Document on 6/22/2018 1:00 PM by Marissa Gamble: AVS - Large Print (below)

AFTER VISIT SUMMARY

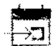
Eugene G. Maurice DoB: 1/2/1949

6/22/2018

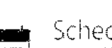
WellStar Paulding Hospital (PH EMERGENCY) 470-644-7170

Instructions

Read the attached information
Epistaxis (Adult) (English)



Schedule an appointment with Jeffrey L Tharp, MD as soon as possible for a visit in 2 days (around 6/24/2018)
Specialty: Internal Medicine
Contact: 176 Charles Hardy Parkway
Unit C
Hiram GA 30141
678-945-8200



Schedule an appointment with Timothy P Ryan Jr., MD as soon as possible for a visit in 2 days (around 6/24/2018)
Specialty: Otolaryngology
Contact: 6002 Professional Parkway
Suite 100
Douglasville GA 30134-5603
770-949-4200

Today's Visit

You were seen by Kevin D Little, MD

Reason for Visit
Epistaxis

Diagnosis
Epistaxis

Today's Visit (continued)

Medications Given

oxymetazoline (AFRIN) last given at 12:04 PM

Your End of Visit Vitals

Blood Pressure	Temperature	Pulse
160/75	96.6 °F	82
Respiration	**Oxygen Saturation**	
17	100%	

What's Next

JUN 25 2018 — New Patient Appointment with Matthew L Estes, NP
Monday June 25 8:45 AM (Arrive by 8:30 AM)
WellStar ENT Hiram
148 Bill Carruth Parkway
Suite 220
HIRAM GA 30141-3756
770-505-0023

JUN 26 2018 — Follow Up Appointment with Abdul M Sheikh, MD
Tuesday June 26 3:00 PM (Arrive by 2:45 PM)
WellStar Cardiovascular Medicine Hiram
144 Bill Carruth Parkway STE 4200
HIRAM GA 30141-3749
678-324-4444

AUG 21 2018 — Follow Up Appointment with Beau N Dusseault, MD
Tuesday August 21 9:15 AM (Arrive by 9:00 AM)
WellStar Urology Hiram
144 Bill Carruth Pkwy
Suite 2300
Hiram GA 30141-3821
770-428-4475

For further follow up if needed, please call Wellstar doctor referral line at 770-956-7827.

You are allergic to the following

No active allergies

If you have any questions about this medication list, please talk to your doctor at your next appointment. You may use this form to make notes about any medications that

you have stopped or started taking, including over the counter medications. Bring the form with you to the appointment as a reminder to discuss with your doctor.

MyChart

View your After Visit Summary and more online at https://mychart.wellstar.org/mychart/.

Changes to Your Medication List

CONTINUE taking these medications

Medication	Instructions
CONTINUE **apixaban** 5 mg tablet Commonly known as: ELIQUIS	Take 1 tablet (5 mg total) by mouth 2 (two) times a day
CONTINUE **atorvastatin** 80 MG tablet Commonly known as: LIPITOR	Take 1 tablet (80 mg total) by mouth nightly
CONTINUE * **blood sugar diagnostic** strip Commonly known as: glucose blood	cvs true test blood glucose strip; test blood sugar ac breakfast and then once more daily as needed..
CONTINUE * **blood sugar diagnostic** strip	True metrix - test blood sugar ac breakfast and then once more daily as needed.. Dx E11.9
CONTINUE **ferrous sulfate** 324 mg (65 mg iron) Tbec	Take 1 tablet (324 mg total) by mouth 2 (two) times a day with meals
CONTINUE **furosemide** 20 MG tablet Commonly known as: LASIX	Take 1 tablet (20 mg total) by mouth every other day
CONTINUE **isosorbide mononitrate** 30 MG 24 hr tablet Commonly known as: IMDUR	Take 2 tablets (60 mg total) by mouth 2 (two) times a day
CONTINUE **metFORMIN** 500 MG tablet Commonly known as: GLUCOPHAGE	2 tablets po in am and 2 in pm
CONTINUE **nitroglycerin** 0.4 MG SL tablet Commonly known as: NITROSTAT	Place 1 tablet (0.4 mg total) under the tongue every 5 (five) minutes as needed for chest pain

Changes to Your Medication List (continued)

CONTINUE taking these medications (continued)

oxymetazoline 0.05 % nasal spray
Commonly known as: AFRIN

2 sprays by Nasal route 2 (two) times a day as needed (nose bleed)

pantoprazole 40 MG EC tablet
Commonly known as: PROTONIX

Take 1 tablet (40 mg total) by mouth 2 (two) times a day before meals

sotalol 80 MG tablet
Commonly known as: BETAPACE

Take 0.5 tablets (40 mg total) by mouth 2 (two) times a day

VITAMIN B12 ORAL

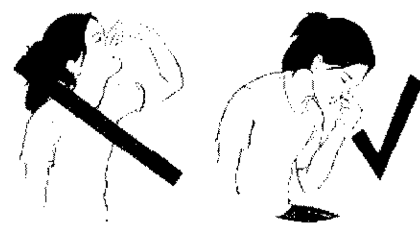
Take 1 tablet by mouth daily

*** DUPLICATE WARNING: This list has medications that are the same as other medications prescribed for you. Read the directions carefully, and ask your doctor or other care provider to review them with you.**

Attached Information

Epistaxis (Adult) (English)

Nosebleed (Adult)



Bleeding from the nose most commonly occurs because of injury or drying and cracking of the inner lining of the nose. Most nosebleeds are because of dry air or nose-picking. They can occur during a common cold or an allergy attack. They can also occur on a very hot day, or from dry air in the winter.

If the bleeding site is found, it may be cauterized. This means it is treated to cause a blood clot to form. This may be done with a chemical, heat, or electricity. If the bleeding continues after the site is cauterized, or if the site cannot be found, packing may be put in your nose. This is to apply pressure and stop the bleeding. The packing may be made of gauze or sponge. A small balloon catheter is sometimes used. These must be removed by your healthcare provider. Some types of packing dissolve on their own. If you are taking blood thinning (anticoagulant) medicine, you may have a blood test.

Home care

- If packing was put in your nose, unless told otherwise, do not pull on it or try to remove it yourself. You will be given an appointment to have it removed. You may also have been given antibiotics to prevent a sinus infection. If so, finish all of the medicine.
- Don't blow your nose for 12 hours after the bleeding stops. This will allow a strong blood clot to form. Don't pick your nose. This may restart bleeding.
- Don't drink alcohol or hot liquids for the next 2 days. Alcohol or hot liquids in your mouth can dilate blood vessels in your nose. This can cause bleeding to start again.

- Don't take ibuprofen, naproxen, or medicines that contain aspirin. These thin the blood and may cause your nose to bleed. You may take acetaminophen for pain, unless another pain medicine was prescribed.
- If the bleeding starts again, sit up and lean forward to prevent swallowing blood. Pinch your nose tightly on both sides, as shown above, for 10 to 15 minutes. Time yourself. Don't release the pressure on your nose until 10 minutes is up. If bleeding does not stop, continue to pinch your nose and call your healthcare provider or return to this facility.
- If you have a cold, allergies, or dry nasal membranes, lubricate the nasal passages. Apply a small amount of petroleum jelly inside the nose with a cotton swab twice a day (morning and night).
- Don't overheat your home. This can dry the air and make your condition worse.
- Put a humidifier in the room where you sleep. This will add moisture to the air. Clean the humidifier as advised by the manufacturer.
- Use a saline nasal spray to keep nasal passages moist.
- Don't pick your nose. Keep fingernails trimmed to decrease risk of bleeds.
- Don't smoke.

Follow-up care

Follow up with your healthcare provider, or as advised. Nasal packing should be rechecked or removed within 2 to 3 days.

When to seek medical advice

Call your healthcare provider right away if any of these occur.

- You have another nosebleed that you cannot control
- Dizziness, weakness, or fainting
- You become tired or confused
- Fever of 100.4°F (38°C) or higher, or as directed by your healthcare provider
- Headache
- Sinus or facial pain
- Shortness of breath or trouble breathing

Date Last Reviewed: 11/1/2017

© 2000-2017 The StayWell Company, LLC. 800 Township Line Road, Yardley, PA 19067. All rights reserved. This information is not intended as a substitute for professional medical care. Always follow your healthcare professional's instructions.

Electronic signature on 6/22/2018 11:49 AM - 1 of 5 e-signatures recorded

Encounter-Level E-Signatures:

CMS IM for Patient Signature (E-Sig) - Received on 6/22/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for medicare & Medicaid Services
OMB Approval No. 0938-0692

AN IMPORTANT MESSAGE FORM MEDICARE ABOUT YOUR RIGHTS

AS A HOSPITAL INPATIENT, YOU HAVE THE RIGHT TO:
Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.

- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to KEPRO:
  1-844-455-8708
  KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609

YOUR MEDICARE DISCHARGE RIGHTS

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by KEPRO. This reviewer was hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
  - **If you want to appeal, you must contact KEPRO no later than your planned discharge date and before you leave the hospital.**
  - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- **Step by step instructions for calling the KEPRO and filing an appeal are on page 2.**

To speak with someone at the hospital about this notice, call (770) 443-7068.

Please sign and date here to show you received this notice and understand your rights.

Patient Name

E D m—— .

CMS-R-193 (approved 07/10)
WMG Cardiovascular Medicine Hiram
An Important Message from Medicare About Your Rights

STEPS TO APPEAL YOUR DISCHARGE

- **STEP 1:** You must contact the KEPRO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
  - Here is the contact information: 1-844-455-8708

All Scans (continued)

Encounter-Level E-Signatures: (continued)

KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609

- You can file a request for an appeal any day of the week. Once you speak to someone or leave a message, your appeal has begun.
- Ask the hospital if you need help contacting KEPRO.
- The name of this hospital is **WMG Cardiovascular Medicine Hiram 110042**

- **STEP 2:** You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.

- **STEP 3:** The KEPRO will ask for your opinion. You or your representative need to be available to speak with KEPRO, if requested. You or your representative may give KEPRO a written statement, but you are not required to do so.

- **STEP 4:** The KEPRO will review your medical records and other important information about your case.

- **STEP 5:** KEPRO will notify you of its decision within 1 day after it receives all necessary information.
  - If KEPRO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  - If KEPRO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after KEPRO notifies you of its decision.

IF YOU MISS THE DEADLINE TO APPEAL, YOU HAVE OTHER APPEAL RIGHTS:

- You can still ask the KEPRO or your plan (if you belong to one) for a review of your case:
  - If you have Original Medicare: Call the KEPRO listed above.
  - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.

- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.
Additional Information: I have received my second notice and understand my appeal rights.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0692. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the ime estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, ATTN: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, MD 21244-1850.

WMG Cardiovascular Medicine Hiram
An Important Message from Medicare
About Your Rights

Name: Eugene G Maurice
MRN: 561253820
HAR: 40001209006

All Scans (continued)

Encounter-Level E-Signatures: (continued)

ENCOUNTER

Patient Class:	OPS		Unit:	PH PRE/POST
Hospital Service:	General Surgery		Bed:	PH PRE POST Pool/PH PRE *
Admitting Provider:	Bruce P Crowley, Md		Referring Physician:	Crowley, Bruce P
Attending Provider:	Bruce p crowley	AD: N	Adm Diagnosis:	Nuclear sclerotic catara*
Admission Date:	4/3/2019		Admission Time:	0953

PATIENT

Name	Eugene George Maurice	Sex:	Male	DOB:	1/2/1949 (70 yrs)
Address:	61 SHOCKLEY WAY			Religion:	Catholic
City:	DALLAS GA 30157-8973			Race:	White or caucasian
County:	PAULDING				
Email Address:	Gene.maurice@sgmservice.*				
Primary Care Provider:	Jeffrey L Tharp, MD			Primary Phone:	678-910-2298

EMERGENCY CONTACT

Contact Name	Legal Guardian?	Relationship to Patient	Home Phone	Work Phone	Mobile Phone
1. Maurice,Shirley		Spouse	(678)398-9479		678-910-2476
2. *No Contact Specified*					678-910-2476

GUARANTOR

Guarantor:	MAURICE,EUGENE GEORGE	DOB:	1/2/1949
Address:	61 SHOCKLEY WAY	Sex:	Male
	DALLAS, GA 30157-8973	Home Phone:	678-398-9479
Relation to Patient:	Self	Work Phone:	
Guarantor ID:	123805	Mobile Phone:	678-910-2298

GUARANTOR EMPLOYER

Employer: Phone: Status: RETIRED

COVERAGE

PRIMARY INSURANCE

Payor:	COVENTRY ADVANTRA M*	Plan:	COVENTRY ADVANTRA /PPO
Group Number:	4916004101	Insurance Type:	INDEMNITY
Subscriber Name:	MAURICE,EUGENE GEOR*	Subscriber DOB:	01/02/1949
Coverage	P O BOX 7156 LONDON, KY 40742-7156	Subscriber ID:	80459609601
		Pat. Rel. to Subscriber:	Self
Phone:	(866)613-4977	Co-In: Deductible:	Out of Pocket Max:

SECONDARY INSURANCE

Payor:		Plan:	N/A
Group Number:		Insurance Type:	
Subscriber Name:		Subscriber DOB:	
Coverage	P O BOX 981106 EL PASO, TX 79998-1106	Subscriber ID:	
		Pat. Rel. to Subscriber:	
Phone:			

Admission Information

Arrival Date/Time:		Admit Date/Time:	04/03/2019 0953	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Ambulatory Surgery Center	Admit Category:	
Means of Arrival:	Car	Primary Service:	General Surgery	Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Paulding Hospital (PH PRE/POST)
Admit Provider:	Bruce P Crowley, MD	Attending Provider:	Bruce P Crowley, MD	Referring Provider:	Bruce P Crowley, MD

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
04/03/2019 1205	Home Or Self Care	None	None	WellStar Paulding Hospital (PH PRE/POST)

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
H25.11 **[Principal]**	Age-related nuclear cataract, right eye				
I11.0	Hypertensive heart disease with heart failure				
I50.9	Heart failure, unspecified				
I25.119	Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris				
I48.0	Paroxysmal atrial fibrillation				
E11.51	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene				
E78.5	Hyperlipidemia, unspecified				
E66.9	Obesity, unspecified				
Z68.32	Body mass index (bmi) 32.0-32.9, adult	Exempt from POA reporting			
Z79.82	Long term (current) use of aspirin	Exempt from POA reporting			
Z79.84	Long term (current) use of oral hypoglycemic drugs	Exempt from POA reporting			
Z79.02	Long term (current) use of antithrombotics/antiplatelets	Exempt from POA reporting			
Z79.899	Other long term (current) drug therapy	Exempt from POA reporting			
Z95.1	Presence of aortocoronary bypass graft	Exempt from POA reporting			
Z95.5	Presence of coronary angioplasty implant and graft	Exempt from POA reporting			
Z87.891	Personal history of nicotine dependence	Exempt from POA reporting			
Z85.46	Personal history of malignant neoplasm of prostate	Exempt from POA reporting			

Events

Admission at 4/3/2019 0953

Unit: WellStar Paulding Hospital (PH MAIN PERIOP) Room: PH MAIN PERIOP POOL Bed: PH MAIN PERIOP POOL
Patient class: Hospital Outpatient Surgery Service: General Surgery

Transfer Out at 4/3/2019 1020

Unit: WellStar Paulding Hospital (PH MAIN PERIOP) Room: PH MAIN PERIOP POOL Bed: PH MAIN PERIOP POOL
Patient class: Hospital Outpatient Surgery Service: General Surgery

Transfer In at 4/3/2019 1020

Unit: WellStar Paulding Hospital (PH PRE/POST) Room: PH PRE POST Pool Bed: PH PRE POST Pool

All Scans (continued)

Events (continued)

Patient class: Hospital Outpatient Surgery | Service: General Surgery

Transfer Out at 4/3/2019 1126

Unit: WellStar Paulding Hospital (PH PRE/POST) | Room: PH PRE POST Pool | Bed: PH PRE POST Pool
Patient class: Hospital Outpatient Surgery | Service: General Surgery

Transfer In at 4/3/2019 1126

Unit: WellStar Paulding Hospital (PH OPERATING ROOM) | Room: PH OR POOL | Bed: PH OR POOL
Patient class: Hospital Outpatient Surgery | Service: General Surgery

Surgery at 4/3/2019 1126

Unit: PH MAIN OR | Room: PH OR 08
Patient class: Hospital Outpatient Surgery | Service: Ophthalmology

Transfer Out at 4/3/2019 1149

Unit: WellStar Paulding Hospital (PH OPERATING ROOM) | Room: PH OR POOL | Bed: PH OR POOL
Patient class: Hospital Outpatient Surgery | Service: General Surgery

Transfer In at 4/3/2019 1149

Unit: WellStar Paulding Hospital (PH PRE/POST) | Room: PH PRE POST Pool | Bed: PH PRE POST Pool
Patient class: Hospital Outpatient Surgery | Service: General Surgery

Discharge at 4/3/2019 1205

Unit: WellStar Paulding Hospital (PH PRE/POST) | Room: PH PRE POST Pool | Bed: PH PRE POST Pool
Patient class: Hospital Outpatient Surgery | Service: General Surgery

Allergies as of 4/3/2019

Reviewed on 4/3/2019

No Known Allergies

Immunizations as of 4/3/2019

Immunizations last reviewed by Lisa M Stephenson, MA on 7/5/2018 1253

Annual Influenza

Administered on: 9/26/2016 0000 | Site: Left deltoid | Route: Intramuscular
Lot number: UI700AA

Annual Influenza

Administered on: 9/28/2017 0000 | Site: Left deltoid | Route: Intramuscular
Lot number: UI842AB

Annual Influenza

Administered on: 10/5/2018 0000 | Site: Right deltoid | Route: Intramuscular
Lot number: UJ031AA

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Jade Westover, LPN | Administered on: 9/26/2016 | Dose: 0.5 mL
Site: Left deltoid | Route: Intramuscular | NDC: 49281-399-88
CVX code: 135 | VIS date: 8/7/2015
Manufacturer: Sanofi Pasteur | Lot number: UI700AA

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Tina M Allen, MA | Administered on: 9/28/2017 | Dose: 0.5 mL
Site: Left deltoid | Route: Intramuscular | NDC: 49281-401-88

All Scans (continued)

Immunizations (continued) as of 4/3/2019

CVX code: 135
VIS date: 09/28/2017
Manufacturer: Sanofi Pasteur
Lot number: UI842AB

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Mary S Wray, MA
Administered on: 10/5/2018
Dose: 0.5 mL
Site: Right deltoid
Route: Intramuscular
NDC: 49281-403-88
CVX code: 135
VIS date: 8/7/2015
Product: Fluzone HD
Manufacturer: Sanofi Pasteur
Lot number: UJ031AA
Expiration date: 5/1/2019

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

Influenza - Unspecified

Administered on: 9/26/2016 0000
Site: Left deltoid
Route: Intramuscular
CVX code: 88
Lot number: UI700AA

Pneumococcal Conjugate 13-Valent

Administered by: Mary S Wray, MA
Administered on: 3/16/2016
Dose: 0.5 mL
Site: Left deltoid
Route: Intramuscular
NDC: 0005-1971-01
CVX code: 133
VIS date: 031616
Manufacturer: Wyeth-Ayerst
Lot number: M51193

Pneumococcal Polysaccharide

Administered by: Mary S Wray, MA
Administered on: 10/5/2018
Dose: 0.5 mL
Site: Left deltoid
Route: Intramuscular
NDC: 0006-4837-01
CVX code: 33
VIS date: 04/24/2015
Manufacturer: Merck & Co. Inc
Lot number: R012497

Questionnaire

Question	Answer
Have you ever had a serious reaction to any vaccine in the past?	NO
Are you sick today with a moderate to severe illness (e.g. fever)	NO

Pneumococcal Polysaccharide

Administered on: 10/5/2018 0000
Site: Left deltoid
Route: Intramuscular
CVX code: 33
Lot number: R012497

Medical as of 4/3/2019

Past Medical History

Diagnosis	Date	Comments	Source
AKI (acute kidney injury) (HCC) [N17.9]	—	—	Provider
CAD (coronary artery disease) [I25.10]	—	—	Provider
Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC) [C61]	1/30/2018	—	Provider
Coronary atherosclerosis of native coronary artery [I25.10]	—	—	Provider
Diabetes mellitus (HCC) [E11.9]	—	—	Provider
Essential hypertension, benign [I10]	—	—	Provider
Family history of ischemic heart disease [Z82.49]	—	—	Provider
Hyperlipidemia [E78.5]	—	—	Provider
Hypertension [I10]	—	—	Provider

All Scans (continued)

Medical as of 4/3/2019 (continued)

Infectious viral hepatitis [B15.9]	—	as teen/cannont recall what type	Provider
Obesity [E66.9]	—	—	Provider
Other and unspecified hyperlipidemia [E78.5]	—	—	Provider
Other symptoms involving cardiovascular system [R09.89]	—	—	Provider
PVD (peripheral vascular disease) (HCC) [I73.9]	—	—	Provider

Pertinent Negatives

Diagnosis	Date Noted	Comments	Source
Abnormal ECG [R94.31]	04/07/2014	—	Provider
Aneurysm (HCC) [I72.9]	04/07/2014	—	Provider
Arrhythmia [I49.9]	04/07/2014	—	Provider
Asthma [J45.909]	04/07/2014	—	Provider
Clotting disorder (HCC) [D68.9]	04/07/2014	—	Provider
Congenital heart disease [Q24.9]	04/07/2014	—	Provider
Deep vein thrombosis (HCC) [I82.409]	04/07/2014	—	Provider
Heart failure (HCC) [I50.9]	04/07/2014	—	Provider
Heart murmur [R01.1]	04/07/2014	—	Provider
Mitral valve prolapse [I34.1]	04/07/2014	—	Provider
Myocardial infarction (HCC) [I21.9]	04/07/2014	—	Provider
Pulmonary embolism (HCC) [I26.99]	04/07/2014	—	Provider
Sleep apnea [G47.30]	04/07/2014	—	Provider
Stroke (HCC) [I63.9]	04/07/2014	—	Provider
Valvular disease [I38]	04/07/2014	—	Provider

ED Records

ED Arrival Information

Patient not seen in ED

ED Disposition

None

H&P - Encounter Notes

H&P filed by Provider Scan at 4/3/2019 12:11 PM

Author: Provider Scan | Service: — | Author Type: —
Filed: 4/3/2019 12:11 PM | Date of Service: 4/3/2019 9:51 AM | Status: Signed
Editor: Interface, Transcription Incoming Scan on 4/3/2019 9:51 AM (below)

Electronically Signed by Interface, Transcription Incoming on 4/3/2019 12:11 PM

OR Nursing - Encounter Notes

OR Nursing by Kimberly R Swanson, RN at 4/3/2019 11:50 AM

Author: Kimberly R Swanson, RN | Service: — | Author Type: Registered Nurse
Filed: 4/3/2019 11:50 AM | Date of Service: 4/3/2019 11:50 AM | Status: Signed
Editor: Kimberly R Swanson, RN (Registered Nurse)

In phase 2 without complaints, tolerating po fluids well, NAD,VSS,family at bedside

Electronically Signed by Kimberly R Swanson, RN on 4/3/2019 11:50 AM

OR Nursing - Encounter Notes (continued)

OR Nursing by Kimberly R Swanson, RN at 4/3/2019 11:54 AM

Author: Kimberly R Swanson, RN | Service: — | Author Type: Registered Nurse
Filed: 4/3/2019 12:04 PM | Date of Service: 4/3/2019 11:54 AM | Status: Signed
Editor: Kimberly R Swanson, RN (Registered Nurse)

D/C criteria met, AVS given to patient and family; voices no concerns or questions.
Up to dress with assistance

Electronically Signed by Kimberly R Swanson, RN on 4/3/2019 12:04 PM

Discharge Instr - Activity - Encounter Notes

Discharge Instr - Activity by Kimberly R Swanson, RN at 4/3/2019 11:51 AM

Author: Kimberly R Swanson, RN | Service: — | Author Type: Registered Nurse
Filed: 4/3/2019 11:51 AM | Date of Service: 4/3/2019 11:51 AM | Status: Written
Editor: Kimberly R Swanson, RN (Registered Nurse)

Cobb Eye Center Post-Op Instructions

Activity
- Do not lift anything over 20 pounds.
- No strenuous activity, this includes swimming until your doctor give you permission.
- Driving a car is permitted depending on your vision. Please check with our doctor before you resume driving.
- You may resume all normal daily activities. For example: reading, watching television, walking, and riding in a car or plane.

Medications
- Resume all your daily medications.

General Information
- Wash your hands before treating your operative eye.
- Wear the protective eye shield over your eye at bedtime and naps until otherwise instructed by your doctor. When putting on your glasses, be careful not to hit your eye with the earpiece.
- Do not touch or rub the upper lid of the operative eye at anytime.
- Unless otherwise instructed by your doctor, keep the patch on your operative eye. It will be removed the day after surgery. You will also be given further instructions on the eye drops and caring for your eye.
- On the day of surgery, you will need someone to drive you home from the surgery center and to our office the next day.
- No eye make-up for 1 week.
- Your eye may feel irritated (like sand is in it) for the first 24-48 hours. You may take Tylenol or Advil to control the discomfort. If over the counter medication does not help, please call our office.

Bathing
- You may bathe or shower. You may shampoo your hair the day after surgery. Keep your operative eye protected from soap and water.

Call You Doctor
- Sudden decrease in you vision.
- Increased redness or pain.

Follow-Up Appointment

Discharge Instr - Activity - Encounter Notes (continued)

Discharge Instr - Activity by Kimberly R Swanson, RN at 4/3/2019 11:51 AM (continued)

- Your first follow-up appointment will be the day after surgery.
- Bring all your eye drops to each follow-up visit.

Electronically Signed by Kimberly R Swanson, RN on 4/3/2019 11:51 AM

Op Note - Encounter Notes

Op Note by Bruce P Crowley, MD at 4/3/2019 11:47 AM

Author: Bruce P Crowley, MD | Service: Ophthalmology | Author Type: Physician
Filed: 4/3/2019 11:48 AM | Date of Service: 4/3/2019 11:47 AM | Status: Signed
Editor: Bruce P Crowley, MD (Physician)

OPERATIVE REPORT

PATIENT: Eugene G Maurice
DOB: 1/2/1949
MRN: 561253820
CSN: 2101351666

DATE OF ADMISSION: **4/3/2019**

DATE OF OPERATION: **4/3/2019**

SURGEON: Bruce P Crowley, MD

PRE-OPERATIVE DIAGNOSIS: Cataract Right eye.

POST-OPERATIVE DIAGNOSIS: Cataract Right eye.

PROCEDURE: Phacoemulsification of a cataract with a posterior chamber intraocular lens, Right eye.

ANESTHESIA: Local MAC

ANESTHEIOLOGIST: Turry

ANESTHETIST: Measel

COMPLICATIONS: None

ESTIMATED BLOOD LOSS: Nil

DESCRIPTION OF PROCEDURE: The patient was prepped and draped in the usual sterile fashion. After Tetracaine was applied, a wire lid speculum was placed into the eye. A 15-degree blade was used to make a paracentesis. Preservative-Free 2% Lidocaine was injected intracamerally as well as topically. Viscoat was used to fill the anterior chamber. A 2.75 keratome was used to enter the anterior chamber at 180-degrees and a circular tear capsulorrhexis was done with Utrata forceps and a cystitome. Balanced salt solution was then used to hydrodissect the nucleus and a Balanced phacoemulsification tip was used in a 2-handed chopping technique with a CDE of 5.99. The irrigation/aspiration machine was then used to remove the remaining cortical material and capsular polishing was not done. Provisc was then used to fill the capsular bag and then

Op Note - Encounter Notes (continued)

Op Note by Bruce P Crowley, MD at 4/3/2019 11:47 AM (continued)

the Alcon Acrysof SN60WF Intraocular lens in a power of 23.00 diopters was inserted into the eye and moved into position within the capsular bag with a Kuglen hook. The I and A was then used to remove the remaining Provisc and vacuum the underside of the anterior capsule where able. The eye was reinflated with a balanced salt solution and the wound was hydrated and found to be watertight. Pilocarpine and Maxitrol were placed in the eye, a shield was placed and the patient was taken to the recovery room in good condition.

Bruce P Crowley, MD

Electronically Signed by Bruce P Crowley, MD on 4/3/2019 11:48 AM

Pre-Procedure Instructions - Encounter Notes

Pre-Procedure Instructions by Sandra Cody, RN at 3/29/2019 9:16 AM

Author: Sandra Cody, RN	Service: —	Author Type: Registered Nurse
Filed: 3/29/2019 9:21 AM	Date of Service: 3/29/2019 9:16 AM	Status: Signed
Editor: Sandra Cody, RN (Registered Nurse)		

PREOPERATIVE INSTRUCTIONS
EYE PATIENTS

Day Before Surgery

- Drink plenty of fluids during the day and evening until midnight. Eat a light evening meal the night before surgery, unless instructed differently by your physician.
- **DO NOT EAT OR DRINK ANYTHING AFTER 12 MIDNIGHT.**
- **Take a shower the night before or morning of procedure and wash face with an antibacterial soap, such as "*Dial*"**
- Notify your physician if there is any change in your physical condition, such as a cold, fever, infection, nausea, vomiting, and/or diarrhea.
- Please call **470-644-7252** the morning of your surgery if you have any questions or concerns.
- **STOP your Metformin 24 hours prior to your procedure,**
- **STOP any vitamins and supplements, stop any NSAID products,**
- **NO diabetic medications or Insulin the morning of your surgery.**
- **Blood thinners (plavix and Aspirin) as per your Dr. Recommendations.**

Morning of Surgery

- Please report to the **Paulding Outpatient Pavilion North,check in at the information desk in the atrium /park in the GREEN PARKING ZONE**
  Date: Wednesday 04/03/2019 Arrive @: 10:00AM Approx. Surgery Time: 11:30AM
- You may take the following medications with a sip of water: **Sotalol, and your Imdur only and use your eye drops**
- You may brush your teeth, but **do not swallow** any water or toothpaste.
- **Do not** chew gum or suck on candy.
- **Do not apply any facial lotion/ moisturizer after washing your face with an antibacterial soap.**
- Bring a container for your dentures, glasses, and contacts (w/ saline solution)
- Wear loose fitting clothing such as a jogging suit. Wear warm socks (you will wear them into the operating room). Wear a button-down or zipper front top or a top that will fit easily over your head. If you are to be admitted after surgery, please leave your suitcase in the car.
- Leave all valuables and jewelry at home. All jewelry, including body piercings, **must be removed.**
- For outpatient surgery, **you must have a responsible adult stay throughout your surgery, recovery, and drive you home and stay with you for 24 hours.** Driving a car, operating machinery or power tools is

Pre-Procedure Instructions - Encounter Notes (continued)

Pre-Procedure Instructions by Sandra Cody, RN at 3/29/2019 9:16 AM (continued)

not recommended for 24 hours after any type of anesthesia. Your surgery may be **canceled or delayed** if you do not have a ride. If you choose public transportation, you will still be required to have a friend or family member accompany you.

- Please, no visitors under the age of twelve. No more than **Two visitors** are allowed in the Surgical Pre/Post-Op Rooms. Additional visitors will be asked to remain in the waiting room area and will be allowed to take turns visiting if time permits.
- **If your surgery time is changed you will be called the evening before your surgery with a new arrival time..**
- Additional instructions: **Do not bring your eye drops with you to the hospital the day of your procedure, BUT you will need to take them with you to your post- op appointment the next day.**

Electronically Signed by Sandra Cody, RN on 3/29/2019 9:21 AM

Paper H&P Update - Encounter Notes

Paper H&P Update by Bruce P Crowley, MD at 4/3/2019 7:10 AM

Author: Bruce P Crowley, MD　Service: Ophthalmology　Author Type: Physician
Filed: 4/3/2019 7:10 AM　Date of Service: 4/3/2019 7:10 AM　Status: Signed
Editor: Bruce P Crowley, MD (Physician)

Original H&P on paper, to be scanned in after discharge.

H & P reviewed, patient examined, and patient's condition unchanged

Bruce P Crowley, MD　April 3, 2019　7:10 AM

Electronically Signed by Bruce P Crowley, MD on 4/3/2019 7:10 AM

Surgery Report

General Information

Date: 4/3/2019 | Time: 1130 | Status: Posted
Location: PH MAIN OR | Room: OR 08 | Service: Ophthalmology
Patient class: Hospital Outpatient Surgery | Case classification: Class F - Elective

Diagnosis Information

Diagnosis
Nuclear sclerotic cataract of right eye

Case Tracking Events

Event	Time In
In Facility	0953
In Pre-Procedure	1020
In Block Room	
Out Block Room	
Pre-Procedure Complete	1045
Out of Pre-op	1125
Anesthesia Available	
In Room	1126
Anesthesia Start	1126
Anesthesia Ready	
Procedure Start	1132
Procedure End	1146
Out of Room	1148
Patient to Floor/ICU	
In Phase I	
Anesthesia Stop	1152
Phase I Criteria Met	
Out of Phase I	
In Phase II	1149
Phase II Care Complete	1202
Out of Phase II	1204
Remove from Status Board	1205
Anesthesia Follow-up Needed	
Anesthesia Follow-up Complete	
Moderate Sedation Begin	
Moderate Sedation End	

Event Tracking

Panel 1

Event	Time In
Procedure Start	
Procedure End	

Procedure : CATARACT PHACOEMULSIFICATION IMPLANTATION INTRAOCULAR LENS

Event	Time In
Procedure Start	1132
Procedure End	1146

Panel Information

Panel 1

Surgeon	Role	Service
Bruce P Crowley, MD	Primary	Ophthalmology

Procedure: CATARACT PHACOEMULSIFICATION IMPLANTATION INTRAOCULAR LENS

Laterality	Wound Class	Incision Closure	Anesthesia	Op Region	
Right	Clean		Monitor Anesthesia Care	Eye	

CATARACT PHACOEMULSIFICATION IMPLANTATION INTRAOCULAR LENS (Right) - Position 1

Body: **Supine/Eye** | Left Arm: **Tucked at Side** | Right Arm: **Tucked at Side**
Head: **Aligned** | Left Leg: **Pillow Under Knees** | Right Leg: **Pillow Under Knees**
Positioned by: **Tammy Neese, RN**
Cole B Wiberley, PAA
Bruce P Crowley, MD
Comments: PT MOVED SELF TO TOP OF STRETCHER; SIDE RAILS UP X2; PT HEAD SECURED WITH TAPE BY

Surgery Report (continued)

Panel Information (continued)

DR. CROWLEY

Staff Info

Staff Type	Staff Member	Start	End	OT
Circulator	**Sandy M Bobb, RN**	1126	1148	
Scrub Person	**Briana Dilks, CST**	1126	1148	
Circulator	**Tammy Neese, RN**	1126	1148	

Questionnaire Data

None

Patient Preparation

Area	Laterality	Scrub	Paint	Hair Removal
Eye	Right	None	Ophthalmic Betadine	N/A

SEVERAL DROPS OF PREP SOLUTION PLACED IN PT RIGHT EYE; PT PREPPED WITH PREP SOLUTION WITH NO SKIN REACTION

Skin Condition

Skin Site	Condition	Comments
Operative	**Warm, Dry, Intact**	

Nursing Notes

OR Nursing by Kimberly R Swanson, RN at 4/3/2019 11:50 AM

Author: Kimberly R Swanson, RN
Service: —
Author Type: Registered Nurse
Filed: 4/3/2019 11:50 AM
Date of Service: 4/3/2019 11:50 AM
Status: Signed
Editor: Kimberly R Swanson, RN (Registered Nurse)

In phase 2 without complaints, tolerating po fluids well, NAD,VSS,family at bedside

OR Nursing by Kimberly R Swanson, RN at 4/3/2019 11:54 AM

Author: Kimberly R Swanson, RN
Service: —
Author Type: Registered Nurse
Filed: 4/3/2019 12:04 PM
Date of Service: 4/3/2019 11:54 AM
Status: Signed
Editor: Kimberly R Swanson, RN (Registered Nurse)

D/C criteria met, AVS given to patient and family; voices no concerns or questions.
Up to dress with assistance

Equipment

Equipment Type	Equipment	Start	End
STOOL HONDA W/ROUND SEAT			
SUCTION SET-UP			
PHACOEMULSIFIER N542836			
MICROSCOPE ZEISS NEW			
HEADREST GEL			
STRETCHER EYE			
MONITOR CARDIAC			
MONITOR OXIMETER OR			

Instruments

Instrument Type	Instrument	Start	End
HANDPIECE I&A			
HANDPIECE PHACO			
PITCHER GRADUATED			
TOWELS CLOTH			

Instruments (continued)

Instrument Type	Instrument	Start	End
TRAY EYE			

Post-op Skin Information

Skin Site	Condition
Operative	**Warm, Dry, Intact**

Counts

No counts needed.

PNDS Information

Outcomes - Pre-op

Used?	Description (Code)
Yes	The patient participates in decisions affecting his or her perioperative plan of care. (O23)
Yes	Confirms identity before the operative or invasive procedure. (I26)
Yes	The patient demonstrates knowledge of the expected responses to the operative or invasive procedure. (O31)
Yes	Assesses pain control. (I16)

Outcomes - Intra-op

Used?	Description (Code)
Yes	The patient is free from signs and symptoms of injury caused by extraneous objects. (O2)
Yes	The patient is free from signs and symptoms of injury related to positioning. (O5)
Yes	The patient is free from signs and symptoms of infection. (O10)

Outcomes - Post-op

Used?	Description (Code)
Yes	The patient is at or returning to normothermia at the conclusion of the immediate postoperative period. (O12)
Yes	The patient's respiratory function is consistent with or improved from baseline levels established preoperatively. (O14)
Yes	The patient demonstrates knowledge of pain management. (O20)
Yes	The patient demonstrates knowledge of wound management. (O22)
Yes	The patient demonstrates and/or reports adequate pain control throughout the perioperative period. (O29)

Diagnoses

Present?	Description (Code)
Yes	Anxiety (X4)
Yes	Ineffective breathing pattern (X7)
Yes	Risk for infection (X28)
Yes	Risk for injury (X29)
Yes	Deficient knowledge (X30)
Yes	Acute pain (X38)
Yes	Risk for impaired skin integrity (X51)
Yes	Risk for imbalanced body temperature (X57)

Case Completion Information

Incision Site	Laterality	Dressings
Eye	Right	Eye Shield

Case Completion - Additional Information

Pre-op diagnosis

Nuclear sclerotic cataract of right eye [H25.11]

Post-op diagnosis

Nuclear sclerotic cataract of right eye [H25.11]

Log Verified By

Ariana Morton, RN	4/3/2019	1045
Sandy M Bobb, RN	4/3/2019	1148
Kimberly R Swanson, RN	4/3/2019	1202

Do Not Proceed History

No information present

Implants

Implants

LENS +23 DIOP 13MM 6MM 1 PC POST CHAMB IOL - S12646059043

Inventory Item: LENS +23 DIOP 13MM 6MM 1 PC POST CHAMB IOL
Serial no.: 12646059043
Model/Cat no.: SN60WF.230
Implant name: LENS +23 DIOP 13MM 6MM 1 PC POST CHAMB IOL - S12646059043
Laterality: Right
Area: Eye
Manufacturer: ALCON SURGICAL INC
Date of Manufacture:
Action: Implanted
Number Used: 1
Device Identifier:
Device Identifier Type:

Timeouts

Pre-Procedure Timeout

Right Patient, Right Site, Right Procedure

Correct patient?: Yes
Correct site?: Yes
Correct procedure?: Yes
Correct laterality?: Yes

Pre-Procedure Verification

H&P note verified?: Yes
Consents verified?: Yes
Site marked?: Yes
Allergies reviewed?: Yes

Surgeons Present: Bruce P Crowley, MD
Anesthesia Staff Present: Cole B Wiberley, PAA
Staff Present: Sandy M Bobb, RN, Briana Dilks, CST, Tammy Neese, RN

Verification Date and Time: 4/3/2019 11:31 AM

Pre-Incision Timeout

Right Patient, Right Site, Right Procedure

Correct patient?: Yes
Correct site?: Yes
Correct procedure?: Yes
Correct position?: Yes
Correct laterality?: Yes

Before Incision

Have all members of the surgical team been introduced?: Yes
Has the surgeon reviewed all the critical or unexpected steps?: Yes
Has the anesthesia team reviewed any patient-specific concerns?: Yes
Has the nursing team confirmed sterility?: Yes
Has prophylaxis been given within the last 60 minutes?: N/A
Is essential imaging displayed?: Yes

Surgeons Present: Bruce P Crowley, MD
Anesthesia Staff Present: Cole B Wiberley, PAA
Staff Present: Sandy M Bobb, RN, Briana Dilks, CST, Tammy Neese, RN

Verification Date and Time: 4/3/2019 11:32 AM

Please use the Print Group Designer activity in Hyperspace to make print groups. Contact your technical support representative for more information.

Anesthesia Encounters

Anesthesia Encounter - Episode ID 34943327

Anesthesia Summary - Maurice, Eugene George [561253820] Male 70 y.o.

Current as of 04/03/19 1150

Height: 67" (1.702 m) (04/03/19)
Weight: 96.6 kg (212 lb 15.4 oz) (04/03/19)
BMI: 33.3 (04/03/19)
NPO Status: 2300
Allergies: No Known Allergies

Procedure Summary

Date: 04/03/19
Room / Location: PH OR 08 / PH MAIN OR
Anesthesia Start: 1126
Anesthesia Stop: 1152
Procedure: CATARACT PHACOEMULSIFICATION IMPLANTATION
Diagnosis:

Anesthesia Encounter - Episode ID 34943327 (continued)

Procedure Summary (continued)

INTRAOCULAR LENS (Right Eye)

Nuclear sclerotic cataract of right eye
(Nuclear sclerotic cataract of right eye [H25.11])

Surgeon: Bruce P Crowley, MD
Anesthesia Type: MAC

Responsible Provider: Paul K Turry, MD
ASA Status: 3

O2	(L/min)	[3]	[3]	[3]	[3]	[0]			
midazolam (VERSED) 1 mg/...	(mg)	0.5	0.5						1 mg
fentaNYL (SUBLIMAZE) 50...	(mcg)	50							50 mcg
sodium chloride 0.9% (N...	(mL)			200				*	200 mL
Urine	(mL)		0						0 mL
EBL	(mL)		0						0 mL
EKG		Sinus Brady...	Sinus Brady...	Sinus Brady...		Sinus Brady...			
Vent Mode		Spontaneous	Spontaneous	Spontaneous		Spontaneous			
EKG		Sinus Brady...	Sinus Brady...	Sinus Brady...		Sinus Brady...			
SpO2	(%)	[100]	[100]	[100]	[100]	99			
ETCO2	(mmHg)	[14]	[28]	[20]	[25]	26			
Vent Mode		Spontaneous	Spontaneous	Spontaneous		Spontaneous			
PEEP/CPAP	(cm H20)	[0]	[0]	[0]	[0]	0			
FiO2	(%)	[23]	[31]	[29]	[31]	34			

Staff

04/03/19

Name	Role	Begin	End
Paul K Turry, MD	ANMD	1126	1152
Nathaniel Measel, PAA	APA	1126	1152

Events

Date	Time	Event
4/3/2019	1126	Anesthesia Start
	1126	Start Data Collection
	1146	Stop Data Collection
	1150	Signed/Cosigned and Ready for Procedure
	1152	Handoff to Receiving Nurse I completed my handoff to the receiving nurse during which we: 1. Identified the patient 2. Identified the responsible providers 3. Discussed the surgical procedure and course 4. Reviewed the pertinent medical history and allergies 5. Reviewed intra-op anesthesia management (airway, medications and I&O) 6. Reviewed nerve block expectations (when applicable) 7. Set expectations for post-procedure period and reviewed post-op orders 8. Allowed opportunity for questions and acknowledgement of understanding

WS Paulding Hospital
2518 Jimmy Lee Smith Parkway
Hiram GA 30141-2068
Inpatient Record

Maurice, Eugene George
MRN: 561253820, DOB: 1/2/1949, Sex: M
Adm: 4/3/2019, D/C: 4/3/2019

Anesthesia Encounter - Episode ID 34943327 (continued)

Events (continued)

Date	Time	Event
	1152	Anesthesia Stop

Anesthesia Medical History

Other symptoms involving cardiovascular system	Coronary atherosclerosis of native coronary artery
Family history of ischemic heart disease	Other and unspecified hyperlipidemia
Essential hypertension, benign	PVD (peripheral vascular disease) (HCC)
Obesity	Hypertension
Hyperlipidemia	CAD (coronary artery disease)
Infectious viral hepatitis	Diabetes mellitus (HCC)
Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC)	AKI (acute kidney injury) (HCC)
Cataracts, both eyes	Gout

Substance History

Smoking Status: Former Smoker - 25 pack years
Quit Smoking: 04/07/92
Smokeless Tobacco Status: Never Used
Alcohol use: Yes; 4.0 standard drinks per week
Drug use: No

Surgical History

APPENDECTOMY	CORONARY ARTERY BYPASS GRAFT
CAROTID ENDARTERECTOMY	CORONARY STENT PLACEMENT
COLONOSCOPY	shingles
EGD	VASCULAR SURGERY

Facility Administered Medications

Taken on 04/03/19

cyclopentolate (CYCLOGYL) 2 % ophthalmic solution	diclofenac (VOLTAREN) ophthalmic solution 0.1%
lidocaine (PF) 3.5 % eye gel	phenylephrine (NEO-SYNEPHRINE) 10 % ophthalmic solution
tetracaine (PF) (PONTOCAINE) 0.5 % eye drops	~~BSS 500 mL + epinephrine 1:1000 0.5 mL (Discontinued)~~
fentaNYL (PF) (SUBLIMAZE) injection 50 mcg/mL	~~lidocaine (PF) (XYLOCAINE-MPF) injection 2 % (Discontinued)~~
midazolam (VERSED) injection 1 mg/mL	~~neomycin-polymyxin-dexamethasone (MAXITROL) ophthalmic suspension (Discontinued)~~
~~pilocarpine (PILOCAR) 2 % ophthalmic solution (Discontinued)~~	~~sod hyaluronate-sod chondroitin-sod hyaluronate (DUOVISC) intra-ocular kit (Discontinued)~~
sodium chloride 0.9% (NS) infusion	~~sodium chloride bacteriostatic injection 0.9 % (Discontinued)~~

Prescription Medications

Within last 14 days from 04/03/19

	Last Taken	Last Updated
aspirin 81 MG EC tablet	4/1/2019	04/03/19 1034
blood sugar diagnostic (ONETOUCH VERIO) strip	4/2/2019	04/03/19 1031
cyanocobalamin, vitamin B-12, (VITAMIN B12 ORAL)	Past Week	04/03/19 1034
ferrous sulfate 324 mg (65 mg iron) TbEC	Past Week	04/03/19 1032
nitroglycerin (NITROSTAT) 0.4 MG SL tablet	More than a month	04/03/19 1034
atorvastatin (LIPITOR) 80 MG tablet	4/2/2019	04/03/19 1032
clopidogrel (PLAVIX) 75 mg tablet	4/1/2019	04/03/19 1034
furosemide (LASIX) 40 MG tablet	4/2/2019	04/03/19 1034
gatifloxacin (ZYMAXID) 0.5 % eye drops	4/3/2019	04/03/19 1034
isosorbide mononitrate (IMDUR) 30 MG 24 hr tablet	4/3/2019	04/03/19 1034
metFORMIN (GLUCOPHAGE) 500 MG tablet	Past Week	04/03/19 1032
prednisoLONE acetate (PRED FORTE) 1 % ophthalmic suspension	4/3/2019	04/03/19 1032
ramipril (ALTACE) 5 MG capsule	4/2/2019	04/03/19 1032
sotalol (BETAPACE) 80 MG tablet	4/3/2019	04/03/19 1032

Preprocedure Vitals

Current as of 04/03/19 1150

BP: 132/53
Pulse: 53
Resp: 18
SpO2: 98
Temp: 97.6 °F (36.4 °C)
Height: 67" (1.702 m) (04/03/19)
Weight: 96.6 kg (212 lb 15.4 oz) (04/03/19)
BMI: 33.3
IBW: 66.1 kg (145 lb 12.2 oz)
Last edited 04/03/19 1150 by KS

Anesthesia Encounter - Episode ID 34943327 (continued)

Preprocedure Vitals (continued) Current as of 04/03/19 1150

Blood Orders Ordered in last 14 days - Current as of 04/03/20 1549

No blood orders found

Hematology Labs (Last 90 days)

	03/17 0914
HGB	13.3 ▼
HCT	--
Plt	--

Electrolyte Labs (Last 90 days)

	03/17 0914
K+	5.2 ▲
Na+	--
Cl-	--
HCO3	--

Procedure Notes

No procedure notes have been written.

Preprocedure Note

Last edited 03/30/19 1008 by Paul K Turry, MD
Date of Service 03/30/19 1007
Status: Signed

Anesthesia Pre-op Evaluation

Patient Name: Eugene G Maurice **MRN:** 561253820
Date of Birth: 1/2/1949 **Age:** 70 yrs **Sex:** Male
Height: 1.702 m (5' 7") **Weight:** 93 kg (205 lb) **BMI:** Body mass index is 32.11 kg/m².

Pre-Assessment Information

No Known Allergies

Relevant Problems

- (+) Acute GI bleeding
- (+) Acute on chronic congestive heart failure, unspecified congestive heart failure type
- (+) Anemia
- (+) Angina pectoris (HCC)
- (+) Controlled type 2 diabetes mellitus with diabetic

peripheral angiopathy without gangrene, without long-term current use of insulin (HCC)
(+) Coronary arteriosclerosis
(+) Coronary artery disease involving native coronary artery of native heart without angina pectoris
(+) Essential hypertension
(+) Localized edema
(+) Obesity
(+) PAF (paroxysmal atrial fibrillation) (HCC)

Past Medical History:

Diagnosis	Date
• AKI (acute kidney injury) (HCC)	
• CAD (coronary artery disease)	
• Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC)	1/30/2018
• Coronary atherosclerosis of native coronary artery	
• Diabetes mellitus (HCC)	
• Essential hypertension, benign	
• Family history of ischemic heart disease	
• Hyperlipidemia	
• Hypertension	
• Infectious viral hepatitis *as teen/cannont recall what type*	
• Obesity	
• Other and unspecified hyperlipidemia	
• Other symptoms involving cardiovascular system	
• PVD (peripheral vascular disease) (HCC)	

Past Surgical History:

Procedure	Laterality	Date
• APPENDECTOMY		
• CAROTID ENDARTERECTOMY *x2*		
• COLONOSCOPY *as of 9/2014 has not had this*		
• CORONARY ARTERY BYPASS GRAFT *X6*		1992
• CORONARY STENT PLACEMENT *sheikh*		2014
• EGD *Procedure: GI-EGD (LVL5) W/ BX; Surgeon: Sohail Asfandiyar, MD; Location: KH GI/BRONCH; Service: Gastroenterology; Laterality: N/A;*	N/A	6/19/2018
• shingles		9/2015
• VASCULAR SURGERY *right leg*		

Social History Main Topics

- Smoking status: Former Smoker
  - Packs/day: 1.00
  - Years: 25.00
  - Types: Cigarettes
  - Quit date: 4/7/1992
- Smokeless tobacco: Never Used
- Alcohol use 2.4 oz/week
  - 2 Glasses of wine, 2 Shots of liquor per week
    - *Comment: rarely*
- Drug use: No
- Sexual activity: Yes
  - Partners: Female
  - Birth control/ protection: None

Documented NPO status:
No Data Recorded

Pre-operative Evaluation

Review of Systems/Medical History

General: Patient summary reviewed and Nursing notes reviewed.
Anesthesia History: No history of anesthetic complications. Patient has no family history of anesthetic complications. No PONV
Cardiovascular:
(+) hypertension: controlled, CAD,

Comments: Results for orders placed or performed during the hospital encounter of 04/09/18
-Echo 2D complete panel (contrast/bubble PRN per protocol)

Narrative
· The left ventricular systolic function is normal, ejection fraction is 50-55%.
· The left ventricular cavity size is normal.
· Left ventricular diastolic function is normal.
· The right ventricular cavity size and systolic function is/are normal.
· There is mild mitral and tricuspid valve regurgitation present.

Results for orders placed or performed during the hospital encounter of 03/29/16
-Echo 2D complete panel (contrast/bubble PRN per protocol)

Narrative
· Left ventricular systolic function is normal, ejection fraction is 50-55%.

· The left ventricle cavity is normal size. Mildly increased concentric left ventricle hypertrophy.
· Right ventricle has normal size and normal systolic function.
· There is mild mitral valve regurgitation present.

Pulmonary: Negative ROS

Neuro/Psych: - Negative ROS

GI/Hepatic/Renal:
(+) hepatitis, liver disease, chronic renal disease: CRI

Endo/Other:
(+) diabetes mellitus: *well controlled*, Type 2,

Physical Exam

Airway:
Mallampati: II
Neck ROM: full
TM distance: >3 FB

Cardiovascular: normal exam

Pulmonary:

Breath sounds clear to auscultation.

Anesthesia Plan

ASA: 3
Anesthetic Plan: MAC

Airway Management: supplemental O2
Premedication Plan: none

Anesthetic plan and risks discussed with: Patient and spouse.

