<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

Coronary Cath\_Intervention Cover

ADDRESSOGRAPH

## Coronary Catheterization / Interventional

☐ Coronary Cath Map	☐ Coronary Interventional Map
Estimated LOS: 12 hrs / 2 days	Date placed on map:
Primary Diagnosis / Procedure:	
Secondary Diagnosis / Procedure:	
Allergies:	
Code Status:	
SIGNIFICANT PAST MEDICAL HSTORY (If taking Glucopahage,	A suppression of the suppression
☐ CHF ☐ PVD ☐ Renal Failure ☐ MI Date:	Hypercholesteriemia COPD
☐ Hypertension ☐ Obesity ☐ Family History ☐ Ce	erebrovascular Disease
☐ Diabetes ☐ Diet ☐ Insulin ☐ Oral	
Smoker: Never Current (use of tobacco product	ts within 1 month of this admission) s greater than 1 month prior to admission)
PREVIOUS CARDIAC SURGERIES / CARDIAC PROCEDURES	
	Date Lesion
Cardiac Catheterization	
Coronary Interventional Procedure:	
Coronary Artery Bypass	
Valve Surgery	
Other:	
Instructions for Documentation: OUTCOMES / INTERVENTIONS: - Initial when met or completed - Use notation N/A, if not applicable for the tin - Initial and circle, if not met or completed	
	iplinary Progress Record when an outcome or intervention is initialed
RN Signature:	Date/Time:
RN Signature:	Date/Time:

Medical Record

Rev. 2/24/04

MR#					_												
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nments:	-						Angios	eal book	let [	Perclos	se book	let					
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Coronary Ca	atheterization	Intervent	ional								
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Problem/	Pre-Admission/	2 hrs. Pre-Pre		D	_		Problem/		D	TE	Т
Needs	Date:						Needs	100		-	
	Verbalizes under	_	1:101	T	T	T		Vital signs stable for patient		T	T
Knowledge Deficit related	pre-procedure in	structions					Unstable Vital	Patient awake,alert and oriented	+-	+	+
to plan of care				+	+	+	Signs	Patient awake, alert and oriented			ı
								Lungs clear to auscultation	+	+	t
										L	Ţ
	Pain free or verb	alizes pain rel	ief after	+	┿	+	Pulses	Distal pulses palpable / audible			
Pain	intervention.	anaco pani ioi					Present	40 March 2014 1975	+	+	t
Management				T	T		1	and the second s			l
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Alterations in ADL's due to:	assistan							April 1900 and 1900 a			
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								and the second second second			
Chest Pain	Chest pain free	7-1-1-1-1		T			B-1112-51	Remains injury free in a safe	T	П	T
Chest Pain							Patient Safety	environment.	+	-	H
								Control College			
								No evidence of skin breakdown.	Ť		T
							Skin Integrity		↓		L
	Cardiac rhythm st	table for patier	nt	T				Patient/family verbalizes satisfaction	+		H
Unstable	En commenced a religionary						Patient/Family	with hospital stay/care.	_		L
Cardiac Rhythm	and the second second second second second						Satisfaction			-	
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Patient Care	and the second replacement of the second			D	E	N	Patient Care		D	E	1
Categories	Assess need for [	Discharge Plan	nning /	┼	-	Н	Categories	* NDO 6 has action to	1	_	L
	Social Service ba						Nutrition	* NPO 6 hrs. prior to procedure, except for medications			
Plan	assessment of ho							The state of the s			$\vdash$
	patient condition.			_		Ш		Section to the section of the section of			
								Paradian in the second second			
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man day make the selection						0.0		ADDIES BONDAR GENERAL			

Patient Care	Pre-Admission/2 hrs. Pre-Procedure	D	E	N	Patient Care		D	E	N
Categories	Date:				Categories	And the second s	-		
Assessment	* History / Physical completed				Teaching	Assess patient/family satisfaction.			
& Treatments	Initial assessment completed				& Psychosocial	Encourage verbalization of fears / concerns.			
	* Consent # 1 obtained					Assess knowledge level and readiness to learn.			
	* Consent # 2 obtained					Instruct patient to anticipate: - EKG to monitor heart rate			
	* If allergic to iodine / shell fish / contrast	-	-		100 100 100 100 100 100 100 100 100 100	- Sensation of heat as dye is injected			
	discuss need for Solucortef.	-				- Coughing and deep breathing during			1
	MD notified at am/pm					procedure			
						- Inform MD if chest pain or difficulty			
	* Shave and prep @ am/pm Right Left Groin					in breathing occurs Review with patient "Take Care of the			
	Right Left Arm					Heart You Have" booklet if indicated			
	Assess and document distal pulses:								
	Dorsalis Pedis	-							
	Lt: Rt: Posterior Tibial								
data per destante	Lt: Rt:				Landau in an	The second second second second second			
		obri				The second section of the second section is			
	Assess lung sounds				-		-0191	14.75	1
	Assess LOC					I* Tests / Procedures			
and house the state of the stat	Encourage patient to void on call to Cath				Specimens				
	Lab								
	PIID lock site:	_		-	Diagnostics				
	Inserted by:							- 30	
1.1	miscriad by:	lle 							
processor to the contraction	* Heparin Drip (25,000u in 250cc D <sub>5</sub> W)								
	D/C on call to Cath Lab					Assess lab results: CXR, CBC,			
	or am/pm					Platelets, SMA - 7, PTT, PT, INR, EKG (on chart to Cath Lab)			
	continue Heparin cc/hr		59333		el colonia amen	MD notified if indicated			
	* Administer pre-medication if ordered	170	2 14						
	* Transfer to Cath Lab:								
	am/pm								
agendaria e e e e e e e e e e e e e e e e e e e									
	AND PROPERTY OF THE PERSON OF	676			Safety	Falls protocol initiated.	-333		
					&	* Activity level:			
		88	70		Activity	* Bedrest maintained after pre- medications			
					N 3 9	Patient Identification bracelet confirmed			
				-					
	sendenck i F -C1	103	goV			The board of the same of			
	Hygiene & Comfort Protocol			$\vdash$		agendros Work			
	Peripheral IV Therapy Protocol								

