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

CABG Uncomplicated	LIMA:	OR Date:
ESTIMATED LOS: 5 Days	Date placed on ma	pp:
EXCLUSIONARY CRITERIA: 1. EF < 20% 2. Second Reop (3rd Surgery) 3. Valve surgery	5. And 6. Car 7. Sev	nal Failure: Dialysis pre-op or CR>2.8 eurysm diogenic shock: CI < 2.0 on inotropes ere COPD/Pre-op ABG reveals any of the following 02 < 60 or SAT < 92% on Room Air/PaCO2 > 50.
CRITERIA FOR REMOVING PATIENTS FROM (Switch to Generic Cardiac Surgery Caremap) 1. > 2 systems failed (including cardiac) 2. CVA (not wake up > 48 post-op)	3. CI	2.0 x 4 days at dependency x 5 days
Primary Diagnosis/Procedure:		
Pertinent Past Medical History:		
Allergies:		
Pre-op Medications:		
Significant Pre-op Lab Work:		
CONSULTS OR DISCIPLINES INVOLVED/NO. 1	Initials Initials Initials Initials	/Date/Time notified:/ /Date/Time notified:/ /Date/Time notified:/ /Date/Time notified:/ /Date/Time notified:/
RN Signature:		Date/Time:
RN Signature:		Date/Time:

Supplemental Documentation is required on the Progress Record / Patient Focus Notes when an outcome or intervention is initialed and circled, indicating it was not met or completed as stated.

- Initial and circle, if not met or completed

- Use notation N/A, if not applicable for the timeframe

Initial when met or completed

Instructions for Documentation: OUTCOMES/INTERVENTIONS:

<u>COURSE/SIGNIFICANT E</u> Admission:					
OD #1:					
-OD #2:			20 - 17 (Sec. 1)		est f
					10.0
POD #3:					8.4
POD #4:				nga di Verana -	
r - yangu Li manifek dari ke Late da					
-OD #5					1100
POD #6:					
POD #7:				- solve programmer, pol	
-OD #1.				(*************************************	:fyJ
					: 44
OTHER:					. 25
RANSFER SUMMARY:					300 0
Invasive Lines		Site	Date In	Removed	
Swan					
DLC					
Aline				2 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	
PIID (HL) Size:				New Site/Date :	
Chest Tubes					
oley	183833			Void:	
_		Av	V		
Pacer Used:					
Other:			- h W -	II/DC	
ast Medicated: Other:				WBC H/H	
CULTURES	8 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -				
Site	Date			Results	
RN Signature:			riberii - 15 L 17 edilir		

Univerity Medical Center CABG Uncomplicated - Cover - back

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ADDRESSOGRAPH DESIRED OUTCOMES D = DAYS E = EVENINGS N = NIGHTSProblem/ Day of Surgery Problem/ D EN E Date: Needs Needs Patient/family verbalizes understanding of Moves all extremities well upon command. Knowledge anticipated plan of care and participates Mobility Deficit related in decision making. to plan of care Patient/family verbalizes decreased anxiety with ICU environment. Pain free or verbalizes relief after Urinary output > 30 cc/hr. intervention. Pain Fluid and Management Electrolytes Labs within therapeutic range. Diet Cardiac Index >= Decreased Tissue Stable HR: Perfusion Dressing dry & intact. Potential For Remains injury free in a safe Infection Glucose <=200 Patient Safety environment. No evidence of skin breakdown. Extubated < = 8 hrs. Skin Integrity Impaired Gas Exchange Denies shortness of breath. Patient/family verbalizes satisfaction with Patient/Family hospital stay/care. Satisfaction INTERVENTIONS (continued on back) Patient Care Patient Care EN D EN Categories Categories Cardiac Surgery nurse contacts NPO while intubated. Discharge Planning / Social Services (if Discharge NGT/OGT as per unit standard. Nutrition problems anticipated). D/C NGT/OGT after extubation. Ice chips, progress clear liquid as tolerated. High risk nutritional assessment completed.

