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

CABG Uncomplicated **LIMA:** _____ **OR Date:** _____

ESTIMATED LOS: **5 Days** **Date placed on map:** _____

EXCLUSIONARY CRITERIA:

1. *EF < 20%*
2. *Second Reop (3rd Surgery)*
3. *Valve surgery*
4. *Renal Failure: Dialysis pre-op or CR>2.8*
5. *Aneurysm*
6. *Cardiogenic shock: CI < 2.0 on inotropes*
7. *Severe COPD/Pre-op ABG reveals any of the following*
   - *PaO2 < 60 or SAT < 92% on Room Air/PaCO2 > 50.*

CRITERIA FOR REMOVING PATIENTS FROM CAREMAP®

(Switch to Generic Cardiac Surgery Caremap)

1. *> 2 systems failed (including cardiac)*
2. *CVA (not wake up > 48 post-op)*
3. *CI < 2.0 x 4 days*
4. *Vent dependency x 5 days*

Primary Diagnosis/Procedure: _____

Pertinent Past Medical History: _____

Allergies: _____

Pre-op Medications: _____

Significant Pre-op Lab Work: _____

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:* _____

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

COURSE/SIGNIFICANT EVENTS THIS ADMISSION:

Admission: _____

_____

POD #1: _____

_____

POD #2: _____

_____

POD #3: _____

_____

POD #4: _____

_____

POD #5: _____

_____

POD #6: _____

_____

POD #7: _____

_____

OTHER: _____

TRANSFER SUMMARY:

Invasive Lines	*Site*	*Date In*	*Removed*
Swan			
DLC			
Aline			
PIID (HL) Size: _____			*New Site/Date :*
Chest Tubes			
Foley		*Void:*	

Pacing Wires: _____*A* _____*A* _____*V* _____*V*

Pacer Used: _____

Other: _____

Last Medicated: _____ ***Most Recent Labs: K+*** _____ ***WBC*** _____ ***H/H*** _____

Other: _____ ***Total I/O Balance (since surgery)*** _____

CULTURES

Site	*Date*	*Results*

RN Signature: _____

CABG Uncomplicated

Signature	Title	Initial

SIGNATURE REQUIRING CO-SIGNATURE		
Signature Requiring Co-Signature	Date/Shift	Initial/Title

ADDRESSOGRAPH

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

Problem/ Needs	Day of Surgery Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of anticipated plan of care and participates in decision making.			
	Patient/family verbalizes decreased anxiety with ICU environment.			
Pain Management	Pain free or verbalizes relief after intervention.			
Decreased Tissue Perfusion	Cardiac Index >=			
	Stable HR:			
Potential For Infection	Dressing dry & intact.			
	Glucose <=200			
Impaired Gas Exchange	Extubated < = 8 hrs.			
	Denies shortness of breath.			

Problem/ Needs		D	E	N
Mobility	Moves all extremities well upon command.			
Fluid and Electrolytes Diet	Urinary output > 30 cc/hr.			
	Labs within therapeutic range.			
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	Cardiac Surgery nurse contacts Discharge Planning / Social Services (if problems anticipated).			

Patient Care Categories		D	E	N
Nutrition	* NPO while intubated. NGT/OGT as per unit standard.			
	* D/C NGT/OGT after extubation. Ice chips, progress clear liquid as tolerated.			
	High risk nutritional assessment completed.			

INTERVENTIONS (continued)

