Milestone Hospice - Bellflower **Plan of Care** From: to

Print Patient's Name: | SEX: | DATE DATA ENTERED:

SOC Date:	MR#	Male	By:
Date of Birth:	Principal Diagnosis:	Female	RN Audit by:
SS#			Date printed:

SUPPLIES

2x2	Nu-gauze
4x4	Cotton Applicators
ABD Pads	Tongue Depressors
Kling	Gloves
Kerlix	Masks
Paper Tape	Isolation Gowns
Plastic Tape	Betadyne
Tegaderm	H202
Duoderm	NaCl
Other	H2O

Surgical Procedures:

Other Pertinent Diagnosis:
1
2

DIET
- Regular
- Puree
- As Tolerated
- Therapeutic

ACTIVITIES PERMITTED

Complete Bedrest	Crutches
Bedrest BRP	Cane
Up As Tolerated	Wheelchair
Transfer Bed/Chair	Walker
Exercises Prescribed	Stand-By Assist.
Partial Weight Bearing	Mod. Assist
Other:	Max Assist

MENTAL STATUS

Oriented	Lethargic
Comatose	Agitated
Forgetful	Depressed
Other:	Disoriented

Current Nutrition Adequate?
- Yes
- No

PROGNOSIS
- Poor
- Guarded
- Fair
- Good
- Excellent

LIST ALLERGIES

REHAB POTENTIAL
- Poor
- Guarded
- Fair
- Good
- Excellent

FUNCTION LIMITATIONS

Amputation	Dyspnea with
Bowel/Bladder (Incontinence)	Minimum Exertion
Contracture	Altered Balance
Hearing	Altered Coordination
Paralysis	Endurance
Speech	Ambulation
Legally Blind	Other:

SPECIFIC PHYSICIAN'S ORDERS

DNR IN EFFECT

MEDICATIONS GIVEN BY:
- Patient
- PCG
- Facility Staff

HOSPICE LEVEL OF CARE
- Routine
- GIP
- Respite
- Continuous Care

PSYCHO-SOCIAL NEEDS
- Family Conflicts
- Financial Concerns
- Family / Patient not coping well
- Pt./Fam Mental Illness
- Good Support Systems

EQUIPMENT IN HOME
- Wheel chair
- Hosp Bed
- O2 Concentrator

Teach pain control, symptom management, possible complications, and S/S to report to MD/hospice. Establish trusting relationship with patient, family. Provide emotional support. Coordinate care with family/PCG. TX:

RN Signature	Date	Time
P.C.P. NAME	SIGNATURE	DATE
P.C.P. ADDRESS	CITY, STATE	ZIP

SPECIFIC NURSING ORDERS

Plan of Care

Patient Name:	MR#:	Plan of Care As Of:

Projected Visits

SN:		MSW:		PC:	
CHHA:		Volunteer:		Therapist:	

Medications:

Allergies:

PHARMACY: PHONE:

Start Date	Drug Name	Dose	Route	Frequency	Indication	C/NC

Meds. Continued on page 2:

Next Plan of Care to be reviewed and updated on: and PRN

IDT Signatures

Signature	Title	Date	Signature	Title	Date
	M.D.			M.S.W.	
	R.N.			CHAPLAIN	

White - CHART Canary - DATA INPUT

GENERAL NURSING ORDERS	START	NURSE	TEACH		START	NURSE	TEACH
Teach Actions / Side Effects of medication				Monitor for s/s of Agitation/Anxiety			
Monitor Effectiveness/Meds Side Effects/Trtmnt				Temperature No. of days ___			
Monitor Pt/PCG compliance with med regimen				Q Hours X			
Monitor pain level				Monitor for s/s of UTI / URI			
Change Pt Position Q2H				Monitor C/P status Q visit			
Monitor resp status / assess lung sounds Q visit				Monitor edema Q visit			
Monitor N/V				Monitor skin integrity			
Teach s/s of: ______________				Monitor wound for s/s of infection			
Suction: (freq.) ______________				Monitor for s/s hypo/hyperglycemia			
Check DME Q visit				Monitor satisfaction with services			
Demonstrate proper use of equipment				Monitor need for and results of lab work			
CHHA to assist with ADL				Monitor for s/s of depression			
For Family: MSW for				Monitor abnormal sleeping pattern			
ForPatient: psychosocial support				Teach coping mechanisms			
Chaplain services for spiritual support							
Volunteer for non-medical services				Teach other coping mechanisms:			

GOALS	DUE	DONE	GOALS	DUE	DONE
Demonstration of compliance with med regimen			No edema of LE		
Pain @ <3 on a 1-10 scale			Fasting Blood Sugar between 60-180		
Wound healing within ___ Weeks			To verbalize satisfaction of services		
Resp rate between 16-24			Blood levels of ______________ WNL		
Lungs clear			Demonstration of coping mechanisms		
No nausea / vomiting			No s/s of depression		
Demonstration of proper use of equipment			Temp / BP / Pulse / Resp Rate / WNL		
No evidence of agitation/anxiety			No s/s of UTI / URI		
No incident of fall			ADL Needs Met		

PAIN	START	NURSE	TEACH		START	NURSE	TEACH
Teach patient/caregiver identification of pain, relief measures, environmental factors, pain control theory & other relief measures.				Assess emotional factors, environmental stressors, psycho/social/spiritual factors, physiological responses.			
Instruct patient/caregiver in medications as ordered & assess proper use & effectiveness of medication.				Ongoing assessment of pain for type, location, duration, frequency or pattern verbal & non-verbal.			
Communicate status/changes to primary physician.							
GOALS		DUE	DONE	**GOALS**		DUE	DONE
Optimal comfort of pain, patient comfort.				Caregiver/patient adequately informed on pain control measures.			

