UNIVERSITY MEDICAL CENTER INTERDISCIPLINARY

is a suggested interdisciplinary plan of Disclaimer: The 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: Date placed on map: 6 days (with dysphagia) 4 days (without dysphagia) 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: Initials/Date/Time notified: Social Services - ext. 2110 3. Discharge Planning - ext. 2299 Initials/Date/Time notified: Initials/Date/Time notified: Initials/Date/Time notified: ____ SIGNIFICANT EVENTS THIS ADMISSION: Date/Event: _____ Date/Event: _____ Date/Event: RN Signature: Date/Time: RN Signature:

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.

Date/Time:

	Signature Title	Title	Ini	itial							
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ignature Requirin	g Co-Signature	Date/Shift	Initial	Title		1					
						1		ADDRESSOGRAPH	NITC.		
Problem/	ETD		DES	D	E	N	OMES Problem/	D = DAYS E = EVENINGS N = NIC	D	E	N
Needs	Date:						Needs				L
Knowledge	Patient / family understanding	of Dx, proced	iures,				Potential	No signs / symptoms: - Infection			
Deficit related to plan of care	treatments, po and plan of car		ne of stroke				Complications	- Deep Vein Thrombosis	+	_	\vdash
					Γ		1	no ser any to any that a con-			
								Bowei / Bladder function normal for	T		
Pain	Pain free or ve intervention.	erbalizes reliet	after				Alteration in Bowel/Bladder	patient.			\vdash
Management							Function	in the second second			
	Neurological d	eficit unchang	ged or	+	-	+	Discharge	To again			
Neuro Deficit/ Altered LOC	resolving.			+	1	-	Plan				
Altered Loc											
	1			1	L						
Alteration in	- Able to swal	low									
Nutrition / Dysphagia	- Tolerates 50)% diet.		+	+	+	Patient Safety	Remains injury free in a safe environment.			
	10116										
Alterations in	Bedrest				Ī	Ī		No evidence of skin breakdown.	+	_	+
ADL's/		3.100		+	T	1	Skin Integrity		_		1
Decreased Mobility										L	
							Patient/Family	Patient / family verbalizes satisfaction with hospital stay/care.			
	1 m 1 m 1 m 1 m 1 m 1 m 1 m 1 m 1 m 1 m						Satisfaction				
			INTERV	ENT	ION	S (C	ontinued on bad	ck)	1		
Patient Care				P	E	N	Patient Care Categories		D	E	N
Categories	1cis n	cetavi o i can S		+	\dagger	\dagger		* Diet ordered, if not dysphagic:	+	T	T
Discharge Plan	1000						Nutrition	% of diet consumed:			
	1 3 5							Breakfast%			
								Lunch % Dinner %			
	1				1	1	1	ACTIVITY OF A SOLD THAT HE SEE NO. DATE:		1	1

INTERVENTIONS (continued)