Patient Care Categories	Day of Surgery Date: _____	D	E	N
Assessment & Treatments	* VS, Hemodynamic monitoring, assessments, I/O, chest tube management, invasive line care and wound care as per unit standard.			
	* - Autotransfusion - Cardiac infusions - titrated according to parameters (see flow sheet).			
	* Pacing set for: _____ pacing at _____ MA _____ rate.			
	* Re-warm patient as per unit standard.			
	Assess need for Demerol IVSS for shivering.			
	Evaluate need for pre-op meds.			
	Assess comfort as per unit standards.			
	* Administer blood and fluid products as per unit standard.			
	* Monitor respiratory status as per unit and respiratory department standards.			
	* Pulmonary toilet as per unit standard. Respiratory support (see flow sheet). Assess need for additional respiratory care.			
	* <u>Pre-Extubation</u>: Draw initial ABG (RT/RN). Monitor patient vent system as per unit standard of care for CS patient.			
	* Begin weaning when indicated as per unit standard.			
	* Extubate as per unit standard.			
	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	Encourage verbalization of fears / concerns.			
	Assess patient / family satisfaction.			
	Learning needs / teaching plan: - ICU routine and enviornment. - Expected post-op course. - Current status. - Cough & deep breathing. - Incentive spirometry use. - Splinting. - Pain management. - Other:			
	Given family information book.			
	Orient patient when appropriate.			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	* CBC, SMA7, PT, PTT, ABG, MVBG, Mg on adm.			
	* BS monitoring as ordered: _____ _____			
	* K+, CBC, ABG, PRN.			
	* CPK-MB 15 hrs. post-op: Time: * 12 lead ECG on admission & in a.m./ only if patient not AV paced.			
	* CXR on admission (if not done in OR).			
	* Tests / Procedures _____ _____ _____ _____ _____ _____ _____			
Safety & Activity	Falls protocol initiated.			
	* Complete bed bath after 6 hr. if stable.			
	* OOB to dangle and to chair, if hemodynamically stable.			
	All alarms and parameters set. Call bell within reach.			

University Medical Center

** indicates medical orders needed*

CABG Uncomplicated

Signature	Title	Initial

SIGNATURE REQUIRING CO-SIGNATURE

Signature Requiring Co-Signature	Date/Shift	Initial/Title

ADDRESSOGRAPH

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

Problem/ Needs	POD #1 Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of anticipated plan of care and participates in decision making.			
	Patient/family verbalizes decreased anxiety with ICU environment & transfer to 4 West Stepdown Unit.			
Pain Management	Pain free or verbalizes relief after intervention.			
Decreased Tissue Perfusion	Stable CI off infusions.			
Potential For Infection	Central and arterial lines removed.			
	Glucose <=200			
Impaired Gas Exchange	Denies shortness of breath.			
	No wheezing / stridor.			
	Incentive spirometry > 500 or:			

Problem/ Needs		D	E	N
Mobility	Transfer to 4 West (SDU)			
	OOB to chair.			
Fluid and Electrolytes Diet	Urinary output > 30 cc/hr.			
	Labs within therapeutic range.			
	Tolerating clear liquids.			
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	Evaluate need for special Discharge Planning. Referral to Discharge Planning/ Social Services if appropriate.			

Patient Care Categories		D	E	N
Nutrition	* Clear liquids and advance diet to 2 gm Na low chol diet, or:			
	% of diet consumed: Breakfast _____% Lunch _____% Dinner _____%			

INTERVENTIONS (continued)

Patient Care Categories	POD #1 Date: _____	D	E	N
Assessment & Treatments	* VS, Hemodynamic monitoring, assessments, I/O, chest tube management, invasive line care and wound care as per unit standard.			
	* Wean cardiac infusions (see flow sheet).			
	* D/C central access and KVO infusion and insert peripheral line.			
	* D/C swan			
	* D/C Aline, consider radial Aline if arterial monitoring continues.			
	* Cap pacing wires if rhythm stable > 24 hrs.			
	* D/C chest tubes. Time: _____ Occlusive dressing x 24 hrs. Obtain CXR after removal of pleural chest tubes.			
	* D/C Foley, call MD if no void in 8 hrs. Removal time:			
	* Remove initial sternal / leg dsg. Time:			
	Assess comfort as per unit standard & evaluate need for pain med.			
	* Transfer to 4 West.			
	* Pulmonary toilet as per unit standard. Respiratory support (see flow sheet).			
	Assess need for additional respiratory care.			
	Incentive Spirometry q 1 hr. while awake.			
	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	Encourage verbalization of fears / concerns.			
	Assess patient / family satisfaction.			
	Learning needs / teaching plan: - ICU enviornment and equipment. - Expected post-op course. - Current status. - Cough & deep breathing. - Incentive spirometry use. - Splinting. - Pain management. - Activity progression . - Other:			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	* EKG, SMA-7, CBC, PLTs, CPK-MB, Triponin, Stat.			
	* BS monitoring as ordered:			
	* K+ and CBC 12 p & 8 p.			
	* Tests / Procedures _____ _____ _____ _____ _____ _____			
Safety & Activity	Falls protocol maintained.			
	Notify PMR for PT evaluation to be completed on Day 2.			
	* Assist with turning and bathing as needed.			
	* After dangling, OOB to chair x 2 (keep feet elevated as much as possible).			
	All alarms and parameters set. Call bell within reach.			

