Plan of Care

Signed Sep 10, 2026

Plan of Care by Lily T, RN at 9/10/2026 1:07 AM

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

Intervention: Low Fall Precautions Interventions-IP
Recent Flowsheet Documentation
Taken 9/9/2026 2000 by Lily Travis, 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

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