Patient Care	1	P	E	N	Patient Care	\$1.00 mm (1.00 mm)	D	E	N
Categories	Date:	-	_	-	Categories				-
	Vital signs q 2 hrs. until stable, then				1	Encourage verbalization of fears /	-	-	
Assessment				_	Teaching	concerns.	1		
&	Neuro assessment q 2 hrs. until stable,				8	Assess patient / family satisfaction.			
Treatments	then q 4 hrs. x 4 (see Flowsheet)	1	1	1	Psychosocial				
* .	- LOC			1		Learning needs / teaching plan:	T		Т
	- Strength / mobility - all extremities			1		- Orient to environment / unit			
	- Assess tongue to be midline	1	1	1		- Diagnostic tests / procedures			
	- Assess smile symmetry			1	I I have been	Medications:	+	-	\vdash
	- Assess speech and cough quality			1		McGicatoris.			
						A ath site or	+	-	⊢
	- Assess swallowing			1		Activity:	1		
. 273	 spontaneously swallows saliva. 			8.5	MAD DETRICE SE		_	_	┖
F 5	- swallows saliva on command.					Diet:			
	*1&O q8 hrs.				1				
		1				Other:			Т
	*Monitor cardiac rhythm.				1	The second second second second			
1 . 1	note:						_	-	\vdash
la l	*O ₂ /Pulse Oximetry	+		_	1	I real response to the control of			
	2, 4,000		l			519- 10 PM- 11 P	9		
	Accord for class of application	+	-	-	1			1	
	Assess for signs of aspiration.			1					
7		+-	_	-	1			1	
	Review medications used at home		-		L value apara	The same of the sa			
mental property	with MD, patient/family.				I			1	1
	* Initiate thrombolysis protocol if					the same of the sa			1
	thrombolysis candidate								
	* Administer Antithrombotic Medication:							l	ı
	- Aspirin			1					1
	- Anti-platelet agent	350	97 C			e se ilik kir iki si gekbur			
			1957			Luine :		1	1
	Or Antique subort if indicated		l						1
	- Anticoagulant if indicated	+	_	-	1			1	1
1				1					_
				1		*CT scan of head without contrast.			
				1	Specimens	Lab / diagnostics results reviewed; MD	20.00	1 13	
					8	notified if indicated.	1		
Secretary in the second	Transfer and the complete complete complete and the compl			1	Diagnostics	Notify M.D. HCT> 45, blood sugar	+	\vdash	+
	Stag is not self-built where it				Diagnosics	> 200ml/dl.		100	
	Property Color of		2.	.076			+	-	+-
			1			*CBC, Chemscreen with SMA 7 STAT,			1
		1	1	1		PT, PTT.	_		1
		1	1	1	100000	*Urine analysis.		_	_
	The contract of the part of the contract of th					*Urine C/S if patient is transferred from			
	11. Santon: 1 4810 acr 22 m sh	1				another facility with catheter.			1
	and the same of th			1	1	*Schedule Echo for a.m.	\top		
		1	1	1	1	*Schedule Carotid Ultra-sound if indicated			+
				1	1	*CXR PA & LAT	+	-	+
	The second secon				1	CARTAGLAI	+-	-	+
	V 81 PREST LUCESCO TREAT	0.000	100		1			1	
		(and		1			-		4
	1			1		Falls protocol initiated.			
					Safety				1
	AND THE RESIDENCE OF THE PROPERTY OF THE PROPE		C.C.	1	&	Bedrest X 12 hrs. HOB 30 degrees.	1		
	and the second of the second o	1			Activity	T 75 M T 71	1	-	1
			1	138		Rehab Therapy Consult:			1
		105		180	1	Enter Physical Therapy screen/evaluate		100	1
	The second secon								
						into IDX within 2 hrs. of admission.	+-	+-	+
			1			P.T. screen completed by therapist		1	
	28 - 32 - 102 (Brt.)				1	within 24 hrs.	1	-	1
	Control of the Contro			1		Rehab orders obtained, as indicated.			
	War and the second of the second						1		
	Hygiene and Comfort Protocol	T		T	1		T		T
	Peripheral IV Therapy Protocol	+	 	+-	1			1	
	Penpheral IV Therapy Protocol	1	1	1	1			1	
	December 111000 December 11100	+-	-	+-	-1				
	Pressure Ulcer Preventions Protocol		1		1			1	
			_	1	4			1	
	* Respiratory Care provided.				1			1	
	(See Respiratory Care Record)			1		1		1	1
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CVA				
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			DES	IPET	0/	ITC	OMES	ADDRESSOGRAPH D = DAYS E = EVENINGS N = NIC	STHS		
Problem/	Day 1		DEG	D	E	N	Problem/	D-DATO E-EVERIMOS W-MI	D	Ε	N
Needs	Date:			1	-	1 "	Needs	30 0.0	1		′*
Needs	Patient / family	verbalizes in	itial	\vdash	-	-	Needs	No signs / symptoms:	+		
Knowledge							Potential	- Infection			
_	understanding							The second secon			
Deficit related	treatments, po		ie of stroke	1			Complications	- Deep Vein Thrombosis	+	_	_
o plan of care	and plan of ca	re.		\vdash	-			200			
				<u> </u>	<u> </u>			Bowel / Bladder function normal for			
	Pain free or ve	erbalizes relief	atter	1	1		Alteration in	patient.	_		_
Pain	intervention.			+-	-	_	Bowel/Bladder	tenderok of heoreth march			
Management							Function	644			
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	Neurological d	eficit unchang	ed or	T			Discharge	established to come the reasons.			
Neuro Deficit/	resolving.			_	_	_	Plan	Ligen			
Altered LOC								age takeful.			
	Liberton State Company				e ver		posts.	I was to see the second second second			
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	Nutritional nee			T	П	Ī		900000000000000000000000000000000000000			
Alteration in			low, tolerates					and the second s			_
Nutrition /		75% or > of			1	1		Remains injury free in a safe			
Dysphagia		Tolerates Tu	be Feeding	+-	┡	-	Patient Safety	environment.	+-	_	
				L	L						
Alterations in	Bedrest			+	\vdash	+-		No evidence of skin breakdown.	+	_	
ADL's /							Skin Integrity				
Decreased											
Mobility								Patient / family verbalizes satisfaction	+	-	<u> </u>
							Patient/Family	,			
					-	-	Satisfaction	with hospital stay/care.	+	-	-
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			INTERVI	-NT	ONS	160	ontinued on bac				
Patient Care	T		MILAVI	TD	_	_	THE RESERVE AND ADDRESS OF THE PARTY OF THE		TD	ΙE	N
Categories	1957	THE P. P. HOUSE	ioda ni ionea				Categories				
	335	VANDEROV VIII	estat year of the					* Diet ordered, if not dysphagic:		-	
Discharge				1		}	Nutrition	Dr. of distances of	1000000		
Plan	WIGHTSH							% of diet consumed:			
						1		Breakfast%	-		
	* 419540F							Lunch %	(1)	-	
								Dinner%	- 11111	-	\vdash
	Ag pv.			1				Assess ability to self feed & follow	8.1		
					1			dysphagic guidelines, if indicated.	+-	-	\vdash
								High risk nutritional assessment completed.			
								ouripiotos.	+		\vdash
								belling with property.			
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Patient Care	Day 1	D	EN	Patient Care	NOT THE PERSON NAMED IN	D	E	N
Categories	Date:			Categories				
	Vital signs q 2 hrs. until stable, then				Encourage verbalization of fears /			T
Assessment	q 4 hrs. X 4			Teaching	concerns.			1
&	Neuro assessment q 2 hrs. until stable,			8	Assess patient/family satisfaction.			Т
Treatments	then q 4 hrs. x 4 (see Flowsheet)			Psychosocial				
	- LOC				Assess patient/family level of			Т
	- Strength / mobility - all extremities				understanding related to condition &			
	- Assess tongue to be midline				potential lifestyle changes.			1
	- Assess smile symmetry				Learning needs / teaching plan:		-	
	- Assess speech and cough quality				- Orient to environment / unit			1
	- Assess swallowing	4		1	- Diagnostic tests / procedures			1
	- spontaneously swallows saliva.			- I	Stroke Education information given	\vdash	\vdash	+
	- swallows saliva on command.		3	19 COTTO 0 19	to patient/family.	-		1
	*1&O q8 hrs.	+		1	Medications:	\vdash		+
	100 40 1110.		100		- Antithrombotic:			L
	*Monitor cardiac rhythm.	+		1	- Other:			
	Monitor Cardiac Hydrin.				- Other.	1 1	100	1
	*O2/Pulse Oximetry.	+	\vdash	1		1 1		
	OZIFulse Oximedy.						1	1
	*Thigh high TEDS/Venous compression	+	\vdash	-	Activity:	\vdash	_	⊢
	device.				Activity.			1
		+	\vdash	-	Diet	\vdash	_	⊢
	Continue thrombolysis protocol if			100000000000000000000000000000000000000	Diet:			
	indicated.	+	-	-	Other	\vdash	\vdash	⊢
	Consult Advanced Practice Nurse if				Other:	39		l
	patient has:					1		1
	- Dysphagia	-						1
	- Complex needs / diagnosis	_		A company of the con-				1
	* Administer Antithrombotic Medication:			1	100000000000000000000000000000000000000		-	1
	- Aspirin	1 1		1				1
	- Anti-platelet agent							1
	or		1 1					<u> </u>
	- Anticoagulant if indicated				Lab / diagnostics results reviewed; MD			П
	Assess for signs/symptoms of bleeding			Specimens	notified if indicated.			
	if on antithrombotic.			8	Notify M.D. HCT> 45, blood sugar			
	* D/C Foley Catheter			Diagnostics	> 200ml/dl.			
	of some the many and a second				*Schedule Echo if indicated.			
	Internal			1	*Schedule Carotid Ultrasound if indicated			Г
			1 1					Т
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	- Continue	all who					1	
	The state of the s	1	in the		Falls protocol maintained.	+-	一	÷
				Safety	Palis protocol maintained.	1	1	1
			1 1		POOR with assist. HOR 20 degrees	\vdash	\vdash	+
	and the second of the second o	The same	200	8	*OOB with assist. HOB 30 degrees	1		1
	A CONTRACTOR OF THE PROPERTY O			Activity	while in bed. ROM q4 hrs. while awake.	\vdash	\vdash	+
					Assist to reposition q 2 hrs. & PRN			1
						_	\vdash	+
	Carl ordered if her exagnings				Physical Therapy screen/evaluate			
	1		100		entered into IDX	_	1	1
	bed transcribed to	7		1	P.T. screen completed by therapist			1
	Senting Senting			1	within 24 hrs.			
	E POSS	1		1	Rehab orders obtained as indicated			
	Hygiene and Comfort Protocol			1				
	Marion A Sant and 14 wilds associa				*Swallow evaluation completed by			
	Peripheral IV Therapy Protocol				therapist if indicated.			
				1		T		T
	Pressure Ulcer Preventions Protocol			1	1	1		
	Total of the control						1	
		1.0	1	-4				1
	* Respiratory Care provided							
	* Respiratory Care provided. (See Respiratory Care Record)	\top						

