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

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/diagnosis 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: _____

Date/Event: _____

Date/Event: _____

Date/Event: _____

Date/Event: _____

Date/Event: _____

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.

Generic Surgical

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 verbalize understanding of post-op treatment plan, diet, medications, and activity; participates in decision making / plan of care.			
Surgical Pain Management	Pain free or verbalizes pain relief after intervention.			
Post-Operative Temperature Elevation	Afebrile			
	Vital signs stable.			
	Dressing clean, dry and intact.			
Immobility due to surgery	Bedrest; completes ADL within functional ability.			

Problem/ Needs		D	E	N
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	Assess need for Discharge Planning / Social Service based on nursing assessment of home environment / patient condition.			
	Insurance:			

Patient Care Categories		D	E	N
Nutrition	* Diet:			
	% of diet consumed:			
	Breakfast _____%			
	Lunch _____ %			
	Dinner _____ %			
	High risk nutritional assessment completed.			

* indicates medical orders needed

INTERVENTIONS (continued)

Patient Care Categories	Day of Surgery Date: _____	D	E	N	Patient Care Categories		D	E	N
Assessment & Treatments	Vital signs q _____ hrs.				Teaching & Psychosocial	Assess patient / family satisfaction.			
	I & O q _____ hrs.					Encourage verbalization of fears / concerns.			
	* Telemetry					Assess knowledge level and readiness to learn.			
	* O_2 / pulse oximetry					Learning needs / teaching plan: - Post-operative routine - Cough / deep breathing - Surgical procedure - Incentive spirometry if ordered - Pain management			
	* Foley catheter inserted:								
	Assess dressing site q 2 hrs.					Medication: _____			
	* Tubes and drains: Type: _____ Type: _____					Activity: _____			
	* TEDS / Venous compression devices.					Diet: _____			
	* Incentive spirometry q1hr. while awake.					Other:			
	C&DB q 1hr. while awake.								
	* IV Fluids as ordered								
	* Medicate for pain PRN								
	* PCA				Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
						* Tests / Procedures _____			
	Hygiene & Comfort Protocol				Safety & Activity	Falls protocol maintained.			
	Peripheral IV Therapy Protocol					* Activity level:			
	Pressure Ulcer Prevention Protocol					Assist to reposition q2hrs. as needed			
	* Respiratory Care provided. (See Respiratory Care Record)								

Generic Surgical

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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 verbalize understanding of post-op treatment plan, diet, medications, and activity; participates in decision making / plan of care.			
Surgical Pain Management	Pain free or verbalizes pain relief after intervention.			
Post-Operative Temperature Elevation	Afebrile			
	Vital signs stable.			
	Dressing clean, dry and intact.			
Immobility due to surgery	Tolerates advancing activity.			

Problem/ Needs		D	E	N
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	Verify discharge needs / plans with patient / family.			

Patient Care Categories		D	E	N
Nutrition	* Diet:			
	% of diet consumed:			
	Breakfast _____ %			
	Lunch _____ %			
	Dinner _____ %			

* *indicates medical orders needed*

INTERVENTIONS (continued)

Patient Care Categories	POD #1 Date: _____	D	E	N	Patient Care Categories		D	E	N
Assessment & Treatments	Vital signs q _____ hrs.				*Teaching & Psychosocial*	Assess patient / family satisfaction.			
	I & O q _____ hrs.					Encourage verbalization of fears / concerns.			
	* Telemetry					Assess knowledge level and readiness to learn.			
	* O_2 / pulse oximetry					Learning needs / teaching plan: - Post-operative routine - Cough / deep breathing - Surgical procedure - Incentive spirometry if ordered - Pain management			
	Surgical site assessment, post initial dressing change.					Medication: _____ Activity: _____ Diet: _____ Other:			
	Dressing change PRN.								
	* Tubes and drains: Type: _____ Type: _____				*Specimens & Diagnostics*	Lab / diagnostics results reviewed; MD notified if indicated.			
	* Maintain bilateral TEDS					* Tests / Procedures _____ _____ _____ _____ _____ _____			
	* Discontinue venous compression devices, when ambulating.								
	* Incentive spirometry q1hr. while awake.				*Safety & Activity*	Falls protocol maintained.			
	C&DB q 1hr. while awake.					* Activity level:			
	* Discontinue IV/PIID					Assist to reposition q2hrs. as needed			
	* Advance to PO pain medication.								
	* PCA								
	* Foley catheter discontinued. Voided at: _____								
	Hygiene & Comfort Protocol								
	Peripheral IV Therapy Protocol								
	Pressure Ulcer Prevention Protocol								
	* Respiratory Care provided. (See Respiratory Care Record)								

Generic Surgical

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ADDRESSOGRAPH

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

Problem/ Needs	POD #2 Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalize understanding of post-op treatment plan, diet, medications, and activity; participates in decision making / plan of care.			
Surgical Pain Management	Pain free or verbalizes pain relief after intervention.			
Post-Operative Temperature Elevation	Afebrile			
	Vital signs returned to baseline.			
	No signs or symptoms of infections.			
Immobility due to surgery	Ambulating			

Problem/ Needs		D	E	N
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	* Diet:			
	% of diet consumed:			
	Breakfast _____ %			
	Lunch _____ %			
	Dinner _____ %			

