

INTERDISCIPLINARY PATIENT / FAMILY TEACHING RECORD

Addressograph: _____

Learner: Patient Family Significant Other
 Comprehensive/ability to grasp concepts: High Medium Low
 Readiness to learn: Eager to learn Extremely anxious
 Asks questions Denies need for education
 Knowledge of current health status: No knowledge Partial understanding Full understanding

Barriers to learning:
 Physical Emotional Language Reading Ability
 Religious Cultural Changes in short term memory None
Preferred Learning Methods:
 Reading Video
 Lecture Demo/Practice

Spiritual/religious practices: _____ Signature/Title: _____ Date: _____ Time: _____

KNOWLEDGE DEFICIT RELATED TO:		P = Psychosocial/Spiritual PM= Pain Management/(Pain Flow Sheet)	OUTCOME CODE	METHOD:
A = Cardio/Pul Teaching B = Diabetes Education C = Discharge/Community Resource Referral D = Disease Process E = Equipment (safe & effective use) F = Medication (safe & effective use)	G = Food/Drug Interaction H = Infection Control I = Nutrition/Diet Therapy J = Plan of Care K = Pre/Post Op Education L = Reportable Incidents M = Procedures/Tests N = Rehab Services O = Wound/Dressing	Q = Advance Directives R = Smoking Cessation S = Personal Hygiene T = Pt/Family (their) responsibilities V = Basic Health Practices & Safety W = End of Life Care Z = Restraints/alternatives to restraints	1 = Learner demonstrates/verbalizes understanding of topic. 2 = Learner requires more teaching. 3 = Support services required.	V = Video L = Literature D = Demonstration E = Discussion 6 = Case Manager 7 = Imaging 8 = Physician 9 = Social Worker 10 = Other: _____
			THE LEARNER IS: F = Family Member P = Patient S = Other	DISCIPLINE: 1 = Nursing 2 = Cardiopulmonary 3 = Pharmacy 4 = Dietary 5 = Rehabilitation

KNOWLEDGE DEFICIT	LECTURE/TOPIC	DATE TAUGHT	OUTCOME CODE LEARNER	METHOD	COMMENTS	DISCIPLINE	SIGNATURE AND TITLE OF TEAM MEMBER
	Assessed Learning Needs Including Patient Preferences						
F	<input type="checkbox"/> Safe/effective use of medication						
E	<input type="checkbox"/> Safe/effective use of med. equipment						
G	<input type="checkbox"/> Food/drug interaction						
I	<input type="checkbox"/> Nutrition, modified diet						
PM	<input type="checkbox"/> Pain Assessment/Management						
C	<input type="checkbox"/> Discharge Planning						
C	<input type="checkbox"/> Community resources; When/how to obtain future treatment						
J	<input type="checkbox"/> Plan of Care						
K	<input type="checkbox"/> Pre and post op teaching						
S	<input type="checkbox"/> Good hygiene and grooming						
N	<input type="checkbox"/> Rehab techniques						
O	<input type="checkbox"/> Skin/wound care						
O	<input type="checkbox"/> Ostomy care						
A	<input type="checkbox"/> Respiratory care: IS, cough & deep breath						
A	<input type="checkbox"/> Congestive Heart Failure / AMI						
	Activity Level						
	Diet-Lipid lowering						
	Discharge Medication						
	Follow-up Appt.						