	CVA					and the last of	The state of the s			
	Signature	Title	Ini	tial		5				
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		DESI	REL	OU	TC	OMES	D = DAYS E = EVENINGS N = NIC	GHTS		
Problem/ Needs	Day 2 Date:		D	E	N	Problem/ Needs	100 67 2	D	E	N
	Patient / family verbalizes kn	owledge	1				No signs / symptoms:			
Knowledge	of plan of care.		-		-	Potential	- Infection			
Deficit related to plan of care	Patient / family demonstrates	S.:				Complications	- Deep Vein Thrombosis	+	-	-
to plair or care	Caregiving skills ROM exercises						Va. Jefferson Stewart Stewart			
	- ADL's						100000000000000000000000000000000000000			
							Bowel / Bladder function normal for	T		
	Pain free or verbalizes relief	after				Alteration in	patient.			_
Pain	intervention.		_	_	_	Bowel/Bladder	Man may man at a de-			
Management	5					Function				1
							Patient / family verbalizes knowledge	T	-	_
	Neurological deficit unchange	ed or				Discharge	of discharge planning process.			
Neuro Deficit/	resolving.			_		Plan	55(2)			Г
Altered LOC	1 1						100			
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	Land Company Control of	man in the second		1000		2	ar ibani da aria senangan			
	Nutritional needs met (choos						PROTEIN A			
Alteration in	Able to swallo	and the second of the second of		i - 1						_
Nutrition / Dysphagia	75% or > of d Tolerates Tut					Patient Safety	Remains injury free in a safe environment.	- 1		
Dyspinagia	Tolerates Tut	oc recomy				radem Salety	environnent.	+	-	-
^ ^ ^ -	T									
	Tolerates OOB to chair with a									L
Alterations in ADL's /	Able to perform ADL's with m	ninimal assist.	_	_	_	Chin total and	No evidence of skin breakdown.		П	П
Decreased						Skin Integrity		+-	⊢	-
Mobility										
							Patient / family verbalizes satisfaction	1		
						Patient/Family	with hospital stay/care.			
	ber Hinn					Satisfaction				
	1 July 20 degree 1			(4	042		4			
		INTERVE	NTI	ONS	/co	ntinued on bac	(k)	_	_	_
Patient Care	Secretary of benefit to	A Course	D	E	N	Patient Care		D	E	N
Categories						Categories				
	Assess home environment/s	upport system				1 1	* Diet ordered, if not dysphagic:		Г	
Discharge	Evaluate for: VNS re					Nutrition				
Plan	Outpatie Other	ent rehab.					% of diet consumed: Breakfast %			
	1 Ither		ed .	and the same of th	-		The condition of the co	10.1	A 10 (1)	

