

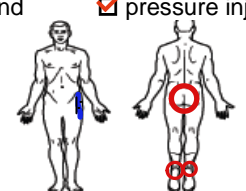
# INITIAL CARE PLAN

Please complete this plan within 48 hours of admission by admission nurse. Review by DON

All problems and goals and interventions will be reviewed and replaced by a comprehensive care plan (21 days after admission)

<b>ADMITTED FOR:</b> <input checked="" type="checkbox"/> Skilled services due to weakness post-surgery Others: _____ <input type="checkbox"/> long-term care due to safety require daily nursing care <input type="checkbox"/> Disease/illness management: _____ <input type="checkbox"/>	<b>ADMISSION GOAL:</b> <input type="checkbox"/> Participate in treatment for _____ <input checked="" type="checkbox"/> Participate in therapy PT/OT _____ <input checked="" type="checkbox"/> Display progress in <u>ambulation and mobility</u> _____ <input type="checkbox"/> _____
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## DISEASE/ ILLNESS MANAGEMENT

<input type="checkbox"/> Diabetic <input type="checkbox"/> Hypertension <input checked="" type="checkbox"/> Post-surgical care <input type="checkbox"/> Seizure <input type="checkbox"/> Respiratory <input type="checkbox"/> Pain <input type="checkbox"/> hemiplegia <input type="checkbox"/> GI problem	<input type="checkbox"/> Catheter <input type="checkbox"/> comatose <input type="checkbox"/> septicemia <input type="checkbox"/> quadriplegia <input type="checkbox"/> pneumonia <input type="checkbox"/> O2 therapy <input type="checkbox"/> Tube feeding <input type="checkbox"/> vomiting	<input checked="" type="checkbox"/> weight loss <input type="checkbox"/> cerebral palsy <input type="checkbox"/> multiple sclerosis <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Alzheimer/ dementia <input type="checkbox"/> on psych medication <input type="checkbox"/> Psychiatric illness <input type="checkbox"/> Using anticoagulant	<input checked="" type="checkbox"/> Nutrition <input checked="" type="checkbox"/> Weakness <input type="checkbox"/> Post CVA <input type="checkbox"/> infection <input type="checkbox"/> on IV medication <input type="checkbox"/> _____	<input checked="" type="checkbox"/> Wound <input checked="" type="checkbox"/> pressure injury 
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**Goal:** Disease/ Illness will be monitored and managed using standards of nursing practices until further instructions

<b>Interventions:</b> Following order for treatments <ul style="list-style-type: none"> <li>▪ Monitor medications: side effects, effectiveness</li> <li>▪ Provide safety environment, properly use devices</li> <li>▪ Monitor for complications of illness</li> </ul>	<ul style="list-style-type: none"> <li>▪ Monitor conditions, progress of illness. Report changes to DON/physician</li> <li>▪ Monitor Lab values and report to the physician</li> <li>▪ Provide comfort and care: _____</li> </ul>
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## ADL/DIETARY MANagements

ADL	DIETARY
<p><b>Problems (circle):</b> require assistance of <u>Grooming</u>  <u>Hygiene</u> <u>Toileting</u> <u>Bathing</u> <u>Dressing</u> Eating</p> <p><b>Goal:</b> All ADL care will be assisted or encouraged for independence until re-evaluated upon comprehensive CP</p> <p><b>Interventions:</b> Assist with ADL and assess for restorative care</p> <ul style="list-style-type: none"> <li>▪ Encourage self-care/participation Setup and monitor</li> <li>▪ Maintain safety precautions due to _____ weakness</li> <li>▪ Provide supportive devices: <u>catheter</u> other: _____</li> <li>▪ Toileting as needed. <u>Monitor for skin issue</u></li> </ul>	<p><b>Problem:</b> <input type="checkbox"/> Tube feeding <input checked="" type="checkbox"/> Regular diet</p> <p><input type="checkbox"/> Mechanical die (circle) t: Soft Pured Clear liquid Regular</p> <p><input type="checkbox"/> Therapeutic diet 9(circle): NAS NCS other: _____</p> <p><b>Goal:</b> Follow dietician's recommendations &amp; physician order for dietary care to assist nutritional intake</p> <p><b>Interventions:</b> Monitor for safety and assist with meals, food consumption</p> <ul style="list-style-type: none"> <li>▪ Monitor intake record &amp; weight. Encourage cooperation</li> <li>▪ Provide diet as ordered. Monitor for safety (swallowing)</li> <li>▪ Provide supportive device(s)</li> </ul>