Signature Requirin	ng Co-Signature	Date/Shift	Initial/i	Title							
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Problem/ Needs	Intra Proced Date:	ure		D	E	N	Problem/ Needs	euro, vincia instituto no sono imento di "	D	E	N
	Verbalizes und			+	$\vdash$			Vital signs stable for patient	+	+	+
Knowledge Deficit related to plan of care	procedural eve	nts			L		Unstable Vital Signs	Patient awake,alert and oriented	+	$\vdash$	+
to plan of care							Signs	Hemodynamic status stable for patient	$\dagger$	T	t
	Pain free or ver	balizes pain re	elief after	<u> </u>	L		Bleeding	Procedure site intact	$\dagger$	T	T
Pain Management	intervention.	- Dunico punt i	oner and	-	-	-		No hematoma noted > 2 inches	$\dagger$	$\vdash$	T
								P. Carry S. P. Stat. Parket Julius Co. S. S.			
							Pulses	Distal pulses palpable / audible			
Alterations in ADL's due to:				eare	944		Present	The second secon			
									$\vdash$	<u> </u>	_
	100										
Chest Pain	Chest pain free						Patient Safety	Remains injury free in a safe environment.			
							Skin Integrity	No evidence of skin breakdown.	I		
Unstable Cardiac Rhythm	Cardiac rhythm	stable for pati	ent				Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care.			
		10.00	INTERVE	NTIC	ONS	(co	ntinued on bac	k)			
Patient Care Categories		200		D	E	N	Patient Care		D	Ε	N
Discharge							Categories  Nutrition	* Diet: NPO	H		-
Plan											
							orders needed	Tentro 17 Implicator 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			

Coronary Catheterization\_Interventional

Title

Initial

Signature

MR# INTERVENTIONS (continued) Patient Care Intra Procedure Patient Care Categories Date: Categories Review completed assessment prior to Assess patient/family satisfaction. Teaching Assessment starting procedure Encourage verbalization of fears / \* IV 0.9% normal saline with 8,000u Treatments Psychosocial concerns. Heparin for intra arterial flush Assess knowledge level and readiness to learn. Assess and document distal pulses: Reinforce pre-procedure teaching Dorsalis Pedis Lt: \_\_\_\_ Rt: \_\_\_\_ Lt: \_\_\_\_\_ Rt: \_\_\_\_ \* Patient prepped and sterile drape applied \* Procedure start time: \* Physician performing: \* Procedure performed: Continuous monitoring of arterial pressure, heart rate, & cardiac rhythm: Lab / diagnostics results reviewed; MD Specimens notified if indicated. \* 2% Lidocaine: \_\_\_\_\_ groin/arm \* Tests / Procedures Diagnostics Injected by Dr. Arterial sheath: FR Venous sheath: \_\_\_\_\_ FR Inserted by Dr. During conscious sedation, vital signs & oxygen saturation monitored and recorded q5min \* IV - see flowsheet Administer 0.9% normal saline at: cc/hr Hygiene & Comfort Protocol Peripheral IV Therapy Protocol Falls protocol initiated. \*02 3L / min via nasal canula Safety \* Activity level: For Cardiac Cath only: Activity Bedrest: Leg: \_\_\_\_\_ Arm: \_\_ Procedure complete \_\_\_\_\_ am/pm immobolized Patient transferred to recovery room: am/pm Patient Identification bracelet confirmed See Recovery Phase