Plan discussed with: Anesthetist

Electronically signed by Paul K Turry, MD at 3/30/2019 10:08 AM

All Postprocedure Notes

Last edited 04/04/19 0852 by Paul K Turry, MD
Date of Service 04/04/19 0852
Status: Signed

Patient Name: Eugene G Maurice

Procedure Summary

Date: 04/03/19
Anesthesia Start: 1126
Procedure: CATARACT PHACOEMULSIFICATION IMPLANTATION INTRAOCULAR LENS (Right Eye)

Surgeon: Bruce P Crowley, MD
Anesthesia Type: MAC

Room / Location: PH OR 08 / PH MAIN OR
Anesthesia Stop: 1152
Diagnosis:
Nuclear sclerotic cataract of right eye
(Nuclear sclerotic cataract of right eye [H25.11])
Responsible Provider: Paul K Turry, MD
ASA Status: 3

Final Anesthesia Type: MAC

Patient location: PACU
Post vital signs: post-procedure vital signs reviewed and stable
Level of consciousness: awake, alert and oriented
Post-anesthesia pain:
Pain Status: adequate analgesia

Airway patency: patent
Respiratory: room air and unassisted
Cardiovascular: blood pressure at baseline and stable

Anesthesia Encounter - Episode ID 34943327 (continued)

All Postprocedure Notes (continued)

Hydration: euvolemic
Nausea and vomiting: no signs of nausea and vomiting
Anesthetic complications: No

Electronically signed by Paul K Turry, MD at 4/4/2019 8:52 AM

Attestation Information

Staff Name	Date	Time	Type
Ariana Morton, RN	04/03/19	1045	Pre-Op
Sandy M Bobb, RN	04/03/19	1148	Intra-Op
Paul K Turry, MD	04/03/19	1150	Pre-Induction Assessment
Paul K Turry, MD	04/03/19	1150	Anesthesia Present
Kimberly R Swanson, RN	04/03/19	1202	Phase II

Medications

Medication	Rate/Dose/Volume	Action	Date Time	Administering User	Audit
midazolam (VERSED) 1 mg/mL injection (mg)	0.5 mg	Given	04/03/19 1129	Nathaniel Measel, PAA	
	0.5 mg	Given	1133	Nathaniel Measel, PAA	
fentaNYL (SUBLIMAZE) 50 mcg/mL injection (mcg)	50 mcg	Given	04/03/19 1129	Nathaniel Measel, PAA	
sodium chloride 0.9% (NS) infusion (mL)	200 mL	Anesthesia Volume Adjustment	04/03/19 1138	Nathaniel Measel, PAA	
		Stopped	1152	Kimberly R Swanson, RN	edited

Signoff Status

None

Flowsheets (all recorded)

Intake/Output

Row Name	04/03/19 1152	04/03/19 1138	04/03/19 1130	04/03/19 1044	
sodium chloride 0.9% (NS) infusion Start: 04/03/19 1100					
Rate	0 mL/hr -KS	—	—	30 mL/hr -AM	
Urine Output					
Voided Urine (mL)	—	—	0 mL -NM	—	
[REMOVED] Anesthesia Airway Nasal Cannula					
AN Airway Properties	Airway Device: Nasal Cannula -NM Removal Date: 08/28/19 -LO Removal Time: 0939 -LO				
Output					
EBL	—	—	0 mL -NM	—	

Flowsheets (all recorded)

Devices Testing Template

Row Name	04/03/19 1146	04/03/19 1145	04/03/19 1144	04/03/19 1143	04/03/19 1142
OTHER					
Product Serial Number	—	10.000000 -DI	10.000000 -DI	10.000000 -DI	10.000000 -DI
HR (ECG)	—	**(!) 49** -DI	50 -DI	50 -DI	50 -DI
SpO2	—	99 % -DI	100 % -DI	99 % -DI	99 % -DI
NIBP	—	—	—	145/64 -DI	—
Anesthesia Monitoring					
FiO2	—	34 % -DI	31 % -DI	36 % -DI	32 % -DI
ETCO2	—	26 mmHg -DI	25 mmHg -DI	22 mmHg -DI	33 mmHg -DI
Agents					
O2	0 L/min -NM	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI
Respiratory					
PEEP/CPAP	—	0 cm H20 -DI	0 cm H20 -DI	0 cm H20 -DI	0 cm H20 -DI

Row Name	04/03/19 1141	04/03/19 1140	04/03/19 1139	04/03/19 1138	04/03/19 1137
OTHER					
Product Serial Number	10.000000 -DI	10.000000 -DI	10.000000 -DI	10.000000 -DI	10.000000 -DI
HR (ECG)	50 -DI	50 -DI	50 -DI	**(!) 49** -DI	**(!) 49** -DI
SpO2	99 % -DI	99 % -DI	100 % -DI	100 % -DI	100 % -DI
NIBP	161/70 -DI	—	—	145/65 -DI	—
Anesthesia Monitoring					
FiO2	30 % -DI	29 % -DI	29 % -DI	31 % -DI	29 % -DI
ETCO2	25 mmHg -DI	24 mmHg -DI	20 mmHg -DI	30 mmHg -DI	30 mmHg -DI
Agents					
O2	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI
Respiratory					
PEEP/CPAP	0 cm H20 -DI	0 cm H20 -DI	0 cm H20 -DI	0 cm H20 -DI	0 cm H20 -DI

Row Name	04/03/19 1136	04/03/19 1135	04/03/19 1134	04/03/19 1133	04/03/19 1132
OTHER					
Product Serial Number	10.000000 -DI	10.000000 -DI	10.000000 -DI	10.000000 -DI	10.000000 -DI
HR (ECG)	**(!) 48** -DI	**(!) 47** -DI	**(!) 47** -DI	**(!) 47** -DI	**(!) 47** -DI
SpO2	99 % -DI	100 % -DI	100 % -DI	100 % -DI	100 % -DI
NIBP	—	—	121/60 -DI	—	—
Anesthesia Monitoring					
FiO2	29 % -DI	32 % -DI	31 % -DI	27 % -DI	32 % -DI
ETCO2	31 mmHg -DI	27 mmHg -DI	28 mmHg -DI	20 mmHg -DI	20 mmHg -DI
Agents					
O2	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI
Respiratory					
PEEP/CPAP	0 cm H20 -DI	0 cm H20 -DI	0 cm H20 -DI	0 cm H20 -DI	0 cm H20 -DI

Row Name	04/03/19 1131	04/03/19 1130	04/03/19 1129	04/03/19 1128	04/03/19 1127
OTHER					
Product Serial Number	10.000000 -DI	10.000000 -DI	10.000000 -DI	10.000000 -DI	10.000000 -DI
HR (ECG)	**(!) 48** -DI	**(!) 47** -DI	**(!) 49** -DI	53 -DI	53 -DI
SpO2	100 % -DI	99 % -DI	100 % -DI	99 % -DI	100 % -DI
NIBP	136/65 -DI	136/65 -DI	—	—	—
Anesthesia Monitoring					
FiO2	24 % -DI	26 % -DI	23 % -DI	26 % -DI	21 % -DI
ETCO2	11 mmHg -DI	9 mmHg -DI	14 mmHg -DI	14 mmHg -DI	0 mmHg -DI
Agents					
O2	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI
Respiratory					
PEEP/CPAP	0 cm H20 -DI	0 cm H20 -DI	0 cm H20 -DI	0 cm H20 -DI	0 cm H20 -DI

Row Name	04/03/19 1126				
OTHER					
Product Serial Number	10.000000 -DI				
Anesthesia Monitoring					

Flowsheets (all recorded) (continued)

Devices Testing Template (continued)

Row Name	04/03/19 1126				
FiO2	21 % -DI				
ETCO2	0 mmHg -DI				
Agents					
O2	3 L/min -DI				
Respiratory					
PEEP/CPAP	0 cm H20 -DI				

Flowsheets (all recorded)

I/O

Row Name	04/03/19 1130				
Output					
Voided Urine (mL)	0 mL -NM				
EBL	0 mL -NM				

Flowsheets (all recorded)

Anesthesia Checklist

Row Name	04/03/19 1128				
Anesthesia Checklist					
Monitors In Use	Pulse oximeter;Capnometer -NM				
NIBP Site	Arm L -NM				
Cardiac	EKG;ST segments -NM				
Leads	3 -NM				
Forced Air Warmer Site	None -NM				

Flowsheets (all recorded)

Agents

Row Name	04/03/19 1146	04/03/19 1145	04/03/19 1144	04/03/19 1143	04/03/19 1142
Agents					
O2	0 L/min -NM	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI

Row Name	04/03/19 1141	04/03/19 1140	04/03/19 1139	04/03/19 1138	04/03/19 1137
Agents					
O2	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI

Row Name	04/03/19 1136	04/03/19 1135	04/03/19 1134	04/03/19 1133	04/03/19 1132
Agents					
O2	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI

Row Name	04/03/19 1131	04/03/19 1130	04/03/19 1129	04/03/19 1128	04/03/19 1127
Agents					
O2	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI

Row Name	04/03/19 1126				
Agents					
O2	3 L/min -DI				

Flowsheets (all recorded)

Anesthesia Monitoring

Row Name	04/03/19 1145	04/03/19 1135	04/03/19 1130	04/03/19 1128
Assessment				
EKG	Sinus Bradycardia -NM	Sinus Bradycardia -NM	Sinus Bradycardia -NM	Sinus Bradycardia -NM
Respiratory				
Vent Mode	Spontaneous -NM	Spontaneous -NM	Spontaneous -NM	Spontaneous -NM

Flowsheets (all recorded)

Positioning

Row Name	04/03/19 1129	04/03/19 1104			
OTHER					
Position	Supine -NM	Supine -NM			
Checklist	PP Checked;PP Padded;Arms Tucked;C-Spine Neutral;Eyes, Nose, Mouth free of pressure;Face Check;Ears Checked -NM	—			

Flowsheets (all recorded)

Medication Exclusion

Row Name	Anesthesia from 4/3/2019 in WellStar Paulding Hospital (PH MAIN PERIOP)				
Antibiotic/Beta Blocker/Antiemetic/Narcotic Admin Exclusions					
Antibiotic Administered?	2 -NM				
Beta Blocker Adminstered?	0 -NM				
Antiemetic Adminstered?	4 -NM				
Has narcotic waste been reconciled?	1 -NM				

User Key

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates
LO	Lisa M Olivarez, RN	02/03/17 -
KS	Kimberly R Swanson, RN	02/03/17 -
AM	Ariana Morton, RN	01/30/18 -
DI	Interface, Device In	—
NM	Nathaniel Measel, PAA	02/13/19 - 04/29/19

Flowsheet Notes

No notes of this type exist for this encounter.

Encounter-Level E-Signatures:

No documentation.

Nursing - Orders and Results

VERIFY INFORMED CONSENT [807984215]

Electronically signed by: **Bruce P Crowley, MD on 03/28/19 1255**
Status: **Discontinued**
Ordering user: Bruce P Crowley, MD 03/28/19 1255
Authorized by: Bruce P Crowley, MD
Quantity: 1
Discontinued by: Automatic Transfer Provider 04/03/19 1149 [Patient Transfer]
Ordering provider: Bruce P Crowley, MD
Ordering mode: Standard
Instance released by: Ariana Morton, RN (auto-released) 4/3/2019 10:21 AM

MAINTAIN IV ACCESS [807984217]

Electronically signed by: **Bruce P Crowley, MD on 03/28/19 1255**
Status: **Discontinued**
Ordering user: Bruce P Crowley, MD 03/28/19 1255
Authorized by: Bruce P Crowley, MD
Quantity: 1
Discontinued by: Automatic Transfer Provider 04/03/19 1149 [Patient Transfer]
Ordering provider: Bruce P Crowley, MD
Ordering mode: Standard
Instance released by: Ariana Morton, RN (auto-released) 4/3/2019 10:21 AM

Code Status - Orders and Results

FULL CODE [807984219]

Electronically signed by: **Bruce P Crowley, MD on 03/28/19 1255**
Status: **Discontinued**
Ordering user: Bruce P Crowley, MD 03/28/19 1255
Authorized by: Bruce P Crowley, MD
Quantity: 1
Instance released by: Ariana Morton, RN (auto-released) 4/3/2019 10:21 AM
Ordering provider: Bruce P Crowley, MD
Ordering mode: Standard
Code status: Full Code
Discontinued by: Automatic Discharge Provider 04/03/19 1405 [Patient Discharge]

IV - Orders and Results

INSERT PERIPHERAL IV [807984216]

IV - Orders and Results (continued)

INSERT PERIPHERAL IV [807984216] (continued)

Electronically signed by: **Bruce P Crowley, MD on 03/28/19 1255** Status: **Discontinued**
Ordering user: Bruce P Crowley, MD 03/28/19 1255
Authorized by: Bruce P Crowley, MD
Quantity: 1
Discontinued by: Automatic Transfer Provider 04/03/19 1149 [Patient Transfer]
Ordering provider: Bruce P Crowley, MD
Ordering mode: Standard
Instance released by: Ariana Morton, RN (auto-released) 4/3/2019 10:21 AM

INT [807984218]

Electronically signed by: **Bruce P Crowley, MD on 03/28/19 1255** Status: **Discontinued**
Ordering user: Bruce P Crowley, MD 03/28/19 1255
Authorized by: Bruce P Crowley, MD
Quantity: 1
Discontinued by: Automatic Transfer Provider 04/03/19 1149 [Patient Transfer]
Ordering provider: Bruce P Crowley, MD
Ordering mode: Standard
Instance released by: Ariana Morton, RN (auto-released) 4/3/2019 10:21 AM

Point of Care Testing-Docked Device - Orders and Results

POC FINGER STICK GLUCOSE [807984214]

Electronically signed by: **Denis Trto, MD on 04/03/19 1027** Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Sandra Cody, RN 03/29/19 0925
Authorized by: Denis Trto, MD
Quantity: 1
Discontinued by: Automatic Transfer Provider 04/03/19 1149 [Patient Transfer]
Communicated by: Sandra Cody, RN
Ordering provider: Denis Trto, MD
Ordering mode: Per protocol: cosign required
Instance released by: Ariana Morton, RN (auto-released) 4/3/2019 10:21 AM

POC FINGER STICK GLUCOSE [807984221]

Electronically signed by: **Interface, Lab In Sunquest on 04/03/19 1046** Status: **Completed**
Ordering user: Interface, Lab In Sunquest 04/03/19 1046
Authorized by: Bruce P Crowley, MD
Quantity: 1
Instance released by: (auto-released) 4/3/2019 10:53 AM
Ordering provider: Bruce P Crowley, MD
Ordering mode: Standard
Lab status: Final result

Specimen Information

Type	Source	Collected By
Blood	Serum	04/03/19 1046

POC FINGER STICK GLUCOSE [807984221] Resulted: 04/03/19 1053, Result status: Final result

Ordering provider: Bruce P Crowley, MD 04/03/19 1046
Filed by: Interface, Lab In Sunquest 04/03/19 1053
External ID: W16090742
Order status: Completed
Resulting lab: WS PAULDING HOSPITAL LAB
Result details

Specimen Information

Type	Source	Collected By
Blood	Serum	04/03/19 1046

Components

Component	Value	Reference Range	Flag	Lab
GLUCOSE, BEDSIDE	89	70 - 99 mg/dL	—	PHLAB
POC-OPERATOR'S ID	61930	—	—	PHLAB

Medications - Orders and Results

phenylephrine (MYDFRIN) 2.5 % ophthalmic solution [807984209]

Electronically signed by: **Bruce P Crowley, MD on 03/28/19 1255** Status: **Cancel Held**
Ordering user: Bruce P Crowley, MD 03/28/19 1255
Authorized by: Bruce P Crowley, MD
Frequency: Routine Q5 Min 03/28/19 1300 - 3 occurrences
Discontinued by: Automatic Order Context Provider 04/04/19 0001
Ordering provider: Bruce P Crowley, MD
Ordering mode: Standard

Medications - Orders and Results (continued)

phenylephrine (MYDFRIN) 2.5 % ophthalmic solution [807984209] (continued)

Admin instructions: Place waste in BLACK hazardous container.

phenylephrine (NEO-SYNEPHRINE) 10 % ophthalmic solution [807984213]

Electronically signed by: **Bruce P Crowley, MD on 04/08/19 1357** Status: **Completed**
Mode: Ordering in Per protocol: cosign required mode
Communicated by: Ariana Morton, RN
Ordering user: Ariana Morton, RN 04/03/19 0611
Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD
Ordering mode: Per protocol: cosign required
Frequency: Routine Q5 Min 04/03/19 1100 - 3 occurrences
Released by: Ariana Morton, RN 04/03/19 1021
Acknowledged: Ariana Morton, RN 04/03/19 1021 for Placing Order
Admin instructions: Place waste in BLACK hazardous container.
Package: 17478-206-05

sodium chloride 0.9 % (NS) flush [807984204]

Electronically signed by: **Bruce P Crowley, MD on 03/28/19 1255** Status: **Discontinued**
Ordering user: Bruce P Crowley, MD 03/28/19 1255
Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD
Ordering mode: Standard
PRN reasons: line care
Frequency: Routine Q1 min PRN 04/03/19 1021 - 04/03/19 1149
Released by: Ariana Morton, RN 04/03/19 1021
Discontinued by: Automatic Transfer Provider 04/03/19 1149 [(Patient Transfer - Internal Use Only)]
Acknowledged: Ariana Morton, RN 04/03/19 1021 for Placing Order
Admin instructions: INT Flush
Package: 8290-306547

sodium chloride 0.9% (NS) infusion [807984205]

Electronically signed by: **Bruce P Crowley, MD on 03/28/19 1255** Status: **Discontinued**
Ordering user: Bruce P Crowley, MD 03/28/19 1255
Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD
Ordering mode: Standard
Frequency: Routine Continuous 04/03/19 1100 - 04/03/19 1405
Released by: Ariana Morton, RN 04/03/19 1021
Discontinued by: Automatic Discharge Provider 04/03/19 1405 [(Patient Discharge - Internal Use Only)]
Acknowledged: Ariana Morton, RN 04/03/19 1021 for Placing Order
Package: 0409-7983-09

cyclopentolate (CYCLOGYL) 2 % ophthalmic solution [807984206]

Electronically signed by: **Bruce P Crowley, MD on 03/28/19 1255** Status: **Completed**
Ordering user: Bruce P Crowley, MD 03/28/19 1255
Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD
Ordering mode: Standard
Frequency: Routine Q5 Min 04/03/19 1021 - 3 occurrences
Released by: Ariana Morton, RN 04/03/19 1021
Acknowledged: Ariana Morton, RN 04/03/19 1021 for Placing Order
Package: 17478-097-02

diclofenac (VOLTAREN) ophthalmic solution 0.1% [807984207]

Electronically signed by: **Bruce P Crowley, MD on 03/28/19 1255** Status: **Completed**
Ordering user: Bruce P Crowley, MD 03/28/19 1255
Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD
Ordering mode: Standard
Frequency: Routine Q5 Min 04/03/19 1021 - 3 occurrences
Released by: Ariana Morton, RN 04/03/19 1021
Acknowledged: Ariana Morton, RN 04/03/19 1021 for Placing Order
Package: 61314-014-25

lidocaine (PF) 3.5 % eye gel [807984208]

Electronically signed by: **Bruce P Crowley, MD on 03/28/19 1255** Status: **Completed**
Ordering user: Bruce P Crowley, MD 03/28/19 1255
Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD
Ordering mode: Standard
Frequency: Routine Once 04/03/19 1100 - 1 occurrence
Released by: Ariana Morton, RN 04/03/19 1021
Acknowledged: Ariana Morton, RN 04/03/19 1021 for Placing Order
Admin instructions: Apply to eye after completion of all dilation drops
Package: 17478-792-01

tetracaine (PF) (PONTOCAINE) 0.5 % eye drops [807984210]

Electronically signed by: **Bruce P Crowley, MD on 03/28/19 1255** Status: **Completed**
Ordering user: Bruce P Crowley, MD 03/28/19 1255
Ordering provider: Bruce P Crowley, MD

Medications - Orders and Results (continued)

tetracaine (PF) (PONTOCAINE) 0.5 % eye drops [807984210] (continued)

Authorized by: Bruce P Crowley, MD
Ordering mode: Standard
Frequency: Routine Once 04/03/19 1100 - 1 occurrence
Released by: Ariana Morton, RN 04/03/19 1021
Acknowledged: Ariana Morton, RN 04/03/19 1021 for Placing Order
Package: 0065-0741-14

lidocaine (PF) (XYLOCAINE-MPF) injection 2 % [807984226]

Electronically signed by: **Sandy M Bobb, RN on 04/03/19 1133**
Status: **Discontinued**
Ordering user: Sandy M Bobb, RN 04/03/19 1133
Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD
Ordering mode: Standard
Frequency: Routine PRN 04/03/19 1132 - 04/03/19 1149
Discontinued by: Automatic Transfer Provider 04/03/19 1149 [(Patient Transfer - Internal Use Only)]
Acknowledged: Sandy M Bobb, RN 04/03/19 1133 for Placing Order
Package: 63323-495-07

sod hyaluronate-sod chondroitin-sod hyaluronate (DUOVISC) intra-ocular kit [807984227]

Electronically signed by: **Sandy M Bobb, RN on 04/03/19 1133**
Status: **Discontinued**
Ordering user: Sandy M Bobb, RN 04/03/19 1133
Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD
Ordering mode: Standard
Frequency: Routine PRN 04/03/19 1132 - 04/03/19 1149
Discontinued by: Automatic Transfer Provider 04/03/19 1149 [(Patient Transfer - Internal Use Only)]
Acknowledged: Sandy M Bobb, RN 04/03/19 1133 for Placing Order
Package: 8065-1831-50

sodium chloride bacteriostatic injection 0.9 % [807984228]

Electronically signed by: **Sandy M Bobb, RN on 04/03/19 1133**
Status: **Discontinued**
Ordering user: Sandy M Bobb, RN 04/03/19 1133
Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD
Ordering mode: Standard
Frequency: Routine PRN 04/03/19 1132 - 04/03/19 1149
Discontinued by: Automatic Transfer Provider 04/03/19 1149 [(Patient Transfer - Internal Use Only)]
Acknowledged: Sandy M Bobb, RN 04/03/19 1133 for Placing Order
Package: 0409-1966-12

BSS 500 mL + epinephrine 1:1000 0.5 mL [807984229]

Electronically signed by: **Sandy M Bobb, RN on 04/03/19 1138**
Status: **Discontinued**
Ordering user: Sandy M Bobb, RN 04/03/19 1138
Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD
Ordering mode: Standard
Frequency: Routine PRN 04/03/19 1137 - 04/03/19 1149
Discontinued by: Automatic Transfer Provider 04/03/19 1149 [(Patient Transfer - Internal Use Only)]
Acknowledged: Sandy M Bobb, RN 04/03/19 1138 for Placing Order

Mixture Ingredients

Medication	Ordered Dose	Calculated Dose
balanced salt irrigation (BSS PLUS)	500 mL	500 mL
EPINEPHrine (ADRENALIN) 1 mg/mL	0.5 mL	0.5 mL

Package: 0065-0800-94, 42023-168-01

neomycin-polymyxin-dexamethasone (MAXITROL) ophthalmic suspension [807984230]

Electronically signed by: **Sandy M Bobb, RN on 04/03/19 1146**
Status: **Discontinued**
Ordering user: Sandy M Bobb, RN 04/03/19 1146
Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD
Ordering mode: Standard
Frequency: Routine PRN 04/03/19 1145 - 04/03/19 1149
Discontinued by: Automatic Transfer Provider 04/03/19 1149 [(Patient Transfer - Internal Use Only)]
Acknowledged: Sandy M Bobb, RN 04/03/19 1146 for Placing Order
Package: 0998-0630-06

pilocarpine (PILOCAR) 2 % ophthalmic solution [807984231]

Electronically signed by: **Sandy M Bobb, RN on 04/03/19 1146**
Status: **Discontinued**
Ordering user: Sandy M Bobb, RN 04/03/19 1146
Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD
Ordering mode: Standard
Frequency: Routine PRN 04/03/19 1146 - 04/03/19 1149
Discontinued by: Automatic Transfer Provider 04/03/19 1149 [(Patient Transfer -

Medications - Orders and Results (continued)

pilocarpine (PILOCAR) 2 % ophthalmic solution [807984231] (continued)

Internal Use Only)]

Acknowledged: Sandy M Bobb, RN 04/03/19 1146 for Placing Order
Package: 61314-204-15

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
22 - PHLAB	WS PAULDING HOSPITAL LAB	Dr. Jonathan Herbst	2518 Jimmy Lee Smith Parkway Hiram GA 30141	08/28/18 1258 - Present

Medications

All Meds and Administrations

sodium chloride 0.9 % (NS) flush [807984204]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/03/19 1021
Dose (Remaining/Total): 3-40 mL (—/—)
Frequency: Every 1 minute PRN
Admin Instructions: INT Flush

Status: Discontinued (Past End Date/Time), Reason: (Patient Transfer - Internal Use Only)
Starts/Ends: 04/03/19 1021 - 04/03/19 1149
Route: Intravenous
Rate/Duration: — / —

(No admins scheduled or recorded for this medication)

sodium chloride 0.9% (NS) infusion [807984205]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/03/19 1021
Dose (Remaining/Total): 30 mL/hr (—/—)
Frequency: Continuous

Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 04/03/19 1100 - 04/03/19 1405
Route: Intravenous
Rate/Duration: 30 mL/hr / —

Line	Med Link Info	Comment
Peripheral IV 04/03/19 22 G Right Hand	04/03/19 1044 by Ariana Morton, RN	—

Timestamps	Action	Dose / Rate	Route	Other Information
Performed 04/03/19 1152 Documented: 04/03/19 1152	Stopped	0 mL/hr 0 mL/hr	Intravenous	Performed by: Kimberly R Swanson, RN
Performed 04/03/19 1138 Documented: 04/03/19 1138	Anesthesia Volume Adjustment	—	Intravenous	Performed by: Nathaniel Measel, PAA
Performed 04/03/19 1044 Documented: 04/03/19 1044	New Bag	30 mL/hr 30 mL/hr	Intravenous	Performed by: Ariana Morton, RN Scanned Package: 0409-7983-09

cyclopentolate (CYCLOGYL) 2 % ophthalmic solution [807984206]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/03/19 1021
Dose (Remaining/Total): 1 drop (0/3)
Frequency: Every 5 min

Status: Completed (Past End Date/Time)
Starts/Ends: 04/03/19 1021 - 04/03/19 1044
Route: Right Eye
Rate/Duration: — / —

Timestamps	Action	Dose	Route	Other Information
Performed 04/03/19 1044 Documented: 04/03/19 1044	Given	1 drop	Right Eye	Performed by: Ariana Morton, RN Scanned Package: 17478-097-02
Performed 04/03/19 1038 Documented: 04/03/19 1038	Given	1 drop	Right Eye	Performed by: Ariana Morton, RN Scanned Package: 17478-097-02
Performed 04/03/19 1032 Documented: 04/03/19 1033	Given	1 drop	Right Eye	Performed by: Ariana Morton, RN Scanned Package: 17478-097-02

diclofenac (VOLTAREN) ophthalmic solution 0.1% [807984207]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/03/19 1021
Dose (Remaining/Total): 1 drop (0/3)
Frequency: Every 5 min

Status: Completed (Past End Date/Time)
Starts/Ends: 04/03/19 1021 - 04/03/19 1044
Route: Right Eye
Rate/Duration: — / —

Timestamps	Action	Dose	Route	Other Information

Medications (continued)

All Meds and Administrations (continued)

Timestamps	Action	Dose	Route	Other Information
Performed 04/03/19 1044 Documented: 04/03/19 1044	Given	1 drop	Right Eye	Performed by: Ariana Morton, RN Scanned Package: 61314-014-25
Performed 04/03/19 1038 Documented: 04/03/19 1038	Given	1 drop	Right Eye	Performed by: Ariana Morton, RN Scanned Package: 61314-014-25
Performed 04/03/19 1032 Documented: 04/03/19 1033	Given	1 drop	Right Eye	Performed by: Ariana Morton, RN Scanned Package: 61314-014-25

lidocaine (PF) 3.5 % eye gel [807984208]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/03/19 1021
Dose (Remaining/Total): 2 drop (0/1)
Frequency: Once
Admin Instructions: Apply to eye after completion of all dilation drops

Status: Completed (Past End Date/Time)
Starts/Ends: 04/03/19 1100 - 04/03/19 1044
Route: Right Eye
Rate/Duration: — / —

Timestamps	Action	Dose	Route	Other Information
Performed 04/03/19 1044 Documented: 04/03/19 1044	Given	2 drop	Right Eye	Performed by: Ariana Morton, RN Scanned Package: 17478-792-01

tetracaine (PF) (PONTOCAINE) 0.5 % eye drops [807984210]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/03/19 1021
Dose (Remaining/Total): 1 drop (0/1)
Frequency: Once

Status: Completed (Past End Date/Time)
Starts/Ends: 04/03/19 1100 - 04/03/19 1030
Route: Right Eye
Rate/Duration: — / —

Timestamps	Action	Dose	Route	Other Information
Performed 04/03/19 1030 Documented: 04/03/19 1030	Given	1 drop	Right Eye	Performed by: Ariana Morton, RN Scanned Package: 0065-0741-14

phenylephrine (NEO-SYNEPHRINE) 10 % ophthalmic solution [807984213]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/03/19 1021
Dose (Remaining/Total): 1 drop (0/3)
Frequency: Every 5 min
Admin Instructions: Place waste in BLACK hazardous container.

Status: Completed (Past End Date/Time)
Starts/Ends: 04/03/19 1100 - 04/03/19 1044
Route: Right Eye
Rate/Duration: — / —

Timestamps	Action	Dose	Route	Other Information
Performed 04/03/19 1044 Documented: 04/03/19 1044	Given	1 drop	Right Eye	Performed by: Ariana Morton, RN Scanned Package: 17478-206-05
Performed 04/03/19 1038 Documented: 04/03/19 1038	Given	1 drop	Right Eye	Performed by: Ariana Morton, RN Scanned Package: 17478-206-05
Performed 04/03/19 1033 Documented: 04/03/19 1033	Given	1 drop	Right Eye	Performed by: Ariana Morton, RN Scanned Package: 17478-206-05

lidocaine (PF) (XYLOCAINE-MPF) injection 2 % [807984226]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/03/19 1133

Status: Discontinued (Past End Date/Time), Reason: (Patient Transfer - Internal Use Only)
Frequency: As needed

Medications (continued)

All Meds and Administrations (continued)

Timestamps	Action	Dose	Route / Site	Other Information
Performed 04/03/19 1132 Documented: 04/03/19 1133	Given	1 mL	Injection Right Eye	Performed by: Bruce P Crowley, MD Documented by: Sandy M Bobb, RN

sod hyaluronate-sod chondroitin-sod hyaluronate (DUOVISC) intra-ocular kit [807984227]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/03/19 1133
Status: Discontinued (Past End Date/Time), Reason: (Patient Transfer - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route / Site	Other Information
Performed 04/03/19 1132 Documented: 04/03/19 1133	Given	1 kit	Intraocular Right Eye	Performed by: Bruce P Crowley, MD Documented by: Sandy M Bobb, RN

sodium chloride bacteriostatic injection 0.9 % [807984228]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/03/19 1133
Status: Discontinued (Past End Date/Time), Reason: (Patient Transfer - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route / Site	Other Information
Performed 04/03/19 1132 Documented: 04/03/19 1133	Given	10 mL	Intraocular Irrigation Right Eye	Performed by: Bruce P Crowley, MD Documented by: Sandy M Bobb, RN

BSS 500 mL + epinephrine 1:1000 0.5 mL [807984229]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/03/19 1138
Status: Discontinued (Past End Date/Time), Reason: (Patient Transfer - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route / Site	Other Information
Performed 04/03/19 1137 Documented: 04/03/19 1138	Given	500 mL	Irrigation Right Eye	Performed by: Bruce P Crowley, MD Documented by: Sandy M Bobb, RN

neomycin-polymyxin-dexamethasone (MAXITROL) ophthalmic suspension [807984230]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/03/19 1146
Status: Discontinued (Past End Date/Time), Reason: (Patient Transfer - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 04/03/19 1145 Documented: 04/03/19 1146	Given	2 drop	Right Eye	Performed by: Bruce P Crowley, MD Documented by: Sandy M Bobb, RN

pilocarpine (PILOCAR) 2 % ophthalmic solution [807984231]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/03/19 1146
Status: Discontinued (Past End Date/Time), Reason: (Patient Transfer - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 04/03/19 1146 Documented: 04/03/19 1146	Given	2 drop	Right Eye	Performed by: Bruce P Crowley, MD Documented by: Sandy M Bobb, RN

Medications (continued)

All Meds and Administrations (continued)

Historical Medications Entered This Encounter

This print group is not available in inpatient encounters. Please contact a system administrator.

Patient Education

Education

Title: Acute MI (MCB) (Resolved)

Topic: Psycho/Social/Spiritual Support (Resolved)

Point: Coping Mechanisms (Resolved)

Description:
Help patient identify healthy coping mechanisms. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Support Systems (Resolved)

Description:
Help patient identify available support systems. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Spiritual/Emotional Needs (Resolved)

Description:
Offer resources to meet spiritual/emotional needs. Refer to Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Resolved)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Prevention (MCB) (Resolved)

Point: When to Call the Doctor (Resolved)

Description:
Educate patient/family/caregiver on when to call the doctor.

Learner Progress: Not documented in this visit.

Point: Protect Others from Infection (Resolved)

Description:
Educate patient/family/caregiver on respiratory hygiene and cough etiquette. To protect from further infection and to protect others from getting an infection, patient should cover nose and mouth with tissues when coughing. Encourage patient to place used tissues in a plastic bag that will not allow secretions to soak through. Patient should always wash his/her hands after using or handling used tissues.

Learner Progress: Not documented in this visit.

Point: Protect Yourself from Further Infection (MCB) (Resolved)

Patient Education (continued)

Education (continued)

Description:
Educate patient/family/caregiver that because patient is in a weakened condition he/she needs to avoid others who are sick as to not acquire another illness. Family/caregiver should wear gloves, gown and face shield/eye protection.

Patient Friendly Description:
Information on Flu.
Information on Pneumonia and Pneumococcal Vaccination.

Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Resolved)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.

Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Resolved)

Point: General Self Care (Resolved)

Description:
Instruct patient on self care needs. These may include: hygiene, how to take a blood pressure, how to change a dressing, etc.

Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Resolved)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.

Learner Progress: Not documented in this visit.

Topic: Pain Management (Resolved)

Point: Pain Medication Actions & Side Effects (Resolved)

Description:
Provide medication specific handouts when available.

Learner Progress: Not documented in this visit.

Point: Discuss Significance of VAS Scores (Resolved)

Description:
Refer to rating score of 0-10.

Learner Progress: Not documented in this visit.

Point: Discuss the Use of Pain Control Measures Before Pain Becomes Severe (MCB) (Resolved)

Description:
Take time to reiterate to patient that he/she should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time before pain becomes severe.

Patient Education (continued)

Education (continued)

Patient Friendly Description:
Please inform staff that if you are having any difficulty breathing, pain or any discomfort at any time before the pain gets severe.

Please read over the items and let anyone on your Care Team know there are any questions about the material by marking below that "I HAVE QUESTIONS".

If once you have received the items and understand the material you can mark this as "I understand".

Learner Progress: Not documented in this visit.

Point: Non-Pharmacological Comfort Measures (Resolved)

Description:
Explain there are other ways of controlling pain than medication. The following are suggestions: position change, aromatherapy, deep slow breathing, distraction, quiet environment, imagery, heat therapy and/or cold therapy, laughter, massage, music, physical therapy, and touch therapy.

Learner Progress: Not documented in this visit.

Point: Patient Controlled Analgesia (Resolved)

Description:
Give the patient written information on Patient Controlled Analgesia. Explain how the pump works. Demonstrate pushing the button to give pain medicine to the patient. Caution the patient and other family/visitors that only the patient should press the PCA button for pain relief to decrease the chance of getting too much pain medicine.

Learner Progress: Not documented in this visit.

Point: Epidural Information (Resolved)

Description:
Give the patient written information on Epidural Analgesia. Explain why an epidural is used, how the epidural is placed and how the medication is given. If the epidural is PCA, demonstrate pushing the button to give pain medicine to the patient. Caution the patient and other family/visitors that only the patient should press the button for pain relief to decrease the chance of getting too much pain medicine.

Learner Progress: Not documented in this visit.

Topic: Signs and Symptoms - Acute MI (Resolved)

Point: Recognizing a Heart Attack (MCB) (Resolved)

Description:
Be sure patient reviews video on Coronary Artery Disease

Patient Friendly Description:
Please watch the video and/or read over the documented material and let anyone on your Care Team know if there are any questions by marking below.
If after watching the video and/or reading the material you have questions, please mark below I have question to let the staff know you have additional questions about a topic and they will be in to discuss your questions.

This will inform you of what to expect if you are diagnosed with a Heart Attack.

Learner Progress: Not documented in this visit.

Point: Risk Factors (Resolved)

Description:
Educate the patient/family/caregiver on coronary risk factors. Explain the controllable and non-controllable risk factors to Coronary Artery Disease. Review how to control coronary artery disease by altering the controllable risk factors. Some examples include: controlling blood pressure, reducing fat and cholesterol in the diet, stopping smoking, exercising regularly, maintaining ideal body weight, dealing with stress in an appropriate manner, drinking alcohol and coffee in moderation and controlling blood sugar levels (if applicable).

Learner Progress: Not documented in this visit.

Topic: Acute MI (MCB) (Resolved)

Patient Education (continued)

Education (continued)

Point: Emergency Plan for Heart Attack Symptoms (Resolved)

Description:
Educate the patient/family/caregiver on how to get help immediately if heart attack symptoms occur. The patient should call 911 or the Emergency Medical Service number. Reinforce that the patient should not delay in obtaining help.

Learner Progress: Not documented in this visit.

Point: Home Activity (Resolved)

Description:
Educate the patient/family/caregiver on home activity guidelines that apply after having had a recent heart attack. Do things in moderation, rest about 30 minutes after eating, pace activities, allow for 7-8 hours of sleep at night, start with short walks 3-5 times a day. Consult with Cardiac Rehab staff, if applicable.

Learner Progress: Not documented in this visit.

Point: Limitations to Activity (Resolved)

Description:
Educate the patient/family/caregiver reagrding the following limitations to activity for 4-6 weeks after discharge. No lifting over 10 pounds (weight of a milk jug), no pushing or pulling motions with the arms (sweeping, vacuuming or raking), no driving (may be changed after talking to the doctor), no bathing in very hot or very cold water.

Learner Progress: Not documented in this visit.

Point: Sexual Activity (Resolved)

Description:
Educate the patient/family/caregiver on the following: Wait 4 weeks before resuming sexual activity. If the patient can climb 2 flights of steps, he/she can assume it is ok to resume sexual activity. Choose a comfortable position. Wait at least 1 hour after a meal. If sex brings on angina, stop and rest. Discuss chest pain during sex with the physician. Some medications can affect sexual desire. If this is the case, talk with the physician.

Learner Progress: Not documented in this visit.

Point: Influenza Vaccine (Resolved)

Description:
Educate the patient/family/caregiver on obatining a yearly influenza vaccine.

Learner Progress: Not documented in this visit.

Point: Smoking Cessation (Resolved)

Description:
Educate the patient/family/caregiver on smoking cessation and smoking cessation programs offered in the community. Explain effects smoking and second hand smoke have on the body. Encourage the patient to ask people that smoke around him/her to smoke outside or in another room. Refer patient to Cardiopulmonary Rehabilitation, if applicable.

Learner Progress: Not documented in this visit.

Title: Diabetes (MCB) (Not Started)

Topic: Psycho/Social/Spiritual Support (Not Started)

Point: Stress Management and Support Systems (Not Started)

Description:
Explain the importance of stress management and support systems in diabetes management. Refer to WellStar diabetes support groups, social services, case management or spiritual care, if needed.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Anxiety Reduction (Not Started)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Treatments/Procedures (MCB) (Not Started)

Point: Introduction to Diabetes (MCB) (Not Started)

Description:
Give patient/family/caregiver written information on diabetes. Explain the definition of the type of diabetes with which the patient was diagnosed, how diabetes works in the body, risk factors, signs and symptoms, and if newly diagnosed, diagnostic criteria. Encourage viewing of diabetes on-demand videos when applicable. Refer to inpatient diabetes educator when applicable.

Patient Friendly Description:
You will receive a booklet entitled Diabetes survival skills. There are also two links to documents about Diabetes for you to read over noted below.

Please read over the items and let anyone on your Care Team know there are any questions about the material by marking below that "I HAVE QUESTIONS".

If once you have received the items and understand the material you can mark this as "I understand".
Learner Progress: Not documented in this visit.

Point: Diabetes Type II management (MCB) (Not Started)

Description:
Patient will watch a video that will discuss information on what to expect if they have Diabetes type II.

Patient Friendly Description:
This will inform you of what to expect if you have Diabetes type II.
Learner Progress: Not documented in this visit.

Point: Diabetic long term complications (MCB) (Not Started)

Description:
Patient will have information from Krames on the long term complications of Diabetes Type II.

Patient Friendly Description:
Some information on the long term complications of Diabetes Type II.
Learner Progress: Not documented in this visit.

Topic: Medications (MCB) (Not Started)

Point: Insulin (MCB) (Not Started)

Description:
Educate patient/family/caregiver on the insulin prescribed. Explain how insulin works in the body. Explain the action of insulin, reason for taking, side effects, signs of allergic reaction and when physician should be called. Reinforce that insulin should be taken exactly as the physician has prescribed. Explain the proper storage of insulin, that extreme temperatures can damage insulin and never take insulin that has expired. Explain that the patient's primary care physician may change the dosage depending on the results of blood glucose tests and/or A1C level.

Patient Friendly Description:
This will inform you of why you are prescribed insulin if you have Diabetes Type II.
Learner Progress: Not documented in this visit.

Point: Hypoglycemic Agents (Not Started)

Description:
Educate patient/family/caregiver on the oral and/or injectable hypoglycemic(s) prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, as well as when the physician should be called. Reinforce that this medication(s) should be taken exactly as the physician has prescribed.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Giving Insulin Injection (Not Started)

Description:
Explain and demonstrate how the injection is given. Allow enough time for the patient/family/caregiver to practice. Have the patient return-demonstrate the technique using normal saline (vial and syringe only unless sterile demonstration pen is also available). Teach the patient how to choose and rotate injection sites. Instruct patient on safe disposal of used needles and syringes.

Learner Progress: Not documented in this visit.

Point: Drawing up Insulin (Not Started)

Description:
Instruct patient/family/caregiver to wash hands before drawing up insulin. Demonstrate and have the patient return-demonstrate drawing up the correct amount of insulin prescribed. If the patient is going to use an insulin pen, demonstrate use and have the patient return-demonstrate. If the patient is going to mix different types of insulin, demonstrate and have the patient return-demonstrate the correct way to draw up and mix the insulin.

Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Not Started)

Point: Exercise (Not Started)

Description:
Encourage patient/family/caregiver to discuss activity limitations, if any, with physician before starting an exercise routine. Stress the importance of regular exercise and activity to control blood sugar levels and weight. Instruct the patient to carry single carohydrates while exercising in case of hypoglycemic reaction. Explain that both concentrated physical activity (such as walking, swimming, running, cycling, strength training) and being more active through the entire day are equally important to blood sugar control and weight management.

Learner Progress: Not documented in this visit.

Point: Blood Glucose Monitoring (MCB) (Not Started)

Description:
Instruct patient/family/caregiver to wash hands before checking blood glucose. Explain and, if possible to use a complementary glucometer, demonstrate how to check and record blood sugars. Instruct the patient to check blood sugars as frequently as ordered by the physician. Explain that stress or illness will increase blood sugar, making it necesary to check blood sugars more often than usual. Instruct patient on blood glucose target ranges and A1C target range. Discuss care of the meter and supplies, including how to obtain supplies. If using a complementary glucometer, have the patient return-demonstrate checking the blood sugar. Instruct the patient on safe disposal of lancets. Refer to inpatient diabetes educator if applicable.

Patient Friendly Description:
Why is it important to check my blood sugar?

Learner Progress: Not documented in this visit.

Point: Diabetic Foot Care (MCB) (Not Started)

Description:
Explain importance of foot care. Patient should have feet examined by a health care provider at least twice a year. Persons with foot problems should have feet examined at every visit. Explain daily foot care. Review importance of wearing well-fitting shoes and stockings/socks. Reinforce the importance of wearing shoes, even indoors, to prevent injury.

Patient Friendly Description:
This will inform you of why you should check your feet if you have diabetes.

Learner Progress: Not documented in this visit.

Point: Diabetes Identification Jewelry (Not Started)

Description:
Encourage the patient to wear a piece of jewelry that identifies patient as a person with diabetes. This will inform medical personnel that patient has diabetes if unable to communicate.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Topic: Prevention/Discharge (Not Started)

Point: Signs and Symptoms of Hypoglycemia (Not Started)

Description:
Define and explain causes of hypoglycemia. Discuss signs and symptoms.

Learner Progress: Not documented in this visit.

Point: Treatment of Hypoglycemia (Not Started)

Description:
Instruct the patient on how to treat low blood sugar using the Rule of 15. Encourage patient to carry a blood sugar treatment at all time.

Learner Progress: Not documented in this visit.

Point: When to Call the Doctor (Not Started)

Description:
Instruct the patient/family/caregiver to call their health care provider if there are symptoms of hypo- or hyperglycemia or if blood sugars are trending high or low and are not controlled by simple measures.

Learner Progress: Not documented in this visit.

Point: Signs and Symptoms of Hyperglycemia (Not Started)

Description:
Define and explain causes of hyperglycemia. Discuss signs and symptoms (mild, moderate, severe, and ketoacidosis).

Learner Progress: Not documented in this visit.

Point: Prevention of Hyperglycemia (Not Started)

Description:
Encourage patient/family/caregiver to follow healthcare providers' instructions for diet, activity and medications. Explain the importance of good diabetes management and learning to detect and treat hyperglycemia early before it worsens. Refer to registered dietitian, when applicable, for meal planning assistance.

Learner Progress: Not documented in this visit.

Point: Prevention of Hypoglycemia (Not Started)

Description:
Encourage patient/family/caregiver to follow healthcare providers' instructions for diet, activity and medications. Explain the importantce of good diabetes management and learning to detect and treat hypoglycemia early before it worsens.

Learner Progress: Not documented in this visit.

Point: WellStar Outpatient Diabetes Education (Not Started)

Description:
Provide information on WellStar Outpatient Diabetes Education when applicable. Information includes a list of classes offered and how to register.

Learner Progress: Not documented in this visit.

Point: Follow-up Appointments (Not Started)

Description:
Give the patient/family written information on when to make follow-up appointments. Reinforce importance of making and keeping the appointments. If appointments were made during the visit, give the patient a written reminder of the time and location.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Topic: Diabetic Diet (MCB) (Not Started)

Point: Meal Planning and Portion Sizes (MCB) (Not Started)

Description:
The patient will view documents in Krames talking about meal planning as well learning about serving and portion sizes.

Patient Friendly Description:
This will inform you of ways to stay on track with your diet.

Learner Progress: Not documented in this visit.

Point: Eating well with Diabetes (MCB) (Not Started)

Description:
Patient will watch a video on healthy eating for people with DM.

Patient Friendly Description:
Healthy eating for people with Diabetes.

Learner Progress: Not documented in this visit.

Point: Carbohydrate Counting (MCB) (Not Started)

Description:
Patient will read Krames documents on healthy meals and meal planing for Diabetes.

Patient Friendly Description:
Learn about counting your carbohydrates.

Learner Progress: Not documented in this visit.

Topic: Survival Skills (Not Started)

Point: Review Diagnosis (Not Started)

Description:
Review the diabetes disagnosis, specific to patient's diabetes type.
Diabetes Survival Skills Booklet provided.

Patient Friendly Description:
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Learner Progress: Not documented in this visit.

Point: Nutrition (Not Started)

Description:
Importance of consistent nutrition habits.

Learner Progress: Not documented in this visit.

Point: Appointments (Not Started)

Description:
Importance of follow up appointment with the health care provider who will provide diabetes care after discharge.

Learner Progress: Not documented in this visit.

Point: Sick Day (Not Started)

Description:
Sick day management

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Insulin Administration (if applicable) (Not Started)

Description:
Insulin administration and proper use and disposal of needles and syringes. How to schedule outpatient diabetes education. Review self-monitoring of blood glucose and home blood glucose goals.

Learner Progress: Not documented in this visit.

Point: Hyperglycemia (Not Started)

Description:
Definition, recognition, treatment and prevention of hyperglycemia.

Learner Progress: Not documented in this visit.

Point: Hypoglycemia (Not Started)

Description:
Definition, recognition, treatment and prevention of hypoglycemia.

Learner Progress: Not documented in this visit.

Point: Glucose Lowering Medications (Not Started)

Description:
When and how to take blood glucose-lowering medications.

Learner Progress: Not documented in this visit.

Topic: Diabetes Zones for Management (Not Started)

Point: Diabetes Zones for Management reviewed (Not Started)

Description:
Diabetes Zones for Management reviewed.

Learner Progress: Not documented in this visit.

Point: Diabetes Zones for Management handout provided (Not Started)

Description:
Diabetes Zones for Management handout provided.

Learner Progress: Not documented in this visit.

Title: WS Cardiac Rehab (Resolved)

Topic: PCI (Resolved)

Point: Books/Educational Material (Resolved)

Description:
Current standardized written information provided specific to diagnosis, recovery, disease progression and prevention.

Learner Progress: Not documented in this visit.

Point: Exercise (Resolved)

Patient Education (continued)

Education (continued)

Description:
Information regarding the benefits of exercise provided. Exercise guidelines provided for initial recovery from acute heart event and long term goals of exercise.

Learner Progress: Not documented in this visit.

Point: Medications (Resolved)

Description:
Medication compliance encouraged. Organization tools discussed and medication information and resources provided.

Learner Progress: Not documented in this visit.

Point: Risk Factors (Resolved)

Description:
Written and verbal information provided on modifiable and non-modifiable factors associated with increased risk of heart disease and stroke.

Learner Progress: Not documented in this visit.

Point: Activity guidelines (Resolved)

Description:
Appropriate activity and/or limitations for diagnosis specific recovery provided.

Learner Progress: Not documented in this visit.

Point: Signs/symptoms/activate EMS (Resolved)

Description:
Information provided on the signs and symptoms which commonly occur with a heart attack or stroke. Emphasis placed on appropriate activation of EMS with recognition of signs and symptoms.

Learner Progress: Not documented in this visit.

Point: Cardiac Rehab participation/location options (Resolved)

Description:
Cardiac rehabilitation benefits highlighted and participation encouraged.

Learner Progress: Not documented in this visit.

Point: Cardiac Diet/low fat/low sodium (Resolved)

Description:
American Heart Association guidelines provided for a reduced fat and reduced sodium diet.

Learner Progress: Not documented in this visit.

Point: Endocarditis education/card (Resolved)

Description:
Written and verbal instruction provided on endocarditis prevention. Temporary Valve card provided.

Learner Progress: Not documented in this visit.

Point: Outpatient education classes/Heart Smart/Device Advice/Heart of the Matter (Resolved)

Description:
Description and registration details of outpatient education classes provided. Participation encouraged.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Title: Cardiac Arrhythmia (MCB) (Not Started)

Topic: Treatment for Atrial Fibrillation/Atrial Flutter (MCB) (Not Started)

Point: Chemical cardioversion (MCB) (Not Started)

Description:
Provide written education on why and how a chemical cardioversion is done. As well as accociated risks.

Patient Friendly Description:
Why and how a chemical cardioversion is done and associated risks.

Learner Progress: Not documented in this visit.

Point: Electrical cardioversion (MCB) (Not Started)

Description:
Provide written education on why and how an electrical cardioversion is done. As well as accociated risks.

Patient Friendly Description:
Why and how a electrical cardioversion is done and associated risks.

Learner Progress: Not documented in this visit.

Point: Ablation (MCB) (Not Started)

Description:
Provide written education on the catheter ablation procedure and discharge instructions.

Patient Friendly Description:
How an ablation is done, and what to do after the procedure.

Learner Progress: Not documented in this visit.

Topic: Prevention/Discharge (MCB) (Not Started)

Point: Anticoagulation (MCB) (Not Started)

Description:
Provide written education on anticoagulation use including contraindications, side effects, interactions, and medication safety.

Patient Friendly Description:
Information on taking blood thinners safely.

Learner Progress: Not documented in this visit.

Point: Discharge with A Fib/Flutter (MCB) (Not Started)

Description:
Provide written education on treatment options, home care, and follow up care for discharging with atrial fibrillation.

Patient Friendly Description:
Information on treatment options, home care, and when to call your healthcare provider after going home with atrial fibrillation/flutter.

Learner Progress: Not documented in this visit.

Point: Atrial fib/flutter: stroke prevention (MCB) (Not Started)

Description:
"Provide written education on risk factors, medication, and prevention of A. Fib.
Hyperlink education materials provided to patient/family/caregiver. "

Patient Friendly Description:
Preventing stroke caused by A. Fib.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Topic: What is atrial fibrillation/flutter (MCB) (Not Started)

Point: You have atrial fibrillation (MCB) (Not Started)

Description:
Provide video education on the signs/symptoms of A. Fib, causes, medication(s), risk factors, prevention, and treatment.

Patient Friendly Description:
What to expect if you are diagnosed with A. Fib: causes, symptoms, and treatment.

Learner Progress: Not documented in this visit.

Point: You have Atrial Flutter (MCB) (Not Started)

Description:
Provide written education on the signs/symptoms of A. Flutter, causes, medication(s), risk factors, prevention, and treatment.

Patient Friendly Description:
What to expect if you are diagnosed with A. Flutter: causes, symptoms, and treatment

Learner Progress: Not documented in this visit.

Title: MyChart Bedside Teaching completed (Not Started)

Points For This Title

Point: All MCB content reviewed with patient and teachback completed. The patient verbalized understanding. (Not Started)

Description:
Go over all the Eduction for the patient in the Education activity. The Education that was provided to the patient via MCB was included as well as education that was noted within the Eduction activity as Education that was beneifical to the patient during this hospital stay.

Learner Progress: Not documented in this visit.

Title: Cardiac Surgery (Resolved)

Topic: PCI (Resolved)

Additional Points For This Title

Point: ACTIVITY (Resolved)

Learner Progress: Not documented in this visit.

Point: SIGNS AND SYMPTOMS/ACTIVATE EMS (Resolved)

Learner Progress: Not documented in this visit.

Point: BOOKS/EDUCATION MATERIAL (Resolved)

Learner Progress: Not documented in this visit.

Point: CARDIAC REHAB (Resolved)

Learner Progress: Not documented in this visit.

Point: DIET (Resolved)

Learner Progress: Not documented in this visit.

Point: EXERCISE (Resolved)

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Medications (Resolved)

Learner Progress: Not documented in this visit.

Point: POST OP CARE (Resolved)

Learner Progress: Not documented in this visit.

Point: RISK FACTORS (Resolved)

Learner Progress: Not documented in this visit.

Title: Coronary Artery Disease (MCB) (Not Started)

Topic: WS Cardiac Rehabilitation for Arrhythmia (MCB)--This is CAD and AMI Cardiac Rehab Program Information for the Patient (Not Started)

Point: Exercise for a Healthier Heart (MCB) (Not Started)

Description:
Explain how exercising regularly offers many health rewards. Provide exercise tips to beginning a new exercise routine; Set Small goals and aim for 150 minutes a week.

Patient Friendly Description:
This provides healthy heart tips on why exercise is important.

Learner Progress: Not documented in this visit.

Point: WellStar Cardiac Rehabilitation Program (MCB) (Not Started)

Description:
At WellStar, our cardiac rehab patients are individually assessed to review medical history, evaluate risk factors, analyze functional abilities and set goals. Ongoing assessments are conducted to ensure patients are making progress toward their goals, educational needs are being met, and any problems or concerns are being addressed with the referring physician.

Patient Friendly Description:
This will help you better understand Cardiac Rehabilitation. At WellStar, our cardiac rehab programs provide education, supervised exercise, lifestyle modification and emotional support to help patients increase physical fitness, reduce cardiac symptoms and improve health and wellbeing.

Learner Progress: Not documented in this visit.

Point: Cardiac Rehabilitation: Emotional Issue (MCB) (Not Started)

Description:
Explain how having heart disease can be stressful. Encourage patient not to ignore feelings of sadness, worry, and depression. Patient should know when to ask for help and/or support.

Patient Friendly Description:
This will explain some emotional feelings related to heart disease.

Learner Progress: Not documented in this visit.

Topic: Heart Healthy Diet- DASH Diet (MCB) (Not Started)

Point: Eating Heart Healthy Food: Using DASH Plan (MCB) (Not Started)

Description:
Review diet information and explain that eating a low salt, low fat and low cholesterol diet with plenty of fruits and vegetables can reduce risk of complications from CAD.

Patient Friendly Description:
This will help you follow a healthy eating plan that can reduce your risk of complications associated with Coronary Artery Disease.

Please watch video/read over the material and let anyone on your Care Team know if there are any questions by marking below.

Patient Education (continued)

Education (continued)

If you understand all material, mark I understand below.
Learner Progress: Not documented in this visit.

Topic: Questions your patient may have for you (MCB) (Not Started)

Point: Questions your patient may have about the AMI (MCB) (Not Started)

Description:
This is information about diet, exercise and medications for patients and it encourages them to ask staff questions.

Patient Friendly Description:
After reading this, you can write down any questions that you have for staff under the Notes section as a reference.
Learner Progress: Not documented in this visit.

Topic: Coronary Artery Disease (MCB) (Not Started)

Point: Recognizing signs and symptoms of Heart Disease (MCB) (Not Started)

Description:
Provide written education on the signs/symptoms of CAD, causes, medication(s), risk factors, prevention and treatment.

Patient Friendly Description:
This will explain some of the causes of Coronary Artery Disease.
Learner Progress: Not documented in this visit.

Point: Understanding Coronary Artery Disease (MCB) (Not Started)

Description:
Give patient written information on CAD. Explain the definition of CAD, causes, signs and symptoms.

Patient Friendly Description:
This will inform you of what to expect if you are diagnosed with Coronary Artery Disease (CAD).

Please watch video/read over the material and let anyone on your Care Team know if there are any questions by marking below.

If you understand all material, mark I understand below.
Learner Progress: Not documented in this visit.

Topic: Risk factors for Heart Disease (MCB) (Not Started)

Point: Tobacco/Smoking Cessation (MCB) (Not Started)

Description:
Give patient written information on Quitting Smoking

Educate the patient/family/caregiver on smoking cessation and smoking cessation programs offered in the community. Explain effects smoking and second hand smoke have on the body. Encourage the patient to ask people that smoke around him/her to smoke outside or in another room. Refer patient to Cardiopulmonary Rehabilitation, if applicable.

Patient Friendly Description:
This will give you some getting started tips to kick the smoking habit.

This will help you plan how to quit the smoking habit.
Learner Progress: Not documented in this visit.