Patient Care	Day of Surgery	10	E	A	S (continued)		To	E	T A/
Categories	Day of Surgery Date:	10	=	"	Patient Care Categories	378	10	=	1"
Categories	* VS, Hemodynamic monitoring,	├	⊢	⊢	Categories	Encourage verbalization of fears /	+	-	╀
Assessment	assessments, I/O, chest tube				Teaching	concerns.	1		1
233033mem &	management, invasive line care and	1			R	Assess patient / family satisfaction.	+-	\vdash	₩
Treatments	wound care as per unit standard.	1	l		Psychosocial	Assess patient / farmly satisfaction.			-
rreadments	* - Autotransfusion	-	\vdash	\vdash	- sychosocial	Learning needs / teaching plan:	+	-	╆
	- Cardiac infusions - titrated according					- ICU routine and enviornment.			
	to parameters (see flow sheet).			1		- Expected post-op course.			
	* Pacing set for:	-	├	⊢	-	- Current status.			
									1
		-	├-	-	-	- Cough & deep breathing.			1
	* Re-warm patient as per unit standard.					- Incentive spirometry use.		ĺ	1
* 57.56	A	-	├—	├-	-	- Splinting.			1
	Assess need for Demerol IVSS for				1000	- Pain management.			1
	shivering.	-	_	_	4	- Other:			1
	Evaluate need for pre-op meds.						-		┺
		_	<u> </u>	_		Given family information book.			1
	Assess comfort as per unit standards.						-	_	1
		_	_		1	Orient patient when appropriate.			
	* Administer blood and fluid products as							_	1
	per unit standard.				1				
	* Monitor respiratory status as per unit				F .				
	and respiratory department standards.]	1 / 2 / 2 / 2 / 3 / 4 / 2 / 2 / 3 / 3 / 3 / 3 / 3 / 3 / 3 / 3	-	100	
	* Pulmonary toilet as per unit standard.					1 700 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
	Respiratory support (see flow sheet).								
	Assess need for additional respiratory	1			1			1	
	care.				1				
	* Pre-Extubation:					Lab / diagnostics results reviewed; MD	T		T
	Draw initial ABG (RT/RN). Monitor				Specimens	notified if indicated.			
	patient vent system as per unit standard			l	&	* CBC, SMA7, PT, PTT, ABG, MVBG,		-	\vdash
	of care for CS patient.				Diagnostics	Mg on adm.			١.
	* Begin weaning when indicated as per				1	* BS monitoring as ordered:	+	_	_
	unit standard.								1
	* Extubate as per unit standard.	_	Г	Γ	1				
	Entodate de per dini didiredia.				1	* K+, CBC, ABG, PRN.	1	-	\vdash
		-	_	-	1	* CPK-MB 15 hrs. post-op:	+	-	+
						Time:		ı	1
				1		* 12 lead ECG on admission & in a.m./			1
				l		only if patient not AV paced.			
						* CXR on admission (if not done in OR).	+-	-	+
						CAR on admission (if not done in OR).			
						* Tests / Procedures	+		+
		[1		Tests / Procedures			
									1
									\perp
				l					1
	and the second s	-				Falls protocol initiated.	0.50		
					Safety	N. C. J. W			
					&	* Complete bed bath after 6 hr. if stable.			
					Activity				
						* OOB to dangle and to chair, if	T		
						hemodynamically stable.	31,35		
						All alarms and parameters set.			T
	Hygiene & Comfort Protocol	\vdash	\vdash		1	Call bell within reach.			1
	I Trygicile & Commont Flotoco					The state of the s	+	_	\vdash
	Peripheral IV Therapy Protocol	-		-	1				
	Peripheral IV Therapy Protocol								1
	Denouse I llear Descention Destacel	-	\vdash	-	1				
	Pressure Ulcer Prevention Protocol			1					
	* D	-	-	-	1				
	* Respiratory Care provided.				l				
	(See Respiratory Care Record)								
	I	1	1	1			1		

