# **University Medical Center** COPD

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		

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COPD -					
Estimated LOS: <u>5 Days</u>	D	ate placed on map			,
INCLUSIONARY CRITERIA: All COPD patients with increased airflow obstruprimary diagnosis or as a major comorbidity with	uction related to th other diagno	Emphysema, Chr sis will be placed o	onic Bronchitis n COPD	, or Asthma	a as a
EXCLUSIONARY CRITERIA: Those patients diagnosed as having CHF, Puln disorder or patients experiencing an acute exact COPD	monary Emboli, cerbation of as	or Respiratory Inst thma without a histo	ufficiency relate ory of COPD w	ed to a met ill not be p	tabolic laced on the
Primary Diagnosis/Procedure:					
Pertinent Past Medical History:					-
Allergies:			7		
Code Status:			* ;		
Consults or Disciplines					
Involved:	Date/Time	Respiratory T		Initials	Date/Time
2.		Nutrition/Diet		-	
3.		Physical Medi			
4.		Pulmonary Re			
5.		Occupational	Therapist		
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 comple - Use notation N/A, if not ap		timeframe			

SUPPLEMENTAL DOCUMENTATION is required on the Progress Record/Patient Focus Notes when an outcome or

Initial and circle, if not met or completed

COPD Title Initial Signature Signature Requiring Co-Signature Date/Shift Initial/Title **ADDRESSOGRAPH** D = DAYS E = EVENINGS N = NIGHTS**DESIRED OUTCOMES** Ε D E N Problem/ Problem/ **ETD** Needs Needs Date: Patient/family verbalizes understanding of Remains injury free in a safe Patient Knowledge anticipated plan of care and participates environment. Deficit related Safety in decision making. No signs or symptoms of: Patient/family verbalizes initial Infection to plan of care DVT or Pulmonary Emboli understanding: Hypokalemia • Dx No evidence of skin breakdown. Procedures/Treatment Activity Limitation Skin · Importance of follow-up care Integrity Pain free or verbalizes relief after Patient/family verbalizes satisfaction Pain intervention. with hospital stay/care. Patient/Family Management Satisfaction Obtains adequate gas exchange as Ineffective evidenced by: Breathing Improved mental status · Improved respiratory rate Pattern Shortness Decreased SOB of Breath Decreased expiratory effort Fears/concerns related to illness and Anxiety hospitalization identified. Bedrest Alterations in ADL's Completes ADL's with assist. INTERVENTIONS (continued on back) Patient Care D E N Patient Care D EN Categories Categories \* Diet: Discharge Nutrition % of diet consumed: Breakfast \_\_\_\_

\* indicates medical orders needed

Lunch \_\_\_\_ Dinner

completed.

High risk nutritional assessment

MR#

INTERVENTIONS

Patient Care		D	E	N	Patient Care	With the second	D	E	N
Categories	Date:				Categories				
	* Vital signs q15 min., until stable, then					Encourage verbalization of fears /			
Assessment	q4 hr. x 1; then q 8 hrs. as ordered.	1			Teaching	concerns.			
&	* O <sub>2</sub> :	+-			R	Learning needs / teaching plan:	+-		
Treatments	-2	1			Psychosocial	Learning needs / teaching plan.			
77000770710	* 1&0	+-	-	-	Paychosocial	the second of th	1		
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	Assess respiratory status.	1				The same of the sa			
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	Assess level of consciousness.	T							
	2942 000 U.B. 1990 B								
	*IV Corticosteroids			100	continue de la contin		_	_	
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	*Antibiotics			-		0.00	75.3	100	
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	IVPO	_							
	Assess need for stomach protection.	1 De	1.81			adapted the second second second			
	At an demand to a second	100							
	Insert PIID								
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	Consider DVT prophylaxis			_					
		1000							
	(Bedrest/limited activity)	-				A CONTRACTOR SECURIOR			
	Blood glucose qhr	31)	6.5						
	The second secon								
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						Lab / diagnostics results reviewed; MD	-		
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	The state of the s	11.50	0.00	2	8	* Tests / Procedures:			
					Diagnostics	* CBC with diff.			
		1				* PT/PTT			
						* Chemscreen, K=level			
	the organic happens being appropriate to the configuration of the config		e main			* Theophylline level if on home			
						maintenance			
		1			Activities a series of the				1
		l				* Sputum gram stain and C & S			
		1			1	* U/A			
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			1	1	Safety		1		$\sqcup$
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	the second contract of		none pi		Activity	* Bedrest with BRP.	1		
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	* Respiratory Care provided.			1					
	(See Respiratory Care Record)						1	1	
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COPD Title Initial Signature Date/Shift Signature Requiring Co-Signature Initial/Title **DESIRED OUTCOMES** DEN Problem/ Day 1 Needs Date: Patient/family verbalizes understanding of anticipated plan of care and participates Knowledge Deficit related in decision making. to plan of care Patient/family verbalizes initial understanding:

ADDRESSOGRAPH

DEN

D = DAYS E = EVENINGS N = NIGHTS

Patient/family verbalizes satisfaction

with hospital stay/care.