Title: First-Dose Education (Not Started)

Points For This Title

Point: hydralazine HCl (Not Started)

Patient Education (continued)

Education (continued)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: iohexol (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: nitroglycerin (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: Ringer's solution,lactated (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: dextrose (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: dextrose 50 % in water (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: calcium carbonate (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: morphine sulfate (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: hydrocodone/acetaminophen (Not Started)

Patient Education (continued)

Education (continued)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: aspirin (Resolved)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: acetaminophen (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: atropine sulfate (Resolved)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: phenylephrine HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: labetalol HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: metoclopramide HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: cyclopentolate HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: furosemide (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: diclofenac sodium (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: gentamicin sulfate (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: diphenhydramine HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: 0.9 % sodium chloride (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: piperacillin sodium/tazobactam (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: insulin lispro (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: ondansetron (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: glucagon,human recombinant (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: gadobenate dimeglumine (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: pantoprazole sodium (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: polyethylene glycol 3350 (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: perflutren lipid microspheres (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: fentanyl citrate/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: lidocaine HCl/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: ondansetron HCl/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: tetracaine HCl/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Title: Congestive Heart Failure (MCB) (Not Started)

Topic: Psycho/Social/Spiritual Support (Not Started)

Point: Stress Management and Support Systems (Not Started)

Description:
Explain the importance of stress management and support systems in diabetes management. Refer to WellStar diabetes support groups, social services, case management or spiritual care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Not Started)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Treatments/Procedures (MCB) (Not Started)

Point: Oxygen (Not Started)

Description:
Educate patient/family/caregiver on why oxygen is needed and how it will be delivered (nasal cannula, mask, etc.). Instruct patient/family/caregiver that the patent should not be smoking while on oxygen.

Learner Progress: Not documented in this visit.

Point: Medical Equipment (Not Started)

Description:
Educate patient/family/caregiver on use of medical equipment and provide educational materials.

Learner Progress: Not documented in this visit.

Point: Introduction to Heart Failure (MCB) (Not Started)

Description:
Give patient written information on congestive heart failure. Explain the definition of CHF, causes, signs and symptoms, expected length of stay and criteria for discharge.

Patient Friendly Description:
This will inform you of what to expect if you are diagnosed with heart failure.

You will be receiving the Congestive Heart Failure red booklet.

Please watch video/read over the material and let anyone on your Care Team know if there are any questions by marking below.

If you understand all material, mark I understand below.
Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Echocardiogram (Not Started)

Description:
Educate patient/family/caregiver on echocardiograms, to include: what the test is, how the test will be performed, and what to expect during the test.

Learner Progress: Not documented in this visit.

Topic: Pain Management (Not Started)

Point: Pain Medication Actions & Side Effects (Not Started)

Description:
Provide medication specific handouts when available.

Learner Progress: Not documented in this visit.

Point: Pain Rating Scale (Not Started)

Description:
Provide patient with information on the Pain Rating Scale. Explain the rating scale of 0 to 10.

Learner Progress: Not documented in this visit.

Point: Non-Pharmacological Comfort Measures (Not Started)

Description:
Explain there are other ways of controlling pain than medication. The following are suggestions: position change, aromatherapy, deep slow breathing, distraction, quiet environment, imagery, heat therapy and/or cold therapy, laughter, massage, music, physical therapy, and touch therapy.

Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Not Started)

Point: Eating well with High Blood Pressure (MCB) (Not Started)

Description:
Information provided to patient to explain what their diet should consist of when they have Heart Failure.

Patient Friendly Description:
This will help you make heart healthy eating choices if you have a diagnosis with heart failure.

Learner Progress: Not documented in this visit.

Point: Heart Failure:Being Active (MCB) (Not Started)

Description:
Explain to the patient how to be active with heart failure.

Patient Friendly Description:
This will explain how to safely be active with heart failure.

Learner Progress: Not documented in this visit.

Point: Heart Failure: Dealing with Sleep problems (MCB) (Not Started)

Description:
Provide tips and ideas to help patient sleep better.

Patient Friendly Description:
This will provide tips on sleeping better with heart faillure.

Learner Progress: Not documented in this visit.

Point: Heart Failure: Know your Baselines (MCB) (Not Started)

Patient Education (continued)

Education (continued)

Description:
Explain to patient how to identify their baseline and recognize changes.

Patient Friendly Description:
This will help you understand what's normal for you and how to watch for changes.

Learner Progress: Not documented in this visit.

Point: Heart Failure : Know your Zones (Not Started)

Description:
Review heart failure zones with patient and educate them on how to know which zone they are in each day.

Learner Progress: Not documented in this visit.

Point: Dealing with Heart Failure: Helping the patient cope (MCB) (Not Started)

Learner Progress: Not documented in this visit.

Point: Daily Weights (MCB) (Not Started)

Description:
Give written information about daily weights. Instruct the patient to weigh on the same scale every day at the same time, wearing the same amount of clothing. Explain why it is important to check weight. Inform the patient that gaining weight from fluid build up may be an early sign that heart failure is getting worse. The patient should call a care provider if there is a weight gain of more than 2-3 pounds in one day or 4-5 pounds in five days.

Patient Friendly Description:
Information on the importance of Daily weights.

Learner Progress: Not documented in this visit.

Point: How to check your Heart Rate and Blood Pressure (MCB) (Not Started)

Description:
Give patient written information on how to take a pulse. Explain the definition of a pulse, normal range, reason for taking a pulse, where pulses can be found. Demonstrate how to find a pulse. Once found, instruct the patient to count the beats for a full minute. Tell the patient to keep a record of the pulse rate, date and time taken, which site (right/left, wrist/neck) and strength of beats (weak, strong or missing beats).

Patient Friendly Description:
This will explain the importance of understanding your vital signs and show you how to take them.

Learner Progress: Not documented in this visit.

Topic: WellStar Cardiac Rehabilitation (MCB) (Not Started)

Point: Exercise for a Healthier Heart (MCB) (Not Started)

Description:
Explain how exercising regularly offers many health rewards. Provide exercise tips to beginning a new exercise routine; Set Small goals and aim for 150 minutes a week.

Patient Friendly Description:
This provides healthy heart tips on why exercise is important.

Learner Progress: Not documented in this visit.

Point: WellStar Cardiac Rehabilitation Program (MCB) (Not Started)

Description:
At WellStar, our cardiac rehab patients are individually assessed to review medical history, evaluate risk factors, analyze functional abilities and set goals. Ongoing assessments are conducted to ensure patients are making progress toward their goals, educational needs are being met, and any problems or concerns are being addressed with the referring physician.

Patient Friendly Description:
This will help you better understand Cardiac Rehabilitation. At WellStar, our cardiac rehab programs provide education, supervised exercise, lifestyle modification and emotional support to help patients increase physical fitness, reduce cardiac symptoms and improve health and wellbeing.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Topic: Review Plan of Care (Not Started)

Point: Review Plan of Care - Day 5 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 1 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 2 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 3 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 4 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Topic: Medications (MCB) (Not Started)

Point: Heart Failure Medications (MCB) (Not Started)

Description:
Educate patient on the drug type, purpose for medication, and common side effects.

Educate patient on Prescribed Medications

Patient Friendly Description:
This will inform you of medications that you may be taking if you are diagnosed with Heart Failure.

Learner Progress: Not documented in this visit.

Point: ACE Inhibitors (Not Started)

Patient Education (continued)

Education (continued)

Description:
Educate patient/family/caregiver on the ACE Inhibitor prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Angiotensin II Receptor Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Angiotensin II Receptor Blockers prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Aspirin (Not Started)

Description:
Give patient written information on Aspirin. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the doctor should be called. Reinforce that this medication should be taken exactly as the doctor has prescribed.

Learner Progress: Not documented in this visit.

Point: Beta Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Beta Blocker prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Digoxin (Not Started)

Description:
Educate patient/family/caregiver on Digoxin and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed. The physician will order a blood test to monitor the concentration of the drug in the patient's blood. The dose of this medication may be changed according to the results of this test.

Learner Progress: Not documented in this visit.

Point: Diuretics (Not Started)

Description:
Educate patient/family/caregiver on the Diuretic prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Inotropes (Not Started)

Description:
Educate patient/family/caregiver on the Inotropes prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Vasodilators (Not Started)

Patient Education (continued)

Education (continued)

Description:
Educate patient/family/caregiver on the Vasodilator prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Topic: Prevention / Discharge (MCB) (Not Started)

Point: Community Resources (Not Started)

Description:
Give written information on available community resources. Refer to Social Services or Case Management, if needed.

Learner Progress: Not documented in this visit.

Point: Home Health Care Services (Not Started)

Description:
Give patient written information on Home Health Care Services that have been arranged. Review the role of the home care nurse and when to expect the first visit. Refer to Case Management or Social Services, if needed.

Learner Progress: Not documented in this visit.

Point: Follow-up Appointments (Not Started)

Description:
Give the patient/family written information on their next appointment and when to make follow-up appointments. Reinforce importance of making and keeping the appointments. If appointments were made during the visit, give the patient a written reminder of the time and location.

Learner Progress: Not documented in this visit.

Point: Influenza Vaccine (Not Started)

Description:
Educate the patient/family/caregiver on obatining a yearly influenza vaccine.

Learner Progress: Not documented in this visit.

Point: Discharge Medications (Not Started)

Description:
Ensure that there are no barriers to obtain medications prior to discharge. Notify Care Coordination if there are any needs for additional resources prior to discharging the patient.

Learner Progress: Not documented in this visit.

Point: When to Call the Doctor (MCB) (Not Started)

Description:
Provide written documentation instructing the patient to call the doctor if the patient has:

1. Ankles and legs that become more swollen.
2. Shoes and socks that get tight suddenly.
3. Shortness of breath that does not go away with rest.
4. Weight gain of 2 - 3 pounds in one day.
5. Weight gain of 4 - 5 pounds in one week.
6. No energy for normal activities.
7. Dizziness or weakness.
8. Yellowish or blue green vision.
9. Heartbeat changes (feels like a butterfly in the chest).
10. Chest pain.
11. Blurred vision.
12. Passing out.
13. Cough that does not go away.

Patient Education (continued)

Education (continued)

Patient Friendly Description:
Heart Failure symptoms to know and when to call your healthcare provider.
Lifestyle changes to help you feel and live better with Heart Failure.

Learner Progress: Not documented in this visit.

Point: Review Discharge Plan (Not Started)

Description:
Review the discharge plan with patient and primary care giver including: diet, activity, medications, and special precautions. Refer to Case Management, if needed.

Learner Progress: Not documented in this visit.

Point: Smoking Cessation (Not Started)

Description:
Educate the patient/family/caregiver on smoking cessation and smoking cessation programs offered in the community. Explain effects smoking and second hand smoke have on the body. Encourage the patient to ask people that smoke around him/her to smoke outside or in another room. Refer patient to Cardiopulmonary Rehabilitation, if applicable.

Learner Progress: Not documented in this visit.

Point: Diet Instructions for CHF Prevention (Not Started)

Description:
Review diet information and explain that eating a low fat and low cholesterol diet with plenty of fruits and vegetables can reduce their chance of suffering a future heart attack.

Learner Progress: Not documented in this visit.

Topic: Heart Failure Discharge Instructions (Not Started)

Point: Follow-up Appointments (Not Started)

Description:
Give the patient/family written information on their next appointment and when to make follow-up appointments. Reinforce importance of making and keeping the appointments. If appointments were made during the visit, give the patient a written reminder of the time and location.

Learner Progress: Not documented in this visit.

Point: Daily Weights (MCB) (Not Started)

Description:
Give written information about daily weights. Instruct the patient to weigh on the same scale every day at the same time, wearing the same amount of clothing. Explain why it is important to check weight. Inform the patient that gaining weight from fluid build up may be an early sign that heart failure is getting worse. The patient should call a care provider if there is a weight gain of more than 2-3 pounds in one day or 4-5 pounds in five days.

Patient Friendly Description:
Information on the importance of Daily weights.

Learner Progress: Not documented in this visit.

Point: When to Call the Doctor (MCB) (Not Started)

Description:
Provide written documentation instructing the patient to call the doctor if the patient has:

1. Ankles and legs that become more swollen.
2. Shoes and socks that get tight suddenly.
3. Shortness of breath that does not go away with rest.
4. Weight gain of 2 - 3 pounds in one day.
5. Weight gain of 4 - 5 pounds in one week.
6. No energy for normal activities.
7. Dizziness or weakness.
8. Yellowish or blue green vision.
9. Heartbeat changes (feels like a butterfly in the chest).

Patient Education (continued)

Education (continued)

10. Chest pain.
11. Blurred vision.
12. Passing out.
13. Cough that does not go away.

Patient Friendly Description:
Heart Failure symptoms to know and when to call your healthcare provider.
Lifestyle changes to help you feel and live better with Heart Failure.

Learner Progress: Not documented in this visit.

Point: Review Discharge Plan (Not Started)

Description:
Review the discharge plan with patient and primary care giver including: diet, activity, medications, and special precautions. Refer to Case Management, if needed.

Learner Progress: Not documented in this visit.

Point: Diet Instructions for CHF Prevention (Not Started)

Description:
Review diet information and explain that eating a low fat and low cholesterol diet with plenty of fruits and vegetables can reduce their chance of suffering a future heart attack.

Learner Progress: Not documented in this visit.

Title: General Patient Education (MCB) (Not Started)

Topic: Psycho/Social/Spiritual Support (Not Started)

Point: Coping Mechanisms (Resolved)

Description:
Help patient identify healthy coping mechanisms. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Support Systems (Resolved)

Description:
Help patient identify available support systems. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Spiritual/Emotional Needs (Resolved)

Description:
Offer resources to meet spiritual/emotional needs. Refer to Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Stress Management and Support Systems (Not Started)

Description:
Explain the importance of stress management and support systems in diabetes management. Refer to WellStar diabetes support groups, social services, case management or spiritual care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Not Started)

Patient Education (continued)

Education (continued)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Pain Management (MCB) (Resolved)

Point: Encourage Patient to Monitor Own Pain (Resolved)

Description:
Provide patient with information on the Pain Rating Scale. Explain the rating scale of 0 to 10.

Learner Progress: Not documented in this visit.

Point: Discuss Significance of VAS Scores (Resolved)

Description:
Refer to rating score of 0-10.

Learner Progress: Not documented in this visit.

Point: Discuss the Use of Pain Control Measures Before Pain Becomes Severe (MCB) (Resolved)

Description:
Take time to reiterate to patient that he/she should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time before pain becomes severe.

Patient Friendly Description:
Please inform staff that if you are having any difficulty breathing, pain or any discomfort at any time before the pain gets severe.

Please read over the items and let anyone on your Care Team know there are any questions about the material by marking below that "I HAVE QUESTIONS".

If once you have received the items and understand the material you can mark this as "I understand".
Learner Progress: Not documented in this visit.

Topic: Prevention (MCB) (Not Started)

Point: When to Call the Doctor (Not Started)

Description:
Educate patient/family/caregiver on when to call the doctor.

Learner Progress: Not documented in this visit.

Point: Protect Others from Infection (Not Started)

Description:
Educate patient/family/caregiver on respiratory hygiene and cough etiquette. To protect from further infection and to protect others from getting an infection, patient should cover nose and mouth with tissues when coughing. Encourage patient to place used tissues in a plastic bag that will not allow secretions to soak through. Patient should always wash his/her hands after using or handling used tissues.

Learner Progress: Not documented in this visit.

Point: Protect Yourself from Further Infection (MCB) (Not Started)

Description:
Educate patient/family/caregiver that because patient is in a weakened condition he/she needs to avoid others who are sick as to not acquire another illness. Family/caregiver should wear gloves, gown and face shield/eye protection.

Patient Friendly Description:
Information on Flu.

Patient Education (continued)

Education (continued)

Information on Pneumonia and Pneumococcal Vaccination.
Learner Progress: Not documented in this visit.

Point: Falls education, precautions, prevention at home and in the hospital (MCB) (Not Started)

Description:
Patient was given information on preventing falls both while in the hospital and when they are at home.

Patient Friendly Description:
Things to help you prevent falls while you are in the hospital and when you are home.
Learner Progress: Not documented in this visit.

Point: Prevention Deep Vein Thrombosis after surgery (MCB) (Not Started)

Description:
Educate patient/family/caregiver to prevent DVT and PE after Suergery

Patient Friendly Description:
In the days and weeks after surgery, you have a higher chance of developing a deep vein thrombosis (DVT).
This is a condition in which a blood clot or thrombus develops in a deep vein.
They are most common in the leg. But, a DVT may develop in an arm, or another deep vein in the body.
A piece of the clot, called an embolus, can separate from the vein and travel to the lungs.
A blood clot in the lungs is called a pulmonary embolus (PE).
This can cut off the flow of blood to the lungs.
It is a medical emergency and may cause death.
Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Not Started)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.
Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Not Started)

Point: General Self Care (Not Started)

Description:
Instruct patient on self care needs. These may include: hygiene, how to take a blood pressure, how to change a dressing, etc.

Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Not Started)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.
Learner Progress: Not documented in this visit.

Topic: Medications (MCB) (Not Started)

Point: Antibiotic Education (Not Started)

Patient Education (continued)

Education (continued)

Description:
If an antibiotic was prescribed, educate patient/family/caregiver on the antibiotics prescribed. Explain how antibiotics work in the body. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed

If a viral diagnosis was made, the patient/family was educated on their viral diagnosis and the reason for no antibiotic this visit.

Learner Progress: Not documented in this visit.

Point: Anticoagulant Therapy (Not Started)

Description:
1-Educate patient/family/caregiver on anticoagulant being prescribed and provide educational materials.
2-Explain action of medication, reason for taking, and importance of adherence to correct medication dose and schedule,
3-Explain potential for adverse drug reactions, signs of allergic reaction, potential for drug-drug and drug-food interactions, and when physician should be called.
4-Reinforce that the medication should be taken exactly as the physician has prescribed.
5-Explain importance of maintaining follow-up appointments and adhering to laboratory testing as prescribed by physician.
6-Explain that the dose of the anticoagulant being prescribed may change depending on the results of the laboratory testing.

Learner Progress: Not documented in this visit.

Point: Insulin (MCB) (Not Started)

Description:
Educate patient/family/caregiver on the insulin prescribed. Explain how insulin works in the body. Explain the action of insulin, reason for taking, side effects, signs of allergic reaction and when physician should be called. Reinforce that insulin should be taken exactly as the physician has prescribed. Explain the proper storage of insulin, that extreme temperatures can damage insulin and never take insulin that has expired. Explain that the patient's primary care physician may change the dosage depending on the results of blood glucose tests and/or A1C level.

Patient Friendly Description:
This will inform you of why you are prescribed insulin if you have Diabetes Type II.

Learner Progress: Not documented in this visit.

Point: Hypoglycemic Agents (Not Started)

Description:
Educate patient/family/caregiver on the oral and/or injectable hypoglycemic(s) prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, as well as when the physician should be called. Reinforce that this medication(s) should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Non-Steroidal Anti-Inflammatory Drugs (Not Started)

Description:
Educate patient/family/caregiver on the NSAID prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Psychotropic Medications (Not Started)

Description:
Educate patient/family/caregiver on the Psychotropic medication prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: ACE Inhibitors (Not Started)

Patient Education (continued)

Education (continued)

Description:
Educate patient/family/caregiver on the ACE Inhibitor prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Angiotensin II Receptor Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Angiotensin II Receptor Blockers prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Beta Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Beta Blocker prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Digoxin (Not Started)

Description:
Educate patient/family/caregiver on Digoxin and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed. The physician will order a blood test to monitor the concentration of the drug in the patient's blood. The dose of this medication may be changed according to the results of this test.

Learner Progress: Not documented in this visit.

Point: Diuretics (Not Started)

Description:
Educate patient/family/caregiver on the Diuretic prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Inotropes (Not Started)

Description:
Educate patient/family/caregiver on the Inotropes prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Vasodilators (Not Started)

Description:
Educate patient/family/caregiver on the Vasodilator prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Antibiotics (Not Started)

Patient Education (continued)

Education (continued)

Description:
Educate patient/family/caregiver on the Antibiotics prescribed. Explain how antibiotics works in the body. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Medication purpose, side effects, schedule, administration (MCB) (Not Started)

Description:
Discussed purpose and possible side effects of medication.

Learner Progress: Not documented in this visit.

All Flowsheets

Flowsheets (all recorded)

Custom Formula Data

Row Name	04/03/19 1201	04/03/19 1150	04/03/19 1035	04/03/19 1020	03/29/19 0858
Vitals					
Pct Wt Change	—	—	—	0 % -AM	0 % -SC
OTHER					
Weight Change (kg)	—	—	—	0 kg -AM	0 kg -SC
Ideal Body Weight	—	—	—	160 lb -AM	160 lb -SC
Visit Weight	—	—	—	213 lb -AM	205 lb -SC
BMI (Calculated)	—	—	—	33.3 -AM	32.1 -SC
IBW/kg (Calculated) Male	—	—	—	66.1 kg -AM	66.1 kg -SC
IBW/kg (Calculated) FEMALE	—	—	—	61.6 kg -AM	61.6 kg -SC
Weight/Scale Event	—	—	—	0 -AM	0 -SC
Weight in (lb) to have BMI = 25	—	—	—	159.3 -AM	159.3 -SC
% Weight Change Since Birth	—	—	—	0 -AM	0 -SC
Vitals Sepsis Risk Score	—	0 -KS	0 -AM	—	—
Adult IBW/VT Calculations					
IBW/kg (Calculated)	—	—	—	66.1 -AM	66.1 -SC
Range Vt 4mL/kg	—	—	—	264.4 mL/kg -AM	264.4 mL/kg -SC
Low Range Vt 6mL/kg	—	—	—	396.6 mL/kg -AM	396.6 mL/kg -SC
Adult Moderate Range Vt 8mL/kg	—	—	—	528.8 mL/kg -AM	528.8 mL/kg -SC
Adult High Range Vt 10mL/kg	—	—	—	661 mL/kg -AM	661 mL/kg -SC
Case Log					
BSA x (CI @3.0)= CO	—	—	—	6.39 CO -AM	6.27 CO -SC
Relevant Labs and Vitals					
Temp (in Celsius)	—	36.4 -KS	36.8 -AM	—	—
Aldrete Phase 1					
Aldrete Score	10 -KS	—	—	—	—

Flowsheets (all recorded)

Clear Lung/ Incentive Spirometry

Row Name	03/29/19 0908				
High Risk Pulmonary Assessment					
Current Inpatient, Add-on, and/or Emergency Surgery	0 -SC				
Active smoker (1 or more cigarettes in the last 12 months)?	0 -SC				
Obstructive Sleep Apnea, history of	0 -SC				
COPD, currently being treated?	0 -SC				
Asthma, currently being treated?	0 -SC				
Dyspnea/shortness of breath (i.e. cannot walk up one flight of stairs due to dyspnea)?	0 -SC				
Inability to perform ADLs (needs assistance with at least one of the following: bathing, feeding, toileting, and mobility)?	0 -SC				
High Risk Pulmonary Assessment Score	0 -SC				

Flowsheets (all recorded)

Risk for Readmission

Row Name	04/03/19 1205				
OTHER					
Risk for Readmission	9 -KS				

Flowsheets (all recorded)

Phone Call

Row Name	03/29/19 0926				
Phone Call					
Surgery Time Verified	Yes -SC				
Arrival Time Verified	1000 -SC				
Surgery Location Verified	Yes -SC				
Medical History Reviewed	Yes -SC				
NPO Status Reinforced	Yes -SC				
Ride and Caregiver Arranged	Yes -SC				
Ride Caregiver Provider	Shirley Maurice -SC				
Phone Number for Ride/Caregiver	678-910-2476 -SC				

Flowsheets (all recorded)

Intake/Output

Row Name	04/03/19 1152	04/03/19 1150	04/03/19 1138	04/03/19 1138	04/03/19 1044
sodium chloride 0.9% (NS) infusion Start: 04/03/19 1100					
Rate	0 mL/hr -KS	—	—	—	30 mL/hr -AM
Volume (mL)	—	—	200 mL -NM	—	—
Simple Vitals					
Pulse	—	53 -KS	—	—	—
Resp	—	18 -KS	—	—	—
Numeric Pain Intensity Score 1	—	0 -KS	—	—	—
[REMOVED] Peripheral IV 04/03/19 22 G Right Hand					
IV Properties	Placement Date: 04/03/19 -AM Placement Time: 1042 -AM Present on arrival to hospital?: No -AM Type of Catheter: Straight -AM Size (Gauge): 22 G -AM Orientation: Right -AM Location: Hand -AM Site Prep: Chlorhexidine -AM Local Anesthetic: None -AM Inserted by: Bridgette Spence, RN -AM Insertion attempts: 1 -AM Successful IV Attempt?: Yes -AM Patient Tolerance: Tolerated well -AM IV Access Problem: No -AM Removal Date: 04/03/19 -KS Removal Time: 1150 -KS Catheter Intact on removal?: Yes -KS Removal Reason : Patient discharged -KS Remaining intact at discharge?: No -KS				

Row Name	04/03/19 1042	04/03/19 1035	04/03/19 1020	03/29/19 0858
Weights				
Weight	—	—	96.6 kg (212 lb 15.4 oz) -AM	93 kg (205 lb) -SC
Weight Method	—	—	Actual -AM	Stated -SC
BSA (Calculated - sq m)	—	—	2.13 sq meters -AM	2.09 sq meters -SC
Simple Vitals				
Pulse	—	51 -AM	—	—
Resp	—	14 -AM	—	—
Numeric Pain Intensity Score 1	—	0 -AM	—	—
[REMOVED] Peripheral IV 04/03/19 22 G Right Hand				
IV Properties	Placement Date: 04/03/19 -AM Placement Time: 1042 -AM Present on arrival to hospital?: No -AM Type of Catheter: Straight -AM Size (Gauge): 22 G -AM Orientation: Right -AM Location: Hand -AM Site Prep: Chlorhexidine -AM Local Anesthetic: None -AM Inserted by: Bridgette Spence, RN -AM Insertion attempts: 1 -AM Successful IV Attempt?: Yes -AM Patient Tolerance: Tolerated well -AM IV Access Problem: No -AM Removal Date: 04/03/19 -KS Removal Time: 1150 -KS Catheter Intact on removal?: Yes -KS Removal Reason : Patient discharged -KS Remaining intact at discharge?: No -KS			
Phlebitis Scale	0 -AM	—	—	—
Infiltration/Extravasation Scale	0 -AM	—	—	—
Line Assessment	Blood return noted;Infusing -AM	—	—	—
Dressing Assesment	Clean;Dry;Intact -AM	—	—	—

Flowsheets (all recorded)

Assessment

Row Name	04/03/19 1201	04/03/19 1150	04/03/19 1149	04/03/19 1041	04/03/19 1037
Respiratory					
Respiratory (WDL)	—	—	—	—	WDL -AM
Oxygen Therapy					
SpO2	—	98 % -KS	—	—	—
Integumentary					
Integumentary (WDL)	—	—	—	—	WDL -AM
Skin Color	Appropriate for ethnicity -KS	—	—	—	—
Skin Condition/Temp	Dry;Cool -KS	—	—	—	—
Braden Scale					
Sensory Perceptions	—	—	—	—	4 -AM
Moisture	—	—	—	—	4 -AM
Activity	—	—	—	—	4 -AM
Mobility	—	—	—	—	4 -AM
Nutrition	—	—	—	—	4 -AM
Friction and Shear	—	—	—	—	3 -AM
Braden Scale Score	—	—	—	—	23 -AM
[REMOVED] Surgical 04/03/19 Eye Right					
Incision Properties	Date Documented: 04/03/19 -SB Time Documented: 1043 -SB Location: Eye -SB Wound Location Orientation: Right -SB Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205				
Dressing	—	—	Eye shield -KS	—	—
Dressing Assesment	—	—	Clean;Dry;Intact -KS	—	—
Hester Davis Fall Risk Assessment					
Last Known Fall	—	—	—	0 -AM	—
Mobility	—	—	—	0 -AM	—
Medications	—	—	—	1 -AM	—
Mental Status/LOC/Awareness	—	—	—	0 -AM	—
Toileting Needs	—	—	—	0 -AM	—
Volume/Electrolyte Status	—	—	—	2 -AM	—
Communication/Sensory	—	—	—	1 -AM	—
Behavior	—	—	—	0 -AM	—
Hester Davis Fall Risk Total	—	—	—	7 -AM	—

Row Name	04/03/19 1035	04/03/19 1020	03/29/19 0858
tPA Time out			
Weight	—	96.6 kg (212 lb 15.4 oz) -AM	93 kg (205 lb) -SC
Oxygen Therapy			
SpO2	96 % -AM	—	—
O2 Device	None (Room air) -AM	—	None (Room air) -SC

Flowsheets (all recorded)

Screenings

Row Name	04/03/19 1037	03/29/19 0858			
Advance Directives (For Healthcare)					
Advance Directive	Patient does not have advance directive -AM	Patient does not have advance directive -SC			
Values/Beliefs					
Cultural Preferences Affecting Hospitalization	—	No -SC			
Spiritual Preferences Affecting Hospitalization	—	No -SC			
Braden Scale					
Sensory Perceptions	4 -AM	—			
Moisture	4 -AM	—			
Activity	4 -AM	—			
Mobility	4 -AM	—			
Nutrition	4 -AM	—			
Friction and Shear	3 -AM	—			
Braden Scale Score	23 -AM	—			
Pressure Ulcer Present on Admission (IF YES, DOCUMENT BY GOING TO: 1) NOTES ACTIVITY 2) PROGRESS NOTES 3) TYPE "PRESSURE ULCER ON ADMISSION" IN SMART TEXT BOX 4) CLICK CO-SIGN WITH MD SIGNATURE)					
Pressure ulcer present on admission	No -AM	—			
Abuse Assessment					
Safe in Home	—	Yes -SC			
Adult Obstructive Sleep Apnea (OSA) Screening Tool					
Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	—	0 -SC			

Flowsheets (all recorded)

Vital Signs

Row Name	04/03/19 1150	04/03/19 1035	03/29/19 0858		
Vital Signs					
Automatic Restart Vitals Timer	Yes -KS	Yes -AM	—		
Pulse	53 -KS	51 -AM	—		
Heart Rate Source	Monitor -KS	Monitor -AM	—		
Resp	18 -KS	14 -AM	—		
BP	132/53 -KS	139/69 -AM	—		
Calculated MAP	79.33 -KS	92.33 -AM	—		
Patient Position	Other (Comment) -KS	Sitting -AM	—		
Temp	97.6 °F (36.4 °C) -KS	98.2 °F (36.8 °C) -AM	—		
Temp src	Temporal -KS	Temporal -AM	—		
Oxygen Therapy					
SpO2	98 % -KS	96 % -AM	—		
O2 Device	—	None (Room air) -AM	None (Room air) -SC		
Vitals Sepsis Score					
Vitals Sepsis Risk Score	0 -KS	0 -AM	—		

Flowsheets (all recorded)

PA Risk Score

Row Name	04/03/19 1201				
Readmission Risk Score					
Readmission	9 -UE				

Flowsheets (all recorded)

Pre-Admission Testing

Row Name	04/03/19 1037	03/29/19 0858			
Pre-AdmissionTesting Checklist					
Correct Patient?	—	Yes -SC			
Correct Procedure?	—	Yes -SC			
Correct Site?	—	Yes -SC			
Patient has been to this health system before?	—	Yes -SC			
Isolation Precautions	N/A -AM	— na -SC			
History of Anesthesia? Type?	—	General -SC			
Problems with Anesthesia?	—	No -SC			
Family Member With Serious Problem with Anesthesia/Sedation?	—	No -SC			
Pacemaker	No -AM	No -SC			
Patient has an ICD?	No -AM	No -SC			
Does patient refuse blood?	—	No -SC			
VTE Diagnostic Test Performed?	—	No -SC			
Advance Directive	Patient does not have advance directive -AM	Patient does not have advance directive -SC			
Patient can read and write?	—	Yes -SC			
History given by	—	Patient -SC			
Providing self care at home?	—	Yes -SC			
Discharge transport	—	Family -SC			
Discharge transport contact #(s)	—	Shirley Maurice spouse 678-910-2476 -SC			
Release of Personal Information to Emergency Contact	—	Yes -SC			
Nutrition					
Diet at home?	—	Low fat, Low cholesterol -SC			
Home glucose monitoring?	—	Yes -SC			
Exercise					
Able to walk up 2 flights of stairs without SOB?	—	Yes -SC			
Functional Capacity/ Assistive Device					
Functional Capacity	—	No Limitations -SC			
Assistive Devices?	—	— na -SC			
Adult Obstructive Sleep Apnea (OSA) Screening Tool					
Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	—	0 -SC			
Do you feel tired, fatigued, or sleepy during daytime hours?	—	1 -SC			
Has anyone observed you stop breathing during your sleep?	—	0 -SC			
Do you have or are you being treated for high blood pressure?	—	1 -SC			
Is your body mass index (BMI) greater than 35?	—	0 -SC			
Are you over 50 years old?	—	1 -SC			

Flowsheets (all recorded) (continued)

Pre-Admission Testing (continued)

Row Name	04/03/19 1037	03/29/19 0858			
Is your neck circumference greater than 16 inches?	—	1 -SC			
Are you a male?	—	1 -SC			
Sleep Apnea Total Score	—	5 -SC			

Flowsheets (all recorded)

OR Lines/Drains/Airways

Row Name	04/03/19 1042
[REMOVED] Peripheral IV 04/03/19 22 G Right Hand	
IV Properties	Placement Date: 04/03/19 -AM Placement Time: 1042 -AM Present on arrival to hospital?: No -AM Type of Catheter: Straight -AM Size (Gauge): 22 G -AM Orientation: Right -AM Location: Hand -AM Site Prep: Chlorhexidine -AM Local Anesthetic: None -AM Inserted by: Bridgette Spence, RN -AM Insertion attempts: 1 -AM Successful IV Attempt?: Yes -AM Patient Tolerance: Tolerated well -AM IV Access Problem: No -AM Removal Date: 04/03/19 -KS Removal Time: 1150 -KS Catheter Intact on removal?: Yes -KS Removal Reason : Patient discharged -KS Remaining intact at discharge?: No -KS
Phlebitis Scale	0 -AM
Infiltration/Extravasation Scale	0 -AM
Line Assessment	Blood return noted;Infusing -AM
Dressing Assesment	Clean;Dry;Intact -AM

Flowsheets (all recorded)

Anthropometrics

Row Name	04/03/19 1020	03/29/19 0858			
Anthropometrics					
Height	67" (1.702 m) -AM	67" (1.702 m) -SC			
Weight	96.6 kg (212 lb 15.4 oz) -AM	93 kg (205 lb) -SC			
Weight Method	Actual -AM	Stated -SC			
Weight Change	3.89 -AM	0 -SC			
BMI (Calculated)	33.3 -AM	32.1 -SC			

Flowsheets (all recorded)

(RETIRED) Travel Screening

Row Name	03/29/19 0856				
RETIRED - Travel outside the U.S.					
RETIRED - Has the patient or a household member traveled outside the U.S. in the past 21 days?	Yes -SC				
RETIRED - If yes, where?	— mexico -SC				

Flowsheets (all recorded)

Interpretation

Row Name	04/03/19 1149	04/03/19 1021			
Medical Interpretation Services Documentation (All fields are required)					
Is patient using Interpretation Services for this encounter?	No -KS	No -AM			

Flowsheets (all recorded)

OR Incisions/Wounds

Row Name	04/03/19 1149				
[REMOVED] Surgical 04/03/19 Eye Right					
Incision Properties	Date Documented: 04/03/19 -SB Time Documented: 1043 -SB Location: Eye -SB Wound Location Orientation: Right -SB Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205				
Dressing	Eye shield -KS				
Dressing Assesment	Clean;Dry;Intact -KS				

Flowsheets (all recorded)

Vitals/Pain

Row Name	04/03/19 1150	04/03/19 1035	04/03/19 1020	03/29/19 0858
OTHER				
Patient Position	Other (Comment) -KS	Sitting -AM	—	—
Height Method	—	—	Stated -AM	Stated -SC
Weight Method	—	—	Actual -AM	Stated -SC
BMI (Calculated)	—	—	33.3 -AM	32.1 -SC
BSA (Calculated - sq m)	—	—	2.13 sq meters -AM	2.09 sq meters -SC
Pain Assessment	0-10 -KS	0-10 -AM	—	—
Vitals				
BP	132/53 -KS	139/69 -AM	—	—
Temp	97.6 °F (36.4 °C) -KS	98.2 °F (36.8 °C) -AM	—	—
Temp src	Temporal -KS	Temporal -AM	—	—
Pulse	53 -KS	51 -AM	—	—
Resp	18 -KS	14 -AM	—	—
SpO2	98 % -KS	96 % -AM	—	—
Height	—	—	67" (1.702 m) -AM	67" (1.702 m) -SC
Weight	—	—	96.6 kg (212 lb 15.4 oz) -AM	93 kg (205 lb) -SC
Vital Signs				
Heart Rate Source	Monitor -KS	Monitor -AM	—	—
Numeric Pain Intensity Scale 1				
Numeric Pain Intensity Score 1	0 -KS	0 -AM	—	—

Flowsheets (all recorded)

PATT Complete

Row Name	03/29/19 0926				
PATT Complete					
PATT Complete	Yes -SC				

Flowsheets (all recorded)

Fall Risk

Row Name	04/03/19 1041				
Hester Davis Fall Risk Assessment					
Last Known Fall	0 -AM				
Mobility	0 -AM				
Medications	1 -AM				
Mental Status/LOC/Awareness	0 -AM				
Toileting Needs	0 -AM				
Volume/Electrolyte Status	2 -AM				
Communication/Sensory	1 -AM				
Behavior	0 -AM				
Hester Davis Fall Risk Total	7 -AM				
Fall Assessment					
Patient Receiving Sedation	Yes -AM				
Fall Risk	Yes -AM				
Fall Band Applied	No -AM				
Yellow socks	Yes -AM				

Flowsheets (all recorded)

Pre-op Checklist

Row Name	04/03/19 1201	04/03/19 1050	04/03/19 1037	03/29/19 0858
Patient Verification				
History and Physical Completed	—	—	Yes -AM	—
Consents Confirmed	—	—	Operative;Informed;Blood products -AM	—
Advance Directive	—	—	Patient does not have advance directive -AM	Patient does not have advance directive -SC
Patient ID and Procedure Verified	—	—	Yes -AM	—
Correct Procedure	—	—	Yes -AM	—
Documents Match	—	—	Yes -AM	—
Pacemaker	—	—	No -AM	No -SC
Patient has an ICD?	—	—	No -AM	No -SC
Pre-op Lab/Test Results Available	—	—	In chart -AM	—
Preg Test	—	—	n/a -AM	—
Blood Glucose Meter (mg/dl)	—	89 -AM	—	—
Prep Verification				
Isolation Precautions	—	—	N/A -AM	— na -SC
Allergy Band Applied	—	—	Yes -AM	—
Anti-embolism	—	—	n/a -AM	—
Pre-op Antibiotic Ordered?	—	—	n/a -AM	—
Beta Blocker Therapy Last Dose Date	—	—	04/03/19 -AM	—
Beta Blocker Last Dose Time	—	—	0800 -AM	—
Anticoagulant Therapy Last Dose Date	—	—	04/01/19 -AM	—
Anticoagulant Last Dose Time	—	—	0900 -AM	—
VTE Assessment Complete?	—	—	Yes -AM	—
Date of last liquid	—	—	04/02/19 -AM	—
Time of last liquid	—	—	2300 -AM	—
Date of last solid	—	—	04/02/19 -AM	—
Time of last solid	—	—	2300 -AM	—
Void Prior to Procedure	—	—	Yes -AM	—
Void Prior to Procedure Time	—	—	0930 -AM	—
Enema Given	—	—	Not applicable -AM	—
Bowel Prep Needed	—	—	No -AM	—
Remove all that apply:	—	—	Other (see comment) -AM	—
Disposition of belongings:	—	—	To family/significant other -AM	—
Side/Site Confirmed	—	—	Right -AM	—
Required items available	—	—	Required test results, blood/antibiotics/irrigation fluids, implants, devices and special needs/equipment are available -AM	—
Transport To	— car -KS	—	OR -AM	—
Mode of Transport	—	—	Stretcher -AM	—
Transport By	RN -KS	—	RN;Circulator -AM	—
Released by (Floor RN or Pre-op RN)	—	—	Ariana Morton, RN -AM	—
Report given to (healthcare professional/RN)	family -KS	—	OR Circulator -AM	—
Metal Implant Present?	—	—	No -AM	—
Skin Prep for Procedure	—	—	No -AM	—

Flowsheets (all recorded) (continued)

Pre-op Checklist (continued)

Row Name	04/03/19 1201	04/03/19 1050	04/03/19 1037	03/29/19 0858	
Skin Care	—	—	Yes;Soap/Water -AM	—	
VTE Diagnostic Test Performed?	—	—	—	No -SC	

Flowsheets (all recorded)

Psychosocial Review

Row Name	03/29/19 0858				
Abuse Assessment					
Safe in Home	Yes -SC				
Values/Beliefs					
Cultural Preferences Affecting Hospitalization	No -SC				
Spiritual Preferences Affecting Hospitalization	No -SC				

Flowsheets (all recorded)

PACU DISCH Assessment

Row Name	04/03/19 1201	04/03/19 1150	04/03/19 1037	04/03/19 1035
PACU DISCH Assessment				
Airway	Natural -KS	—	—	—
LOC	Oriented;Awake -KS	—	—	—
Resp	Equal -KS	—	—	—
O2	Room Air -KS	—	—	—
SpO2	—	98 % -KS	—	96 % -AM
Resp	—	18 -KS	—	14 -AM
Expected Outcome	1 Patent / clear airway maintained -KS	—	—	—
Pulse	—	53 -KS	—	51 -AM
Temp	—	97.6 °F (36.4 °C) -KS	—	98.2 °F (36.8 °C) -AM
Temp src	—	Temporal -KS	—	Temporal -AM
Skin Condition/Temp	Dry;Cool -KS	—	—	—
Skin Color	Appropriate for ethnicity -KS	—	—	—
Anti-embolism	—	—	n/a -AM	—
Expected Outcome	1 Vital signs within acceptable limits;2 Cardiac rhythm within acceptable limits;3 No evidence of excessive bleeding -KS	—	—	—
Expected Outcome	1 Effects of comfort measure noted -KS	—	—	—
Activity	2 -KS	—	—	—
Respiration	2 -KS	—	—	—
Circulation	2 -KS	—	—	—
Consciousness	2 -KS	—	—	—
O2 Saturation	2 -KS	—	—	—
Aldrete Score (PAR)	10 -KS	—	—	—
PADS-Ambulation	2 -KS	—	—	—
PADS-Fasting/Feeding	2 -KS	—	—	—
PADS-Urine output	1 -KS	—	—	—
PADS-Pain	2 -KS	—	—	—
PADS-Dressing	2 -KS	—	—	—
PAD Score:	9 -KS	—	—	—
PAR + PADS Score Total:	19 -KS	—	—	—
Pt Discharged with Personal Effects Bag	Yes -KS	—	—	—
Floor notified of special needs	n/a -KS	—	—	—
Transport with	n/a -KS	—	—	—
Report given to (healthcare professional/RN)	family -KS	—	OR Circulator -AM	—
Transport By	RN -KS	—	RN;Circulator -AM	—
Acuity Class	Class II -KS	—	—	—
Transport To	— car -KS	—	OR -AM	—

Flowsheets (all recorded)

ED Sepsis Screen

Row Name	04/03/19 1150	04/03/19 1035			
Vital sign parameters					
BP	132/53 -KS	139/69 -AM			
Pulse	53 -KS	51 -AM			
Calculated MAP	79.33 -KS	92.33 -AM			
Resp	18 -KS	14 -AM			
Temp	97.6 °F (36.4 °C) -KS	98.2 °F (36.8 °C) -AM			
Vitals Sepsis Risk Score	0 -KS	0 -AM			
Vital Signs					
Automatic Restart Vitals Timer	Yes -KS	Yes -AM			

Flowsheets (all recorded)

Call Complete

Row Name	03/29/19 0928				
Call Complete					
Pre-op Call Complete	Yes -SC				

Flowsheets (all recorded)

Phone Assessment

Row Name	04/03/19 1150	04/03/19 1035	04/03/19 1020	03/29/19 0858	
Pain Assessment					
Currently in Pain	—	—	—	No/denies pain -SC	
Numeric Pain Intensity Score 1	0 -KS	0 -AM	—	—	
Pain Goal					
Patient's Stated Pain Goal	—	—	—	0 (No Pain) -SC	
Oxygen Therapy					
SpO2	98 % -KS	96 % -AM	—	—	
O2 Device	—	None (Room air) -AM	—	None (Room air) -SC	
Height and Weight					
Height	—	—	67" (1.702 m) -AM	67" (1.702 m) -SC	
Height Method	—	—	Stated -AM	Stated -SC	
Weight	—	—	96.6 kg (212 lb 15.4 oz) -AM	93 kg (205 lb) -SC	
Weight Method	—	—	Actual -AM	Stated -SC	
BMI (Calculated)	—	—	33.3 -AM	32.1 -SC	
BSA (Calculated - sq m)	—	—	2.13 sq meters -AM	2.09 sq meters -SC	

Flowsheets (all recorded)

Vitals/Pain

Row Name	04/03/19 1150	04/03/19 1035	04/03/19 1020	03/29/19 0858
Vitals				
Temp	97.6 °F (36.4 °C) -KS	98.2 °F (36.8 °C) -AM	—	—
Temp src	Temporal -KS	Temporal -AM	—	—
Pulse	53 -KS	51 -AM	—	—
Heart Rate Source	Monitor -KS	Monitor -AM	—	—
Resp	18 -KS	14 -AM	—	—
BP	132/53 -KS	139/69 -AM	—	—
Patient Position	Other (Comment) -KS	Sitting -AM	—	—
Oxygen Therapy				
SpO2	98 % -KS	96 % -AM	—	—
O2 Device	—	None (Room air) -AM	—	None (Room air) -SC
Height and Weight				
Height	—	—	67" (1.702 m) -AM	67" (1.702 m) -SC
Height Method	—	—	Stated -AM	Stated -SC
Weight	—	—	96.6 kg (212 lb 15.4 oz) -AM	93 kg (205 lb) -SC
Weight Method	—	—	Actual -AM	Stated -SC
BMI (Calculated)	—	—	33.3 -AM	32.1 -SC
BSA (Calculated - sq m)	—	—	2.13 sq meters -AM	2.09 sq meters -SC
Pain Assessment				
Pain Assessment	0-10 -KS	0-10 -AM	—	—
Pain Goal				
Patient's Stated Pain Goal	—	—	—	0 (No Pain) -SC
Numeric Pain Intensity Scale				
Numeric Pain Intensity Score 1	0 -KS	0 -AM	—	—

User Key

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates
UE	Epic, User	—
SC	Sandra Cody, RN	02/03/17 -
KS	Kimberly R Swanson, RN	02/03/17 -
SB	Sandy M Bobb, RN	02/03/17 -
AM	Ariana Morton, RN	01/30/18 -
CR	Chris Russell	—
NM	Nathaniel Measel, PAA	02/13/19 - 04/29/19
EI	Epicweb Interface	—

Flowsheet Notes

No notes of this type exist for this encounter.

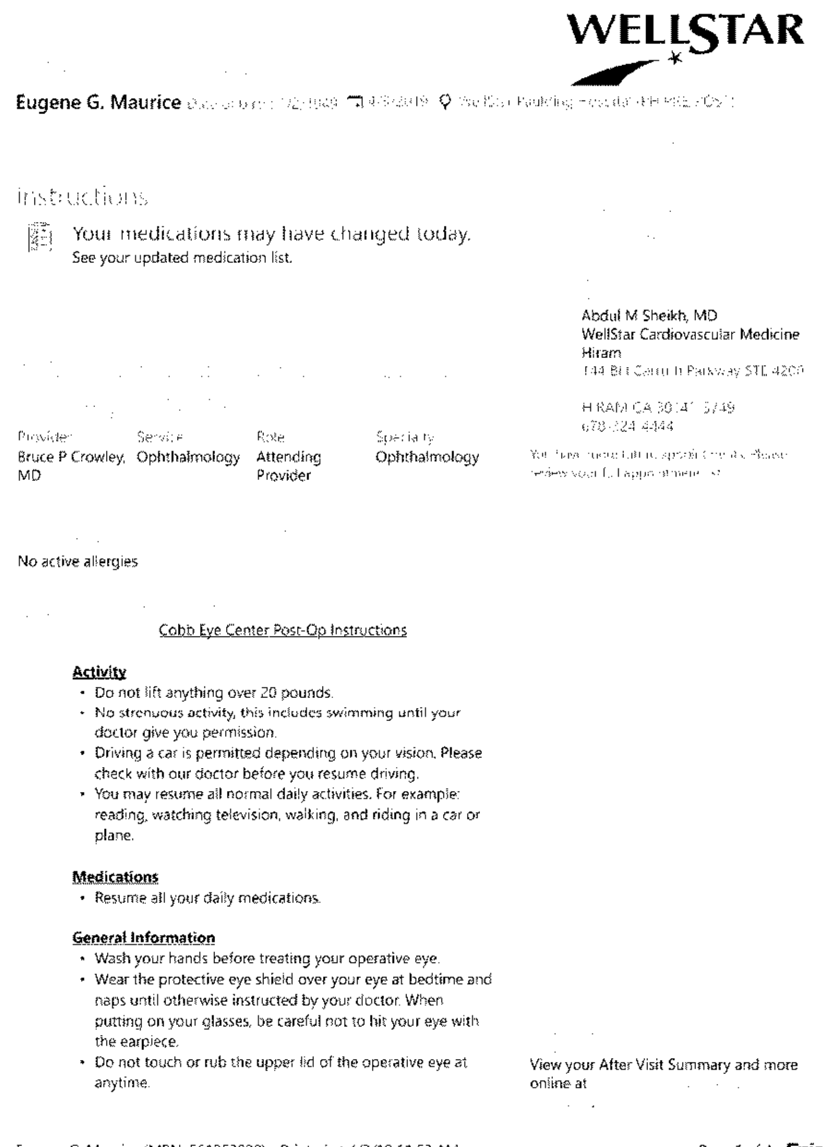
All Scans

Encounter-Level Documents - 04/03/2019:

Scan on 4/18/2019 1:41 PM (below)

Scan on 4/4/2019 3:45 PM (below)

Document on 4/3/2019 11:52 AM by Kimberly R Swanson, RN: IP AVS (below)



WELLSTAR

Eugene G. Maurice

Instructions

Your medications may have changed today.
See your updated medication list.

Abdul M Sheikh, MD
WellStar Cardiovascular Medicine
Hiram

Provider	Service	Role	Specialty
Bruce P Crowley, MD	Ophthalmology	Attending Provider	Ophthalmology

No active allergies

Cobb Eye Center Post-Op Instructions

Activity
- Do not lift anything over 20 pounds.
- No strenuous activity, this includes swimming until your doctor give you permission.
- Driving a car is permitted depending on your vision. Please check with our doctor before you resume driving.
- You may resume all normal daily activities. For example: reading, watching television, walking, and riding in a car or plane.

Medications
- Resume all your daily medications.

General Information
- Wash your hands before treating your operative eye.
- Wear the protective eye shield over your eye at bedtime and naps until otherwise instructed by your doctor. When putting on your glasses, be careful not to hit your eye with the earpiece.
- Do not touch or rub the upper lid of the operative eye at anytime.

View your After Visit Summary and more online at

Eugene G. Maurice (MRN: 561253820) • Printed at 4/3/19 11:52 AM

Page 1 of 4 Epic

- Unless otherwise instructed by your doctor, keep the patch on your operative eye. It will be removed the day after surgery. You will also be given further instructions on the eye drops and caring for your eye.
- On the day of surgery, you will need someone to drive you home from the surgery center and to our office the next day.
- No eye make-up for 1 week.
- Your eye may feel irritated (like sand is in it) for the first 24-48 hours. You may take Tylenol or Advil to control the discomfort. If over the counter medication does not help, please call our office.

Bathing

- You may bathe or shower. You may shampoo your hair the day after surgery. Keep your operative eye protected from soap and water.

Call You Doctor

- Sudden decrease in you vision.
- Increased redness or pain.

Follow-Up Appointment

- Your first follow-up appointment will be the day after surgery
- Bring all your eye drops to each follow-up visit.

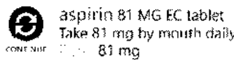
Tuesday Apr 9, 2019 9:30 AM (Arrive by 9:15 AM)	WellStar Cardiovascular Medicine Hiram 144 Bill Carruth Parkway STE 4200 HIRAM GA 30141-3749 678 324 4444
Thursday May 9, 2019 8:15 AM (Arrive by 8:00 AM)	WellStar Urology Hiram 144 Bill Carruth Pkwy Suite 2300 Hiram GA 30141-[illegible] 770 426 4475

As part of your treatment plan, please call 770-956-STAR to register for our free Heart Failure Academy program.

Medication List

CONTINUE taking these medications

Morning Noon Evening Bedtime As Needed



aspirin 81 MG EC tablet
Take 81 mg by mouth daily
81 mg

atorvastatin 80 MG tablet
LIPITOR
Take 1 tablet (80 mg total) by mouth nightly
80 mg

blood sugar diagnostic strip
ONETOUCH VERIO
Use to check blood sugar twice daily as directed.
DX: E11.9

clopidogrel 75 mg tablet
PLAVIX
Take 1 tablet (75 mg total) by mouth daily
75 mg

ferrous sulfate 324 mg (65 mg iron) Tbec
Take 1 tablet (324 mg total) by mouth 2 (two) times a day with meals
324 mg

furosemide 40 MG tablet
LASIX
Take 1 tablet (40 mg total) by mouth daily
40 mg

gatifloxacin 0.5 % eye drops
ZYMAXID

isosorbide mononitrate 30 MG 24 hr tablet
IMDUR
Take 2 tablets (60 mg total) by mouth 2 (two) times a day
60 mg

metFORMIN 500 MG tablet
GLUCOPHAGE
1 tablet po in am and 1 in pm
type 2 diabetes mellitus

Medication List (continued)

CONTINUE taking these medications (continued)

Morning Noon Evening Bedtime As Needed

CONTINUE **nitroglycerin** 0.4 MG SL tablet
NITROSTAT
Place 1 tablet (0.4 mg total) under the tongue every 5 (five) minutes as needed for chest pain
0.4 mg

CONTINUE **predniSOLONE acetate** 1 % ophthalmic suspension
PRED FORTE

CONTINUE **ramipril** 5 MG capsule
ALTACE
Take 1 capsule (5 mg total) by mouth daily
5 mg

CONTINUE **sotalol** 80 MG tablet
BETAPACE
Take 0.5 tablets (40 mg total) by mouth 2 (two) times a day
40 mg

CONTINUE **VITAMIN B12 ORAL**
Take 1 tablet by mouth daily
1 tablet

Scan on 4/3/2019 11:28 AM (below)

Electronic signature on 4/3/2019 9:49 AM - 1 of 5 e-signatures recorded

Encounter-Level E-Signatures:

CMS IM for Patient Signature (E-Sig) - Received on 4/3/2019

Encounter-Level E-Signatures: (continued)

DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for medicare & Medicaid Services
OMB Approval No. 0938-0692

AN IMPORTANT MESSAGE FORM MEDICARE ABOUT YOUR RIGHTS

AS A HOSPITAL INPATIENT, YOU HAVE THE RIGHT TO:
Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.

- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to KEPRO:
  1-844-455-8708
  KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609

YOUR MEDICARE DISCHARGE RIGHTS

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by KEPRO. This reviewer was hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
  - **If you want to appeal, you must contact KEPRO no later than your planned discharge date and before you leave the hospital.**
  - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- **Step by step instructions for calling the KEPRO and filing an appeal are on page 2.**

To speak with someone at the hospital about this notice, call (770) 443-7068.

Please sign and date here to show you received this notice and understand your rights.

Patient Name

[signature]

CMS-R-193 (approved 07/10)
WS Paulding Hospital
An Important Message from Medicare About Your Rights

STEPS TO APPEAL YOUR DISCHARGE

- **STEP 1:** You must contact the KEPRO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
  - Here is the contact information: 1-844-455-8708
    KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609

- You can file a request for an appeal any day of the week. Once you speak to someone or leave a message, your appeal has begun.
- Ask the hospital if you need help contacting KEPRO.
- The name of this hospital is **WS Paulding Hospital** 110042
-

- **STEP 2:** You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.

- **STEP 3:** The KEPRO will ask for your opinion. You or your representative need to be available to speak with KEPRO, if requested. You or your representative may give KEPRO a written statement, but you are not required to do so.

- **STEP 4:** The KEPRO will review your medical records and other important information about your case.

- **STEP 5:** KEPRO will notify you of its decision within 1 day after it receives all necessary information.
  - If KEPRO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  - If KEPRO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after KEPRO notifies you of its decision.