NUTRITION / FLUID BALANCE	START	NURSE	TEACH		START	NURSE	TEACH
Ongoing assessment of intake, personal preferences, anorexia, indigestion, weight change.				Consult with Registered Dietitian PRN.			
				Encourage small frequent meals.			
Teach need for offering fluids, nutritious liquids, supplements, ice chips, positioning - allow patient control				Encourage high protein, high carbohydrate dietary supplement as patient tolerates.			
GOALS		DUE	DONE	**GOALS**		DUE	DONE
Optimal nutritional status & patient comfort.				Minimal anxiety regarding altered nutritional status.			

URINARY ELIMINATION / BLADDER / BOWEL	START	NURSE	TEACH		START	NURSE	TEACH
Teach use/care of equipment, skin & foley catheter care, relief measures, medications & treatment as ordered.				Teach patient/caregiver importance of diet in maintenance of adequate bowel function (e.g., bulk foods, fruit juices, increased fluids).			
Foley catheter PRN as required for progressive symptoms including lower abdominal pain, bladder distention, inability/difficulty voiding. Catheter to be changed monthly & PRN.				Teach/establish bowel protocol including increasing of fluids, stool softeners, laxatives, exercise as tolerated, use of enemas & suppositories.			
Communicate status/changes to primary physician.				Ongoing assessment of urinary elimination status, & complications / alterations.			
Ongoing assessment of alterations in bowel elimination, abdomen bowel sounds.							
GOALS		DUE	DONE	**GOALS**		DUE	DONE
Optimal bladder status & patient comfort.				Understanding by caregivers of changes that occur in elimination with progressive disease process.			
Optimal bowel elimination status & patient comfort.							

FATIGUE	START	NURSE	TEACH		START	NURSE	TEACH
Ongoing assessment of patient's tolerance to activities chosen.				Encourage rest periods between activities.			
				Explanation to family of reasons to expect increase in weakness & fatigue.			
Evaluate & prioritize patient's daily goals.							
GOALS				**GOALS**			
Optimal patient participation in chosen activity.				Patient comfort.			

NAUSEA / VOMITTING	START	NURSE	TEACH		START	NURSE	TEACH
Ongoing assessment of nausea for frequency, pattern, presence of emesis, type & amount, environmental stressors.				Teach relief measures, non-irritating diet, small frequent			
				Communicate status/changes to primary physician.			
Ongoing assessment of effectiveness of meds				**GOALS**		DUE	DONE
GOALS		DUE	DONE	Patient/caregivers to have adequate knowledge of anti-emetics & comfort measures.			
Optimal control N/V, patient comfort & safety.							

SKIN	START	NURSE	TEACH		START	NURSE	TEACH
Assess alteration(s) in skin integrity, size integrity, location, size, type/stage, s/s of infection, drainage, current treatment, high risk areas, & provide ongoing assessment.				Instruct uses of elbow/heel pads to prevent skin friction, use of eggcrate, massage, lotions, & use of physical devices (APP, sheep skin, etc.) as appropriate.			
				Instruct/provide decubitus care as ordered.			
Instruct need to turn patient Q2H, positioning techniques with proper body mechanics.				Encourage participation in care by patient/caregiver.			
				Communicate status/changes to primary			
GOALS		DUE	DONE	**GOALS**		DUE	DONE
Optimal skin integrity, patient comfort.				Patient/caregiver participation in care.			

SAFETY	START	NURSE	TEACH		START	NURSE	TEACH
Assess safety risk, history of injury, patient supervision, pla for emergency, & provide ongoing assessment.				Instruct caregiver in seizure precautions			
				Instruct medication as ordered (route/dosage) & monitor efficacy.			
Instruct in safety care of ambulatory patients & identify household risks				Assist caregiver/patient in identifying plans for emergencies PRN.			
Instruct patient/caregiver in safety care of bed-confined patients (i.e., transfer techniques, use of side rails, trapeze, etc.)				Instruct in use of equipment needed in patient's care			
GOALS		DUE	DONE	**GOALS**		DUE	DONE
Optimal patient/caregiver safety				Emergency preparedness			