* indicates medical orders needed

INTERVENTIONS (continued)

Patient Care Categories	POD #2 Date: _____	D	E	N
Assessment & Treatments	Vital signs q _____ hrs.			
	I & O q _____ hrs.			
	* Telemetry			
	* O_2 / pulse oximetry			
	Surgical site assessment, post initial dressing change.			
	Dressing change PRN.			
	* Tubes and drains: Type: _____ Type: _____			
	* Maintain bilateral TEDS			
	* Discontinue venous compression devices, when ambulating.			
	* Incentive spirometry q1hr. while awake.			
	C&DB q 1hr. while awake.			
	* Discontinue IV/PIID			
	* PO pain medication, PRN.			
	* PCA discontinued			
	* Foley catheter discontinued. Voided at: _____			
	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	Assess patient / family satisfaction.			
	Encourage verbalization of fears / concerns.			
	Learning needs / teaching plan: - Progressive post operative routine - _____ - _____ - _____ - _____ - _____			
	Discharge instructions: • incision care • food & drug interactions • MD follow-up • Modifiable risk factors.			
	Medication: _____			
	Activity: _____			
	Diet: _____			
	Other:			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	* Tests / Procedures _____ _____ _____ _____ _____ _____ _____			
Safety & Activity	Falls protocol maintained.			
	* Activity level:			
	Assist to reposition q2hrs. as needed			

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** 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	Problem/ Needs		D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalize understanding of post-op treatment plan, diet, medications, and activity; participates in decision making / plan of care.								
Surgical Pain Management	Pain free or verbalizes pain relief after intervention.								
Post-Operative Temperature Elevation	Afebrile								
	Vital signs returned to baseline.								
	No signs or symptoms of infections.								
Immobility due to surgery	Ambulating								
					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	Patient Care Categories		D	E	N
Discharge Plan	Completed Discharge Plan				Nutrition	* Diet:			
						% of diet consumed:			
						Breakfast _____%			
						Lunch _____ %			
						Dinner _____ %			

* indicates medical orders needed

INTERVENTIONS (continued)

Patient Care Categories	POD #3 Date: _____	D	E	N
Assessment & Treatments	Vital signs q _____ hrs.			
	I & O q _____ hrs.			
	* Telemetry discontinued			
	Surgical site assessment.			
	Dressing change PRN.			
	* Maintain bilateral TEDS			
	* Incentive spirometry q1hr. while awake.			
	C&DB q1hr while awake.			
	* PO pain medications PRN			
	Discontinue IV / PIID			
	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	Assess patient / family satisfaction.			
	Encourage verbalization of fears / concerns.			
	Learning needs / teaching plan: - Progressive post operative routine - _____ - _____ - _____ - _____ - _____			
	Discharge instructions: • incision care • food & drug interactions • MD follow-up • Modifiable risk factors.			
	Medication: _____ Activity: _____ Diet: _____ Other:			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	* Tests / Procedures _____			
Safety & Activity	Falls protocol maintained.			
	* Activity level:			
	Assist to reposition q2hrs. as needed			

University Medical Center — ** indicates medical orders needed*

Generic Surgical

Signature	Title	Initial

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ADDRESSOGRAPH

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

Problem/ Needs	POD #4 Date: _____	D	E	N
Knowledge Deficit related to plan of care	Patient/family verbalize understanding of post-op treatment plan, diet, medications, and activity; participates in decision making / plan of care.			
Surgical Pain Management	Pain free or verbalizes pain relief after intervention.			
Post-Operative Temperature Elevation	Afebrile			
	Vital signs returned to baseline.			
	No signs or symptoms of infections.			
Immobility due to surgery	Ambulating			

Problem/ Needs		D	E	N
Discharge Plan	Discharged			
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	Insurance:			

Patient Care Categories		D	E	N
Nutrition	* Diet:			
	% of diet consumed:			
	Breakfast _____%			
	Lunch _____ %			
	Dinner _____ %			

** indicates medical orders needed*

INTERVENTIONS (continued)

Patient Care Categories	POD #4 Date: _____	D	E	N
Assessment & Treatments	Vital signs q _____ hrs.			
	I & O q _____ hrs.			
	* Telemetry discontinued			
	Surgical site assessment.			
	Dressing change PRN.			
	* Maintain bilateral TEDS			
	* Incentive spirometry q1hr. while awake.			
	C&DB q1hr while awake.			
	* PO pain medications PRN			
	Discontinue IV / PIID			
	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	Assess patient / family satisfaction.			
	Encourage verbalization of fears / concerns.			
	Learning needs / teaching plan: - Progressive post operative routine - _____ - _____ - _____ - _____ - _____			
	Discharge instructions: - incision care - food & drug interactions - MD follow-up - Modifiable risk factors.			
	Medication: _____ Activity: _____ Diet: _____ Other:			
Specimens & Diagnostics	Lab / diagnostics results reviewed; MD notified if indicated.			
	* Tests / Procedures _____ _____ _____ _____ _____ _____			
Safety & Activity	Falls protocol maintained.			
	* Activity level:			
	Assist to reposition q2hrs. as needed			

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** indicates medical orders needed*