CABG Uncomplicated

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ADDRESSOGRAPH

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

Problem/ Needs	POD #2 Date: _____	D	E	N	Problem/ Needs		D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of anticipated plan of care and participates in decision making. Aware of pending discharge.				Mobility	Patient ambulating 40 ft. with or without assistive device. Requires no more than assist of 1 to transfer OOB.			
Pain Management	Pain free or verbalizes relief after intervention.				Fluid and Electrolytes Diet	Urinary output > 720 cc in 24 hrs.			
	Comfortable on PO pain medication.					Labs within therapeutic range.			
						Advance to solid diet.			
Decreased Tissue Perfusion	Stable rhythm (asymptomatic)								
Potential For Infection	Chest tube, foley and all dressings removed.				Patient Safety	Remains injury free in a safe environment.			
Impaired Gas Exchange	O_2 needed for activity only				Skin Integrity	No evidence of skin breakdown.			
	Incentive spirometry > 750-1000 or:								
					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	Evaluate need for special Discharge Planning. Referral to Discharge Planning/ Social Services if appropriate.				Nutrition	* Advance diet to 2 gm Na low chol diet, or:			
						% of diet consumed: Breakfast _____% Lunch _____ % Dinner _____ %			

** indicates medical orders needed*

INTERVENTIONS (continued)

Patient Care Categories	POD #2 Date: _____	D	E	N
Assessment & Treatments	* VS, Hemodynamic monitoring, assessments, I/O, chest tube management, invasive line care and wound care as per unit standard.			
	* Assess comfort as per unit standard. Evaluate need for laxatives and pain meds.			
	* D/C chest tubes. Time: _____ Occlusive dressing x 24 hrs. Obtain CXR after removal of pleural chest tubes.			
	* D/C Foley, call MD is no void in 8 hrs. Time:			
	* Cap pacing wires if rhythm stable > 24 hrs.			
	* Removal of initial sternal/leg dsg. (P/S). Time:			
	* Pulmonary toilet as per unit standard. Respiratory support (see flow sheet).			
	Assess need for additional respiratory care.			
	Incentive Spirometry q 1 hr. while awake.			
	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	Encourage verbalization of fears / concerns.			
	Assess patient / family satisfaction.			
	Learning needs / teaching plan: - Cough & deep breathing. - Insentive Spirometry. - Activity progression. - Incision care. - Signs / symptoms of infection. - Medications: action, purpose, side effects, dose, frequency. - Pain management. - Other:			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	* CBC, SMA7 in am.			
	* BS monitoring as ordered:			
	* Follow-up on post-op CPK-MB results.			
	* Tests / Procedures _____ _____ _____ _____ _____ _____			
Safety & Activity	Falls protocol maintained.			
	PMR to complete PT evaluation.			
	* OOB TID (feel elevated, when possible) and ambulate width of room BID. BRP and bathe with assist.			
	All alarms and parameters set. Call bell within reach.			