INTERVENTIONS (continued)

Patient Care	Day 2	D	E	N	Patient Care	1000	D	E	N
Categories	Date:				Categories				
	Vital signs q 8 hrs. and PRN					Encourage verbalization of fears /			
Assessment					Teaching	concerns.			
&	Neuro assessment q 8 hrs. and PRN				8	Assess patient / family satisfaction.			
Treatments	(see Flowsheet)				Psychosocial			- 1	7, 97
	- LOC					Learning needs / teaching plan:			
	- Strength / mobility - all extremities					- Assess family's ability to learn			
	- Assess tongue to be midline				1 1	caregiving skills			
	- Assess smile symmetry					- Involve family in ROM and ADL's			
	- Assess speech and cough quality								
	- Assess swallowing					Review Stroke Education information			
	- spontaneously swallows saliva.				a - votile di	with patient / family.			
	- swallows saliva on command.								
	*I&O q8 hrs.					Medications:			
	*Monitor position shidhan	-	-			- Antithrombotic:			
	*Monitor cardiac rhythm.					- Other:			
	*D/C oxygen.				5-37 M				
	D/C dxygen.	- 1							
	Assess skin integrity.	\vdash	\vdash			Activity:	-	-	-
	100000 Skill littegrity.					nouvity.			- 1
par vizer reject	*Thigh high TEDS/Venous compression	\vdash		-		Diet:	\vdash	\dashv	\dashv
	device.		7 7 2	31,74		40 40 50 50 50 50 50 50 50 50 50 50 50 50 50	. 7		
	Assess & document BM;		012		econs 1	Other:		\dashv	\dashv
	intervene if no BM in 24 hrs.		140	1000					
	Continue thrombolysis protocol if								
A	indicated.								
	* Administer Antithrombotic Medication:			71.11		of the control of the control			
	- Aspirin		1	47				100	
	- Anti-platelet agent							20.	
	or								
	- Anticoagulant if indicated					Lab / diagnostics results reviewed; MD			
	Assess for signs/symptoms of bleeding				Specimens	notified if indicated.			
	if on antithrombotic.				&	*PTT, if on heparin: sec.			
in the select	* D/C Foley Catheter			C.L. 1.7	Diagnostics	*Pro Time if on coumadin: sec.			
	elizione en l'auginanti a			1		INR		1.15	
	- Ingress				1	Carotid Ultrasound completed.			
						Echo completed.	1	_	\blacksquare
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	Student Military		0.0		169				
-	The second secon					Falls protocol maintained.			
					Safety	*OOB with assist. HOB 30 degrees	\vdash	-	\dashv
					&	while in bed. ROM q4 hrs. while awake.			
Copper of the con-					Activity	Assist to reposition g 2 hrs. & PRN			
1.4						Rehab orders obtained as indicated			
				200					
-	Land of the second of the seco					*P.T. Bedside: Dept.:			
			200	100		ROM / Therapeutic Procedures:			
	34 WE 5 95 W					Dangling / Therapeutic Activities:			
	[] [] [] [] [] [] [] [] [] []					Gait Training:			
	1200					*O.T. Bedside: Dept.:			
	Hygiene and Comfort Protocol					The test of things to take a con-			
						and the second s			
	Peripheral IV Therapy Protocol					*S.L.P. Speech: Swallowing:			
	Description Description Business			-		SEE FOCUS NOTES.	-		
	Pressure Ulcer Preventions Protocol					11776 2403			
	* Respiratory Care provided.		-		- I- I- I	2/30			
	(See Respiratory Care Record)					27.000000000000000000000000000000000000			
	(See Respiratory Gale Record)					The second secon			
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Signature Requiring Co-Signature	Date/Shift	Initial/T	itle				

ADDRESSOGRAPH DESIRED OUTCOMES D = DAYS E = EVENINGS N = NIGHTSProblem/ Day 3 E Problem/ DEN Needs Date: Needs Patient / family verbalizes knowledge No signs / symptoms: Knowledge - Infection of plan of care. Potential Deficit related Patient / family demonstrates: Complications - Deep Vein Thrombosis to plan of care Caregiving skills ROM exercises - ADL's Bowel / Bladder function normal for Pain free or verbalizes relief after Alteration in patient. intervention. Bowel/Bladder Pain Function Management Discharge Neurological deficit improved. Neuro Deficit/ Plan Altered LOC Nutritional needs met (choose one): Able to swallow, tolerates Alteration in 75% or > of diet. Nutrition / Remains injury free in a safe Dysphagia Tolerates Tube Feeding Patient Safety environment. Ambulating with / without assist. Able to perform ADL's with minimal assist. Alterations in No evidence of skin breakdown. ADL's / Skin Integrity Decreased Mobility Patient / family verbalizes satisfaction Patient/Family with hospital stay/care. Satisfaction INTERVENTIONS (continued on back) Patient Care Patient Care EN EN Categories Categories *Diet: Discharge Nutrition Plan % 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.

