Evidence Based Guidelines

- **HEART FAILURE**
- **IDDM**
- **DM**
- **ACUTE PULMONARY (Pneumonia, Acute Asthma, Bronchitis)**
- **COPD**
- **Acute Wound**
- **Chronic Wound**
- **CVA**
- **Ortho**
- **Bariatric Surgery Care**

References: VNA First, through Innovative Healthcare Solutions

Heart Failure Care Path

Patient Education Tools in Patient's Primary Language ☐CHF Patient Education Booklet - CFYH

Assessment and Planning

First visit and ongoing:
Assess for other disciplines: PT, OT, Speech, SW, HHA. If needed:

- Obtain approval from A.D.N.
- Speak with MD, obtain verbal orders; site and send Interim Orders
- Request in Managed Care Report

SN Visit Frequency: 3w1, 2w1, 1w2
Reassess d/c plan at every visit
If further visits needed – at least 1 weeks prior to planned D/C date:

- Obtain approval from A.D.N.
- Speak with MD, obtain verbal orders, write and send Interim Orders,
- Write Managed Care Report 1 week prior to any change

INTERVENTIONS to OCCUR DURING CARE PERIOD

1. Assess/reconcile all medications. Assess knowledge. Instruct in purpose, route, frequency, side effects.
2. Assess circulatory/cardiac status: VS; heart rate/rhythm; weight, edema; note change in status. Initial visit, establish Target Weight, take BP in both arms in 2 positions, identify arm with higher bp, document and continue using that arm for BP.
3. Assess level of dyspnea with activity and at rest, note change in status.
4. Assess LE edema, measuring bilateral ankle and calf at SOC and regularly. Instruct in self assessment. If edema, assess regularly for skin breakdown and instruct in self assessment.
3. Instruct to record weight daily; report gain of 2-3 lbs. one day/5 lbs. one week or as per physician order.
4. Instruct on use of oxygen for disease process if applicable
5. Instruct on self-monitoring: weight, edema, pulse, S/S pain; actions to take with abnormal findings.
6. Instruct on hidden sources of sodium in commercial foods; provide written information as needed.
7. Instruct on effects of cholesterol, salt, and fat on cardiac disorders.
8. Instruct on salt substitutes and need for physician approval and how to flavor foods with herbs and spices.
9. Instruct on foods high in potassium if on potassium-depleting diuretic; provide list of foods
10. Instruct on importance of frequent rest periods, pacing activities and avoiding overexertion.
11. Instruct to elevate feet/legs when sitting or lying if appropriate
12. Instruct on semi or high Fowlers position to improve breathing/respirations if appropriate.
13. Assess home for fire extinguisher and other oxygen safety precautions.
14. Evaluate knowledge of safe and correct use of oxygen, instruct as needed.
15. Instruct to reduce or stop smoking if applicable

PATIENT/CAREGIVER OUTCOMES (V) Verbalizes (D) Demonstrates

1. Compliance/understanding of purpose, route, frequency, side effects of all medications (V)	2. Importance of monitoring daily weight. Weight consistent with goals (D & V)
3. Compliance with activities to improve cardiac status: gradual increases, feet/legs elevated, positioning, etc. (V&D)	4. Decreased edema, if appropriate (D)
5. Importance of frequent rest periods and pacing activities. (V)	6. Nutrition: Sources of hidden sodium in commercial foods; 3 foods high in sodium; 3 foods low in sodium; approved salt substitutes; importance of potassium rich foods, & 3 foods high in K, if on K wasting diuretics (V&D)
7. Importance of not straining with bowel movements. (V)	8. Maintain intact skin in edematous areas. (D)