#### Needs Remains injury free in a safe Patient environment. No signs or symptoms of: Safety Infection DVT or Pulmonary Emboli Hypokalemia Dx No evidence of skin breakdown. Procedures/Treatment Skin Activity Limitation Braden Scale initiated Integrity · Importance of follow-up care COPD Teaching Plan developed. Pain free or verbalizes relief after

Problem/

Patient/Family

Satisfaction

Obtains adequate gas exchange as
Ineffective evidenced by:
Improved mental status
Pattern Improved respiratory rate
Shortness of Breath

Discharge
Plan

Initial Discharge Plan identified.

Discharge
Plan

TBedrest

hospitalization identified.

Completes ADL's with assist.

Fears/concerns related to illness and

intervention.

2-31-2 B

INTERVENTIONS (continued on back) Patient Care Patient Care Е Categories Categories \* Diet: Nutrition Discharge % of diet consumed: Plan Breakfast \_\_\_\_ Lunch \_ Dinner High risk nutritional assessment completed. Notify RD if diet is: Protien restricted · ADA Intake < 50%</li>

Pain

Management

Anxiety

Alterations in ADL's Patient Care DAY 1 E N Patient Care Categories Date: Categories Vital signs q \_\_\_ hr. Encourage verbalization of fears / Assessment Teaching concerns. \* O<sub>2</sub>: \_ Assess readiness to learn Treatments Psychosocial \* I&O Initial learning needs identified: Assess respiratory status. Assess level of consciousness. \*IV Corticosteroids COPD booklet given to patient/family. \*Antibiotics COPD Teaching Protocol initiated. PO Assess need for stomach protection. Insert PIID Consider DVT prophylaxis (Bedrest/limited activity) Blood glucose q \_\_\_\_hr Lab / diagnostics results reviewed; MD Specimens notified if indicated. Sputum gram stain and C & S Diagnostics Falls protocol initiated. Safety \* Activity level: Activity \* Bedrest with BRP. Provide for uninterrupted sleep / rest periods. \* Respiratory Care provided. (See Respiratory Care Record)

INTERVENTIONS

University Medical Center

indicates medical orders needed

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DESIRED OUTCOMES

### D = DAYS E = EVENINGS N = NIGHTS

	DESI	RED	OU	TCC	DMES	D = DAYS E = EVENINGS N = NI	GHIS		
Problem/ Needs	Day 2 Date:	D	Ε	N	Problem/ Needs	row mark	D	Ε	٨
Knowledge Deficit related	Patient/family verbalizes understanding of anticipated plan of care and participates in decision making.				Patient Safety	Remains injury free in a safe environment.  No signs or symptoms of:			F
to plan of care	Verbalizes / demonstrates knowledge of : • Medications • Activity Limitations					Infection     DVT or Pulmonary Emboli     Hypokalemia			
	Importance of follow-up care				Skin	No evidence of skin breakdown.			
					Integrity				
Pain	Pain free or verbalizes relief after intervention.					Patient/family verbalizes satisfaction	+		Ļ
Management	intervention.				Patient/Family Satisfaction	with hospital stay/care.	+	_	$\vdash$
							$\perp$		L
Ineffective	Demonstrates improved gas exchange evidenced by:				Discharge Plan		_		L
Breathing	Stable Mental Status				, ,,,,,				
Pattern	Improved breath sounds								
Shortness of Breath	Decreased expiratory effort     Increased clearing of secretions								
Anxiety	Verbalizes decreasing anxiety						T		Г
				1					
Alterations	Able to perform ADL's with minimal assist						+		L
in ADL's	Tolerates OOB to chair								
	Ambulates with assistance								

INTERVENTIONS (continued on back)