SLEEP / REST	START	NURSE	TEACH		START	NURSE	TEACH
Identify sleep pattern, normal pattern, environmental stressors, fears, exacerbating factors such as pain.				Teach/treat relief measures, relaxation techniques, warm drinks, warm baths, medications as prescribed, role of reassurance/companionship during waking hours.			
Communicate status/changes to primary physiciar							
GOALS		DUE	DONE	**GOALS**		DUE	DONE
Optimal sleep/rest for patien				Optimal sleep/rest for caregiver			

EMOTIONAL STATUS / COPING	START	NURSE	TEACH		START	NURSE	TEACH
Ongoing assessment of emotional status, concerns, mode of management, medication(s) interference with ADL.				Allow/encourage patient/caregiver to verbalize feelings, questions, & provide support.			
Communicate status/changes to physiciar							
GOALS		DUE	DONE	**GOALS**		DUE	DONE
Optimal emotional status				Optimal support to patient & caregiver			

SPIRITUAL / RELIGION	START	NURSE	TEACH		START	NURSE	TEACH
Provide availability of multi-disciplinary team to aid in support.				Ongoing assessment of patient/caregivers perception of spiritual/religious needs, concerns, & provide support			
Facilitate communication between clergy & IDT				Contact local clergy PRN.			
GOALS		DUE	DONE				
Optimal spiritual/emotional support to patient & all involved in care.							

MOUTH CARE	START	NURSE	TEACH		START	NURSE	TEACH
Use cold, wet wash cloth or ice chips to keep lips & mouth moist when patient is unable to tolerate liquids.				Brush teeth frequently if able, using mouthwash in between brushing to moisten (discourage alcohol based mouthwash)			
Assessment of effectiveness of medication.				Ongoing assessment of oral cavity for signsof redness, soreness, or infection.			
GOALS		DUE	DONE				
Optimal patient comfort							

RESPIRATORY / VENTILATION	START	NURSE	TEACH		START	NURSE	TEACH
Ongoing assessment of respiratory status for changes in pattern, respiratory rate, lung sounds, cough, SOB, cyanosis.				Instruct caregiver(s) in chest percussions & PD as ordered.			
Instruct medications as ordered (route, dose, side effects & rationale), monitor proper use & efficacy.				Instruct energy saving techniques to decrease exertion.			
Identify activity level precipitant SOB & emotional components of complaints.				Allow patient/caregiver to verbalize feelings/provide support PRN			
Instruct in measures to maximize respiratory status (cough				Communicate status/changes to primary physiciar			
Instruct relief measures of respiratory distress (positioning				Instruct use of oxygen & equipment & monitor efficacy			
GOALS		DUE	DONE	**GOALS**		DUE	DONE
Optimal respiratory status, patient comfort				Caregiver knowledgeable in treatment & comfort intervention & changes			

IMPAIRED MOBILITY	START	NURSE	TEACH		START	NURSE	TEACH
Assess mobility impairment, history, causes, affects on ADL need for assistance, strength & mobility, safety needs, & provide ongoing assessment				Review safety risks & measures with patient/caregiver, i.e., removing throw rugs, use of shower chair, use of side rails, etc.			
Teach measures to promote optimal mobility (active/passive ROM, turning, breathing exercises, proper body alignment).				Assess patient/family's response to impaired function, participationin care & provide support PRN.			
Teach/demonstrate positioning/transferring using body mechanics.				Refer to PT/OT as needed.			
Instruct ways to prevent increased mobility impairments (activity/exercise schedule, skin care program, pain control regimen, optimal nutrition, environmental safety measures, use of energy saving techniques.				Assess caregiver's ability to meet patient's needs & arrange/supervise assistance PRN.			
				Assess need for equipment/assistance devices & instruct proper use to patient/caregiver.			
Communicate status/changes to primary physician.							
GOALS		DUE	DONE	**GOALS**		DUE	DONE
Optimal strength, mobility, & independence				Minimal complications due to impaired mobility statu			
Patient comfort & safety.				Optimal support to caregiver			

CONFUSION / MENTAL CHANGES /	START	NURSE	TEACH		START	NURSE	TEACH
Ongoing assessment of mental status for changes in ability to communicate, memory lapses, incoherence, belligerence, LOC, orientation to person, place, time; medication effects; pattern of occurrence.				Ongoing support of patient & family with explanation of medical diagnosis for cause of confusion & behavior changes.			
				Communicate status/changes to primary physician.			
Determine frequency, pattern & contributing factors to change in mental status.				Teach/treat relief measures including use of simple verbal messages, minimum stimuli, direct verbal reassurance, reality ort.			
GOALS		DUE	DONE	**GOALS**		DUE	DONE
Optimal mental status/LOC, patient safety & family functior				Optimal communication, minimal anxiety R/T impaire			

CAREGIVER / FAMILY CONCERN							
Ongoing assessment of caregivers/family needs/concerns for assistance, support &/or counseling.				Family conferences when appropriate			
				Refer to appropriate interdisciplinary team member PRN.			
Allow caregivers to express needs/concerns & provide support.							
GOALS		DUE	DONE	**GOALS**		DUE	DONE
Optimal family functioning				Optimal support to family/caregivers			