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ADDRESSOGRAPH DESIRED OUTCOMES D = DAYS E = EVENINGS N = NIGHTSPOD #1 Problem/ E N Problem/ $D \mid E \mid N$ Needs Date: Needs Patient/family verbalizes understanding of Transfer to 4 West (SDU) Knowledge anticipated plan of care and participates Mobility Deficit related in decision making. OOB to chair. to plan of care Patient/family verbalizes decreased anxiety with ICU environment & transfer to 4 West Stepdown Unit. Pain free or verbalizes relief after Urinary output > 30 cc/hr. Pain intervention. Fluid and Management Electrolytes Labs within therapeutic range. Diet Tolerating clear liquids. Stable CI off infusions. Decreased Tissue Perfusion Central and arterial lines removed. Potential For Remains injury free in a safe Infection Glucose <=200 Patient Safety environment. No evidence of skin breakdown. Denies shortness of breath. Skin Integrity Impaired Gas Exchange No wheezing / stridor. Patient/family verbalizes satisfaction with Incentive spirometry > 500 or: Patient/Family hospital stay/care. Satisfaction INTERVENTIONS (continued on back) Patient Care D E N Patient Care D EN Categories Categories Evaluate need for special Discharge Clear liquids and advance diet to 2 gm Discharge Planning. Referral to Discharge Planning/ Nutrition Na low chol diet, or: Plan Social Services if appropriate. % of diet consumed: Breakfast Lunch Dinner

Patient Care	POD #1	D	E	N	Patient Care	T T	ID	E	N
Categories	Date:	1	-	Ι"	Categories			-	1"
	* VS, Hemodynamic monitoring,	\vdash	\vdash			Encourage verbalization of fears /	\vdash		
Assessment	assessments, I/O, chest tube		1	1	Teaching	concerns.			
&	management, invasive line care and				8	Assess patient / family satisfaction.			Г
Treatments	wound care as per unit standard.		<u></u>	_	Psychosocial				
	* Wean cardiac infusions (see flow					Learning needs / teaching plan:			Г
	sheet).	_				- ICU enviornment and equipment.			
	* D/C central access and KVO infusion	1			1	- Expected post-op course.			
	and insert peripheral line.	_			l	- Current status.			
	* D/C swan	1			1	- Cough & deep breathing.			
	A DIO Alliano di Li Alliano di	-				- Incentive spirometry use.			
	* D/C Aline, consider radial Aline if	1			1	- Splinting.			
	arterial monitoring continues.	-				- Pain management.			
	* Cap pacing wires if rhythm stable > 24 hrs.					- Activity progression Other:			
	* D/C chest tubes. Time:	-			1	- Other.			
	Occlusive dressing x 24 hrs.				1				
	Obtain CXR after removal of pleural				1		+	-	\vdash
	chest tubes.								
	* D/C Foley, call MD if no void in 8 hrs.	-			1				1
	Removal time:								
	* Remove initial sternal / leg dsg.		_		1				
	Time:	1			1				
	Assess comfort as per unit standard &			Г	1			1	
	evaluate need for pain med.								
	* Transfer to 4 West.		1		1				
					-	Lab / diagnostics results reviewed; MD	T T		
	* Pulmonary toilet as per unit standard.				Specimens	notified if indicated.			
	Respiratory support (see flow	1	l		&	* EKG, SMA-7, CBC, PLTs, CPK-MB,	-		
	sheet).				Diagnostics	Triponin, Stat.			
	Assess need for additional respiratory					* BS monitoring as ordered:			
	care.			_					
	Incentive Spirometry q 1 hr. while awake.							_	<u>_</u>
			<u> </u>	_	l	* K+ and CBC 12 p & 8 p.			
		1	l		l	* Tools / Dropp dures	-		-
		l				* Tests / Procedures			
					1, 1		1		
					1				
		1	1				1		
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		1	1						
				l	l				
					1				
		1	1			Falls protocol maintained.			
		1	1		Safety		_		
		1	1	l	&	Notify PMR for PT evaluation to be			
		-	1	1	Activity	completed on Day 2.	-	_	_
		1			1	* Assist with turning and bathing as			
		1	1	1	I	needed.	+	-	-
				1		* After dangling, OOB to chair x 2 (keep			
						feet elevated as much as possible).	+	-	\vdash
					I	All alarms and parameters set. Call bell within reach.			
	Hygiene & Comfort Protocol	-	-	-	1	Can ben within reach.	+-	-	1
	Hygiene & Comon Protocol	1	1	1					
	Peripheral IV Therapy Protocol	\vdash	\vdash	-	ł				1
	respire at the tapy Flotocol				1				
	Pressure Ulcer Prevention Protocol	\vdash	\vdash	\vdash	1				1
	1 1633016 Older Flevention Frotocol				l				
	* Respiratory Care provided.	1	1	1	1				
	(See Respiratory Care Record)				1	1			
	(555 : 155)				1				
11-2	iversity Medical Center	_	* ir	ndice	tes medical orders	needed			