Diabetes with Insulin Care Path

☐Diabetes Patient Education Materials Provided in Patient's Primary Language:
Assessment and Planning
First visit and ongoing: Assess for other disciplines: PT, OT, Speech, SW, HHA. If needed: • Obtain approval from A.D.N. • Speak with MD, obtain verbal orders; write and send Interim Orders • Request in Managed Care Report
SN Visit Frequency: 3w1, 2w1, 1w2 Reassess d/c plan at every visit If further visits needed – at least 1 weeks prior to planned D/C date: • Obtain approval from A.D.N. • Speak with MD, obtain verbal orders, write and send Interim Orders, • Write Managed Care Report 1 week prior to any change

INTERVENTION to OCCUR DURING CARE PERIOD	
1. Assess and reconcile all medications. Instruct in purpose, route, frequency, side effects.	
2. Assess knowledge of ABCs: A=HbA1C, B=Blood Pressure, C=Cholesterol	
3. Assess for effects of diabetes and instruct in: S/S hyper/hypoglycemia, peripheral neuropathy and circulation, and skin breakdown including proper foot care with regular inspection of feet.	
4. Evaluate knowledge of S/S of hypoglycemia and hyperglycemia and actions to take.	
5. Evaluate blood glucose results in daily log or history and investigate reasons for fluctuations.	
6. Evaluate compliance with proper glucose testing technique.	
7. Evaluate compliance with proper insulin preparation and administration.	
8. Evaluate compliance: instructing family/friends on actions to take for hypoglycemic and hyperglycemic reaction.	
9. Instruct on effects of poor control: retinopathy, neuropathy, ASHD hypertension, hyperglycemia, hyperlipidemia and renal disease.	
10. Evaluate knowledge of importance of yearly eye, dental and podiatry exams.	
11. Instruct on prescribed diet, portion control and carbohydrate planning.	
12. Instruct on importance of Medi-Alert identification and procedure to obtain.	
PATIENT/CAREGIVER OUTCOMES (V) Verbalizes (D) Demonstrates	
1. Knowledge of reasons to take medications as ordered with understanding of route, frequency, purpose and side effects, as appropriate. (V)	9. Three (3) S/S of hypoglycemia and appropriate actions to take. (V)
2. Proper technique and timing for blood glucose monitoring. (D)	10. Knowledge of prescribed diet, portion control, and carbohydrate planning. (V)
3. Blood glucose levels within normal range for patient. (D)	11. Self care needed to prevent complications secondary to disease. (V)
4. Correct procedure for cleaning and calibrating glucose meter. (V)	12. Importance of annual eye, dental, and podiatry exams.(V)
5. Ability to prepare and administer insulin using proper technique. (D)	13. Compliance with appropriate measures of diabetic foot care. (D)
6. Ability to interpret BS results and take appropriate actions. (D)	14. Appropriate actions to take to manage diabetes when ill.(V)
7. Three (3) potential effects of poor diabetic control. (V)	15. Use of medical-alert identification jewelry.(D)
8. Three (3) S/S of hyperglycemia and appropriate actions to take. (V)	

Diabetes without Insulin Care Path

☐Diabetes without Insulin Patient Education Materials Provided in Patient's Primary Language:_____

Assessment and Planning

First visit and ongoing:
Assess for other disciplines: PT, OT, Speech, SW, HHA. If needed:

- Obtain approval from A.D.N.
- Speak with MD, obtain verbal orders; write and send Interim Orders
- Request in Managed Care Report

SN Visit Frequency: 2w1,1w2
Reassess d/c plan at every visit
If further visits needed – at least 1 weeks prior to planned D/C date:

- Obtain approval from A.D.N.
- Speak with MD, obtain verbal orders, write and send Interim Orders,
- Write Managed Care Report 1 week prior to any change

