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

interventions identified on the	ADDITECTOR	
Generic Surgical		
ESTIMATED LOS: Days	Date placed on map:	
INCLUSIONARY CRITERIA: All patients undergoing surgery will be placed on this	, unless there is a case-specific	available.
CRITERIA FOR REMOVING PATIENTS FROM	· · · · · · · · · · · · · · · · · · ·	
Remove patients from this if clinical status/diagram	nosis changes and there is a case specific	•
Primary Diagnosis/Procedure:		
Pertinent Past Medical History:		
Allergies:		
Pre-op 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:		
Instructions for Documentation:		

- 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.

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University Medical Center

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University Medical Center

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University Medical Center

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Patient Care	POD #3	D	E	N	Patient Care		D	E	N
Categories	Date:				Categories				
Assessment	Vital signs q hrs.				Teaching	Assess patient / family satisfaction.			
&	I & O q hrs.				&	Encourage verbalization of fears /			
Treatments					Psychosocial	concerns. Learning needs / teaching plan:	-		\vdash
	* Telemetry discontinued	_	\vdash			- Progressive post operative routine			
	Surgical site assessment.					-			
	Dressing change PRN.					-			
	COPESSORES					-			
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		100				incision care	None	144	
					10	food & drug interactions			
	* Maintain bilateral TEDS	-	-			MD follow-up Modifiable risk factors.			
						Medication:			
	* Incentive spirometry q1hr. while awake.					Activity:	.		
	C&DB q1hr while awake.					Activity.			
	* PO pain medications PRN	_				Diet:			
	PO pain medications PRN				The state of the s	Other:			
	Discontinue IV / PIID					71	100	S. 1753)	
And the state of t				- 1	Specimens	Lab / diagnostics results reviewed; MD notified if indicated.			
					& &	* Tests / Procedures	10.10	griss	\vdash
					Diagnostics		(0))(0)	es in S	
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	MAY (CORRIGER SECRETARISE)					Falls protocol maintained.	+		\forall
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		Rvoj	2.75						Ш
	ANO.					Assist to reposition q2hrs. as needed			
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	Lhusiana & Comfort Protocol			_					
	Hygiene & Comfort Protocol								
	Peripheral IV Therapy Protocol								
	Pressure Ulcer Prevention Protocol								
	* Respiratory Care provided. (See Respiratory Care Record)								
	(See Respiratory Care Record)								

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	Signature	Title	Ini	tial						
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Signature Requiring	g Co-Signature Date/Shift	Initial/T	itle							
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Problem/	POD #4	DESI	REL	E	N	OMES Problem/	D = DAYS E = EVENINGS N = NIGI	D	E	N
Needs	Date:			_		Needs				
	Patient/family verbalize ur post-op treatment plan, die and activity; participates ir making / plan of care.	et, medications,					CGST contain the second of the contained of			
Surgical	Pain free or verbalizes pai after intervention.	n relief					PO per medica do Polis			
Pain _Management							SPATVEN BURGLER			Cuping of American
					a distance of					
Post-Operative	Afebrile		unti							
Temperature Elevation	Vital signs returned to bas	eline.	10							
	No signs or symptoms of i	infections.				Discharge Plan	Discharged			
					C. T. C. CRISSIPPI					
							Remains injury free in a safe			
Immobility due	Ambulating	1				Patient Safety	environment.			
to surgery							No evidence of skin breakdown.			
Delta property of the second					The State of the	Skin Integrity			_	
							Patient/family verbalizes satisfaction with			
	1989 (1898)					Patient/Family Satisfaction	hospital stay/care.			
	537	INTERVE	NTI	ONS	1/00	ontinued on bac	(k)			
Patient Care		HVILIVE	D	Quinter married			l l	D	E	N
Categories	Insurance:		_			Categories	* Diet:			
Discharge	insurance.					Nutrition		555555	2000000	191919191
Plan							% of diet consumed: Breakfast %			
							Breakfast% Lunch%			
							Dinner %			- 1
							Prespiratory Cara provided			

Patient Care	POD #4	D	E	N	Patient Care	201 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	D	E	N
Categories	Date:				Categories				
	Vital signs q hrs.				TO A CONTROL OF THE C	Assess patient / family satisfaction.			
Assessment	4				Teaching				
&	I & O q hrs.				. &	Encourage verbalization of fears /			
Treatments					Psychosocial	concerns. Learning needs / teaching plan:	\vdash	-	-
	* Telemetry discontinued	-	-			- Progressive post operative routine	1		
	Surgical site assessment.	_	_			-			and the same transfer
					Section of the sectio	-			
	Dressing change PRN.				Population and a company of the same in taken.				
	AND THE SECOND CONTRACTOR OF THE SECOND CONTRA				properties of the property of the pro-	Piachara instructions	\vdash		
						Discharge instructions: - incision care		0.15	
			MA.		e replace a subject to the contract of the con	- food & drug interactions	10.08		
						- MD follow-up			
	* Maintain bilateral TEDS					- Modifiable risk factors.			
						Medication:	8 10		0.8
	* Incentive spirometry q1hr. while awake.				Provincial Comments of the Comments of		.		
	C2 DP of he while swake					Activity:			
	C&DB q1hr while awake.					Diet:			
	* PO pain medications PRN		-	- 1		Document of service of the service o			
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	Discontinue IV / PIID								
	The second secon				Village Committee				
						Lab / diagnostics results reviewed; MD	+		
				- 1	Specimens	notified if indicated.			
				100	&	* Tests / Procedures			
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						Assist to reposition q2hrs. as needed	of the fi		
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	Hygiene & Comfort Protocol			STATE OF STREET					
	Peripheral IV Therapy Protocol			1					
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	Pressure Ulcer Prevention Protocol								
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	* Respiratory Care provided.			- Section					1
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