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ADDRESSOGRAPH DESIRED OUTCOMES D = DAYS E = EVENINGS N = NIGHTSProblem/ POD #2 E N Problem/ DEN Needs Needs Date: Patient/family verbalizes understanding of Patient ambulating 40 ft. with or without Mobility assistive device. Requires no more Knowledge anticipated plan of care and participates Deficit related in decision making. Aware of pending than assist of 1 to transfer OOB. to plan of care discharge. Pain free or verbalizes relief after Urinary output > 720 cc in 24 hrs. Fluid and Pain intervention. Comfortable on PO pain medication. Electrolytes Labs within therapeutic range. Management Diet Advance to solid diet. Stable rhythm (asymptomatic) Decreased Tissue Perfusion Chest tube, foley and all dressings Potential For removed. Remains injury free in a safe Infection Patient Safety environment. No evidence of skin breakdown. O2 needed for activity only Skin Integrity Impaired Gas Exchange Incentive spirometry > 750-1000 or: Patient/family verbalizes satisfaction with Patient/Family hospital stay/care. Satisfaction INTERVENTIONS (continued on back) Patient Care D E Patient Care Ν DEN Categories Categories Evaluate need for special Discharge 'Advance diet to 2 gm Na low chol diet, Planning. Referral to Discharge Planning/ Discharge Nutrition or: Social Services if appropriate. % of diet consumed: Breakfast _ Lunch _ Dinner

	POD #2	D	E	N	Patient Care	3857	D	Ε	N
Categories	Date:				Categories				
	* VS, Hemodynamic monitoring,					Encourage verbalization of fears /			
Assessment	assessments, I/O, chest tube				Teaching	concerns.			
&	management, invasive line care and					Assess patient / family satisfaction.			
Treatments	wound care as per unit standard.				Psychosocial				
	* Assess comfort as per unit standard.					Learning needs / teaching plan:			
	Evaluate need for laxatives and pain					- Cough & deep breathing.			
	meds.					- Insentive Spirometry.			
	* D/C chest tubes. Time:					7			
	Occlusive dressing x 24 hrs.								
	Obtain CXR after removal of pleural								
	chest tubes.					., , .			
	* D/C Foley, call MD is no void in 8 hrs.								
	Time:								
	* Cap pacing wires if rhythm stable					- Other:			
	> 24 hrs.			_			\vdash	_	ш
	* Removal of initial sternal/leg dsg. (P/S).								
	Time:	_		-					
	* Pulmonary toilet as per unit standard.								
	Respiratory support (see flow								
	sheet).		_	-					
	Assess need for additional respiratory				1.11 1.11 1.11				
	Incentive Spirometry a 1 hr while awake			\vdash					
	Incentive Spirometry q 1 hr. while awake.								
		_		-					
						Lab / diagnostics results reviewed: MD		-	-
					Specimens	-			
					&		\vdash		\vdash
					Diagnostics				
		Teaching & Psychosocial Psychosocial Learning needs / teaching plan: - Cough & deep breathing Insentive Spirometry Activity progression Incision care Signs / symptoms of infection Medications: action, purpose, side effects, dose, frequency Pain management Other: Lab / diagnostics results reviewed; MD notified if indicated. CBC, SMA7 in am. BS monitoring as ordered: Follow-up on post-op CPK-MB results Tests / Procedures Falls protocol maintained. PMR to complete PT evaluation.	* BS monitoring as ordered:						
, ,									
						* Follow-up on post-op CPK-MB results.			
1									
						* Tests / Procedures			
2									
								_	-
· . · · · · · · · · · · · · · · · · · ·									
						Falls protocol maintained			
					Safetv				
						PMR to complete PT evaluation.	\vdash		
						* OOB TID (feel elevated, when possible)			
						and ambulate width of room BID. BRP			
						and bathe with assist.			
					, ,	All alarms and parameters set.			
						Call bell within reach.			
	Hygiene & Comfort Protocol								
	Peripheral IV Therapy Protocol								
	Drangura I lices Desugation Destacet			\vdash					
	Pressure Ulcer Prevention Protocol								
-	* Respiratory Care provided.	_		\vdash					
	(See Respiratory Care Record)								
	(Jee Nespiratory Care Nessolu)								