CABG Uncomplicated

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ADDRESSOGRAPH

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

Problem/ Needs	POD #3 Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of anticipated plan of care and participates in decision making.			
Pain Management	Pain free or verbalizes relief after intervention.			
	Comfortable on PO pain medication.			
Decreased Tissue Perfusion	Stable rhythm (asymptomatic)			
Potential For Infection	WBC returned to normal range.			
	Wounds without drainage.			
	Afebrile.			
Impaired Gas Exchange	Tolerates activity progression without need for O_2.			
	Incentive spirometry = or > 1000 or:			

Problem/ Needs		D	E	N
Mobility	Patient ambulating 40 ft. with or without assistive device. Requires no more than assist of 1 to transfer OOB.			
	Walks 3-4 min. with assistance TID.			
Fluid and Electrolytes Diet	I & O balance achieved.			
	Tolerates > 50% of diet.			
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	2 gm Na low chol diet, or:			
	% of diet consumed: Breakfast _____% Lunch _____ % Dinner _____ %			
	If consuming < 50% or specialty diet needed, notify dietitian.			

* *indicates medical orders needed*

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ADDRESSOGRAPH

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

Problem/ Needs	POD #3 Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of anticipated plan of care and participates in decision making.			
Pain Management	Pain free or verbalizes relief after intervention.			
	Comfortable on PO pain medication.			
Decreased Tissue Perfusion	Stable rhythm (asymptomatic)			
Potential For Infection	WBC returned to normal range.			
	Wounds without drainage.			
	Afebrile.			
Impaired Gas Exchange	Tolerates activity progression without need for O_2.			
	Incentive spirometry = or > 1000 or:			

Problem/ Needs		D	E	N
Mobility	Patient ambulating 40 ft. with or without assistive device. Requires no more than assist of 1 to transfer OOB.			
	Walks 3-4 min. with assistance TID.			
Fluid and Electrolytes Diet	I & O balance achieved.			
	Tolerates > 50% of diet.			
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	2 gm Na low chol diet, or:			
	% of diet consumed: Breakfast _____% Lunch _____ % Dinner _____ %			
	If consuming < 50% or specialty diet needed, notify dietitian.			

* *indicates medical orders needed*

CABG Uncomplicated

Signature	Title	Initial

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ADDRESSOGRAPH

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

Problem/ Needs	POD #4 Date: _____	D	E	N	Problem/ Needs		D	E	N
Knowledge Deficit related to plan of care	Patient / family verbalizes questions / concerns about discharge.				Mobility	Ambulates independently, performs ADL's, begins stairs.			
	Dietary instructions complete.					Patient ambulating 100 ft. Able to go up and down stairs. OOB independently.			
Pain Management	Pain free or verbalizes relief after intervention.				Fluid and Electrolytes Diet	Weight within 2 lbs. of pre-op; no edema.			
						Tolerates > 50% of diet.			
Decreased Tissue Perfusion	Stable rhythm > 24 hrs. & requires no further cardiac monitoring.								
Potential For Infection	Pacing wires removed. Wounds without drainage or redness.				Patient Safety	Remains injury free in a safe environment.			
	Afebrile.								
Impaired Gas Exchange	Denies SOB with activity progression and without O_2.				Skin Integrity	No evidence of skin breakdown.			
	Incentive spirometry = or > 1000 or:								
					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	Discharge assessment / plans complete by **Discharge Planner**.				Nutrition	2 gm Na low chol diet, or:			
	Referral to appropriate facility as needed by **Social Worker**.					% of diet consumed:			
						Breakfast _____%			
						Lunch _____ %			
						Dinner _____ %			

* *indicates medical orders needed*

INTERVENTIONS (continued)