Patient Care	TO ALL PERSONS AND ADDRESS OF THE PARTY OF T	D	E	N	Patient Care		D	E	N
Categories	0 01 1 14 7 5.1				Categories				
Discharge	Initiate Discharge Plan				Nutrition	* Diet:			
Plan				1		% of diet consumed:		Ш	Ш
				1		Breakfast%			
						Lunch %			
						Dinner %			
						Intake < 50 % - notify RD			
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MR# INTERVENTIONS Patient Care DAY 2 EN Patient Care E Categories Date: Categories Vital signs q \_\_\_ hr. Encourage verbalization of fears / Assessment Teaching concerns. \* O<sub>2</sub>: \_ Instruct: Treatments Psychosocial Medications: \* 1&0 Dosage, indications, actions and side effects / interactions Assess respiratory status. List medications: Assess level of consciousness. \*IV Corticosteroids Use of MDI \*Antibiotics PO Smoking cessation -Assess need for stomach protection. Maintain or dc'd PIID Activity limitations Consider DVT prophylaxis (Bedrest/limited activity) Diet Blood glucose q \_\_\_\_hr Consider referral to Pulmonary Rehab · Importance of follow-up care · Consider referral to smoking cessation Lab / diagnostics results reviewed; MD program Specimens notified if indicated. \* Repeat K+ Level Diagnostics \* OOB to chair with BRP Safety Ambulates with assist Provide for uninterrupted sleep / rest Activity periods. Assess need for functional evaluation by physical medicine and rehabilitation.

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\* Respiratory Care provided.

(See Respiratory Care Record)

indicates medical orders needed

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DESIRED OUTCOMES

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Problem/ Needs	Day 3 Date:	D	E	N	Problem/ Needs		D	E	^
Knowledge Deficit related	Patient/family verbalizes understanding of anticipated plan of care and participates in decision making.				Patient Safety	Remains injury free in a safe environment.  No signs or symptoms of:	F		F
to plan of care	Verbalizes / demonstrates knowledge of :  • Dx  • Medications					Infection     DVT or Pulmonary Emboli     Hypokalemia			
	Activity Limitations     Importance of follow-up care				Skin Integrity	No evidence of skin breakdown.			
Pain	Pain free or verbalizes relief after intervention.					Patient/family verbalizes satisfaction	<u> </u>		L
Management				Patient/Family Satisfaction	with hospital stay/care.			+	
	Tolerates increased activity with minimal				Discharge	Discharge Plan completed and communicated to patient / family	$\dagger$		t
Ineffective Breathing Pattern Shortness of Breath	SOB				Plan	communicated to patient / family			T
Anxiety	Verbalizes the level of anxiety has decreased								T
Alterations	Able to perform ADL's with minimal assist						_		ļ
in ADL's	Tolerates ambulation (choose one):  — with assistance — without assistance								

INTERVENTIONS (continued on back)

Patient Care	D	E	N	Patient Care		D	E	N
Categories				Categories				
Discharge			7	Nutrition	* Diet:			
Plan					% of diet consumed:			
			- 1		Breakfast%			
	1				Lunch %			
					Dinner %			
	4		- 1		Intake < 50 % - notify RD	T		
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MR# INTERVENTIONS Patient Care DAY 3 D E D E N Patient Care Categories Categories Date: \* Vital signs q \_\_\_ hr. Encourage verbalization of fears / Assessment Teaching concerns. \* O<sub>2</sub>: \_\_ Instruct: Treatments Psychosocial Discharge Medications: \* 1&0 Dosage, indications, actions and side effects / interactions List medications: Assess respiratory status. Assess level of consciousness. \*IV Corticosteroids Meter Dose Inhaler use IV \_ PO \*Antibiotics Activity limitations PO Assess need for stomach protection. Maintain or dc'd PIID Diet Consider DVT prophylaxis · Importance of follow-up care (Bedrest/limited activity) Blood glucose q \_\_\_\_hr Lab / diagnostics results reviewed; MD notified if indicated. Specimens Diagnostics \* OOB to chair with BRP Safety Ambulates (choose one): Activity with assistance without assistance

University Medical Center

\* indicates medical orders needed

Medical Record

Respiratory Care provided.
 (See Respiratory Care Record)