Patient Care	Day 3	D	E	N	Patient Care	COUNTY OF THE PROPERTY OF THE PARTY OF THE P	D	E	N
Categories	Date:				Categories				-
	Vital signs q 8 hrs. and PRN					Encourage verbalization of fears /			_
Assessment					Teaching	concerns.			-
&	Neuro assessment q 8 hrs. and PRN				&				
Treatments	(see Flowsheet)				Psychosocial	Assess patient/family satisfaction.			
	- LOC								
	- Strength / mobility - all extremities					Learning needs / teaching plan:			
	- Assess tongue to be midline				1 10 10 10	- Rehab program		1	
	- Assess smile symmetry				a from the	- Dysphagia Guidelines		La	
	- Assess speech and cough quality					- Modifiable risk factors			
	- Assess swallowing				m, jagaman	Review Stroke Education information			
	 spontaneously swallows saliva. 			90	March - 1777 1186	with patient / family.			-
	- swallows saliva on command.						-		
	*D/C I&O if appropriate				1 10 10 10 10 10	Medications:			
			13.7	Y.		- Antithrombotic:	-		
	*D/C telemetry if rhythm stable					- Other:			
	Letter 4, 1		N. 3						
	Assess skin integrity.		100						
					1			2.0	100
	*D/C TEDS / venous compression				1 1 1	Activity:			
	device if ambulatory.								
	Assess & document BM;					Diet:	5-3-0	Maria.	15.79
	intervene if no BM in 24 hrs.	0.5	100			First Louis Res Strong Company of the			_
	* Administer Antithrombotic Medication:	700				Other:			
	- Aspirin	1 1	2712	100					
and the same	- Anti-platelet agent	10	ne-		real or the second				
	or				the second	of the second se			
	- Anticoagulant if indicated					.02 Vigo 10000 II. 4go 11 14		-	
	Assess for signs/symptoms of bleeding	1 1	- 1		1 - 4				. 1
	if on antithrombotic.			_					
				- 1		Lab / diagnostics results reviewed; MD			
4 - 1 - 1				- 1	Specimens	notified if indicated.			
				- 1	&	Assess for signs/symptoms of bleeding		100	
See Springer	the same function where the same of the sa		F 77		Diagnostics	if anticoagulated.	\Box	-	_
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	the rank of the first own and the particular designation	ALC:			Activity	*P.T. Bedside: Dept.:			
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i make and in it					1 1 1	*S.L.P. Speech: Swallowing:			
	Hygiene and Comfort Protocol					SEE FOCUS NOTES.			
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	Peripheral IV Therapy Protocol								
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	Pressure Ulcer Preventions Protocol								
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Manual and		verbalizes kno	owledge of:					No signs / symptoms:			
Knowledge Deficit related	- Plan of Care - Medications	r					Potential	- Infection			
to plan of care	- Medications - Diet / Hydrat	ion needs					Complications	- Deep Vein Thrombosis	+	⊢	₩
to plan or our	- Rehab Progr							to find a Affair grouping of the party	1		
		contributing to	stroke					Andrew State of the State of th			
		otoms of stroke						Bowel / Bladder function normal for	T		
121		rbalizes relief a	after				Alteration in	patient.	\perp		
Pain	intervention.			├		_	Bowel/Bladder	The result (Nak)			
Management							Function				
								Discharge plan completed and	+	-	\vdash
Neuro Deficit/	Neurological de	eficit improved.		Г			Discharge Plan	communicated to patient/family (non-dysphagic)			
Altered LOC				\vdash			1	(non-ayapriagio)	+	_	
	17.57					1000					
	Nutritional nee	ds met (choose	0.00/-	-	-	-					
Alteration in	Troulouiai nee	Able to swallo									
Nutrition /		75% or > of di	iet.					Remains injury free in a safe	十		
Dysphagia		Tolerates Tub	e Feeding				Patient Safety	environment.			
	Ambulating wit	th / without ass	ist.	⊢	-	-					
Alterations in		n ADL's with m		\vdash				No evidence of skin breakdown.	+	+	1
ADL's/							Skin Integrity				
Decreased									1		
Mobility								Detical (feet)	+	Ļ	_
							Patient/Family	Patient / family verbalizes satisfaction with hospital stay/care.			
	1 1 1 1 1 1 1 1 1				C y	G, q f	Satisfaction	with hospital stay/care.	+	\vdash	\vdash
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			INTERVE	וזע	ONS	/60	ontinued on bac				
Patient Care			MILITER	D	E	N		1	LA	E	N
Categories					-	"	Categories		10	-	1"
	Evaluation con	npleted for place	cement, if not				Jacogomes	*Diet:	+	\vdash	_
Discharge	dysphagic:	K 50.					Nutrition				
Plan	Rehab							% of diet consumed:	8553		
	Subac							Breakfast%			
		erm care						Lunch %			
	Other							Dinner %		┺	\perp
				-	-	-	p = 4 - 16 - 1	Assess ability to self feed & follow			
								dysphagic guidelines, if indicated. Intake <50%, notify RD.	+-	+	\vdash
								To a state of the			
								*peg inserted if still Dysphagic			

Feeding Tube:

Assess Residual: if > 100% of rate, stop feeding for 2 hrs. and reassess.

assist TID. *P.T. Bedside: ___ Dept.: ___ Activity 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)

