UNIVERSITY MEDICAL CENTER
INTERDISCIPLINARY

Disclaimer: *The is a suggested interdisciplinary plan of care. This is only a guideline. The patient problem, outcomes and interventions may be changed to meet the individual needs of the patient. Physician/Medical orders supersede all pre-printed interventions identified on the*

ADDRESSOGRAPH

CVA: ____ R/O CVA: _____ TIA: _____ Cerebral Hemorrhage: _____

ESTIMATED LOS: 6 days (with dysphagia)
4 days (without dysphagia)

Date placed on map: _____

INCLUSIONARY CRITERIA:

All patients diagnosed with a CVA, R/O CVA, TIA or Cerebral Hemorrhage will be placed on the CVA

CRITERIA FOR REMOVING PATIENTS FROM

Patients will be removed from the CVA

- Who have a terminal prognosis related to the CVA.
- Who prove not to have had a CVA.

Primary Diagnosis/Procedure: _____

Pertinent Past Medical History: _____

Allergies: _____

Code Status: _____

CONSULTS OR DISCIPLINES INVOLVED/NOTIFIED:

1. Physical Medicine & Rehabilitation - entered into IDX *Initials/Date/Time notified:* _____

2. Social Services - ext. 2110 *Initials/Date/Time notified:* _____

3. Discharge Planning - ext. 2299 *Initials/Date/Time notified:* _____

4. _____ *Initials/Date/Time notified:* _____

5. _____ *Initials/Date/Time notified:* _____

SIGNIFICANT EVENTS THIS ADMISSION:

Date/Event: _____

Date/Event: _____

Date/Event: _____

Date/Event: _____

RN Signature: _____ ***Date/Time:*** _____

RN Signature: _____ ***Date/Time:*** _____

Instructions for Documentation:

OUTCOMES/INTERVENTIONS:

- *Initial when met or completed*
- *Use notation N/A, if not applicable for the timeframe*
- *Initial and circle, if not met or completed*

Supplemental Documentation is required on the Interdisciplinary Progress Record when an outcome or intervention is initialed and circled, indicating it was not met or completed as stated.

CVA

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

ADDRESSOGRAPH

DESIRED OUTCOMES

D = DAYS E = EVENINGS N = NIGHTS

Problem/ Needs	ETD Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient / family verbalizes initial understanding of Dx, procedures, treatments, potential outcome of stroke and plan of care.			
Pain Management	Pain free or verbalizes relief after intervention.			
Neuro Deficit/ Altered LOC	Neurological deficit unchanged or resolving.			
Alteration in Nutrition / Dysphagia	Nutritional needs met. - Able to swallow - Tolerates 50% diet.			
Alterations in ADL's / Decreased Mobility	Bedrest			

Problem/ Needs		D	E	N
Potential Complications	No signs / symptoms: - Infection - Deep Vein Thrombosis			
Alteration in Bowel/Bladder Function	Bowel / Bladder function normal for patient.			
Discharge Plan				
Patient Safety	Remains injury free in a safe environment.			
Skin Integrity	No evidence of skin breakdown.			
Patient/Family Satisfaction	Patient / family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan				

Patient Care Categories		D	E	N
Nutrition	* Diet ordered, if not dysphagic:			
	% of diet consumed: Breakfast _____% Lunch _____% Dinner _____%			

* indicates medical orders needed

INTERVENTIONS (continued)