INTERVENTIONS to OCCUR DURING CARE PERIOD
1. Assess and reconcile all medications. Instruct in purpose, route, frequency, side effects.
2. Assess knowledge of ABCs: A=HbA1C, B=Blood Pressure, C=Cholesterol
3. Assess for effects of diabetes and instruct in: S/S hyper/hypoglycemia, peripheral neuropathy and circulation, and skin breakdown including proper foot care with regular inspection of feet.
4. Evaluate knowledge of S/S of hypoglycemia and hyperglycemia and actions to take.
5. Evaluate blood glucose results in daily log or history and investigate reasons for fluctuations.
6. Evaluate compliance with proper glucose testing technique.
7. Evaluate compliance: instructing family/friends on actions to take for hypoglycemic/hyperglycemic reaction.
8. Instruct on effects of poor control including retinopathy, neuropathy, ASHD hypertension, hyperglycemia, hyperlipidemia and renal disease.
9. Evaluate knowledge of importance of yearly eye, dental and podiatry exams.
10. Instruct on prescribed diet, portion control and carbohydrate planning.
11. Instruct on importance of Medi-Alert identification and procedure to obtain.

PATIENT/CAREGIVER OUTCOMES (V) Verbalizes (D) Demonstrates	
1. Knowledge of reasons to take medications as ordered with understanding of route, frequency, purpose and side effects, as appropriate (V)	8. Knowledge of prescribed diet, portion control, and carbohydrate planning. (V)
2. Proper technique and timing for blood glucose monitoring. (D)	9. Use of medical-alert identification jewelry. (D)
3. Correct procedure for cleaning and calibrating glucose meter. (V)	10. Three (3) potential effects of poor diabetic control. (V)
4. Blood glucose levels within normal range for patient. (D)	11. Appropriate actions to take to manage diabetes when ill. (V)
5. Ability to accurately interpret BS and take appropriate actions. (D)	12. Self care to prevent complications: skin, foot, eye, oral care. (V)
6. Three (3) S/S of hypoglycemia and appropriate actions to take. (V)	13. Compliance with appropriate measures of diabetic foot care. (V)
7. Three (3) S/S of hyperglycemia and appropriate actions to take. (V)	14. Importance of annual eye, dental, and podiatry exams.(V)

Pneumonia, Acute Asthma, Bronchitis Care Path

☐Pulmonary Patient Education Materials Provided in Patient's Primary Language: _____

Assessment and Planning

First visit and ongoing:
Assess for other disciplines: PT, OT, Speech, SW, HHA. If needed:

- Obtain approval from A.D.N.
- Speak with MD, obtain verbal orders; write and send Interim Orders
- Request in Managed Care Report

SN Visit Frequency: 2w1, 1w2
Reassess d/c plan at every visit
If further visits needed – at least 1 weeks prior to planned D/C date:

- Obtain approval from A.D.N.
- Speak with MD, obtain verbal orders, write and send Interim Orders,

INTERVENTIONS to OCCUR DURING CARE PERIOD
1. Assess and reconcile all medications. Instruct in purpose, route, frequency, side effects. Instruct on use of bronchodilator, mucolytics, expectorants, and nebulizers as ordered.
2. Assess respiratory status - lung sounds, respiration rate, depth, rhythm, use of accessory muscles etc.
3. Assess level of dyspnea with activity and at rest, note change in status or assessment goal.
4. Instruct to avoid stressors precipitate disease exacerbation of (including temperature extremes &infection).
5. Instruct: S/S infection including temp. elevation, change in sputum to yellow/green, and increased viscosity.
6. Instruct: administration of oxygen; Instruct on oxygen safety precautions; Instruct on No Smoking
7. Instruct: use of humidifier to thin secretions.; Instruct on use, abuse of prn inhalers; avoid persons w/ URIs
8. Instruct: abdominal deep breathing, coughing exercise, use of splinting method; energy conservation measures
9. Instruct: maintenance, cleaning,, care of respiratory equipment.; check oxygen backup equipment weekly
10. Instruct on use of anti-infectives, antitussives and expectorants; instruct on pain management for pleuritic chest pain.
11. Instruct not to take any over-the-counter medications or supplements without consulting a physician.
12. Instruct on high calorie/ high carbohydrate foods and fluids; adequate hydration of 6-8 cups fluids/day
13. Instruct to avoid gas-forming foods to prevent gastric distention and decreased lung expansion.
14. Instruct: body positioning -enhance upper airway availability, semi fowlers/sitting upright/leaning over
15. Assess home for fire extinguisher and other oxygen safety precautions.
16. Instruct to avoid stressful situations that effect respirations.