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	Day 5			10	E	N	Problem/	and the second s	D	E	N
Needs	Date:	. washaliana la	and adapt of	+	-	-	Needs		4	_	_
Knowledge	Patient / family - Plan of Care		owleage or:	1			Potential	No signs / symptoms: - Infection	1		
Deficit related	- Medications			1			Complications	- Deep Vein Thrombosis	1		1
to plan of care	- Diet / Hydrat	ion needs					Complications	- Deep Veill Tillottibosis	+-	\vdash	+
	- Rehab Progr							1 20			1
	- Risk factors		stroke					17, 10, 10, 10	1		
	- Signs / symp							Bowel / Bladder function normal for	T		T
Dele	Pain free or ve	rbalizes relief	after				Alteration in	patient.	1		
Pain	intervention.			-	-	_	Bowel/Bladder	alt durations on			
Management				1			Function	In the first of the last of the stand			
1								Discharge plan completed and	+-	-	┾
	Neurological d	eficit improved		$\overline{}$			Discharge	communicated to patient / family.	1		
Neuro Deficit/							Plan	Ischemic Stroke/TIA Patient discharged	+		+
Altered LOC				T			1	on antithrombotic medication.	1		
								Discharged (non-dysphagic).			
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	Nutritional nee	de met (choos	e one/:	+-	-	-			1		
Alteration in	Truckional fice	Abie to swall		1							
Nutrition /		75% or > of d			100	190	-	Remains injury free in a safe	+	-	\vdash
Dysphagia		Tolerates Tub	e Feeding				Patient Safety	environment.			1
				Т					\top		
	I Ambuilating with	b freelband		-	_		Į		1		
Alterations in	Ambulating wit Able to perform			+-	-	-			<u> </u>		<u> </u>
ADL's /	Able to periori	ADLS WILL IS	unichal assist.	-	-	-	Skin Integrity	No evidence of skin breakdown.			
Decreased							Skiii linegrity		+-	-	┼
Mobility				i					1		1
10	1							Patient / family verbalizes satisfaction	†		+
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				1		KYE	Satisfaction				
1 1	3 45			1		1					
			INTERVE	NTI	ONS	(60	ontinued on bac	i i		_	
Patient Care				ID	E	N	Patient Care		T D	TE	N
Categories	1 1 1 1 1 1 1				-		Categories		1	-	1"
	Evaluation con	npleted for pla	cement:					*Diet:	\vdash	\vdash	-
Discharge	Rehab			1	1		Nutrition				
Plan	Subac	ute care		1				% of diet consumed:	200		100.0
		erm care		1				Breakfast%			
	Other	W SH						Lunch %			
	Discharge to:	2011/10	37.50	-	-			Dinner %			
	Discharge to:						1	Assess ability to self feed & follow			
				+	-	-	1	dysphagic guidelines, if indicated.	-	-	-
,				1			1	Intake <50%, notify RD.			

* indicates medical orders needed Medical Record

Feeding Tube:

Assess Residual: if > 100% of rate, stop feeding for 2 hrs. and reassess. Medical Record # _____ INTERVENTIONS (continued)

Patient Care	Day 5	D	E	N	Patient Care	and a section of	D	E	N
Categories	Date:				Categories				
	Vital signs q 8 hrs. and PRN					Encourage verbalization of fears /	\vdash		\dashv
Assessment					Teaching	concerns.			
. &	Neuro assessment q 8 hrs. and PRN				&	Assess patient/family satisfaction.			\neg
Treatments	(see Flowsheet)				Psychosocial	Review Stroke Education information			\neg
	-LOC					with patient / family.			
	- Strength / mobility - all extremities					Learning needs / teaching plan:			\Box
	- Assess tongue to be midline					- Dysphagia Guidelines			
	- Assess smile symmetry					- peg care, tube feeding			, L
	- Assess speech and cough quality					- Rehab program			
	Assess swallowing spontaneously swallows saliva.					- Assistive Devices	\vdash		_
	- swallows saliva on command.			- 4		Discharge instructions:			
	Assess skin integrity.		_	-		- Signs / symptoms of stroke			
	in the second state of the		22.54	- 4		- Food & drug interactions - MD follow-up			- 1
	Assess & document BM;					- Modifiable risk factors			
	intervene if no BM in 24 hrs.		611.7	101		Medications:	\vdash	-	\dashv
	* Administer Antithrombotic Medication:					- Antithrombotic:	П	100	
	- Aspirin					- Other:			
	- Anti-platelet agent						1 1		
	or						1 1	- 1	
	- Anticoagulant if indicated					1.7	.		
	Assess for signs/symptoms of bleeding			77		Activity:			\neg
	if on antithrombotic.						Ш		
	Review hydration needs if indicated.					Diet:			
				\neg		Other:			\dashv
ļ						119-V6740479) 11 (30 × 1041 × 11 × 14			
) .									- 1
1		ll							- 1
1		ll				Lab / diagnostics results reviewed; MD		-	_
					Specimens	notified if indicated.			- 1
					&	*PTT if on heparin:sec.	\vdash	\dashv	\dashv
Land more	and the secondary of the second of the				Diagnostics				- 1
	1 (2) (3) (100 C)					*Pro Time if on cournadin sec.			- 1
4-1						INR			
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Lance de	20.00 to 10.00 to 10.								140
	The state of the s						H		
						Falls protocol maintained.			
					Safety	*OOB ambulating with or without			
					8	assist TID.	\vdash	_	
	SET DE FORM. CONT. CONT. CO. C.				Activity	*P.T. Bedside: Dept.:	110000		
						ROM / Therapeutic Procedures: Dangling / Therapeutic Activities:			
						Gait Training:			
2 1						*O.T. Bedside: Dept.:	-		
	7 10 7 2 3 10 1 1 2 2								
	"a a b e b								
						*S.L.P. Speech: Swallowing:			
	Hygiene and Comfort Protocol					SEE FOCUS NOTES.	_		
	Peripheral IV Therapy Protocol	\vdash				100 300 1100			
	Pressure Ulcer Preventions Protocol								
	* Description Community	\square							
	* Respiratory Care provided.								
	(See Respiratory Care Record)								
							1	_	20000000