University Medical Center

indicates medical orders needed

Coronary Catheterization_ Interventional					Procedures			
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PTCA/STENT	RN			CA/STEN		RN	PTCA/STENT	RN
Post-Roto Post Angiojet	Init	☐ Pos			t Angiojet	Init	☐ Post-Roto ☐ Post Angiojet	Init
Lesion #	of party	Lesion			and accord		Lesion #	<del>  ""</del>
Lesion visualized		Lesion	visuali	zed	500 E 20		Lesion visualized	+
Turk in the second	iii bibar.							
Wire advanced to lesion	-	Wire a	dvance	d to lesion	1		Wire advanced to lesion	-
Type:		Type:				4.5.33	Type:	
Balloon advanced over guide wire	1. 12	Balloor	n advar	nced over	guide wire	1 1/1/2	Balloon advanced over guide wire	
Type:		Type:	land a second			16 6	Type:	1000
Location:		Locatio	n:			190512	Location:	1 00
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Cutting balloon advanced:		THE RESERVE AND ADDRESS OF THE PARTY OF THE		n advance	ad.		Location:	
Type:	(8774)			ir auvarice		63/05-201	Cutting balloon advanced: Type:	
Location:	.5.00	Locatio	n:				Location:	
Balloon inflation:		Balloon			The second	75.3.3	Balloon inflation:	1
ST's: Baseline	N. COLLEGE	ST's:					ST's: Baseline	
☐ Increased			_	creased			☐ Increased	
☐ Decreased Chest pain ☐ Yes ☐ No		044-		ecreased	carriero la		Decreased	
Balloon deflation:		Balloon		Yes 🗌	No		Chest pain Yes No	
ST's: Baseline		ST's:					Balloon deflation:	
☐ Yes ☐ No		0.3.		es 🗌 N	Vo.		ST's: Baseline	
Chest pain relieved ☐ Yes ☐ No		Chest p			Yes 🗌 No		Chest pain relieved Yes No	
ACT:		ACT:					ACT:	
Time: ACT:		Time: _		ACT:			Time:ACT:	
Time: ACT:		Time:		ACT:			Time: ACT:	
Stent deployed:		Stent de					Stent deployed:	
Type:		l ocation	n·				Type:	5-, 11
Type:		The same of the sa				Install	Location:	
Location:		Location					Type:	
Inflation of Stent balloon:		Inflation	of Ste	nt balloon	:		Inflation of Stent balloon:	
ST's: Baseline		ST's:					ST's : Baseline	1013
☐ Increased				creased			☐ Increased	
☐ Decreased Chest pain ☐ Yes ☐ No	to style	Oh4-		creased		Space	Decreased	151 S.A.
Deflation of stent balloon	-	Defletie	ain 📋	Yes 🔲	No		Chest pain Yes No	
ST's: Baseline	1000	ST's:		nt balloon	1		Deflation of stent balloon	
Yes No		513.		es 🗌 N	0	37 11	ST's: Baseline  Yes No	
Chest pain relieved Yes No	6101 CT	Chest pa			res 🗆 No	100	Chest pain relieved Yes No	ayaday v
II B / III A		II B / III				-	II B / III A	
Bolus given	Yw or	Bolus gi	ven 🗌		Special Committee		Bolus given	
Infusion Started am / pm		Infusion	Started	d 🗌	am / pm		Infusion Started am / pm	
Procedure Completed		Procedu		-	31.	07 z =	Procedure Completed	
am / pm Arterial Sheath:		Artorial					am / pm	
Sutured in place am/pm		Arterial S			m/nm	1	Arterial Sheath:	
			al deni	e a oyed	_ am/pm		Sutured in place am/pm	
Perclose deployed am/pm Perclose dep					am/pm		Angioseal deployed am/pm Perclose deployed am/pm	
Total Contrast cc		Total Co			CC		Total Contrast cc	
Transferred to Recovery Room				Recovery			Transferred to Recovery Room	
am / pm			a	m / pm			am / pm	
Hackensack University Medical Center			*Indicat	ted medical o	orders needed			

Coronary Interventional CareMap® Diagnosis/Procedures	MR#
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Procedure				Procedure			
ROTATIONAL ARTHRECTOMY	RN Init	BRACHY THERAPY	RN Init	ANGIOJET	RN Init		
Arterial sheath upsize fr		Angioplasty complete am / pm		Lesion visualized:			
TVP inserted by:		Arterial sheath upsized fr.		Angiojet system prepped & purged			
TVP Settings: Rate: MA: Mode:		Radiation therapy catheter advanced & delivered across lesion by cardiologist		Angiojet cath advanced to lesion			
TVP removed at end of procedure by MD		Radiation oncologist delivered radioactive source		Angiojet in progress ST's increased decreased			
Lesion visualized		Dwell in place for: minutes seconds	Della Trans	Chest pain  Yes  No Heart Rate:  increased decreased Blood Pressure:			
Roto wire advanced Type:		ST's increased decreased Chest pain Yes No	5 67 10 1	increased decreased passes			
Burr advanced to lesion burr size lesion burr size lesion		Radiation source returned into device by radiation oncologist Radiation delivery catheter removed by cardiologist		Angiojet complete ST's baseline  Yes  No Chest pain relieved Yes  No HR / BP stable Yes  No			
Roto in progress		Room & patient surveyed by physicist with negative results Procedure complete		ACT: Time: ACT: Time: ACT: Time: ACT:			
ST's increased decreased Chest pain Yes No Heart Rate:	1 28 (3) 1 9 (22) 1 3 (3 (4)	am / pm see immediate post - procedure intervention Arterial sheath:		Time: ACT:			
☐ increased ☐ decreased Pacing ☐ Yes ☐ No Blood Pressure:	7 2 77	Sutured in place am/pm Perclose deployed am/pm Angioseal deployed am/pm		See PTCA / Stent interventions			
□ increased □ decreased  Roto completed ST's baseline □ Yes □ No HR / BP stable □ Yes □ No Chest pain relieved □ Yes □ No		Brachy therapy consent on chart	0.16%				
ACT: Time: ACT: Time: ACT:	10 mg	PROCEDURE INTRAVASCULAR ULTRASOUND	RN Init	PROCEDURE PRESSURE WAVE WIRE	RN Init		
Time: ACT:	13000	Vessel visualized:	140	Vessel visualized:			
Balloon advanced. See PTCA / Stent interventions.		Wire advanced to vessel		Wave wire prepped, zeroed & normalized			
Procedure complete am/pm See immediate post-procedure interventions		Intravascular Ultrasound cath prepped & advanced to vessel Intravascular Ultrasound in		Wave wire advanced to lesion proximal / distal as per			
Arterial sheath:	9	progress ST's baseline  Yes  No		protocol Flow rates			
Sutured in place am/pm Perclose deployed am/pm		Chest pain  Yes  No		Flow rates			
Angioseal deployed am/pm		Intravascular Ultrasound Complete: am/pm See PTCA / Stent or immediate post-procedure		Wave wire removed See PTCA / Stent or immediate post-procedure			
200 C		mg/se bevo can			1000 P. 1 044 N. 1		