Patient Care Categories	ETD Date: _____	D	E	N
Assessment & Treatments	Vital signs q 2 hrs. until stable, then q 4 hrs. X 4			
	Neuro assessment q 2 hrs. until stable, then q 4 hrs. x 4 (see Flowsheet) - LOC - Strength / mobility - all extremities - Assess tongue to be midline - Assess smile symmetry - Assess speech and cough quality - Assess swallowing - spontaneously swallows saliva. - swallows saliva on command.			
	*I&O q8 hrs.			
	*Monitor cardiac rhythm.			
	*O_2/Pulse Oximetry			
	Assess for signs of aspiration.			
	Review medications used at home with MD, patient/family.			
	* Initiate thrombolysis protocol if thrombolysis candidate			
	* Administer Antithrombotic Medication: - Aspirin - Anti-platelet agent or - Anticoagulant if indicated			
	Hygiene and Comfort Protocol			
	Peripheral IV Therapy Protocol			
	Pressure Ulcer Preventions Protocol			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Encourage verbalization of fears / concerns.			
	Assess patient / family satisfaction.			
	Learning needs / teaching plan: - Orient to environment / unit - Diagnostic tests / procedures			
	Medications:			
	Activity:			
	Diet:			
	Other:			
Specimens & Diagnostics	*CT scan of head without contrast.			
	Lab / diagnostics results reviewed; MD notified if indicated.			
	Notify M.D. HCT> 45, blood sugar > 200ml/dl.			
	*CBC, Chemscreen with SMA 7 STAT, PT, PTT.			
	*Urine analysis.			
	*Urine C/S if patient is transferred from another facility with catheter.			
	*Schedule Echo for a.m.			
	*Schedule Carotid Ultra-sound if indicated.			
	*CXR PA & LAT			
Safety & Activity	Falls protocol initiated.			
	Bedrest X 12 hrs. HOB 30 degrees.			
	Rehab Therapy Consult: Enter Physical Therapy screen/evaluate into IDX within 2 hrs. of admission.			
	P.T. screen completed by therapist within 24 hrs.			
	Rehab orders obtained, as indicated.			

** indicates medical orders needed*

CVA

Signature	Title	Initial

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ADDRESSOGRAPH

DESIRED OUTCOMES

D = DAYS E = EVENINGS N = NIGHTS

Problem/ Needs	Day 1 Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient / family verbalizes initial understanding of Dx, procedures, treatments, potential outcome of stroke and plan of care.			
Pain Management	Pain free or verbalizes relief after intervention.			
Neuro Deficit/ Altered LOC	Neurological deficit unchanged or resolving.			
Alteration in Nutrition / Dysphagia	Nutritional needs met (choose one): _____ Able to swallow, tolerates 75% or > of diet. _____ Tolerates Tube Feeding			
Alterations in ADL's / Decreased Mobility	Bedrest			

Problem/ Needs		D	E	N
Potential Complications	No signs / symptoms: - Infection - Deep Vein Thrombosis			
Alteration in Bowel/Bladder Function	Bowel / Bladder function normal for patient.			
Discharge Plan				
Patient Safety	Remains injury free in a safe environment.			
Skin Integrity	No evidence of skin breakdown.			
Patient/Family Satisfaction	Patient / family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan				

Patient Care Categories		D	E	N
Nutrition	* Diet ordered, if not dysphagic:			
	% of diet consumed: Breakfast _____% Lunch _____ % Dinner _____ %			
	Assess ability to self feed & follow dysphagic guidelines, if indicated.			
	High risk nutritional assessment completed.			

* indicates medical orders needed

Medical Record # _____ INTERVENTIONS (continued)

Patient Care Categories	Day 1 Date: _____	D	E	N
Assessment & Treatments	Vital signs q 2 hrs. until stable, then q 4 hrs. X 4			
	Neuro assessment q 2 hrs. until stable, then q 4 hrs. x 4 (see Flowsheet) - LOC - Strength / mobility - all extremities - Assess tongue to be midline - Assess smile symmetry - Assess speech and cough quality - Assess swallowing - spontaneously swallows saliva. - swallows saliva on command.			
	*I&O q8 hrs.			
	*Monitor cardiac rhythm.			
	*O2/Pulse Oximetry.			
	*Thigh high TEDS/Venous compression device.			
	Continue thrombolysis protocol if indicated.			
	Consult Advanced Practice Nurse if patient has: - Dysphagia - Complex needs / diagnosis			
	* Administer Antithrombotic Medication: - Aspirin - Anti-platelet agent or - Anticoagulant if indicated			
	Assess for signs/symptoms of bleeding if on antithrombotic.			
	* D/C Foley Catheter			
	Hygiene and Comfort Protocol			
	Peripheral IV Therapy Protocol			
	Pressure Ulcer Preventions Protocol			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Encourage verbalization of fears / concerns.			
	Assess patient/family satisfaction.			
	Assess patient/family level of understanding related to condition & potential lifestyle changes.			
	Learning needs / teaching plan: - Orient to environment / unit - Diagnostic tests / procedures			
	Stroke Education information given to patient/family.			
	Medications: - Antithrombotic: _____ - Other: _____ _____ _____			
	Activity:			
	Diet:			
	Other:			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	Notify M.D. HCT> 45, blood sugar > 200ml/dl.			
	*Schedule Echo if indicated.			
	*Schedule Carotid Ultrasound if indicated.			
Safety & Activity	Falls protocol maintained.			
	*OOB with assist. HOB 30 degrees while in bed. ROM q4 hrs. while awake.			
	Assist to reposition q 2 hrs. & PRN			
	Physical Therapy screen/evaluate entered into IDX			
	P.T. screen completed by therapist within 24 hrs.			
	Rehab orders obtained as indicated			
	*Swallow evaluation completed by therapist if indicated.			