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	E	DESIRE	00	J JTC	OMES	D = DAYS E = EVENINGS N = NIG	HTS	;	
Problem/	Day 6	D	E	N	Problem/		D	E	٨
Needs	Date:				Needs				
	Patient / family verbalizes knowledge of	of:				No signs / symptoms:			Γ
Knowledge	- Plan of Care	34			Potential	- Infection		1	
Deficit related	- Medications			1	Complications	- Deep Vein Thrombosis			
to plan of care	- Diet / Hydration needs		1						Γ
	- Rehab Program					a transport production			
	- Risk factors contributing to stroke		1						
	- Signs / symptoms of stroke					Bowel / Bladder function normal for			
	Pain free or verbalizes relief after				Alteration in	patient.	\perp		L
Pain	intervention.		_	_	Bowel/Bladder	34/90/			
Management					Function				
			1						L
			╄	<u> </u>		Discharged (if dysphagic discharge			
Name Dafair	Neurologic status stable.		1		Discharge	day 7).	\vdash		┺
Neuro Deficit/ Altered LOC		-+	+-	+-	Plan	Discharge plan completed and			
Altered LOC	I	1				communicated to patient / family.	\vdash	-	⊢
	Tel. 201 21 2 2 200 10 200 10 20 20 20 20 20 20 20 20 20 20 20 20 20	- 4		-		Ischemic Stroke/TIA Patient discharged			
	and promote the second second second					on antithrombotic medication.	+	\vdash	┝
	Tolerates tube feeding		T	T	1				
Alteration in									
Nutrition /	Nutritional needs met.		Т			Remains injury free in a safe	T		Г
Dysphagia			-	-	Patient Safety	environment.	_	_	L
	Ambulating with / without assist.		İ	İ					
Alterations in	Able to perform ADL's with minimal as	sist.				No evidence of skin breakdown.	T		Г
ADL's / Decreased					Skin Integrity		_	\vdash	┡
Mobility							1		
oz.iii.y						Patient / family verbalizes satisfaction	+	H	⊨
					Patient/Family	with hospital stay/care.			1
	and the state of t	736	. S	1	Satisfaction	Will Hoophal Stayroure.	+	\vdash	H
		502	00						
	INTE	RVENT	ONS	S (C	ontinued on bac	(k)			_
Patient Care		D	E	N	Patient Care		D	E	1
Categories	sens in Appending 1 confirm	5.0			Categories				
	Evaluation completed for placement:	3.50	T			*Diet:			Г
Discharge	Rehab.				Nutrition				
Plan	Subacute care	1		1		% of diet consumed:			
	Long term care		1			Breakfast%			
	Other					Lunch %		T	
	22104.11.1.13	13.	1			Dinner %		1	Γ
	Discharge to:		T		1	Assess ability to self feed & follow	T		T
						dysphagic guidelines, if indicated.	1		

Intake <50%, notify RD.

Assess Residual: if > 100% of rate, stop feeding for 2 hrs. and reassess.

Feeding Tube:

Patient Care	Day 6	D	E	N	Patient Care		D	E	N
Categories	Date:				Categories				
	Vital signs q 8 hrs. and PRN					Encourage verbalization of fears /	\vdash	-	
Assessment					Teaching	concerns.			
&	Neuro assessment q 8 hrs. and PRN				8	Assess patient/family satisfaction.			
Treatments	(see Flowsheet)				Psychosocial	Review Stroke Education information			
	-LOC	j				with patient / family.			
	- Strength / mobility - all extremities					Learning needs / teaching plan:		$\overline{}$	
	- Assess tongue to be midline					- Dysphagia Guidelines		-	1
	- Assess smile symmetry					- peg care, tube feeding		-	
	- Assess speech and cough quality					- Rehab program			
	- Assess swallowing					- Assistive Devices			
	 spontaneously swallows saliva. 		l			Discharge instructions:			
The second	- swallows saliva on command.			× - 1		- Signs / symptoms of stroke			
8 6 3	Assess skin integrity.		7		31 - 2 - 5	- Food & drug interactions			
1						- MD follow-up			
	Assess & document BM;					- Modifiable risk factors			
	intervene if no BM in 24 hrs.			100		Medications:			
	* Administer Antithrombotic Medication:			A STATE		- Antithrombotic:			
	- Aspirin				1 1	- Other:			
	- Anti-platelet agent								
	or	10.74				N 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			
	- Anticoagulant if indicated				The second of				
	Assess for signs/symptoms of bleeding	151			1 1	Activity:			
	if on antithrombotic.		100		M				
1 1				27/	1	Diet:	1		
Landing Co.	and the second processing a second process				and the second		\Box		
	and the second s				The second second	Other:		3,633	
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	184 1530 500 1 1380 1 18 0						\sqsubseteq		
						Lab / diagnostics results reviewed; MD			
*					Specimens	notified if indicated.	\vdash		_
					6	*PTT if on heparin: sec.		1	
		-1			Diagnostics	*Des Time if an assumedia	\vdash		\vdash
						*Pro Time if on coumadin sec.			
						INR	\vdash		-
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	4 455 14 15	ng m	v-Fry	200					
		ήo	tari			Falls protocol maintained.		-	
	,				Safety	*OOB ambulating with or without			
					&	assist TID.			
			5.8		Activity	*P.T. Bedside: Dept.:			
					141316	ROM / Therapeutic Procedures:			
			1.10	1		Dangling / Therapeutic Activities:		-10	
						Gait Training:			
			be fred			*O.T. Bedside: Dept.:	-	12.1	
	Continued in					V 1 Mb 1 3	1	1:1	
	* of the second					#0.15 PRINT (p	1		
						*S.L.P. Speech: Swallowing:			
	Hygiene and Comfort Protocol					SEE FOCUS NOTES.			
	Val. 7 a per les il 1 gints il 1 al								
	Peripheral IV Therapy Protocol								
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	Pressure Ulcer Preventions Protocol						1		
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	* Respiratory Care provided.								
1	(See Respiratory Care Record)						1		
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Problem/	Day 7	D	E	N	Problem/	100000000000000000000000000000000000000	D	E	N
Needs	Date:				Needs				
	Patient / family verbalizes knowledge of:					No signs / symptoms:			
Knowledge	- Plan of Care	1		1	Potential	- Infection			
Deficit related	- Medications		1		Complications	- Deep Vein Thrombosis			
to plan of care	- Diet / Hydration needs		1						
	- Rehab Program	1							
	- Risk factors contributing to stroke		1						
	- Signs / symptoms of stroke		1			Bowel / Bladder function normal for	T		
	Pain free or verbalizes relief after	П	\Box	T	Alteration in	patient.			
Pain	intervention.				Bowel/Bladder				
Management					Function				
			l						
		_	<u></u>			Discharged	T		П
	Neurologic status stable.		П	T	1				
Neuro Deficit/					Discharge	Discharge plan completed and			
Altered LOC					Plan	communicated to patient / family.			
						Ischemic Stroke/TIA Patient discharged			
	7					on antithrombotic medication.			
	Tolerates tube feeding				1				
Alteration in									
Nutrition /	Nutritional needs met.					Remains injury free in a safe	T		
Dysphagia					Patient Safety	environment.			
			<u></u>						
	Ambulating with / without assist.								
Alterations in	Able to perform ADL's with minimal assist.					No evidence of skin breakdown.			
ADL's/			1		Skin Integrity				
Decreased		1							
Mobility		1		1					_
						Patient / family verbalizes satisfaction			
	The state of the s				Patient/Family	with hospital stay/care.			L
	0.000				Satisfaction				
	to the second street program			100					
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Patient Care		_	-	_	ntinued on bac	·k)	1.5		-
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Categories		-	-	-	Categories		+-		L
1	Discharge to:					*Diet:			
Discharge			\vdash		Nutrition				
Plan	y					% of diet consumed:			
	The second secon	1				Breakfast%			
		1				Lunch%			
	and the second s	1			1	Dinner %			
						Assess ability to self feed & follow			
						dysphagic guidelines, if indicated.			
						Intake <50%, notify RD.	1		
		1				W2 10 10 10 10 10 10 10 10 10 10 10 10 10			
					1	Feeding Tube:			
						Assess Residual: if > 100% of rate,			1
		1				stop feeding for 2 hrs. and reassess.			

INTERVENTIONS (continued)

	Day 7	D	E	N	Patient Care	The second secon	D	E	N
Categories	Date:				Categories			-	-
	Vital signs q 8 hrs. and PRN				7	Encourage verbalization of fears /			
Assessment					Teaching	concerns.			
&	Neuro assessment q 8 hrs. and PRN				&	Assess patient/family satisfaction.	-		-
Treatments	(see Flowsheet)				Psychosocial	Review Stroke Education information			
	- LOC					with patient / family.			
	- Strength / mobility - all extremities					Learning needs / teaching plan:			
	- Assess tongue to be midline		1			- Dysphagia Guidelines			
	- Assess smile symmetry				j jui	- peg care, tube feeding			
	- Assess speech and cough quality					- Rehab program		7 4	N 1 7
	- Assess swallowing					- Assistive Devices			
	- spontaneously swallows saliva.					Discharge instructions:			
	 swallows saliva on command. 					- Signs / symptoms of stroke			
	Assess skin integrity.		11/3			- Food & drug interactions			
			2	20		- MD follow-up		-	
	Assess & document BM;					- Modifiable risk factors			
	intervene if no BM in 24 hrs.		1,1	0.00		Medications:			
	* Administer Antithrombotic Medication:		- 73		mendi i i i	- Antithrombotic:			
	- Aspirin					- Other:		, ,	. 11
	- Anti-platelet agent]		
	or								
	- Anticoagulant if indicated					2 - 2 - 2 - 2			
	Assess for signs/symptoms of bleeding	91			person The	Activity:			
	if on antithrombotic.			107.4	0.01	30,000			
			5.0	7 - 74		Diet:		7	111
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	Hygiene and Comfort Protocol					SEE FOCUS NOTES.			
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