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ADDRESSOGRAPH D = DAYS E = EVENINGS N = NIGHTSDESIRED OUTCOMES DE POD #3 E N Problem/ Problem/ Needs Needs Date: Patient ambulating 40 ft. with or without Patient/family verbalizes understanding of assistive device. Requires no more Mobility anticipated plan of care and participates Knowledge than assist of 1 to transfer OOB. Deficit related in decision making. Walks 3-4 min. with assistance TID. to plan of care I & O balance achieved. Pain free or verbalizes relief after Fluid and Pain intervention. Tolerates > 50% of diet. Electrolytes Comfortable on PO pain medication. Management Diet Stable rhythm (asymptomatic) Decreased Tissue Perfusion WBC returned to normal range. Potential For Remains injury free in a safe Infection Wounds without drainage. Patient Safety environment. Afebrile. No evidence of skin breakdown. Tolerates activity progression without Skin Integrity need for O2. Impaired Gas Incentive spirometry = or > 1000 or: Exchange Patient/family verbalizes satisfaction with Patient/Family hospital stay/care. Satisfaction INTERVENTIONS (continued on back) EN Patient Care Patient Care $D \mid E \mid N$ Categories Categories 2 gm Na low chol diet, or: Nutrition Discharge Plan % of diet consumed: Breakfast ____ Lunch ____ Dinner ____ If consuming < 50% or specialty diet needed, notify dietitian.

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ADDRESSOGRAPH D = DAYS E = EVENINGS N = NIGHTSDESIRED OUTCOMES DE POD #3 E N Problem/ Problem/ Needs Needs Date: Patient ambulating 40 ft. with or without Patient/family verbalizes understanding of assistive device. Requires no more Mobility anticipated plan of care and participates Knowledge than assist of 1 to transfer OOB. Deficit related in decision making. Walks 3-4 min. with assistance TID. to plan of care I & O balance achieved. Pain free or verbalizes relief after Fluid and Pain intervention. Tolerates > 50% of diet. Electrolytes Comfortable on PO pain medication. Management Diet Stable rhythm (asymptomatic) Decreased Tissue Perfusion WBC returned to normal range. Potential For Remains injury free in a safe Infection Wounds without drainage. Patient Safety environment. Afebrile. No evidence of skin breakdown. Tolerates activity progression without Skin Integrity need for O2. Impaired Gas Incentive spirometry = or > 1000 or: Exchange Patient/family verbalizes satisfaction with Patient/Family hospital stay/care. Satisfaction INTERVENTIONS (continued on back) EN Patient Care Patient Care $D \mid E \mid N$ Categories Categories 2 gm Na low chol diet, or: Nutrition Discharge Plan % of diet consumed: Breakfast ____ Lunch ____ Dinner ____ If consuming < 50% or specialty diet needed, notify dietitian.

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Signature Requiring Co-Signature	Date/Shift	Initial/	Title

ADDRESSOGRAPH **DESIRED OUTCOMES** D = DAYS E = EVENINGS N = NIGHTSPOD #4 Problem/ Problem/ E N EN Needs Needs Date: Patient / family verbalizes questions / Ambulates independently, performs Mobility ADL's, begins stairs. Knowledge concerns about discharge. Patient ambulating 100 ft. Able to go Deficit related Dietary instructions complete. up and down stairs. OOB independently. to plan of care Pain free or verbalizes relief after Weight within 2 lbs. of pre-op; no edema. Pain intervention. Fluid and Tolerates > 50% of diet. Management Electrolytes Diet Stable rhythm > 24 hrs. & requires no Decreased further cardiac monitoring. Tissue Perfusion Pacing wires removed. Wounds without Potential For drainage or redness. Remains injury free in a safe Infection Afebrile. Patient Safety environment. No evidence of skin breakdown. Denies SOB with activity progression Skin Integrity Impaired Gas and without O2. Incentive spirometry = or > 1000 or: Exchange Patient/family verbalizes satisfaction with Patient/Family hospital stay/care. Satisfaction INTERVENTIONS (continued on back) Patient Care E Patient Care DEN Categories Categories Discharge assessment / plans complete 2 gm Na low chol diet, or: Discharge by Discharge Planner. Nutrition Referral to appropriate facility as needed Plan by Social Worker. % of diet consumed: Breakfast _____ Lunch Dinner __

