Plan of Care

Signed Sep 8, 2026

Plan of Care by Courtney J, RN at 9/8/2026 4:19 PM

Problem: Risk for Fall-Universal
Goal: Fall Prevention During Hospitalization-Universal
Outcome: Progressing

Intervention: Universal Fall Precautions Interventions-IP
Recent Flowsheet Documentation
Taken 9/8/2026 1000 by Courtney L Johnson, RN
HD IP Universal Fall Precautions Interventions:
- Call light/belongings in reach
- Bed in low position and locked
- Wheelchairs and chairs locked
- Siderails up X2
- Ensure adequate lighting
- Clutter free and spill free environment
- Educate to the purpose of universal fall precautions
- Educate to call for assistance
- Keep closet and bathroom doors closed when not in use
- Use of footwear (See row information)

Problem: Chronic Kidney Disease
Goal: Maintain best kidney function
Outcome: Progressing

Goal: Educate about Dialysis
Outcome: Progressing

Goal: Educate about nutrition for renal disease
Outcome: Progressing

Goal: Educate about complications of Renal Disease
Outcome: Progressing

Problem: Cardiac: Heart Failure
Goal: Hemodynamic stability will improve by discharge
Description: Hemodynamic stability will improve by discharge
Outcome: Progressing

Goal: Cardiac arrhythmias will improve or return to baseline by discharge
Description: Cardiac arrhythmias will improve or return to baseline by discharge
Outcome: Progressing

Problem: Risk for Decreased Mobility
Goal: Patient's mobility will be maintained/improved during hospital stay
Outcome: Progressing

Goal: Mobility Care consults utilized appropriately
Outcome: Progressing

Goal: Patient mobilizes safely throughout hospitalization
Outcome: Progressing

Problem: Risk for Fall-Low-IP
Goal: Patient will remain free of falls during hospital stay-IP
Outcome: Progressing

Intervention: Universal Fall Precautions Interventions-IP
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HD IP Universal Fall Precautions Interventions:
- Call light/belongings in reach
- Bed in low position and locked
- Wheelchairs and chairs locked
- Siderails up X2
- Ensure adequate lighting
- Clutter free and spill free environment
- Educate to the purpose of universal fall precautions
- Educate to call for assistance
- Keep closet and bathroom doors closed when not in use
- Use of footwear (See row information)

Intervention: Low Fall Precautions Interventions-IP
Recent Flowsheet Documentation
Taken 9/8/2026 1000 by Courtney L Johnson, RN
HD IP Low Fall Risk Interventions (7-10):
- Initiate universal fall precautions
- Individualize HD Falls Care Plan
- Place fall risk patient ID band on patient
- Provide patient/family education based on risk assessment using the HDS
- Instruct patient/family to call staff for assistance when getting out of bed or accessing out of reach items
- Place Green Fall Precaution signage outside patient door
- Do not leave patient unattended while toileting or in the bathroom. For rehab, follow facility toileting protocol

Intervention: Mobility Interventions-IP

Recent Flowsheet Documentation

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HD IP Mobility Interventions:

- Schedule physical activity with assistance throughout the day and inform patient/ family of activity schedule
- Reduce environmental triggers causing dizziness: Keep room cool, avoid helium filled balloons, and provide comfort measures during transport, dangle prior to standing, set up environment to avoid movements that result in dizziness
- Ensure that ambulating patients have mobile IV pole if applicable
- If patient is MODERATE or HIGH RISK: Utilize a bed/ chair fall alarm
- If patient is MODERATE or HIGH RISK: Use fall mats on one or both sides of the bed or in front of chair when OOB. For rehab, at minimum, use mat(s) overnight and when fatigued (in bed).
- Remove fall mat from floor when patient getting out of bed or chair and replace upon return
- If using a low bed, ensure proper positioning (patient's knee at a 90 degree angle with feet flat on floor) of low beds when rising from and returning to bed
- Provide assistive device to patients who use at home (walker, cane, etc.). Educate the remaining patients on the correct use of assistive devices and the importance of utilizing the device to ambulate when applicable
- Instruct patient/family to exit bed on their strongest side
- Use proper positioning assist devices (chair belts, wedges, recliners)
- Use gait belt when assisting patient to ambulate when not contraindicated
- Initiate PT Consult (Requires physician order)
- Patient on bedrest should use a bedpan
- Patient requiring the assist of 2 or more for safe ambulation- bedpan if 2 staff are unavailable, BSC when staff is available for entire time
- Patient requiring assist of 1 for safe ambulation- consider BSC or bathroom
- Provide bed baths for patient on bedrest or those requiring the assistance of 2 or more for safe ambulation (see Row information)
- Use a shower chair for patient requiring the assistance of one person and do not leave alone while in the shower

