UNIVERSITY MEDICAL CENTER

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

Generic Medical

ESTIMATED LOS: _____ ***Days*** ***Date placed on map:*** _____

INCLUSIONARY CRITERIA:

All patients admitted with a medical diagnosis will be placed on this , unless there is a case-specific available.

CRITERIA FOR REMOVING PATIENTS FROM

Remove patients from this if clinical status/diagnosis changes and there is a case specific .

Primary Diagnosis/Procedure: _____

Pertinent Past Medical History: _____

Allergies: _____

Medications: _____

Code Status: _____

CONSULTS OR DISCIPLINES INVOLVED/NOTIFIED:

1. _____ *Initials/Date/Time notified:* _____
2. _____ *Initials/Date/Time notified:* _____
3. _____ *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: _____

Date/Event: _____

Date/Event: _____

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 Progress Record / Patient Focus Notes when an outcome or intervention is initialed and circled, indicating it was not met or completed as stated.

Generic Medical

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

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 understanding of diagnosis and plan of care, participates in decision making.			
Pain Management	Pain free or verbalizes pain relief after intervention.			
Alterations in ADL's due to: _____ _____ _____ _____ _____	Able to perform ADL's with (choose one): ____ assistance ____ independently			
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.			

Problem/ Needs		D	E	N

INTERVENTIONS (continued on back)

Patient Care Categories		D	E	N
Discharge Plan	Assess need for Discharge Planning / Social Service based on nursing assessment of home environment / patient condition.			
	Insurance:			

Patient Care Categories		D	E	N
Nutrition	* Diet:			
	% of diet consumed:			
	Breakfast _____ %			
	Lunch _____ %			
	Dinner _____ %			

* indicates medical orders needed

INTERVENTIONS (continued)

Patient Care Categories	Day 1 Date: _____	D	E	N	Patient Care Categories		D	E	N
Assessment & Treatments	Vital signs q ____ hrs.				*Teaching & Psychosocial*	Assess patient/family satisfaction.			
	I & O q _____ hrs.					Encourage verbalization of fears / concerns.			
	* Telemetry					Assess knowledge level and readiness to learn.			
	* O2:								
					Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
						* Tests / Procedures _____ _____ _____ _____ _____ _____			
					Safety & Activity	Falls protocol initiated.			
						* Activity level:			
						Assess need for functional evaluation by rehab.			
	Hygiene & Comfort Protocol								
	Peripheral IV Therapy Protocol								
	Pressure Ulcer Prevention Protocol								
	* Respiratory Care provided. (See Respiratory Care Record)								

Generic Medical

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

ADDRESSOGRAPH

DESIRED OUTCOMES

D = DAYS E = EVENINGS N = NIGHTS

Problem/ Needs	Day 2 Date: _____	D	E	N	Problem/ Needs		D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of diagnosis and plan of care, participates in decision making.								
Pain Management	Pain free or verbalizes pain relief after intervention.								
Alterations in ADL's due to: _____ _____ _____ _____ _____	Able to perform ADL's with (choose one): ____ assistance ____ independently								
					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	Patient Care Categories		D	E	N
Discharge Plan					Nutrition	* Diet:			
						% of diet consumed:			
						Breakfast _____ %			
						Lunch _____ %			
						Dinner _____ %			

INTERVENTIONS (continued)

Patient Care Categories	Day 2 Date: _____	D	E	N
Assessment & Treatments	Vital signs q ____ hrs.			
	I & O q _____ hrs.			
	* Telemetry			
	* O2:			
	Hygiene & Comfort Protocol			
	Peripheral IV Therapy Protocol			
	Pressure Ulcer Prevention Protocol			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Assess patient/family satisfaction.			
	Encourage verbalization of fears / concerns.			
	Learning needs / teaching plan: Medication:			
	Activity:			
	Diet:			
	Modifiable Risk Factors:			
	Other:			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	* Tests / Procedures _____ _____ _____ _____ _____ _____			
Safety & Activity	Falls protocol maintained.			
	* Activity level:			

University Medical Center

** indicates medical orders needed*

Generic Medical

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

ADDRESSOGRAPH

DESIRED OUTCOMES D = DAYS E = EVENINGS N = NIGHTS

Problem/ Needs	Day 3 Date: _____	D	E	N	Problem/ Needs		D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of diagnosis and plan of care, participates in decision making.								
Pain Management	Pain free or verbalizes pain relief after intervention.								
Alterations in ADL's due to: _____ _____ _____ _____ _____	Able to perform ADL's with (choose one): ____ assistance ____ independently								
					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	Patient Care Categories		D	E	N
Discharge Plan					Nutrition	* Diet:			
						% of diet consumed:			
						Breakfast _____ %			
						Lunch _____ %			
						Dinner _____ %			

* indicates medical orders needed

INTERVENTIONS (continued)

Patient Care Categories	Day 3 Date: _____	D	E	N
Assessment & Treatments	Vital signs q ____ hrs.			
	I & O q _____ hrs.			
	* Telemetry			
	* O2:			
	Hygiene & Comfort Protocol			
	Peripheral IV Therapy Protocol			
	Pressure Ulcer Prevention Protocol			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Assess patient/family satisfaction.			
	Encourage verbalization of fears / concerns.			
	Learning needs / teaching plan: Medication:			
	Activity:			
	Diet:			
	Modifiable Risk Factors:			
	Other:			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	* Tests / Procedures _____ _____ _____ _____ _____ _____			
Safety & Activity	Falls protocol maintained.			
	* Activity level:			

University Medical Center

** indicates medical orders needed*

Generic Medical

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	Problem/ Needs		D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of diagnosis and plan of care, participates in decision making.								
Pain Management	Pain free or verbalizes pain relief after intervention.								
	Pain management established for discharge.								
Alterations in ADL's due to: _____ _____ _____ _____ _____	Able to perform ADL's with (choose one): ____ assistance ____ independently								
					Discharge Plan	Discharged			
					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	Patient Care Categories		D	E	N
Discharge Plan					Nutrition	* Diet:			
						% of diet consumed:			
						Breakfast _____ %			
						Lunch _____ %			
						Dinner _____ %			

* indicates medical orders needed

INTERVENTIONS (continued)

Patient Care Categories	Day 4 Date: _____	D	E	N
Assessment & Treatments	Vital signs q ____ hrs.			
	I & O q _____ hrs.			
	* Telemetry D/C'd			
	* O2:			
	Hygiene & Comfort Protocol			
	Peripheral IV Therapy Protocol			
	Pressure Ulcer Prevention Protocol			
	* Respiratory Care provided. (See Respiratory Care Record)			

Patient Care Categories		D	E	N
Teaching & Psychosocial	Assess patient/family satisfaction.			
	Encourage verbalization of fears / concerns.			
	Learning needs / teaching plan: Medication:			
	Activity:			
	Diet:			
	Modifiable Risk Factors:			
	Other:			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	* Tests / Procedures _____ _____ _____ _____ _____ _____ _____			
Safety & Activity	Falls protocol maintained.			
	* Activity level:			

University Medical Center

** indicates medical orders needed*