	Weight Monitor						
	What to do if symptoms worsen						
R	<input type="checkbox"/> Smoking Cessation						
F	<input type="checkbox"/> Pneumovax/Influenza Vaccine						
A	<input type="checkbox"/> Open heart pre-op teaching						
D	<input type="checkbox"/> Stroke Education						



INTERDISCIPLINARY PLAN OF CARE

ADMITTING DIAGNOSIS: _____

DATE: _____ SIGNATURE OF NURSE ADMITTING PATIENT: _____

DATE/INITIALS		PATIENT PROBLEMS	INTERVENTIONS/APPROACHES	EXPECTED OUTCOME/GOALS	DATE INITIALS
ENTRY	PRIORITY #				
		1. ANXIETY RELATED TO <input type="checkbox"/> Hospitalization <input type="checkbox"/> Disease process <input type="checkbox"/> Operative/other procedures <input type="checkbox"/> Perceived threat to self concept or health status <input type="checkbox"/> Alteration in body image <input type="checkbox"/> Ineffective coping <input type="checkbox"/> Other _____	<input type="checkbox"/> Encourage pt/family/significant other to verbalize feelings <input type="checkbox"/> Give information re: operative/other procedures as patient is ready to learn <input type="checkbox"/> Answer questions appropriately and concisely <input type="checkbox"/> Encourage pt/family/significant other input into plan of care <input type="checkbox"/> Offer appropriate reassurance and support <input type="checkbox"/> Refer to Case Manager <input type="checkbox"/> Refer to Behavioral Medicine /Psychiatry <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient/family/significant other will verbalize decreased feelings of anxiety during hospitalization <input type="checkbox"/> Other _____	
		2. ASPIRATION. POTENTIAL RELATED TO <input type="checkbox"/> Alteration in level of consciousness <input type="checkbox"/> Depressed cough & gag reflex <input type="checkbox"/> Presence of tracheostomy or ET tube <input type="checkbox"/> Tube feedings <input type="checkbox"/> Gastric problems <input type="checkbox"/> Swallowing difficulties <input type="checkbox"/> Other _____	<input type="checkbox"/> HOB elevated at least 45 degrees <input type="checkbox"/> Order foods of appropriate consistency <input type="checkbox"/> Give nothing by mouth if swallowing is severely impaired <input type="checkbox"/> Provide rest periods during meals <input type="checkbox"/> Have suction equipment at bedside. Stay with pt during meals <input type="checkbox"/> Teach patient/family/significant other methods to prevent and/or treat aspiration <input type="checkbox"/> Refer to Speech Therapy <input type="checkbox"/> Refer to Nutrition Services <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient will not aspirate during hospitalization <input type="checkbox"/> Other _____	
		3. BLEEDING. POTENTIAL RELATED TO <input type="checkbox"/> Medication <input type="checkbox"/> Operative/other procedures <input type="checkbox"/> Trauma <input type="checkbox"/> Disease process <input type="checkbox"/> Procedure <input type="checkbox"/> Other _____	<input type="checkbox"/> Observe for changes in mental status <input type="checkbox"/> Monitor vital signs <input type="checkbox"/> Observe for changes in skin color, turgor, and temperature <input type="checkbox"/> Monitor for tachycardia/hypotension <input type="checkbox"/> Increase fluid intake as per Physician order <input type="checkbox"/> Monitor & record blood loss <input type="checkbox"/> Monitor CBC <input type="checkbox"/> Monitor PT/PTT <input type="checkbox"/> Monitor procedural site for further signs/symptoms of bleeding <input type="checkbox"/> For bleeding apply direct manual pressure to procedural site & notify physician <input type="checkbox"/> Report any changes of VS and/or procedural site to physician <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient's bleeding will be controlled & vital signs returned to baseline within normal limits <input type="checkbox"/> Other _____	
		4. BOWEL FUNCTION ALTERED RELATED TO <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Incontinence <input type="checkbox"/> Other _____	<input type="checkbox"/> Administer meds as ordered <input type="checkbox"/> Offer appropriate diet as per physician order <input type="checkbox"/> Increase fluid intake as per physician order <input type="checkbox"/> Per order assist to commode or provide bedpan <input type="checkbox"/> Encourage ambulation if activity permits <input type="checkbox"/> Provide privacy <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient will return to normal elimination patterns prior to discharge <input type="checkbox"/> Other _____	