Patient Care Categories	*POD #4 Date: _____*	*D*	*E*	*N*	*Patient Care Categories*		*D*	*E*	*N*
Assessment & Treatments	* VS, assessments, I/O, invasive line care and wound care as per unit standard.				*Teaching & Psychosocial*	Encourage verbalization of fears / concerns.			
	* Evaluate need for continued telemetry and discontinue if possible. Discontinue peripheral line if telemetry discontinued.					Assess patient / family satisfaction.			
	* Assess comfort as per unit standard. Evaluate need for laxatives and pain meds.					Discharge instructions in progress. Reinforce all previous teachings. - When to call MD. - Review medications. - Incision care, signs / symptoms of infection. - Give discharge booklet. - Activity / exercise: lifting, driving, socializing, ADL's, sexual activity & limitations. - Reinforce dietary teaching. - Risk factors, stress management.			
	* Pacing wires removed as per unit standard.								
	* D/C O_2 if not already done.								
	* If still on nebulizer treatments, evaluate need to continue.								
	* Pulmonary toilet as per unit standard. Respiratory support (see flow sheet). Assess need for additional respiratory care.								
	D/C I & O 48 hrs. out of ICU (if not done).								
	Incentive Spirometry q 1 hr. while awake.								
					Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
						* BS monitoring as ordered:			
						* Tests / Procedures _____ _____ _____ _____ _____ _____			
					Safety & Activity	Falls protocol maintained.			
						Keep feel elevated when in chair. Walk 150 ft. in the hallway without assistance TID. Begin stairs. Bathe independently.			
						All alarms and parameters set. Call bell within reach.			
	Hygiene & Comfort Protocol								
	Peripheral IV Therapy Protocol								
	Pressure Ulcer Prevention Protocol								
	* Respiratory Care provided. (See Respiratory Care Record)								

CABG Uncomplicated

Signature	Title	Initial

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Signature Requiring Co-Signature	Date/Shift	Initial/Title

ADDRESSOGRAPH

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

Problem/ Needs	POD #5 - Discharge Day Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalizes questions / concerns of discharge, home care, post-op follow-up care and dietary instructions.			
Pain Management	Pain free or verbalizes relief after intervention.			
Decreased Tissue Perfusion	Stable hemodynamics (VSS, rhythm stable, skin warm and dry).			
Potential For Infection	Incisions intact without redness, swelling or drainage.			
	Temperature <= 100° F for > 24 hrs.			
Impaired Gas Exchange	Lungs clear.			
	Denies SOB with activity progression and without O_2.			
	Incentive spirometry = or > 1000 or:			

Problem/ Needs		D	E	N
Mobility	Patient ambulating 100 ft. Able to go up and down stairs. OOB independently.			
Fluid and Electrolytes Diet	Weight within 2 lbs. of Pre-op; no edema.			
	Labs within therapeutic range.			
	Tolerates > 50% of diet.			
Discharge Plan	Discharge			
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 orders, instructions and prescriptions written.			
	Referral to appropriate facility for home care as needed by **Discharge Planner**.			
	* Discharge to home or transfer to appropriate facility. Time:			

Patient Care Categories		D	E	N
Nutrition	2 gm Na low chol diet, or:			
	% of diet consumed: Breakfast _____% Lunch _____ % Dinner _____ %			
	Reinforce dietary instruction as needed.			

INTERVENTIONS (continued)

Patient Care Categories	POD #5 - Discharge Day Date: _____	D	E	N
Assessment & Treatments	* VS, assessments, I/O, invasive line care and wound care as per unit standard.			
	D/C telemetry and peripheral line (if not already done).			
	* Assess comfort as per unit standard. Evaluate need for laxatives and pain meds.			
	* Pulmonary toilet as per unit standard. Respiratory support (see flow sheet).			
	Assess need for additional respiratory care.			
	D/C I & O 48 hrs. out of ICU (if not done).			
	Incentive Spirometry q 1 hr. while awake.			
	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	Encourage verbalization of fears / concerns.			
	Assess patient / family satisfaction.			
	Discharge instructions in progress. Reinforce all previous teachings.			
	Follow-up appointment & emergency contact given by nursing: - When to call MD. - Ensure discharge booklet given. - Activity / exercise: lifting, driving, socializing, sexual activity & limitations. - Risk factors, stress management. - Pulse taking. - Information about cardiac rehabilitation program.			
	Provide reassurance to patient / family regarding going home.			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	* Tests / Procedures _____ _____ _____ _____ _____ _____			
Safety & Activity	Falls protocol maintained.			
	Ambulate independently with stairs. Able to walk 200 ft. Perform ADL's independently. Bathe independently.			
	All alarms and parameters set. Call bell within reach.			