\*Indicated medical orders needed

Coronary Ca	theterization	n_ Interven	tional								
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Problem/	Recovery Ph	nase		D	E	-	Problem/	D-DATO E-EVERNINGO IV-IVI	D	-	1
Needs	Date:	arhalizas und	antanding of	+	$\vdash$	+	Needs	and the first section will be		┸	1
Knowledge	Patient/family v post instruction		_				Bleeding	Hemostasis obtained			
Deficit related to plan of care	1-40					T	from Cath site	No hematoma noted > 2 inches		T	$\dagger$
								0.000		Τ	T
								Distal pulses palpable / audible	+	╁	+
Pain	Pain free or ver intervention.	rbalizes relief a	after	Τ	Π	I	Pulses Present		_	╄	4
Management	intervention.			$\vdash$	$\vdash$	+	Present				
	Supposed to a superior to the superior of the			-							
	Charles in face										I
Chest Pain	Chest pain free after intervention		relief								
-	Cardiac rhythm	etable for nati	ent	<u> </u>	L	L					
Unstable Cardiac		stable for pati	ont		_	H					
Rhythm							Patient Safety	Remains injury free in a safe environment.	$\dagger$		t
	Vital signs stab	e for nationt			_	_			$\top$	$\vdash$	+
Unstable	vitai signis stabi	e for patient						No evidence of skin breakdown.	+	$\vdash$	┾
Vital Signs	Patient awake,	alert and orien	ted			1	Skin Integrity		_	L	L
	Hemodynamic s	status stable fo	or patient	-	$\vdash$	$\vdash$		Annual Control of the			
				_	_	-	Patient/Femiles	Patient/family verbalizes satisfaction	T		T
1 100							Patient/Family Satisfaction	with hospital stay/care.	+	-	+
			INTERVE	NTI	ONS	(co	ntinued on bac	:k)		_	_
Patient Care				D	E				D	E	N
Categories				_	_		Categories	* E	1		L
Discharge							Nutrition	* Encourage fluid intake			
Plan								% of diet consumed:			
								Breakfast% Lunch%	-		
								Dinner %			1000
		and the second second					Language water	Section (Spine)	13.3	200	

	Recovery Phase	D	E	N	Patient Care		D	E	N
Categories	Date:				Categories	and the second s			
	* Monitor cardiac rhythm continuously					Post-procedure teaching			
Assessment					Teaching	Instruct:			
&	* Monitor VS continuously and record				8	Rationale for bedrest/HOB 30 degrees;			
Treatments	q15min until discharged from recovery		-		Psychosocial	immobilization of affected extremity.			
-	ACT = am/pm				angual comment of the second	<ul> <li>Inform nurse of numbness or tingling of affected extremity, or bleeding from</li> </ul>			
	* Arterial/Venous sheaths removed		$\vdash$	-		cath site.			
1	according to established guideline:					Apply pressure to area when coughing	MW9	12	
	am/pm by:				and the second s	or sneezing.			
	* Apply manual pressure to site until				principal and the second	Inform nurse of any chest pain or			
	hemostasis obtained: am/pm				TATTE SET OF THE STATE OF	difficulty breathing.			
15 (1554 m)	Topical patch applied@				A CONTRACTOR OF THE PARTY OF TH	Increase fluid intake.	ligar.		
a management of the second	am/pm	00			1 1 7 1	If Vascular Hemstatis Device utilized,			
	Assess and document distal pulses:					give patient "VHD Information" booklet.			
in a second of	Dorsalis Pedis					Stentcard reviewed with patient - placed	(her)		
	Lt: Rt:	1255		-		on chart / given to patient	0.75		
	Posterior Tibial	817					() E)(l	0.00	
	Lt: Rt:								
Commence of the Commence of th	DSD applied: groin								
	The second secon		1. 5.4			and the second control of the second	eri.	27.00	
pat and from the first state of the	A THE PARTY OF THE PROPERTY OF THE PARTY OF	e de la constante de la consta		100	The second second second second		and and		
	Donat shorts			-		10 1 10 10 10 10 10 10 10 10 10 10 10 10	11.9		
	Report given toRN								
	Initial voiding: CC			-					
	Illitial voiding.					EKG complete	-		-
A CONTRACTOR OF THE PARTY OF TH	The company of the second of t				Specimens	LICO COMplete			
					8				
	* Transfer to: unit				Diagnostics	72-9 ( 780) ( 790) ( 790) ( 790)	1.30	gr ? i	
	am/pm. Instable condition					parties of the second s			
		to describ		4	1 1 1				
1 f 22 d 2 d 1 = 4 = 4								and the same of	
	* IV - see flowsheet				parties of the part of the Co.				
	Condition:						100	1111	
					and a second of the				
	The second secon		1,50,500						
A CONTRACTOR OF THE PARTY OF TH	Site:								
						and the second of the second o	100	1000	
	10 (15 1-1		-	_	The state of the s	The second secon			- 1
	Hygiene and Comfort Protocol	-70	200						
and the second	Implemented			-		The result of Colombian and Co		-22	
	Peripheral IV Therapy Protocol implemented					many to the second and a second to the second and the second and			
	Implemented	_		-					
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	manufactured with the Min	wa To	100			Falls protocol initiated.			
1 1	and the same of th	(2°5)()	- 13		Safety				
					&	* Bedrest with immobilization of affected	are feet to	S 100	
1 1 1					Activity	extremity hrs.			
of the second	and the second s	110	200			* 5 lb. Sandbag applied to groin	< 0		
and the second second second	and the same of th	0	1		At 1 2 1 12 1	for hrs. if ordered.			
10.00									
	A Face today today to								
		300					. 4	-25	
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	theterization_ Interventional Signature Title	In	itial			THE RELIGIOUS	7		
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Signature Requirin		ul/Title				ADDRESSOGRAPH			_
Problem/ Needs	Post Procedures 1 - 4 hours Date:	SIRE	E	N	OMES Problem/ Needs	D = DAYS E = EVENINGS N = NIC	D	-	T
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding anticipated plan of care and participates in decision making.								
							$\perp$	F	+
Pain Management	Pain free or verbalizes relief after intervention. Chest pain free			-					
lla etabla	Cardiac rhythm stable for patient	101 00							
Unstable Cardiac Rhythm							$\perp$	T	
Unstable Vital	Vital signs stable for patient Patient awake, alert and oriented Lungs clear to ausculation								
Signs					Patient Safety	Remains injury free in a safe environment.	F		T
Bleeding From Cath Site	No hematoma noted > 2 inches	+			Skin Integrity	No evidence of skin breakdown.	<u> </u>	F	+
Diminshed Pulses	Distal pulses palpable / audible		100		Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care.	+		+
	INTER	VENTI	ONS	(cc	ntinued on bac	(k)			
Patient Care		D	E	_	Patient Care		D	E	T
Categories Discharge		+	-		Categories  Nutrition	* Diet: Resume diet:	_		+
Plan						% of diet consumed: Breakfast% Lunch % Dinner % Encourage fluid intake			
								e at	