		5. CARDIAC STATUS/ALTERED RELATED TO <input type="checkbox"/> Decrease/Increase cardiac output <input type="checkbox"/> Fluid volume overload <input type="checkbox"/> Chest Pain/Angina <input type="checkbox"/> Cardiac Arrhythmias <input type="checkbox"/> AICD/Pace Maker Malfunctions <input type="checkbox"/> Other _____	<input type="checkbox"/> Administer meds/IV drips as ordered <input type="checkbox"/> Monitor intake/output daily weights <input type="checkbox"/> Monitor electrolytes/EKG's and cardiac enzymes as ordered <input type="checkbox"/> Monitor vital signs/Hemodynamics and report changes <input type="checkbox"/> Monitor rhythm strips and report changes to physicians <input type="checkbox"/> Report malfunctioning pacer and AICD to Physician. <input type="checkbox"/> Provide educational information on diagnosis and community resources. <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient will have optimal cardiac functions as evidenced by: <input type="checkbox"/> Free of chest pain <input type="checkbox"/> Pacer/AICD functioning optimally <input type="checkbox"/> Clear lung sounds <input type="checkbox"/> Lower extremity edema minimized or eliminated <input type="checkbox"/> Cardiac output will be maintained at an optimum level <input type="checkbox"/> Other _____	
		6. CIRCULATION. IMPAIRED RELATED TO <input type="checkbox"/> Trauma <input type="checkbox"/> Disease process <input type="checkbox"/> Operative/other procedures <input type="checkbox"/> Invasive lines <input type="checkbox"/> Medication <input type="checkbox"/> Other _____	<input type="checkbox"/> Assess vital signs, B/P and peripheral pulses & report changes to physician <input type="checkbox"/> Monitor skin color, turgor and temperature & report any changes to physician <input type="checkbox"/> Position for comfort <input type="checkbox"/> Administer medications as ordered <input type="checkbox"/> Maintain strict I&O <input type="checkbox"/> Daily weight as ordered <input type="checkbox"/> Monitor electrolytes <input type="checkbox"/> Antiembolic hose as ordered/SCD <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient's circulation will return to optimal level prior to discharge <input type="checkbox"/> Other _____	

DATE/ INITIALS		PATIENT PROBLEMS	INTERVENTIONS/APPROACHES	EXPECTED OUTCOME/GOALS	DATE INITIALS
ENTRY	PRIORITY				RESOLVED
		7. COMFORT, ALTERED RELATED TO <input type="checkbox"/> Pain <input type="checkbox"/> Illness <input type="checkbox"/> Operative/other procedures <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Itching <input type="checkbox"/> Sleep pattern disturbance <input type="checkbox"/> Environment <input type="checkbox"/> Other _____	<input type="checkbox"/> Initiate pain assessment using Pain Assessment Tool <input type="checkbox"/> Reassess pain & document effectiveness using Pain Assessment Tool <input type="checkbox"/> Instruct patient on use of pain scale <input type="checkbox"/> Instruct patient to report symptoms at onset <input type="checkbox"/> Timely administration of Pain Meds as per MD order <input type="checkbox"/> Teach alternate relief measures <input type="checkbox"/> relaxation <input type="checkbox"/> position changes <input type="checkbox"/> distraction <input type="checkbox"/> breathing exercise <input type="checkbox"/> Refer to PT/OT <input type="checkbox"/> Provide written information on Pain Management <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient verbalizes satisfaction with pain management during their hospital stay & is able to carry out ADL <input type="checkbox"/> Other _____	
		8. COMMUNICATION DEFICIT RELATED TO <input type="checkbox"/> CVA <input type="checkbox"/> Head trauma <input type="checkbox"/> Maxillofacial impairment <input type="checkbox"/> Visual impairment <input type="checkbox"/> Speech pathology <input type="checkbox"/> Impaired receptive language <input type="checkbox"/> Impaired expressive language <input type="checkbox"/> Swallowing disorder <input type="checkbox"/> Endotracheal tube <input type="checkbox"/> Trach tube <input type="checkbox"/> Language barrier <input type="checkbox"/> Visual/hearing impairment <input type="checkbox"/> Other _____	<input type="checkbox"/> Allow extra time for giving care to ensure successful communication <input type="checkbox"/> Use pictures, items, gestures to aid in communication as needed <input type="checkbox"/> Refer to physical therapy and/or occupational therapy <input type="checkbox"/> Refer to Speech Therapy <input type="checkbox"/> Utilize translators <input type="checkbox"/> Utilize AT&T Language Line <input type="checkbox"/> Obtain enhanced audio phone receiver from page operator <input type="checkbox"/> Utilize closed caption TV <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient will communicate at optimal level prior to discharge <input type="checkbox"/> Other _____	