PATIENT/CAREGIVER OUTCOMES (V) Verbalizes (D) Demonstrates	
1. Knowledge of reasons to take medications as ordered with understanding of route, frequency, purpose and side effects, as appropriate. (V)	8. Proper body positioning for maximum airway availability. (D)
2. Correct use of 02, nebulizers, inhalers (D)	9. 3 safety issues regarding use of oxygen.(V)
3. Effects of stressors on disease process, breathing and lifestyle. (V)	10. Safe use of oxygen, if appropriate. (D)
4. Coughing and deep breathing exercises; energy conservation. (D)	11. Compliance with dietary measures. (D)
5. Correct use of bronchodilators, mucolytics, expectorants, nebulizers. (D)	12. Importance: Consulting with physician before using OTC meds. (V)
6. Adequate fluid intake to help liquefy secretion. (V)	13. Compliance with avoiding stressful situations. (D)
7. 3 S/S of respiratory infection to report. (V)	

COPD Care Path

☐COPD Patient Education Materials Provided in patient's primary language _____

Assessment and Planning

First visit and ongoing:
Assess for other disciplines: PT, OT, Speech, SW, HHA. If needed:

- Obtain approval from A.D.N.
- Speak with MD, obtain verbal orders; write and send Interim Orders
- Request in Managed Care Report

SN Visit Frequency: 3w1, 2w1, 1w2
Reassess d/c plan at every visit
If further visits needed – at least 1 weeks prior to planned D/C date:

- Obtain approval from A.D.N.
- Speak with MD, obtain verbal orders, write and send Interim Orders,
- Write Managed Care Report 1 week prior to any change

INTERVENTIONS to OCCUR DURING CARE PERIOD

1. Assess and reconcile all medications. Instruct in purpose, route, frequency, side effects.
2. Assess respiratory status including lung sounds, respiration rate, depth, rhythm, use accessory muscles
3. Assess level of dyspnea with activity and at rest, not change in status
4. Instruct: avoid stressors that may precipitate exacerbation of disease (including temperature extremes and infection).
5. Instruct: S/S of respiratory infection: temperature, change in sputum color to yellow/green, increased viscosity.
6. Instruct: administration of oxygen if applicable
7. Instruct: use, abuse of prn inhalers.
8. Instruct: maintenance, cleaning, and care of respiratory equipment If applicable
9. Instruct: high calorie/ high carbohydrate foods and fluids.
10. Instruct: importance of increased fluids to liquefy respiratory secretions.
11. Instruct: avoid gas-forming foods to prevent gastric distention and decreased lung expansion.
12. Instruct: body positioning to enhance upper airway availability, semi fowlers/sitting upright/ leaning over bed table.
13. Instruct: energy conservation techniques.
14. Assess home for fire extinguisher and other oxygen safety precautions.
15. Instruct: oxygen safety precautions.

PATIENT/CAREGIVER OUTCOMES (V) Verbalizes (D) Demonstrates

1. 3 S/S of respiratory infection to report (V)	8. Adequate fluid intake to liquefy secretion. (V)
2. Effect of stressors on disease, breathing lifestyle (V)	9. (2) techniques for energy conservation. (D&V)
3. Need to take medications as ordered with understanding of route, frequency, purpose and side effects, as appropriate (V)	10. Proper body positioning (V)
4. Correct use of oxygen, nebulizers, inhalers, as appropriate (D)	11. 3 safety issues regarding use of oxygen (V)
5. Effective coughing & deep breathing exercises. (D)	12. Safe use of oxygen, if appropriate (D)
6. Correct use of bronchodilators, expectorants/ nebulizers (D)	13. Avoiding stressful situations (V)
7. (3) gas-forming foods and reasons to avoid. (V)	