Patient Care	POD #4	D	E	N	Patient Care		In	F	M
Categories	Date:	0	=	"	Categories		1	-	"
Categories	* VS, assessments, I/O, invasive		-		Categories	Encourage verbalization of fears /	+-		-
Assessment	line care and wound care as per unit				Teaching	concerns.			
&	standard.				8	Assess patient / family satisfaction.	+	\vdash	\vdash
Treatments	* Evaluate need for continued telemetry		\vdash		Psychosocial	The state of the s			
	and discontinue if possible.				,	Discharge instructions in progress.			\vdash
	Discontinue peripheral line if telemetry					Reinforce all previous teachings.			1
	discontinued.					- When to call MD.			
	* Assess comfort as per unit standard.					- Review medications.			
	Evaluate need for laxatives and pain					- Incision care, signs / symptoms of			
	meds.					infection.			
_	* Pacing wires removed as per unit					- Give discharge booklet.			1
	standard.				4 4	- Activity / exercise: lifting, driving,			1
	* D/C O ₂ if not already done.					socializing, ADL's, sexual activity &			
						limitations.			1
	* If still on nebulizer treatments, evaluate					- Reinforce dietary teaching.			1
	need to continue.					- Risk factors, stress management.			1
	* Pulmonary toilet as per unit standard.								
	Respiratory support (see flow				l				
	sheet).				l				
-	Assess need for additional respiratory				l				
	care.								
	D/C I & O 48 hrs. out of ICU (if not done).				1				
	4								
	Incentive Spirometry q 1 hr. while awake.								
						Lab / diagnostics results reviewed; MD	T		Г
					Specimens	notified if indicated.			
					8	* BS monitoring as ordered:			\vdash
					Diagnostics				1
						* Tests / Procedures			
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					L				
			1			Falls protocol maintained.	T		
					Safety				
					&	Keep feel elevated when in chair. Walk			
					Activity	150 ft. in the hallway without assistance			
			1			TID.			
						Begin stairs.		1	
			1		l	Bathe independently.			
		1			1	All alarms and parameters set.			
					l	Call bell within reach.			
			1		l		T	1	Г
	Hygiene & Comfort Protocol		\vdash		1			1	
	Peripheral IV Therapy Protocol			_	1			1	
	I subustant triangly transact	1			l				
	1								
	Pressure Ulcer Prevention Protocol		\vdash		1		1		
	Pressure Ulcer Prevention Protocol		Г		1				
	* Respiratory Care provided. (See Respiratory Care Record)								

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ESIRED OUTCOMES	D = DAYS	E = EVENINGS	N