		9. FLUID AND ELECTROLYTE BALANCE, ALTERED RELATED TO <input type="checkbox"/> Trauma <input type="checkbox"/> Disease process <input type="checkbox"/> Operative/other procedures <input type="checkbox"/> Dialysis <input type="checkbox"/> Other _____	<input type="checkbox"/> Assess for signs and symptoms of dehydration and/or volume overload <input type="checkbox"/> Record intake / output <input type="checkbox"/> Daily weight as ordered <input type="checkbox"/> Monitor vital signs including B/P & heart rate <input type="checkbox"/> Assess neurological status for orientation, confusion, lethargy, responsiveness & report changes to physician <input type="checkbox"/> Monitor lab values & report abnormal results to physician <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient shows improved hydration during hospitalization <input type="checkbox"/> Patient's electrolytes return to acceptable range as identified by physician prior to discharge <input type="checkbox"/> Other _____	
		10. INFECTION, POTENTIAL RELATED TO <input type="checkbox"/> Incision <input type="checkbox"/> Invasive lines <input type="checkbox"/> Indwelling foley catheter <input type="checkbox"/> Ventilator associated <input type="checkbox"/> Disease process <input type="checkbox"/> Immunocompromised <input type="checkbox"/> Other _____	<input type="checkbox"/> Assess for signs and symptoms of infection <input type="checkbox"/> Monitor vital signs and lab values <input type="checkbox"/> Assess IV sites <input type="checkbox"/> Cap all invasive lines to maintain closed system <input type="checkbox"/> Assess sputum for changes <input type="checkbox"/> Assess dressings & change prn &/or per physician order <input type="checkbox"/> Provide foley care/pericare <input type="checkbox"/> Infection Control Nurse <input type="checkbox"/> Assess all incisions for signs & symptoms of infection <input type="checkbox"/> Maintain sterility during operative/other procedure <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient will be free from infection during hospitalization <input type="checkbox"/> Other _____	
		11. KNOWLEDGE DEFICIT RELATED TO <input type="checkbox"/> Health or disease process <input type="checkbox"/> Diabetes <input type="checkbox"/> Environment <input type="checkbox"/> Procedures/treatments <input type="checkbox"/> Discharge education <input type="checkbox"/> ADL <input type="checkbox"/> Medication <input type="checkbox"/> Nutrition <input type="checkbox"/> Advance Directives <input type="checkbox"/> Food/Drug interactions <input type="checkbox"/> Other _____	<input type="checkbox"/> Assess patient/family/significant other readiness to learn <input type="checkbox"/> Orient patient/family/significant other to environment <input type="checkbox"/> Encourage patient/family/significant other to verbalize questions and concerns <input type="checkbox"/> Explain pending tests/procedures <input type="checkbox"/> Teach appropriate ADL activities <input type="checkbox"/> Provide videotapes <input type="checkbox"/> Provide teaching brochures <input type="checkbox"/> Obtain demonstration <input type="checkbox"/> Refer to Clinical Pharmacist <input type="checkbox"/> Refer to Nutrition Services <input type="checkbox"/> Refer to Risk Management <input type="checkbox"/> Refer to Business Office <input type="checkbox"/> Refer to Case Management <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient/family/significant other will verbalize and/or demonstrate understanding of teaching <input type="checkbox"/> Patient/family/significant other will verbalize understanding of discharge instructions: <input type="checkbox"/> Medications <input type="checkbox"/> Bathing <input type="checkbox"/> Wound care <input type="checkbox"/> Activity <input type="checkbox"/> Diet <input type="checkbox"/> Food/Drug interactions <input type="checkbox"/> Follow-up care <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____	
