CAREPATHrx

Nursing Plan of Care

Dates: **to**

Patient Name: _____ **Patient DOB:** _____

Physician's Name: _____ **Allergies:** _____ ☐ NKDA

Therapy: ☐ IV ☐ Enteral ☐ Cath Care ☐ IT
☐ Other: _____

Principal Diagnosis(es): _____
(Primary Reason for Service)

Type of Venous Access: _____ ☐ N/A

Other Pertinent Diagnosis(es) and Surgeries: _____

Type of Enteral Access: _____ ☐ N/A

Therapy & Reason/Dx: _____

Therapy Orders (IV or Cath Care)

Administer: **Choose one:**
☐ continuous at _____ ml/hr over _____ hours
☐ every _____ hours at _____ ml/hr over
☐ Other: _____

Flush IV with:
☐ _____ ml NS before & after medication/labs & p.r.n.
☐ Final flush _____ ml Heparin (_____ units/ml)

Therapy Orders (Enteral)

Administer:
☐ Pump at _____ ml/hr
☐ Bolus _____ ml every _____ hour
☐ Gravity at _____ ml/hour
☐ Oral _____ cans per day

Flush Enteral with:
_____ ml water _____ (frequency)

Intrathecal

Administer via medtronic pump
☐ simple continuous
☐ complex continuous

Concentration __mg/__ml
Dose ___mcg/day as directed

☐ Other: _____

Nutritional Requirements

Nutritional consult with dietitian p.r.n. and Choose one:

Safety Measures:

☐ UNIVERSAL ☐ Chemo ☐ Environmental
☐ Neutropenic ☐ Aspiration ☐ OTHER:

Comments:

Functional Limitations:

☐ Amputation
☐ Paralysis
☐ Legally Blind
☐ Bowel/Bladder
☐ Endurance
☐ Speech
☐ Contracture
☐ Ambulation
☐ Hearing
☐ Dyspnea w/Exertion
☐ Infant
☐ NO LIMITATIONS
☐ OTHER:

Activities Permitted:

☐ Infant
☐ Crutches
☐ Bedrest BRP
☐ Complete Bedrest
☐ Walker
☐ Wheelchair
☐ Transfer bed/chair
☐ Independent at home
☐ Cane
☐ Up as Tolerated
☐ Partial Wt. Bearing
☐ NO RESTRICTION
☐ OTHER:

Mental Status:

☐ Oriented
☐ Forgetful
☐ Disoriented
☐ Agitated
☐ Depressed
☐ Comatose
☐ Lethargic
☐ Infant
☐ Other:

Nursing Prognosis:

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Guarded

Orders for Disciplines and Treatments: (Specify Frequency and Duration)

1. Nurse to visit patient for comprehensive nursing assessment/follow-up with: Choose one: ☐ Other: _____

2. Nurse will administer and/or instruct patient and/or caregiver re medication and to:
   - ☐ Administer therapy as noted in Therapy Orders Section above.
   - ☐ Maintain IV line. Dressing change per aseptic technique weekly and p.r.n. with: Choose one: _____
   - ☐ Change cap weekly with each lab draw and p.r.n.
   - ☐ Insert and maintain peripheral IV every 48-72 hours. ☐ Other: _____
   - ☐ Draw labs _____ via Choose one: Addtl. lab info: _____ ☐ None requested.
   - ☐ Monitor patient's: ☐ Vital signs ☐ Weight I & O ☐ Other: _____
   - ☐ Insert Peripheral IV prior to dose; remove line when dose completed.
   - ☐ Access Port monthly, lock and access.
   - ☐ Access Port prior to dose. Deaccess and lock port when dose completed.

3. Evaluate and instruct patient and/or caregiver re:
   ☐ disease process ☐ S/S of infection ☐ S/S of complications ☐ emergency action ☐ safety measures ☐ diet & fluid restrictions
   ☐ Other: _____

4. Goals/Rehabilitation Potential/Discharge Plan
   ☐ Maintain safe environment ☐ Achieve optimal level of independence ☐ Complete therapy, services as ordered
   ☐ Compliant with all aspects of medical management regime ☐ Other:

5. Extenuating circumstances and additional comments:

Physician's Signature: _____ **Clinician Name:** _____ **Date:** _____

Date: _____ **Clinician Signature:** _____

Agency Name: _____ **Phone Number:** _____