IF YOU MISS THE DEADLINE TO APPEAL, YOU HAVE OTHER APPEAL RIGHTS:
- You can still ask the KEPRO or your plan (if you belong to one) for a review of your case:
  - If you have Original Medicare: Call the KEPRO listed above.
  - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.
Additional Information: I have received my second notice and understand my appeal rights.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0692. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the ime estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, ATTN: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, MD 21244-1850.

WS Paulding Hospital
An Important Message from Medicare
About Your Rights

Name: Eugene G Maurice
MRN: 561253820
HAR: 40001376764

Encounter-Level E-Signatures: (continued)

ENCOUNTER

Patient Class:	OPS		Unit:	PH PRE/POST
Hospital Service:	General Surgery		Bed:	PH PRE POST Pool/PH PRE *
Admitting Provider:	Bruce P Crowley, Md		Referring Physician:	Crowley, Bruce P
Attending Provider:	Bruce p crowley	AD: N	Adm Diagnosis:	Nuclear sclerotic catara*
Admission Date:	4/17/2019		Admission Time:	0952

PATIENT

Name	Eugene George Maurice	Sex:	Male	DOB:	1/2/1949 (70 yrs)
Address:	61 SHOCKLEY WAY			Religion:	Catholic
City:	DALLAS GA 30157-8973			Race:	White or caucasian
County:	PAULDING				
Email Address:	Gene.maurice@sgmservice.*				
Primary Care Provider:	Jeffrey L Tharp, MD			Primary Phone:	678-910-2298

EMERGENCY CONTACT

Contact Name	Legal Guardian?	Relationship to Patient	Home Phone	Work Phone	Mobile Phone
1. Maurice,Shirley		Spouse	(678)398-9479		678-910-2476
2. *No Contact Specified*					678-910-2476

GUARANTOR

Guarantor:	MAURICE,EUGENE GEORGE	DOB:	1/2/1949
Address:	61 SHOCKLEY WAY	Sex:	Male
	DALLAS, GA 30157-8973	Home Phone:	678-398-9479
Relation to Patient:	Self	Work Phone:	
Guarantor ID:	123805	Mobile Phone:	678-910-2298

GUARANTOR EMPLOYER

Employer:		Phone:		Status:	RETIRED

COVERAGE

PRIMARY INSURANCE

Payor:	COVENTRY ADVANTRA M*	Plan:	COVENTRY ADVANTRA /PPO
Group Number:	4916004101	Insurance Type:	INDEMNITY
Subscriber Name:	MAURICE,EUGENE GEOR*	Subscriber DOB:	01/02/1949
Coverage	P O BOX 7156 LONDON, KY 40742-7156	Subscriber ID:	80459609601
		Pat. Rel. to Subscriber:	Self
Phone:	(866)613-4977	Co-In: Deductible:	Out of Pocket Max:

SECONDARY INSURANCE

Payor:		Plan:	N/A
Group Number:		Insurance Type:	
Subscriber Name:		Subscriber DOB:	
Coverage	P O BOX 981106 EL PASO, TX 79998-1106	Subscriber ID:	
		Pat. Rel. to Subscriber:	
Phone:			

Admission Information

Arrival Date/Time:		Admit Date/Time:	04/17/2019 0952	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Ambulatory Surgery Center	Admit Category:	
Means of Arrival:	Car	Primary Service:	General Surgery	Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Paulding Hospital (PH PRE/POST)
Admit Provider:	Bruce P Crowley, MD	Attending Provider:	Bruce P Crowley, MD	Referring Provider:	Bruce P Crowley, MD

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
04/17/2019 1157	Home Or Self Care	None	None	WellStar Paulding Hospital (PH PRE/POST)

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
H26.9 **[Principal]**	Unspecified cataract				
I10	Essential (primary) hypertension				
E11.9	Type 2 diabetes mellitus without complications				
E78.5	Hyperlipidemia, unspecified				
Z79.84	Long term (current) use of oral hypoglycemic drugs	Exempt from POA reporting			
Z87.891	Personal history of nicotine dependence	Exempt from POA reporting			

Events

Admission at 4/17/2019 0952

Unit: WellStar Paulding Hospital (PH MAIN PERIOP) | Room: PH MAIN PERIOP POOL | Bed: PH MAIN PERIOP POOL
Patient class: Hospital Outpatient Surgery | Service: General Surgery

Transfer Out at 4/17/2019 0954

Unit: WellStar Paulding Hospital (PH MAIN PERIOP) | Room: PH MAIN PERIOP POOL | Bed: PH MAIN PERIOP POOL
Patient class: Hospital Outpatient Surgery | Service: General Surgery

Transfer In at 4/17/2019 0954

Unit: WellStar Paulding Hospital (PH PRE/POST) | Room: PH PRE POST Pool | Bed: PH PRE POST Pool
Patient class: Hospital Outpatient Surgery | Service: General Surgery

Transfer Out at 4/17/2019 1045

Unit: WellStar Paulding Hospital (PH PRE/POST) | Room: PH PRE POST Pool | Bed: PH PRE POST Pool
Patient class: Hospital Outpatient Surgery | Service: General Surgery

Transfer In at 4/17/2019 1045

Unit: WellStar Paulding Hospital (PH OPERATING ROOM) | Room: PH OR POOL | Bed: PH OR POOL
Patient class: Hospital Outpatient Surgery | Service: General Surgery

Surgery at 4/17/2019 1045

Unit: PH MAIN OR | Room: PH OR 08
Patient class: Hospital Outpatient Surgery | Service: Ophthalmology

Transfer Out at 4/17/2019 1109

Unit: WellStar Paulding Hospital (PH OPERATING ROOM) | Room: PH OR POOL | Bed: PH OR POOL
Patient class: Hospital Outpatient Surgery | Service: General Surgery

Transfer In at 4/17/2019 1109

Unit: WellStar Paulding Hospital (PH PRE/POST) | Room: PH PRE POST Pool | Bed: PH PRE POST Pool

All Scans (continued)

Events (continued)

Patient class: Hospital Outpatient Surgery   Service: General Surgery

Discharge at 4/17/2019 1157

Unit: WellStar Paulding Hospital (PH PRE/POST)   Room: PH PRE POST Pool   Bed: PH PRE POST Pool
Patient class: Hospital Outpatient Surgery   Service: General Surgery

Allergies as of 4/17/2019

Reviewed on 4/17/2019

No Known Allergies

Immunizations as of 4/17/2019

Immunizations last reviewed by Lisa M Stephenson, MA on 7/5/2018 1253

Annual Influenza

Administered on: 9/26/2016 0000   Site: Left deltoid   Route: Intramuscular
Lot number: UI700AA

Annual Influenza

Administered on: 9/28/2017 0000   Site: Left deltoid   Route: Intramuscular
Lot number: UI842AB

Annual Influenza

Administered on: 10/5/2018 0000   Site: Right deltoid   Route: Intramuscular
Lot number: UJ031AA

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Jade Westover, LPN   Administered on: 9/26/2016   Dose: 0.5 mL
Site: Left deltoid   Route: Intramuscular   NDC: 49281-399-88
CVX code: 135   VIS date: 8/7/2015
Manufacturer: Sanofi Pasteur   Lot number: UI700AA

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Tina M Allen, MA   Administered on: 9/28/2017   Dose: 0.5 mL
Site: Left deltoid   Route: Intramuscular   NDC: 49281-401-88
CVX code: 135   VIS date: 09/28/2017
Manufacturer: Sanofi Pasteur   Lot number: UI842AB

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Mary S Wray, MA   Administered on: 10/5/2018   Dose: 0.5 mL
Site: Right deltoid   Route: Intramuscular   NDC: 49281-403-88
CVX code: 135   VIS date: 8/7/2015
Product: Fluzone HD   Manufacturer: Sanofi Pasteur   Lot number: UJ031AA
Expiration date: 5/1/2019

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

Influenza - Unspecified

Administered on: 9/26/2016 0000   Site: Left deltoid   Route: Intramuscular

All Scans (continued)

Immunizations (continued) as of 4/17/2019

CVX code: 88
Lot number: UI700AA

Pneumococcal Conjugate 13-Valent

Administered by: Mary S Wray, MA
Site: Left deltoid
CVX code: 133
Manufacturer: Wyeth-Ayerst
Administered on: 3/16/2016
Route: Intramuscular
VIS date: 031616
Lot number: M51193
Dose: 0.5 mL
NDC: 0005-1971-01

Pneumococcal Polysaccharide

Administered by: Mary S Wray, MA
Site: Left deltoid
CVX code: 33
Manufacturer: Merck & Co. Inc
Administered on: 10/5/2018
Route: Intramuscular
VIS date: 04/24/2015
Lot number: R012497
Dose: 0.5 mL
NDC: 0006-4837-01

Questionnaire

Question	Answer
Have you ever had a serious reaction to any vaccine in the past?	NO
Are you sick today with a moderate to severe illness (e.g. fever)	NO

Pneumococcal Polysaccharide

Administered on: 10/5/2018 0000
CVX code: 33
Lot number: R012497
Site: Left deltoid
Route: Intramuscular

Medical as of 4/17/2019

Past Medical History

Diagnosis	Date	Comments	Source
AKI (acute kidney injury) (HCC) [N17.9]	—	—	Provider
CAD (coronary artery disease) [I25.10]	—	—	Provider
Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC) [C61]	1/30/2018	—	Provider
Cataracts, both eyes [H26.9]	—	—	Provider
Coronary atherosclerosis of native coronary artery [I25.10]	—	—	Provider
Diabetes mellitus (HCC) [E11.9]	—	—	Provider
Essential hypertension, benign [I10]	—	—	Provider
Family history of ischemic heart disease [Z82.49]	—	—	Provider
Hyperlipidemia [E78.5]	—	—	Provider
Hypertension [I10]	—	—	Provider
Infectious viral hepatitis [B15.9]	—	as teen/cannont recall what type	Provider
Obesity [E66.9]	—	—	Provider
Other and unspecified hyperlipidemia [E78.5]	—	—	Provider
Other symptoms involving cardiovascular system [R09.89]	—	—	Provider
PVD (peripheral vascular disease) (HCC) [I73.9]	—	—	Provider

Pertinent Negatives

Diagnosis	Date Noted	Comments	Source
Abnormal ECG [R94.31]	04/07/2014	—	Provider
Aneurysm (HCC) [I72.9]	04/07/2014	—	Provider
Arrhythmia [I49.9]	04/07/2014	—	Provider
Asthma [J45.909]	04/07/2014	—	Provider
Clotting disorder (HCC) [D68.9]	04/07/2014	—	Provider
Congenital heart disease [Q24.9]	04/07/2014	—	Provider
Deep vein thrombosis (HCC) [I82.409]	04/07/2014	—	Provider
Heart failure (HCC) [I50.9]	04/07/2014	—	Provider
Heart murmur [R01.1]	04/07/2014	—	Provider
Mitral valve prolapse [I34.1]	04/07/2014	—	Provider
Myocardial infarction (HCC) [I21.9]	04/07/2014	—	Provider
Pulmonary embolism (HCC) [I26.99]	04/07/2014	—	Provider
Sleep apnea [G47.30]	04/07/2014	—	Provider

All Scans (continued)

Medical as of 4/17/2019 (continued)

Stroke (HCC) [I63.9]	04/07/2014	—	Provider
Valvular disease [I38]	04/07/2014	—	Provider

ED Records

ED Arrival Information

Patient not seen in ED

ED Disposition

None

H&P - Encounter Notes

H&P filed by Provider Scan at 4/17/2019 11:34 AM

Author: Provider Scan | Service: — | Author Type: —
Filed: 4/17/2019 11:34 AM | Date of Service: 4/17/2019 11:31 AM | Status: Signed
Editor: Interface, Transcription Incoming
Scan on 4/17/2019 11:31 AM (below)

Electronically Signed by Interface, Transcription Incoming on 4/17/2019 11:34 AM

OR Nursing - Encounter Notes

OR Nursing by Kimberly R Swanson, RN at 4/17/2019 11:16 AM

Author: Kimberly R Swanson, RN | Service: — | Author Type: Registered Nurse
Filed: 4/17/2019 11:16 AM | Date of Service: 4/17/2019 11:16 AM | Status: Signed
Editor: Kimberly R Swanson, RN (Registered Nurse)

In phase 2 without complaints, tolerating po fluids well, NAD,VSS,family at bedside

Electronically Signed by Kimberly R Swanson, RN on 4/17/2019 11:16 AM

OR Nursing by Kimberly R Swanson, RN at 4/17/2019 11:40 AM

Author: Kimberly R Swanson, RN | Service: — | Author Type: Registered Nurse
Filed: 4/17/2019 11:56 AM | Date of Service: 4/17/2019 11:40 AM | Status: Signed
Editor: Kimberly R Swanson, RN (Registered Nurse)

D/C criteria met, AVS given to patient and family; voices no concerns or questions.up to dress with assistance

Electronically Signed by Kimberly R Swanson, RN on 4/17/2019 11:56 AM

OR Nursing by Kimberly R Swanson, RN at 4/17/2019 11:54 AM

Author: Kimberly R Swanson, RN | Service: — | Author Type: Registered Nurse
Filed: 4/17/2019 11:55 AM | Date of Service: 4/17/2019 11:54 AM | Status: Signed
Editor: Kimberly R Swanson, RN (Registered Nurse)

D/C to front entry via wheelchair to front passenger seat car without incident.

Electronically Signed by Kimberly R Swanson, RN on 4/17/2019 11:55 AM

Discharge Instr - Activity - Encounter Notes

OR Nursing - Encounter Notes (continued)

Discharge Instr - Activity by Kimberly R Swanson, RN at 4/16/2019 11:28 AM

Author: Kimberly R Swanson, RN   Service: —   Author Type: Registered Nurse
Filed: 4/16/2019 11:28 AM   Date of Service: 4/16/2019 11:28 AM   Status: Written
Editor: Kimberly R Swanson, RN (Registered Nurse)

Cobb Eye Center Post-Op Instructions

Activity

- Do not lift anything over 20 pounds.
- No strenuous activity, this includes swimming until your doctor give you permission.
- Driving a car is permitted depending on your vision. Please check with our doctor before you resume driving.
- You may resume all normal daily activities. For example: reading, watching television, walking, and riding in a car or plane.

Medications

- Resume all your daily medications.

General Information

- Wash your hands before treating your operative eye.
- Wear the protective eye shield over your eye at bedtime and naps until otherwise instructed by your doctor. When putting on your glasses, be careful not to hit your eye with the earpiece.
- Do not touch or rub the upper lid of the operative eye at anytime.
- Unless otherwise instructed by your doctor, keep the patch on your operative eye. It will be removed the day after surgery. You will also be given further instructions on the eye drops and caring for your eye.
- On the day of surgery, you will need someone to drive you home from the surgery center and to our office the next day.
- No eye make-up for 1 week.
- Your eye may feel irritated (like sand is in it) for the first 24-48 hours. You may take Tylenol or Advil to control the discomfort. If over the counter medication does not help, please call our office.

Bathing

- You may bathe or shower. You may shampoo your hair the day after surgery. Keep your operative eye protected from soap and water.

Call You Doctor

- Sudden decrease in you vision.
- Increased redness or pain.

Follow-Up Appointment

- Your first follow-up appointment will be the day after surgery.
- Bring all your eye drops to each follow-up visit.

Electronically Signed by Kimberly R Swanson, RN on 4/16/2019 11:28 AM

Op Note - Encounter Notes

Op Note by Bruce P Crowley, MD at 4/17/2019 11:08 AM

Author: Bruce P Crowley, MD
Filed: 4/17/2019 11:09 AM
Editor: Bruce P Crowley, MD (Physician)
Service: Ophthalmology
Date of Service: 4/17/2019 11:08 AM
Author Type: Physician
Status: Signed

OPERATIVE REPORT

PATIENT: Eugene G Maurice
DOB: 1/2/1949
MRN: 561253820
CSN: 2101351746

DATE OF ADMISSION: **4/17/2019**
DATE OF OPERATION: **4/17/2019**

SURGEON: Bruce P Crowley, MD

PRE-OPERATIVE DIAGNOSIS: Cataract left eye.

POST-OPERATIVE DIAGNOSIS: Cataract left eye.

PROCEDURE: Phacoemulsification of a cataract with a posterior chamber intraocular lens, left eye.

ANESTHESIA: Local MAC

ANESTHEIOLOGIST: Turry

ANESTHETIST: Gurney

COMPLICATIONS: None

ESTIMATED BLOOD LOSS: Nil

DESCRIPTION OF PROCEDURE: The patient was prepped and draped in the usual sterile fashion. After Tetracaine was applied, a wire lid speculum was placed into the eye. A 15-degree blade was used to make a paracentesis. Preservative-Free 2% Lidocaine was injected intracamerally as well as topically. Viscoat was used to fill the anterior chamber. A 2.75 keratome was used to enter the anterior chamber at 180-degrees and a circular tear capsulorrhexis was done with Utrata forceps and a cystitome. Balanced salt solution was then used to hydrodissect the nucleus and a Balanced phacoemulsification tip was used in a 2-handed chopping technique with a CDE of 5.26. The irrigation/aspiration machine was then used to remove the remaining cortical material and capsular polishing was done. Provisc was then used to fill the capsular bag and then the Alcon Acrysof SN60WF Intraocular lens in a power of 24.5 diopters was inserted into the eye and moved into position within the capsular bag with a Kuglen hook. The I and A was then used to remove the remaining Provisc and vacuum the underside of the anterior capsule where able. The eye was reinflated with a balanced salt solution and the wound was hydrated and found to be watertight. Pilocarpine and Maxitrol were placed in the eye, a shield was placed and the patient was taken to the recovery room in good condition.

Bruce P Crowley, MD

Electronically Signed by Bruce P Crowley, MD on 4/17/2019 11:09 AM

Op Note - Encounter Notes (continued)

Op Note by Bruce P Crowley, MD at 4/17/2019 11:08 AM (continued)

Pre-Procedure Instructions - Encounter Notes

Pre-Procedure Instructions by Sandra Cody, RN at 4/12/2019 4:06 PM

Author: Sandra Cody, RN | Service: — | Author Type: Registered Nurse
Filed: 4/12/2019 4:10 PM | Date of Service: 4/12/2019 4:06 PM | Status: Signed
Editor: Sandra Cody, RN (Registered Nurse)

PREOPERATIVE INSTRUCTIONS
EYE PATIENTS

Day Before Surgery

- Drink plenty of fluids during the day and evening until midnight. Eat a light evening meal the night before surgery, unless instructed differently by your physician.
- **DO NOT EAT OR DRINK ANYTHING AFTER 12 MIDNIGHT.**
- **Take a shower the night before or morning of procedure and wash face with an antibacterial soap, such as "*Dial*"**
- Notify your physician if there is any change in your physical condition, such as a cold, fever, infection, nausea, vomiting, and/or diarrhea.
- Please call **470-644-7252** the morning of your surgery if you have any questions or concerns.
- STOP your metformin 24 hours prior to procedure
- Stop vitamins and supplements,stop any NSAID products.
- NO diabetic medications or Insulins the morning of your surgery.
- Blood thinners (Plavix and Asa)as per your Dr. Recommendations.

Morning of Surgery

- Please report to the **Paulding Outpatient Pavilion North / GREEN PARKING ZONE**
  Date: Wednesday 04/17/2019 Arrive @: 09:30AM Approx. Surgery Time: 11:00AM
- You may take the following medications with a sip of water: **Sotalol, and your Imdur and use your eye drops.**
- You may brush your teeth, but **do not swallow** any water or toothpaste.
- **Do not** chew gum or suck on candy.
- **Do not wear any makeup, mascara, eye shadow, eyeliner, or false eyelashes.**
- **Do not apply any facial lotion/ moisturizer after washing your face with an antibacterial soap.**
- Remove all fingernail and toenail polish, except clear.
- Bring a container for your dentures, glasses, and contacts (w/ saline solution)
- Wear loose fitting clothing such as a jogging suit. Wear warm socks (you will wear them into the operating room). Wear a button-down or zipper front top or a top that will fit easily over your head. If you are to be admitted after surgery, please leave your suitcase in the car.
- Leave all valuables and jewelry at home. All jewelry, including body piercings, **must be removed.**
- For outpatient surgery, **you must have a responsible adult stay throughout your surgery, recovery, and drive you home and stay with you for 24 hours.** Driving a car, operating machinery or power tools is not recommended for 24 hours after any type of anesthesia. Your surgery may be **canceled or delayed** if you do not have a ride. If you choose public transportation, you will still be required to have a friend or family member accompany you.
- Please, no visitors under the age of twelve. No more than **Two visitors** are allowed in the Surgical Pre/Post-Op Rooms. Additional visitors will be asked to remain in the waiting room area and will be allowed to take turns visiting if time permits.

Pre-Procedure Instructions - Encounter Notes (continued)

Pre-Procedure Instructions by Sandra Cody, RN at 4/12/2019 4:06 PM (continued)

- Additional instructions: **Do not bring your eye drops with you to the hospital the day of your procedure, BUT you will need to take them with you to your post- op appointment the next day.**

Electronically Signed by Sandra Cody, RN on 4/12/2019 4:10 PM

Paper H&P Update - Encounter Notes

Paper H&P Update by Bruce P Crowley, MD at 4/17/2019 7:11 AM

Author: Bruce P Crowley, MD | Service: Ophthalmology | Author Type: Physician
Filed: 4/17/2019 7:11 AM | Date of Service: 4/17/2019 7:11 AM | Status: Signed
Editor: Bruce P Crowley, MD (Physician)

Original H&P on paper, to be scanned in after discharge.

H & P reviewed, patient examined, and patient's condition unchanged

Bruce P Crowley, MD April 17, 2019 7:11 AM

Electronically Signed by Bruce P Crowley, MD on 4/17/2019 7:11 AM

Surgery Report

General Information

Date: 4/17/2019
Location: PH MAIN OR
Patient class: Hospital Outpatient Surgery
Time: 1100
Room: OR 08
Case classification: Class F - Elective
Status: Posted
Service: Ophthalmology

Diagnosis Information

Diagnosis
Nuclear sclerotic cataract of left eye

Case Tracking Events

Event	Time In
In Facility	0952
In Pre-Procedure	0954
In Block Room	
Out Block Room	
Pre-Procedure Complete	1022
Out of Pre-op	1044
Anesthesia Available	
In Room	1045
Anesthesia Start	1045
Anesthesia Ready	
Procedure Start	1052
Procedure End	1107
Out of Room	1109
Patient to Floor/ICU	
In Phase I	
Anesthesia Stop	1110
Phase I Criteria Met	
Out of Phase I	
In Phase II	1109
Phase II Care Complete	1118
Out of Phase II	1154
Remove from Status Board	1157
Anesthesia Follow-up Needed	
Anesthesia Follow-up Complete	
Moderate Sedation Begin	
Moderate Sedation End	

Event Tracking

Panel 1

Event	Time In
Procedure Start	
Procedure End	

Procedure : CATARACT PHACOEMULSIFICATION IMPLANTATION INTRAOCULAR LENS

Event	Time In
Procedure Start	1052
Procedure End	1107

Panel Information

Panel 1

Surgeon	Role	Service
Bruce P Crowley, MD	Primary	Ophthalmology

Procedure: CATARACT PHACOEMULSIFICATION IMPLANTATION INTRAOCULAR LENS

Laterality	Wound Class	Incision Closure	Anesthesia	Op Region	
Left	Clean		Monitor Anesthesia Care	Eye	

CATARACT PHACOEMULSIFICATION IMPLANTATION INTRAOCULAR LENS (Left) - Position 1

Body: **Supine/Eye**
Head: **Aligned**
Left Arm: **Tucked at Side**
Left Leg: **Pillow Under Knees**
Right Arm: **Tucked at Side**
Right Leg: **Pillow Under Knees**
Positioned by: **Jeffrey P Barber, RN**
Cindy T Huff, RN
Cara M Gurney, PAA
Bruce P Crowley, MD
Comments: PT MOVED SELF TO TOP OF STRETCHER; SIDE RAILS UP X2; PT HEAD SECURED WITH TAPE BY

Surgery Report (continued)

Panel Information (continued)

DR. CROWLEY

Staff Info

Staff Type	Staff Member	Start	End	OT
Circulator	**Sandy M Bobb, RN**	1045	1109	
Scrub Person	**Briana Dilks, CST**	1045	1109	
Additional Circulator	**Jeffrey P Barber, RN**	1045	1109	
Circulator	**Cindy T Huff, RN**	1045	1109	

Questionnaire Data

None

Patient Preparation

Area	Laterality	Scrub	Paint	Hair Removal
Eye	Left	None	Ophthalmic Betadine	N/A

SEVERAL DROPS OF PREP SOLUTION PLACED IN PT LEFT EYE; PT PREPPED WITH PREP SOLUTION WITH NO SKIN REACTION

Skin Condition

Skin Site	Condition	Comments
Operative	**Warm, Dry, Intact**	

Nursing Notes

OR Nursing by Kimberly R Swanson, RN at 4/17/2019 11:16 AM

Author: Kimberly R Swanson, RN | Service: — | Author Type: Registered Nurse
Filed: 4/17/2019 11:16 AM | Date of Service: 4/17/2019 11:16 AM | Status: Signed
Editor: Kimberly R Swanson, RN (Registered Nurse)

In phase 2 without complaints, tolerating po fluids well, NAD,VSS,family at bedside

OR Nursing by Kimberly R Swanson, RN at 4/17/2019 11:40 AM

Author: Kimberly R Swanson, RN | Service: — | Author Type: Registered Nurse
Filed: 4/17/2019 11:56 AM | Date of Service: 4/17/2019 11:40 AM | Status: Signed
Editor: Kimberly R Swanson, RN (Registered Nurse)

D/C criteria met, AVS given to patient and family; voices no concerns or questions.up to dress with assistance

OR Nursing by Kimberly R Swanson, RN at 4/17/2019 11:54 AM

Author: Kimberly R Swanson, RN | Service: — | Author Type: Registered Nurse
Filed: 4/17/2019 11:55 AM | Date of Service: 4/17/2019 11:54 AM | Status: Signed
Editor: Kimberly R Swanson, RN (Registered Nurse)

D/C to front entry via wheelchair to front passenger seat car without incident.

Equipment

Equipment Type	Equipment	Start	End
STOOL HONDA W/ROUND SEAT			
SUCTION SET-UP			
PHACOEMULSIFIER N542836			
MICROSCOPE ZEISS NEW			
HEADREST GEL			
STRETCHER EYE			

Equipment (continued)

Equipment Type	Equipment	Start	End
MONITOR CARDIAC			
MONITOR OXIMETER OR			

Instruments

Instrument Type	Instrument	Start	End
HANDPIECE I&A			
HANDPIECE PHACO			
PITCHER GRADUATED			
TOWELS CLOTH			
TRAY EYE			

Post-op Skin Information

Skin Site	Condition
Operative	**Warm, Dry, Intact**

Counts

No counts needed.

PNDS Information

Outcomes - Pre-op

Used?	Description (Code)
Yes	The patient participates in decisions affecting his or her perioperative plan of care. (O23)
Yes	Confirms identity before the operative or invasive procedure. (I26)
	The patient demonstrates knowledge of the expected responses to the operative or invasive procedure. (O31)

Outcomes - Intra-op

Used?	Description (Code)
Yes	The patient is free from signs and symptoms of injury caused by extraneous objects. (O2)
Yes	The patient is free from signs and symptoms of injury related to positioning. (O5)
Yes	The patient is free from signs and symptoms of infection. (O10)

Outcomes - Post-op

Used?	Description (Code)
Yes	The patient is at or returning to normothermia at the conclusion of the immediate postoperative period. (O12)
Yes	The patient's respiratory function is consistent with or improved from baseline levels established preoperatively. (O14)
Yes	The patient demonstrates knowledge of pain management. (O20)
Yes	The patient demonstrates knowledge of wound management. (O22)
Yes	The patient demonstrates and/or reports adequate pain control throughout the perioperative period. (O29)

Diagnoses

Present?	Description (Code)
Yes	Anxiety (X4)
	Ineffective breathing pattern (X7)
	Risk for infection (X28)
	Risk for injury (X29)
	Deficient knowledge (X30)
	Acute pain (X38)
	Risk for impaired skin integrity (X51)
	Risk for imbalanced body temperature (X57)

Case Completion Information

Incision Site	Laterality	Dressings
Eye	Left	Eye Shield

Case Completion - Additional Information

Pre-op diagnosis

Nuclear sclerotic cataract of left eye [H25.12]

Post-op diagnosis

Case Completion - Additional Information (continued)

Nuclear sclerotic cataract of left eye [H25.12]

Log Verified By

Ariana Morton, RN	4/17/2019	1022
Sandy M Bobb, RN	4/17/2019	1113
Kimberly R Swanson, RN	4/17/2019	1154

Do Not Proceed History

No information present

Implants

Implants

LENS +24.5 DIOP 13MM 6MM 1 PC POST CHAMB IOL - S12443854056

Inventory Item: LENS +24.5 DIOP 13MM 6MM 1 PC POST CHAMB IOL	Serial no.: 12443854056	Model/Cat no.: SN60WF.245
Implant name: LENS +24.5 DIOP 13MM 6MM 1 PC POST CHAMB IOL - S12443854056	Laterality: Left	Area: Eye
Manufacturer: ALCON SURGICAL INC	Date of Manufacture:	
Action: Implanted	Number Used: 1	
Device Identifier:	Device Identifier Type:	

Timeouts

Pre-Procedure Timeout

Right Patient, Right Site, Right Procedure	Pre-Procedure Verification
Correct patient?: Yes	H&P note verified?: Yes
Correct site?: Yes	Consents verified?: Yes
Correct procedure?: Yes	Site marked?: Yes
Correct laterality?: Yes	Allergies reviewed?: Yes

Anesthesia Staff Present: Cara M Gurney, PAA
Staff Present: Sandy M Bobb, RN, Briana Dilks, CST, Jeffrey P Barber, RN, Cindy T Huff, RN

Verification Date and Time: 4/17/2019 10:53 AM

Pre-Incision Timeout

Right Patient, Right Site, Right Procedure	Before Incision
Correct patient?: Yes	Have all members of the surgical team been introduced?: Yes
Correct site?: Yes	Has the surgeon reviewed all the critical or unexpected steps?: Yes
Correct procedure?: Yes	Has the anesthesia team reviewed any patient-specific concerns?: Yes
Correct position?: Yes	Has the nursing team confirmed sterility?: Yes
Correct laterality?: Yes	Has prophylaxis been given within the last 60 minutes?: N/A
	Is essential imaging displayed?: Yes

Surgeons Present: Bruce P Crowley, MD
Anesthesia Staff Present: Cara M Gurney, PAA
Staff Present: Sandy M Bobb, RN, Briana Dilks, CST, Jeffrey P Barber, RN, Cindy T Huff, RN

Verification Date and Time: 4/17/2019 10:54 AM

Please use the Print Group Designer activity in Hyperspace to make print groups. Contact your technical support representative for more information.

Anesthesia Encounters

Anesthesia Encounter - Episode ID 35322107

Anesthesia Summary - Maurice, Eugene George [561253820] Male 70 y.o. Current as of 04/17/19 1018

Height: 67" (1.702 m) (04/17/19)

Anesthesia Encounter - Episode ID 35322107 (continued)

Anesthesia Summary - Maurice, Eugene George [561253820] Male 70 y.o. (continued)

Current as of 04/17/19 1018

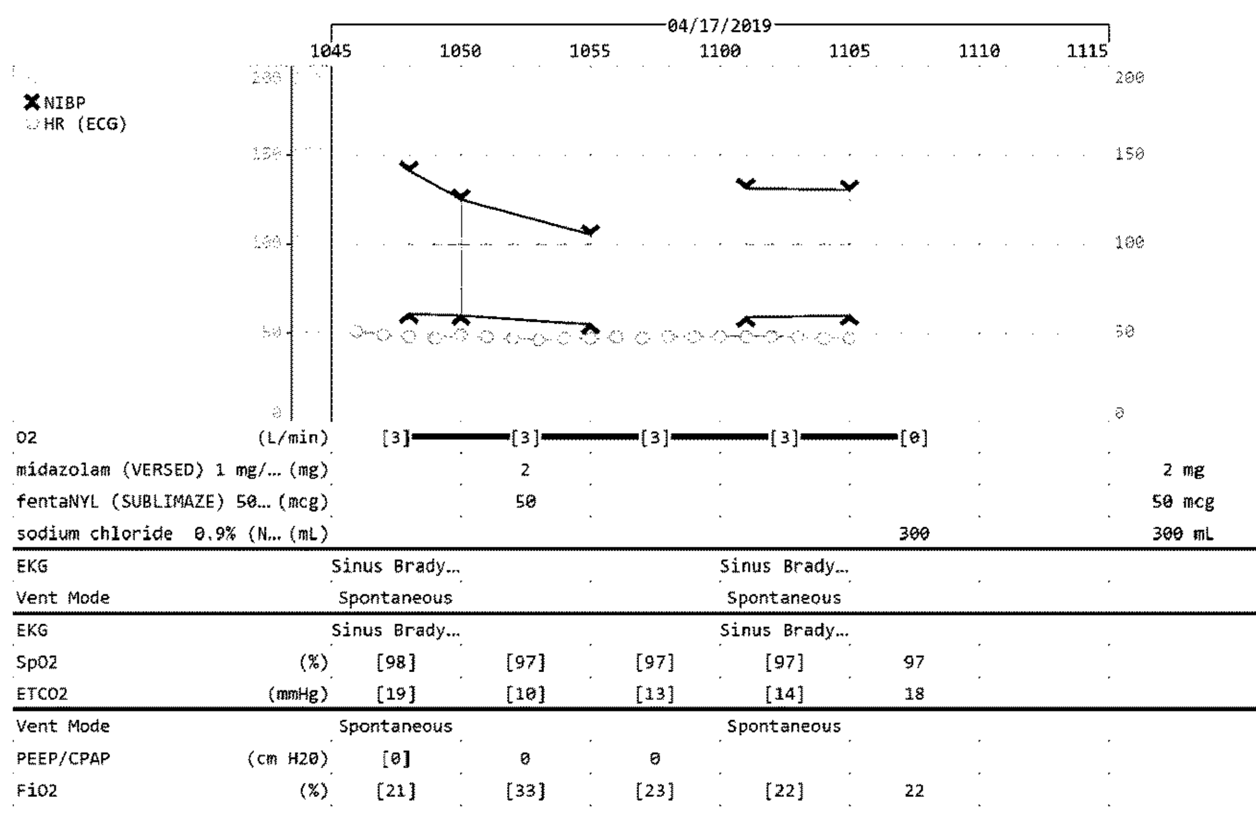
Weight: 96.6 kg (212 lb 15.4 oz) (04/17/19)
BMI: 33.3 (04/17/19)
NPO Status: 2200
Allergies: No Known Allergies

Procedure Summary

Date: 04/17/19
Anesthesia Start: 1045
Procedure: CATARACT PHACOEMULSIFICATION IMPLANTATION INTRAOCULAR LENS (Left Eye)

Surgeon: Bruce P Crowley, MD
Anesthesia Type: MAC

Room / Location: PH OR 08 / PH MAIN OR
Anesthesia Stop: 1110
Diagnosis:
Nuclear sclerotic cataract of left eye
(Nuclear sclerotic cataract of left eye [H25.12])
Responsible Provider: Paul K Turry, MD
ASA Status: 3



Staff

04/17/19

Name	Role	Begin	End
Paul K Turry, MD	ANMD	1045	1110
Cara M Gurney, PAA	APA	1045	1110

Events

Date	Time	Event
4/17/2019	1018	Signed/Cosigned and Ready for Procedure
	1045	Anesthesia Start
	1045	Start Data Collection
	1106	Stop Data Collection
	1110	Handoff to Receiving Nurse I completed my handoff to the receiving nurse during which we: 1. Identified the patient

Anesthesia Encounter - Episode ID 35322107 (continued)

Events (continued)

Date	Time	Event
		2. Identified the responsible providers 3. Discussed the surgical procedure and course 4. Reviewed the pertinent medical history and allergies 5. Reviewed intra-op anesthesia management (airway, medications and I&O) 6. Reviewed nerve block expectations (when applicable) 7. Set expectations for post-procedure period and reviewed post-op orders 8. Allowed opportunity for questions and acknowledgement of understanding
	1110	Anesthesia Stop

Anesthesia Medical History

Other symptoms involving cardiovascular system	Coronary atherosclerosis of native coronary artery
Family history of ischemic heart disease	Other and unspecified hyperlipidemia
Essential hypertension, benign	PVD (peripheral vascular disease) (HCC)
Obesity	Hypertension
Hyperlipidemia	CAD (coronary artery disease)
Infectious viral hepatitis	Diabetes mellitus (HCC)
Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC)	AKI (acute kidney injury) (HCC)
Cataracts, both eyes	Gout

Substance History

Smoking Status: Former Smoker - 25 pack years
Quit Smoking: 04/07/92
Smokeless Tobacco Status: Never Used
Alcohol use: Yes; 4.0 standard drinks per week
Drug use: No

Surgical History

APPENDECTOMY	CORONARY ARTERY BYPASS GRAFT
CAROTID ENDARTERECTOMY	CORONARY STENT PLACEMENT
COLONOSCOPY	shingles
EGD	VASCULAR SURGERY

Facility Administered Medications

Taken on 04/17/19

cyclopentolate (CYCLOGYL) 2 % ophthalmic solution	diclofenac (VOLTAREN) ophthalmic solution 0.1%
lidocaine (PF) 3.5 % eye gel	phenylephrine (MYDFRIN) 2.5 % ophthalmic solution
tetracaine (PF) (PONTOCAINE) 0.5 % eye drops	BSS 500 mL + epinephrine 1:1000 0.5 mL
fentaNYL (PF) (SUBLIMAZE) injection 50 mcg/mL	lidocaine (PF) (XYLOCAINE-MPF) injection 2 %
midazolam (VERSED) injection 1 mg/mL	sod hyaluronate-sod chondroitin-sod hyaluronate (DUOVISC) intra-ocular kit
sodium chloride 0.9% (NS) infusion	sodium chloride bacteriostatic injection 0.9 %

Prescription Medications

Within last 14 days from 04/17/19

	Last Taken	Last Updated
aspirin 81 MG EC tablet	4/13/2019	04/17/19 1013
blood sugar diagnostic (ONETOUCH VERIO) strip	4/16/2019	04/17/19 1013
cyanocobalamin, vitamin B-12, (VITAMIN B12 ORAL)	Past Week	04/17/19 1013
ferrous sulfate 324 mg (65 mg iron) TbEC	Past Week	04/17/19 1013
nitroglycerin (NITROSTAT) 0.4 MG SL tablet	More than a month	04/17/19 1013
~~atorvastatin (LIPITOR) 80 MG tablet (Discontinued)~~	~~Taking~~	~~04/09/19 1430~~
atorvastatin (LIPITOR) 80 MG tablet	4/16/2019	04/17/19 1013
~~clopidogrel (PLAVIX) 75 mg tablet (Discontinued)~~	~~Taking~~	~~04/09/19 1430~~
clopidogrel (PLAVIX) 75 mg tablet	4/13/2019	04/17/19 1013
~~furosemide (LASIX) 40 MG tablet (Discontinued)~~	~~Taking~~	~~04/09/19 1430~~
furosemide (LASIX) 40 MG tablet	4/16/2019	04/17/19 1013
gatifloxacin (ZYMAXID) 0.5 % eye drops	4/17/2019	04/17/19 1013
~~isosorbide mononitrate (IMDUR) 30 MG 24 hr tablet (Discontinued)~~	~~Taking~~	~~04/09/19 1430~~
isosorbide mononitrate (IMDUR) 60 MG 24 hr tablet	4/17/2019	04/17/19 1013
metFORMIN (GLUCOPHAGE) 500 MG tablet	4/16/2019	04/17/19 1013
prednisoLONE acetate (PRED FORTE) 1 % ophthalmic suspension	4/17/2019	04/17/19 1013
ramipril (ALTACE) [illegible] MG capsule	4/16/2019	04/17/19 1013

Anesthesia Encounter - Episode ID 35322107 (continued)

Prescription Medications (continued) — Within last 14 days from 04/17/19

	Last Taken	Last Updated
sotalol (BETAPACE) 80 MG tablet	4/17/2019	04/17/19 1013

Preprocedure Vitals — Current as of 04/17/19 1018

BP: 153/51
Resp: 14
Temp: 98.5 °F (36.9 °C)
Height: 67" (1.702 m) (04/17/19)
BMI: **33.3**
Last edited 04/17/19 1015 by AM

Pulse: 50
SpO2: 96
Weight: 96.6 kg (212 lb 15.4 oz) (04/17/19)
IBW: 66.1 kg (145 lb 12.2 oz)

Blood Orders — Ordered in last 14 days - Current as of 04/03/20 1549

No blood orders found

Hematology Labs (Last 90 days)

	03/17 0914
HGB	**13.3** ▼
HCT	--
Plt	--

Electrolyte Labs (Last 90 days)

	03/17 0914
K+	**5.2** ^
Na+	--
Cl-	--
HCO3	--

Procedure Notes

No procedure notes have been written.

Preprocedure Note

Last edited 04/17/19 1018 by Paul K Turry, MD
Date of Service 04/17/19 1017
Status: Addendum

Anesthesia Pre-op Evaluation

Patient Name: Eugene G Maurice **MRN:** 561253820
Date of Birth: 1/2/1949 **Age:** 70 yrs **Sex:** Male
Height: 1.702 m (5' 7") **Weight:** 96.6 kg (212 lb 15.4 oz) **BMI:** Body mass index is 33.35 kg/m².

Pre-Assessment Information

No Known Allergies

Relevant Problems

(+) Acute GI bleeding
(+) Acute on chronic congestive heart failure, unspecified congestive heart failure type
(+) Anemia
(+) Angina pectoris (HCC)
(+) Atherosclerosis of native coronary artery of native heart with stable angina pectoris (HCC)
(+) Controlled type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene, without long-term current use of insulin (HCC)
(+) Essential hypertension
(+) Localized edema
(+) Obesity
(+) PAF (paroxysmal atrial fibrillation) (HCC)

Past Medical History:

Diagnosis	Date
• AKI (acute kidney injury) (HCC)	
• CAD (coronary artery disease)	
• Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC)	1/30/2018
• Cataracts, both eyes	
• Coronary atherosclerosis of native coronary artery	
• Diabetes mellitus (HCC)	
• Essential hypertension, benign	
• Family history of ischemic heart disease	
• Hyperlipidemia	
• Hypertension	
• Infectious viral hepatitis *as teen/cannont recall what type*	
• Obesity	
• Other and unspecified hyperlipidemia	
• Other symptoms involving cardiovascular system	
• PVD (peripheral vascular disease) (HCC)	

Past Surgical History:

Procedure	Laterality	Date
• APPENDECTOMY		
• CAROTID ENDARTERECTOMY *x2*		
• COLONOSCOPY *as of 9/2014 has not had this*		
• CORONARY ARTERY BYPASS GRAFT *X6*		1992
• CORONARY STENT PLACEMENT		2014

sheikh

• EGD	N/A	6/19/2018
Procedure: GI-EGD (LVL5) W/ BX; Surgeon: Sohail Asfandiyar, MD; Location: KH GI/BRONCH; Service: Gastroenterology; Laterality: N/A;		
• shingles		9/2015
• VASCULAR SURGERY		
right leg		

Social History Main Topics

• Smoking status:	Former Smoker
Packs/day:	1.00
Years:	25.00
Types:	Cigarettes
Quit date:	4/7/1992
• Smokeless tobacco:	Never Used
• Alcohol use	2.4 oz/week
2 Glasses of wine, 2 Shots of liquor per week	
Comment: rarely	
• Drug use:	No
• Sexual activity:	Yes
Partners:	Female
Birth control/ protection:	None

Documented NPO status:
No Data Recorded

Pre-operative Evaluation

Review of Systems/Medical History

General: Patient summary reviewed and Nursing notes reviewed.
Anesthesia History: No history of anesthetic complications. Patient has no family history of anesthetic complications. No PONV
Cardiovascular: Patient's ECG and ECHO reviewed.
(+) hypertension: controlled, CAD,

Comments: Results for orders placed or performed during the hospital encounter of 04/09/18
-Echo 2D complete panel (contrast/bubble PRN per protocol)

Narrative
· The left ventricular systolic function is normal, ejection fraction is 50-55%.
· The left ventricular cavity size is normal.
· Left ventricular diastolic function is normal.
· The right ventricular cavity size and systolic function is/are normal.
· There is mild mitral and tricuspid valve regurgitation present.

Results for orders placed or performed during the hospital encounter of 03/29/16
-Echo 2D complete panel (contrast/bubble PRN per protocol)

Narrative
· Left ventricular systolic function is normal, ejection fraction is 50-55%.
· The left ventricle cavity is normal size. Mildly increased concentric left ventricle hypertrophy.
· Right ventricle has normal size and normal systolic function.
· There is mild mitral valve regurgitation present.

Pulmonary: Negative ROS

Neuro/Psych: - Negative ROS

GI/Hepatic/Renal: Negative GI/hepatic ROS
(+) chronic renal disease:

Endo/Other:
(+) diabetes mellitus: *well controlled*, Type 2,

Physical Exam

Airway:
Mallampati: II
Neck ROM: full
TM distance: >3 FB

Cardiovascular: normal exam

Preprocedure Note (continued)

Pulmonary:

Breath sounds clear to auscultation.

Anesthesia Plan

ASA: 3
Anesthetic Plan: MAC

Airway Management: supplemental O2
Premedication Plan: none

Anesthetic plan and risks discussed with: Patient and spouse.

Plan discussed with: Anesthetist

Electronically signed by Paul K Turry, MD at 4/17/2019 10:18 AM

All Postprocedure Notes

Last edited 04/17/19 1455 by Paul K Turry, MD
Date of Service 04/17/19 1455
Status: Signed

Patient Name: Eugene G Maurice

Procedure Summary

Date: 04/17/19
Anesthesia Start: 1045
Procedure: CATARACT PHACOEMULSIFICATION IMPLANTATION INTRAOCULAR LENS (Left Eye)

Surgeon: Bruce P Crowley, MD
Anesthesia Type: MAC

Room / Location: PH OR 08 / PH MAIN OR
Anesthesia Stop: 1110
Diagnosis:
Nuclear sclerotic cataract of left eye
(Nuclear sclerotic cataract of left eye [H25.12])
Responsible Provider: Paul K Turry, MD
ASA Status: 3

Final Anesthesia Type: MAC

Patient location: PACU
Post vital signs: post-procedure vital signs reviewed and stable

All Postprocedure Notes (continued)

Level of consciousness: awake, alert and oriented
Post-anesthesia pain:
Pain Status: adequate analgesia

Airway patency: patent
Respiratory: room air and unassisted
Cardiovascular: blood pressure at baseline and stable
Hydration: euvolemic
Nausea and vomiting: no signs of nausea and vomiting
Anesthetic complications: No

Electronically signed by Paul K Turry, MD at 4/17/2019 2:55 PM

Attestation Information

Staff Name	Date	Time	Type
Paul K Turry, MD	04/17/19	1018	Anesthesia Present
Paul K Turry, MD	04/17/19	1018	Pre-Induction Assessment
Ariana Morton, RN	04/17/19	1022	Pre-Op
Sandy M Bobb, RN	04/17/19	1113	Intra-Op
Kimberly R Swanson, RN	04/17/19	1154	Phase II

Medications

Medication	Rate/Dose/Volume	Action	Date Time	Administering User	Audit
midazolam (VERSED) 1 mg/mL injection (mg)	2 mg	Given	04/17/19 1050	Cara M Gurney, PAA	
fentaNYL (SUBLIMAZE) 50 mcg/mL injection (mcg)	50 mcg	Given	04/17/19 1050	Cara M Gurney, PAA	
sodium chloride 0.9% (NS) infusion (mL) Dosing weight: 93.9 kg	300 mL	Anesthesia Volume Adjustment	04/17/19 1106	Cara M Gurney, PAA	

Signoff Status

None

Flowsheets (all recorded)

Intake/Output

Row Name	04/17/19 1155	04/17/19 1106	04/17/19 1021		
sodium chloride 0.9% (NS) infusion Start: 04/17/19 1000					
Rate	0 mL/hr -KS	—	30 mL/hr -AM		
[REMOVED] Anesthesia Airway Nasal Cannula					
AN Airway Properties	Airway Device: Nasal Cannula -CG Removal Date: 08/28/19 -LO Removal Time: 0939 -LO				

WS Paulding Hospital
2518 Jimmy Lee Smith Parkway
Hiram GA 30141-2068
Anesthesia Report

Maurice, Eugene George
MRN: 561253820, DOB: 1/2/1949, Sex: M
Adm: 4/17/2019, D/C: 4/17/2019

Flowsheets (all recorded)

Devices Testing Template

Row Name	04/17/19 1106	04/17/19 1105	04/17/19 1104	04/17/19 1103	04/17/19 1102
OTHER					
Product Serial Number	—	10.000000 -DI	10.000000 -DI	10.000000 -DI	10.000000 -DI
HR (ECG)	—	**(!) 47** -DI	**(!) 47** -DI	**(!) 48** -DI	**(!) 48** -DI
SpO2	—	97 % -DI	97 % -DI	97 % -DI	98 % -DI
NIBP	—	130/60 -DI	—	—	—
Anesthesia Monitoring					
FiO2	—	22 % -DI	22 % -DI	23 % -DI	22 % -DI
ETCO2	—	18 mmHg -DI	14 mmHg -DI	12 mmHg -DI	16 mmHg -DI
Agents					
O2	0 L/min -CG	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI

Row Name	04/17/19 1101	04/17/19 1100	04/17/19 1059	04/17/19 1058	04/17/19 1057
OTHER					
Product Serial Number	10.000000 -DI	10.000000 -DI	10.000000 -DI	10.000000 -DI	10.000000 -DI
HR (ECG)	**(!) 48** -DI	**(!) 48** -DI	**(!) 48** -DI	**(!) 48** -DI	**(!) 47** -DI
SpO2	97 % -DI	97 % -DI	97 % -DI	97 % -DI	97 % -DI
NIBP	131/59 -DI	—	—	—	—
Anesthesia Monitoring					
FiO2	24 % -DI	31 % -DI	23 % -DI	22 % -DI	22 % -DI
ETCO2	16 mmHg -DI	15 mmHg -DI	13 mmHg -DI	13 mmHg -DI	12 mmHg -DI
Agents					
O2	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI

Row Name	04/17/19 1056	04/17/19 1055	04/17/19 1054	04/17/19 1053	04/17/19 1052
OTHER					
Product Serial Number	10.000000 -DI	10.000000 -DI	10.000000 -DI	10.000000 -DI	10.000000 -DI
HR (ECG)	**(!) 48** -DI	**(!) 47** -DI	**(!) 47** -DI	**(!) 46** -DI	**(!) 47** -DI
SpO2	97 % -DI	97 % -DI	97 % -DI	97 % -DI	97 % -DI
NIBP	—	105/55 -DI	—	—	—
Anesthesia Monitoring					
FiO2	23 % -DI	22 % -DI	33 % -DI	23 % -DI	24 % -DI
ETCO2	11 mmHg -DI	16 mmHg -DI	10 mmHg -DI	11 mmHg -DI	13 mmHg -DI
Agents					
O2	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI
Respiratory					
PEEP/CPAP	0 cm H20 -DI	—	—	—	—

Row Name	04/17/19 1051	04/17/19 1050	04/17/19 1049	04/17/19 1048	04/17/19 1047
OTHER					
Product Serial Number	10.000000 -DI	10.000000 -DI	10.000000 -DI	10.000000 -DI	10.000000 -DI
HR (ECG)	**(!) 48** -DI	**(!) 49** -DI	**(!) 47** -DI	**(!) 48** -DI	**(!) 49** -DI
SpO2	96 % -DI	97 % -DI	98 % -DI	100 % -DI	100 % -DI
NIBP	—	125/60 -DI	—	141/61 -DI	—
Anesthesia Monitoring					
FiO2	23 % -DI	22 % -DI	21 % -DI	21 % -DI	21 % -DI
ETCO2	14 mmHg -DI	16 mmHg -DI	19 mmHg -DI	21 mmHg -DI	28 mmHg -DI
Agents					
O2	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI
Respiratory					
PEEP/CPAP	0 cm H20 -DI	—	—	—	0 cm H20 -DI

Row Name	04/17/19 1046	04/17/19 1045			
OTHER					
Product Serial Number	10.000000 -DI	10.000000 -DI			
HR (ECG)	51 -DI	—			
SpO2	99 % -DI	—			
Anesthesia Monitoring					
FiO2	21 % -DI	21 % -DI			
ETCO2	26 mmHg -DI	0 mmHg -DI			

Flowsheets (all recorded) (continued)

Devices Testing Template (continued)

Row Name	04/17/19 1046	04/17/19 1045			
Agents					
O2	3 L/min -DI	3 L/min -DI			
Respiratory					
PEEP/CPAP	0 cm H20 -DI	0 cm H20 -DI			

Flowsheets (all recorded)

Anesthesia Checklist

Row Name	04/17/19 0957				
Anesthesia Checklist					
Monitors In Use	Pulse oximeter;Capnometer -CG				
NIBP Site	Arm R -CG				
Cardiac	EKG -CG				
Leads	3 -CG				

Flowsheets (all recorded)

Agents

Row Name	04/17/19 1106	04/17/19 1105	04/17/19 1104	04/17/19 1103	04/17/19 1102
Agents					
O2	0 L/min -CG	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI

Row Name	04/17/19 1101	04/17/19 1100	04/17/19 1059	04/17/19 1058	04/17/19 1057
Agents					
O2	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI

Row Name	04/17/19 1056	04/17/19 1055	04/17/19 1054	04/17/19 1053	04/17/19 1052
Agents					
O2	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI

Row Name	04/17/19 1051	04/17/19 1050	04/17/19 1049	04/17/19 1048	04/17/19 1047
Agents					
O2	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI	3 L/min -DI

Row Name	04/17/19 1046	04/17/19 1045			
Agents					
O2	3 L/min -DI	3 L/min -DI			

Flowsheets (all recorded)

Anesthesia Monitoring

Row Name	04/17/19 1102	04/17/19 1049			
Assessment					
EKG	Sinus Bradycardia -CG	Sinus Bradycardia -CG			
Respiratory					
Vent Mode	Spontaneous -CG	Spontaneous -CG			

Flowsheets (all recorded)

Positioning

Row Name	04/17/19 0958				
OTHER					
Position	Supine -CG				

Flowsheets (all recorded)

Medication Exclusion

Row Name	Anesthesia from 4/17/2019 in WellStar Paulding Hospital (PH MAIN PERIOP)				
Antibiotic/Beta Blocker/Antiemetic/Narcotic Admin Exclusions					
Antibiotic Administered?	2 -CG				
Beta Blocker Adminstered?	0 -CG				
Antiemetic Adminstered?	5 -CG				
Has narcotic waste been reconciled?	1 -CG				

User Key

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates
LO	Lisa M Olivarez, RN	02/03/17 -
KS	Kimberly R Swanson, RN	02/03/17 -
AM	Ariana Morton, RN	01/30/18 -
DI	Interface, Device In	—
CG	Cara M Gurney, PAA	04/12/19 - 04/19/19

Flowsheet Notes

No notes of this type exist for this encounter.

Encounter-Level E-Signatures:

No documentation.

Nursing - Orders and Results

VERIFY INFORMED CONSENT [807984250]

Electronically signed by: **Bruce P Crowley, MD on 04/15/19 0809** Status: **Discontinued**
Ordering user: Bruce P Crowley, MD 04/15/19 0809
Authorized by: Bruce P Crowley, MD
Quantity: 1
Discontinued by: Automatic Transfer Provider 04/17/19 1109 [Patient Transfer]
Ordering provider: Bruce P Crowley, MD
Ordering mode: Standard
Instance released by: Amber Estes, RN (auto-released) 4/17/2019 9:55 AM

MAINTAIN IV ACCESS [812019586]

Electronically signed by: **Bruce P Crowley, MD on 04/15/19 0809** Status: **Discontinued**
Ordering user: Bruce P Crowley, MD 04/15/19 0809
Authorized by: Bruce P Crowley, MD
Quantity: 1
Discontinued by: Automatic Transfer Provider 04/17/19 1109 [Patient Transfer]
Ordering provider: Bruce P Crowley, MD
Ordering mode: Standard
Instance released by: Amber Estes, RN (auto-released) 4/17/2019 9:55 AM

DISCHARGE FOLLOW UP [812019604]

Electronically signed by: **Bruce P Crowley, MD on 04/17/19 1110** Status: **Active**
Ordering user: Bruce P Crowley, MD 04/17/19 1110
Authorized by: Bruce P Crowley, MD
Frequency: Routine 04/17/19 -
Released by: Kimberly R Swanson, RN 04/17/19 1115
Ordering provider: Bruce P Crowley, MD
Ordering mode: Standard
Quantity: 1
Order comments: Follow up in office tomorrow and see Cobb Eye Center post op instruction sheet.