MR # \_\_\_\_\_ INTERVENTIONS

Patient Care	Post Procedure 1 - 4 Hours	D	E	N	Patient Care		D	E	N
Categories	Date:	1	-		Categories				
- Cartogonico	VS q 15 mins X 4; q 30 min X 2 and					Encourage verbalization of fears /			
Assessment	g 1 hr X 4 and PRN				Teaching	concerns.			
&	Monitor site for bleeding, tenderness,					Learning needs / teaching plan:		-	
Treatments	and hematoma q 15 min X 4,	1		1	Psychosocial	- Rationale for bedrest and	-		
	q 30 min X 2, q 1hr X 4 and PRN					immobilization of affected extremity			
	Assess lung sounds					- Inform nurses of numbness or tingling			
		-	_			of affected extremity or bleeding from			
1	Initial voiding cc					cath site			
1	Distal pulse assessment q 15 min X 4,	-	$\vdash$	-		<ul> <li>Apply pressure to area when coughing or sneezing</li> </ul>			
	q 30 min X 2, q 1 hr X 4 and PRN					Coughing of sheezing			
	4 SO Hill X 2, 4 TH X 4 and From		(3)		100 2	A CONTRACTOR OF THE PROPERTY O			
1995	Document distal pulses:								
	Dorsalis Pedis: Lt: Rt:	-				A CONTRACTOR OF THE PROPERTY O			
	Posterior Tibial: Lt: Rt:							70	
							7		
	IV: See Flowsheet			1		and the second s	120		1
	Site:								
	Condition:								
	Assess and dearment for built with a dear	-	-	-			200	-	
	Assess and document for bruit q 1hr X				er par en personale de la				į
	hrs					1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			1
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Park the Company of the State o					Specimens				
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					Diagnostics	3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3			
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	and the second s	-	pe s	ud. I	1 and 1 and 1 and 1 and 1	The state of the s			
- 1 150 · · · · · · · · · · · · · · · · · · ·	The second secon					Felle protocol initiated			
	The same of the sa				Safety	Falls protocol initiated.			
1					Salety &	* Activity level:	$\vdash$	$\vdash$	$\vdash$
					Activity	Keep leg immobile. Complete bedrest			
Contract Contract	and the second s	70.00			, tourney	for hr			-
	the same of the sa								
Marie Control						HOB elevated 30 degrees			
	and the same of th								
	Audit medical	200	Solve			5 lb. Sandbag to groin			
5-1						for hrs			
Appear of the second							$\Box$		
1	1 (med 6, w.d.)					Brachial Technique:			
Harris Inne	Market S					Bedrest for 2 hrs. Keep arm straight for			
	11.70					4 hrs.			
	Bankel & Parket and Co.					OOB after 3 hrs if VHD	$\vdash$	-	-
	* Respiratory Care provided.	$\vdash$	_	-		OOD alter 3 lils if VIID			
	respiratory dare provided.								
A continued to		_	_	_				_	-