		12. MOBILITY, IMPAIRED RELATED TO <input type="checkbox"/> Muscular weakness <input type="checkbox"/> Paralysis of extremities <input type="checkbox"/> Operative/Other procedures <input type="checkbox"/> Disease process <input type="checkbox"/> Altered mental status <input type="checkbox"/> Functional decline <input type="checkbox"/> Other _____	<input type="checkbox"/> Provide Range of Motion <input type="checkbox"/> Assist with ambulation and transfers <input type="checkbox"/> Turn patient every 2 hrs <input type="checkbox"/> Instruct patient/family/significant other in transfer, turning and ROM techniques <input type="checkbox"/> Encourage family/significant other participation in care <input type="checkbox"/> Provide diversional activities <input type="checkbox"/> Provide safety measures, siderails up, call button within reach <input type="checkbox"/> Refer to physical therapy and/or occupational therapy <input type="checkbox"/> Initiate wound care consult <input type="checkbox"/> Provide assistive devices as ordered <input type="checkbox"/> Ortho Tech consult <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient will be free of complications such as skin breakdown, contractures, loss of joint mobility during hospitalization <input type="checkbox"/> Patient will attain highest level of functional mobility prior to discharge <input type="checkbox"/> Other _____	

DATE/INITIALS		PATIENT PROBLEMS	INTERVENTIONS/APPROACHES	EXPECTED OUTCOME/GOALS	DATE INITIALS
ENTRY	PRIORITY #				
		13. NEUROLOGICAL STATUS ALTERED RELATED TO <input type="checkbox"/> Neuro checks altered <input type="checkbox"/> Organic Brain Syndrome <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Disease processes <input type="checkbox"/> Medications <input type="checkbox"/> Post Neuro Procedures/Surgeries <input type="checkbox"/> Stroke _____ <input type="checkbox"/> Other _____ _____ _____	<input type="checkbox"/> Reorient to person/place/time <input type="checkbox"/> Monitor neuro checks as ordered <input type="checkbox"/> Maintain patient's safety <input type="checkbox"/> Monitor and report neuro changes immediately. <input type="checkbox"/> Monitor and report signs and symptoms of increase intracranial pressure. i.e. vomiting Headache. blurred vision. <input type="checkbox"/> Monitor vital signs and report abnormalities _____ <input type="checkbox"/> Other _____ _____ _____	<input type="checkbox"/> Pt will return to baseline neurological functioning prior to discharge <input type="checkbox"/> Other _____ _____ _____ _____ _____ _____	
		14. NONCOMPLIANCE RELATED TO <input type="checkbox"/> Lack of recall <input type="checkbox"/> Irrational beliefs <input type="checkbox"/> Lack of interest in learning <input type="checkbox"/> Misinterpretation of information <input type="checkbox"/> Willful behavior <input type="checkbox"/> Lack of knowledge <input type="checkbox"/> Fear <input type="checkbox"/> Medications <input type="checkbox"/> Hx of substance abuse <input type="checkbox"/> Pre-existing diseases/conditions <input type="checkbox"/> Cultural diversity <input type="checkbox"/> Other _____ _____ _____	<input type="checkbox"/> Establish environment conducive to learning <input type="checkbox"/> Actively involve pt/family/significant other in decision making <input type="checkbox"/> Provide rewards for maintenance of positive health behaviors <input type="checkbox"/> Provide pt/family/significant other information on how to find, use and evaluate community resources - i.e. education, support, treatment <input type="checkbox"/> Set clear, mutually agreed upon learning goals <input type="checkbox"/> Provide educational materials <input type="checkbox"/> Assess pt's/family's significant other's ideas about illness as a starting point for education and training <input type="checkbox"/> Refer to Nutrition Services <input type="checkbox"/> Refer to Case Management <input type="checkbox"/> Refer to Behavioral Medicine/ Psychiatry <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Patient/family/significant other will verbalize understanding of: <input type="checkbox"/> Diet <input type="checkbox"/> Medications <input type="checkbox"/> Activity <input type="checkbox"/> Risk & benefits of their decisions <input type="checkbox"/> Other _____ <input type="checkbox"/> Health care professionals will provide every opportunity to inform the pt/family/significant other of the risks & benefits associated with their decisions <input type="checkbox"/> Other _____ _____	
