Prevent Problems: Critically review the necessity of all tests/procedures.

Pressure Ulcers: Ambulate; avoid “bed rest” order. Correct nutrition restrictions. Turn q 2 hrs. if bedridden.


Immobility/Falls: Prescribe assist device; physical therapy. Order acute rehab therapy consult. Walk with assist. (Else, consider DVT prophylaxis.)

Functional Decline: Define baseline ADLs. Increase activity level. Avoid restraint and catheters.

Constipation: Provide prune juice/power pudding. Provide stool softener.

Undernutrition: Review serum albumin. Consider nutrition consult; supplement. Could medications contribute to anorexia?

Depersonalization: Music, pictures, food from home. Encourage visitors, stuffed animals. Chaplain visit (hospice care).
History:
Collaborate data with family; nursing staff.
Define goals of care.
Define Advanced Directives.
Assess for pain.
Define baseline functional status ADLs.

Physical Exam:
Assess for delirium.
Assess risk for pressure ulcer.
Is patient out of bed?
Can urine catheter, IV line be removed?
Avoid restraints.

Data Collection:
Review vital signs, intake/output, daily weight, diet intake, bowel movement.
Review the medication cardex;
   How does it compare to Rx prior to admit?
Could problems be caused by the Rx?
Should any Rx be stopped?
Add multiple vitamin.
Review therapy notes (PT/OT/speech).
Review social service note
   (living situation/support).
Review dietitian notes; lab data changes.

Communicate:
Talk with the nurse to assess status;
   discuss goals and anticipated discharge.
Update family of anticipated discharge plans or change in status.