** indicates medical orders needed*

CVA

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ADDRESSOGRAPH

DESIRED OUTCOMES

D = DAYS E = EVENINGS N = NIGHTS

Problem/ Needs	Day 2 Date:	D	E	N
Knowledge Deficit related to plan of care	Patient / family verbalizes knowledge of plan of care.			
	Patient / family demonstrates: - Caregiving skills - ROM exercises - ADL's			
Pain Management	Pain free or verbalizes relief after intervention.			
Neuro Deficit/ Altered LOC	Neurological deficit unchanged or resolving.			
Alteration in Nutrition / Dysphagia	Nutritional needs met (choose one): _____ Able to swallow, tolerates 75% or > of diet. _____ Tolerates Tube Feeding			
Alterations in ADL's / Decreased Mobility	Tolerates OOB to chair with assist.			
	Able to perform ADL's with minimal assist.			

Problem/ Needs		D	E	N
Potential Complications	No signs / symptoms: - Infection - Deep Vein Thrombosis			
Alteration in Bowel/Bladder Function	Bowel / Bladder function normal for patient.			
Discharge Plan	Patient / family verbalizes knowledge of discharge planning process.			
Patient Safety	Remains injury free in a safe environment.			
Skin Integrity	No evidence of skin breakdown.			
Patient/Family Satisfaction	Patient / family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan	Assess home environment/support system			
	Evaluate for: ____ VNS referral ____ Outpatient rehab. ____ Other			
	Investigate insurance benefits/coverage.			
	Assess insurance eligibility for diagnosis.			
	Social Service - referral to: _____ Subacute care _____ Rehab facility _____ Long term care _____ Other			
	Medicaid application conversion initiated.			
	See Focus Notes			

Patient Care Categories		D	E	N
Nutrition	* Diet ordered, if not dysphagic:			
	% of diet consumed: Breakfast _____ % Lunch _____ % Dinner _____ %			
	Assess ability to self feed & follow dysphagic guidelines, if indicated.			
	* KeoFeed inserted if dysphagic			