		15. NUTRITION ALTERED R/T <input type="checkbox"/> Poor oral intake <input type="checkbox"/> GI Problems <input type="checkbox"/> Tube feedings <input type="checkbox"/> Difficulty Chewing <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Weight loss <input type="checkbox"/> Disease Process <input type="checkbox"/> Food Allergies/Intolerance <input type="checkbox"/> NPO > 4 Days <input type="checkbox"/> Surgical Patient > 80 Years Old <input type="checkbox"/> Skin Breakdown <input type="checkbox"/> Other _____ _____ _____	<input type="checkbox"/> Complete nutritional assessment <input type="checkbox"/> Provide diet as appropriate for diagnosis/per Physician order <input type="checkbox"/> Provide nutritional supplements/snacks _____ (include #/day) <input type="checkbox"/> Calorie count <input type="checkbox"/> Monitor tolerance/response to <input type="checkbox"/> tube feeding <input type="checkbox"/> TPN/PPN <input type="checkbox"/> Provide education re: <input type="checkbox"/> diet _____ <input type="checkbox"/> food/drug interaction _____ <input type="checkbox"/> Reassess for change in nutritional status every _____ <input type="checkbox"/> Refer to OT _____ <input type="checkbox"/> Refer to Speech Therapy _____ <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Patient will maintain nutritional status as evidenced by: <input type="checkbox"/> Weight maintenance <input type="checkbox"/> Oral intake <input type="checkbox"/> Patient's nutritional status will improve as evidenced by: <input type="checkbox"/> Weight maintenance or loss < 5% <input type="checkbox"/> Improved oral intake to 75 to 100% of trays/supplements <input type="checkbox"/> Initiation/tolerance of nutrition support which meets > 75% of nutritional needs <input type="checkbox"/> Patient will have nutrition support in place on the 5th day of NPO status <input type="checkbox"/> Patient or significant other will understand and follow diet restrictions <input type="checkbox"/> Other _____ _____	
		16. PSYCHOSOCIAL ALTERATIONS/ DISCHARGE PLANNING RELATED TO <input type="checkbox"/> Living will <input type="checkbox"/> Disabling illness <input type="checkbox"/> Lack of family support <input type="checkbox"/> Financial crisis <input type="checkbox"/> ETOH/Drug dependency <input type="checkbox"/> Violence <input type="checkbox"/> Grief / End of Life Care <input type="checkbox"/> Relocation <input type="checkbox"/> Hospitalization <input type="checkbox"/> Spiritual <input type="checkbox"/> Depression / Suicide <input type="checkbox"/> Other _____ _____ _____	<input type="checkbox"/> Initiate end of life guidelines <input type="checkbox"/> Provide education/support re: the dying process & grieving <input type="checkbox"/> Encourage expression of feelings, questions <input type="checkbox"/> Identify existing support systems <input type="checkbox"/> Respect culture, religion, race and values of pt/family/significant other <input type="checkbox"/> Allow patient/family/significant other to express fears and concerns to help identify feelings related to: <input type="checkbox"/> Advance Directives <input type="checkbox"/> Organ Procurement Inquiry <input type="checkbox"/> Terminal condition <input type="checkbox"/> Ethical issues <input type="checkbox"/> Life decisions <input type="checkbox"/> Refer to case management for initial evaluation of placement. Discharge needs <input type="checkbox"/> Other _____ <input type="checkbox"/> Refer to Case Management to arrange for: <input type="checkbox"/> Home Health <input type="checkbox"/> Hospice <input type="checkbox"/> SNF/Subacute <input type="checkbox"/> Transportation <input type="checkbox"/> Nursing Home <input type="checkbox"/> Rehabilitation/Subacute <input type="checkbox"/> Nutrition Program (meals on wheels) <input type="checkbox"/> Durable medical equipment/O2 <input type="checkbox"/> Provide discharge instruction re: living arrangements and other service arranged <input type="checkbox"/> Refer to Pastoral Care to address spiritual needs <input type="checkbox"/> Refer to Business Office <input type="checkbox"/> Refer to Behavioral Medicine/Psychiatry <input type="checkbox"/> Refer to appropriate community resources and/or support services <input type="checkbox"/> Other _____ _____	<input type="checkbox"/> Patient/family/significant other will verbalize increased coping abilities prior to discharge <input type="checkbox"/> Patient/family/significant other will be aware of appropriate discharge arrangements as evidenced by verbalizing what services are being arranged <input type="checkbox"/> Patient will be discharged to an appropriate level of care <input type="checkbox"/> Other _____ _____ _____	

