EP13 Evidence

Hyperspace - GH TELEMETRY/INTERMEDIATE CARE - PRD Environment (dr-ecp3_PRDAPP4) - GINA T.

Epic | Patient Lists | Unit Census Logs | Patient Station | Unit Manager | My Reports | Tips Sheets | Today's Pts | Rothman Index by Unit | User SmartSets | Clinical Skills | Chart Central | Tools | Smartweb | Print | Log Out

Epiccare GINA T.

Legal Sex: | Last BMI: None | Allergies: No Known Allergies | HM Due?: None | NonCode Additional Limitations ... | Specialty Comments:
Gender Identity: None | PCP: Odierna, Elizabeth | Current Smoker: Never Smoker | Coverage: MEDICARE/MEDICARE... | Adv. Care Plan: Yes | My Sticky Note:
Pref Language: English | MyChart: Code expired | Med Contract: (None) | Patient Type: None | Out Info: None | NarxScore: None,
Phone: | My Pat List Reminders: None | (None) | CSN: None | Fall Risk: Not Done | General Risk: N/A
Phone: | Pref Lab: None | MRN: | Next Appt Date by Dept: None
BestPractice Advisory: None | Code: Prior | Iso Reason: None

SnapShot | Chart Review | Care Everywh... | Order Inquiry | Review Flows... | Results Review | Report Viewer | Allergies | History | Problem List | Implants | Demographics | Letters | Identity Manager | Patient Station | Customize | More

Flowsheet Report

Load More

Select Flowsheets to View
IOP CLIN VALUES/BELIEFS/SPIRITUAL CARE [12
ADVANCE DIRECTIVE [1150]

Values/Beliefs/Spiritual Care	11/2/2016	10/ /2016
[Retired] Spiritual Care Comment	Pt nonresponsive	
Advance Directive		10/ /2016
Type of Healthcare Directive		Living will;Healthcare Agent- pre 10/1/2006
Most current copy in chart?		Yes
Patient expressed wishes		Yes

Abnormal/Panic

Dates in: Columns Rows

Copy to Clipboard | Refresh | Print Flowsheet | Graph Region

11:54 AM 11/27/2019

EP13 Evidence

/Down Split Left/Right Reattach Window

Plan of Care by Trovato, Gina, RN filed on 11/ /2016 2:56 AM.

Author: Trovato, Gina, RN Service: — Author Type: Registered Nurse
Filed: 11/ /2016 2:56 AM Status: Addendum
Editor: Trovato, Gina, RN (Registered Nurse)

Hide copied text
Hover for details

Problem: Fall Risk (Adult)
Goal: Identify Related Risk Factors and Signs and Symptoms
Related risk factors and signs and symptoms are identified upon initiation of Human Response Clinical Practice Guideline (CPG)
Outcome: Ongoing (Interventions implemented as appropriate)

	11/01/16 0236
Fall Risk	
Fall Risk: Related Risk Factors	age-related changes;gait/mobility problems;neuro disease/injury;polypharmacy
Fall Risk: Signs and Symptoms	presence of risk factors

See flowsheet documentation for assessment and interventions
Goal: Absence of Falls
Patient will demonstrate the desired outcomes by discharge/transition of care.
Outcome: Ongoing (Interventions implemented as appropriate)

	11/01/16 0236
Fall Risk (Adult)	
Absence of Falls	making progress toward outcome

See flowsheet documentation for assessment and interventions

Patient/Family acknowledge understanding of fall prevention education including to call nurse with assistance with ambulation.

Bed alarm activated/audible.

Call light and belongings in reach, freq rounding done.

Video monitoring continued.

Problem: Patient Care Overview (Adult)
Goal: Plan of Care Review
Outcome: Ongoing (Interventions implemented as appropriate)

	10/ /16 2030	11/ /16 0236
Coping/Psychosocial Response Interventions		
Plan Of Care Reviewed With	patient *(family friends in to visit pt)*	--
Patient Care Overview		
Progress	--	unable to show any progress toward functional goals

Plan of Care Overview/ Patient Status

wn Split Left/Right Reattach Window

Progress	--	progress toward functional goals

Plan of Care Overview/ Patient Status

Pt received in bed w/ eyes closed, arouses to voice/touch but does open eyes spontaneously at times. Unable to assess mental status, attempt to use blinking once/twice for no/yes but unsure if pt could follow as pt cannot follow any other simple commands. +PERRLA, R facial droop noted, R hemiparesis present. Tele Aflutter 100s. SpO2 94% on 50% VM, pt becomes centrally cyanotic when lying flat during turning/positioning. Maxi lift used. Incontinent large amt liquid stool, care provided, skin to sacrum intact. +4 edema to BLE, elevated on pillows. Pt restless in bed, moving L leg and L arm often, taking off sheet. T/Pq2hr. Foley catheter in place, small amt bloody drainage around urethral meatus. Pt updated on POC, freq oral care provided. Full bath given. Safety maintained, cont to monitor.

*Pt has cortrak to R nare for meds only placed 10/30 per MD notes. Discussed appropriateness of tube w/ Dr. Rashid and Dr. Kathrada as pt's living will states he does not want tube feeds, writer questioned an ethics consult. Dr. Kathrada made aware that pt not receiving tube feeds or IV fluids, FSG ordered - 105. Per Dr. Kathrada, pt's family approved cortrak but unknown if family approved it for tube feeds, family considering hospice; Dr. Kathrada will address this concern in the am w/ the day staff. Nursing supervisor Gladys and Gloria aware of situation; will update nurse manager Ann Marie in the am.

Goal: Individualization and Mutuality
Outcome: Ongoing (Interventions implemented as appropriate)
See flowsheet documentation for assessment and interventions
Goal: Discharge Needs Assessment
Outcome: Ongoing (Interventions implemented as appropriate)
See flowsheet documentation for assessment and interventions

Problem: Arrhythmia/Dysrhythmia (Symptomatic) (Adult)
Goal: Signs and Symptoms of Listed Potential Problems Will be Absent or Manageable (Arrhythmia/Dysrhythmia)
Signs and symptoms of listed potential problems will be absent or manageable by discharge/transition of care (reference Arrhythmia/Dysrhythmia (Symptomatic) (Adult) CPG).
Outcome: Ongoing (Interventions implemented as appropriate)

	11/ 6 0236
Arrhythmia/Dysrhythmia (Symptomatic)	
Problems Assessed (Arrhythmia/Dysrhythmia)	all
[illegible]	electrophysiological conduction