CVA

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

ADDRESSOGRAPH

DESIRED OUTCOMES

D = DAYS E = EVENINGS N = NIGHTS

Problem/ Needs	Day ___ 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 ___ 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*