DATE/INITIALS		PATIENT PROBLEMS	INTERVENTIONS/APPROACHES	EXPECTED OUTCOME/GOALS	DATE/INITIALS RESOLVED
ENTRY	PRIORITY				
		17. RESPIRATORY INSUFFICIENCY RELATED TO <input type="checkbox"/> Impaired gas exchange <input type="checkbox"/> Bronchoconstriction <input type="checkbox"/> Shallow respirations <input type="checkbox"/> Retained secretions <input type="checkbox"/> Respiratory distress <input type="checkbox"/> Inadequate ventilation <input type="checkbox"/> Operative/Other procedures <input type="checkbox"/> Trauma <input type="checkbox"/> Disease process <input type="checkbox"/> Other _____	<input type="checkbox"/> Monitor/observe for changes in respiratory status <input type="checkbox"/> Plan care to allow for frequent rest periods <input type="checkbox"/> Observe for signs/symptoms of respiratory distress <input type="checkbox"/> Monitor ABG's as ordered <input type="checkbox"/> Monitor O2 end tidal volume as ordered or SpO2 as ordered <input type="checkbox"/> Position to allow for maximum lung expansion <input type="checkbox"/> Suction as needed <input type="checkbox"/> Auscultate breath sounds and report deviations <input type="checkbox"/> Minimize noxious environmental stimuli <input type="checkbox"/> Monitor response and side effects of prescribed medications O2 by: <input type="checkbox"/> Mask <input type="checkbox"/> Nasal cannula <input type="checkbox"/> Vent mask <input type="checkbox"/> Non rebreather <input type="checkbox"/> Other _____ <input type="checkbox"/> Bronchodilator, mucolytic therapy, hand held nebulizer, inhalers <input type="checkbox"/> Lung inflation: Incentive spirometer, IPPB, including Diaphragmatic Breathing <input type="checkbox"/> Incentive spirometer <input type="checkbox"/> Aerosol, Ultrasonic therapy, side arm nebulizer, mist tent. <input type="checkbox"/> Encourage cough & deep breathing <input type="checkbox"/> Refer to Case Management to arrange for durable medical equipment <input type="checkbox"/> Chest wall manipulation: cpt. postural drainage <input type="checkbox"/> Treat specific cause of respiratory distress with IPPB, mechanical ventilation <input type="checkbox"/> Refer to Pulmonary Rehab <input type="checkbox"/> Other _____	<input type="checkbox"/> Prior to discharge the Patient will demonstrate: <input type="checkbox"/> Improved oxygenation <input type="checkbox"/> Reduced CO2 tension <input type="checkbox"/> Relieve of bronchoconstriction <input type="checkbox"/> Prevention of atelectasis <input type="checkbox"/> Mobilization of secretion <input type="checkbox"/> Relief of respiratory distress <input type="checkbox"/> Improve ventilation <input type="checkbox"/> Other _____	
		18. RESTRAINTS <input type="checkbox"/> Threatens to disrupt medical interventions <input type="checkbox"/> Unable to follow commands to avoid self injury <input type="checkbox"/> Danger to self/others/environment <input type="checkbox"/> Other _____	<input type="checkbox"/> Obtain order for restraints (documentation restraints flowsheet) <input type="checkbox"/> Assess patient every 2 hours for non-violent, non self destructive pt Documentation restraint flowsheet <input type="checkbox"/> Assess patient every 15 minutes for violent, self destructive pt Documentation on restraint flowsheet <input type="checkbox"/> Educate patient/family/significant other on the use of restraints <input type="checkbox"/> Utilize alternatives to restraints as appropriate <input type="checkbox"/> Refer to Behavioral Health/Psychiatry <input type="checkbox"/> Refer to Case Management <input type="checkbox"/> Other _____	<input type="checkbox"/> Maintains patient safety and well being while restrained <input type="checkbox"/> Remove restraints as soon as possible <input type="checkbox"/> Other _____	