* indicates medical orders needed

Medical Record # _____ **INTERVENTIONS (continued)**

Patient Care Categories	Day 2 Date: _____	D	E	N
Assessment & Treatments	Vital signs q 8 hrs. and PRN			
	Neuro assessment q 8 hrs. and PRN (see Flowsheet) - LOC - Strength / mobility - all extremities - Assess tongue to be midline - Assess smile symmetry - Assess speech and cough quality - Assess swallowing - spontaneously swallows saliva. - swallows saliva on command.			
	*I&O q8 hrs.			
	*Monitor cardiac rhythm.			
	*D/C oxygen.			
	Assess skin integrity.			
	*Thigh high TEDS/Venous compression device.			
	Assess & document BM; intervene if no BM in 24 hrs.			
	Continue thrombolysis protocol if indicated.			
	* Administer Antithrombotic Medication: - Aspirin - Anti-platelet agent or - Anticoagulant if indicated			
	Assess for signs/symptoms of bleeding if on antithrombotic.			
	* D/C Foley Catheter			
	Hygiene and Comfort Protocol			
	Peripheral IV Therapy Protocol			
	Pressure Ulcer Preventions Protocol			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Encourage verbalization of fears / concerns.			
	Assess patient / family satisfaction.			
	Learning needs / teaching plan: - Assess family's ability to learn caregiving skills			
	- Involve family in ROM and ADL's			
	Review Stroke Education information with patient / family.			
	Medications: - Antithrombotic: _____ - Other: _____ _____ _____			
	Activity:			
	Diet:			
	Other:			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	*PTT, if on heparin: _____ sec.			
	*Pro Time if on coumadin: _____ sec. INR_____			
	Carotid Ultrasound completed.			
	Echo completed.			
Safety & Activity	Falls protocol maintained.			
	*OOB with assist. HOB 30 degrees while in bed. ROM q4 hrs. while awake.			
	Assist to reposition q 2 hrs. & PRN			
	Rehab orders obtained as indicated			
	*P.T. Bedside: ___ Dept.: ___ ROM / Therapeutic Procedures: ___ Dangling / Therapeutic Activities: ___ Gait Training: ___			
	*O.T. Bedside: ___ Dept.: ___			
	*S.L.P. Speech: ___ Swallowing: ___ SEE FOCUS NOTES.			

** indicates medical orders needed*

CVA

Signature	Title	Initial

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ADDRESSOGRAPH

DESIRED OUTCOMES — **D = DAYS E = EVENINGS N = NIGHTS**

Problem/ Needs	Day 3 Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient / family verbalizes knowledge of plan of care.			
	Patient / family demonstrates: - Caregiving skills - ROM exercises - ADL's			
Pain Management	Pain free or verbalizes relief after intervention.			
Neuro Deficit/ Altered LOC	Neurological deficit improved.			
Alteration in Nutrition / Dysphagia	Nutritional needs met (choose one): _____ Able to swallow, tolerates 75% or > of diet. _____ Tolerates Tube Feeding			
Alterations in ADL's / Decreased Mobility	Ambulating with / without assist.			
	Able to perform ADL's with minimal assist.			

Problem/ Needs		D	E	N
Potential Complications	No signs / symptoms: - Infection - Deep Vein Thrombosis			
Alteration in Bowel/Bladder Function	Bowel / Bladder function normal for patient.			
Discharge Plan				
Patient Safety	Remains injury free in a safe environment.			
Skin Integrity	No evidence of skin breakdown.			
Patient/Family Satisfaction	Patient / family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan				

Patient Care Categories		D	E	N
Nutrition	*Diet:			
	% of diet consumed: Breakfast _____% Lunch _____ % Dinner _____ %			
	Assess ability to self feed & follow dysphagic guidelines, if indicated.			
	Intake <50%, notify RD.			
	Feeding Tube: Assess Residual: if > 100% of rate, stop feeding for 2 hrs. and reassess.			

* indicates medical orders needed

Medical Record # _____ **INTERVENTIONS (continued)**

Patient Care Categories	Day 3 Date: _____	D	E	N
Assessment & Treatments	Vital signs q 8 hrs. and PRN			
	Neuro assessment q 8 hrs. and PRN (see Flowsheet) - LOC - Strength / mobility - all extremities - Assess tongue to be midline - Assess smile symmetry - Assess speech and cough quality - Assess swallowing - spontaneously swallows saliva. - swallows saliva on command.			
	*D/C I&O if appropriate			
	*D/C telemetry if rhythm stable			
	Assess skin integrity.			
	*D/C TEDS / venous compression device if ambulatory.			
	Assess & document BM; intervene if no BM in 24 hrs.			
	* Administer Antithrombotic Medication: - Aspirin - Anti-platelet agent or - Anticoagulant if indicated			
	Assess for signs/symptoms of bleeding if on antithrombotic.			
	Hygiene and Comfort Protocol			
	Peripheral IV Therapy Protocol			
	Pressure Ulcer Preventions Protocol			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Encourage verbalization of fears / concerns.			
	Assess patient/family satisfaction.			
	Learning needs / teaching plan: - Rehab program - Dysphagia Guidelines - Modifiable risk factors			
	Review Stroke Education information with patient / family.			
	Medications: - Antithrombotic: _____ - Other: _____ _____ _____			
	Activity:			
	Diet:			
	Other:			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	Assess for signs/symptoms of bleeding if anticoagulated.			
	*PTT if on heparin: _____ sec.			
	*Pro Time if on Coumadin: _____sec. INR_____			
Safety & Activity	Falls protocol maintained.			
	*OOB ambulating with or without assist TID. HOB 30 degress while in bed			
	*P.T. Bedside: ___ Dept.: ___ ROM / Therapeutic Procedures: ___ Dangling Therapeutic Activities: ___ Gait Training: ___			
	*O.T. Bedside: ___ Dept.: ___			
	*S.L.P. Speech: ___ Swallowing: ___ SEE FOCUS NOTES.			