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Problem/	Day 4	D	E	N	Problem/		D	E	N
Needs	Date:				Needs				
	DESIRED OUTCOMES   D = DAYS E = EVENINGS N = NIGHT			Г					
Knowledge					Patient	environment.			
Deficit related					Safety	No signs or symptoms of:	T		Γ
to plan of care		DESIRED OUTCOMES   D = DAYS E = EVENINGS N = NIGHTS							
						DVT or Pulmonary Emboli			
	Day 4   Date:   D   E   N   Problem/ Date:   Patient/family verbalizes understanding of anticipated plan of care and participates of in decision making.   Patient Safety   No signs or symptoms of:   Infection   DVT or Pulmonary Emboli   Hypokalemia   No evidence of skin breakdown.   No evidence of skin breakdown.   Patient Intervention.   Patient Intervention.   Patient Intervention.   Patient Intervention.   Patient Intervention.   Discharge Plan   Discharge			L					
	Activity Limitations	DESIRED OUTCOMES   D = DAYS E = EVENINGS N = NIGHT:   D   E   N   Problem/ Needs   D   D   D   D   D   D   D   D   D	T		Т				
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Pain	intervention.		ı			Patient/family verbalizes satisfaction	T		T
Management			$\vdash$	1	Patient/Family				
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Ineffective	SOB	-	├-	+-	Pian				
Breathing Pattern							+	$\vdash$	╁
Shortness			1	1		1			
of Breath				1					
	Verbalizes the level of anxiety has	$\overline{}$	+	+	<del>†                                      </del>		+	一	
Anxiety	,		1						
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	Able to perform ADL's with minimal	T	T						L
Alterations	assist						T	Г	T
in ADL's	Tolerates ambulation (choose one):		Т		1			1	ı
	- with assistance	/S 1993							1
	- without assistance	1			1				
	INTER	VENTI	ONS	S (cc	ntinued on bac				
Patient Care			_	_		T	D	F	IN
Categories			-	"			1	-	1"
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Patient Care	D	Ε	N	Patient Care		D	Ε	N
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Discharge				Nutrition				L
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MR# INTERVENTIONS Patient Care DAY 4 E N Patient Care DEN Date: Categories Categories \* Vital signs q \_\_\_ hr. Encourage verbalization of fears / Assessment Teaching concerns. \* O<sub>2</sub>: \_ Instruct: Treatments Psychosocial Discharge Medications: \* 1&0 Dosage, indications, actions and side effects / interactions Assess respiratory status. List medications: Assess level of consciousness. \*IV Corticosteroids · Meter Dose Inhaler use IV \_\_\_\_ PO \*Antibiotics IV PO Activity limitations Assess need for stomach protection. Maintain or dc'd PIID Diet Consider DVT prophylaxis (Bedrest/limited activity) · Importance of follow-up care Blood glucose q \_\_\_\_hr Lab / diagnostics results reviewed; MD notified if indicated. Specimens Diagnostics \* OOB to chair with BRP Safety Ambulates (choose one): Activity - with assistance without assistance

University Medical Center

\* Respiratory Care provided. (See Respiratory Care Record)

\* indicates medical orders needed

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ADDRESSOGRAPH

DESIRED OUTCOMES

#### D = DAYS E = EVENINGS N = NIGHTS

	DESI	RED OUTCOMES				D = DAYS E = EVENINGS N = NIGHTS			
Problem/ Needs	Day 5 Date:	D	Ε	N	Problem/ Needs		D	Ε	^
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of anticipated plan of care and participates in decision making.  Verbalizes / demonstrates knowledge of :  Dx  Medications				Patient Safety	Remains injury free in a safe environment.  No signs or symptoms of:  Infection  DVT or Pulmonary Emboli  Hypokalemia			
	Activity Limitations     Importance of follow-up care				Skin Integrity	No evidence of skin breakdown.			I
Pain Management	Pain free or verbalizes relief after intervention.				Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care.			
Ineffective Breathing Pattern Shortness	Tolerates increased activity with minimal SOB ABG's stable at baseline				Discharge Plan				F
of Breath  Anxiety	Verbalizes the level of anxiety has decreased								
Alterations in ADL's	Able to perform ADL's with minimal assist Tolerates ambulation (choose one): — with assistance — without assistance								

INTERVENTIONS (continued on back)

INTERVENTIONS (continued on back)											
Patient Care	And the state of the state of	D	Ε	N	Patient Care		D	E	N		
Categories					Categories						
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MR# INTERVENTIONS Patient Care DAY 5 Patient Care EN E N Categories Date: Categories \* Vital signs q \_\_\_ hr. Encourage verbalization of fears / Assessment Teaching concerns. \* O<sub>2</sub>: \_\_\_ Instruct: Treatments Psychosocial Discharge Medications: \* 1&0 Dosage, indications, actions and side effects / interactions Assess respiratory status. List medications: Assess level of consciousness. \*IV Corticosteroids Meter Dose Inhaler use PO \*Antibiotics PO Activity limitations Assess need for stomach protection. Maintain or dc'd PIID Diet Consider DVT prophylaxis (Bedrest/limited activity) Importance of follow-up care Blood glucose q \_\_\_\_hr Consider referral to Pulmonary Rehab Consider referral to smoking cessation Lab / diagnostics results reviewed; MD program Specimens notified if indicated. Diagnostics \* OOB to chair with BRP Safety Ambulates (choose one): Activity with assistance without assistance Respiratory Care provided.

University Medical Center

(See Respiratory Care Record)

\* indicates medical orders needed