## SAFETY CARE

**Problems:**  Fall  Elopement Wandering  Ambulation  Transfer  Balance  Locomotion  Using brace/splint

Using mobility devices(circle): manual/ electric wheelchair  walker  can  others \_\_\_\_\_

**Goal:** Safety measurement will be monitored and managed until further instruction of an official care plan

<b>Interventions:</b> Monitor physical safety; follow physician order Provide informed consent to family and resident safety instruction <ul style="list-style-type: none"> <li>▪ Transfer with <u>2</u> staff assist <input type="checkbox"/> Independence <input type="checkbox"/> Lift <input checked="" type="checkbox"/> gait belt</li> <li>▪ Weight bearing (circle that apply): R L: Encourage Discourage</li> <li>▪ Assist/encourage bed mobility</li> </ul>	<ul style="list-style-type: none"> <li>▪ Monitor for fall, unsteady gait, loss balance, be mobility</li> <li>▪ Provided mobility devices: _____</li> <li>▪ Educate/ instruct on how to use: _____</li> <li>▪ Monitor for location</li> <li>▪ Assist with ambulation</li> </ul>
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## PSYCHO SOCIAL WELL/ILL-BEING CARE

<input type="checkbox"/> sad / crying <input type="checkbox"/> aggression <input type="checkbox"/> resist care	<input type="checkbox"/> verbal abuse <input type="checkbox"/> physical abuse <input type="checkbox"/> agitation	<input type="checkbox"/> combative <input type="checkbox"/> Blind <input type="checkbox"/> Deaf	<input type="checkbox"/> Non-English <input type="checkbox"/> Confused <input type="checkbox"/> Non-verbal	<input type="checkbox"/> sexual inappropriate <input type="checkbox"/> Mood fluctuated <input checked="" type="checkbox"/> Cognitive intact	<input type="checkbox"/> Others : _____ _____
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**Goal:** Mood and behavior will be monitored and managed medically through nursing care until further instructions by CP/QA team

<b>Interventions:</b> Provide emotional support for new environment, life style and monitor for safety related to behaviors <ul style="list-style-type: none"> <li>▪ Visit and encourage ventilate feelings. Referral to special care</li> <li>▪ Provide instruction, redirection for episode of behavior</li> <li>▪ Communication hoard</li> </ul>	<ul style="list-style-type: none"> <li>▪ PASSAR recommendation</li> <li>▪ Monitor medications: side effect and effectiveness</li> <li>▪ Provide comfort and safety environment</li> <li>▪ Assess and monitor for cause/ Notify physician of changes</li> <li>▪ Redirect</li> </ul>
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## OTHER SPECIAL CARE INSTRUCTIONS

<input checked="" type="checkbox"/> Therapy service: <u>PT</u> OT ST RT (attached POS for order) <input checked="" type="checkbox"/> Follow the medication administrations and treatment(s) as ordered by physician/ NP (attached POS). Review the MAR and TAR prior administering <input checked="" type="checkbox"/> Follow dietary orders by physician or NP (attached POS)	<input checked="" type="checkbox"/> Follow protocol to care for <input type="checkbox"/> Foley catheter <input type="checkbox"/> Suprapubic catheter <input type="checkbox"/> Ostomy <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Central line <input type="checkbox"/> Oxygen <input type="checkbox"/> pacemaker <input checked="" type="checkbox"/> Wound care <input checked="" type="checkbox"/> Others: <u>skin breakdown protocol</u> <input checked="" type="checkbox"/> weight loss <input type="checkbox"/> _____
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<b>RESIDENT:</b>	<b>ROOM:</b>	<b>PHYSICIAN:</b>
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# PHYSICIAN ORDERS