** indicates medical orders needed*

CVA

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

ADDRESSOGRAPH

DESIRED OUTCOMES

D = DAYS E = EVENINGS N = NIGHTS

Problem/ Needs	Day 4 Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient / family verbalizes knowledge of: - Plan of Care - Medications - Diet / Hydration needs - Rehab Program - Risk factors contributing to stroke - Signs / symptoms of stroke			
Pain Management	Pain free or verbalizes relief after intervention.			
Neuro Deficit/ Altered LOC	Neurological deficit improved.			
Alteration in Nutrition / Dysphagia	Nutritional needs met (choose one): _____ Able to swallow, tolerates 75% or > of diet. _____ Tolerates Tube Feeding			
Alterations in ADL's / Decreased Mobility	Ambulating with / without assist.			
	Able to perform ADL's with minimal assist.			

Problem/ Needs		D	E	N
Potential Complications	No signs / symptoms: - Infection - Deep Vein Thrombosis			
Alteration in Bowel/Bladder Function	Bowel / Bladder function normal for patient.			
Discharge Plan	Discharge plan completed and communicated to patient/family (non-dysphagic)			
Patient Safety	Remains injury free in a safe environment.			
Skin Integrity	No evidence of skin breakdown.			
Patient/Family Satisfaction	Patient / family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan	Evaluation completed for placement, if not dysphagic: _____ Rehab. _____ Subacute care _____ Long term care _____ Other			

Patient Care Categories		D	E	N
Nutrition	*Diet:			
	% of diet consumed: Breakfast _____% Lunch _____% Dinner _____%			
	Assess ability to self feed & follow dysphagic guidelines, if indicated.			
	Intake <50%, notify RD.			
	*peg inserted if still Dysphagic			
	Feeding Tube: Assess Residual: if > 100% of rate, stop feeding for 2 hrs. and reassess.			

* indicates medical orders needed

Medical Record # _____ **INTERVENTIONS (continued)**

Patient Care Categories	Day 4 Date: _____	D	E	N
Assessment & Treatments	Vital signs q 8 hrs. and PRN			
	Neuro assessment q 8 hrs. and PRN (see Flowsheet) - LOC - Strength / mobility - all extremities - Assess tongue to be midline - Assess smile symmetry - Assess speech and cough quality - Assess swallowing - spontaneously swallows saliva. - swallows saliva on command.			
	Assess skin integrity.			
	Assess & document BM; intervene if no BM in 24 hrs.			
	Consider consult with Advanced Practice Nurse if not progressing with Plan of Care (i.e., dysphagic without peg, complex needs, or discharge barriers).			
	* Administer Antithrombotic Medication: - Aspirin - Anti-platelet agent or - Anticoagulant if indicated			
	Assess for signs/symptoms of bleeding if on antithrombotic.			
	Hygiene and Comfort Protocol			
	Peripheral IV Therapy Protocol			
	Pressure Ulcer Preventions Protocol			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Encourage verbalization of fears / concerns.			
	Assess patient/family satisfaction.			
	Review Stroke Education information with patient / family.			
	Learning needs / teaching plan: - Dysphagia Guidelines - peg care, tube feeding - Rehab program - Assistive Devices			
	Discharge instructions: - Signs / symptoms of stroke - Food & drug interactions - MD follow-up - Modifiable risk factors			
	Medications: - Antithrombotic: _____ - Other: _____ _____ _____			
	Activity:			
	Diet:			
	Other:			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	*PTT if on heparin: _____ sec.			
	*Pro Time if on coumadin _____ sec. INR _____			
Safety & Activity	Falls protocol maintained.			
	*OOB ambulating with or without assist TID.			
	*P.T. Bedside: ___ Dept.: ___ ROM / Therapeutic Procedures: ___ Dangling / Therapeutic Activities: ___ Gait Training: ___			
	*O.T. Bedside: ___ Dept.: ___			
	*S.L.P. Speech: ___ Swallowing: ___ SEE FOCUS NOTES.			