Acute Wound Care Path

☐Wound Patient Education Materials Provided in Patient's Primary Language _____

Assessment and Planning

First visit and ongoing:
Assess for other disciplines: PT, OT, Speech, SW, HHA. If needed:

- Obtain approval from A.D.N.
- Speak with MD, obtain verbal orders; write and send Interim Orders
- Request in Managed Care Report

SN Visit Frequency: 3w1, 2w1, 1w2
Reassess d/c plan at every visit
If further visits needed – at least 1 weeks prior to planned D/C date:

- Obtain approval from A.D.N.
- Speak with MD, obtain verbal orders, write and send Interim Orders,
- Write Managed Care Report 1 week prior to any change

INTERVENTIONS to OCCUR DURING CARE PERIOD

1. Assess and reconcile all medications. Instruct in purpose, route, frequency, side effects.
2. Fully assess wound at SOC and all subsequent visits. Compare to baseline status at every visit.
3. Assess wound in the context of comorbidities. Instruct pt/caregiver(s) on wound healing, including effect of comorbid conditions. Instruct patient/caregivers all aspects of assessment including s/s infection, size, all aspects of drainage, changes in wound bed, slough/eschar, periwound for skin integrity, wound edges.
4. Photograph wound at first or second visit and send to CWCN for consult.
5. Provide wound care as ordered and instruct patient/caregiver, as appropriate, on wound care procedure per agency protocol and physician order.
6. Evaluate ability to perform wound care independently. Teach and observe return demonstration, including all aspects of infection control. Continue to observe until patient/caregiver are safe in performing all aspects of wound care safely.
7. Instruct on wound healing diet, including foods high in protein and Vitamin C.

PATIENT/CAREGIVER OUTCOMES (V) Verbalizes (D) Demonstrates

1. Knowledge of reasons to take medications as ordered with understanding of route, frequency, purpose and side effects, as appropriate (V)	5. Knowledge of 3 foods high in protein (V)
2. Knowledge of 3 s/s infection and methods to prevent. (V)	6. Knowledge of 3 foods high in Vitamin C. (V)
3. Provides safe wound care following proper technique (D)	7. Knowledgeable regarding any comorbidities that will impact wound healing. (V)
4. Knowledge of wound deterioration and when to call CHN or MD based on wound bed, drainage, periwound, other. (V)	

Chronic Wound Care Path

☐Wound Patient Education Materials Provided in Patient's Primary Language _____

Assessment and Planning

First visit and ongoing:

Assess for other disciplines: PT, OT, Speech, SW, HHA. If needed:

- Obtain approval from A.D.N.
- Speak with MD, obtain verbal orders; write and send Interim Orders
- Request in Managed Care Report

SN Visit Frequency: 3w1, 2w1, 1w2

Reassess d/c plan at every visit

If further visits needed – at least 1 weeks prior to planned D/C date:

- Obtain approval from A.D.N.
- Speak with MD, obtain verbal orders, write and send Interim Orders,
- Write Managed Care Report 1 week prior to any change

INTERVENTIONS to OCCUR DURING CARE PERIOD
1. Assess and reconcile all medications. Instruct in purpose, route, frequency, side effects.
2. Assess wound for size, presence of tunneling, undermining, color, granulation, epithelialization, exudate (amount/type), odor, pain, condition of surrounding skin, presence of callous.
3. Assess wound for S/S of infection: erythema, edema, induration, warmth, etc.
4. Instruct on S/S of infection and methods to prevent infection.
5. Assess for risk of Pressure Ulcers using Braden Scale. If risk identified, institute all procedures to decrease risk of pressure ulcers including off loading, safe turning and positioning, incontinence management and obtaining support surface, if appropriate.
6. Instruct to monitor skin on extremities for trauma and impaired integrity and actions to take.
7. Instruct on wound care procedure per agency protocol and physician order
8. Evaluate ability to perform wound care independently; effectiveness of wound care, treatment, preventive measures.
9. Instruct on effects of physical activity on disease process.
10. Instruct foods high in Vitamin C and protein.
11. Instruct on importance of avoiding trauma to healing wounds or newly epithelialized wounds.
12. Evaluate compliance with measures to prevent trauma to affected areas.