		19 SAFETY CONCERNS RELATED TO <input type="checkbox"/> New Equipment <input type="checkbox"/> Disease process <input type="checkbox"/> Environment <input type="checkbox"/> Operative/Other procedures <input type="checkbox"/> High risk for falls <input type="checkbox"/> Medications <input type="checkbox"/> Other _____	<input type="checkbox"/> Orient pt/family/significant other to room equipment (call bell, lights, TV, siderails) <input type="checkbox"/> Provide a safe, clean environment, free of obstacles <input type="checkbox"/> Teach patient/family/significant other proper handling of equipment <input type="checkbox"/> Refer to Physical therapy <input type="checkbox"/> Initiate fall prevention protocol for high risk patients <input type="checkbox"/> Lock wheels on beds/chairs <input type="checkbox"/> Provide education on safe use of medication <input type="checkbox"/> Provide pre/post op education <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient will be discharged without any hospital acquired injury <input type="checkbox"/> Other _____	
		20. SELF CARE DEFICIT RELATED TO <input type="checkbox"/> Impaired cognition <input type="checkbox"/> Impaired motor function <input type="checkbox"/> Immobility <input type="checkbox"/> Chronic disability <input type="checkbox"/> Psychological conditions <input type="checkbox"/> Disease process <input type="checkbox"/> Personal Hygiene <input type="checkbox"/> Other _____	<input type="checkbox"/> Include patient in planning own self-care activities. <input type="checkbox"/> Allow patient enough time to complete activities of daily living <input type="checkbox"/> Encourage patient to participate in any part of activity of daily living <input type="checkbox"/> Provide privacy <input type="checkbox"/> Instruct patient/family/significant other on techniques that may help with activity of daily living <input type="checkbox"/> Refer to Occupational therapy <input type="checkbox"/> Refer to Behavioral Medicine/Psychiatry <input type="checkbox"/> Refer to Case Management <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient will perform activities of daily living appropriate with physical capabilities. <input type="checkbox"/> Other _____	
		21. SKIN INTEGRITY, ALTERED RELATED TO <input type="checkbox"/> Decreased mobility <input type="checkbox"/> Altered nutritional status <input type="checkbox"/> Decreased tissue perfusion <input type="checkbox"/> Disease process <input type="checkbox"/> Medications <input type="checkbox"/> Actual breakdown <input type="checkbox"/> Other _____	<input type="checkbox"/> Assess and document skin condition q shift <input type="checkbox"/> Reposition q 2 hr. with proper body alignment <input type="checkbox"/> Instruct patient on importance of nutrition and mobility <input type="checkbox"/> Refer to Wound Care <input type="checkbox"/> Refer to Nutrition Services <input type="checkbox"/> Relieve pressure points / Prevent Shearing <input type="checkbox"/> Refer to Physical therapy <input type="checkbox"/> Refer to Case Management <input type="checkbox"/> Provide Diabetic Education <input type="checkbox"/> Other _____	<input type="checkbox"/> Patients skin integrity will be maintained or improved during hospitalization <input type="checkbox"/> Other _____	
		22. URINARY ELIMINATION, ALTERED RELATED TO <input type="checkbox"/> Incontinence <input type="checkbox"/> Dribbling <input type="checkbox"/> Disease process <input type="checkbox"/> Urinary retention <input type="checkbox"/> Burning <input type="checkbox"/> Other _____	<input type="checkbox"/> Increase fluid intake as ordered <input type="checkbox"/> Assist with elimination per physician order <input type="checkbox"/> Provide opportunity for frequent elimination <input type="checkbox"/> Monitor intake and output per physician order <input type="checkbox"/> Inform patient/family/significant other of special orders regarding urine collection <input type="checkbox"/> Palpate bladder for distention <input type="checkbox"/> Teach perineal exercise to help regain urinary control <input type="checkbox"/> Reassure that initial "dribbling" or burning is to be expected after catheter is removed <input type="checkbox"/> Other _____	<input type="checkbox"/> Patient will maintain urinary output of 30cc per hour or greater <input type="checkbox"/> Patient verbalizes no post voiding discomfort <input type="checkbox"/> Other _____	

