

**Interdisciplinary Care Plan** MS5 ICU Medical Review by: \_\_\_\_\_  
 Date of Admission: \_\_\_\_\_ With RN: \_\_\_\_\_ on \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Discharge Planning Conference held on: \_\_\_\_\_ Allergy: \_\_\_\_\_

Identified Date/RN Initials	Problem/Nursing Diagnosis	Desired Outcome(s)	Interventions	Resolved-Ongoing Date / RN Initials
<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<b>1. Environmental Safety</b>  Risk for Injury  At risk for impaired skin integrity  Braden Scale <16  Infant Safety  Risk for infection	Injury free hospitalization  Skin integrity is maintained or improved.  Restraint free environment  Environment prevents abduction  Absence of iatrogenic infection	<input type="checkbox"/> Bedside orientation documented <input type="checkbox"/> Fall risk assessments DOA/BID/PRN <input type="checkbox"/> Implement Fall Risk Standards <input type="checkbox"/> Involve family members when appropriate. <input type="checkbox"/> Daily environmental safety checks including bed safety & re-orientation. <input type="checkbox"/> Skin care protocol implemented <input type="checkbox"/> Security measures appropriately instituted. <input type="checkbox"/> Aseptic Technique/ Isolation <input checked="" type="checkbox"/> <b>Physical Therapy Referral</b> _____ <input type="checkbox"/> Additional needs:	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<b>2. Medications</b>  At risk for injury  Therapeutic regimen, Ineffective  Polypharmacy	Effective pharmaceutical therapy without adverse effects  Right patient receives right medication	<input type="checkbox"/> Initiate medication specific teaching. <input type="checkbox"/> Assess for therapeutic responses <input type="checkbox"/> Identification procedures followed prior to medication administration. <input type="checkbox"/> Food/Drug Interaction education. <input checked="" type="checkbox"/> <b>Pharmacy Referral</b> _____ <input type="checkbox"/> Additional needs:	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<b>3. Pain</b>  Acute Pain  Chronic Pain  Anxiety	Patient will communicate acceptable level of comfort as it relates to disease process or intervention	<input type="checkbox"/> Pain assessed with vital signs <input type="checkbox"/> Assess relief of pain from therapies. <input type="checkbox"/> Provide appropriate analgesia as ordered <input type="checkbox"/> Utilize alternative therapy for pain relief. <input type="checkbox"/> Emotional support. <input type="checkbox"/> Additional needs:	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<b>4. Oxygenation</b>  Altered tissue perfusion  Ineffective Airway clearance  Ineffective Breathing Pattern	Patient will maintain patent airway and functional respiratory pattern and signs of adequate oxygenation and circulation.	<input type="checkbox"/> Assess respiratory status <input type="checkbox"/> Monitor diagnostic results <input type="checkbox"/> Administer therapeutic modalities <input type="checkbox"/> Encourage incentive spirometer use, coughing, deep breathing, position changes for enhanced breathing patterns. <input type="checkbox"/> Endotracheal or tracheostomy tube care <input type="checkbox"/> Additional needs:	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<b>5. Nutritional Status</b>  Altered Nutrition: Less than body req. More than body req.  Fluid Volume: Deficit Excess  Risk for imbalance	Provide for adequate nutrition during hospitalization  Weight stabilization  Control of nausea and vomiting.	<input checked="" type="checkbox"/> <b>Nutrition Services Referral</b> _____ <input type="checkbox"/> Intake and Output assessed and documented <input type="checkbox"/> Weigh daily as per standard of care <input type="checkbox"/> Administer and monitor IV or PO therapies as ordered <input type="checkbox"/> Calorie counts as needed <input type="checkbox"/> NG, PEG or gastric tube care <input type="checkbox"/> Antiemetics as needed <input type="checkbox"/> Additional needs:	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____

