

Activity Pursuits Altered

GOAL: Activities as desired until discharge achieved

Introduce to activities offered _____

Interview to interests _____

DATE: _____

ADL Decline

GOAL: Improve ADL skills to achieve Discharge

Plan _____

Rehab: _____

Grooming: _____

Dressing: _____

Dining: _____

Ambulation: _____

Siderails: _____

Transfer: _____

Toileting: _____

DATE: _____

Amputation: BK or AK

GOAL: Heal without complications

Assess wound site _____

Rehab: _____

Nsg: _____

Restorative: _____

Dressing: _____

Monitor for depression _____

DATE: _____

Anemia

GOAL: Minimize complications

Monitor for complications _____

Monitor nutritional intake _____

Labs: _____

V.S. each shift: _____

DATE: _____

Resident: _____

Anticoagulant Therapy

GOAL: No complications

Monitor for s/s bleeding: _____

Protect from injury: _____

Labs/ Meds as ordered: _____

Pro times as ordered: _____

Safety measures: _____

DATE: _____

Behavior Symptom

GOAL: Fewer symptoms

Redirect by: _____

Assess Internal Contributors: _____

Assess External Contributors: _____

R/O Delirium: _____

DATE: _____

Bladder Training/Foley

GOAL: Increased continence to achieve Discharge

Plan _____

Encourage fluids _____

Foley Cath Care: _____

Toilet type: _____

Scheduled toileting: _____

Bladder training: _____

R/O cause of incontinence: _____

I&O: _____

DATE: _____

Bowel Training/Altered Bowel

Elimination

GOAL: Establish bowel routine

Dietary referral: _____

Meds as ordered: _____

Bowel training: _____

Monitor elimination pattern, color, consistency, odor _____

DATE: _____

Room: _____ Adm.# _____

Cancer

GOAL: Achieve physical & mental

comfort

Vital signs: _____

Hospice: _____

Skin status: _____

I&O: _____

Weight/Appetite: _____

Complications: fatigue, attitude, apprehension, N/V: _____

Pain management: _____

DATE: _____

Cardiac

GOAL: No complications

Meds _____

Assess heart rate, B/P, resps _____

Monitor for edema _____

Diet restrictions: _____

Elevate: _____

O2: _____

Monitor endurance/complications _____

Rehab: _____

DATE: _____

CVA/Stroke Rehab

GOAL: Achieve Rehab goals for discharge

Rehab: _____

Grooming: _____

Dressing: _____

Dining: _____

Transfer: _____

Ambulation: _____

Toileting: _____

Siderails: _____

DATE: _____

Cognitive Decline

GOAL: Establish daily routine

Task segments _____

Cue as needed _____

Reality orientation PRN _____

Offer choices _____

Visual cues: _____

Speech therapy: _____

DATE: _____

Dr. _____

Resident: _____

Anticoagulant Therapy

GOAL: No complications

Monitor for s/s bleeding: _____

INITIAL CARE PLAN

Communications Decline

GOAL: Increase ability to communicate

Communication techniques:

Speech Therapy referral:

Evaluate hearing loss:

Check ears for wax:

DATE:

Dehydration/Risk of

GOAL: Consume adequate fluids

I&O

Determine likes/dislikes:

Offer fluids between meals:

Monitor for dehydration:

Specific Gravity

DATE:

Delirium Present

GOAL: Resolve Acute Condition

Meds:

R/O for acute illness/Labs:

Orient PRN

Assess for pain/constipation/UTI

DATE:

Dental Problems

GOAL: Resolve

Meds/TX's:

Monitor appetite:

Assess oral cavity:

Evaluate need for dental exam:

DATE:

Resident: _____

Diabetic Alert

Mood Symptoms

GOAL: Decreased symptoms

GOAL: No complications

Meds:

Diet:

Monitor S/S Hypo/hyperglycemia

Accuchecks as ordered:

Labs as ordered:

DATE:

Discharge Planning

GOAL: Achieve discharge as planned

Interview Resident

Interview Family

Arrange Post-discharge

DATE:

Fall/Safety Risk

GOAL: No injury falls

Assess for contributors: Bps standing, sitting, pain, need to void, meds gait

Encourage to use call light

P.T. referral

Instruct on safety measures

Adaptive Device (OT)

DATE:

Feeding Tube

GOAL: No complications

I&O

T.F. Order

Speech Therapy referral

Assess for placement:

Labs:

DATE:

