile - Weight reduction - Diabetes Control - Sedentary Life Style			
Specimens & Diagnostics	Lab / diagnostics results reviewed, MD notified, if indicated			
	* PT: _____ sec. if on Coumadin			
	* Schedule EKG for day of discharge, Day 6			
	* Submaximal stress test scheduled for a.m. if appropriate			
Safety & Activity	Falls Protocol, if indicated			
	* Ambulate in hallway 5-10 min. Assess activity tolerance Shower with seat			

** indicates medical orders needed*

Myocardial Infarction

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

ADDRESSOGRAPH

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

Problem/ Needs	Day 6 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 Recovery Plan			
	- Diet			
	- Medications			
	- Activity Limitations			
	- Follow-up plan to eliminate / avoid risk factors for CAD			
	- Action to take if chest pain or SOB occurs			
Chest Pain	Chest pain free.			
Pain Management	Pain free or verbalizes relief after intervention.			
VS Unstable	Vital signs stable for patient.			

Problem/ Needs		D	E	N
Cardiac Dysrhythmias CHF	No dysrhythmias observed.			
	Lungs clear.			
Activity Intolerance	Tolerates hall ambulation without 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				

Patient Care Categories		D	E	N
Nutrition	* Diet:			
	Assess tolerance to diet			
	% of diet consumed: Breakfast _____% Lunch _____ % Dinner _____ %			
	Instruct: fat, sodium, cholesterol restrictions			

** indicates medical orders needed*

MR # _____ **INTERVENTIONS (continued)**

Patient Care Categories	Day 6 Date: _____	D	E	N
Assessment & Treatments	* VS q 8 hr. or per unit protocol			
	* Assess chest pain / notify MD EKG for chest pain or associated anginal symptoms			
	Assess for bleeding			
	* Weight: _____ lbs./kg			
	* ASA continued			
	* Initiate oral anticoagulant if indicated Consider discontinuing heparin			
	* Discontinue all PIID devices except one			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Encourage verbalization of fears / concerns			
	Learning needs / teaching plan: - MI disease process - Dietary fat / cholesterol restrictions - Activity restrictions - Discharge medication List: _____ including aspiring or alternative (purpose, dosage, frequency, adverse reactions, food / drug interactions) - Weight reduction - Radial pulse taking if indicated - Action to take if chest pain / SOB occurs <u>Instruct post discharge activity</u>: - Activity limitations / restrictions - Valsalva - Bursts of Activity - Sexual Activity - Aerobics / Isometrics			
	Discuss home exercise options, i.e., home walking program, cardiac rehabilitation program			
	Risk Factor Reduction: - Smoking - HTN - High Lipid Profile - Weight reduction - Diabetes Control - Sedentary Life Style			
Specimens & Diagnostics	Lab / diagnostics results reviewed, MD notified, if indicated			
	* PT: _____ sec.			
Safety & Activity	Falls Protocol, if indicated			
	* Ambulate in hallway 5-10 min. Assess activity tolerance Shower with seat			

** indicates medical orders needed*