Code Status - Orders and Results

FULL CODE [812019588]

Electronically signed by: **Bruce P Crowley, MD on 04/15/19 0809** Status: **Discontinued**
Ordering user: Bruce P Crowley, MD 04/15/19 0809
Ordering provider: Bruce P Crowley, MD

Code Status - Orders and Results (continued)

FULL CODE [812019588] (continued)

Authorized by: Bruce P Crowley, MD
Quantity: 1
Instance released by: Amber Estes, RN (auto-released) 4/17/2019 9:55 AM
Ordering mode: Standard
Code status: Full Code
Discontinued by: Automatic Discharge Provider 04/17/19 1402 [Patient Discharge]

IV - Orders and Results

INSERT PERIPHERAL IV [812019585]

Electronically signed by: **Bruce P Crowley, MD on 04/15/19 0809**
Status: **Discontinued**
Ordering user: Bruce P Crowley, MD 04/15/19 0809
Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Amber Estes, RN (auto-released) 4/17/2019 9:55 AM
Discontinued by: Automatic Transfer Provider 04/17/19 1109 [Patient Transfer]

INT [812019587]

Electronically signed by: **Bruce P Crowley, MD on 04/15/19 0809**
Status: **Discontinued**
Ordering user: Bruce P Crowley, MD 04/15/19 0809
Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Amber Estes, RN (auto-released) 4/17/2019 9:55 AM
Discontinued by: Automatic Transfer Provider 04/17/19 1109 [Patient Transfer]

DISCONTINUE IV [812019608]

Electronically signed by: **Bruce P Crowley, MD on 04/17/19 1110**
Status: **Discontinued**
Ordering user: Bruce P Crowley, MD 04/17/19 1110
Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Kimberly R Swanson, RN (auto-released) 4/17/2019 11:15 AM
Discontinued by: Automatic Discharge Provider 04/17/19 1402 [Patient Discharge]

Discharge - Orders and Results

DISCHARGE PATIENT [812019607]

Electronically signed by: **Bruce P Crowley, MD on 04/17/19 1110**
Status: **Completed**
Ordering user: Bruce P Crowley, MD 04/17/19 1110
Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Kimberly R Swanson, RN (auto-released) 4/17/2019 11:15 AM

CORE MEASURES - Orders and Results

REASON FOR NO VTE PROPHYLAXIS AT ADMISSION [812019610]

Electronically signed by: **Bruce P Crowley, MD on 04/17/19 1110**
Status: **Completed**
Ordering user: Bruce P Crowley, MD 04/17/19 1110
Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Kimberly R Swanson, RN (auto-released) 4/17/2019 11:15 AM

Questionnaire

Question	Answer
Reason for no pharm VTE prophylaxis at admission?	Patient is at low risk for VTE - No pharm VTE Prophylaxis required

REASON FOR NO MECHANICAL PROPHYLAXIS [812019611]

Electronically signed by: **Bruce P Crowley, MD on 04/17/19 1110**
Status: **Completed**
Ordering user: Bruce P Crowley, MD 04/17/19 1110
Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Kimberly R Swanson, RN (auto-released) 4/17/2019 11:15 AM

CORE MEASURES - Orders and Results (continued)

REASON FOR NO MECHANICAL PROPHYLAXIS [812019611] (continued)

Questionnaire

Question	Answer
If SCDs NOT ordered, indicate reason:	Total Risk Factor Score less than or equal to 1

Point of Care Testing-Docked Device - Orders and Results

POC FINGER STICK GLUCOSE [807984249]

Electronically signed by: **Denis Trto, MD on 04/17/19 1951** Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Sandra Cody, RN 04/12/19 1604
Authorized by: Denis Trto, MD
Quantity: 1
Discontinued by: Automatic Transfer Provider 04/17/19 1109 [Patient Transfer]
Communicated by: Sandra Cody, RN
Ordering provider: Denis Trto, MD
Ordering mode: Per protocol: cosign required
Instance released by: Amber Estes, RN (auto-released) 4/17/2019 9:55 AM

POC FINGER STICK GLUCOSE [812019592]

Electronically signed by: **Interface, Lab In Sunquest on 04/17/19 1017** Status: **Completed**
Ordering user: Interface, Lab In Sunquest 04/17/19 1017
Authorized by: Bruce P Crowley, MD
Quantity: 1
Instance released by: (auto-released) 4/17/2019 10:25 AM
Ordering provider: Bruce P Crowley, MD
Ordering mode: Standard
Lab status: Final result

Specimen Information

Type	Source	Collected By
Blood	Blood	04/17/19 1017

POC FINGER STICK GLUCOSE [812019592] (Abnormal)

Resulted: 04/17/19 1025, Result status: Final result
Ordering provider: Bruce P Crowley, MD 04/17/19 1017
Filed by: Interface, Lab In Sunquest 04/17/19 1025
External ID: W16125145
Order status: Completed
Resulting lab: WS PAULDING HOSPITAL LAB
Result details

Specimen Information

Type	Source	Collected By
Blood	Blood	04/17/19 1017

Components

Component	Value	Reference Range	Flag	Lab
GLUCOSE, BEDSIDE	134	70 - 99 mg/dL	H ^	PHLAB
POC-OPERATOR'S ID	59394	—	—	PHLAB

Diet - Orders and Results

DIET, CLEAR LIQUID [812019609]

Electronically signed by: **Bruce P Crowley, MD on 04/17/19 1110** Status: **Discontinued**
Ordering user: Bruce P Crowley, MD 04/17/19 1110
Authorized by: Bruce P Crowley, MD
Quantity: 1
Instance released by: Kimberly R Swanson, RN (auto-released) 4/17/2019 11:15 AM
Ordering provider: Bruce P Crowley, MD
Ordering mode: Standard
Diet: Clear Liquid
Discontinued by: Automatic Discharge Provider 04/17/19 1402 [Patient Discharge]

Medications - Orders and Results

sodium chloride 0.9 % (NS) flush [807984241]

Medications - Orders and Results (continued)

sodium chloride 0.9 % (NS) flush [807984241] (continued)

Electronically signed by: **Bruce P Crowley, MD on 04/15/19 0809** Status: **Discontinued**
Ordering user: Bruce P Crowley, MD 04/15/19 0809 Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD Ordering mode: Standard
PRN reasons: line care
Frequency: Routine Q1 min PRN 04/17/19 0955 - 04/17/19 1109 Released by: Amber Estes, RN 04/17/19 0955
Discontinued by: Automatic Transfer Provider 04/17/19 1109 [(Patient Transfer - Internal Use Only)]
Acknowledged: Amber Estes, RN 04/17/19 0955 for Placing Order
Admin instructions: INT Flush
Package: 8290-306547

sodium chloride 0.9% (NS) infusion [807984242]

Electronically signed by: **Bruce P Crowley, MD on 04/15/19 0809** Status: **Discontinued**
Ordering user: Bruce P Crowley, MD 04/15/19 0809 Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD Ordering mode: Standard
Frequency: Routine Continuous 04/17/19 1000 - 04/17/19 1357 Released by: Amber Estes, RN 04/17/19 0955
Discontinued by: Automatic Discharge Provider 04/17/19 1357 [(Patient Discharge - Internal Use Only)]
Acknowledged: Amber Estes, RN 04/17/19 0955 for Placing Order
Package: 0409-7983-09

cyclopentolate (CYCLOGYL) 2 % ophthalmic solution [807984243]

Electronically signed by: **Bruce P Crowley, MD on 04/15/19 0809** Status: **Completed**
Ordering user: Bruce P Crowley, MD 04/15/19 0809 Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD Ordering mode: Standard
Frequency: Routine Q5 Min 04/17/19 0955 - 3 occurrences Released by: Amber Estes, RN 04/17/19 0955
Acknowledged: Amber Estes, RN 04/17/19 0955 for Placing Order
Package: 17478-097-02

diclofenac (VOLTAREN) ophthalmic solution 0.1% [807984244]

Electronically signed by: **Bruce P Crowley, MD on 04/15/19 0809** Status: **Completed**
Ordering user: Bruce P Crowley, MD 04/15/19 0809 Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD Ordering mode: Standard
Frequency: Routine Q5 Min 04/17/19 0955 - 3 occurrences Released by: Amber Estes, RN 04/17/19 0955
Acknowledged: Amber Estes, RN 04/17/19 0955 for Placing Order
Package: 61314-014-25

lidocaine (PF) 3.5 % eye gel [807984245]

Electronically signed by: **Bruce P Crowley, MD on 04/15/19 0809** Status: **Completed**
Ordering user: Bruce P Crowley, MD 04/15/19 0809 Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD Ordering mode: Standard
Frequency: Routine Once 04/17/19 1000 - 1 occurrence Released by: Amber Estes, RN 04/17/19 0955
Acknowledged: Amber Estes, RN 04/17/19 0955 for Placing Order
Admin instructions: Apply to eye after completion of all dilation drops
Package: 17478-792-01

phenylephrine (MYDFRIN) 2.5 % ophthalmic solution [807984246]

Electronically signed by: **Bruce P Crowley, MD on 04/15/19 0809** Status: **Completed**
Ordering user: Bruce P Crowley, MD 04/15/19 0809 Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD Ordering mode: Standard
Frequency: Routine Q5 Min 04/17/19 0955 - 3 occurrences Released by: Amber Estes, RN 04/17/19 0955
Acknowledged: Amber Estes, RN 04/17/19 0955 for Placing Order
Admin instructions: Place waste in BLACK hazardous container.
Package: 17478-201-02

tetracaine (PF) (PONTOCAINE) 0.5 % eye drops [807984247]

Electronically signed by: **Bruce P Crowley, MD on 04/15/19 0809** Status: **Completed**
Ordering user: Bruce P Crowley, MD 04/15/19 0809 Ordering provider: Bruce P Crowley, MD
Authorized by: Bruce P Crowley, MD Ordering mode: Standard
Frequency: Routine Once 04/17/19 1000 - 1 occurrence Released by: Amber Estes, RN 04/17/19 0955
Acknowledged: Amber Estes, RN 04/17/19 0955 for Placing Order
Package: 0065-0741-14

Medications - Orders and Results (continued)

BSS 500 mL + epinephrine 1:1000 0.5 mL [812019593]

Electronically signed by: **Sandy M Bobb, RN on 04/17/19 1057** Status: **Discontinued**
Ordering user: Sandy M Bobb, RN 04/17/19 1057
Authorized by: Bruce P Crowley, MD
Frequency: Routine PRN 04/17/19 1057 - 04/17/19 1109
Ordering provider: Bruce P Crowley, MD
Ordering mode: Standard
Discontinued by: Automatic Transfer Provider 04/17/19 1109 [(Patient Transfer - Internal Use Only)]

Acknowledged: Sandy M Bobb, RN 04/17/19 1057 for Placing Order

Mixture Ingredients

Medication	Ordered Dose	Calculated Dose
balanced salt irrigation (BSS PLUS)	500 mL	500 mL
EPINEPHrine (ADRENALIN) 1 mg/mL	0.5 mL	0.5 mL

Package: 0065-0800-94, 42023-168-01

lidocaine (PF) (XYLOCAINE-MPF) injection 2 % [812019594]

Electronically signed by: **Sandy M Bobb, RN on 04/17/19 1057** Status: **Discontinued**
Ordering user: Sandy M Bobb, RN 04/17/19 1057
Authorized by: Bruce P Crowley, MD
Frequency: Routine PRN 04/17/19 1052 - 04/17/19 1109
Ordering provider: Bruce P Crowley, MD
Ordering mode: Standard
Discontinued by: Automatic Transfer Provider 04/17/19 1109 [(Patient Transfer - Internal Use Only)]

Acknowledged: Sandy M Bobb, RN 04/17/19 1057 for Placing Order
Package: 63323-495-07

sod hyaluronate-sod chondroitin-sod hyaluronate (DUOVISC) intra-ocular kit [812019595]

Electronically signed by: **Sandy M Bobb, RN on 04/17/19 1058** Status: **Discontinued**
Ordering user: Sandy M Bobb, RN 04/17/19 1058
Authorized by: Bruce P Crowley, MD
Frequency: Routine PRN 04/17/19 1052 - 04/17/19 1109
Ordering provider: Bruce P Crowley, MD
Ordering mode: Standard
Discontinued by: Automatic Transfer Provider 04/17/19 1109 [(Patient Transfer - Internal Use Only)]

Acknowledged: Sandy M Bobb, RN 04/17/19 1058 for Placing Order
Package: 8065-1831-50

sodium chloride bacteriostatic injection 0.9 % [812019596]

Electronically signed by: **Sandy M Bobb, RN on 04/17/19 1058** Status: **Discontinued**
Ordering user: Sandy M Bobb, RN 04/17/19 1058
Authorized by: Bruce P Crowley, MD
Frequency: Routine PRN 04/17/19 1052 - 04/17/19 1109
Ordering provider: Bruce P Crowley, MD
Ordering mode: Standard
Discontinued by: Automatic Transfer Provider 04/17/19 1109 [(Patient Transfer - Internal Use Only)]

Acknowledged: Sandy M Bobb, RN 04/17/19 1058 for Placing Order
Package: 0409-1966-12

neomycin-polymyxin-dexamethasone (MAXITROL) ophthalmic suspension [812019599]

Electronically signed by: **Sandy M Bobb, RN on 04/17/19 1106** Status: **Discontinued**
Ordering user: Sandy M Bobb, RN 04/17/19 1106
Authorized by: Bruce P Crowley, MD
Frequency: Routine PRN 04/17/19 1106 - 04/17/19 1109
Ordering provider: Bruce P Crowley, MD
Ordering mode: Standard
Discontinued by: Automatic Transfer Provider 04/17/19 1109 [(Patient Transfer - Internal Use Only)]

Acknowledged: Sandy M Bobb, RN 04/17/19 1106 for Placing Order
Package: 0998-0630-06

pilocarpine (PILOCAR) 2 % ophthalmic solution [812019600]

Electronically signed by: **Sandy M Bobb, RN on 04/17/19 1106** Status: **Discontinued**
Ordering user: Sandy M Bobb, RN 04/17/19 1106
Authorized by: Bruce P Crowley, MD
Frequency: Routine PRN 04/17/19 1106 - 04/17/19 1109
Ordering provider: Bruce P Crowley, MD
Ordering mode: Standard
Discontinued by: Automatic Transfer Provider 04/17/19 1109 [(Patient Transfer - Internal Use Only)]

Acknowledged: Sandy M Bobb, RN 04/17/19 1106 for Placing Order
Package: 61314-204-15

Testing Performed By

Medications - Orders and Results (continued)

Testing Performed By (continued)

Lab - Abbreviation	Name	Director	Address	Valid Date Range
22 - PHLAB	WS PAULDING HOSPITAL LAB	Dr. Jonathan Herbst	2518 Jimmy Lee Smith Parkway Hiram GA 30141	08/28/18 1258 - Present

Medications

All Meds and Administrations

sodium chloride 0.9 % (NS) flush [807984241]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/17/19 0955
Dose (Remaining/Total): 3-40 mL (—/—)
Frequency: Every 1 minute PRN
Admin Instructions: INT Flush

Status: Discontinued (Past End Date/Time), Reason: (Patient Transfer - Internal Use Only)
Starts/Ends: 04/17/19 0955 - 04/17/19 1109
Route: Intravenous
Rate/Duration: — / —

(No admins scheduled or recorded for this medication)

sodium chloride 0.9% (NS) infusion [807984242]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/17/19 0955
Dose (Remaining/Total): 30 mL/hr (—/—)
Frequency: Continuous

Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 04/17/19 1000 - 04/17/19 1357
Route: Intravenous
Rate/Duration: 30 mL/hr / —

Line	Med Link Info	Comment
Peripheral IV 04/17/19 22 G Left Hand	04/17/19 1021 by Ariana Morton, RN	—

Timestamps	Action	Dose / Rate	Route	Other Information
Performed 04/17/19 1155 Documented: 04/17/19 1155	Stopped	0 mL/hr 0 mL/hr	Intravenous	Performed by: Kimberly R Swanson, RN
Performed 04/17/19 1106 Documented: 04/17/19 1106	Anesthesia Volume Adjustment	—	Intravenous	Performed by: Cara M Gurney, PAA
Performed 04/17/19 1021 Documented: 04/17/19 1021	New Bag	30 mL/hr 30 mL/hr	Intravenous	Performed by: Ariana Morton, RN Scanned Package: 0409-7983-09

cyclopentolate (CYCLOGYL) 2 % ophthalmic solution [807984243]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/17/19 0955
Dose (Remaining/Total): 1 drop (0/3)
Frequency: Every 5 min

Status: Completed (Past End Date/Time)
Starts/Ends: 04/17/19 0955 - 04/17/19 1021
Route: Left Eye
Rate/Duration: — / —

Timestamps	Action	Dose	Route	Other Information
Performed 04/17/19 1021 Documented: 04/17/19 1021	Given	1 drop	Left Eye	Performed by: Ariana Morton, RN Scanned Package: 17478-097-02
Performed 04/17/19 1014 Documented: 04/17/19 1016	Given	1 drop	Left Eye	Performed by: Ariana Morton, RN Scanned Package: 17478-097-02
Performed 04/17/19 1009 Documented: 04/17/19 1014	Given	1 drop	Left Eye	Performed by: Ariana Morton, RN Scanned Package: 17478-097-02

diclofenac (VOLTAREN) ophthalmic solution 0.1% [807984244]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/17/19 0955
Dose (Remaining/Total): 1 drop (0/3)
Frequency: Every 5 min

Status: Completed (Past End Date/Time)
Starts/Ends: 04/17/19 0955 - 04/17/19 1021
Route: Left Eye
Rate/Duration: — / —

Timestamps	Action	Dose	Route	Other Information

Medications (continued)

All Meds and Administrations (continued)

Timestamps	Action	Dose	Route	Other Information
Performed 04/17/19 1021 Documented: 04/17/19 1021	Given	1 drop	Left Eye	Performed by: Ariana Morton, RN Scanned Package: 61314-014-25
Performed 04/17/19 1014 Documented: 04/17/19 1016	Given	1 drop	Left Eye	Performed by: Ariana Morton, RN Scanned Package: 61314-014-25
Performed 04/17/19 1009 Documented: 04/17/19 1014	Given	1 drop	Left Eye	Performed by: Ariana Morton, RN Scanned Package: 61314-014-25

lidocaine (PF) 3.5 % eye gel [807984245]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/17/19 0955
Dose (Remaining/Total): 2 drop (0/1)
Frequency: Once
Admin Instructions: Apply to eye after completion of all dilation drops

Status: Completed (Past End Date/Time)
Starts/Ends: 04/17/19 1000 - 04/17/19 1021
Route: Left Eye
Rate/Duration: — / —

Timestamps	Action	Dose	Route	Other Information
Performed 04/17/19 1021 Documented: 04/17/19 1021	Given	2 drop	Left Eye	Performed by: Ariana Morton, RN Scanned Package: 17478-792-01

phenylephrine (MYDFRIN) 2.5 % ophthalmic solution [807984246]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/17/19 0955
Dose (Remaining/Total): 1 drop (0/3)
Frequency: Every 5 min
Admin Instructions: Place waste in BLACK hazardous container.

Status: Completed (Past End Date/Time)
Starts/Ends: 04/17/19 0955 - 04/17/19 1021
Route: Left Eye
Rate/Duration: — / —

Timestamps	Action	Dose	Route	Other Information
Performed 04/17/19 1021 Documented: 04/17/19 1021	Given	1 drop	Left Eye	Performed by: Ariana Morton, RN Scanned Package: 17478-201-02
Performed 04/17/19 1014 Documented: 04/17/19 1016	Given	1 drop	Left Eye	Performed by: Ariana Morton, RN Scanned Package: 17478-201-02
Performed 04/17/19 1009 Documented: 04/17/19 1014	Given	1 drop	Left Eye	Performed by: Ariana Morton, RN Scanned Package: 17478-201-02

tetracaine (PF) (PONTOCAINE) 0.5 % eye drops [807984247]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/17/19 0955
Dose (Remaining/Total): 1 drop (0/1)
Frequency: Once

Status: Completed (Past End Date/Time)
Starts/Ends: 04/17/19 1000 - 04/17/19 1009
Route: Left Eye
Rate/Duration: — / —

Timestamps	Action	Dose	Route	Other Information
Performed 04/17/19 1009 Documented: 04/17/19 1009	Given	1 drop	Left Eye	Performed by: Ariana Morton, RN Scanned Package: 0065-0741-14

BSS 500 mL + epinephrine 1:1000 0.5 mL [812019593]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/17/19 1057

Status: Discontinued (Past End Date/Time), Reason: (Patient Transfer - Internal Use Only)
Frequency: As needed

Medications (continued)

All Meds and Administrations (continued)

Timestamps	Action	Dose	Route / Site	Other Information
Performed 04/17/19 1057 Documented: 04/17/19 1057	Given	500 mL	Irrigation Left Eye	Performed by: Bruce P Crowley, MD Documented by: Sandy M Bobb, RN

lidocaine (PF) (XYLOCAINE-MPF) injection 2 % [812019594]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/17/19 1057
Status: Discontinued (Past End Date/Time), Reason: (Patient Transfer - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route / Site	Other Information
Performed 04/17/19 1052 Documented: 04/17/19 1057	Given	1 mL	Injection Left Eye	Performed by: Bruce P Crowley, MD Documented by: Sandy M Bobb, RN

sod hyaluronate-sod chondroitin-sod hyaluronate (DUOVISC) intra-ocular kit [812019595]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/17/19 1058
Status: Discontinued (Past End Date/Time), Reason: (Patient Transfer - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route / Site	Other Information
Performed 04/17/19 1052 Documented: 04/17/19 1058	Given	1 kit	Intraocular Left Eye	Performed by: Bruce P Crowley, MD Documented by: Sandy M Bobb, RN

sodium chloride bacteriostatic injection 0.9 % [812019596]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/17/19 1058
Status: Discontinued (Past End Date/Time), Reason: (Patient Transfer - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route / Site	Other Information
Performed 04/17/19 1052 Documented: 04/17/19 1058	Given	10 mL	Intraocular Irrigation Left Eye	Performed by: Bruce P Crowley, MD Documented by: Sandy M Bobb, RN

neomycin-polymyxin-dexamethasone (MAXITROL) ophthalmic suspension [812019599]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/17/19 1106
Status: Discontinued (Past End Date/Time), Reason: (Patient Transfer - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 04/17/19 1106 Documented: 04/17/19 1106	Given	2 drop	Left Eye	Performed by: Bruce P Crowley, MD Documented by: Sandy M Bobb, RN

pilocarpine (PILOCAR) 2 % ophthalmic solution [812019600]

Ordering Provider: Bruce P Crowley, MD
Ordered On: 04/17/19 1106
Status: Discontinued (Past End Date/Time), Reason: (Patient Transfer - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 04/17/19 1106 Documented: 04/17/19 1106	Given	2 drop	Left Eye	Performed by: Bruce P Crowley, MD Documented by: Sandy M Bobb, RN

Medications (continued)

All Meds and Administrations (continued)

Historical Medications Entered This Encounter

This print group is not available in inpatient encounters. Please contact a system administrator.

Patient Education

Education

Title: Acute MI (MCB) (Resolved)

Topic: Psycho/Social/Spiritual Support (Resolved)

Point: Coping Mechanisms (Resolved)

Description:
Help patient identify healthy coping mechanisms. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Support Systems (Resolved)

Description:
Help patient identify available support systems. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Spiritual/Emotional Needs (Resolved)

Description:
Offer resources to meet spiritual/emotional needs. Refer to Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Resolved)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Prevention (MCB) (Resolved)

Point: When to Call the Doctor (Resolved)

Description:
Educate patient/family/caregiver on when to call the doctor.

Learner Progress: Not documented in this visit.

Point: Protect Others from Infection (Resolved)

Description:
Educate patient/family/caregiver on respiratory hygiene and cough etiquette. To protect from further infection and to protect others from getting an infection, patient should cover nose and mouth with tissues when coughing. Encourage patient to place used tissues in a plastic bag that will not allow secretions to soak through. Patient should always wash his/her hands after using or handling used tissues.

Learner Progress: Not documented in this visit.

Point: Protect Yourself from Further Infection (MCB) (Resolved)

Patient Education (continued)

Education (continued)

Description:
Educate patient/family/caregiver that because patient is in a weakened condition he/she needs to avoid others who are sick as to not acquire another illness. Family/caregiver should wear gloves, gown and face shield/eye protection.

Patient Friendly Description:
Information on Flu.
Information on Pneumonia and Pneumococcal Vaccination.

Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Resolved)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.

Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Resolved)

Point: General Self Care (Resolved)

Description:
Instruct patient on self care needs. These may include: hygiene, how to take a blood pressure, how to change a dressing, etc.

Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Resolved)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.

Learner Progress: Not documented in this visit.

Topic: Pain Management (Resolved)

Point: Pain Medication Actions & Side Effects (Resolved)

Description:
Provide medication specific handouts when available.

Learner Progress: Not documented in this visit.

Point: Discuss Significance of VAS Scores (Resolved)

Description:
Refer to rating score of 0-10.

Learner Progress: Not documented in this visit.

Point: Discuss the Use of Pain Control Measures Before Pain Becomes Severe (MCB) (Resolved)

Description:
Take time to reiterate to patient that he/she should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time before pain becomes severe.

Patient Education (continued)

Education (continued)

Patient Friendly Description:
Please inform staff that if you are having any difficulty breathing, pain or any discomfort at any time before the pain gets severe.

Please read over the items and let anyone on your Care Team know there are any questions about the material by marking below that "I HAVE QUESTIONS".

If once you have received the items and understand the material you can mark this as "I understand".
Learner Progress: Not documented in this visit.

Point: Non-Pharmacological Comfort Measures (Resolved)

Description:
Explain there are other ways of controlling pain than medication. The following are suggestions: position change, aromatherapy, deep slow breathing, distraction, quiet environment, imagery, heat therapy and/or cold therapy, laughter, massage, music, physical therapy, and touch therapy.

Learner Progress: Not documented in this visit.

Point: Patient Controlled Analgesia (Resolved)

Description:
Give the patient written information on Patient Controlled Analgesia. Explain how the pump works. Demonstrate pushing the button to give pain medicine to the patient. Caution the patient and other family/visitors that only the patient should press the PCA button for pain relief to decrease the chance of getting too much pain medicine.

Learner Progress: Not documented in this visit.

Point: Epidural Information (Resolved)

Description:
Give the patient written information on Epidural Analgesia. Explain why an epidural is used, how the epidural is placed and how the medication is given. If the epidural is PCA, demonstrate pushing the button to give pain medicine to the patient. Caution the patient and other family/visitors that only the patient should press the button for pain relief to decrease the chance of getting too much pain medicine.

Learner Progress: Not documented in this visit.

Topic: Signs and Symptoms - Acute MI (Resolved)

Point: Recognizing a Heart Attack (MCB) (Resolved)

Description:
Be sure patient reviews video on Coronary Artery Disease

Patient Friendly Description:
Please watch the video and/or read over the documented material and let anyone on your Care Team know if there are any questions by marking below.
If after watching the video and/or reading the material you have questions, please mark below I have question to let the staff know you have additional questions about a topic and they will be in to discuss your questions.

This will inform you of what to expect if you are diagnosed with a Heart Attack.
Learner Progress: Not documented in this visit.

Point: Risk Factors (Resolved)

Description:
Educate the patient/family/caregiver on coronary risk factors. Explain the controllable and non-controllable risk factors to Coronary Artery Disease. Review how to control coronary artery disease by altering the controllable risk factors. Some examples include: controlling blood pressure, reducing fat and cholesterol in the diet, stopping smoking, exercising regularly, maintaining ideal body weight, dealing with stress in an appropriate manner, drinking alcohol and coffee in moderation and controlling blood sugar levels (if applicable).

Learner Progress: Not documented in this visit.

Topic: Acute MI (MCB) (Resolved)

Patient Education (continued)

Education (continued)

Point: Emergency Plan for Heart Attack Symptoms (Resolved)

Description:
Educate the patient/family/caregiver on how to get help immediately if heart attack symptoms occur. The patient should call 911 or the Emergency Medical Service number. Reinforce that the patient should not delay in obtaining help.

Learner Progress: Not documented in this visit.

Point: Home Activity (Resolved)

Description:
Educate the patient/family/caregiver on home activity guidelines that apply after having had a recent heart attack. Do things in moderation, rest about 30 minutes after eating, pace activities, allow for 7-8 hours of sleep at night, start with short walks 3-5 times a day. Consult with Cardiac Rehab staff, if applicable.

Learner Progress: Not documented in this visit.

Point: Limitations to Activity (Resolved)

Description:
Educate the patient/family/caregiver reagrding the following limitations to activity for 4-6 weeks after discharge. No lifting over 10 pounds (weight of a milk jug), no pushing or pulling motions with the arms (sweeping, vacuuming or raking), no driving (may be changed after talking to the doctor), no bathing in very hot or very cold water.

Learner Progress: Not documented in this visit.

Point: Sexual Activity (Resolved)

Description:
Educate the patient/family/caregiver on the following: Wait 4 weeks before resuming sexual activity. If the patient can climb 2 flights of steps, he/she can assume it is ok to resume sexual activity. Choose a comfortable position. Wait at least 1 hour after a meal. If sex brings on angina, stop and rest. Discuss chest pain during sex with the physician. Some medications can affect sexual desire. If this is the case, talk with the physician.

Learner Progress: Not documented in this visit.

Point: Influenza Vaccine (Resolved)

Description:
Educate the patient/family/caregiver on obatining a yearly influenza vaccine.

Learner Progress: Not documented in this visit.

Point: Smoking Cessation (Resolved)

Description:
Educate the patient/family/caregiver on smoking cessation and smoking cessation programs offered in the community. Explain effects smoking and second hand smoke have on the body. Encourage the patient to ask people that smoke around him/her to smoke outside or in another room. Refer patient to Cardiopulmonary Rehabilitation, if applicable.

Learner Progress: Not documented in this visit.

Title: Diabetes (MCB) (Not Started)

Topic: Psycho/Social/Spiritual Support (Not Started)

Point: Stress Management and Support Systems (Not Started)

Description:
Explain the importance of stress management and support systems in diabetes management. Refer to WellStar diabetes support groups, social services, case management or spiritual care, if needed.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Anxiety Reduction (Not Started)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Treatments/Procedures (MCB) (Not Started)

Point: Introduction to Diabetes (MCB) (Not Started)

Description:
Give patient/family/caregiver written information on diabetes. Explain the definition of the type of diabetes with which the patient was diagnosed, how diabetes works in the body, risk factors, signs and symptoms, and if newly diagnosed, diagnostic criteria. Encourage viewing of diabetes on-demand videos when applicable. Refer to inpatient diabetes educator when applicable.

Patient Friendly Description:
You will receive a booklet entitled Diabetes survival skills. There are also two links to documents about Diabetes for you to read over noted below.

Please read over the items and let anyone on your Care Team know there are any questions about the material by marking below that "I HAVE QUESTIONS".

If once you have received the items and understand the material you can mark this as "I understand".
Learner Progress: Not documented in this visit.

Point: Diabetes Type II management (MCB) (Not Started)

Description:
Patient will watch a video that will discuss information on what to expect if they have Diabetes type II.

Patient Friendly Description:
This will inform you of what to expect if you have Diabetes type II.
Learner Progress: Not documented in this visit.

Point: Diabetic long term complications (MCB) (Not Started)

Description:
Patient will have information from Krames on the long term complications of Diabetes Type II.

Patient Friendly Description:
Some information on the long term complications of Diabetes Type II.
Learner Progress: Not documented in this visit.

Topic: Medications (MCB) (Not Started)

Point: Insulin (MCB) (Not Started)

Description:
Educate patient/family/caregiver on the insulin prescribed. Explain how insulin works in the body. Explain the action of insulin, reason for taking, side effects, signs of allergic reaction and when physician should be called. Reinforce that insulin should be taken exactly as the physician has prescribed. Explain the proper storage of insulin, that extreme temperatures can damage insulin and never take insulin that has expired. Explain that the patient's primary care physician may change the dosage depending on the results of blood glucose tests and/or A1C level.

Patient Friendly Description:
This will inform you of why you are prescribed insulin if you have Diabetes Type II.
Learner Progress: Not documented in this visit.

Point: Hypoglycemic Agents (Not Started)

Description:
Educate patient/family/caregiver on the oral and/or injectable hypoglycemic(s) prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, as well as when the physician should be called. Reinforce that this medication(s) should be taken exactly as the physician has prescribed.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Giving Insulin Injection (Not Started)

Description:
Explain and demonstrate how the injection is given. Allow enough time for the patient/family/caregiver to practice. Have the patient return-demonstrate the technique using normal saline (vial and syringe only unless sterile demonstration pen is also available). Teach the patient how to choose and rotate injection sites. Instruct patient on safe disposal of used needles and syringes.

Learner Progress: Not documented in this visit.

Point: Drawing up Insulin (Not Started)

Description:
Instruct patient/family/caregiver to wash hands before drawing up insulin. Demonstrate and have the patient return-demonstrate drawing up the correct amount of insulin prescribed. If the patient is going to use an insulin pen, demonstrate use and have the patient return-demonstrate. If the patient is going to mix different types of insulin, demonstrate and have the patient return-demonstrate the correct way to draw up and mix the insulin.

Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Not Started)

Point: Exercise (Not Started)

Description:
Encourage patient/family/caregiver to discuss activity limitations, if any, with physician before starting an exercise routine. Stress the importance of regular exercise and activity to control blood sugar levels and weight. Instruct the patient to carry single carohydrates while exercising in case of hypoglycemic reaction. Explain that both concentrated physical activity (such as walking, swimming, running, cycling, strength training) and being more active through the entire day are equally important to blood sugar control and weight management.

Learner Progress: Not documented in this visit.

Point: Blood Glucose Monitoring (MCB) (Not Started)

Description:
Instruct patient/family/caregiver to wash hands before checking blood glucose. Explain and, if possible to use a complementary glucometer, demonstrate how to check and record blood sugars. Instruct the patient to check blood sugars as frequently as ordered by the physician. Explain that stress or illness will increase blood sugar, making it necesary to check blood sugars more often than usual. Instruct patient on blood glucose target ranges and A1C target range. Discuss care of the meter and supplies, including how to obtain supplies. If using a complementary glucometer, have the patient return-demonstrate checking the blood sugar. Instruct the patient on safe disposal of lancets. Refer to inpatient diabetes educator if applicable.

Patient Friendly Description:
Why is it important to check my blood sugar?

Learner Progress: Not documented in this visit.

Point: Diabetic Foot Care (MCB) (Not Started)

Description:
Explain importance of foot care. Patient should have feet examined by a health care provider at least twice a year. Persons with foot problems should have feet examined at every visit. Explain daily foot care. Review importance of wearing well-fitting shoes and stockings/socks. Reinforce the importance of wearing shoes, even indoors, to prevent injury.

Patient Friendly Description:
This will inform you of why you should check your feet if you have diabetes.

Learner Progress: Not documented in this visit.

Point: Diabetes Identification Jewelry (Not Started)

Description:
Encourage the patient to wear a piece of jewelry that identifies patient as a person with diabetes. This will inform medical personnel that patient has diabetes if unable to communicate.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Topic: Prevention/Discharge (Not Started)

Point: Signs and Symptoms of Hypoglycemia (Not Started)

Description:
Define and explain causes of hypoglycemia. Discuss signs and symptoms.

Learner Progress: Not documented in this visit.

Point: Treatment of Hypoglycemia (Not Started)

Description:
Instruct the patient on how to treat low blood sugar using the Rule of 15. Encourage patient to carry a blood sugar treatment at all time.

Learner Progress: Not documented in this visit.

Point: When to Call the Doctor (Not Started)

Description:
Instruct the patient/family/caregiver to call their health care provider if there are symptoms of hypo- or hyperglycemia or if blood sugars are trending high or low and are not controlled by simple measures.

Learner Progress: Not documented in this visit.

Point: Signs and Symptoms of Hyperglycemia (Not Started)

Description:
Define and explain causes of hyperglycemia. Discuss signs and symptoms (mild, moderate, severe, and ketoacidosis).

Learner Progress: Not documented in this visit.

Point: Prevention of Hyperglycemia (Not Started)

Description:
Encourage patient/family/caregiver to follow healthcare providers' instructions for diet, activity and medications. Explain the importance of good diabetes management and learning to detect and treat hyperglycemia early before it worsens. Refer to registered dietitian, when applicable, for meal planning assistance.

Learner Progress: Not documented in this visit.

Point: Prevention of Hypoglycemia (Not Started)

Description:
Encourage patient/family/caregiver to follow healthcare providers' instructions for diet, activity and medications. Explain the importantce of good diabetes management and learning to detect and treat hypoglycemia early before it worsens.

Learner Progress: Not documented in this visit.

Point: WellStar Outpatient Diabetes Education (Not Started)

Description:
Provide information on WellStar Outpatient Diabetes Education when applicable. Information includes a list of classes offered and how to register.

Learner Progress: Not documented in this visit.

Point: Follow-up Appointments (Not Started)

Description:
Give the patient/family written information on when to make follow-up appointments. Reinforce importance of making and keeping the appointments. If appointments were made during the visit, give the patient a written reminder of the time and location.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Topic: Diabetic Diet (MCB) (Not Started)

Point: Meal Planning and Portion Sizes (MCB) (Not Started)

Description:
The patient will view documents in Krames talking about meal planning as well learning about serving and portion sizes.

Patient Friendly Description:
This will inform you of ways to stay on track with your diet.

Learner Progress: Not documented in this visit.

Point: Eating well with Diabetes (MCB) (Not Started)

Description:
Patient will watch a video on healthy eating for people with DM.

Patient Friendly Description:
Healthy eating for people with Diabetes.

Learner Progress: Not documented in this visit.

Point: Carbohydrate Counting (MCB) (Not Started)

Description:
Patient will read Krames documents on healthy meals and meal planing for Diabetes.

Patient Friendly Description:
Learn about counting your carbohydrates.

Learner Progress: Not documented in this visit.

Topic: Survival Skills (Not Started)

Point: Review Diagnosis (Not Started)

Description:
Review the diabetes disagnosis, specific to patient's diabetes type.
Diabetes Survival Skills Booklet provided.

Patient Friendly Description:
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Learner Progress: Not documented in this visit.

Point: Nutrition (Not Started)

Description:
Importance of consistent nutrition habits.

Learner Progress: Not documented in this visit.

Point: Appointments (Not Started)

Description:
Importance of follow up appointment with the health care provider who will provide diabetes care after discharge.

Learner Progress: Not documented in this visit.

Point: Sick Day (Not Started)

Description:
Sick day management

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Insulin Administration (if applicable) (Not Started)

Description:
Insulin administration and proper use and disposal of needles and syringes. How to schedule outpatient diabetes education. Review self-monitoring of blood glucose and home blood glucose goals.

Learner Progress: Not documented in this visit.

Point: Hyperglycemia (Not Started)

Description:
Definition, recognition, treatment and prevention of hyperglycemia.

Learner Progress: Not documented in this visit.

Point: Hypoglycemia (Not Started)

Description:
Definition, recognition, treatment and prevention of hypoglycemia.

Learner Progress: Not documented in this visit.

Point: Glucose Lowering Medications (Not Started)

Description:
When and how to take blood glucose-lowering medications.

Learner Progress: Not documented in this visit.

Topic: Diabetes Zones for Management (Not Started)

Point: Diabetes Zones for Management reviewed (Not Started)

Description:
Diabetes Zones for Management reviewed.

Learner Progress: Not documented in this visit.

Point: Diabetes Zones for Management handout provided (Not Started)

Description:
Diabetes Zones for Management handout provided.

Learner Progress: Not documented in this visit.

Title: WS Cardiac Rehab (Resolved)

Topic: PCI (Resolved)

Point: Books/Educational Material (Resolved)

Description:
Current standardized written information provided specific to diagnosis, recovery, disease progression and prevention.

Learner Progress: Not documented in this visit.

Point: Exercise (Resolved)

Patient Education (continued)

Education (continued)

Description:
Information regarding the benefits of exercise provided. Exercise guidelines provided for initial recovery from acute heart event and long term goals of exercise.

Learner Progress: Not documented in this visit.

Point: Medications (Resolved)

Description:
Medication compliance encouraged. Organization tools discussed and medication information and resources provided.

Learner Progress: Not documented in this visit.

Point: Risk Factors (Resolved)

Description:
Written and verbal information provided on modifiable and non-modifiable factors associated with increased risk of heart disease and stroke.

Learner Progress: Not documented in this visit.

Point: Activity guidelines (Resolved)

Description:
Appropriate activity and/or limitations for diagnosis specific recovery provided.

Learner Progress: Not documented in this visit.

Point: Signs/symptoms/activate EMS (Resolved)

Description:
Information provided on the signs and symptoms which commonly occur with a heart attack or stroke. Emphasis placed on appropriate activation of EMS with recognition of signs and symptoms.

Learner Progress: Not documented in this visit.

Point: Cardiac Rehab participation/location options (Resolved)

Description:
Cardiac rehabilitation benefits highlighted and participation encouraged.

Learner Progress: Not documented in this visit.

Point: Cardiac Diet/low fat/low sodium (Resolved)

Description:
American Heart Association guidelines provided for a reduced fat and reduced sodium diet.

Learner Progress: Not documented in this visit.

Point: Endocarditis education/card (Resolved)

Description:
Written and verbal instruction provided on endocarditis prevention. Temporary Valve card provided.

Learner Progress: Not documented in this visit.

Point: Outpatient education classes/Heart Smart/Device Advice/Heart of the Matter (Resolved)

Description:
Description and registration details of outpatient education classes provided. Participation encouraged.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Title: Cardiac Arrhythmia (MCB) (Not Started)

Topic: Treatment for Atrial Fibrillation/Atrial Flutter (MCB) (Not Started)

Point: Chemical cardioversion (MCB) (Not Started)

Description:
Provide written education on why and how a chemical cardioversion is done. As well as accociated risks.

Patient Friendly Description:
Why and how a chemical cardioversion is done and associated risks.

Learner Progress: Not documented in this visit.

Point: Electrical cardioversion (MCB) (Not Started)

Description:
Provide written education on why and how an electrical cardioversion is done. As well as accociated risks.

Patient Friendly Description:
Why and how a electrical cardioversion is done and associated risks.

Learner Progress: Not documented in this visit.

Point: Ablation (MCB) (Not Started)

Description:
Provide written education on the catheter ablation procedure and discharge instructions.

Patient Friendly Description:
How an ablation is done, and what to do after the procedure.

Learner Progress: Not documented in this visit.

Topic: Prevention/Discharge (MCB) (Not Started)

Point: Anticoagulation (MCB) (Not Started)

Description:
Provide written education on anticoagulation use including contraindications, side effects, interactions, and medication safety.

Patient Friendly Description:
Information on taking blood thinners safely.

Learner Progress: Not documented in this visit.

Point: Discharge with A Fib/Flutter (MCB) (Not Started)

Description:
Provide written education on treatment options, home care, and follow up care for discharging with atrial fibrillation.

Patient Friendly Description:
Information on treatment options, home care, and when to call your healthcare provider after going home with atrial fibrillation/flutter.

Learner Progress: Not documented in this visit.

Point: Atrial fib/flutter: stroke prevention (MCB) (Not Started)

Description:
"Provide written education on risk factors, medication, and prevention of A. Fib.
Hyperlink education materials provided to patient/family/caregiver. "

Patient Friendly Description:
Preventing stroke caused by A. Fib.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Topic: What is atrial fibrillation/flutter (MCB) (Not Started)

Point: You have atrial fibrillation (MCB) (Not Started)

Description:
Provide video education on the signs/symptoms of A. Fib, causes, medication(s), risk factors, prevention, and treatment.

Patient Friendly Description:
What to expect if you are diagnosed with A. Fib: causes, symptoms, and treatment.

Learner Progress: Not documented in this visit.

Point: You have Atrial Flutter (MCB) (Not Started)

Description:
Provide written education on the signs/symptoms of A. Flutter, causes, medication(s), risk factors, prevention, and treatment.

Patient Friendly Description:
What to expect if you are diagnosed with A. Flutter: causes, symptoms, and treatment

Learner Progress: Not documented in this visit.

Title: MyChart Bedside Teaching completed (Not Started)

Points For This Title

Point: All MCB content reviewed with patient and teachback completed. The patient verbalized understanding. (Not Started)

Description:
Go over all the Eduction for the patient in the Education activity. The Education that was provided to the patient via MCB was included as well as education that was noted within the Eduction activity as Education that was beneifical to the patient during this hospital stay.

Learner Progress: Not documented in this visit.

Title: Cardiac Surgery (Resolved)

Topic: PCI (Resolved)

Additional Points For This Title

Point: ACTIVITY (Resolved)

Learner Progress: Not documented in this visit.

Point: SIGNS AND SYMPTOMS/ACTIVATE EMS (Resolved)

Learner Progress: Not documented in this visit.

Point: BOOKS/EDUCATION MATERIAL (Resolved)

Learner Progress: Not documented in this visit.

Point: CARDIAC REHAB (Resolved)

Learner Progress: Not documented in this visit.

Point: DIET (Resolved)

Learner Progress: Not documented in this visit.

Point: EXERCISE (Resolved)

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Medications (Resolved)

Learner Progress: Not documented in this visit.

Point: POST OP CARE (Resolved)

Learner Progress: Not documented in this visit.

Point: RISK FACTORS (Resolved)

Learner Progress: Not documented in this visit.

Title: Coronary Artery Disease (MCB) (Not Started)

Topic: WS Cardiac Rehabilitation for Arrhythmia (MCB)--This is CAD and AMI Cardiac Rehab Program Information for the Patient (Not Started)

Point: Exercise for a Healthier Heart (MCB) (Not Started)

Description:
Explain how exercising regularly offers many health rewards. Provide exercise tips to beginning a new exercise routine; Set Small goals and aim for 150 minutes a week.

Patient Friendly Description:
This provides healthy heart tips on why exercise is important.

Learner Progress: Not documented in this visit.

Point: WellStar Cardiac Rehabilitation Program (MCB) (Not Started)

Description:
At WellStar, our cardiac rehab patients are individually assessed to review medical history, evaluate risk factors, analyze functional abilities and set goals. Ongoing assessments are conducted to ensure patients are making progress toward their goals, educational needs are being met, and any problems or concerns are being addressed with the referring physician.

Patient Friendly Description:
This will help you better understand Cardiac Rehabilitation. At WellStar, our cardiac rehab programs provide education, supervised exercise, lifestyle modification and emotional support to help patients increase physical fitness, reduce cardiac symptoms and improve health and wellbeing.

Learner Progress: Not documented in this visit.

Point: Cardiac Rehabilitation: Emotional Issue (MCB) (Not Started)

Description:
Explain how having heart disease can be stressful. Encourage patient not to ignore feelings of sadness, worry, and depression. Patient should know when to ask for help and/or support.

Patient Friendly Description:
This will explain some emotional feelings related to heart disease.

Learner Progress: Not documented in this visit.

Topic: Heart Healthy Diet- DASH Diet (MCB) (Not Started)

Point: Eating Heart Healthy Food: Using DASH Plan (MCB) (Not Started)

Description:
Review diet information and explain that eating a low salt, low fat and low cholesterol diet with plenty of fruits and vegetables can reduce risk of complications from CAD.

Patient Friendly Description:
This will help you follow a healthy eating plan that can reduce your risk of complications associated with Coronary Artery Disease.

Please watch video/read over the material and let anyone on your Care Team know if there are any questions by marking below.

Patient Education (continued)

Education (continued)

If you understand all material, mark I understand below.
Learner Progress: Not documented in this visit.

Topic: Questions your patient may have for you (MCB) (Not Started)

Point: Questions your patient may have about the AMI (MCB) (Not Started)

Description:
This is information about diet, exercise and medications for patients and it encourages them to ask staff questions.

Patient Friendly Description:
After reading this, you can write down any questions that you have for staff under the Notes section as a reference.
Learner Progress: Not documented in this visit.

Topic: Coronary Artery Disease (MCB) (Not Started)

Point: Recognizing signs and symptoms of Heart Disease (MCB) (Not Started)

Description:
Provide written education on the signs/symptoms of CAD, causes, medication(s), risk factors, prevention and treatment.

Patient Friendly Description:
This will explain some of the causes of Coronary Artery Disease.
Learner Progress: Not documented in this visit.

Point: Understanding Coronary Artery Disease (MCB) (Not Started)

Description:
Give patient written information on CAD. Explain the definition of CAD, causes, signs and symptoms.

Patient Friendly Description:
This will inform you of what to expect if you are diagnosed with Coronary Artery Disease (CAD).

Please watch video/read over the material and let anyone on your Care Team know if there are any questions by marking below.

If you understand all material, mark I understand below.
Learner Progress: Not documented in this visit.

Topic: Risk factors for Heart Disease (MCB) (Not Started)

Point: Tobacco/Smoking Cessation (MCB) (Not Started)

Description:
Give patient written information on Quitting Smoking

Educate the patient/family/caregiver on smoking cessation and smoking cessation programs offered in the community. Explain effects smoking and second hand smoke have on the body. Encourage the patient to ask people that smoke around him/her to smoke outside or in another room. Refer patient to Cardiopulmonary Rehabilitation, if applicable.

Patient Friendly Description:
This will give you some getting started tips to kick the smoking habit.

This will help you plan how to quit the smoking habit.
Learner Progress: Not documented in this visit.

Title: First-Dose Education (Not Started)

Points For This Title

Point: hydralazine HCl (Not Started)

Patient Education (continued)

Education (continued)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: iohexol (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: nitroglycerin (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: Ringer's solution,lactated (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: dextrose (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: dextrose 50 % in water (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: calcium carbonate (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: morphine sulfate (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: hydrocodone/acetaminophen (Not Started)

Patient Education (continued)

Education (continued)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: aspirin (Resolved)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: acetaminophen (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: atropine sulfate (Resolved)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: phenylephrine HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: labetalol HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: metoclopramide HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: cyclopentolate HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: furosemide (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: diclofenac sodium (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: gentamicin sulfate (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: diphenhydramine HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: 0.9 % sodium chloride (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: piperacillin sodium/tazobactam (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: insulin lispro (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: ondansetron (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: glucagon,human recombinant (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: gadobenate dimeglumine (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: pantoprazole sodium (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: polyethylene glycol 3350 (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: perflutren lipid microspheres (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: fentanyl citrate/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: lidocaine HCl/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: ondansetron HCl/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: tetracaine HCl/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Title: Congestive Heart Failure (MCB) (Not Started)

Topic: Psycho/Social/Spiritual Support (Not Started)

Point: Stress Management and Support Systems (Not Started)

Description:
Explain the importance of stress management and support systems in diabetes management. Refer to WellStar diabetes support groups, social services, case management or spiritual care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Not Started)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Treatments/Procedures (MCB) (Not Started)

Point: Oxygen (Not Started)

Description:
Educate patient/family/caregiver on why oxygen is needed and how it will be delivered (nasal cannula, mask, etc.). Instruct patient/family/caregiver that the patent should not be smoking while on oxygen.

Learner Progress: Not documented in this visit.

Point: Medical Equipment (Not Started)

Description:
Educate patient/family/caregiver on use of medical equipment and provide educational materials.

Learner Progress: Not documented in this visit.

Point: Introduction to Heart Failure (MCB) (Not Started)

Description:
Give patient written information on congestive heart failure. Explain the definition of CHF, causes, signs and symptoms, expected length of stay and criteria for discharge.

Patient Friendly Description:
This will inform you of what to expect if you are diagnosed with heart failure.

You will be receiving the Congestive Heart Failure red booklet.

Please watch video/read over the material and let anyone on your Care Team know if there are any questions by marking below.

If you understand all material, mark I understand below.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Echocardiogram (Not Started)

Description:
Educate patient/family/caregiver on echocardiograms, to include: what the test is, how the test will be performed, and what to expect during the test.

Learner Progress: Not documented in this visit.

Topic: Pain Management (Not Started)

Point: Pain Medication Actions & Side Effects (Not Started)

Description:
Provide medication specific handouts when available.

Learner Progress: Not documented in this visit.

Point: Pain Rating Scale (Not Started)

Description:
Provide patient with information on the Pain Rating Scale. Explain the rating scale of 0 to 10.

Learner Progress: Not documented in this visit.

Point: Non-Pharmacological Comfort Measures (Not Started)

Description:
Explain there are other ways of controlling pain than medication. The following are suggestions: position change, aromatherapy, deep slow breathing, distraction, quiet environment, imagery, heat therapy and/or cold therapy, laughter, massage, music, physical therapy, and touch therapy.

Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Not Started)

Point: Eating well with High Blood Pressure (MCB) (Not Started)

Description:
Information provided to patient to explain what their diet should consist of when they have Heart Failure.

Patient Friendly Description:
This will help you make heart healthy eating choices if you have a diagnosis with heart failure.

Learner Progress: Not documented in this visit.

Point: Heart Failure:Being Active (MCB) (Not Started)

Description:
Explain to the patient how to be active with heart failure.

Patient Friendly Description:
This will explain how to safely be active with heart failure.

Learner Progress: Not documented in this visit.

Point: Heart Failure: Dealing with Sleep problems (MCB) (Not Started)

Description:
Provide tips and ideas to help patient sleep better.

Patient Friendly Description:
This will provide tips on sleeping better with heart faillure.

Learner Progress: Not documented in this visit.

Point: Heart Failure: Know your Baselines (MCB) (Not Started)

Patient Education (continued)

Education (continued)

Description:
Explain to patient how to identify their baseline and recognize changes.

Patient Friendly Description:
This will help you understand what's normal for you and how to watch for changes.

Learner Progress: Not documented in this visit.

Point: Heart Failure : Know your Zones (Not Started)

Description:
Review heart failure zones with patient and educate them on how to know which zone they are in each day.

Learner Progress: Not documented in this visit.

Point: Dealing with Heart Failure: Helping the patient cope (MCB) (Not Started)

Learner Progress: Not documented in this visit.

Point: Daily Weights (MCB) (Not Started)

Description:
Give written information about daily weights. Instruct the patient to weigh on the same scale every day at the same time, wearing the same amount of clothing. Explain why it is important to check weight. Inform the patient that gaining weight from fluid build up may be an early sign that heart failure is getting worse. The patient should call a care provider if there is a weight gain of more than 2-3 pounds in one day or 4-5 pounds in five days.

Patient Friendly Description:
Information on the importance of Daily weights.

Learner Progress: Not documented in this visit.

Point: How to check your Heart Rate and Blood Pressure (MCB) (Not Started)

Description:
Give patient written information on how to take a pulse. Explain the definition of a pulse, normal range, reason for taking a pulse, where pulses can be found. Demonstrate how to find a pulse. Once found, instruct the patient to count the beats for a full minute. Tell the patient to keep a record of the pulse rate, date and time taken, which site (right/left, wrist/neck) and strength of beats (weak, strong or missing beats).

Patient Friendly Description:
This will explain the importance of understanding your vital signs and show you how to take them.

Learner Progress: Not documented in this visit.

Topic: WellStar Cardiac Rehabilitation (MCB) (Not Started)

Point: Exercise for a Healthier Heart (MCB) (Not Started)

Description:
Explain how exercising regularly offers many health rewards. Provide exercise tips to beginning a new exercise routine; Set Small goals and aim for 150 minutes a week.

Patient Friendly Description:
This provides healthy heart tips on why exercise is important.

Learner Progress: Not documented in this visit.

Point: WellStar Cardiac Rehabilitation Program (MCB) (Not Started)

Description:
At WellStar, our cardiac rehab patients are individually assessed to review medical history, evaluate risk factors, analyze functional abilities and set goals. Ongoing assessments are conducted to ensure patients are making progress toward their goals, educational needs are being met, and any problems or concerns are being addressed with the referring physician.

Patient Friendly Description:
This will help you better understand Cardiac Rehabilitation. At WellStar, our cardiac rehab programs provide education, supervised exercise, lifestyle modification and emotional support to help patients increase physical fitness, reduce cardiac symptoms and improve health and wellbeing.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Topic: Review Plan of Care (Not Started)

Point: Review Plan of Care - Day 5 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 1 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 2 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 3 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 4 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Topic: Medications (MCB) (Not Started)

Point: Heart Failure Medications (MCB) (Not Started)

Description:
Educate patient on the drug type, purpose for medication, and common side effects.