** indicates medical orders needed*

CVA

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ADDRESSOGRAPH

DESIRED OUTCOMES

D = DAYS E = EVENINGS N = NIGHTS

Problem/ Needs	Day 5 Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient / family verbalizes knowledge of: - Plan of Care - Medications - Diet / Hydration needs - Rehab Program - Risk factors contributing to stroke - Signs / symptoms of stroke			
Pain Management	Pain free or verbalizes relief after intervention.			
Neuro Deficit/ Altered LOC	Neurological deficit improved.			
Alteration in Nutrition / Dysphagia	Nutritional needs met (choose one): _____ Able to swallow, tolerates 75% or > of diet. _____ Tolerates Tube Feeding			
Alterations in ADL's / Decreased Mobility	Ambulating with / without assist.			
	Able to perform ADL's with minimal assist.			

Problem/ Needs		D	E	N
Potential Complications	No signs / symptoms: - Infection - Deep Vein Thrombosis			
Alteration in Bowel/Bladder Function	Bowel / Bladder function normal for patient.			
Discharge Plan	Discharge plan completed and communicated to patient / family.			
	Ischemic Stroke/TIA Patient discharged on antithrombotic medication.			
	Discharged (non-dysphagic).			
Patient Safety	Remains injury free in a safe environment.			
Skin Integrity	No evidence of skin breakdown.			
Patient/Family Satisfaction	Patient / family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan	Evaluation completed for placement: _____ Rehab. _____ Subacute care _____ Long term care _____ Other			
	Discharge to:			

Patient Care Categories		D	E	N
Nutrition	*Diet:			
	% of diet consumed: Breakfast _____% Lunch _____ % Dinner _____ %			
	Assess ability to self feed & follow dysphagic guidelines, if indicated.			
	Intake <50%, notify RD.			
	Feeding Tube: Assess Residual: if > 100% of rate, stop feeding for 2 hrs. and reassess.			

Medical Record # _____ **INTERVENTIONS (continued)**

Patient Care Categories	Day 5 Date: _____	D	E	N
Assessment & Treatments	Vital signs q 8 hrs. and PRN			
	Neuro assessment q 8 hrs. and PRN (see Flowsheet) - LOC - Strength / mobility - all extremities - Assess tongue to be midline - Assess smile symmetry - Assess speech and cough quality - Assess swallowing - spontaneously swallows saliva. - swallows saliva on command.			
	Assess skin integrity.			
	Assess & document BM; intervene if no BM in 24 hrs.			
	* Administer Antithrombotic Medication: - Aspirin - Anti-platelet agent or - Anticoagulant if indicated			
	Assess for signs/symptoms of bleeding if on antithrombotic.			
	Review hydration needs if indicated.			
	Hygiene and Comfort Protocol			
	Peripheral IV Therapy Protocol			
	Pressure Ulcer Preventions Protocol			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Encourage verbalization of fears / concerns.			
	Assess patient/family satisfaction.			
	Review Stroke Education information with patient / family.			
	Learning needs / teaching plan: - Dysphagia Guidelines - peg care, tube feeding - Rehab program - Assistive Devices			
	Discharge instructions: - Signs / symptoms of stroke - Food & drug interactions - MD follow-up - Modifiable risk factors			
	Medications: - Antithrombotic: _____ - Other: _____ _____ _____			
	Activity:			
	Diet:			
	Other:			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	*PTT if on heparin: _____ sec.			
	*Pro Time if on coumadin _____ sec. INR _____			
Safety & Activity	Falls protocol maintained.			
	*OOB ambulating with or without assist TID.			
	*P.T. Bedside: ___ Dept.: ___ ROM / Therapeutic Procedures: ___ Dangling / Therapeutic Activities: ___ Gait Training: ___			
	*O.T. Bedside: ___ Dept.: ___			
	*S.L.P. Speech: ___ Swallowing: ___ SEE FOCUS NOTES.			