Intervention: Medication Interventions-IP

Recent Flowsheet Documentation

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HD IP Medication Interventions:

- Review medications daily with patient and family and educate on side effects
- Collaborate with physician and pharmacist to assess for medications that can be discontinued or dosage decreased
- Limit combination of PRN medications when possible (ex., sedative, analgesics, etc.)

• Provide patient who received diuretics/laxatives frequent assistive opportunities to use bathroom
• Toilet patient before giving pain medication
• Avoid showering or bathing after giving pain medications
• Adjust medication schedule to time meds with side effects to be given during appropriate period of time (i.e., Lasix to be given in am)
• Collaborate with physician and pharmacist to assess need for orthostatic hypotension (0H) evaluation

Intervention: Volume/Electrolyte Interventions-IP

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HD IP Volume/Electrolyte Interventions:
• Ensure that the patient remains hydrated
• If diabetic, monitor blood sugar and facilitate interventions to maintain appropriate blood sugar
• Ensure that IV tubing length does not create risk for falls
• Advance diet as tolerated when applicable to minimize use of intravenous and enteral feeds
• Administer medications as ordered for n/v and provide interventions to prevent/minimize n/v
• Monitor abnormal lab values
• Collaborate with care team to ensure IV fluids are appropriate to patient's current condition
• Teach patient to dangle before rising if hypotensive
• Patient with low blood sugar or hypotension should be toileted using a bedpan. For rehab, should use BSC or bathroom and follow facility toileting protocol.

Problem: Knowledge Deficit
Goal: Patient/family/caregiver demonstrates understanding of disease process, treatment plan, medications, and discharge instructions
Description: Complete learning assessment and assess knowledge base.

Outcome: Progressing

Problem: Compromised Skin Integrity
Goal: Skin integrity is maintained or improved
Description: Assess and monitor skin integrity. Identify patients at risk for skin breakdown on admission and per policy. Collaborate with interdisciplinary team and initiate plans and interventions as needed.

Outcome: Progressing

Goal: Fluid and electrolyte balance are achieved/maintained
Description: Assess and monitor vital signs (orthostatic vitals if applicable), fluid intake and output, urine color, labs, skin turgor, mucous membranes, jugular venous distention, edema, circumference of edematous extremities and abdominal girth, respiratory status, and mental status. Monitor for signs and symptoms of hypovolemia (tachycardia, rapid breathing, decreased urine output, postural hypotension, confusion, syncope). Monitor for signs and symptoms of hypervolemia (strong rapid pulse, shortness of breath, difficulty breathing lying down, crackles heard in lung fields, edema). Collaborate with interdisciplinary team and initiate plan and interventions as ordered.

Outcome: Progressing

Goal: Nutritional status is improving
Description: Monitor and assess patient for malnutrition (ex- brittle hair, bruises, dry skin, pale skin and conjunctiva, muscle wasting, smooth red tongue, and disorientation). Collaborate with interdisciplinary team and initiate plan and interventions as ordered. Monitor patient's weight and dietary intake as ordered or per policy. Utilize nutrition screening tool and intervene per policy. Determine patient's food preferences and provide high-protein, high-caloric foods as appropriate.

Outcome: Progressing

Problem: Urinary Incontinence
Goal: Perineal skin integrity is maintained or improved
Description: Assess genitourinary system, perineal skin, labs (urinalysis), and history of incontinence to include past management, aggravating, and alleviating factors. Collaborate with interdisciplinary team and initiate plans and interventions as needed.

Outcome: Progressing