Educate patient on Prescribed Medications

Patient Friendly Description:
This will inform you of medications that you may be taking if you are diagnosed with Heart Failure.

Learner Progress: Not documented in this visit.

Point: ACE Inhibitors (Not Started)

Patient Education (continued)

Education (continued)

Description:
Educate patient/family/caregiver on the ACE Inhibitor prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Angiotensin II Receptor Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Angiotensin II Receptor Blockers prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Aspirin (Not Started)

Description:
Give patient written information on Aspirin. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the doctor should be called. Reinforce that this medication should be taken exactly as the doctor has prescribed.

Learner Progress: Not documented in this visit.

Point: Beta Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Beta Blocker prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Digoxin (Not Started)

Description:
Educate patient/family/caregiver on Digoxin and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed. The physician will order a blood test to monitor the concentration of the drug in the patient's blood. The dose of this medication may be changed according to the results of this test.

Learner Progress: Not documented in this visit.

Point: Diuretics (Not Started)

Description:
Educate patient/family/caregiver on the Diuretic prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Inotropes (Not Started)

Description:
Educate patient/family/caregiver on the Inotropes prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Vasodilators (Not Started)

Patient Education (continued)

Education (continued)

Description:
Educate patient/family/caregiver on the Vasodilator prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Topic: Prevention / Discharge (MCB) (Not Started)

Point: Community Resources (Not Started)

Description:
Give written information on available community resources. Refer to Social Services or Case Management, if needed.

Learner Progress: Not documented in this visit.

Point: Home Health Care Services (Not Started)

Description:
Give patient written information on Home Health Care Services that have been arranged. Review the role of the home care nurse and when to expect the first visit. Refer to Case Management or Social Services, if needed.

Learner Progress: Not documented in this visit.

Point: Follow-up Appointments (Not Started)

Description:
Give the patient/family written information on their next appointment and when to make follow-up appointments. Reinforce importance of making and keeping the appointments. If appointments were made during the visit, give the patient a written reminder of the time and location.

Learner Progress: Not documented in this visit.

Point: Influenza Vaccine (Not Started)

Description:
Educate the patient/family/caregiver on obatining a yearly influenza vaccine.

Learner Progress: Not documented in this visit.

Point: Discharge Medications (Not Started)

Description:
Ensure that there are no barriers to obtain medications prior to discharge. Notify Care Coordination if there are any needs for additional resources prior to discharging the patient.

Learner Progress: Not documented in this visit.

Point: When to Call the Doctor (MCB) (Not Started)

Description:
Provide written documentation instructing the patient to call the doctor if the patient has:

1. Ankles and legs that become more swollen.
2. Shoes and socks that get tight suddenly.
3. Shortness of breath that does not go away with rest.
4. Weight gain of 2 - 3 pounds in one day.
5. Weight gain of 4 - 5 pounds in one week.
6. No energy for normal activities.
7. Dizziness or weakness.
8. Yellowish or blue green vision.
9. Heartbeat changes (feels like a butterfly in the chest).
10. Chest pain.
11. Blurred vision.
12. Passing out.
13. Cough that does not go away.

Patient Education (continued)

Education (continued)

Patient Friendly Description:
Heart Failure symptoms to know and when to call your healthcare provider.
Lifestyle changes to help you feel and live better with Heart Failure.

Learner Progress: Not documented in this visit.

Point: Review Discharge Plan (Not Started)

Description:
Review the discharge plan with patient and primary care giver including: diet, activity, medications, and special precautions. Refer to Case Management, if needed.

Learner Progress: Not documented in this visit.

Point: Smoking Cessation (Not Started)

Description:
Educate the patient/family/caregiver on smoking cessation and smoking cessation programs offered in the community. Explain effects smoking and second hand smoke have on the body. Encourage the patient to ask people that smoke around him/her to smoke outside or in another room. Refer patient to Cardiopulmonary Rehabilitation, if applicable.

Learner Progress: Not documented in this visit.

Point: Diet Instructions for CHF Prevention (Not Started)

Description:
Review diet information and explain that eating a low fat and low cholesterol diet with plenty of fruits and vegetables can reduce their chance of suffering a future heart attack.

Learner Progress: Not documented in this visit.

Topic: Heart Failure Discharge Instructions (Not Started)

Point: Follow-up Appointments (Not Started)

Description:
Give the patient/family written information on their next appointment and when to make follow-up appointments. Reinforce importance of making and keeping the appointments. If appointments were made during the visit, give the patient a written reminder of the time and location.

Learner Progress: Not documented in this visit.

Point: Daily Weights (MCB) (Not Started)

Description:
Give written information about daily weights. Instruct the patient to weigh on the same scale every day at the same time, wearing the same amount of clothing. Explain why it is important to check weight. Inform the patient that gaining weight from fluid build up may be an early sign that heart failure is getting worse. The patient should call a care provider if there is a weight gain of more than 2-3 pounds in one day or 4-5 pounds in five days.

Patient Friendly Description:
Information on the importance of Daily weights.

Learner Progress: Not documented in this visit.

Point: When to Call the Doctor (MCB) (Not Started)

Description:
Provide written documentation instructing the patient to call the doctor if the patient has:
1. Ankles and legs that become more swollen.
2. Shoes and socks that get tight suddenly.
3. Shortness of breath that does not go away with rest.
4. Weight gain of 2 - 3 pounds in one day.
5. Weight gain of 4 - 5 pounds in one week.
6. No energy for normal activities.
7. Dizziness or weakness.
8. Yellowish or blue green vision.
9. Heartbeat changes (feels like a butterfly in the chest).

Patient Education (continued)

Education (continued)

10. Chest pain.
11. Blurred vision.
12. Passing out.
13. Cough that does not go away.

Patient Friendly Description:
Heart Failure symptoms to know and when to call your healthcare provider.
Lifestyle changes to help you feel and live better with Heart Failure.

Learner Progress: Not documented in this visit.

Point: Review Discharge Plan (Not Started)

Description:
Review the discharge plan with patient and primary care giver including: diet, activity, medications, and special precautions. Refer to Case Management, if needed.

Learner Progress: Not documented in this visit.

Point: Diet Instructions for CHF Prevention (Not Started)

Description:
Review diet information and explain that eating a low fat and low cholesterol diet with plenty of fruits and vegetables can reduce their chance of suffering a future heart attack.

Learner Progress: Not documented in this visit.

Title: General Patient Education (MCB) (Not Started)

Topic: Psycho/Social/Spiritual Support (Not Started)

Point: Coping Mechanisms (Resolved)

Description:
Help patient identify healthy coping mechanisms. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Support Systems (Resolved)

Description:
Help patient identify available support systems. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Spiritual/Emotional Needs (Resolved)

Description:
Offer resources to meet spiritual/emotional needs. Refer to Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Stress Management and Support Systems (Not Started)

Description:
Explain the importance of stress management and support systems in diabetes management. Refer to WellStar diabetes support groups, social services, case management or spiritual care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Not Started)

Patient Education (continued)

Education (continued)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Pain Management (MCB) (Resolved)

Point: Encourage Patient to Monitor Own Pain (Resolved)

Description:
Provide patient with information on the Pain Rating Scale. Explain the rating scale of 0 to 10.

Learner Progress: Not documented in this visit.

Point: Discuss Significance of VAS Scores (Resolved)

Description:
Refer to rating score of 0-10.

Learner Progress: Not documented in this visit.

Point: Discuss the Use of Pain Control Measures Before Pain Becomes Severe (MCB) (Resolved)

Description:
Take time to reiterate to patient that he/she should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time before pain becomes severe.

Patient Friendly Description:
Please inform staff that if you are having any difficulty breathing, pain or any discomfort at any time before the pain gets severe.

Please read over the items and let anyone on your Care Team know there are any questions about the material by marking below that "I HAVE QUESTIONS".

If once you have received the items and understand the material you can mark this as "I understand".

Learner Progress: Not documented in this visit.

Topic: Prevention (MCB) (Not Started)

Point: When to Call the Doctor (Not Started)

Description:
Educate patient/family/caregiver on when to call the doctor.

Learner Progress: Not documented in this visit.

Point: Protect Others from Infection (Not Started)

Description:
Educate patient/family/caregiver on respiratory hygiene and cough etiquette. To protect from further infection and to protect others from getting an infection, patient should cover nose and mouth with tissues when coughing. Encourage patient to place used tissues in a plastic bag that will not allow secretions to soak through. Patient should always wash his/her hands after using or handling used tissues.

Learner Progress: Not documented in this visit.

Point: Protect Yourself from Further Infection (MCB) (Not Started)

Description:
Educate patient/family/caregiver that because patient is in a weakened condition he/she needs to avoid others who are sick as to not acquire another illness. Family/caregiver should wear gloves, gown and face shield/eye protection.

Patient Friendly Description:
Information on Flu.

Patient Education (continued)

Education (continued)

Information on Pneumonia and Pneumococcal Vaccination.
Learner Progress: Not documented in this visit.

Point: Falls education, precautions, prevention at home and in the hospital (MCB) (Not Started)

Description:
Patient was given information on preventing falls both while in the hospital and when they are at home.

Patient Friendly Description:
Things to help you prevent falls while you are in the hospital and when you are home.
Learner Progress: Not documented in this visit.

Point: Prevention Deep Vein Thrombosis after surgery (MCB) (Not Started)

Description:
Educate patient/family/caregiver to prevent DVT and PE after Suergery

Patient Friendly Description:
In the days and weeks after surgery, you have a higher chance of developing a deep vein thrombosis (DVT).
This is a condition in which a blood clot or thrombus develops in a deep vein.
They are most common in the leg. But, a DVT may develop in an arm, or another deep vein in the body.
A piece of the clot, called an embolus, can separate from the vein and travel to the lungs.
A blood clot in the lungs is called a pulmonary embolus (PE).
This can cut off the flow of blood to the lungs.
It is a medical emergency and may cause death.
Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Not Started)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.
Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Not Started)

Point: General Self Care (Not Started)

Description:
Instruct patient on self care needs. These may include: hygiene, how to take a blood pressure, how to change a dressing, etc.

Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Not Started)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.
Learner Progress: Not documented in this visit.

Topic: Medications (MCB) (Not Started)

Point: Antibiotic Education (Not Started)

Patient Education (continued)

Education (continued)

Description:
If an antibiotic was prescribed, educate patient/family/caregiver on the antibiotics prescribed. Explain how antibiotics work in the body. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed

If a viral diagnosis was made, the patient/family was educated on their viral diagnosis and the reason for no antibiotic this visit.

Learner Progress: Not documented in this visit.

Point: Anticoagulant Therapy (Not Started)

Description:
1-Educate patient/family/caregiver on anticoagulant being prescribed and provide educational materials.
2-Explain action of medication, reason for taking, and importance of adherence to correct medication dose and schedule,
3-Explain potential for adverse drug reactions, signs of allergic reaction, potential for drug-drug and drug-food interactions, and when physician should be called.
4-Reinforce that the medication should be taken exactly as the physician has prescribed.
5-Explain importance of maintaining follow-up appointments and adhering to laboratory testing as prescribed by physician.
6-Explain that the dose of the anticoagulant being prescribed may change depending on the results of the laboratory testing.

Learner Progress: Not documented in this visit.

Point: Insulin (MCB) (Not Started)

Description:
Educate patient/family/caregiver on the insulin prescribed. Explain how insulin works in the body. Explain the action of insulin, reason for taking, side effects, signs of allergic reaction and when physician should be called. Reinforce that insulin should be taken exactly as the physician has prescribed. Explain the proper storage of insulin, that extreme temperatures can damage insulin and never take insulin that has expired. Explain that the patient's primary care physician may change the dosage depending on the results of blood glucose tests and/or A1C level.

Patient Friendly Description:
This will inform you of why you are prescribed insulin if you have Diabetes Type II.

Learner Progress: Not documented in this visit.

Point: Hypoglycemic Agents (Not Started)

Description:
Educate patient/family/caregiver on the oral and/or injectable hypoglycemic(s) prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, as well as when the physician should be called. Reinforce that this medication(s) should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Non-Steroidal Anti-Inflammatory Drugs (Not Started)

Description:
Educate patient/family/caregiver on the NSAID prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Psychotropic Medications (Not Started)

Description:
Educate patient/family/caregiver on the Psychotropic medication prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: ACE Inhibitors (Not Started)

Patient Education (continued)

Education (continued)

Description:
Educate patient/family/caregiver on the ACE Inhibitor prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Angiotensin II Receptor Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Angiotensin II Receptor Blockers prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Beta Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Beta Blocker prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Digoxin (Not Started)

Description:
Educate patient/family/caregiver on Digoxin and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed. The physician will order a blood test to monitor the concentration of the drug in the patient's blood. The dose of this medication may be changed according to the results of this test.

Learner Progress: Not documented in this visit.

Point: Diuretics (Not Started)

Description:
Educate patient/family/caregiver on the Diuretic prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Inotropes (Not Started)

Description:
Educate patient/family/caregiver on the Inotropes prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Vasodilators (Not Started)

Description:
Educate patient/family/caregiver on the Vasodilator prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Antibiotics (Not Started)

Patient Education (continued)

Education (continued)

Description:
Educate patient/family/caregiver on the Antibiotics prescribed. Explain how antibiotics works in the body. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Medication purpose, side effects, schedule, administration (MCB) (Not Started)

Description:
Discussed purpose and possible side effects of medication.

Learner Progress: Not documented in this visit.

All Flowsheets

Flowsheets (all recorded)

Custom Formula Data

Row Name	04/17/19 1111	04/17/19 1015	04/17/19 0954	04/12/19 1558	
Vitals					
Pct Wt Change	—	—	0 % -AE	0 % -SC	
OTHER					
Weight Change (kg)	—	—	0 kg -AE	0 kg -SC	
Ideal Body Weight	—	—	160 lb -AE	160 lb -SC	
Visit Weight	—	—	213 lb -AE	207 lb -SC	
BMI (Calculated)	—	—	33.3 -AE	32.4 -SC	
IBW/kg (Calculated) Male	—	—	66.1 kg -AE	66.1 kg -SC	
IBW/kg (Calculated) FEMALE	—	—	61.6 kg -AE	61.6 kg -SC	
Weight/Scale Event	—	—	0 -AE	0 -SC	
Weight in (lb) to have BMI = 25	—	—	159.3 -AE	159.3 -SC	
% Weight Change Since Birth	—	—	0 -AE	0 -SC	
Vitals Sepsis Risk Score	0 -KS	0 -AM	—	—	
Adult IBW/VT Calculations					
IBW/kg (Calculated)	—	—	66.1 -AE	66.1 -SC	
Range Vt 4mL/kg	—	—	264.4 mL/kg -AE	264.4 mL/kg -SC	
Low Range Vt 6mL/kg	—	—	396.6 mL/kg -AE	396.6 mL/kg -SC	
Adult Moderate Range Vt 8mL/kg	—	—	528.8 mL/kg -AE	528.8 mL/kg -SC	
Adult High Range Vt 10mL/kg	—	—	661 mL/kg -AE	661 mL/kg -SC	
Case Log					
BSA x (CI @3.0)= CO	—	—	6.39 CO -AE	6.3 CO -SC	
Relevant Labs and Vitals					
Temp (in Celsius)	36.3 -KS	36.9 -AM	—	—	

Flowsheets (all recorded)

Clear Lung/ Incentive Spirometry

Row Name	04/12/19 1605				
High Risk Pulmonary Assessment					
Current Inpatient, Add-on, and/or Emergency Surgery	0 -SC				
Active smoker (1 or more cigarettes in the last 12 months)?	0 -SC				
Obstructive Sleep Apnea, history of	0 -SC				
COPD, currently being treated?	0 -SC				
Asthma, currently being treated?	0 -SC				
Dyspnea/shortness of breath (i.e. cannot walk up one flight of stairs due to dyspnea)?	0 -SC				
Inability to perform ADLs (needs assistance with at least one of the following: bathing, feeding, toileting, and mobility)?	0 -SC				
High Risk Pulmonary Assessment Score	0 -SC				

Flowsheets (all recorded)

Risk for Readmission

Row Name	04/17/19 1157				
OTHER					
Risk for Readmission	9 -KS				

Flowsheets (all recorded)

Phone Call

Row Name	04/12/19 1612				
Phone Call					
Surgery Time Verified	Yes -SC				
Arrival Time Verified	0930 -SC				
Surgery Location Verified	Yes -SC				
Medical History Reviewed	Yes -SC				
NPO Status Reinforced	Yes -SC				
Ride and Caregiver Arranged	Yes -SC				
Ride Caregiver Provider	Shirley Maurice -SC				
Phone Number for Ride/Caregiver	678-910-2476 -SC				

Flowsheets (all recorded)

Intake/Output

Row Name	04/17/19 1155	04/17/19 1111	04/17/19 1106	04/17/19 1106	04/17/19 1021
sodium chloride 0.9% (NS) infusion Start: 04/17/19 1000					
Rate	0 mL/hr -KS	—	—	—	30 mL/hr -AM
Volume (mL)	—	—	300 mL -CG	—	—
Simple Vitals					
Pulse	—	(!) 49 -KS	—	—	—
Resp	—	16 -KS	—	—	—
Numeric Pain Intensity Score 1	—	0 -KS	—	—	—
[REMOVED] Peripheral IV 04/17/19 22 G Left Hand					
IV Properties	Placement Date: 04/17/19 -AM Placement Time: 1019 -AM Present on arrival to hospital?: No -AM Type of Catheter: Straight -AM Size (Gauge): 22 G -AM Orientation: Left -AM Location: Hand -AM Site Prep: Chlorhexidine -AM Local Anesthetic: None -AM Inserted by: Amber Estes, RN -AM Insertion attempts: 1 -AM Successful IV Attempt?: Yes -AM Patient Tolerance: Tolerated well -AM IV Access Problem: No -AM Removal Date: 04/17/19 -KS Removal Time: 1115 -KS Catheter Intact on removal?: Yes -KS Removal Reason : Patient discharged -KS Remaining intact at discharge?: No -KS				

Row Name	04/17/19 1019	04/17/19 1015	04/17/19 0954	04/12/19 1558	
Weights					
Weight	—	—	96.6 kg (212 lb 15.4 oz) -AE	93.9 kg (207 lb) -SC	
Weight Method	—	—	Actual -AE	Stated -SC	
BSA (Calculated - sq m)	—	—	2.13 sq meters -AE	2.1 sq meters -SC	
Simple Vitals					
Pulse	—	50 -AM	—	—	
Resp	—	14 -AM	—	—	
Numeric Pain Intensity Score 1	—	0 -AM	—	—	
[REMOVED] Peripheral IV 04/17/19 22 G Left Hand					
IV Properties	Placement Date: 04/17/19 -AM Placement Time: 1019 -AM Present on arrival to hospital?: No -AM Type of Catheter: Straight -AM Size (Gauge): 22 G -AM Orientation: Left -AM Location: Hand -AM Site Prep: Chlorhexidine -AM Local Anesthetic: None -AM Inserted by: Amber Estes, RN -AM Insertion attempts: 1 -AM Successful IV Attempt?: Yes -AM Patient Tolerance: Tolerated well -AM IV Access Problem: No -AM Removal Date: 04/17/19 -KS Removal Time: 1115 -KS Catheter Intact on removal?: Yes -KS Removal Reason : Patient discharged -KS Remaining intact at discharge?: No -KS				
Phlebitis Scale	0 -AM	—	—	—	
Infiltration/Extravasation Scale	0 -AM	—	—	—	
Line Assessment	Blood return noted;Infusing -AM	—	—	—	
Dressing Assesment	Clean;Dry;Intact -AM	—	—	—	

Flowsheets (all recorded)

Assessment

Row Name	04/17/19 1115	04/17/19 1111	04/17/19 1018	04/17/19 1015	04/17/19 1013
Respiratory					
Respiratory (WDL)	—	—	—	WDL -AM	—
Oxygen Therapy					
SpO2	—	93 % -KS	—	96 % -AM	—
O2 Device	—	—	—	None (Room air) -AM	—
Integumentary					
Integumentary (WDL)	—	—	—	WDL -AM	—
Braden Scale					
Sensory Perceptions	—	—	—	—	4 -AM
Moisture	—	—	—	—	4 -AM
Activity	—	—	—	—	4 -AM
Mobility	—	—	—	—	4 -AM
Nutrition	—	—	—	—	4 -AM
Friction and Shear	—	—	—	—	3 -AM
Braden Scale Score	—	—	—	—	23 -AM
[REMOVED] Surgical 04/17/19 Eye Left					
Incision Properties	Date Documented: 04/17/19 -SB Time Documented: 1009 -SB Location: Eye -SB Wound Location Orientation: Left -SB Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205				
Dressing	Eye shield left eye -KS	—	—	—	—
Hester Davis Fall Risk Assessment					
Last Known Fall	—	—	0 -AM	—	—
Mobility	—	—	0 -AM	—	—
Medications	—	—	2 -AM	—	—
Mental Status/LOC/Awareness	—	—	0 -AM	—	—
Toileting Needs	—	—	0 -AM	—	—
Volume/Electrolyte Status	—	—	2 -AM	—	—
Communication/Sensory	—	—	1 -AM	—	—
Behavior	—	—	0 -AM	—	—
Hester Davis Fall Risk Total	—	—	8 -AM	—	—

Row Name	04/17/19 0954	04/12/19 1558
tPA Time out		
Weight	96.6 kg (212 lb 15.4 oz) -AE	93.9 kg (207 lb) -SC
Oxygen Therapy		
O2 Device	—	None (Room air) -SC
[REMOVED] Surgical 04/17/19 Eye Left		
Incision Properties	Date Documented: 04/17/19 -SB Time Documented: 1009 -SB Location: Eye -SB Wound Location Orientation: Left -SB Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205	

Flowsheets (all recorded)

Screenings

Row Name	04/17/19 1013	04/12/19 1558			
Values/Beliefs					
Cultural Preferences Affecting Hospitalization	—	No -SC			
Spiritual Preferences Affecting Hospitalization	—	No -SC			
Braden Scale					
Sensory Perceptions	4 -AM	—			
Moisture	4 -AM	—			
Activity	4 -AM	—			
Mobility	4 -AM	—			
Nutrition	4 -AM	—			
Friction and Shear	3 -AM	—			
Braden Scale Score	23 -AM	—			
Pressure Ulcer Present on Admission (IF YES, DOCUMENT BY GOING TO: 1) NOTES ACTIVITY 2) PROGRESS NOTES 3) TYPE "PRESSURE ULCER ON ADMISSION" IN SMART TEXT BOX 4) CLICK CO-SIGN WITH MD SIGNATURE)					
Pressure ulcer present on admission	No -AM	—			
Abuse Assessment					
Safe in Home	—	Yes -SC			
Adult Obstructive Sleep Apnea (OSA) Screening Tool					
Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	—	0 -SC			

Flowsheets (all recorded)

Vital Signs

Row Name	04/17/19 1111	04/17/19 1015	04/12/19 1558		
Vital Signs					
Automatic Restart Vitals Timer	Yes -KS	Yes -AM	—		
Pulse	(!) 49 -KS	50 -AM	—		
Heart Rate Source	Monitor -KS	Monitor -AM	—		
Resp	16 -KS	14 -AM	—		
BP	138/60 -KS	153/51 -AM	—		
Calculated MAP	86 -KS	85 -AM	—		
Patient Position	Other (Comment) -KS	Sitting -AM	—		
Temp	97.4 °F (36.3 °C) -KS	98.5 °F (36.9 °C) -AM	—		
Temp src	Temporal -KS	Temporal -AM	—		
Oxygen Therapy					
SpO2	93 % -KS	96 % -AM	—		
O2 Device	—	None (Room air) -AM	None (Room air) -SC		
Vitals Sepsis Score					
Vitals Sepsis Risk Score	0 -KS	0 -AM	—		

Flowsheets (all recorded)

Pre-Admission Testing

Row Name	04/17/19 1015	04/12/19 1558			
Pre-AdmissionTesting Checklist					
Correct Patient?	—	Yes -SC			
Correct Procedure?	—	Yes -SC			
Correct Site?	—	Yes -SC			
Patient has been to this health system before?	—	Yes -SC			
Isolation Precautions	N/A -AM	— na -SC			
History of Anesthesia? Type?	—	General -SC			
Problems with Anesthesia?	—	No -SC			
Family Member With Serious Problem with Anesthesia/Sedation?	—	No -SC			
Pacemaker	No -AM	No -SC			
Patient has an ICD?	No -AM	No -SC			
Does patient refuse blood?	—	No -SC			
VTE Diagnostic Test Performed?	—	Yes -SC			
Patient can read and write?	—	Yes -SC			
History given by	—	Patient -SC			
Providing self care at home?	—	Yes -SC			
Discharge transport	—	Family -SC			
Discharge transport contact #(s)	—	Shirley Maurice 678-910-2476 -SC			
Release of Personal Information to Emergency Contact	—	Yes -SC			
Nutrition					
Diet at home?	—	Low fat, Low cholesterol -SC			
Home glucose monitoring?	—	Yes -SC			
Exercise					
Able to walk up 2 flights of stairs without SOB?	—	Yes -SC			
Functional Capacity/ Assistive Device					
Functional Capacity	—	No Limitations -SC			
Assistive Devices?	—	— na -SC			
Adult Obstructive Sleep Apnea (OSA) Screening Tool					
Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	—	0 -SC			
Do you feel tired, fatigued, or sleepy during daytime hours?	—	0 -SC			
Has anyone observed you stop breathing during your sleep?	—	0 -SC			
Do you have or are you being treated for high blood pressure?	—	1 -SC			
Is your body mass index (BMI) greater than 35?	—	0 -SC			
Are you over 50 years old?	—	1 -SC			
Is your neck circumference greater	—	1 -SC			

Flowsheets (all recorded) (continued)

Pre-Admission Testing (continued)

Row Name	04/17/19 1015	04/12/19 1558			
than 16 inches?					
Are you a male?	—	1 -SC			
Sleep Apnea Total Score	—	4 -SC			

Flowsheets (all recorded)

OR Lines/Drains/Airways

Row Name	04/17/19 1019
[REMOVED] Peripheral IV 04/17/19 22 G Left Hand	
IV Properties	Placement Date: 04/17/19 -AM Placement Time: 1019 -AM Present on arrival to hospital?: No -AM Type of Catheter: Straight -AM Size (Gauge): 22 G -AM Orientation: Left -AM Location: Hand -AM Site Prep: Chlorhexidine -AM Local Anesthetic: None -AM Inserted by: Amber Estes, RN -AM Insertion attempts: 1 -AM Successful IV Attempt?: Yes -AM Patient Tolerance: Tolerated well -AM IV Access Problem: No -AM Removal Date: 04/17/19 -KS Removal Time: 1115 -KS Catheter Intact on removal?: Yes -KS Removal Reason : Patient discharged -KS Remaining intact at discharge?: No -KS
Phlebitis Scale	0 -AM
Infiltration/Extravasation Scale	0 -AM
Line Assessment	Blood return noted;Infusing -AM
Dressing Assesment	Clean;Dry;Intact -AM

Flowsheets (all recorded)

Anthropometrics

Row Name	04/17/19 0954	04/12/19 1558			
Anthropometrics					
Height	67" (1.702 m) -AE	67" (1.702 m) -SC			
Weight	96.6 kg (212 lb 15.4 oz) -AE	93.9 kg (207 lb) -SC			
Weight Method	Actual -AE	Stated -SC			
Weight Change	2.88 -AE	0 -SC			
BMI (Calculated)	33.3 -AE	32.4 -SC			

Flowsheets (all recorded)

(RETIRED) Travel Screening

Row Name	04/12/19 1557				
RETIRED - Travel outside the U.S.					
RETIRED - Has the patient or a household member traveled outside the U.S. in the past 21 days?	No -SC				

Flowsheets (all recorded)

Interpretation

Row Name	04/17/19 1115	04/17/19 0955			
Medical Interpretation Services Documentation (All fields are required)					
Is patient using Interpretation Services for this encounter?	No -KS	No -AE			

Flowsheets (all recorded)

OR Incisions/Wounds

Row Name	04/17/19 1115
[REMOVED] Surgical 04/17/19 Eye Left	
Incision Properties	Date Documented: 04/17/19 -SB Time Documented: 1009 -SB Location: Eye -SB Wound Location Orientation: Left -SB Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205
Dressing	Eye shield left eye -KS

WS Paulding Hospital
2518 Jimmy Lee Smith Parkway
Hiram GA 30141-2068
Inpatient Record

Maurice, Eugene George
MRN: 561253820, DOB: 1/2/1949, Sex: M
Adm: 4/17/2019, D/C: 4/17/2019

Flowsheets (all recorded)

Vitals/Pain

Row Name	04/17/19 1111	04/17/19 1015	04/17/19 0954	04/12/19 1558
OTHER				
Patient Position	Other (Comment) -KS	Sitting -AM	—	—
Height Method	—	—	Stated -AE	Stated -SC
Weight Method	—	—	Actual -AE	Stated -SC
BMI (Calculated)	—	—	33.3 -AE	32.4 -SC
BSA (Calculated - sq m)	—	—	2.13 sq meters -AE	2.1 sq meters -SC
Pain Assessment	0-10 -KS	0-10 -AM	—	—
Vitals				
BP	138/60 -KS	153/51 -AM	—	—
Temp	97.4 °F (36.3 °C) -KS	98.5 °F (36.9 °C) -AM	—	—
Temp src	Temporal -KS	Temporal -AM	—	—
Pulse	**(!) 49** -KS	50 -AM	—	—
Resp	16 -KS	14 -AM	—	—
SpO2	93 % -KS	96 % -AM	—	—
Height	—	—	67" (1.702 m) -AE	67" (1.702 m) -SC
Weight	—	—	96.6 kg (212 lb 15.4 oz) -AE	93.9 kg (207 lb) -SC
Vital Signs				
Heart Rate Source	Monitor -KS	Monitor -AM	—	—
Numeric Pain Intensity Scale 1				
Numeric Pain Intensity Score 1	0 -KS	0 -AM	—	—

Flowsheets (all recorded)

PATT Complete

Row Name	04/12/19 1612				
PATT Complete					
PATT Complete	Yes -SC				

Flowsheets (all recorded)

Fall Risk

Row Name	04/17/19 1018				
Hester Davis Fall Risk Assessment					
Last Known Fall	0 -AM				
Mobility	0 -AM				
Medications	2 -AM				
Mental Status/LOC/Awareness	0 -AM				
Toileting Needs	0 -AM				
Volume/Electrolyte Status	2 -AM				
Communication/Sensory	1 -AM				
Behavior	0 -AM				
Hester Davis Fall Risk Total	8 -AM				
Fall Assessment					
Patient Receiving Sedation	Yes -AM				
Fall Risk	Yes -AM				
Fall Band Applied	No -AM				
Yellow socks	Yes -AM				

Flowsheets (all recorded)

Pre-op Checklist

Row Name	04/17/19 1015	04/12/19 1558			
Patient Verification					
History and Physical Completed	Yes -AM	—			
Consents Confirmed	Operative;Informed;Blood products -AM	—			
Patient ID and Procedure Verified	Yes -AM	—			
Correct Procedure	Yes -AM	—			
Documents Match	Yes -AM	—			
Pacemaker	No -AM	No -SC			
Patient has an ICD?	No -AM	No -SC			
Pre-op Lab/Test Results Available	In chart -AM	—			
Preg Test	n/a -AM	—			
Prep Verification					
Isolation Precautions	N/A -AM	— na -SC			
Allergy Band Applied	Yes -AM	—			
Anti-embolism	n/a -AM	—			
Pre-op Antibiotic Ordered?	Yes (see MAR) -AM	—			
Beta Blocker Therapy Last Dose Date	04/16/19 -AM	—			
Beta Blocker Last Dose Time	0800 -AM	—			
Anticoagulent Therapy Last Dose Date	04/13/19 -AM	—			
Anticoagulant Last Dose Time	0800 -AM	—			
VTE Assessment Complete?	Yes -AM	—			
Date of last liquid	04/16/19 -AM	—			
Time of last liquid	2200 -AM	—			
Date of last solid	04/16/19 -AM	—			
Time of last solid	2200 -AM	—			
Void Prior to Procedure	Yes -AM	—			
Void Prior to Procedure Time	0915 -AM	—			
Enema Given	Not applicable -AM	—			
Bowel Prep Needed	No -AM	—			
Remove all that apply:	Other (see comment) -AM	—			
Disposition of belongings:	To family/significant other -AM	—			
Side/Site Confirmed	Left -AM	—			
Required items available	Required test results, blood/antibiotics/irrigation fluids, implants, devices and special needs/equipment are available -AM	—			
Transport To	OR -AM	—			
Mode of Transport	Stretcher -AM	—			
Transport By	RN;Circulator -AM	—			
Released by (Floor RN or Pre-op RN)	Ariana Morton, RN -AM	—			
Report given to (healthcare professional/RN)	OR Circulator -AM	—			
Metal Implant Present?	No -AM	—			
Skin Prep for Procedure	N/A -AM	—			
Skin Care	Soap/Water -AM	—			
VTE Diagnostic Test Performed?	—	Yes -SC			

Flowsheets (all recorded)

Psychosocial Review

Row Name	04/12/19 1558				
Abuse Assessment					
Safe in Home	Yes -SC				
Values/Beliefs					
Cultural Preferences Affecting Hospitalization	No -SC				
Spiritual Preferences Affecting Hospitalization	No -SC				

Flowsheets (all recorded)

ED Sepsis Screen

Row Name	04/17/19 1111	04/17/19 1015			
Vital sign parameters					
BP	138/60 -KS	153/51 -AM			
Pulse	**(!) 49** -KS	50 -AM			
Calculated MAP	86 -KS	85 -AM			
Resp	16 -KS	14 -AM			
Temp	97.4 °F (36.3 °C) -KS	98.5 °F (36.9 °C) -AM			
Vitals Sepsis Risk Score	0 -KS	0 -AM			
Vital Signs					
Automatic Restart Vitals Timer	Yes -KS	Yes -AM			

Flowsheets (all recorded)

Call Complete

Row Name	04/12/19 1612				
Call Complete					
Pre-op Call Complete	Yes -SC				

Flowsheets (all recorded)

Phone Assessment

Row Name	04/17/19 1111	04/17/19 1015	04/17/19 0954	04/12/19 1558
Pain Assessment				
Currently in Pain	—	—	—	No/denies pain -SC
Numeric Pain Intensity Score 1	0 -KS	0 -AM	—	—
Pain Goal				
Patient's Stated Pain Goal	—	—	—	0 (No Pain) -SC
Oxygen Therapy				
SpO2	93 % -KS	96 % -AM	—	—
O2 Device	—	None (Room air) -AM	—	None (Room air) -SC
Height and Weight				
Height	—	—	67" (1.702 m) -AE	67" (1.702 m) -SC
Height Method	—	—	Stated -AE	Stated -SC
Weight	—	—	96.6 kg (212 lb 15.4 oz) -AE	93.9 kg (207 lb) -SC
Weight Method	—	—	Actual -AE	Stated -SC
BMI (Calculated)	—	—	33.3 -AE	32.4 -SC
BSA (Calculated - sq m)	—	—	2.13 sq meters -AE	2.1 sq meters -SC

Flowsheets (all recorded)

Vitals/Pain

Row Name	04/17/19 1111	04/17/19 1015	04/17/19 0954	04/12/19 1558
Vitals				
Temp	97.4 °F (36.3 °C) -KS	98.5 °F (36.9 °C) -AM	—	—
Temp src	Temporal -KS	Temporal -AM	—	—
Pulse	(!) **49** -KS	50 -AM	—	—
Heart Rate Source	Monitor -KS	Monitor -AM	—	—
Resp	16 -KS	14 -AM	—	—
BP	138/60 -KS	153/51 -AM	—	—
Patient Position	Other (Comment) -KS	Sitting -AM	—	—
Oxygen Therapy				
SpO2	93 % -KS	96 % -AM	—	—
O2 Device	—	None (Room air) -AM	—	None (Room air) -SC
Height and Weight				
Height	—	—	67" (1.702 m) -AE	67" (1.702 m) -SC
Height Method	—	—	Stated -AE	Stated -SC
Weight	—	—	96.6 kg (212 lb 15.4 oz) -AE	93.9 kg (207 lb) -SC
Weight Method	—	—	Actual -AE	Stated -SC
BMI (Calculated)	—	—	33.3 -AE	32.4 -SC
BSA (Calculated - sq m)	—	—	2.13 sq meters -AE	2.1 sq meters -SC
Pain Assessment				
Pain Assessment	0-10 -KS	0-10 -AM	—	—
Pain Goal				
Patient's Stated Pain Goal	—	—	—	0 (No Pain) -SC
Numeric Pain Intensity Scale				
Numeric Pain Intensity Score 1	0 -KS	0 -AM	—	—

User Key

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates
SC	Sandra Cody, RN	02/03/17 -
KS	Kimberly R Swanson, RN	02/03/17 -
SB	Sandy M Bobb, RN	02/03/17 -
AE	Amber Estes, RN	02/03/17 -
AM	Ariana Morton, RN	01/30/18 -
CR	Chris Russell	—
CG	Cara M Gurney, PAA	04/12/19 - 04/19/19
EI	Epicweb Interface	—

Flowsheet Notes

No notes of this type exist for this encounter.

All Scans

Encounter-Level Documents - 04/17/2019:

Scan on 4/18/2019 2:01 PM (below)

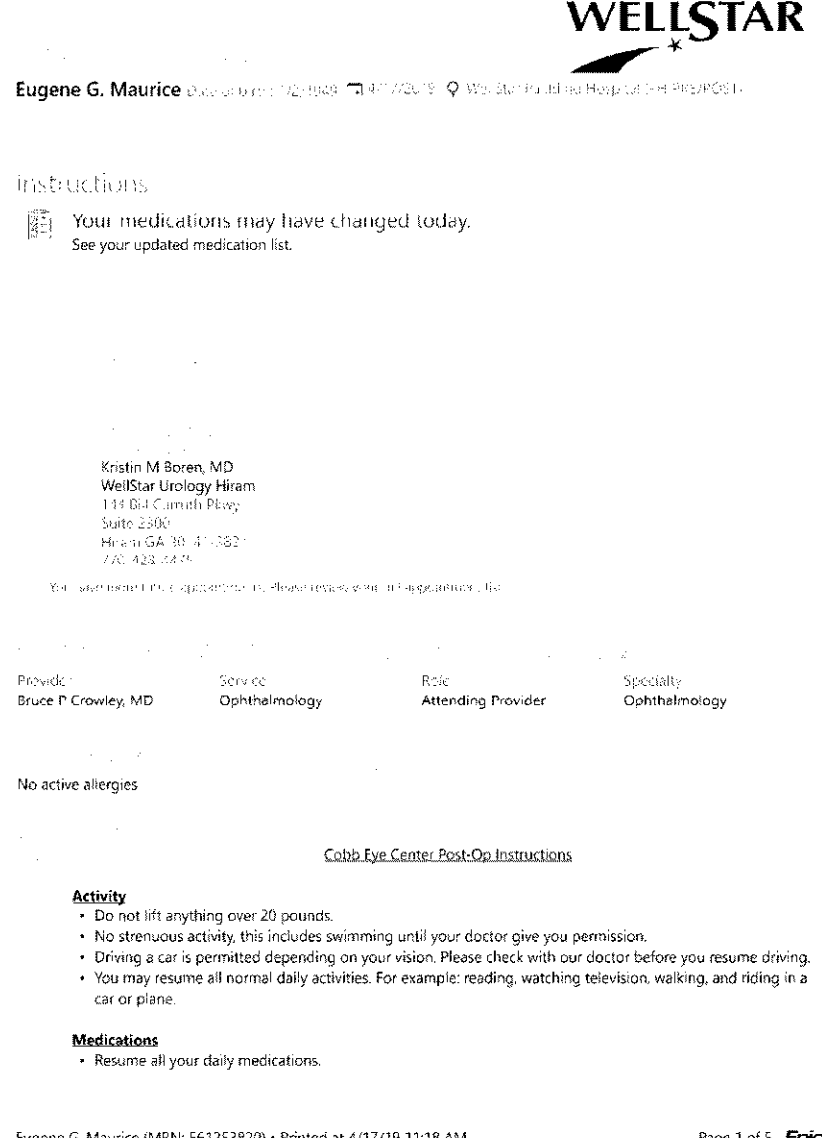
Scan on 4/18/2019 1:41 PM (below)

Scan on 4/18/2019 1:23 PM (below)

Scan on 4/17/2019 4:20 PM (below)

Scan on 4/17/2019 4:20 PM (below)

Document on 4/17/2019 11:18 AM by Kimberly R Swanson, RN: IP AVS (below)



WELLSTAR

Eugene G. Maurice

Instructions

Your medications may have changed today.
See your updated medication list.

Kristin M Boren, MD
WellStar Urology Hiram
Suite 2300

Provider	Service	Role	Specialty
Bruce P Crowley, MD	Ophthalmology	Attending Provider	Ophthalmology

No active allergies

Cobb Eye Center Post-Op Instructions

Activity

- Do not lift anything over 20 pounds.
- No strenuous activity, this includes swimming until your doctor give you permission.
- Driving a car is permitted depending on your vision. Please check with our doctor before you resume driving.
- You may resume all normal daily activities. For example: reading, watching television, walking, and riding in a car or plane.

Medications

- Resume all your daily medications.

Eugene G. Maurice (MRN: 561253820) • Printed at 4/17/19 11:18 AM

Page 1 of 5 Epic

General Information

- Wash your hands before treating your operative eye.
- Wear the protective eye shield over your eye at bedtime and naps until otherwise instructed by your doctor. When putting on your glasses, be careful not to hit your eye with the earpiece.
- Do not touch or rub the upper lid of the operative eye at anytime.
- Unless otherwise instructed by your doctor, keep the patch on your operative eye. It will be removed the day after surgery. You will also be given further instructions on the eye drops and caring for your eye.
- On the day of surgery, you will need someone to drive you home from the surgery center and to our office the next day.
- No eye make-up for 1 week.
- Your eye may feel irritated (like sand is in it) for the first 24-48 hours. You may take Tylenol or Advil to control the discomfort. If over the counter medication does not help, please call our office.

Bathing

- You may bathe or shower. You may shampoo your hair the day after surgery. Keep your operative eye protected from soap and water.

Call You Doctor

- Sudden decrease in you vision.
- Increased redness or pain.

Follow-Up Appointment

- Your first follow-up appointment will be the day after surgery.
- Bring all your eye drops to each follow-up visit.

Other Follow-up
Follow up in office tomorrow and see Cobb Eye Center post op instruction sheet.

	176 Charles Hardy Parkway Unit C Hiram GA 30141 678-945-8200
Thursday May 9, 2019 8:15 AM (Arrive by 8:00 AM)	WellStar Urology Hiram 344 Bill Carruth Pkwy Suite 2300 Hiram GA 30141-3821 770-428-4475
Wednesday Jul 24, 2019 11:00 AM (Arrive by 10:45 AM)	WellStar Cardiovascular Medicine Hiram 344 Bill Carruth Parkway STE 4200 HIRAM GA 30141-3749 678-324-4444
Thursday Aug 8, 2019 11:30 AM (Arrive by 11:15 AM)	WellStar Cardiovascular Medicine Hiram 344 Bill Carruth Parkway STE 4200 HIRAM GA 30141-3749 678-324-4444

You have been diagnosed with or have the risk for stroke. Review the following to reduce your risk of stroke:

Discharge Medications

Taking your medications as prescribed is one of the most vital aspects of reducing your risk for stroke. It is important to know the names of your medications, how they work, how much to take, and when to take them. You should take your medications at the same time every day. Do not stop your prescribed medications or begin taking over-the-counter or herbal medications without first speaking with your physician

General Risk Factors for Stroke

Your care team will discuss your individual risk factors for Stroke and how best to modify and/or treat them.

High blood pressure - High blood pressure is the most important risk factor for stroke. People who have high blood pressure have more than half the lifetime risk of having stroke compared to those who consistently have an optimal blood pressure reading of 120/80.
Tobacco Use - Tobacco use doubles the risk for another stroke. Stop smoking if you smoke
High cholesterol - Cholesterol or plaque build-up in the arteries can block normal blood flow to the brain and cause a stroke and increase risk of heart disease. Maintain healthy cholesterol levels
Diabetes - People with diabetes are up to 4 times as likely to have a stroke as someone who does not have the disease.
Atrial fibrillation - Atrial fibrillation increases your stroke risk 5 times, so it's important to work with a doctor to control it. Eat a healthy diet — maintaining a diet low in calories, saturated and trans fats and cholesterol helps manage both obesity and healthy cholesterol levels in the blood, which also reduces risk for stroke.
Physical activity - Physical activity reduces stroke risk. A recent study showed that people who exercise five or more times per week are less likely to have another stroke. Increase your physical activity.
Alcohol use - Some studies say that drinking more than 2 drinks per day may increase stroke risk by 50 percent. Other studies have indicated that one alcoholic beverage a day may lower a person's risk for stroke, provided that there is no other medical reason for avoiding alcohol. Talk with a doctor about alcohol use and how it can best be controlled to prevent another stroke.

Warning Signs of Stroke

Use FAST to remember warning signs of stroke:
Face - Ask the person to smile. Does one side of the face droop?
Arms - Ask the person to raise both arms. Does one arm drift downward?
Speech - Ask the person to repeat a simple phrase. Is their speech slurred or strange?
Time - If you observe any of these signs, call 9-1-1 immediately.

Symptoms of Stroke

Sudden numbness or weakness of face, arm or leg - especially on one side of the body.
Sudden confusion, trouble speaking or understanding.
Sudden trouble seeing in one or both eyes
Sudden trouble walking, dizziness, loss of balance or coordination.
Sudden severe headache with no known cause.

As part of your treatment plan, please call 770-956-STAR to register for our free Heart Failure Academy program.

Medication List

CONTINUE taking these medications

Morning Noon Evening Bedtime As Needed

CONTINUE **aspirin** 81 MG EC tablet
Take 81 mg by mouth daily
81 mg

CONTINUE **atorvastatin** 80 MG tablet
LIPITOR
Take 1 tablet (80 mg total) by mouth nightly
80 mg

CONTINUE **blood sugar diagnostic** strip
ONETOUCH VERIO
Use to check blood sugar twice daily as directed.
DX: E11.9

CONTINUE **clopidogrel** 75 mg tablet
PLAVIX
Take 1 tablet (75 mg total) by mouth daily
75 mg

CONTINUE **ferrous sulfate** 324 mg (65 mg iron) Tbec
Take 1 tablet (324 mg total) by mouth 2 (two) times a day with meals
324 mg

CONTINUE **furosemide** 40 MG tablet
LASIX
Take 1 tablet (40 mg total) by mouth daily
40 mg

CONTINUE **gatifloxacin** 0.5 % eye drops
ZYMAXID

CONTINUE **isosorbide mononitrate** 60 MG 24 hr tablet
IMDUR
Take 1 tablet (60 mg total) by mouth 2 (two) times a day
60 mg

CONTINUE **metFORMIN** 500 MG tablet
GLUCOPHAGE
1 tablet po in am and 1 in pm
type 2 diabetes mellitus

Medication List (continued)

CONTINUE taking these medications (continued)

Morning | Noon | Evening | Bedtime | As Needed

CONTINUE **nitroglycerin** 0.4 MG SL tablet
NITROSTAT
Place 1 tablet (0.4 mg total) under the tongue every 5 (five) minutes as needed for chest pain
0.4 mg

CONTINUE **prednisoLONE acetate** 1 % ophthalmic suspension
PRED FORTE

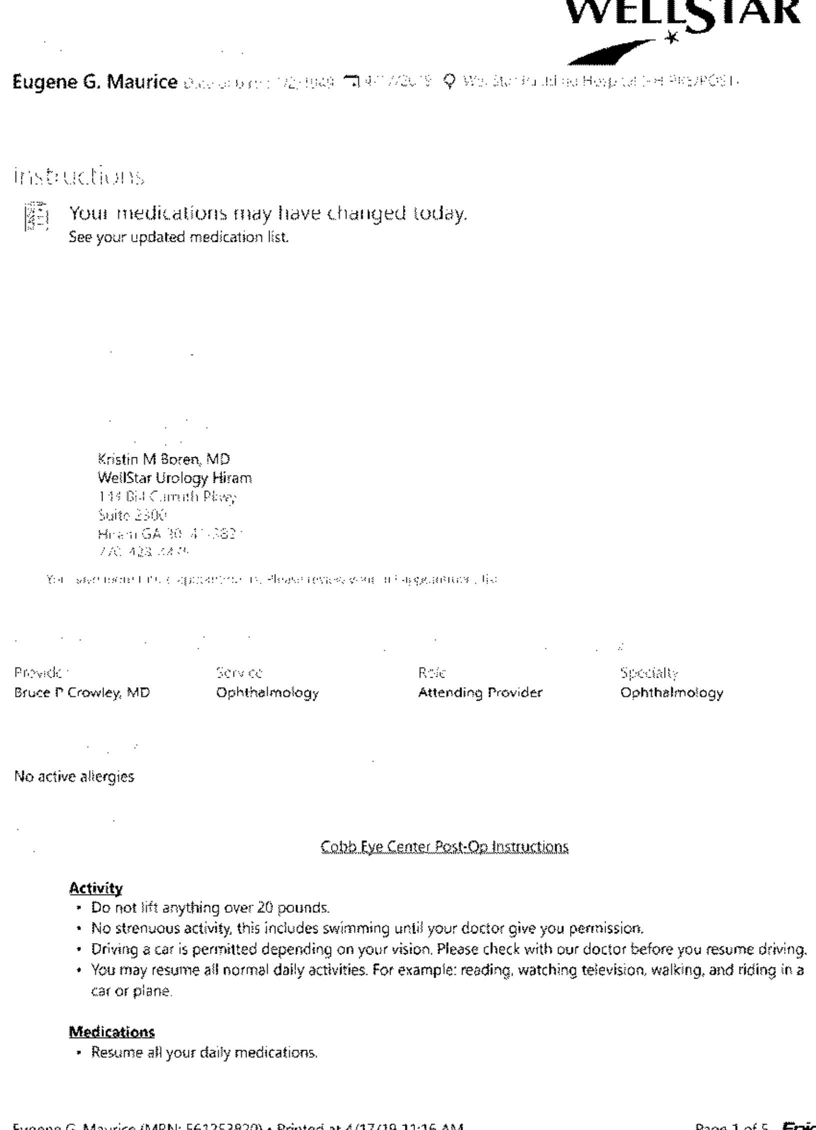
CONTINUE **ramipril** 5 MG capsule
ALTACE
Take 1 capsule (5 mg total) by mouth daily
5 mg

CONTINUE **sotalol** 80 MG tablet
BETAPACE
Take 0.5 tablets (40 mg total) by mouth 2 (two) times a day
40 mg

CONTINUE **VITAMIN B12 ORAL**
Take 1 tablet by mouth daily
1 tablet

View your After Visit Summary and more online at

Document on 4/17/2019 11:16 AM by Kimberly R Swanson, RN: IP AVS (below)



WELLSTAR

Eugene G. Maurice

Instructions

Your medications may have changed today.
See your updated medication list.

Kristin M Boren, MD
WellStar Urology Hiram
Suite 2300

Provider	Service	Role	Specialty
Bruce P Crowley, MD	Ophthalmology	Attending Provider	Ophthalmology

No active allergies

Cobb Eye Center Post-Op Instructions

Activity

- Do not lift anything over 20 pounds.
- No strenuous activity, this includes swimming until your doctor give you permission.
- Driving a car is permitted depending on your vision. Please check with our doctor before you resume driving.
- You may resume all normal daily activities. For example: reading, watching television, walking, and riding in a car or plane.

Medications

- Resume all your daily medications.

Eugene G. Maurice (MRN: 561253820) • Printed at 4/17/19 11:16 AM   Page 1 of 5 Epic

General Information

- Wash your hands before treating your operative eye.
- Wear the protective eye shield over your eye at bedtime and naps until otherwise instructed by your doctor. When putting on your glasses, be careful not to hit your eye with the earpiece.
- Do not touch or rub the upper lid of the operative eye at anytime.
- Unless otherwise instructed by your doctor, keep the patch on your operative eye. It will be removed the day after surgery. You will also be given further instructions on the eye drops and caring for your eye.
- On the day of surgery, you will need someone to drive you home from the surgery center and to our office the next day.
- No eye make-up for 1 week.
- Your eye may feel irritated (like sand is in it) for the first 24-48 hours. You may take Tylenol or Advil to control the discomfort. If over the counter medication does not help, please call our office.

Bathing

- You may bathe or shower. You may shampoo your hair the day after surgery. Keep your operative eye protected from soap and water.

Call You Doctor

- Sudden decrease in you vision.
- Increased redness or pain.

Follow-Up Appointment

- Your first follow-up appointment will be the day after surgery.
- Bring all your eye drops to each follow-up visit.

Other Follow-up
Follow up in office tomorrow and see Cobb Eye Center post op instruction sheet.

	176 Charles Hardy Parkway Unit C Hiram GA 30141 678 945 8200
Thursday May 9, 2019 8:15 AM (Arrive by 8:00 AM)	WellStar Urology Hiram 144 Bill Carruth Pkwy Suite 2300 Hiram GA 30141 3827 770 428 4475
Wednesday Jul 24, 2019 11:00 AM (Arrive by 10:45 AM)	WellStar Cardiovascular Medicine Hiram 144 Bill Carruth Parkway STE 4200 HIRAM GA 30141-3749 678-324-4444
Thursday Aug 8, 2019 11:30 AM (Arrive by 11:15 AM)	WellStar Cardiovascular Medicine Hiram 144 Bill Carruth Parkway STE 4200 HIRAM GA 30141-3749 678 324 4444

You have been diagnosed with or have the risk for stroke. Review the following to reduce your risk of stroke:

Discharge Medications
Taking your medications as prescribed is one of the most vital aspects of reducing your risk for stroke. It is important to know the names of your medications, how they work, how much to take, and when to take them. You should take your medications at the same time every day. Do not stop your prescribed medications or begin taking over-the-counter or herbal medications without first speaking with your physician

General Risk Factors for Stroke
Your care team will discuss your individual risk factors for Stroke and how best to modify and/or treat them.

High blood pressure - High blood pressure is the most important risk factor for stroke. People who have high blood pressure have more than half the lifetime risk of having stroke compared to those who consistently have an optimal blood pressure reading of 120/80.
Tobacco Use - Tobacco use doubles the risk for another stroke. Stop smoking if you smoke
High cholesterol - Cholesterol or plaque build-up in the arteries can block normal blood flow to the brain and cause a stroke and increase risk of heart disease. Maintain healthy cholesterol levels
Diabetes - People with diabetes are up to 4 times as likely to have a stroke as someone who does not have the disease.
Atrial fibrillation - Atrial fibrillation increases your stroke risk 5 times, so it's important to work with a doctor to control it.
Eat a healthy diet — maintaining a diet low in calories, saturated and trans fats and cholesterol helps manage both obesity and healthy cholesterol levels in the blood, which also reduces risk for stroke.
Physical activity - Physical activity reduces stroke risk. A recent study showed that people who exercise five or more times per week are less likely to have another stroke. Increase your physical activity
Alcohol use - Some studies say that drinking more than 2 drinks per day may increase stroke risk by 50 percent. Other studies have indicated that one alcoholic beverage a day may lower a person's risk for stroke, provided that there is no other medical reason for avoiding alcohol. Talk with a doctor about alcohol use and how it can best be controlled to prevent another stroke.

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Use FAST to remember warning signs of stroke:
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Speech - Ask the person to repeat a simple phrase. Is their speech slurred or strange?
Time - If you observe any of these signs, call 9-1-1 immediately.

Symptoms of Stroke
Sudden numbness or weakness of face, arm or leg - especially on one side of the body
Sudden confusion, trouble speaking or understanding.
Sudden trouble seeing in one or both eyes
Sudden trouble walking, dizziness, loss of balance or coordination.
Sudden severe headache with no known cause.

As part of your treatment plan, please call 770-956-STAR to register for our free Heart Failure Academy program.