University Medical Center

Coronary Catheterization_ Intervention			1 1-	total.	7	1		1			
Coronary Catheterization_ Interv		Title	In	itial	-		COURTHERNIZATION	1			
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Problem/	Post Procedur	res 5 - 12 hou		D	E	N	Problem/		D	-	T N
Needs	Date:	25 SON SON T					Needs				
	Patient/family v						1				
Knowledge Deficit related	anticipated plar in decision make		participates								
to plan of care	In decision mar	King.		+	-	-	1	The second secon			
	1. 690 PG 1.8										
	Pain free or ver	rhalizes relief	offer	_		_	4				
Pain	intervention.	rbalizes rener a	atter								
Management	Chest pain free	à		-			1				
and the same of the	temperature market ar	econi su mana a									
	1			303		1					
	Cardiac rhythm	stable for pat	tient	-			4				
Unstable								I			
Cardiac							1 1 1 .				
Rhythm									-	<u> </u>	_
			1								
	Vital signs stabl	le for patient					1				
Unstable	Patient awake,		nted								
Vital	Lungs clear to a	ausculation							$\perp$		
Signs				$\vdash$	H	$\vdash$	Patient Safety	Remains injury free in a safe environment.			
							ration, ource,	environment.	+-	$\vdash$	$\vdash$
	Hemostatis mai										
	No hematoma r	noted > 2 inch	es					No evidence of skin breakdown,			
From Cath Site							Skin Integrity		+	<u> </u>	
Outil Oile									1 1		
	Distal pulses pa	alpable / audib	le					Patient/family verbalizes satisfaction	+		_
Diminshed							Patient/Family	with hospital stay/care.			
Pulses							Satisfaction				
1			a grand		2						
		. 100	INTERVE	NTIC	ONS	(co	ntinued on bac	(k)			
Patient Care				D	E	N	Patient Care		D	E	N
Categories						1	Categories		-		
	Discharge to:							* Diet:	$\Box$		
Discharge Plan	Home:						Nutrition				
riaii	Admit:							% of diet consumed:			
								Breakfast%			
								Lunch %		3131-1-1	iii
			- 1					Dinner %			
1			1					Encourage fluid intake			
								b. In the least of the last			
									1		
		A SHALL STORY									

MR # \_\_\_\_

INTERVENTIONS

	Post Procedures 5 - 12 hours	D	E	N	Patient Care		D	E	N
Categories	Date:	-	_		Categories				
Accesement	VS q 4 hrs until discharge				Tanahina	Encourage verbalization of fears /			
	Assess site for bleeding, tenderness	-	-	-	Teaching	Learning peeds / teaching plan:	-	-	-
Assessment & Treatments	and hematoma				Psychosocial	Learning needs / teaching plan: - Instruct activity program			
	Pulse q 1 hr until discharge		-			<ul> <li>Inform nurses of numbness or tingling of affected extremity or bleeding from</li> </ul>			
1	Assess and document distal pulses on	-	-	-		cath site - Apply pressure to area when			
	Flowsheet				92 196 1	coughing or sneezing			
	Left Right					Instruct patient/family on care:			_
0.000	DUD look semand	_				- Action to take if chest pain occurs			
	FIID lock removed				-	Cath site care, including signs and symptoms of infection and action			
	Voidedoc			1		to take if bleeding - Follow-up appointment with MD			
Voided	No bruit present					- Fluids, diet, meds and new Rx if any	13		
							0.3.72	-	
						The state of the s	uns Lans		
			807.4		Specimens				
					& Diagnostics			30	
							343		
			4						
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					the second second second		e: 67		
							200		
		S. 1051					- 27		
							700	18110	
	CONTRACTOR OF THE PROPERTY OF				Safety	Falls protocol initiated.			
						* Activity level: Ambulating ad lib			
					A 12 2 12 1		9/16		
		30							
			in a	cia					
	and the second								
	* Respiratory Care provided.	+	+	$\dashv$					

University Medical Center

Coronary Ca	atheterization_ Interv	/entional			_	Marie Marie				
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			1		1	(1/4/1)	MILL WALLE			
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1 1 11		DES	IREI	ο οι	јтс	OMES	D = DAYS E = EVENINGS N = NIG	3HTS	ŝ	
Problem/	Post Procedure Day 1	NAME AND ADDRESS OF TAXABLE PARTY.	D	_	_	Problem/		D	E	N
Needs	Date:	104				Needs				
11	Patient/family verbalizes u						Remains WNL for patient	1		
Knowledge Deficit related	diagnosis and plan of care	e, participates in				Telemetry				1
to plan of care	decision making.  Orient to telemetry unit, ca	all hell system	$\vdash$	+	-	-		1		
to plan or our	TV, & bed controls, post p	-					a rought that the same and the same	1 7		
	Patient/family verbalizes u	understanding of	+	+-	$\vdash$	1		1 /		
	post-procedure instruction	ns.					Vital Signs stable for patient.	+-	<del>-</del>	+
	Pain free or verbalizes pai	in relief after		T		Unstable	Commence of the Commence of th			
Pain Management	Intervention.	200	1	_	1	Vital Signs	Patient awake, alert and oriented.			
Management	Remains free of chest pair or back discomfort	n, SOB, groin					I the state of the		<u></u> '	_
	or pack disconner,						Hemodynamic status stable for patient.	1 - 1	1	
			$\vdash$	$\vdash$	1			+=	<del> </del>	+
	<u>L</u>							1 /	1	
	Able to perform ADL's with	n (choose one):		243			A STATE OF THE STA	1	1	
Alterations in ADL's due to:	assistance							1 /	1	
ADL's due to: Bedrest	independently			$\vdash$	-		and the second s	1	1	
Sheath					1 7			+	<u> </u>	<u> </u>
Placement					1 /			1 1	1	
					1 /			1 1	1	
					1 /			1 1	1	
	To-mains from of blood, he		Ļ	1						
Sheath	Remains free of bleed, her bruit, signs and symptoms				1 '	Patient Safety	Remains injury free in a safe			
Access	ecchymosis	Of Infection,		1	1 1	Patient Salety	environment.		$\vdash$	-
Site					1_1			1 1	1 1	
							No evidence of skin breakdown.	-		
					1 1	Skin Integrity				
4					1 1					
	Will have (+) peripheral pu	ilses.	-				Patient/family verbalizes satisfaction	<del>     </del>		
Tissue	extremities warm bilateral;					Patient/Family	with hospital stay/care.	1	1 1	
Perfussion	(-) numbness / tingling				1	Satisfaction	mui mospital stayloare.	-	$\overline{}$	-
4			15,50		1 1				1	
5 11 15		INTERVE	NTIC	-	(co	ntinued on bac	:k)			
Patient Care			D	E	N	Patient Care		D	E	N
Categories	Assess acad for Discharge	Stanies I	$\vdash$	$\Box$		Categories				
	Assess need for Discharge Social Service based on nu		11		1		% of diet consumed:			
	assessment of home enviro					Nutrition	Breakfast% Lunch %			
	patient condition.						Dinner %			
	Insurance:			$\Box$	7		Encourage P.O. fluids	E1010(1)		
							imple Comme variation			
		na pri si te deservi								
							and the control of th			
						1				
							100 mm and and 100 mm		1	
Les bandonille		And an own or constitution of		455				1		