	DES	IREL	OU	ITC	OMES	D = DAYS E = EVENINGS N = NIG	HTS		
Problem/	POD #5 - Discharge Day	D	E	N	Problem/		D	E	N
Needs	Date:	╀	┞		Needs		_	_	<u> </u>
Vacudadaa	Patient/family verbalizes questions /				Makilla	Patient ambulating 100 ft. Able to go			
Knowledge	concerns of discharge, home care,		1		Mobility	up and down stairs. OOB independently.	-	-	⊢
Deficit related	post-op follow-up care and dietary				1				
to plan of care	instructions.	-	-	_					
					l				
					1				
	Pain free or verbalizes relief after	╁				Weight within 2 lbs. of Pre-op; no edema.	-	_	⊢
Pain Management	intervention.				Fluid and		1		
	_				Electrolytes	Labs within therapeutic range.			
					Diet				
						Tolerates > 50% of diet.			
							_	_	╙
	Stable hemodynamics (VSS, rhythm	+	_				1		
Decreased	stable, skin warm and dry).	1				Discharge		_	⊨
Tissue	oracio, oracio del prima d	+			Discharge	Districting			
Perfusion					Plan				
		<u> </u>			ļ				
D-44-1 F	Incisions intact without redness,								
Potential For		-		_					
Infection	remperature <= 100 F for > 24 hrs.				Patient Safety	environment.	_	_	-
		\vdash		-					
						INo evidence of skin breakdown.			-
	Lungs clear.	Ť			Skin Integrity				
Impaired Gas									
Exchange									
						Patient/family verbalizes satisfaction with			
	Incentive spirometry = or > 1000 or:				Patient/Family	hospital stay/care.			
		-			Satisfaction				
	INTERV	NTI	ONS	(co	ntinued on hac	(c)			_
Patient Care	1777		_	N			D	E	M
Categories		1	-	"			-	-	1"
	Discharge orders, instructions and	1			Jategories	2 gm Na low chol diet, or			-
Discharge	swelling or drainage. Temperature <= 100° F for > 24 hrs. Lungs clear. Denies SOB with activity progression and without O2. Incentive spirometry = or > 1000 or: INTERVENTIONS (continued on back) Patient Care Categories Discharge orders, instructions and prescriptions written. Referral to appropriate facility for home care as needed by Discharge Planner. Remains injury free in a safe environment. Repair In a safe environment.								
Plan	Referral to appropriate facility for home					· ·			
	care as needed by Discharge Planner.					% of diet consumed:			
						Breakfast%			
	appropriate facility.					Lunch %			
	Time:	_				Dinner %			
						Reinforce dietary instruction as needed.			
,									
						was a second of the second		4.5-17	
	• :	inata			orders needed				

Patient Care	POD #5 - Discharge Day	D	E	N	Patient Care		D	E	N
Categories	Date:	آ	-	"	Categories			-	"
	* VS, assessments, I/O, invasive	\vdash		\neg		Encourage verbalization of fears /			
Assessment	line care and wound care as per unit				Teaching	concerns.			
&	standard.				&	Assess patient / family satisfaction.			
Treatments	D/C telemetry and peripheral line (if not				Psychosocial				
l	already done).					Discharge instructions in progress.			
l	* Assess comfort as per unit standard.					Reinforce all previous teachings.			\perp
l	Evaluate need for laxatives and pain		1			Follow-up appointment & emergency			
1	meds.		_			contact given by nursing:			
l	* Pulmonary toilet as per unit standard.					- When to call MD.			
	Respiratory support (see flow	1				- Ensure discharge booklet given.			
	sheet). Assess need for additional respiratory	-	-	-		- Activity / exercise: lifting, driving, socializing, sexual activity & limitations.			
	care.					- Risk factors, stress management.			
	D/C I & O 48 hrs. out of ICU (if not done).	-		\vdash		- Pulse taking.			
	bio i di o 40 ma. odi di 100 (ii noi done).	1				- Information about cardiac rehabilitation			
	Incentive Spirometry q 1 hr. while awake.	_		\vdash		program.			
I	The state of the s	1				Provide reassurance to patient / family			Т
1				\vdash		regarding going home.			1
		1				regarding going frome.	_	_	+-
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I						Lab / diagnostics results reviewed; MD			T
l					Specimens	notified if indicated.			
					&	* Tests / Procedures			T
1					Diagnostics				
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I						Falls protocol maintained.			十
I					Safety	- Sile processing in the internal			
I	1.				8	Ambulate independently with stairs.	_	\vdash	1
					Activity	Able to walk 200 ft.			
1						Perform ADL's independently.			
						Bathe independently.			
						All alarms and parameters set.			
						Call bell within reach.			
			1						
1					1			1	
	Hygiene & Comfort Protocol	_	\top		1				
	1				l				
1	Peripheral IV Therapy Protocol	\vdash			1				
	, cipilota i i inciap, i iodo			1			1		
	Pressure Ulcer Prevention Protocol	\vdash	1	1	1				
I					l				
1	* Respiratory Care provided.		\top	1	1				
1	(See Respiratory Care Record)	1			l				
	ivorcity Medical Center	-	* 10	odica	tes medical orders	c pooded		-	