Medication List

CONTINUE taking these medications

Morning | Noon | Evening | Bedtime | As Needed

CONTINUE **aspirin** 81 MG EC tablet
Take 81 mg by mouth daily
81 mg

CONTINUE **atorvastatin** 80 MG tablet
LIPITOR
Take 1 tablet (80 mg total) by mouth nightly
80 mg

CONTINUE **blood sugar diagnostic** strip
ONETOUCH VERIO
Use to check blood sugar twice daily as directed.
DX: E11.9

CONTINUE **clopidogrel** 75 mg tablet
PLAVIX
Take 1 tablet (75 mg total) by mouth daily
75 mg

CONTINUE **ferrous sulfate** 324 mg (65 mg iron) Tbec
Take 1 tablet (324 mg total) by mouth 2 (two) times a day with meals
324 mg

CONTINUE **furosemide** 40 MG tablet
LASIX
Take 1 tablet (40 mg total) by mouth daily
40 mg

CONTINUE **gatifloxacin** 0.5 % eye drops
ZYMAXID

CONTINUE **isosorbide mononitrate** 60 MG 24 hr tablet
IMDUR
Take 1 tablet (60 mg total) by mouth 2 (two) times a day
60 mg

CONTINUE **metFORMIN** 500 MG tablet
GLUCOPHAGE
1 tablet po in am and 1 in pm
type 2 diabetes mellitus

Medication List (continued)

CONTINUE taking these medications (continued)

Morning | Noon | Evening | Bedtime | As Needed

nitroglycerin 0.4 MG SL tablet
NITROSTAT
CONTINUE
Place 1 tablet (0.4 mg total) under the tongue every 5 (five) minutes as needed for chest pain
0.4 mg

prednisoLONE acetate 1 % ophthalmic suspension
CONTINUE
PRED FORTE

ramipril 5 MG capsule
ALTACE
CONTINUE
Take 1 capsule (5 mg total) by mouth daily
5 mg

sotalol 80 MG tablet
BETAPACE
CONTINUE
Take 0.5 tablets (40 mg total) by mouth 2 (two) times a day
40 mg

VITAMIN B12 ORAL
CONTINUE
Take 1 tablet by mouth daily
1 tablet

View your After Visit Summary and more online at

Electronic signature on 4/17/2019 9:49 AM - 1 of 5 e-signatures recorded

Encounter-Level E-Signatures:

CMS IM for Patient Signature (E-Sig) - Received on 4/17/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers
for medicare & Medicaid Services
OMB Approval No. 0938-0692

AN IMPORTANT MESSAGE FORM MEDICARE ABOUT YOUR RIGHTS

AS A HOSPITAL INPATIENT, YOU HAVE THE RIGHT TO:
Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.

- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to KEPRO:
  1-844-455-8708
  KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609

YOUR MEDICARE DISCHARGE RIGHTS

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by KEPRO. This reviewer was hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
  - **If you want to appeal, you must contact KEPRO no later than your planned discharge date and before you leave the hospital.**
  - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- **Step by step instructions for calling the KEPRO and filing an appeal are on page 2.**

To speak with someone at the hospital about this notice, call (770) 443-7068.

Please sign and date here to show you received this notice and understand your rights.

Patient Name

[signature]

CMS-R-193 (approved 07/10)
WS Paulding Hospital
An Important Message from Medicare About Your Rights

STEPS TO APPEAL YOUR DISCHARGE

- **STEP 1:** You must contact the KEPRO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
  - Here is the contact information: 1-844-455-8708
    KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609

- You can file a request for an appeal any day of the week. Once you speak to someone or leave a message, your appeal has begun.
- Ask the hospital if you need help contacting KEPRO.
- The name of this hospital is **WS Paulding Hospital 110042**
-

- **STEP 2:** You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
- **STEP 3:** The KEPRO will ask for your opinion. You or your representative need to be available to speak with KEPRO, if requested. You or your representative may give KEPRO a written statement, but you are not required to do so.
- **STEP 4:** The KEPRO will review your medical records and other important information about your case.
- **STEP 5:** KEPRO will notify you of its decision within 1 day after it receives all necessary information.
  - If KEPRO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  - If KEPRO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after KEPRO notifies you of its decision.

IF YOU MISS THE DEADLINE TO APPEAL, YOU HAVE OTHER APPEAL RIGHTS:

- You can still ask the KEPRO or your plan (if you belong to one) for a review of your case:
  - If you have Original Medicare: Call the KEPRO listed above.
  - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.
Additional Information: I have received my second notice and understand my appeal rights.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0692. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the ime estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, ATTN: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, MD 21244-1850.

WS Paulding Hospital
An Important Message from Medicare
About Your Rights

Name: Eugene G Maurice
MRN: 561253820
HAR: 40001383952

All Scans (continued)

Encounter-Level E-Signatures: (continued)

ENCOUNTER

Patient Class:	OP		Unit:	PIC DIAG XR
Hospital Service:	No service for patient encounter.		Bed:	Room/bed info not found
Admitting Provider:			Referring Physician:	Tharp, Jeffrey L
Attending Provider:	Jeffrey l tharp	AD: N	Adm Diagnosis:	Leukocytosis, unspecifie*
Admission Date:	11/4/2019		Admission Time:	1031

PATIENT

Name	Eugene George Maurice	Sex:	Male	DOB:	1/2/1949 (70 yrs)
Address:	61 SHOCKLEY WAY			Religion:	Catholic
City:	DALLAS GA 30157-8973			Race:	White or caucasian
County:	PAULDING				
Email Address:	Gene.maurice@sgmservice.*				
Primary Care Provider:	Jeffrey L Tharp, MD			Primary Phone:	678-910-2298

EMERGENCY CONTACT

Contact Name	Legal Guardian?	Relationship to Patient	Home Phone	Work Phone	Mobile Phone
1. Maurice,Shirley		Spouse	(678)398-9479		678-910-2476
2. *No Contact Specified*					678-910-2476

GUARANTOR

Guarantor:	MAURICE,EUGENE GEORGE	DOB:	1/2/1949
Address:	61 SHOCKLEY WAY	Sex:	Male
	DALLAS, GA 30157-8973	Home Phone:	678-398-9479
Relation to Patient:	Self	Work Phone:	
Guarantor ID:	123805	Mobile Phone:	678-910-2298

GUARANTOR EMPLOYER

Employer: Phone: Status: RETIRED

COVERAGE

PRIMARY INSURANCE

Payor:	COVENTRY ADVANTRA M*	Plan:	COVENTRY ADVANTRA /PPO
Group Number:	4916004101	Insurance Type:	INDEMNITY
Subscriber Name:	MAURICE,EUGENE GEOR*	Subscriber DOB:	01/02/1949
Coverage	P O BOX 7156 LONDON, KY 40742-7156	Subscriber ID:	80459609601
		Pat. Rel. to Subscriber:	Self
Phone:	(866)613-4977	Co-In: Deductible:	Out of Pocket Max:

SECONDARY INSURANCE

Payor:		Plan:	N/A
Group Number:		Insurance Type:	
Subscriber Name:		Subscriber DOB:	
Coverage		Subscriber ID:	
		Pat. Rel. to Subscriber:	
Phone:			

Contact Serial# April 3, 2020 Chart ID

Admission Information

Arrival Date/Time:		Admit Date/Time:	11/04/2019 1031	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Referral	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Paulding Imaging Center
Admit Provider:		Attending Provider:	Jeffrey L Tharp, MD	Referring Provider:	Jeffrey L Tharp, MD

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
11/05/2019 2359	Home Or Self Care	None	None	WellStar Paulding Imaging Center

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
D72.829 **[Principal]**	Elevated white blood cell count, unspecified				

Events

Hospital Outpatient at 11/4/2019 1031

Unit: WellStar Paulding Imaging Center
Patient class: Outpatient

Discharge at 11/5/2019 2359

Unit: WellStar Paulding Imaging Center
Patient class: Outpatient

Allergies as of 11/5/2019

Reviewed on 10/30/2019

No Known Allergies

Immunizations as of 11/5/2019

Immunizations last reviewed by Lisa M Stephenson, MA on 7/5/2018 1253

Annual Influenza

Administered on: 9/26/2016 0000 | Site: Left deltoid | Route: Intramuscular
Lot number: UI700AA

Annual Influenza

Administered on: 9/28/2017 0000 | Site: Left deltoid | Route: Intramuscular
Lot number: UI842AB

Annual Influenza

Administered on: 10/5/2018 0000 | Site: Right deltoid | Route: Intramuscular
Lot number: UJ031AA

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Jade Westover, LPN
Site: Left deltoid
CVX code: 135
Manufacturer: Sanofi Pasteur

Administered on: 9/26/2016
Route: Intramuscular
VIS date: 8/7/2015
Lot number: UI700AA

Dose: 0.5 mL
NDC: 49281-399-88

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Tina M Allen, MA
Site: Left deltoid
CVX code: 135
Manufacturer: Sanofi Pasteur

Administered on: 9/28/2017
Route: Intramuscular
VIS date: 09/28/2017
Lot number: UI842AB

Dose: 0.5 mL
NDC: 49281-401-88

All Scans (continued)

Immunizations (continued) as of 11/5/2019

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Mary S Wray, MA
Site: Right deltoid
CVX code: 135
Product: Fluzone HD
Expiration date: 5/1/2019
Administered on: 10/5/2018
Route: Intramuscular
VIS date: 8/7/2015
Manufacturer: Sanofi Pasteur
Dose: 0.5 mL
NDC: 49281-403-88
Lot number: UJ031AA

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Mary S Wray, MA
Site: Left deltoid
CVX code: 135
Product: FLUZONE HIGH-DOSE 2019-20 (PF)
Administered on: 10/30/2019
Route: Intramuscular
VIS date: 8/15/2019
Manufacturer: Sanofi Pasteur
Dose: 0.5 mL
NDC: 49281-405-88
Lot number: UJ285AA

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

Influenza - Unspecified

Administered on: 9/26/2016 0000
CVX code: 88
Lot number: UI700AA
Site: Left deltoid
Route: Intramuscular

Pneumococcal Conjugate 13-Valent

Administered by: Mary S Wray, MA
Site: Left deltoid
CVX code: 133
Manufacturer: Wyeth-Ayerst
Administered on: 3/16/2016
Route: Intramuscular
VIS date: 031616
Lot number: M51193
Dose: 0.5 mL
NDC: 0005-1971-01

Pneumococcal Polysaccharide

Administered by: Mary S Wray, MA
Site: Left deltoid
CVX code: 33
Manufacturer: Merck & Co. Inc
Administered on: 10/5/2018
Route: Intramuscular
VIS date: 04/24/2015
Lot number: R012497
Dose: 0.5 mL
NDC: 0006-4837-01

Questionnaire

Question	Answer
Have you ever had a serious reaction to any vaccine in the past?	NO
Are you sick today with a moderate to severe illness (e.g. fever)	NO

Pneumococcal Polysaccharide

Administered on: 10/5/2018 0000
CVX code: 33
Lot number: R012497
Site: Left deltoid
Route: Intramuscular

Medical as of 11/5/2019

Past Medical History

Diagnosis	Date	Comments	Source
AKI (acute kidney injury) (HCC) [N17.9]	—	—	Provider

All Scans (continued)

Medical as of 11/5/2019 (continued)

Diagnosis	Date Noted	Comments	Source
CAD (coronary artery disease) [I25.10]	—	—	Provider
Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC) [C61]	1/30/2018	—	Provider
Cataracts, both eyes [H26.9]	—	—	Provider
Coronary atherosclerosis of native coronary artery [I25.10]	—	—	Provider
Diabetes mellitus (HCC) [E11.9]	—	—	Provider
Essential hypertension, benign [I10]	—	—	Provider
Family history of ischemic heart disease [Z82.49]	—	—	Provider
Hyperlipidemia [E78.5]	—	—	Provider
Hypertension [I10]	—	—	Provider
Infectious viral hepatitis [B15.9]	—	as teen/cannont recall what type	Provider
Obesity [E66.9]	—	—	Provider
Other and unspecified hyperlipidemia [E78.5]	—	—	Provider
Other symptoms involving cardiovascular system [R09.89]	—	—	Provider
PVD (peripheral vascular disease) (HCC) [I73.9]	—	—	Provider

Pertinent Negatives

Diagnosis	Date Noted	Comments	Source
Abnormal ECG [R94.31]	04/07/2014	—	Provider
Aneurysm (HCC) [I72.9]	04/07/2014	—	Provider
Arrhythmia [I49.9]	04/07/2014	—	Provider
Asthma [J45.909]	04/07/2014	—	Provider
Clotting disorder (HCC) [D68.9]	04/07/2014	—	Provider
Congenital heart disease [Q24.9]	04/07/2014	—	Provider
Deep vein thrombosis (HCC) [I82.409]	04/07/2014	—	Provider
Heart failure (HCC) [I50.9]	04/07/2014	—	Provider
Heart murmur [R01.1]	04/07/2014	—	Provider
Mitral valve prolapse [I34.1]	04/07/2014	—	Provider
Myocardial infarction (HCC) [I21.9]	04/07/2014	—	Provider
Pulmonary embolism (HCC) [I26.99]	04/07/2014	—	Provider
Sleep apnea [G47.30]	04/07/2014	—	Provider
Stroke (HCC) [I63.9]	04/07/2014	—	Provider
Valvular disease [I38]	04/07/2014	—	Provider

ED Records

ED Arrival Information

Patient not seen in ED

ED Disposition

None

Hospital Encounter Notes

Encounter Notes

No notes exist for this encounter.

Imaging - Orders and Results

XR CHEST PA AND LATERAL (2 VIEWS) [852125404]

Electronically signed by: **Susan E Ashworth, NP on 10/31/19 2221**
Status: **Completed**
Ordering user: Susan E Ashworth, NP 10/31/19 2221
Authorized by: Jeffrey L Tharp, MD
Ordering mode: Standard
Quantity: 1
Lab status: Final result
Instance released by: Jennifer F Jones 11/4/2019 10:31 AM
Diagnoses
Leukocytosis, unspecified type [D72.829]

XR CHEST PA AND LATERAL (2 VIEWS) [852125404]

Resulted: 11/04/19 1141, Result status: Final result

Order status: Completed
Resulted by: Christopher C Oh, MD
Filed by: Interface, Rad Powerscribe 11/04/19 1142
Performed: 11/04/19 1042 - 11/04/19 1051
Accession number: 31967474
Result details
Narrative:
EXAM: PIC XR CHEST PA AND LATERAL (2 VIEWS)

CLINICAL INDICATION: D72.829 (Elevated white blood cell count, unspecified)

COMPARISON: Chest x-ray 6/18/2018

FINDINGS: Sternotomy wires and surgical clips overlie the mediastinum. Pulmonary vascular congestion persists, likely slightly improved from prior. Mild hazy airspace opacity at the left lung base with obscuration of the left heart border may reflect
mild asymmetric edema versus pneumonia, though the appearance is slightly improved compared to prior. No pneumothorax or large pleural effusion. Cardiac silhouette is upper limits of normal in size. No acute osseous abnormality is identified.

The Results Reporting Office (F1) will complete appropriate follow-up actions based on defined processes. F1

Released By: CHRISTOPHER OH, MD 11/4/2019 11:41 AM
Acknowledged by
Susan E Ashworth, NP on 11/04/19 1636
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Medications

All Meds and Administrations

(There are no med orders for this encounter)

Patient Education

Education

Title: Diabetes (MCB) (Not Started)

Topic: Psycho/Social/Spiritual Support (Not Started)

Point: Stress Management and Support Systems (Not Started)

Description:
Explain the importance of stress management and support systems in diabetes management. Refer to WellStar diabetes support groups, social services, case management or spiritual care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Not Started)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Treatments/Procedures (MCB) (Not Started)

Point: Introduction to Diabetes (MCB) (Not Started)

Description:
Give patient/family/caregiver written information on diabetes. Explain the definition of the type of diabetes with which the patient was diagnosed, how diabetes works in the body, risk factors, signs and symptoms, and if newly diagnosed, diagnostic criteria. Encourage viewing of diabetes on-demand videos when applicable. Refer to inpatient diabetes educator when applicable.

Patient Friendly Description:
You will receive a booklet entitled Diabetes survival skills. There are also two links to documents about Diabetes for you to read over noted below.

Please read over the items and let anyone on your Care Team know there are any questions about the material by marking below that "I HAVE QUESTIONS".

If once you have received the items and understand the material you can mark this as "I understand".
Learner Progress: Not documented in this visit.

Point: Diabetes Type II management (MCB) (Not Started)

Description:
Patient will watch a video that will discuss information on what to expect if they have Diabetes type II.

Patient Friendly Description:
This will inform you of what to expect if you have Diabetes type II.
Learner Progress: Not documented in this visit.

Point: Diabetic long term complications (MCB) (Not Started)

Description:
Patient will have information from Krames on the long term complications of Diabetes Type II.

Patient Friendly Description:
Some information on the long term complications of Diabetes Type II.
Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Topic: Medications (MCB) (Not Started)

Point: Insulin (MCB) (Not Started)

Description:
Educate patient/family/caregiver on the insulin prescribed. Explain how insulin works in the body. Explain the action of insulin, reason for taking, side effects, signs of allergic reaction and when physician should be called. Reinforce that insulin should be taken exactly as the physician has prescribed. Explain the proper storage of insulin, that extreme temperatures can damage insulin and never take insulin that has expired. Explain that the patient's primary care physician may change the dosage depending on the results of blood glucose tests and/or A1C level.

Patient Friendly Description:
This will inform you of why you are prescribed insulin if you have Diabetes Type II.

Learner Progress: Not documented in this visit.

Point: Hypoglycemic Agents (Not Started)

Description:
Educate patient/family/caregiver on the oral and/or injectable hypoglycemic(s) prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, as well as when the physician should be called. Reinforce that this medication(s) should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Giving Insulin Injection (Not Started)

Description:
Explain and demonstrate how the injection is given. Allow enough time for the patient/family/caregiver to practice. Have the patient return-demonstrate the technique using normal saline (vial and syringe only unless sterile demonstration pen is also available). Teach the patient how to choose and rotate injection sites. Instruct patient on safe disposal of used needles and syringes.

Learner Progress: Not documented in this visit.

Point: Drawing up Insulin (Not Started)

Description:
Instruct patient/family/caregiver to wash hands before drawing up insulin. Demonstrate and have the patient return-demonstrate drawing up the correct amount of insulin prescribed. If the patient is going to use an insulin pen, demonstrate use and have the patient return-demonstrate. If the patient is going to mix different types of insulin, demonstrate and have the patient return-demonstrate the correct way to draw up and mix the insulin.

Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Not Started)

Point: Exercise (Not Started)

Description:
Encourage patient/family/caregiver to discuss activity limitations, if any, with physician before starting an exercise routine. Stress the importance of regular exercise and activity to control blood sugar levels and weight. Instruct the patient to carry single carohydrates while exercising in case of hypoglycemic reaction. Explain that both concentrated physical activity (such as walking, swimming, running, cycling, strength training) and being more active through the entire day are equally important to blood sugar control and weight management.

Learner Progress: Not documented in this visit.

Point: Blood Glucose Monitoring (MCB) (Not Started)

Description:
Instruct patient/family/caregiver to wash hands before checking blood glucose. Explain and, if possible to use a complementary glucometer, demonstrate how to check and record blood sugars. Instruct the patient to check blood sugars as frequently as ordered by the physician. Explain that stress or illness will increase blood sugar, making it necesary to check blood sugars more often than usual. Instruct patient on blood glucose target ranges and A1C target range. Discuss care of the meter and supplies, including how to obtain supplies. If using a complementary glucometer, have the patient return-demonstrate checking the blood sugar. Instruct the patient on safe disposal of lancets. Refer to inpatient diabetes educator if applicable.

Patient Friendly Description:
Why is it important to check my blood sugar?

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Diabetic Foot Care (MCB) (Not Started)

Description:
Explain importance of foot care. Patient should have feet examined by a health care provider at least twice a year. Persons with foot problems should have feet examined at every visit. Explain daily foot care. Review importance of wearing well-fitting shoes and stockings/socks. Reinforce the importance of wearing shoes, even indoors, to prevent injury.

Patient Friendly Description:
This will inform you of why you should check your feet if you have diabetes.

Learner Progress: Not documented in this visit.

Point: Diabetes Identification Jewelry (Not Started)

Description:
Encourage the patient to wear a piece of jewelry that identifies patient as a person with diabetes. This will inform medical personnel that patient has diabetes if unable to communicate.

Learner Progress: Not documented in this visit.

Topic: Prevention/Discharge (Not Started)

Point: Signs and Symptoms of Hypoglycemia (Not Started)

Description:
Define and explain causes of hypoglycemia. Discuss signs and symptoms.

Learner Progress: Not documented in this visit.

Point: Treatment of Hypoglycemia (Not Started)

Description:
Instruct the patient on how to treat low blood sugar using the Rule of 15. Encourage patient to carry a blood sugar treatment at all time.

Learner Progress: Not documented in this visit.

Point: When to Call the Doctor (Not Started)

Description:
Instruct the patient/family/caregiver to call their health care provider if there are symptoms of hypo- or hyperglycemia or if blood sugars are trending high or low and are not controlled by simple measures.

Learner Progress: Not documented in this visit.

Point: Signs and Symptoms of Hyperglycemia (Not Started)

Description:
Define and explain causes of hyperglycemia. Discuss signs and symptoms (mild, moderate, severe, and ketoacidosis).

Learner Progress: Not documented in this visit.

Point: Prevention of Hyperglycemia (Not Started)

Description:
Encourage patient/family/caregiver to follow healthcare providers' instructions for diet, activity and medications. Explain the importance of good diabetes management and learning to detect and treat hyperglycemia early before it worsens. Refer to registered dietitian, when applicable, for meal planning assistance.

Learner Progress: Not documented in this visit.

Point: Prevention of Hypoglycemia (Not Started)

Patient Education (continued)

Education (continued)

Description:
Encourage patient/family/caregiver to follow healthcare providers' instructions for diet, activity and medications. Explain the importantce of good diabetes management and learning to detect and treat hypoglycemia early before it worsens.

Learner Progress: Not documented in this visit.

Point: WellStar Outpatient Diabetes Education (Not Started)

Description:
Provide information on WellStar Outpatient Diabetes Education when applicable. Information includes a list of classes offered and how to register.

Learner Progress: Not documented in this visit.

Point: Follow-up Appointments (Not Started)

Description:
Give the patient/family written information on when to make follow-up appointments. Reinforce importance of making and keeping the appointments. If appointments were made during the visit, give the patient a written reminder of the time and location.

Learner Progress: Not documented in this visit.

Topic: Diabetic Diet (MCB) (Not Started)

Point: Meal Planning and Portion Sizes (MCB) (Not Started)

Description:
The patient will view documents in Krames talking about meal planning as well learning about serving and portion sizes.

Patient Friendly Description:
This will inform you of ways to stay on track with your diet.

Learner Progress: Not documented in this visit.

Point: Eating well with Diabetes (MCB) (Not Started)

Description:
Patient will watch a video on healthy eating for people with DM.

Patient Friendly Description:
Healthy eating for people with Diabetes.

Learner Progress: Not documented in this visit.

Point: Carbohydrate Counting (MCB) (Not Started)

Description:
Patient will read Krames documents on healthy meals and meal planing for Diabetes.

Patient Friendly Description:
Learn about counting your carbohydrates.

Learner Progress: Not documented in this visit.

Topic: Survival Skills (Not Started)

Point: Review Diagnosis (Not Started)

Description:
Review the diabetes disagnosis, specific to patient's diabetes type.
Diabetes Survival Skills Booklet provided.

Patient Friendly Description:
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Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Nutrition (Not Started)

Description:
Importance of consistent nutrition habits.

Learner Progress: Not documented in this visit.

Point: Appointments (Not Started)

Description:
Importance of follow up appointment with the health care provider who will provide diabetes care after discharge.

Learner Progress: Not documented in this visit.

Point: Sick Day (Not Started)

Description:
Sick day management

Learner Progress: Not documented in this visit.

Point: Insulin Administration (if applicable) (Not Started)

Description:
Insulin administration and proper use and disposal of needles and syringes. How to schedule outpatient diabetes education. Review self-monitoring of blood glucose and home blood glucose goals.

Learner Progress: Not documented in this visit.

Point: Hyperglycemia (Not Started)

Description:
Definition, recognition, treatment and prevention of hyperglycemia.

Learner Progress: Not documented in this visit.

Point: Hypoglycemia (Not Started)

Description:
Definition, recognition, treatment and prevention of hypoglycemia.

Learner Progress: Not documented in this visit.

Point: Glucose Lowering Medications (Not Started)

Description:
When and how to take blood glucose-lowering medications.

Learner Progress: Not documented in this visit.

Topic: Diabetes Zones for Management (Not Started)

Point: Diabetes Zones for Management reviewed (Not Started)

Description:
Diabetes Zones for Management reviewed.

Learner Progress: Not documented in this visit.

Point: Diabetes Zones for Management handout provided (Not Started)

Description:
Diabetes Zones for Management handout provided.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Title: Cardiac Arrhythmia (MCB) (Not Started)

Topic: Treatment for Atrial Fibrillation/Atrial Flutter (MCB) (Not Started)

Point: Chemical cardioversion (MCB) (Not Started)

Description:
Provide written education on why and how a chemical cardioversion is done. As well as accociated risks.

Patient Friendly Description:
Why and how a chemical cardioversion is done and associated risks.
Learner Progress: Not documented in this visit.

Point: Electrical cardioversion (MCB) (Not Started)

Description:
Provide written education on why and how an electrical cardioversion is done. As well as accociated risks.

Patient Friendly Description:
Why and how a electrical cardioversion is done and associated risks.
Learner Progress: Not documented in this visit.

Point: Ablation (MCB) (Not Started)

Description:
Provide written education on the catheter ablation procedure and discharge instructions.

Patient Friendly Description:
How an ablation is done, and what to do after the procedure.
Learner Progress: Not documented in this visit.

Topic: Prevention/Discharge (MCB) (Not Started)

Point: Anticoagulation (MCB) (Not Started)

Description:
Provide written education on anticoagulation use including contraindications, side effects, interactions, and medication safety.

Patient Friendly Description:
Information on taking blood thinners safely.
Learner Progress: Not documented in this visit.

Point: Discharge with A Fib/Flutter (MCB) (Not Started)

Description:
Provide written education on treatment options, home care, and follow up care for discharging with atrial fibrillation.

Patient Friendly Description:
Information on treatment options, home care, and when to call your healthcare provider after going home with atrial fibrillation/flutter.
Learner Progress: Not documented in this visit.

Point: Atrial fib/flutter: stroke prevention (MCB) (Not Started)

Description:
"Provide written education on risk factors, medication, and prevention of A. Fib.
Hyperlink education materials provided to patient/family/caregiver. "

Patient Friendly Description:
Preventing stroke caused by A. Fib.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Topic: What is atrial fibrillation/flutter (MCB) (Not Started)

Point: You have atrial fibrillation (MCB) (Not Started)

Description:
Provide video education on the signs/symptoms of A. Fib, causes, medication(s), risk factors, prevention, and treatment.

Patient Friendly Description:
What to expect if you are diagnosed with A. Fib: causes, symptoms, and treatment.

Learner Progress: Not documented in this visit.

Point: You have Atrial Flutter (MCB) (Not Started)

Description:
Provide written education on the signs/symptoms of A. Flutter, causes, medication(s), risk factors, prevention, and treatment.

Patient Friendly Description:
What to expect if you are diagnosed with A. Flutter: causes, symptoms, and treatment

Learner Progress: Not documented in this visit.

Title: MyChart Bedside Teaching completed (Not Started)

Points For This Title

Point: All MCB content reviewed with patient and teachback completed. The patient verbalized understanding. (Not Started)

Description:
Go over all the Eduction for the patient in the Education activity. The Education that was provided to the patient via MCB was included as well as education that was noted within the Eduction activity as Education that was beneifical to the patient during this hospital stay.

Learner Progress: Not documented in this visit.

Title: Coronary Artery Disease (MCB) (Not Started)

Topic: WS Cardiac Rehabilitation for Arrhythmia (MCB)--This is CAD and AMI Cardiac Rehab Program Information for the Patient (Not Started)

Point: Exercise for a Healthier Heart (MCB) (Not Started)

Description:
Explain how exercising regularly offers many health rewards. Provide exercise tips to beginning a new exercise routine; Set Small goals and aim for 150 minutes a week.

Patient Friendly Description:
This provides healthy heart tips on why exercise is important.

Learner Progress: Not documented in this visit.

Point: WellStar Cardiac Rehabilitation Program (MCB) (Not Started)

Description:
At WellStar, our cardiac rehab patients are individually assessed to review medical history, evaluate risk factors, analyze functional abilities and set goals. Ongoing assessments are conducted to ensure patients are making progress toward their goals, educational needs are being met, and any problems or concerns are being addressed with the referring physician.

Patient Friendly Description:
This will help you better understand Cardiac Rehabilitation. At WellStar, our cardiac rehab programs provide education, supervised exercise, lifestyle modification and emotional support to help patients increase physical fitness, reduce cardiac symptoms and improve health and wellbeing.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Cardiac Rehabilitation: Emotional Issue (MCB) (Not Started)

Description:
Explain how having heart disease can be stressful. Encourage patient not to ignore feelings of sadness, worry, and depression. Patient should know when to ask for help and/or support.

Patient Friendly Description:
This will explain some emotional feelings related to heart disease.

Learner Progress: Not documented in this visit.

Topic: Heart Healthy Diet- DASH Diet (MCB) (Not Started)

Point: Eating Heart Healthy Food: Using DASH Plan (MCB) (Not Started)

Description:
Review diet information and explain that eating a low salt, low fat and low cholesterol diet with plenty of fruits and vegetables can reduce risk of complications from CAD.

Patient Friendly Description:
This will help you follow a healthy eating plan that can reduce your risk of complications associated with Coronary Artery Disease.

Please watch video/read over the material and let anyone on your Care Team know if there are any questions by marking below.

If you understand all material, mark I understand below.

Learner Progress: Not documented in this visit.

Topic: Questions your patient may have for you (MCB) (Not Started)

Point: Questions your patient may have about the AMI (MCB) (Not Started)

Description:
This is information about diet, exercise and medications for patients and it encourages them to ask staff questions.

Patient Friendly Description:
After reading this, you can write down any questions that you have for staff under the Notes section as a reference.

Learner Progress: Not documented in this visit.

Topic: Coronary Artery Disease (MCB) (Not Started)

Point: Recognizing signs and symptoms of Heart Disease (MCB) (Not Started)

Description:
Provide written education on the signs/symptoms of CAD, causes, medication(s), risk factors, prevention and treatment.

Patient Friendly Description:
This will explain some of the causes of Coronary Artery Disease.

Learner Progress: Not documented in this visit.

Point: Understanding Coronary Artery Disease (MCB) (Not Started)

Description:
Give patient written information on CAD. Explain the definition of CAD, causes, signs and symptoms.

Patient Friendly Description:
This will inform you of what to expect if you are diagnosed with Coronary Artery Disease (CAD).

Please watch video/read over the material and let anyone on your Care Team know if there are any questions by marking below.

If you understand all material, mark I understand below.

Learner Progress: Not documented in this visit.

Topic: Risk factors for Heart Disease (MCB) (Not Started)

Patient Education (continued)

Education (continued)

Point: Tobacco/Smoking Cessation (MCB) (Not Started)

Description:
Give patient written information on Quitting Smoking

Educate the patient/family/caregiver on smoking cessation and smoking cessation programs offered in the community. Explain effects smoking and second hand smoke have on the body. Encourage the patient to ask people that smoke around him/her to smoke outside or in another room. Refer patient to Cardiopulmonary Rehabilitation, if applicable.

Patient Friendly Description:
This will give you some getting started tips to kick the smoking habit.

This will help you plan how to quit the smoking habit.
Learner Progress: Not documented in this visit.

Title: First-Dose Education (Not Started)

Points For This Title

Point: hydralazine HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: iohexol (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: nitroglycerin (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: Ringer's solution,lactated (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: dextrose (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: dextrose 50 % in water (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: calcium carbonate (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: morphine sulfate (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: hydrocodone/acetaminophen (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: acetaminophen (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: phenylephrine HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: labetalol HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: metoclopramide HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: cyclopentolate HCl (Not Started)

Patient Education (continued)

Education (continued)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: furosemide (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: diclofenac sodium (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: gentamicin sulfate (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: diphenhydramine HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: 0.9 % sodium chloride (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: piperacillin sodium/tazobactam (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: insulin lispro (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: ondansetron (Not Started)

Patient Education (continued)

Education (continued)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: glucagon,human recombinant (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: gadobenate dimeglumine (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: pantoprazole sodium (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: polyethylene glycol 3350 (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: perflutren lipid microspheres (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: fentanyl citrate/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: lidocaine HCl/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: ondansetron HCl/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: tetracaine HCl/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: sodium chloride 0.9 % (flush) (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Title: Congestive Heart Failure (MCB) (Not Started)

Topic: Psycho/Social/Spiritual Support (Not Started)

Point: Stress Management and Support Systems (Not Started)

Description:
Explain the importance of stress management and support systems in diabetes management. Refer to WellStar diabetes support groups, social services, case management or spiritual care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Not Started)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Treatments/Procedures (MCB) (Not Started)

Point: Oxygen (Not Started)

Description:
Educate patient/family/caregiver on why oxygen is needed and how it will be delivered (nasal cannula, mask, etc.). Instruct patient/family/caregiver that the patent should not be smoking while on oxygen.

Learner Progress: Not documented in this visit.

Point: Medical Equipment (Not Started)

Description:
Educate patient/family/caregiver on use of medical equipment and provide educational materials.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Introduction to Heart Failure (MCB) (Not Started)

Description:
Give patient written information on congestive heart failure. Explain the definition of CHF, causes, signs and symptoms, expected length of stay and criteria for discharge.

Patient Friendly Description:
This will inform you of what to expect if you are diagnosed with heart failure.

You will be receiving the Congestive Heart Failure red booklet.

Please watch video/read over the material and let anyone on your Care Team know if there are any questions by marking below.

If you understand all material, mark I understand below.

Learner Progress: Not documented in this visit.

Point: Echocardiogram (Not Started)

Description:
Educate patient/family/caregiver on echocardiograms, to include: what the test is, how the test will be performed, and what to expect during the test.

Learner Progress: Not documented in this visit.

Topic: Pain Management (Not Started)

Point: Pain Medication Actions & Side Effects (Not Started)

Description:
Provide medication specific handouts when available.

Learner Progress: Not documented in this visit.

Point: Pain Rating Scale (Not Started)

Description:
Provide patient with information on the Pain Rating Scale. Explain the rating scale of 0 to 10.

Learner Progress: Not documented in this visit.

Point: Non-Pharmacological Comfort Measures (Not Started)

Description:
Explain there are other ways of controlling pain than medication. The following are suggestions: position change, aromatherapy, deep slow breathing, distraction, quiet environment, imagery, heat therapy and/or cold therapy, laughter, massage, music, physical therapy, and touch therapy.

Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Not Started)

Point: Eating well with High Blood Pressure (MCB) (Not Started)

Description:
Information provided to patient to explain what their diet should consist of when they have Heart Failure.

Patient Friendly Description:
This will help you make heart healthy eating choices if you have a diagnosis with heart failure.

Learner Progress: Not documented in this visit.

Point: Heart Failure:Being Active (MCB) (Not Started)

Description:
Explain to the patient how to be active with heart failure.

Patient Education (continued)

Education (continued)

Patient Friendly Description:
This will explain how to safely be active with heart failure.

Learner Progress: Not documented in this visit.

Point: Heart Failure: Dealing with Sleep problems (MCB) (Not Started)

Description:
Provide tips and ideas to help patient sleep better.

Patient Friendly Description:
This will provide tips on sleeping better with heart faillure.

Learner Progress: Not documented in this visit.

Point: Heart Failure: Know your Baselines (MCB) (Not Started)

Description:
Explain to patient how to identify their baseline and recognize changes.

Patient Friendly Description:
This will help you understand what's normal for you and how to watch for changes.

Learner Progress: Not documented in this visit.

Point: Heart Failure : Know your Zones (Not Started)

Description:
Review heart failure zones with patient and educate them on how to know which zone they are in each day.

Learner Progress: Not documented in this visit.

Point: Dealing with Heart Failure: Helping the patient cope (MCB) (Not Started)

Learner Progress: Not documented in this visit.

Point: Daily Weights (MCB) (Not Started)

Description:
Give written information about daily weights. Instruct the patient to weigh on the same scale every day at the same time, wearing the same amount of clothing. Explain why it is important to check weight. Inform the patient that gaining weight from fluid build up may be an early sign that heart failure is getting worse. The patient should call a care provider if there is a weight gain of more than 2-3 pounds in one day or 4-5 pounds in five days.

Patient Friendly Description:
Information on the importance of Daily weights.

Learner Progress: Not documented in this visit.

Point: How to check your Heart Rate and Blood Pressure (MCB) (Not Started)

Description:
Give patient written information on how to take a pulse. Explain the definition of a pulse, normal range, reason for taking a pulse, where pulses can be found. Demonstrate how to find a pulse. Once found, instruct the patient to count the beats for a full minute. Tell the patient to keep a record of the pulse rate, date and time taken, which site (right/left, wrist/neck) and strength of beats (weak, strong or missing beats).

Patient Friendly Description:
This will explain the importance of understanding your vital signs and show you how to take them.

Learner Progress: Not documented in this visit.

Topic: WellStar Cardiac Rehabilitation (MCB) (Not Started)

Point: Exercise for a Healthier Heart (MCB) (Not Started)

Description:
Explain how exercising regularly offers many health rewards. Provide exercise tips to beginning a new exercise routine; Set Small goals and aim for 150 minutes a week.

Patient Education (continued)

Education (continued)

Patient Friendly Description:
This provides healthy heart tips on why exercise is important.

Learner Progress: Not documented in this visit.

Point: WellStar Cardiac Rehabilitation Program (MCB) (Not Started)

Description:
At WellStar, our cardiac rehab patients are individually assessed to review medical history, evaluate risk factors, analyze functional abilities and set goals. Ongoing assessments are conducted to ensure patients are making progress toward their goals, educational needs are being met, and any problems or concerns are being addressed with the referring physician.

Patient Friendly Description:
This will help you better understand Cardiac Rehabilitation. At WellStar, our cardiac rehab programs provide education, supervised exercise, lifestyle modification and emotional support to help patients increase physical fitness, reduce cardiac symptoms and improve health and wellbeing.

Learner Progress: Not documented in this visit.

Topic: Review Plan of Care (Not Started)

Point: Review Plan of Care - Day 5 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 1 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 2 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 3 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 4 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Topic: Medications (MCB) (Not Started)

Point: Heart Failure Medications (MCB) (Not Started)

Description:
Educate patient on the drug type, purpose for medication, and common side effects.

Educate patient on Prescribed Medications

Patient Friendly Description:
This will inform you of medications that you may be taking if you are diagnosed with Heart Failure.

Learner Progress: Not documented in this visit.

Point: ACE Inhibitors (Not Started)

Description:
Educate patient/family/caregiver on the ACE Inhibitor prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Angiotensin II Receptor Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Angiotensin II Receptor Blockers prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Aspirin (Not Started)

Description:
Give patient written information on Aspirin. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the doctor should be called. Reinforce that this medication should be taken exactly as the doctor has prescribed.

Learner Progress: Not documented in this visit.

Point: Beta Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Beta Blocker prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Digoxin (Not Started)

Description:
Educate patient/family/caregiver on Digoxin and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed. The physician will order a blood test to monitor the concentration of the drug in the patient's blood. The dose of this medication may be changed according to the results of this test.

Learner Progress: Not documented in this visit.

Point: Diuretics (Not Started)

Description:
Educate patient/family/caregiver on the Diuretic prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Inotropes (Not Started)

Description:
Educate patient/family/caregiver on the Inotropes prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Vasodilators (Not Started)

Description:
Educate patient/family/caregiver on the Vasodilator prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Topic: Prevention / Discharge (MCB) (Not Started)

Point: Community Resources (Not Started)

Description:
Give written information on available community resources. Refer to Social Services or Case Management, if needed.

Learner Progress: Not documented in this visit.

Point: Home Health Care Services (Not Started)

Description:
Give patient written information on Home Health Care Services that have been arranged. Review the role of the home care nurse and when to expect the first visit. Refer to Case Management or Social Services, if needed.

Learner Progress: Not documented in this visit.

Point: Follow-up Appointments (Not Started)

Description:
Give the patient/family written information on their next appointment and when to make follow-up appointments. Reinforce importance of making and keeping the appointments. If appointments were made during the visit, give the patient a written reminder of the time and location.

Learner Progress: Not documented in this visit.

Point: Influenza Vaccine (Not Started)

Description:
Educate the patient/family/caregiver on obatining a yearly influenza vaccine.

Learner Progress: Not documented in this visit.

Point: Discharge Medications (Not Started)

Description:
Ensure that there are no barriers to obtain medications prior to discharge. Notify Care Coordination if there are any needs for additional resources prior to discharging the patient.

Learner Progress: Not documented in this visit.

Point: When to Call the Doctor (MCB) (Not Started)

Patient Education (continued)

Education (continued)

Description:
Provide written documentation instructing the patient to call the doctor if the patient has:

1. Ankles and legs that become more swollen.
2. Shoes and socks that get tight suddenly.
3. Shortness of breath that does not go away with rest.
4. Weight gain of 2 - 3 pounds in one day.
5. Weight gain of 4 - 5 pounds in one week.
6. No energy for normal activities.
7. Dizziness or weakness.
8. Yellowish or blue green vision.
9. Heartbeat changes (feels like a butterfly in the chest).
10. Chest pain.
11. Blurred vision.
12. Passing out.
13. Cough that does not go away.

Patient Friendly Description:
Heart Failure symptoms to know and when to call your healthcare provider.
Lifestyle changes to help you feel and live better with Heart Failure.

Learner Progress: Not documented in this visit.

Point: Review Discharge Plan (Not Started)

Description:
Review the discharge plan with patient and primary care giver including: diet, activity, medications, and special precautions. Refer to Case Management, if needed.

Learner Progress: Not documented in this visit.

Point: Smoking Cessation (Not Started)

Description:
Educate the patient/family/caregiver on smoking cessation and smoking cessation programs offered in the community. Explain effects smoking and second hand smoke have on the body. Encourage the patient to ask people that smoke around him/her to smoke outside or in another room. Refer patient to Cardiopulmonary Rehabilitation, if applicable.

Learner Progress: Not documented in this visit.

Point: Diet Instructions for CHF Prevention (Not Started)

Description:
Review diet information and explain that eating a low fat and low cholesterol diet with plenty of fruits and vegetables can reduce their chance of suffering a future heart attack.

Learner Progress: Not documented in this visit.

Topic: Heart Failure Discharge Instructions (Not Started)

Point: Follow-up Appointments (Not Started)

Description:
Give the patient/family written information on their next appointment and when to make follow-up appointments. Reinforce importance of making and keeping the appointments. If appointments were made during the visit, give the patient a written reminder of the time and location.

Learner Progress: Not documented in this visit.

Point: Daily Weights (MCB) (Not Started)

Description:
Give written information about daily weights. Instruct the patient to weigh on the same scale every day at the same time, wearing the same amount of clothing. Explain why it is important to check weight. Inform the patient that gaining weight from fluid build up may be an early sign that heart failure is getting worse. The patient should call a care provider if there is a weight gain of more than 2-3 pounds in one day or 4-5 pounds in five days.

Patient Friendly Description:
Information on the importance of Daily weights.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: When to Call the Doctor (MCB) (Not Started)

Description:
Provide written documentation instructing the patient to call the doctor if the patient has:

1. Ankles and legs that become more swollen.
2. Shoes and socks that get tight suddenly.
3. Shortness of breath that does not go away with rest.
4. Weight gain of 2 - 3 pounds in one day.
5. Weight gain of 4 - 5 pounds in one week.
6. No energy for normal activities.
7. Dizziness or weakness.
8. Yellowish or blue green vision.
9. Heartbeat changes (feels like a butterfly in the chest).
10. Chest pain.
11. Blurred vision.
12. Passing out.
13. Cough that does not go away.

Patient Friendly Description:
Heart Failure symptoms to know and when to call your healthcare provider.
Lifestyle changes to help you feel and live better with Heart Failure.

Learner Progress: Not documented in this visit.

Point: Review Discharge Plan (Not Started)

Description:
Review the discharge plan with patient and primary care giver including: diet, activity, medications, and special precautions. Refer to Case Management, if needed.

Learner Progress: Not documented in this visit.

Point: Diet Instructions for CHF Prevention (Not Started)

Description:
Review diet information and explain that eating a low fat and low cholesterol diet with plenty of fruits and vegetables can reduce their chance of suffering a future heart attack.

Learner Progress: Not documented in this visit.

Title: General Patient Education (MCB) (Not Started)

Topic: Psycho/Social/Spiritual Support (Not Started)

Point: Stress Management and Support Systems (Not Started)

Description:
Explain the importance of stress management and support systems in diabetes management. Refer to WellStar diabetes support groups, social services, case management or spiritual care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Not Started)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Prevention (MCB) (Not Started)

Patient Education (continued)

Education (continued)

Point: When to Call the Doctor (Not Started)

Description:
Educate patient/family/caregiver on when to call the doctor.

Learner Progress: Not documented in this visit.

Point: Protect Others from Infection (Not Started)

Description:
Educate patient/family/caregiver on respiratory hygiene and cough etiquette. To protect from further infection and to protect others from getting an infection, patient should cover nose and mouth with tissues when coughing. Encourage patient to place used tissues in a plastic bag that will not allow secretions to soak through. Patient should always wash his/her hands after using or handling used tissues.

Learner Progress: Not documented in this visit.

Point: Protect Yourself from Further Infection (MCB) (Not Started)

Description:
Educate patient/family/caregiver that because patient is in a weakened condition he/she needs to avoid others who are sick as to not acquire another illness. Family/caregiver should wear gloves, gown and face shield/eye protection.

Patient Friendly Description:
Information on Flu.
Information on Pneumonia and Pneumococcal Vaccination.

Learner Progress: Not documented in this visit.

Point: Falls education, precautions, prevention at home and in the hospital (MCB) (Not Started)

Description:
Patient was given information on preventing falls both while in the hospital and when they are at home.

Patient Friendly Description:
Things to help you prevent falls while you are in the hospital and when you are home.

Learner Progress: Not documented in this visit.

Point: Prevention Deep Vein Thrombosis after surgery (MCB) (Not Started)

Description:
Educate patient/family/caregiver to prevent DVT and PE after Suergery

Patient Friendly Description:
In the days and weeks after surgery, you have a higher chance of developing a deep vein thrombosis (DVT).
This is a condition in which a blood clot or thrombus develops in a deep vein.
They are most common in the leg. But, a DVT may develop in an arm, or another deep vein in the body.
A piece of the clot, called an embolus, can separate from the vein and travel to the lungs.
A blood clot in the lungs is called a pulmonary embolus (PE).
This can cut off the flow of blood to the lungs.
It is a medical emergency and may cause death.

Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Not Started)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.

Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Not Started)

Patient Education (continued)

Education (continued)

Point: General Self Care (Not Started)

Description:
Instruct patient on self care needs. These may include: hygiene, how to take a blood pressure, how to change a dressing, etc.

Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Not Started)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.

Learner Progress: Not documented in this visit.

Topic: Medications (MCB) (Not Started)

Point: Antibiotic Education (Not Started)

Description:
If an antibiotic was prescribed, educate patient/family/caregiver on the antibiotics prescribed. Explain how antibiotics work in the body. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed

If a viral diagnosis was made, the patient/family was educated on their viral diagnosis and the reason for no antibiotic this visit.

Learner Progress: Not documented in this visit.

Point: Anticoagulant Therapy (Not Started)

Description:
1-Educate patient/family/caregiver on anticoagulant being prescribed and provide educational materials.
2-Explain action of medication, reason for taking, and importance of adherence to correct medication dose and schedule,
3-Explain potential for adverse drug reactions, signs of allergic reaction, potential for drug-drug and drug-food interactions, and when physician should be called.
4-Reinforce that the medication should be taken exactly as the physician has prescribed.
5-Explain importance of maintaining follow-up appointments and adhering to laboratory testing as prescribed by physician.
6-Explain that the dose of the anticoagulant being prescribed may change depending on the results of the laboratory testing.

Learner Progress: Not documented in this visit.

Point: Insulin (MCB) (Not Started)

Description:
Educate patient/family/caregiver on the insulin prescribed. Explain how insulin works in the body. Explain the action of insulin, reason for taking, side effects, signs of allergic reaction and when physician should be called. Reinforce that insulin should be taken exactly as the physician has prescribed. Explain the proper storage of insulin, that extreme temperatures can damage insulin and never take insulin that has expired. Explain that the patient's primary care physician may change the dosage depending on the results of blood glucose tests and/or A1C level.

Patient Friendly Description:
This will inform you of why you are prescribed insulin if you have Diabetes Type II.

Learner Progress: Not documented in this visit.

Point: Hypoglycemic Agents (Not Started)

Description:
Educate patient/family/caregiver on the oral and/or injectable hypoglycemic(s) prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, as well as when the physician should be called. Reinforce that this medication(s) should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Non-Steroidal Anti-Inflammatory Drugs (Not Started)

Description:
Educate patient/family/caregiver on the NSAID prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Psychotropic Medications (Not Started)

Description:
Educate patient/family/caregiver on the Psychotropic medication prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: ACE Inhibitors (Not Started)

Description:
Educate patient/family/caregiver on the ACE Inhibitor prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Angiotensin II Receptor Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Angiotensin II Receptor Blockers prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Beta Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Beta Blocker prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Digoxin (Not Started)

Description:
Educate patient/family/caregiver on Digoxin and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed. The physician will order a blood test to monitor the concentration of the drug in the patient's blood. The dose of this medication may be changed according to the results of this test.

Learner Progress: Not documented in this visit.

Point: Diuretics (Not Started)

Description:
Educate patient/family/caregiver on the Diuretic prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Inotropes (Not Started)

Patient Education (continued)

Education (continued)

Description:
Educate patient/family/caregiver on the Inotropes prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Vasodilators (Not Started)

Description:
Educate patient/family/caregiver on the Vasodilator prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Antibiotics (Not Started)

Description:
Educate patient/family/caregiver on the Antibiotics prescribed. Explain how antibiotics works in the body. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Medication purpose, side effects, schedule, administration (MCB) (Not Started)

Description:
Discussed purpose and possible side effects of medication.

Learner Progress: Not documented in this visit.

All Flowsheets

Flowsheets (all recorded)

Risk for Readmission

Row Name	11/06/19 0214				
OTHER					
Risk for Readmission	7 -UE				

User Key

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates
UE	Epic, User	—

Flowsheet Notes

No notes of this type exist for this encounter.

All Scans

Encounter-Level Documents - 11/04/2019:

Electronic signature on 11/4/2019 10:31 AM - E-signed

Encounter-Level E-Signatures:

Hosp Consent for Tx/Assgn of Ben/Fin Res (E-Signature Encounter) - Received on 11/4/2019

CONSENT TO ROUTINE PROCEDURES AND TREATMENTS & FINANCIAL RESPONSIBILITY STATEMENT

Section I **CONSENT TO ROUTINE PROCEDURES AND TREATMENTS**

I consent to routine procedures and treatments at a WellStar Health System "WellStar" facility as an outpatient, inpatient, or emergency department patient, depending on my medical needs. Routine procedures and treatments can include testing (for example, x-rays and blood tests), routine care and procedures (for example, intravenous fluids, injections, or bladder or stomach tubes) and evaluation (for example, interviews and physical exams). However, this consent to routine procedures and treatments does not include consent for other invasive procedures (for example, surgery, amniocentesis, or diagnostic tests such as colonoscopy or those requiring the use of contrast material), consent for blood or blood products, general anesthesia, or my participation in research. These circumstances require a separate consent process. I understand it is the responsibility of my physician or surgeon to obtain any required separate consent(s).

I understand that I may receive treatment and healthcare services given by WellStar employees (such as nurses and technicians) and by physicians and other independent medical professionals on the medical staff of WellStar facilities (for example, Emergency Department physicians, radiologists, and surgeons) who are NOT WellStar employees. I understand that the healthcare services provided by these independent medical professionals, using independent medical judgment, at a WellStar facility in no way create any type of employment, partnership, or other relationship other than as an independent contractor. These independent contractors are responsible for their own actions and WellStar shall not be liable for the acts or omissions of any such independent contractors.

While I am a patient at a WellStar facility, I understand that I may be observed by or receive healthcare services from students enrolled in training programs. Students are supervised by instructors, WellStar employees, or other independent medical professionals on the medical staff of the WellStar facility, depending on the type of training program the students are enrolled in. I understand that I have the right to request that someone other than a student provide my care.

I understand that I retain no property rights to any tissue samples or bodily fluids removed from my body (specimens) as part of procedures or treatment given to me. I further understand that WellStar has no obligation to preserve these specimens; that it will retain or dispose of specimens according to its usual practices.

I understand that I have the right to ask questions about a proposed procedure or treatment (including the identity of any person providing or observing treatment and his or her affiliation with WellStar) at any time. I understand the practice of medicine is not an exact science and diagnosis and outcomes of treatment depend upon my medical condition and may involve risks or even death. I understand that no guarantees can be made as to the outcome of my care.

Section II **MATERNITY PATIENTS**

If I deliver an infant(s) while I am a patient at a WellStar facility, I agree that this same Consent to Routine Procedures and Treatments applies to the infant(s).

Section III **EMERGENCY OR LABORING PATIENTS**

In accordance with federal law, I understand my right to receive an appropriate medical screening examination performed by a physician or other qualified medical professional to determine whether I am suffering from an emergency medical condition. If such a condition exists, stabilizing treatment will be provided within the capabilities of this WellStar facility and its staff, even if I cannot pay for these services, do not have medical insurance coverage, or am not entitled to Medicare or Medicaid.

Eugene George Maurice

Patient's Signature	Relationship to Patient
Eugene G Maurice	SELF

Section IV **ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY**

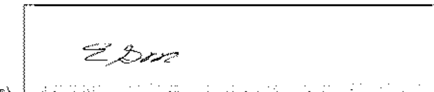
I assign any right I may have to receive payment from a health insurance plan, ERISA, Medicare, Medicaid, Social Security, or other payor(s) for services rendered by WellStar and the medical professionals caring for me during my treatment. I understand that I am financially responsible for all healthcare services, including amounts that are not covered by my health insurance plan or payor, as appropriate, based on the terms of the health plan contracts or the law. For example, the payment of non-covered services, deductibles, and co-payments is the patient's responsibility. For healthcare services provided by independent medical professionals, I understand that I will receive separate bills and that I am responsible for paying them. I agree to provide WellStar with all health insurance coverage information if I choose to use my insurance for payment of services. I agree to respond to all requests for benefit information and complete any forms required by my

insurance plan. I am responsible for understanding and following the terms of my health insurance plan. I authorize WellStar and its medical professionals to submit appeals for payment, including arbitration and formal complaints, on my behalf as required by my insurance company. I also understand that I am financially responsible for collection costs if my account becomes delinquent and that all delinquent accounts will bear interest at the legal rate, unless prohibited by law. I understand that WellStar may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options.

For Medicare/Medicaid Patients: I certify that the information given by me in applying for payment under Title XVII and XIX of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf. I assign payment for the unpaid charges to WellStar or the independent medical professionals providing healthcare services to me. I understand that I am responsible for any remaining balance not covered by other insurance.
If I am signing this form and am not the patient, I understand that I am also responsible for and agree to pay charges not covered by the assignments made in this Section IV, including any Medicare deductibles

Section V **FINANCIAL ASSISTANCE STATEMENT**

It is WellStar's policy to provide medical care at no cost to qualified members of the WellStar-served communities, and to provide significantly discounted medical care to certain qualified members of our communities faced with financial hardship due to medical misfortune, according to policy. I understand that if payment of my bill creates a financial hardship, I may qualify for assistance with all or part of my medical expenses associated with my treatment at a WellStar facility and that I can call 678-838-5750 for more information.



(Patient Initials)

Section VI **CONSENT TO PHOTOGRAPHY AND VIDEOTAPING**

Sometimes, WellStar facilities and physicians use patient photographs and videos for identification, clinical, educational, or research-related purposes. These photographs, recordings or videos could be in digital or other formats and may be reproduced for scientific or treatment reasons. I consent to having photographs, recordings or videos taken for patient care, educational, research, or other clinical benefits.

Section VII **NOTICE REGARDING RELEASE OF HEALTH INFORMATION**

As explained in WellStar's Notice of Privacy Practices, WellStar may use and disclose medical information including privileged information (i.e. mental health, alcohol/drug abuse or HIV/AIDS), to physicians or other healthcare providers for the purposes of providing treatment, and to payors for the purposes of payment for medical treatment. HIPAA also permits WellStar and its affiliated companies to use medical information for healthcare operations. I expressly authorize WellStar's use and disclosure of my medical information as described in this Section VII.