Patient Care	Post Procedure Day 1	D	E	N	Patient Care		D	E	N
Categories	Date:				Categories	The same of the sa			
	Monitor and record vital signs, distal					Assess patient/family satisfaction.			
Assessment	pulses, sheath access site every				Teaching				1
					, oddining	Encourage verbalization of fears /	$\vdash$		-
	15 mins. X 1 hr., every 30 mins. X 2 hrs.,				G G				
Treatments	every 1 hr. x 4 hrs. post procedure and				Psychosocial	concerns,			
l	post sheath removal.				1	Assess knowledge level and readiness		-	
l	[ & O q 8 hrs.	4.1				to learn.			
l	W					Inform patient of possible discharge in	$\vdash$		
1	* Telemetry #	_	-	-	Lancard Lance			0	
ĺ	Telemetry #				9711.05	a.m.	-	_	_
l						Provide patient with procedural and	1 1		
	* O <sub>2</sub> : 3 liters nasal cannula prn					educational materials.			
1	chest pain				T 3325	Instruct patient to maintain bedrest with			
37343%	Change sheath dressing PRN sterile				The same of the sa	alignment of limb.			
and the same of th	technique				1 2 (9)	Instruct patient to inform the RN of	$\vdash$		-
	teornique							·	
			_		15 00	numbness, tingling of leg and bleeding	1 1		
	MD notified of variances per protocol					from groin.			
	Yes No	WC110			1 ( 1	Instruct patient to notify RN if having			
					Lie danie in	chest discomfort or SOB			
	Arterial / venous sheath removed and				1 1 1		$\vdash$		
					1 1 1 4				
	documented in progress notes according				1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	The state of the s			
	to protocol					Langua cam emilitada della cal			
THE THE ASSESSMENT OF THE PERSONS	Notify MD of significant changes in vital				LE LINE CONTROL	The state of the s			
	signs, dimished distal pulses, persistant					THE RESERVE OF THE PARTY OF THE			
and the second	bleeding or hematoma > 2 cms.		900			GAR STEEL			
		-	-	-					
	Notify MD if ckmb > 8.					Linguist Control of the Control of t	1 1		- 1
	and the production of William Production of the Pro-						Ш		_
	Apply pressure dessing and additional					Lab / diagnostics results reviewed; MD			
The state of the state of the	manual pressure if bleeding or oozing			- 1	Specimens	notified if indicated.	1 1		- 1
	persists.	- 1			R	* Tests / Procedures	$\vdash$		
		$\overline{}$	-	_	Diagnostica		1 1		- 1
		- 1	- 1	- 1	Diagnostics	CBC 4 hours post	1 1	111	- 1
	@ cc/hr.	- 1		- 1		CKMB 8 hours post	1 1	- 1	- 1
	Discontinue @				and a second of the second	EKG stat post		200	- 1
	IV:								- 1
day be you who no	@cc/hr.								- 1
				- 1					- 1
	Discontinue @			_			1 1		- 1
		- 1	- 1	- 1					
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The first consider proplems				1		Annual Control of the			
	4. 1 (A. 1940) 1 (			- 1		Falls protocol initiated.		11.	
y week the grown			100	1	Safety				- 1
		- 1	- 1	- 1		* A ativity layed	<del>                                     </del>		$\dashv$
	1			- 1	&	* Activity level:			
	and the second s				Activity	Bedrest x hrs. after sheath			- 1
Table 1 Condition (1995 of the property	7.2%					removal			
Marchael Sanka, in classic	The state of the s			- 1		Assess need for functional evaluation			
27 7 7 4 4			100	- 1		by rehab.			
						Follow post interventional orders	<del></del>	1	$\dashv$
	Section (1990)(1990 (1990)(1990 (1990)(1990 (1990)(1990 (1990)(1990 (1990 (1990 (1990 (1990 (1990 (1990 (1990 (1990 (1990 (199			1				origon	ା
Particular School of the State	The state of the s	0.75				regarding activity			
and the same of the	ar 1000 - 1000 - 1					Hemostatis obtained @			- 1
	Hygiene & Comfort Protocol			$\neg$					- 1
		.				HOB limited to < 30 degress during bed	-		$\neg$
	Parinhard B/ Thansau Burtansi			$\dashv$					- 1
	Peripheral IV Therapy Protocol			- 1		rest period.	$\vdash$		
						Immobilize involved extremity for			- 1
.,	Pressure Ulcer Prevention Protocol					hrs.			1
Treatments ever poor living the living per l		Apply leg or arm immbilizer prn.							
	* Respiratory Care provided.		-+	$\dashv$			ļ I		- 1
				1		May apply condhea to consecute	$\vdash$		$\dashv$
P	(See Respiratory Care Record)		- 1	1		May apply sandbag to access site.			- 1