CPR    DNR    ADVANCED DIRECTIVE

Admitting diagnosis • Z96.641 - Presence of right artificial hip joint • Z47.1 - Aftercare following joint replacement surgery • L89.90 - Pressure ulcer of unspecified site/stage	Allergies (including food, medications) • NKDA • _____ • _____
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## PHYSICIAN ORDER FOR THERAPY

• PT <input checked="" type="checkbox"/> screening <input checked="" type="checkbox"/> Evaluation <input checked="" type="checkbox"/> Treatment	• ST(speech) <input type="checkbox"/> screening <input type="checkbox"/> Evaluation <input type="checkbox"/> Treatment
• OT <input checked="" type="checkbox"/> screening <input checked="" type="checkbox"/> Evaluation <input checked="" type="checkbox"/> Treatment	• RT (respiratory) <input type="checkbox"/> screening <input type="checkbox"/> Evaluation <input type="checkbox"/> Treatment

## PHYSICIAN ORDER FOR DIETARY

<input checked="" type="checkbox"/> Regular <input type="checkbox"/> Mechanical soft <input type="checkbox"/> Pureed <input type="checkbox"/> Bland diet	<input type="checkbox"/> Renal diet <input type="checkbox"/> Clear liquid <input type="checkbox"/> Thicken liquid (circle consistency) honey nectar thin pudding <input type="checkbox"/> Others:	<input type="checkbox"/> No concentrated sweet <input type="checkbox"/> No added salt <input type="checkbox"/> Tube feeding <input type="checkbox"/> Fluid restriction
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## PHYSICIAN ORDER FOR ACTIVITY/MOBILITY/LABS

ACTIVITY/MOBILITY	LABS
<input type="checkbox"/> Bed rest <input type="checkbox"/> Up ad lib <input checked="" type="checkbox"/> Up with assistance <input type="checkbox"/> weight bearing <input type="checkbox"/> non weight bearing <input checked="" type="checkbox"/> limited weight bearing on L (R) <input checked="" type="checkbox"/> As tolerated <input type="checkbox"/> Comfort care ; end-of life care	<input checked="" type="checkbox"/> CBC <input checked="" type="checkbox"/> Chemistry panel <input checked="" type="checkbox"/> Metabolic panels <input type="checkbox"/> EKG <input type="checkbox"/> Finger stick <input type="checkbox"/> INR <input type="checkbox"/> Digoxin <input type="checkbox"/> Serum K <input type="checkbox"/> Anticonvulsant <input type="checkbox"/> Culture for

## PHYSICIAN ORDER FOR SPECIAL NURSING CARE

Follow the nursing care protocols/policies & procedures or manufacturer recommendations for clinical care on (check what applies)

<input type="checkbox"/> Oxygen therapy <input type="checkbox"/> immunizations <input type="checkbox"/> TB test	<input type="checkbox"/> PEG tube <input type="checkbox"/> Ostomy <input type="checkbox"/> Tracheostomy	<input type="checkbox"/> Colostomy <input type="checkbox"/> Foley catheter <input type="checkbox"/> Suprapubic catheter	<input type="checkbox"/> central line <input type="checkbox"/> Port-a-cath <input type="checkbox"/> Pacemaker	<input checked="" type="checkbox"/> wound care <input checked="" type="checkbox"/> skin breakdown <input checked="" type="checkbox"/> weight loss
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## PHYSICIAN ORDER FOR MEDICATIONS/TREATMENT

*Send the orders to pharmacy. Licensed nurses to establish the schedule of administration on the MAR and TAR*

MEDICATIONS	DOSAGE	ROUTE	FREQUENCY	DIAGNOSIS
Tylenol #3 30mg/300mg	1-2 tabs	by mouth	4-6 hours PRN	Right Hip Pain

<b>RESIDENT:</b>	<b>ROOM:</b>	<b>PHYSICIAN:</b>
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