Section VIII **INPATIENT INFORMATION**

I have received a copy of the Patient Admission Packet that includes "Patient Rights and Responsibilities" and information regarding Advance Care Planning. If I am a Medicare beneficiary, I have also received a notice entitled "Important Message from Medicare."

Section IX **ADVANCE DIRECTIVE**

I have an Advance Directive (Choose One)
Yes:

No:

If yes; I will provide a copy to WellStar. I have been advised that WellStar does not honor Advance Directives in Pre-admission Testing or in the Outpatient Diagnostics and Treatment setting.

Section X **PERSONAL VALUABLES**

I understand that WellStar is not liable or responsible for lost or damaged personal belongings and valuables (for example, money, jewelry, hearing aids, or dentures) unless placed in a WellStar safe. I will ask family members or friends to take home my personal belongings and valuables. I also understand and will inform the staff if I have dentures, eyeglasses, contact lenses, prosthetics or other items that I need to retain close by for personal functioning to assure safekeeping.

Section XI **CONSENT TO CONTACT**

All Scans (continued)

Encounter-Level E-Signatures: (continued)

By providing a telephone number, I expressly consent and authorize WellStar Health System, any practitioner or clinical provider as well as any of their related entities, agents, or contractors including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I am providing today, have provided previously, or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have to the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number, I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically and claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical, and education information including exchange news, changes to health care law, health care coverage, care followup, and other health care opportunities, goods, and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C. § 7701, et seq. By providing an email address, I represent that I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a telephone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify Provider immediately of any change in telephone number or email address.

I confirm that I have read and understood and accept the terms of this document, that I am the patient or patient's representative, and that I am authorized to sign this document and accept its terms.

Name: Eugene George Maurice

Patient's Signature	Relationship to Patient
[signature]	SELF

Name: Eugene George Maurice
MRN: 561253820
HAR: 40001531542

Encounter-Level E-Signatures: (continued)

ENCOUNTER

Patient Class:	**OP**		Unit:	**PIC DIAG XR**
Hospital Service:	**No service for patient encounter.**		Bed:	**Room/bed info not found**
Admitting Provider:			Referring Physician:	**Tharp, Jeffrey L**
Attending Provider:	**Jeffrey l tharp**	AD: N	Adm Diagnosis:	**Abnormal CXR [R93.89]**
Admission Date:	**11/21/2019**		Admission Time:	**0955**

PATIENT

Name	**Eugene George Maurice**	Sex:	**Male**	DOB:	**1/2/1949 (70 yrs)**
Address:	**61 SHOCKLEY WAY**			Religion:	**Catholic**
City:	**DALLAS GA 30157-8973**			Race:	**White or caucasian**
County:	**PAULDING**				
Email Address:	**Gene.maurice@sgmservice.***				
Primary Care Provider:	**Jeffrey L Tharp, MD**			Primary Phone:	**678-910-2298**

EMERGENCY CONTACT

Contact Name	Legal Guardian?	Relationship to Patient	Home Phone	Work Phone	Mobile Phone
1. Maurice,Shirley		**Spouse**	**(678)398-9479**		**678-910-2476**
2. *No Contact Specified*					**678-910-2476**

GUARANTOR

Guarantor:	**MAURICE,EUGENE GEORGE**	DOB:	**1/2/1949**
Address:	**61 SHOCKLEY WAY**	Sex:	**Male**
	DALLAS, GA 30157-8973	Home Phone:	**678-398-9479**
Relation to Patient:	**Self**	Work Phone:	
Guarantor ID:	**123805**	Mobile Phone:	**678-910-2298**

GUARANTOR EMPLOYER

Employer: Phone: Status: **RETIRED**

COVERAGE

PRIMARY INSURANCE

Payor:	**COVENTRY ADVANTRA M***	Plan:	**COVENTRY ADVANTRA /PPO**
Group Number:	**4916004101**	Insurance Type:	**INDEMNITY**
Subscriber Name:	**MAURICE,EUGENE GEOR***	Subscriber DOB:	**01/02/1949**
Coverage	**P O BOX 7156** **LONDON, KY 40742-7156**	Subscriber ID:	**80459609601**
		Pat. Rel. to Subscriber:	**Self**
Phone:	**(866)613-4977**	Co-In: Deductible: Out of Pocket Max:	

SECONDARY INSURANCE

Payor:		Plan:	**N/A**
Group Number:		Insurance Type:	
Subscriber Name:		Subscriber DOB:	
Coverage		Subscriber ID:	
		Pat. Rel. to Subscriber:	
Phone:			

Contact Serial# April 3, 2020 **Chart ID**

Admission Information

Arrival Date/Time:		Admit Date/Time:	11/21/2019 0955	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Referral	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Paulding Imaging Center
Admit Provider:		Attending Provider:	Jeffrey L Tharp, MD	Referring Provider:	Jeffrey L Tharp, MD

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
11/22/2019 2359	Home Or Self Care	None	None	WellStar Paulding Imaging Center

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
R93.89 **[Principal]**	Abnormal findings on diagnostic imaging of other specified body structures				

Events

Hospital Outpatient at 11/21/2019 0955

Unit: WellStar Paulding Imaging Center
Patient class: Outpatient

Discharge at 11/22/2019 2359

Unit: WellStar Paulding Imaging Center
Patient class: Outpatient

Allergies as of 11/22/2019

Reviewed on 11/15/2019

No Known Allergies

Immunizations as of 11/22/2019

Immunizations last reviewed by Lisa M Stephenson, MA on 7/5/2018 1253

Annual Influenza

Administered on: 9/26/2016 0000 | Site: Left deltoid | Route: Intramuscular
Lot number: UI700AA

Annual Influenza

Administered on: 9/28/2017 0000 | Site: Left deltoid | Route: Intramuscular
Lot number: UI842AB

Annual Influenza

Administered on: 10/5/2018 0000 | Site: Right deltoid | Route: Intramuscular
Lot number: UJ031AA

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Jade Westover, LPN | Administered on: 9/26/2016 | Dose: 0.5 mL
Site: Left deltoid | Route: Intramuscular | NDC: 49281-399-88
CVX code: 135 | VIS date: 8/7/2015
Manufacturer: Sanofi Pasteur | Lot number: UI700AA

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Tina M Allen, MA | Administered on: 9/28/2017 | Dose: 0.5 mL
Site: Left deltoid | Route: Intramuscular | NDC: 49281-401-88
CVX code: 135 | VIS date: 09/28/2017
Manufacturer: Sanofi Pasteur | Lot number: UI842AB

All Scans (continued)

Immunizations (continued) as of 11/22/2019

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Mary S Wray, MA | Administered on: 10/5/2018 | Dose: 0.5 mL
Site: Right deltoid | Route: Intramuscular | NDC: 49281-403-88
CVX code: 135 | VIS date: 8/7/2015
Product: Fluzone HD | Manufacturer: Sanofi Pasteur | Lot number: UJ031AA
Expiration date: 5/1/2019

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Mary S Wray, MA | Administered on: 10/30/2019 | Dose: 0.5 mL
Site: Left deltoid | Route: Intramuscular | NDC: 49281-405-88
CVX code: 135 | VIS date: 8/15/2019
Product: FLUZONE HIGH-DOSE 2019-20 (PF) | Manufacturer: Sanofi Pasteur | Lot number: UJ285AA

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

Influenza - Unspecified

Administered on: 9/26/2016 0000 | Site: Left deltoid | Route: Intramuscular
CVX code: 88
Lot number: UI700AA

Pneumococcal Conjugate 13-Valent

Administered by: Mary S Wray, MA | Administered on: 3/16/2016 | Dose: 0.5 mL
Site: Left deltoid | Route: Intramuscular | NDC: 0005-1971-01
CVX code: 133 | VIS date: 031616
Manufacturer: Wyeth-Ayerst | Lot number: M51193

Pneumococcal Polysaccharide

Administered by: Mary S Wray, MA | Administered on: 10/5/2018 | Dose: 0.5 mL
Site: Left deltoid | Route: Intramuscular | NDC: 0006-4837-01
CVX code: 33 | VIS date: 04/24/2015
Manufacturer: Merck & Co. Inc | Lot number: R012497

Questionnaire

Question	Answer
Have you ever had a serious reaction to any vaccine in the past?	NO
Are you sick today with a moderate to severe illness (e.g. fever)	NO

Pneumococcal Polysaccharide

Administered on: 10/5/2018 0000 | Site: Left deltoid | Route: Intramuscular
CVX code: 33
Lot number: R012497

Medical as of 11/22/2019

Past Medical History

Diagnosis	Date	Comments	Source
AKI (acute kidney injury) (HCC) [N17.9]	—	—	Provider

All Scans (continued)

Medical as of 11/22/2019 (continued)

Diagnosis	Date Noted	Comments	Source
CAD (coronary artery disease) [I25.10]	—	—	Provider
Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC) [C61]	1/30/2018	—	Provider
Cataracts, both eyes [H26.9]	—	—	Provider
Coronary atherosclerosis of native coronary artery [I25.10]	—	—	Provider
Diabetes mellitus (HCC) [E11.9]	—	—	Provider
Essential hypertension, benign [I10]	—	—	Provider
Family history of ischemic heart disease [Z82.49]	—	—	Provider
Hyperlipidemia [E78.5]	—	—	Provider
Hypertension [I10]	—	—	Provider
Infectious viral hepatitis [B15.9]	—	as teen/cannont recall what type	Provider
Obesity [E66.9]	—	—	Provider
Other and unspecified hyperlipidemia [E78.5]	—	—	Provider
Other symptoms involving cardiovascular system [R09.89]	—	—	Provider
PVD (peripheral vascular disease) (HCC) [I73.9]	—	—	Provider

Pertinent Negatives

Diagnosis	Date Noted	Comments	Source
Abnormal ECG [R94.31]	04/07/2014	—	Provider
Aneurysm (HCC) [I72.9]	04/07/2014	—	Provider
Arrhythmia [I49.9]	04/07/2014	—	Provider
Asthma [J45.909]	04/07/2014	—	Provider
Clotting disorder (HCC) [D68.9]	04/07/2014	—	Provider
Congenital heart disease [Q24.9]	04/07/2014	—	Provider
Deep vein thrombosis (HCC) [I82.409]	04/07/2014	—	Provider
Heart failure (HCC) [I50.9]	04/07/2014	—	Provider
Heart murmur [R01.1]	04/07/2014	—	Provider
Mitral valve prolapse [I34.1]	04/07/2014	—	Provider
Myocardial infarction (HCC) [I21.9]	04/07/2014	—	Provider
Pulmonary embolism (HCC) [I26.99]	04/07/2014	—	Provider
Sleep apnea [G47.30]	04/07/2014	—	Provider
Stroke (HCC) [I63.9]	04/07/2014	—	Provider
Valvular disease [I38]	04/07/2014	—	Provider

ED Records

ED Arrival Information

Patient not seen in ED

ED Disposition

None

Hospital Encounter Notes

Encounter Notes

No notes exist for this encounter.

Imaging - Orders and Results

XR CHEST PA AND LATERAL (2 VIEWS) [855232763]

Electronically signed by: **Susan E Ashworth, NP on 11/15/19 0812**
Status: **Completed**
Ordering user: Susan E Ashworth, NP 11/15/19 0812
Authorized by: Jeffrey L Tharp, MD
Ordering mode: Standard
Quantity: 1
Lab status: Final result
Instance released by: Jennifer F Jones 11/21/2019 9:55 AM
Diagnoses
Abnormal CXR [R93.89]

XR CHEST PA AND LATERAL (2 VIEWS) [855232763]

Resulted: 11/21/19 1238, Result status: Final result

Order status: Completed
Resulted by: Mark L Wetherly, MD
Filed by: Interface, Rad Powerscribe 11/21/19 1240
Performed: 11/21/19 0959 - 11/21/19 1008
Accession number: 32050615
Result details
Narrative:
EXAM: PIC XR CHEST PA AND LATERAL (2 VIEWS)

CLINICAL INDICATION: R93.89 (Abnormal findings on diagnostic imaging of other specified body structures) . Physical exam. Fluid levels versus pneumonia.

COMPARISON: Chest x-ray 6/18/2018 and 11/4/2019

FINDINGS: Prominent cardiac shadow of 54% cardiothoracic ratio, similar to previous exams. Adequate mediastinal contour with atherosclerotic aortic knob. Prior coronary intervention with median sternotomy, bypass clips and radiopaque framework of
coronary stenting. Lung fields look clear. Normal pulmonary vascularity. Adequate pleural contours and skeleton. Median sternotomy wires look similar to the exam 11/4/2019.

Impression:

1. No acute chest radiographic abnormality identified relative to the prior exam of 11/4/2019.

Released By: MARK L WETHERLY, MD 11/21/2019 12:38 PM
Acknowledged by
Susan E Ashworth, NP on 11/21/19 1741
Tonzey Watson, MA on 11/25/19 0938

Medications

All Meds and Administrations

(There are no med orders for this encounter)

Patient Education

Education

Title: Diabetes (MCB) (Not Started)

Topic: Psycho/Social/Spiritual Support (Not Started)

Point: Stress Management and Support Systems (Not Started)

Description:
Explain the importance of stress management and support systems in diabetes management. Refer to WellStar diabetes support groups, social services, case management or spiritual care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Not Started)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Treatments/Procedures (MCB) (Not Started)

Point: Introduction to Diabetes (MCB) (Not Started)

Description:
Give patient/family/caregiver written information on diabetes. Explain the definition of the type of diabetes with which the patient was diagnosed, how diabetes works in the body, risk factors, signs and symptoms, and if newly diagnosed, diagnostic criteria. Encourage viewing of diabetes on-demand videos when applicable. Refer to inpatient diabetes educator when applicable.

Patient Friendly Description:
You will receive a booklet entitled Diabetes survival skills. There are also two links to documents about Diabetes for you to read over noted below.

Please read over the items and let anyone on your Care Team know there are any questions about the material by marking below that "I HAVE QUESTIONS".

If once you have received the items and understand the material you can mark this as "I understand".

Learner Progress: Not documented in this visit.

Point: Diabetes Type II management (MCB) (Not Started)

Description:
Patient will watch a video that will discuss information on what to expect if they have Diabetes type II.

Patient Friendly Description:
This will inform you of what to expect if you have Diabetes type II.

Learner Progress: Not documented in this visit.

Point: Diabetic long term complications (MCB) (Not Started)

Description:
Patient will have information from Krames on the long term complications of Diabetes Type II.

Patient Friendly Description:
Some information on the long term complications of Diabetes Type II.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Topic: Medications (MCB) (Not Started)

Point: Insulin (MCB) (Not Started)

Description:
Educate patient/family/caregiver on the insulin prescribed. Explain how insulin works in the body. Explain the action of insulin, reason for taking, side effects, signs of allergic reaction and when physician should be called. Reinforce that insulin should be taken exactly as the physician has prescribed. Explain the proper storage of insulin, that extreme temperatures can damage insulin and never take insulin that has expired. Explain that the patient's primary care physician may change the dosage depending on the results of blood glucose tests and/or A1C level.

Patient Friendly Description:
This will inform you of why you are prescribed insulin if you have Diabetes Type II.

Learner Progress: Not documented in this visit.

Point: Hypoglycemic Agents (Not Started)

Description:
Educate patient/family/caregiver on the oral and/or injectable hypoglycemic(s) prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, as well as when the physician should be called. Reinforce that this medication(s) should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Giving Insulin Injection (Not Started)

Description:
Explain and demonstrate how the injection is given. Allow enough time for the patient/family/caregiver to practice. Have the patient return-demonstrate the technique using normal saline (vial and syringe only unless sterile demonstration pen is also available). Teach the patient how to choose and rotate injection sites. Instruct patient on safe disposal of used needles and syringes.

Learner Progress: Not documented in this visit.

Point: Drawing up Insulin (Not Started)

Description:
Instruct patient/family/caregiver to wash hands before drawing up insulin. Demonstrate and have the patient return-demonstrate drawing up the correct amount of insulin prescribed. If the patient is going to use an insulin pen, demonstrate use and have the patient return-demonstrate. If the patient is going to mix different types of insulin, demonstrate and have the patient return-demonstrate the correct way to draw up and mix the insulin.

Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Not Started)

Point: Exercise (Not Started)

Description:
Encourage patient/family/caregiver to discuss activity limitations, if any, with physician before starting an exercise routine. Stress the importance of regular exercise and activity to control blood sugar levels and weight. Instruct the patient to carry single carohydrates while exercising in case of hypoglycemic reaction. Explain that both concentrated physical activity (such as walking, swimming, running, cycling, strength training) and being more active through the entire day are equally important to blood sugar control and weight management.

Learner Progress: Not documented in this visit.

Point: Blood Glucose Monitoring (MCB) (Not Started)

Description:
Instruct patient/family/caregiver to wash hands before checking blood glucose. Explain and, if possible to use a complementary glucometer, demonstrate how to check and record blood sugars. Instruct the patient to check blood sugars as frequently as ordered by the physician. Explain that stress or illness will increase blood sugar, making it necesary to check blood sugars more often than usual. Instruct patient on blood glucose target ranges and A1C target range. Discuss care of the meter and supplies, including how to obtain supplies. If using a complementary glucometer, have the patient return-demonstrate checking the blood sugar. Instruct the patient on safe disposal of lancets. Refer to inpatient diabetes educator if applicable.

Patient Friendly Description:
Why is it important to check my blood sugar?

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Diabetic Foot Care (MCB) (Not Started)

Description:
Explain importance of foot care. Patient should have feet examined by a health care provider at least twice a year. Persons with foot problems should have feet examined at every visit. Explain daily foot care. Review importance of wearing well-fitting shoes and stockings/socks. Reinforce the importance of wearing shoes, even indoors, to prevent injury.

Patient Friendly Description:
This will inform you of why you should check your feet if you have diabetes.

Learner Progress: Not documented in this visit.

Point: Diabetes Identification Jewelry (Not Started)

Description:
Encourage the patient to wear a piece of jewelry that identifies patient as a person with diabetes. This will inform medical personnel that patient has diabetes if unable to communicate.

Learner Progress: Not documented in this visit.

Topic: Prevention/Discharge (Not Started)

Point: Signs and Symptoms of Hypoglycemia (Not Started)

Description:
Define and explain causes of hypoglycemia. Discuss signs and symptoms.

Learner Progress: Not documented in this visit.

Point: Treatment of Hypoglycemia (Not Started)

Description:
Instruct the patient on how to treat low blood sugar using the Rule of 15. Encourage patient to carry a blood sugar treatment at all time.

Learner Progress: Not documented in this visit.

Point: When to Call the Doctor (Not Started)

Description:
Instruct the patient/family/caregiver to call their health care provider if there are symptoms of hypo- or hyperglycemia or if blood sugars are trending high or low and are not controlled by simple measures.

Learner Progress: Not documented in this visit.

Point: Signs and Symptoms of Hyperglycemia (Not Started)

Description:
Define and explain causes of hyperglycemia. Discuss signs and symptoms (mild, moderate, severe, and ketoacidosis).

Learner Progress: Not documented in this visit.

Point: Prevention of Hyperglycemia (Not Started)

Description:
Encourage patient/family/caregiver to follow healthcare providers' instructions for diet, activity and medications. Explain the importance of good diabetes management and learning to detect and treat hyperglycemia early before it worsens. Refer to registered dietitian, when applicable, for meal planning assistance.

Learner Progress: Not documented in this visit.

Point: Prevention of Hypoglycemia (Not Started)

Patient Education (continued)

Education (continued)

Description:
Encourage patient/family/caregiver to follow healthcare providers' instructions for diet, activity and medications. Explain the importantce of good diabetes management and learning to detect and treat hypoglycemia early before it worsens.

Learner Progress: Not documented in this visit.

Point: WellStar Outpatient Diabetes Education (Not Started)

Description:
Provide information on WellStar Outpatient Diabetes Education when applicable. Information includes a list of classes offered and how to register.

Learner Progress: Not documented in this visit.

Point: Follow-up Appointments (Not Started)

Description:
Give the patient/family written information on when to make follow-up appointments. Reinforce importance of making and keeping the appointments. If appointments were made during the visit, give the patient a written reminder of the time and location.

Learner Progress: Not documented in this visit.

Topic: Diabetic Diet (MCB) (Not Started)

Point: Meal Planning and Portion Sizes (MCB) (Not Started)

Description:
The patient will view documents in Krames talking about meal planning as well learning about serving and portion sizes.

Patient Friendly Description:
This will inform you of ways to stay on track with your diet.

Learner Progress: Not documented in this visit.

Point: Eating well with Diabetes (MCB) (Not Started)

Description:
Patient will watch a video on healthy eating for people with DM.

Patient Friendly Description:
Healthy eating for people with Diabetes.

Learner Progress: Not documented in this visit.

Point: Carbohydrate Counting (MCB) (Not Started)

Description:
Patient will read Krames documents on healthy meals and meal planing for Diabetes.

Patient Friendly Description:
Learn about counting your carbohydrates.

Learner Progress: Not documented in this visit.

Topic: Survival Skills (Not Started)

Point: Review Diagnosis (Not Started)

Description:
Review the diabetes disagnosis, specific to patient's diabetes type.
Diabetes Survival Skills Booklet provided.

Patient Friendly Description:
.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Nutrition (Not Started)

Description:
Importance of consistent nutrition habits.

Learner Progress: Not documented in this visit.

Point: Appointments (Not Started)

Description:
Importance of follow up appointment with the health care provider who will provide diabetes care after discharge.

Learner Progress: Not documented in this visit.

Point: Sick Day (Not Started)

Description:
Sick day management

Learner Progress: Not documented in this visit.

Point: Insulin Administration (if applicable) (Not Started)

Description:
Insulin administration and proper use and disposal of needles and syringes. How to schedule outpatient diabetes education. Review self-monitoring of blood glucose and home blood glucose goals.

Learner Progress: Not documented in this visit.

Point: Hyperglycemia (Not Started)

Description:
Definition, recognition, treatment and prevention of hyperglycemia.

Learner Progress: Not documented in this visit.

Point: Hypoglycemia (Not Started)

Description:
Definition, recognition, treatment and prevention of hypoglycemia.

Learner Progress: Not documented in this visit.

Point: Glucose Lowering Medications (Not Started)

Description:
When and how to take blood glucose-lowering medications.

Learner Progress: Not documented in this visit.

Topic: Diabetes Zones for Management (Not Started)

Point: Diabetes Zones for Management reviewed (Not Started)

Description:
Diabetes Zones for Management reviewed.

Learner Progress: Not documented in this visit.

Point: Diabetes Zones for Management handout provided (Not Started)

Description:
Diabetes Zones for Management handout provided.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Title: Cardiac Arrhythmia (MCB) (Not Started)

Topic: Treatment for Atrial Fibrillation/Atrial Flutter (MCB) (Not Started)

Point: Chemical cardioversion (MCB) (Not Started)

Description:
Provide written education on why and how a chemical cardioversion is done. As well as accociated risks.

Patient Friendly Description:
Why and how a chemical cardioversion is done and associated risks.

Learner Progress: Not documented in this visit.

Point: Electrical cardioversion (MCB) (Not Started)

Description:
Provide written education on why and how an electrical cardioversion is done. As well as accociated risks.

Patient Friendly Description:
Why and how a electrical cardioversion is done and associated risks.

Learner Progress: Not documented in this visit.

Point: Ablation (MCB) (Not Started)

Description:
Provide written education on the catheter ablation procedure and discharge instructions.

Patient Friendly Description:
How an ablation is done, and what to do after the procedure.

Learner Progress: Not documented in this visit.

Topic: Prevention/Discharge (MCB) (Not Started)

Point: Anticoagulation (MCB) (Not Started)

Description:
Provide written education on anticoagulation use including contraindications, side effects, interactions, and medication safety.

Patient Friendly Description:
Information on taking blood thinners safely.

Learner Progress: Not documented in this visit.

Point: Discharge with A Fib/Flutter (MCB) (Not Started)

Description:
Provide written education on treatment options, home care, and follow up care for discharging with atrial fibrillation.

Patient Friendly Description:
Information on treatment options, home care, and when to call your healthcare provider after going home with atrial fibrillation/flutter.

Learner Progress: Not documented in this visit.

Point: Atrial fib/flutter: stroke prevention (MCB) (Not Started)

Description:
"Provide written education on risk factors, medication, and prevention of A. Fib.
Hyperlink education materials provided to patient/family/caregiver. "

Patient Friendly Description:
Preventing stroke caused by A. Fib.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Topic: What is atrial fibrillation/flutter (MCB) (Not Started)

Point: You have atrial fibrillation (MCB) (Not Started)

Description:
Provide video education on the signs/symptoms of A. Fib, causes, medication(s), risk factors, prevention, and treatment.

Patient Friendly Description:
What to expect if you are diagnosed with A. Fib: causes, symptoms, and treatment.

Learner Progress: Not documented in this visit.

Point: You have Atrial Flutter (MCB) (Not Started)

Description:
Provide written education on the signs/symptoms of A. Flutter, causes, medication(s), risk factors, prevention, and treatment.

Patient Friendly Description:
What to expect if you are diagnosed with A. Flutter: causes, symptoms, and treatment

Learner Progress: Not documented in this visit.

Title: MyChart Bedside Teaching completed (Not Started)

Points For This Title

Point: All MCB content reviewed with patient and teachback completed. The patient verbalized understanding. (Not Started)

Description:
Go over all the Eduction for the patient in the Education activity. The Education that was provided to the patient via MCB was included as well as education that was noted within the Eduction activity as Education that was beneifical to the patient during this hospital stay.

Learner Progress: Not documented in this visit.

Title: Coronary Artery Disease (MCB) (Not Started)

Topic: WS Cardiac Rehabilitation for Arrhythmia (MCB)--This is CAD and AMI Cardiac Rehab Program Information for the Patient (Not Started)

Point: Exercise for a Healthier Heart (MCB) (Not Started)

Description:
Explain how exercising regularly offers many health rewards. Provide exercise tips to beginning a new exercise routine; Set Small goals and aim for 150 minutes a week.

Patient Friendly Description:
This provides healthy heart tips on why exercise is important.

Learner Progress: Not documented in this visit.

Point: WellStar Cardiac Rehabilitation Program (MCB) (Not Started)

Description:
At WellStar, our cardiac rehab patients are individually assessed to review medical history, evaluate risk factors, analyze functional abilities and set goals. Ongoing assessments are conducted to ensure patients are making progress toward their goals, educational needs are being met, and any problems or concerns are being addressed with the referring physician.

Patient Friendly Description:
This will help you better understand Cardiac Rehabilitation. At WellStar, our cardiac rehab programs provide education, supervised exercise, lifestyle modification and emotional support to help patients increase physical fitness, reduce cardiac symptoms and improve health and wellbeing.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Cardiac Rehabilitation: Emotional Issue (MCB) (Not Started)

Description:
Explain how having heart disease can be stressful. Encourage patient not to ignore feelings of sadness, worry, and depression. Patient should know when to ask for help and/or support.

Patient Friendly Description:
This will explain some emotional feelings related to heart disease.

Learner Progress: Not documented in this visit.

Topic: Heart Healthy Diet- DASH Diet (MCB) (Not Started)

Point: Eating Heart Healthy Food: Using DASH Plan (MCB) (Not Started)

Description:
Review diet information and explain that eating a low salt, low fat and low cholesterol diet with plenty of fruits and vegetables can reduce risk of complications from CAD.

Patient Friendly Description:
This will help you follow a healthy eating plan that can reduce your risk of complications associated with Coronary Artery Disease.

Please watch video/read over the material and let anyone on your Care Team know if there are any questions by marking below.

If you understand all material, mark I understand below.

Learner Progress: Not documented in this visit.

Topic: Questions your patient may have for you (MCB) (Not Started)

Point: Questions your patient may have about the AMI (MCB) (Not Started)

Description:
This is information about diet, exercise and medications for patients and it encourages them to ask staff questions.

Patient Friendly Description:
After reading this, you can write down any questions that you have for staff under the Notes section as a reference.

Learner Progress: Not documented in this visit.

Topic: Coronary Artery Disease (MCB) (Not Started)

Point: Recognizing signs and symptoms of Heart Disease (MCB) (Not Started)

Description:
Provide written education on the signs/symptoms of CAD, causes, medication(s), risk factors, prevention and treatment.

Patient Friendly Description:
This will explain some of the causes of Coronary Artery Disease.

Learner Progress: Not documented in this visit.

Point: Understanding Coronary Artery Disease (MCB) (Not Started)

Description:
Give patient written information on CAD. Explain the definition of CAD, causes, signs and symptoms.

Patient Friendly Description:
This will inform you of what to expect if you are diagnosed with Coronary Artery Disease (CAD).

Please watch video/read over the material and let anyone on your Care Team know if there are any questions by marking below.

If you understand all material, mark I understand below.

Learner Progress: Not documented in this visit.

Topic: Risk factors for Heart Disease (MCB) (Not Started)

Patient Education (continued)

Education (continued)

Point: Tobacco/Smoking Cessation (MCB) (Not Started)

Description:
Give patient written information on Quitting Smoking

Educate the patient/family/caregiver on smoking cessation and smoking cessation programs offered in the community. Explain effects smoking and second hand smoke have on the body. Encourage the patient to ask people that smoke around him/her to smoke outside or in another room. Refer patient to Cardiopulmonary Rehabilitation, if applicable.

Patient Friendly Description:
This will give you some getting started tips to kick the smoking habit.

This will help you plan how to quit the smoking habit.
Learner Progress: Not documented in this visit.

Title: First-Dose Education (Not Started)

Points For This Title

Point: hydralazine HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: iohexol (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: nitroglycerin (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: Ringer's solution,lactated (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: dextrose (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: dextrose 50 % in water (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: calcium carbonate (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: morphine sulfate (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: hydrocodone/acetaminophen (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: acetaminophen (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: phenylephrine HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: labetalol HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: metoclopramide HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: cyclopentolate HCl (Not Started)

Patient Education (continued)

Education (continued)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: furosemide (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: diclofenac sodium (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: gentamicin sulfate (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: diphenhydramine HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: 0.9 % sodium chloride (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: piperacillin sodium/tazobactam (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: insulin lispro (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: ondansetron (Not Started)

Patient Education (continued)

Education (continued)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: glucagon,human recombinant (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: gadobenate dimeglumine (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: pantoprazole sodium (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: polyethylene glycol 3350 (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: perflutren lipid microspheres (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: fentanyl citrate/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: lidocaine HCl/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: ondansetron HCl/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: tetracaine HCl/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: sodium chloride 0.9 % (flush) (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Title: Congestive Heart Failure (MCB) (Not Started)

Topic: Psycho/Social/Spiritual Support (Not Started)

Point: Stress Management and Support Systems (Not Started)

Description:
Explain the importance of stress management and support systems in diabetes management. Refer to WellStar diabetes support groups, social services, case management or spiritual care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Not Started)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Treatments/Procedures (MCB) (Not Started)

Point: Oxygen (Not Started)

Description:
Educate patient/family/caregiver on why oxygen is needed and how it will be delivered (nasal cannula, mask, etc.). Instruct patient/family/caregiver that the patent should not be smoking while on oxygen.

Learner Progress: Not documented in this visit.

Point: Medical Equipment (Not Started)

Description:
Educate patient/family/caregiver on use of medical equipment and provide educational materials.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Introduction to Heart Failure (MCB) (Not Started)

Description:
Give patient written information on congestive heart failure. Explain the definition of CHF, causes, signs and symptoms, expected length of stay and criteria for discharge.

Patient Friendly Description:
This will inform you of what to expect if you are diagnosed with heart failure.

You will be receiving the Congestive Heart Failure red booklet.

Please watch video/read over the material and let anyone on your Care Team know if there are any questions by marking below.

If you understand all material, mark I understand below.

Learner Progress: Not documented in this visit.

Point: Echocardiogram (Not Started)

Description:
Educate patient/family/caregiver on echocardiograms, to include: what the test is, how the test will be performed, and what to expect during the test.

Learner Progress: Not documented in this visit.

Topic: Pain Management (Not Started)

Point: Pain Medication Actions & Side Effects (Not Started)

Description:
Provide medication specific handouts when available.

Learner Progress: Not documented in this visit.

Point: Pain Rating Scale (Not Started)

Description:
Provide patient with information on the Pain Rating Scale. Explain the rating scale of 0 to 10.

Learner Progress: Not documented in this visit.

Point: Non-Pharmacological Comfort Measures (Not Started)

Description:
Explain there are other ways of controlling pain than medication. The following are suggestions: position change, aromatherapy, deep slow breathing, distraction, quiet environment, imagery, heat therapy and/or cold therapy, laughter, massage, music, physical therapy, and touch therapy.

Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Not Started)

Point: Eating well with High Blood Pressure (MCB) (Not Started)

Description:
Information provided to patient to explain what their diet should consist of when they have Heart Failure.

Patient Friendly Description:
This will help you make heart healthy eating choices if you have a diagnosis with heart failure.

Learner Progress: Not documented in this visit.

Point: Heart Failure:Being Active (MCB) (Not Started)

Description:
Explain to the patient how to be active with heart failure.

Patient Education (continued)

Education (continued)

Patient Friendly Description:
This will explain how to safely be active with heart failure.
Learner Progress: Not documented in this visit.

Point: Heart Failure: Dealing with Sleep problems (MCB) (Not Started)

Description:
Provide tips and ideas to help patient sleep better.

Patient Friendly Description:
This will provide tips on sleeping better with heart faillure.
Learner Progress: Not documented in this visit.

Point: Heart Failure: Know your Baselines (MCB) (Not Started)

Description:
Explain to patient how to identify their baseline and recognize changes.

Patient Friendly Description:
This will help you understand what's normal for you and how to watch for changes.
Learner Progress: Not documented in this visit.

Point: Heart Failure : Know your Zones (Not Started)

Description:
Review heart failure zones with patient and educate them on how to know which zone they are in each day.

Learner Progress: Not documented in this visit.

Point: Dealing with Heart Failure: Helping the patient cope (MCB) (Not Started)

Learner Progress: Not documented in this visit.

Point: Daily Weights (MCB) (Not Started)

Description:
Give written information about daily weights. Instruct the patient to weigh on the same scale every day at the same time, wearing the same amount of clothing. Explain why it is important to check weight. Inform the patient that gaining weight from fluid build up may be an early sign that heart failure is getting worse. The patient should call a care provider if there is a weight gain of more than 2-3 pounds in one day or 4-5 pounds in five days.

Patient Friendly Description:
Information on the importance of Daily weights.
Learner Progress: Not documented in this visit.

Point: How to check your Heart Rate and Blood Pressure (MCB) (Not Started)

Description:
Give patient written information on how to take a pulse. Explain the definition of a pulse, normal range, reason for taking a pulse, where pulses can be found. Demonstrate how to find a pulse. Once found, instruct the patient to count the beats for a full minute. Tell the patient to keep a record of the pulse rate, date and time taken, which site (right/left, wrist/neck) and strength of beats (weak, strong or missing beats).

Patient Friendly Description:
This will explain the importance of understanding your vital signs and show you how to take them.
Learner Progress: Not documented in this visit.

Topic: WellStar Cardiac Rehabilitation (MCB) (Not Started)

Point: Exercise for a Healthier Heart (MCB) (Not Started)

Description:
Explain how exercising regularly offers many health rewards. Provide exercise tips to beginning a new exercise routine; Set Small goals and aim for 150 minutes a week.

Patient Education (continued)

Education (continued)

Patient Friendly Description:
This provides healthy heart tips on why exercise is important.

Learner Progress: Not documented in this visit.

Point: WellStar Cardiac Rehabilitation Program (MCB) (Not Started)

Description:
At WellStar, our cardiac rehab patients are individually assessed to review medical history, evaluate risk factors, analyze functional abilities and set goals. Ongoing assessments are conducted to ensure patients are making progress toward their goals, educational needs are being met, and any problems or concerns are being addressed with the referring physician.

Patient Friendly Description:
This will help you better understand Cardiac Rehabilitation. At WellStar, our cardiac rehab programs provide education, supervised exercise, lifestyle modification and emotional support to help patients increase physical fitness, reduce cardiac symptoms and improve health and wellbeing.

Learner Progress: Not documented in this visit.

Topic: Review Plan of Care (Not Started)

Point: Review Plan of Care - Day 5 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 1 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 2 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 3 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 4 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Topic: Medications (MCB) (Not Started)

Point: Heart Failure Medications (MCB) (Not Started)

Description:
Educate patient on the drug type, purpose for medication, and common side effects.

Educate patient on Prescribed Medications

Patient Friendly Description:
This will inform you of medications that you may be taking if you are diagnosed with Heart Failure.

Learner Progress: Not documented in this visit.

Point: ACE Inhibitors (Not Started)

Description:
Educate patient/family/caregiver on the ACE Inhibitor prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Angiotensin II Receptor Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Angiotensin II Receptor Blockers prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Aspirin (Not Started)

Description:
Give patient written information on Aspirin. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the doctor should be called. Reinforce that this medication should be taken exactly as the doctor has prescribed.

Learner Progress: Not documented in this visit.

Point: Beta Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Beta Blocker prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Digoxin (Not Started)

Description:
Educate patient/family/caregiver on Digoxin and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed. The physician will order a blood test to monitor the concentration of the drug in the patient's blood. The dose of this medication may be changed according to the results of this test.

Learner Progress: Not documented in this visit.

Point: Diuretics (Not Started)

Description:
Educate patient/family/caregiver on the Diuretic prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Inotropes (Not Started)

Description:
Educate patient/family/caregiver on the Inotropes prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Vasodilators (Not Started)

Description:
Educate patient/family/caregiver on the Vasodilator prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Topic: Prevention / Discharge (MCB) (Not Started)

Point: Community Resources (Not Started)

Description:
Give written information on available community resources. Refer to Social Services or Case Management, if needed.

Learner Progress: Not documented in this visit.

Point: Home Health Care Services (Not Started)

Description:
Give patient written information on Home Health Care Services that have been arranged. Review the role of the home care nurse and when to expect the first visit. Refer to Case Management or Social Services, if needed.

Learner Progress: Not documented in this visit.

Point: Follow-up Appointments (Not Started)

Description:
Give the patient/family written information on their next appointment and when to make follow-up appointments. Reinforce importance of making and keeping the appointments. If appointments were made during the visit, give the patient a written reminder of the time and location.

Learner Progress: Not documented in this visit.

Point: Influenza Vaccine (Not Started)

Description:
Educate the patient/family/caregiver on obatining a yearly influenza vaccine.

Learner Progress: Not documented in this visit.

Point: Discharge Medications (Not Started)

Description:
Ensure that there are no barriers to obtain medications prior to discharge. Notify Care Coordination if there are any needs for additional resources prior to discharging the patient.

Learner Progress: Not documented in this visit.

Point: When to Call the Doctor (MCB) (Not Started)

Patient Education (continued)

Education (continued)

Description:
Provide written documentation instructing the patient to call the doctor if the patient has:

1. Ankles and legs that become more swollen.
2. Shoes and socks that get tight suddenly.
3. Shortness of breath that does not go away with rest.
4. Weight gain of 2 - 3 pounds in one day.
5. Weight gain of 4 - 5 pounds in one week.
6. No energy for normal activities.
7. Dizziness or weakness.
8. Yellowish or blue green vision.
9. Heartbeat changes (feels like a butterfly in the chest).
10. Chest pain.
11. Blurred vision.
12. Passing out.
13. Cough that does not go away.

Patient Friendly Description:
Heart Failure symptoms to know and when to call your healthcare provider.
Lifestyle changes to help you feel and live better with Heart Failure.

Learner Progress: Not documented in this visit.

Point: Review Discharge Plan (Not Started)

Description:
Review the discharge plan with patient and primary care giver including: diet, activity, medications, and special precautions. Refer to Case Management, if needed.

Learner Progress: Not documented in this visit.

Point: Smoking Cessation (Not Started)

Description:
Educate the patient/family/caregiver on smoking cessation and smoking cessation programs offered in the community. Explain effects smoking and second hand smoke have on the body. Encourage the patient to ask people that smoke around him/her to smoke outside or in another room. Refer patient to Cardiopulmonary Rehabilitation, if applicable.

Learner Progress: Not documented in this visit.

Point: Diet Instructions for CHF Prevention (Not Started)

Description:
Review diet information and explain that eating a low fat and low cholesterol diet with plenty of fruits and vegetables can reduce their chance of suffering a future heart attack.

Learner Progress: Not documented in this visit.

Topic: Heart Failure Discharge Instructions (Not Started)

Point: Follow-up Appointments (Not Started)

Description:
Give the patient/family written information on their next appointment and when to make follow-up appointments. Reinforce importance of making and keeping the appointments. If appointments were made during the visit, give the patient a written reminder of the time and location.

Learner Progress: Not documented in this visit.

Point: Daily Weights (MCB) (Not Started)

Description:
Give written information about daily weights. Instruct the patient to weigh on the same scale every day at the same time, wearing the same amount of clothing. Explain why it is important to check weight. Inform the patient that gaining weight from fluid build up may be an early sign that heart failure is getting worse. The patient should call a care provider if there is a weight gain of more than 2-3 pounds in one day or 4-5 pounds in five days.

Patient Friendly Description:
Information on the importance of Daily weights.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: When to Call the Doctor (MCB) (Not Started)

Description:
Provide written documentation instructing the patient to call the doctor if the patient has:

1. Ankles and legs that become more swollen.
2. Shoes and socks that get tight suddenly.
3. Shortness of breath that does not go away with rest.
4. Weight gain of 2 - 3 pounds in one day.
5. Weight gain of 4 - 5 pounds in one week.
6. No energy for normal activities.
7. Dizziness or weakness.
8. Yellowish or blue green vision.
9. Heartbeat changes (feels like a butterfly in the chest).
10. Chest pain.
11. Blurred vision.
12. Passing out.
13. Cough that does not go away.

Patient Friendly Description:
Heart Failure symptoms to know and when to call your healthcare provider.
Lifestyle changes to help you feel and live better with Heart Failure.

Learner Progress: Not documented in this visit.

Point: Review Discharge Plan (Not Started)

Description:
Review the discharge plan with patient and primary care giver including: diet, activity, medications, and special precautions. Refer to Case Management, if needed.

Learner Progress: Not documented in this visit.

Point: Diet Instructions for CHF Prevention (Not Started)

Description:
Review diet information and explain that eating a low fat and low cholesterol diet with plenty of fruits and vegetables can reduce their chance of suffering a future heart attack.

Learner Progress: Not documented in this visit.

Title: General Patient Education (MCB) (Not Started)

Topic: Psycho/Social/Spiritual Support (Not Started)

Point: Stress Management and Support Systems (Not Started)

Description:
Explain the importance of stress management and support systems in diabetes management. Refer to WellStar diabetes support groups, social services, case management or spiritual care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Not Started)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Prevention (MCB) (Not Started)

Patient Education (continued)

Education (continued)

Point: When to Call the Doctor (Not Started)

Description:
Educate patient/family/caregiver on when to call the doctor.

Learner Progress: Not documented in this visit.

Point: Protect Others from Infection (Not Started)

Description:
Educate patient/family/caregiver on respiratory hygiene and cough etiquette. To protect from further infection and to protect others from getting an infection, patient should cover nose and mouth with tissues when coughing. Encourage patient to place used tissues in a plastic bag that will not allow secretions to soak through. Patient should always wash his/her hands after using or handling used tissues.

Learner Progress: Not documented in this visit.

Point: Protect Yourself from Further Infection (MCB) (Not Started)

Description:
Educate patient/family/caregiver that because patient is in a weakened condition he/she needs to avoid others who are sick as to not acquire another illness. Family/caregiver should wear gloves, gown and face shield/eye protection.

Patient Friendly Description:
Information on Flu.
Information on Pneumonia and Pneumococcal Vaccination.
Learner Progress: Not documented in this visit.

Point: Falls education, precautions, prevention at home and in the hospital (MCB) (Not Started)

Description:
Patient was given information on preventing falls both while in the hospital and when they are at home.

Patient Friendly Description:
Things to help you prevent falls while you are in the hospital and when you are home.
Learner Progress: Not documented in this visit.

Point: Prevention Deep Vein Thrombosis after surgery (MCB) (Not Started)

Description:
Educate patient/family/caregiver to prevent DVT and PE after Suergery

Patient Friendly Description:
In the days and weeks after surgery, you have a higher chance of developing a deep vein thrombosis (DVT).
This is a condition in which a blood clot or thrombus develops in a deep vein.
They are most common in the leg. But, a DVT may develop in an arm, or another deep vein in the body.
A piece of the clot, called an embolus, can separate from the vein and travel to the lungs.
A blood clot in the lungs is called a pulmonary embolus (PE).
This can cut off the flow of blood to the lungs.
It is a medical emergency and may cause death.
Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Not Started)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.
Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Not Started)

Patient Education (continued)

Education (continued)

Point: General Self Care (Not Started)

Description:
Instruct patient on self care needs. These may include: hygiene, how to take a blood pressure, how to change a dressing, etc.

Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Not Started)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.

Learner Progress: Not documented in this visit.

Topic: Medications (MCB) (Not Started)

Point: Antibiotic Education (Not Started)

Description:
If an antibiotic was prescribed, educate patient/family/caregiver on the antibiotics prescribed. Explain how antibiotics work in the body. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed

If a viral diagnosis was made, the patient/family was educated on their viral diagnosis and the reason for no antibiotic this visit.

Learner Progress: Not documented in this visit.

Point: Anticoagulant Therapy (Not Started)

Description:
1-Educate patient/family/caregiver on anticoagulant being prescribed and provide educational materials.
2-Explain action of medication, reason for taking, and importance of adherence to correct medication dose and schedule,
3-Explain potential for adverse drug reactions, signs of allergic reaction, potential for drug-drug and drug-food interactions, and when physician should be called.
4-Reinforce that the medication should be taken exactly as the physician has prescribed.
5-Explain importance of maintaining follow-up appointments and adhering to laboratory testing as prescribed by physician.
6-Explain that the dose of the anticoagulant being prescribed may change depending on the results of the laboratory testing.

Learner Progress: Not documented in this visit.

Point: Insulin (MCB) (Not Started)

Description:
Educate patient/family/caregiver on the insulin prescribed. Explain how insulin works in the body. Explain the action of insulin, reason for taking, side effects, signs of allergic reaction and when physician should be called. Reinforce that insulin should be taken exactly as the physician has prescribed. Explain the proper storage of insulin, that extreme temperatures can damage insulin and never take insulin that has expired. Explain that the patient's primary care physician may change the dosage depending on the results of blood glucose tests and/or A1C level.

Patient Friendly Description:
This will inform you of why you are prescribed insulin if you have Diabetes Type II.

Learner Progress: Not documented in this visit.

Point: Hypoglycemic Agents (Not Started)

Description:
Educate patient/family/caregiver on the oral and/or injectable hypoglycemic(s) prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, as well as when the physician should be called. Reinforce that this medication(s) should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Non-Steroidal Anti-Inflammatory Drugs (Not Started)

Description:
Educate patient/family/caregiver on the NSAID prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Psychotropic Medications (Not Started)

Description:
Educate patient/family/caregiver on the Psychotropic medication prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: ACE Inhibitors (Not Started)

Description:
Educate patient/family/caregiver on the ACE Inhibitor prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Angiotensin II Receptor Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Angiotensin II Receptor Blockers prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Beta Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Beta Blocker prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Digoxin (Not Started)

Description:
Educate patient/family/caregiver on Digoxin and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed. The physician will order a blood test to monitor the concentration of the drug in the patient's blood. The dose of this medication may be changed according to the results of this test.

Learner Progress: Not documented in this visit.

Point: Diuretics (Not Started)

Description:
Educate patient/family/caregiver on the Diuretic prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Inotropes (Not Started)

Patient Education (continued)

Education (continued)

Description:
Educate patient/family/caregiver on the Inotropes prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Vasodilators (Not Started)

Description:
Educate patient/family/caregiver on the Vasodilator prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Antibiotics (Not Started)

Description:
Educate patient/family/caregiver on the Antibiotics prescribed. Explain how antibiotics works in the body. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Medication purpose, side effects, schedule, administration (MCB) (Not Started)

Description:
Discussed purpose and possible side effects of medication.

Learner Progress: Not documented in this visit.

All Flowsheets

Flowsheets (all recorded)

Risk for Readmission

Row Name	11/23/19 0213				
OTHER					
Risk for Readmission	7 -UE				

User Key

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates
UE	Epic, User	—

Flowsheet Notes

No notes of this type exist for this encounter.

All Scans

Encounter-Level Documents - 11/21/2019:

Electronic signature on 11/21/2019 9:54 AM - E-signed

Encounter-Level E-Signatures:

Hosp Consent for Tx/Assgn of Ben/Fin Res (E-Signature Encounter) - Received on 11/21/2019

CONSENT TO ROUTINE PROCEDURES AND TREATMENTS & FINANCIAL RESPONSIBILITY STATEMENT

Section I **CONSENT TO ROUTINE PROCEDURES AND TREATMENTS**

I consent to routine procedures and treatments at a WellStar Health System "WellStar" facility as an outpatient, inpatient, or emergency department patient, depending on my medical needs. Routine procedures and treatments can include testing (for example, x-rays and blood tests), routine care and procedures (for example, intravenous fluids, injections, or bladder or stomach tubes) and evaluation (for example, interviews and physical exams). However, this consent to routine procedures and treatments does not include consent for other invasive procedures (for example, surgery, amniocentesis, or diagnostic tests such as colonoscopy or those requiring the use of contrast material), consent for blood or blood products, general anesthesia, or my participation in research. These circumstances require a separate consent process. I understand it is the responsibility of my physician or surgeon to obtain any required separate consent(s).

I understand that I may receive treatment and healthcare services given by WellStar employees (such as nurses and technicians) and by physicians and other independent medical professionals on the medical staff of WellStar facilities (for example, Emergency Department physicians, radiologists, and surgeons) who are NOT WellStar employees. I understand that the healthcare services provided by these independent medical professionals, using independent medical judgment, at a WellStar facility in no way create any type of employment, partnership, or other relationship other than as an independent contractor. These independent contractors are responsible for their own actions and WellStar shall not be liable for the acts or omissions of any such independent contractors.

While I am a patient at a WellStar facility, I understand that I may be observed by or receive healthcare services from students enrolled in training programs. Students are supervised by instructors, WellStar employees, or other independent medical professionals on the medical staff of the WellStar facility, depending on the type of training program the students are enrolled in. I understand that I have the right to request that someone other than a student provide my care.

I understand that I retain no property rights to any tissue samples or bodily fluids removed from my body (specimens) as part of procedures or treatment given to me. I further understand that WellStar has no obligation to preserve these specimens; that it will retain or dispose of specimens according to its usual practices.

I understand that I have the right to ask questions about a proposed procedure or treatment (including the identity of any person providing or observing treatment and his or her affiliation with WellStar) at any time. I understand the practice of medicine is not an exact science and diagnosis and outcomes of treatment depend upon my medical condition and may involve risks or even death. I understand that no guarantees can be made as to the outcome of my care.

Section II **MATERNITY PATIENTS**

If I deliver an infant(s) while I am a patient at a WellStar facility, I agree that this same Consent to Routine Procedures and Treatments applies to the infant(s).

Section III **EMERGENCY OR LABORING PATIENTS**

In accordance with federal law, I understand my right to receive an appropriate medical screening examination performed by a physician or other qualified medical professional to determine whether I am suffering from an emergency medical condition. If such a condition exists, stabilizing treatment will be provided within the capabilities of this WellStar facility and its staff, even if I cannot pay for these services, do not have medical insurance coverage, or am not entitled to Medicare or Medicaid.

Eugene George Maurice

Patient's Signature	Relationship to Patient
Eugene Maurice	E. L. [illegible]

Section IV **ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY**

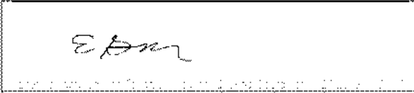
I assign any right I may have to receive payment from a health insurance plan, ERISA, Medicare, Medicaid, Social Security, or other payor(s) for services rendered by WellStar and the medical professionals caring for me during my treatment. I understand that I am financially responsible for all healthcare services, including amounts that are not covered by my health insurance plan or payor, as appropriate, based on the terms of the health plan contracts or the law. For example, the payment of non-covered services, deductibles, and co-payments is the patient's responsibility. For healthcare services provided by independent medical professionals, I understand that I will receive separate bills and that I am responsible for paying them. I agree to provide WellStar with all health insurance coverage information if I choose to use my insurance for payment of services. I agree to respond to all requests for benefit information and complete any forms required by my

insurance plan. I am responsible for understanding and following the terms of my health insurance plan. I authorize WellStar and its medical professionals to submit appeals for payment, including arbitration and formal complaints, on my behalf as required by my insurance company. I also understand that I am financially responsible for collection costs if my account becomes delinquent and that all delinquent accounts will bear interest at the legal rate, unless prohibited by law. I understand that WellStar may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options.

For Medicare/Medicaid Patients: I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf. I assign payment for the unpaid charges to WellStar or the independent medical professionals providing healthcare services to me. I understand that I am responsible for any remaining balance not covered by other insurance.
If I am signing this form and am not the patient, I understand that I am also responsible for and agree to pay charges not covered by the assignments made in this Section IV, including any Medicare deductibles

Section V **FINANCIAL ASSISTANCE STATEMENT**

It is WellStar's policy to provide medical care at no cost to qualified members of the WellStar-served communities, and to provide significantly discounted medical care to certain qualified members of our communities faced with financial hardship due to medical misfortune, according to policy. I understand that if payment of my bill creates a financial hardship, I may qualify for assistance with all or part of my medical expenses associated with my treatment at a WellStar facility and that I can call 678-838-5750 for more information.



(Patient Initials)

Section VI **CONSENT TO PHOTOGRAPHY AND VIDEOTAPING**

Sometimes, WellStar facilities and physicians use patient photographs and videos for identification, clinical, educational, or research-related purposes. These photographs, recordings or videos could be in digital or other formats and may be reproduced for scientific or treatment reasons. I consent to having photographs, recordings or videos taken for patient care, educational, research, or other clinical benefits.

Section VII **NOTICE REGARDING RELEASE OF HEALTH INFORMATION**

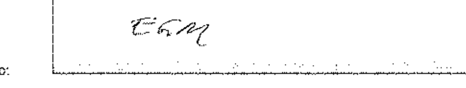
As explained in WellStar's Notice of Privacy Practices, WellStar may use and disclose medical information including privileged information (i.e. mental health, alcohol/drug abuse or HIV/AIDS), to physicians or other healthcare providers for the purposes of providing treatment, and to payors for the purposes of payment for medical treatment. HIPAA also permits WellStar and its affiliated companies to use medical information for healthcare operations. I expressly authorize WellStar's use and disclosure of my medical information as described in this Section VII.

Section VIII **INPATIENT INFORMATION**

I have received a copy of the Patient Admission Packet that includes "Patient Rights and Responsibilities" and information regarding Advance Care Planning. If I am a Medicare beneficiary, I have also received a notice entitled "Important Message from Medicare."

Section IX **ADVANCE DIRECTIVE**

I have an Advance Directive (Choose One)
Yes:



No:

If yes; I will provide a copy to WellStar. I have been advised that WellStar does not honor Advance Directives in Pre-admission Testing or in the Outpatient Diagnostics and Treatment setting.

Section X **PERSONAL VALUABLES**

I understand that WellStar is not liable or responsible for lost or damaged personal belongings and valuables (for example, money, jewelry, hearing aids, or dentures) unless placed in a WellStar safe. I will ask family members or friends to take home my personal belongings and valuables. I also understand and will inform the staff if I have dentures, eyeglasses, contact lenses, prosthetics or other items that I need to retain close by for personal functioning to assure safekeeping.

Section XI **CONSENT TO CONTACT**

All Scans (continued)

Encounter-Level E-Signatures: (continued)

By providing a telephone number, I expressly consent and authorize WellStar Health System, any practitioner or clinical provider as well as any of their related entities, agents, or contractors including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I am providing today, have provided previously, or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have to the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number, I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically and claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical, and education information including exchange news, changes to health care law, health care coverage, care followup, and other health care opportunities, goods, and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C. § 7701, et seq. By providing an email address, I represent that I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a telephone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify Provider immediately of any change in telephone number or email address.

I confirm that I have read and understood and accept the terms of this document, that I am the patient or patient's representative, and that I am authorized to sign this document and accept its terms.

Name: Eugene George Maurice

Patient's Signature	Relationship to Patient
[signature]	[signature]

Name: Eugene George Maurice
MRN: 561253820
HAR: 40001544144

All Scans (continued)

Encounter-Level E-Signatures: (continued)

END OF REPORT