** indicates medical orders needed*

CVA

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

ADDRESSOGRAPH

DESIRED OUTCOMES

D = DAYS E = EVENINGS N = NIGHTS

Problem/ Needs	Day 6 Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient / family verbalizes knowledge of: - Plan of Care - Medications - Diet / Hydration needs - Rehab Program - Risk factors contributing to stroke - Signs / symptoms of stroke			
Pain Management	Pain free or verbalizes relief after intervention.			
Neuro Deficit/ Altered LOC	Neurologic status stable.			
Alteration in Nutrition / Dysphagia	Tolerates tube feeding			
	Nutritional needs met.			
Alterations in ADL's / Decreased Mobility	Ambulating with / without assist.			
	Able to perform ADL's with minimal assist.			

Problem/ Needs		D	E	N
Potential Complications	No signs / symptoms: - Infection - Deep Vein Thrombosis			
Alteration in Bowel/Bladder Function	Bowel / Bladder function normal for patient.			
Discharge Plan	Discharged (if dysphagic discharge day 7).			
	Discharge plan completed and communicated to patient / family.			
	Ischemic Stroke/TIA Patient discharged on antithrombotic medication.			
Patient Safety	Remains injury free in a safe environment.			
Skin Integrity	No evidence of skin breakdown.			
Patient/Family Satisfaction	Patient / family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan	Evaluation completed for placement: _____ Rehab. _____ Subacute care _____ Long term care _____ Other			
	Discharge to:			

Patient Care Categories		D	E	N
Nutrition	*Diet:			
	% of diet consumed: Breakfast _____% Lunch _____ % Dinner _____ %			
	Assess ability to self feed & follow dysphagic guidelines, if indicated.			
	Intake <50%, notify RD.			
	Feeding Tube: Assess Residual: if > 100% of rate, stop feeding for 2 hrs. and reassess.			

* indicates medical orders needed

Medical Record # _____ **INTERVENTIONS (continued)**

Patient Care Categories	Day 6 Date: _____	D	E	N	Patient Care Categories		D	E	N
Assessment & Treatments	Vital signs q 8 hrs. and PRN				*Teaching & Psychosocial*	Encourage verbalization of fears / concerns.			
	Neuro assessment q 8 hrs. and PRN (see Flowsheet) - LOC - Strength / mobility - all extremities - Assess tongue to be midline - Assess smile symmetry - Assess speech and cough quality - Assess swallowing - spontaneously swallows saliva. - swallows saliva on command.					Assess patient/family satisfaction.			
						Review Stroke Education information with patient / family.			
						Learning needs / teaching plan: - Dysphagia Guidelines - peg care, tube feeding - Rehab program - Assistive Devices			
	Assess skin integrity.					Discharge instructions: - Signs / symptoms of stroke - Food & drug interactions - MD follow-up - Modifiable risk factors			
	Assess & document BM; intervene if no BM in 24 hrs.					Medications: - Antithrombotic: _____ - Other: _____ _____ _____ _____			
	* Administer Antithrombotic Medication: - Aspirin - Anti-platelet agent or - Anticoagulant if indicated					Activity:			
	Assess for signs/symptoms of bleeding if on antithrombotic.					Diet:			
						Other:			
					Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
						*PTT if on heparin: _____ sec.			
						*Pro Time if on coumadin _____ sec. INR _____			
					Safety & Activity	Falls protocol maintained.			
						*OOB ambulating with or without assist TID.			
						*P.T. Bedside: ___ Dept.: ___ ROM / Therapeutic Procedures: ___ Dangling / Therapeutic Activities: ___ Gait Training: ___			
						*O.T. Bedside: ___ Dept.: ___			
						*S.L.P. Speech: ___ Swallowing: ___ SEE FOCUS NOTES.			
	Hygiene and Comfort Protocol								
	Peripheral IV Therapy Protocol								
	Pressure Ulcer Preventions Protocol								
	* Respiratory Care provided. (See Respiratory Care Record)								