Room: _____ Adm.# _____

Fracture/Fractured Hip

GOAL: No complications

INITIAL CARE PLAN

Activities:

Cast:

Positioning:

Pain:

Safety Procedures:

Rehab:

DATE:

G.I. Disorder

GOAL: Decreased symptoms

Nutrition:

Meds:

Bowel sounds:

Monitor Bms for consistency, color, odor

I&O

DATE:

Infection Alert

GOAL: Resolve infection

Monitor for S.S. for infections

Tx:

Wound status and progress

DATE:

I.V. Therapy

GOAL: No complications

I&O

I.V. orders:

Weigh every:

Monitor for complications

DATE:

Depression scale:

Meds:

Likes to: _____
 S.S. 1:1 _____

DATE: _____

Nausea and Vomiting

GOAL: Resolve _____

Intake: _____
 Monitor for dehydration: _____
 Document frequency, amount, color/consistency of emesis: _____
 Meds: _____

DATE: _____

Nutrition

GOAL: Achieve/maintain weight of: _____

Intake/Appetite: _____
 Diet: _____
 Weigh q: _____
 S.T. Ref. _____
 Determine likes/dislikes: _____

 Supplements: _____

DATE: _____

Ostomy

GOAL: Participate in ostomy care _____

Ostomy protocol: _____
 Teach self-care: _____
 Monitor for complications: _____
 Monitor for infections at ostomy site: _____

DATE: _____

Resident: _____

Pain

GOAL: Experience less pain _____

Meds: _____

Non-drug interventions: _____

Monitor pain q shift _____
 Assess pain tolerance _____

DATE: _____

Physical Restraints

GOAL: Experience no complications _____

Assess for alternatives: _____
 Restraint reduction initiated: _____
 Restraint order: _____
 Alternatives: _____

DATE: _____

Pressure Sore/Skin at Risk

GOAL: Prevent/heal pressure sores _____

Tx: _____
 Preventive: _____

 Position: _____

 Supplements: _____
 Wound team referral: _____

DATE: _____

Psychosocial Well-being

GOAL: Express satisfaction _____

Orient to facility: _____
 Activities: _____
 1:1 by Social Service: _____
 Customary routine: _____

DATE: _____

Room: _____ Adm.#: _____

Psychotropic Drug Use

GOAL: Benefit without side effects _____

Monitor for side effects: _____

Assess for non-drug interventions: _____
 Trial reduction: _____
 Monitor Behavior or Mood Symptoms

DATE: _____

Renal Failure with Dialysis

GOAL: Experience no complications _____

Weigh: _____
 Assess for S/S infection, hypovolemia _____
 Observe for S/S bleeding _____
 Dialysis schedule: _____
 No BP in shunt arm: _____

DATE: _____

Respiratory/Tracheostomy

GOAL: Maintain patent airway _____

Lung sounds/cough sounds/Resp.: _____
 O2: _____
 Suction: _____
 Trach care: _____
 Meds: _____

DATE: _____

Seizure Disorder

GOAL: Will not injure self or others _____

Seizure precautions: _____
 Meds: _____
 Side rails: _____

DATE: _____

Dr. _____

Skin Condition (non-decub)

GOAL: Resolve

Treatment: _____
 Monitor for infection: _____

Preventive: _____
 Positioning: _____

DATE: _____

Terminal Care

GOAL: Death with dignity

Meds: _____
 1:1 _____

Hospice _____
 Pain Management: _____

Comfort measures: _____
 Treatment: _____

DATE: _____

TPN Therapy

GOAL: No complications

Monitor for infection & complications
 Line type: _____

Flow rate: _____
 TX protocol: _____

Monitor nutrition: _____
 I&O _____

DATE: _____

URI/Pulmonary Disease

GOAL: Resolve

Lung sounds/resp: _____
 Cough status: _____

Level of consciousness: _____

Tx: _____
 Suction: _____

O2 _____

DATE: _____

Resident: _____

UTI Alert

GOAL: Resolve

I&O: _____

Status of continence: _____

Meds / side effects: _____

Urine color, frequency, burning: _____

DATE: _____

Vision Altered

GOAL: Participate in ADL's to optimal level

Verbal cues: _____

Meds: _____

Eye exam: _____

Wears _____

Post-surgical care: _____

DATE: _____

GOAL: _____

DATE: _____

GOAL: _____

DATE: _____

GOAL: _____

DATE: _____

GOAL: _____

DATE: _____

Room: _____ Adm.# _____

GOAL: _____

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Dr. _____