Hospital Center

MULTIDISCIPLINARY PLAN OF CARE:

CRITICAL CARE - UNIT ____________

Diagnosis: ______________________________

Date: ______________ Days in Critical Care ______________

ADDRESSOGRAPH AREA

PATIENT CARE GOALS	PLAN OF CARE
ADEQUATE SEDATION ☐ Yes ☐ No ☐ N/A	☐ Wean ☐ Change ☐ SEDATION VACATION - TIME: ________
PAIN CONTROLLED ☐ Yes ☐ No ☐ N/A	☐ TITRATE ______________ ☐ PRN ______________
PREVENTION OF GASTRITIS ☐ Yes ☐ No ☐ N/A	☐ MEDS ______________ ☐ FEEDS
PREVENTION OF DVT ☐ Yes ☐ No ☐ N/A	☐ Anticoagulants ☐ SCD ☐ IVC Filter
PRESSURE ULCERS ☐ Yes ☐ No	☐ Specialty Bed ☐ Elevate heels ☐ Wound care referral
RESTRAINTS ☐ Yes ☐ No	☐ Orders Complete ☐ Type of restraint ______________
PREVENTION OF INFECTION 1 PA line day ______ 2 Arterial line day ______ 3. TLC line day ______ Foley Catheter ☐ Yes ☐ No	CULTURES ☐ Blood ☐ urine ☐ sputum ☐ catheter tip Antibiotics 1 ______________________ day ______ 2 ______________________ day ______ 3 ______________________ day ______ ☐ Change line ☐ Remove lines ☐ Rewire line ☐ Change Foley catheter ☐ Remove Foley catheter
HEMODYNAMIC STABILITY MAP/HR/SBP Maintained ☐ Yes ☐ No Labs Reviewed	Drips (↑↓) 1. ________ 2. ________ 3. ________ 4. ________ Transfusion: ☐ RBC ☐ Platelets ☐ Cryoprecipitate ☐ FFP Fluid Bolus: ______________ Pacemaker Settings: ______________
ADEQUATE VENTILATION Ventilator Changes ☐ Yes ☐ No ☐ N/A HOB > 30 degrees ☐ Yes ☐ No ☐ N/A	☐ Wean ☐ Extubate ☐ Change settings ______________ ☐ Suctioning frequency ______________ ☐ Bronchoscopy ☐ Trachostomy
OPTIMAL NUTRITION ☐ Yes ☐ No ☐ N/A	☐ NPO ☐ TPN/PPN ☐ PEG ☐ NGT/OGT placement ☐ Tube feeds current rate ____________ target ____________
CENTRAL NERVOUS SYSTEM Mental Status Changes ☐ Yes ☐ No ☐ N/A ICP/CPP Maintained ☐ Yes ☐ No ☐ N/A Seizures ☐ Yes ☐ No ☐ N/A	 ☐ STROKE CARE MAP ☐ Ventriculostomy Drain ☐ Lumbar Drain ☐ Dilantin/Phenobarbital LEVEL ______________
DISCHARGE PLANNING End of Life Issues ☐ Yes ☐ No ☐ N/A Advance Directives ☐ Yes ☐ No ☐ N/A Health care Proxy ☐ Yes ☐ No ☐ N/A	Referrals: ☐ Social work ☐ PT/OT ☐ Rehab ☐ Speech & Swallow Issues: ☐ Ethics Committee ☐ Pastoral Care ☐ Withdrawal of Care Discharge needs: ☐ Skilled Nursing Facility ☐ Home care services ☐ Ventilator - dependent ☐ Other ____________
TESTS/PROCEDURES	☐ CT ☐ TEE ☐ Echo ☐ MRI ☐ EEG ☐ OR ____________
COMPLICATIONS ☐ Yes ☐ No ☐ N/A (List) 1. ______________________ 2. ______________________ 3. ______________________	Date/Outcome: (List) 1. ______________________ 2. ______________________ 3. ______________________

TODAY'S CARE GOALS	Signature	Credentials
1.		
2.		
3.		

(02/04)