** indicates medical orders needed*

CVA

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

ADDRESSOGRAPH

DESIRED OUTCOMES

D = DAYS E = EVENINGS N = NIGHTS

Problem/ Needs	Day 7 Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient / family verbalizes knowledge of: - Plan of Care - Medications - Diet / Hydration needs - Rehab Program - Risk factors contributing to stroke - Signs / symptoms of stroke			
Pain Management	Pain free or verbalizes relief after intervention.			
Neuro Deficit/ Altered LOC	Neurologic status stable.			
Alteration in Nutrition / Dysphagia	Tolerates tube feeding			
	Nutritional needs met.			
Alterations in ADL's / Decreased Mobility	Ambulating with / without assist.			
	Able to perform ADL's with minimal assist.			

Problem/ Needs		D	E	N
Potential Complications	No signs / symptoms: - Infection - Deep Vein Thrombosis			
Alteration in Bowel/Bladder Function	Bowel / Bladder function normal for patient.			
Discharge Plan	Discharged			
	Discharge plan completed and communicated to patient / family.			
	Ischemic Stroke/TIA Patient discharged on antithrombotic medication.			
Patient Safety	Remains injury free in a safe environment.			
Skin Integrity	No evidence of skin breakdown.			
Patient/Family Satisfaction	Patient / family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan	Discharge to:			

Patient Care Categories		D	E	N
Nutrition	*Diet:			
	% of diet consumed: Breakfast _____% Lunch _____ % Dinner _____ %			
	Assess ability to self feed & follow dysphagic guidelines, if indicated.			
	Intake <50%, notify RD.			
	Feeding Tube: Assess Residual: if > 100% of rate, stop feeding for 2 hrs. and reassess.			

* indicates medical orders needed

Medical Record # _____ **INTERVENTIONS (continued)**

Patient Care Categories	Day 7 Date: _____	D	E	N
Assessment & Treatments	Vital signs q 8 hrs. and PRN			
	Neuro assessment q 8 hrs. and PRN (see Flowsheet) - LOC - Strength / mobility - all extremities - Assess tongue to be midline - Assess smile symmetry - Assess speech and cough quality - Assess swallowing - spontaneously swallows saliva. - swallows saliva on command.			
	Assess skin integrity.			
	Assess & document BM; intervene if no BM in 24 hrs.			
	* Administer Antithrombotic Medication: - Aspirin - Anti-platelet agent or - Anticoagulant if indicated			
	Assess for signs/symptoms of bleeding if on antithrombotic.			
	Hygiene and Comfort Protocol			
	Peripheral IV Therapy Protocol			
	Pressure Ulcer Preventions Protocol			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Encourage verbalization of fears / concerns.			
	Assess patient/family satisfaction.			
	Review Stroke Education information with patient / family.			
	Learning needs / teaching plan: - Dysphagia Guidelines - peg care, tube feeding - Rehab program - Assistive Devices			
	Discharge instructions: - Signs / symptoms of stroke - Food & drug interactions - MD follow-up - Modifiable risk factors			
	Medications: - Antithrombotic: _____ - Other: _____ _____ _____			
	Activity:			
	Diet:			
	Other:			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	*PTT if on heparin: _____ sec.			
	*Pro Time if on coumadin _____ sec. INR _____			
Safety & Activity	Falls protocol maintained.			
	*OOB ambulating with or without assist TID.			
	*P.T. Bedside: ___ Dept.: ___ ROM / Therapeutic Procedures: ___ Dangling Therapeutic Activities: ___ Gait Training: ___			
	*O.T. Bedside: ___ Dept.: ___			
	*S.L.P. Speech: ___ Swallowing: ___ SEE FOCUS NOTES.			

** indicates medical orders needed*