ADDRESSOGRAPH

**NHBREM 6150/90(10-02)**  
**ORIGNATOR: NURSING ACUTE CARE**  
**KEPT IN MEDICAL RECORDS JACKET**

Identified Date/Initials	Problem	Desired Outcome(s)	Interventions	Resolved-Ongoing Date / RN Initials
<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<b>6. Elimination</b> Alteration in bowel or bladder function  Anxiety related to disease process or intervention  Body Image Disturbance	Maintain skin integrity  Patient will have verbalized realistic expectations for urinary, bowel and sexual functioning.	<input type="checkbox"/> Daily GI and GU assessments <input type="checkbox"/> Output from catheters or drains recorded. <input type="checkbox"/> Catheter care as needed. <input type="checkbox"/> Emotional support <input type="checkbox"/> Additional needs:	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<b>7. Activities of Daily Living</b> Alteration in ambulation  Activity intolerance or Risk for.  Impaired physical mobility  Sleep Integrity or sleep pattern disturbance	Patient will maintain or improve mobility status.  Patient identifies activity goal as influenced by diagnosis.  Involvement of family/SO when possible.  Established support structure	<input type="checkbox"/> Full or Partial assist with meal/hygiene <input type="checkbox"/> Active/Passive Range of motion <input type="checkbox"/> Administer thrombolytics as ordered. <input type="checkbox"/> Monitor lab studies for therapeutic response <input type="checkbox"/> <b>Physical Therapy referral</b> _____ <input type="checkbox"/> Patient transfers and ambulation as guided by Fall Risk standard <input type="checkbox"/> Bed rest when appropriate. <input type="checkbox"/> Encourage interdependent functioning. <input type="checkbox"/> <b>Social Service referral</b> _____ <input type="checkbox"/> Additional needs:	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<b>8. Adaptation to Condition</b> Ineffective or Defensive coping  Impaired communication  Anxiety  Noncompliance	Patient will express thoughts, concerns, and feelings to their ability.  Patient will communicate effectively and participate in care.  Reduction or management of anxiety.  Enhanced or supportive coping obtained.	<input type="checkbox"/> Provide therapeutic communication <input type="checkbox"/> Interpretive services as needed <input type="checkbox"/> <b>Spiritual referral</b> _____ <input type="checkbox"/> Provide age appropriate treatment instructions or resources for care. <input type="checkbox"/> Suicide precautions/one to one watch. <input type="checkbox"/> <b>Mental Health referral</b> _____ <input type="checkbox"/> <b>Social Service referral</b> _____ <input type="checkbox"/> Additional needs:	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
<input type="checkbox"/> _____ <input type="checkbox"/> _____	<b>9. Education</b>  Knowledge deficit  _____	Patient/Family will demonstrate knowledge of disease/disability/care  Resources identified	<input type="checkbox"/> Use age appropriate interventions <input type="checkbox"/> <b>Patient Education Referral</b> _____ <input type="checkbox"/> Initiate diagnosis specific teaching. <input type="checkbox"/> Explain procedures and treatments. <input type="checkbox"/> Additional needs:	<input type="checkbox"/> _____ <input type="checkbox"/> _____
<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<b>10. Age-Specific</b>  Self-care deficit  Fear  Altered Role performance	Patient centered care based on educational, physical and developmental level  Patient advocacy and safety is maintained  Self-potential is maximized.	<input type="checkbox"/> Age appropriate communications & interventions implemented <input type="checkbox"/> Significant others/parents are included in care when appropriate. <input type="checkbox"/> Self-care maximized <input type="checkbox"/> Developmental education-pt /family <input type="checkbox"/> Additional needs:	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
<input type="checkbox"/> _____ <input type="checkbox"/> _____	<b>11. Health Maintenance</b> Access to care End of Life Support Community Risks: STD, Immunizations Smoking cessation Alcohol Substance abuse Weight control Hypertension Diabetes management	Patient/Family will have support through end of life decisions/care.  Educational opportunities utilized by patient/family.  Appropriate referrals initiated.	<input type="checkbox"/> <b>Primary Care Provider referral</b> or follow-up _____ <input type="checkbox"/> <b>Patient Education referral</b> _____ <input type="checkbox"/> Access to care education. <input type="checkbox"/> <b>Outpatient clinic treatment referral</b> _____ <input type="checkbox"/> <b>Social Service referral</b> _____ <input type="checkbox"/> Educate on age appropriate safety issues, diagnosis, follow-up treatment. <input type="checkbox"/> Additional needs:	<input type="checkbox"/> _____ <input type="checkbox"/> _____

Initials	Signature & Title	Initials	Signature & Title