\* indicates medical orders needed

	Signature		Title	In	nitial		3 6	The same of the sa			
						-		DOWNERNE WOOD			
				-	_	-	700	TO Eline			
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				-	_	1		ADDRESSORBABLI			
			DES	IREL	0 01	JTC	OMES	D = DAYS E = EVENINGS N = NIG	HTS	;	
	Day 2			D	E	N	Problem/	Company of the control of the contro	D	Ε	N
Needs Date:  Patient/family verbalizes understanding of diagnosis and plan of care, participates in decision making.					Telemetry	Remains WNL for patient			_		
	TPain free or ve	malizes nain n	alief after				Mastable	Remains WNL for patient  Vital Signs stable for patient.  Patient awake, alert and oriented.  Hemodynamic status stable for patient.  Remains injury free in a safe environment.  No evidence of skin breakdown.  prity  Patient/family verbalizes satisfaction with hospital stay/care.  Patient/family verbalizes satisfaction with hospital stay/care.  D E / Sare ies D E / Sare ies D D D E / Sare ies D D D D D D D D D D D D D D D D D D D	_		
Pain Management	intervention.					1	Vital Signs	Patient awake, alert and oriented.	patient DEN  atient DEN  r patient.  and oriented.  s stable for patient.  n a safe  breakdown.  Zees satisfaction ee.  DEN  DEN  DEN  A		
management	Day 2   Date:   D E N   Problem/ Needs   Patient/family verbalizes understanding of diagnosis and plan of care, participates in diagnosis and plan of care, participates in decision making.   Vital Signs stable for patient	Hemodynamic status stable for patient.	-	$\vdash$	+						
	1	Maria Caranta			Service Servic						
Alterations in ADL's due to:	assista indepe	ance endently	000		(self)						
Sheath Access Site	ecchymosis, sig						Patient Safety				
Needs  Knowledge Deficit related to plan of care  Pain Management  Alterations in ADL's due to:  Sheath Access Site  Tissue Perfussion  Patient Care Categories							Skin Integrity	No evidence of skin breakdown.			
	affected extremi	ity warm bilater									
			INTERVE	NTIC		(co	The Real Property lies and the least lies and the lies and the least lies and the lies and the least lies and the lies and t	:k)			
			-	D	E	N			D	Ε	N
	Patient will be di	scharged in a.	m.	$\top$	1	$\forall$		* Diet:		$\dashv$	
								Breakfast% Lunch % Dinner % Encourage P.O fluids			

Coronary Catheterization\_Interventional

Patient Care	Day 2	_	_	_	S (continued)		15		_
		D	E	N	Patient Care	The last of the la	D	E	1
Categories	Date:				Categories				
Assessment	Vital signs q hrs. as per post interventional orders				Teaching	Assess patient/family satisfaction.		-,1	Γ
&	I & O q hrs.				8	Encourage verbalization of fears /	1	$\vdash$	r
Treatments	* Tolomoto	-	_	_	Psychosocial	concerns.			L
	* Telemetry		-	-		Discharge teaching completed, see discharge summary	1		
	* O <sub>2</sub> :	$\top$				and the same of th			r
	Change sheath dressing prn sterile	+	-						
	tech					and the second s	-		l
	Final groin assessment and dressing	+			EG GENTER				ľ
	change done prior to discharge and documented		3				100		
	Discontinue PIID with catheter intact					Let a work to the box of the Park State		e A	
		$\vdash$		Н		The second secon			
		1000	LVC 0		parameter - 100 to 100 Miles				
	The same of the sa		52A 52A						
	5 Year 180 Y					1 71 1 1 2 1 4 1			
	The second secon		51533			Lab / diagnostics results reviewed; MD	+		
					Specimens &	notified if indicated. * Tests / Procedures	$\perp$		-
					Diagnostics	CBC a.m.	-	5794	
- 0				4		EKG a.m.			
-	and the second control of the programmer and the second control of		n siri						
					acceptance of the second		-		
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				-		The second secon	- 1	100	
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			0.01		Safety	Falls protocol maintained.			
					&	* Activity level:			
					Activity	Ambulatory ad lib			
TOTAL					N N N				
						the state of proposition and the second of	e co		
	Husiana & Camfart Protocal			$\perp$					
	Hygiene & Comfort Protocol								
	Peripheral IV Therapy Protocol								
	Pressure Ulcer Prevention Protocol								
	* Respiratory Care provided. (See Respiratory Care Record)								