PATIENT/CAREGIVER OUTCOMES (V) Verbalizes (D) Demonstrates	
1. Knowledge of reasons to take medications as ordered with understanding of route, frequency, purpose and side effects, as appropriate. (V)	8. Compliance with skin care measures. (D)
2. Wound(s) free of S/S infection or complications. (D)	9. Moisture/incontinence management. (V)
3. Three (3) S/S of infection and methods to prevent. (V)	10. Compliance with turning/repositioning schedule.(D)
4. Knowledge of treatment plan. (V)	11. Compliance with pressure, friction and shear relief measures. (D)
5. Compliance with measures to support circulation. (D)	12. Knowledge of nutrition needed to support healing. (V)
6. Willingness to learn dressing change procedure. (V)	13. Compliance with measures to prevent trauma to affected areas. (V)
7. Independence in care of wound using proper technique. (D)	14. Intact skin/healed wound. (D)

CVA Care Path

☐Stroke Patient Education Materials provided in Patient's Primary Language:_____

Assessment and Planning

First visit and ongoing:
Assess for other disciplines: PT, OT, Speech, SW, HHA. If needed:

- Obtain approval from A.D.N.
- Speak with MD, obtain verbal orders; srite and send Interim Orders
- Request in Managed Care Report

SN Visit Frequency: 3w1, 2w1, 1w1
Reassess d/c plan at every visit
If further visits needed – at least 1 weeks prior to planned D/C date:

- Obtain approval from A.D.N.
- Speak with MD, obtain verbal orders, write and send Interim Orders,
- Write Managed Care Report 1 week prior to any change

INTERVENTIONS to OCCUR DURING CARE PERIOD

1. Assess and reconcile all medications. Instruct in purpose, route, frequency, side effects.
2. Assess neurological status including posture, muscle mass, atrophy, ROM, motor function, sensory function, and mental function.
3. Assess speech including safe ability to call for help and safe swallowing
4. Instruct on anticoagulant precautions if appropriate
5. Evaluate knowledge of measures to prevent/relieve pressure, friction, shearing if appropriate.
6. Evaluate compliance with ROM exercises or other exercises.
7. Evaluate effectiveness of bowel/bladder training program if appropriate
8. Evaluate need for absorption products (diaper) or external catheter products if appropriate
9. Instruct on emergency response systems available for home settings.
10. Assess caregiver for stress/potential risk for caregiver burnout.

PATIENT/CAREGIVER OUTCOMES (V) Verbalizes (D)

1. 3 abnormal findings from a neurological self-assessment. .(V)	8. Progression with planned activity schedule. (D)
2. Need to take medications as ordered with understanding of route, frequency, purpose and side effects, as appropriate (V)	9. Need for supervision if judgment is impaired. (V)
3. Improvement in thought process. (D)	10. 2 emergency response systems available for home use and how to obtain. (V)
4. 3 anticoagulant precautions, if appropriate. (V)	11. Safe feeding methods. (V)
5. Ability to take blood pressure properly (D)	12. Methods of bowel and bladder retraining. (V)
6. Skin care for incontinence if appropriate. (V)	13. Adequate bowel/urinary function/ control. (D)
7. Safe ambulation and transfers. (D)	14. Ability to communicate using alternative nonverbal methods. (D)

Orthopedic Care Path

☐Ortho Patient Education Materials Provided in Patient's Primary Language _____

Assessment and Planning

First visit and ongoing:
Assess for other disciplines: PT, OT, Speech, SW, HHA. Generally, Ortho patients will need PT. If needed:

- Obtain approval from A.D.N.
- Speak with MD, obtain verbal orders; write and send Interim Orders
- Request in Managed Care Report

SN Visit Frequency: 2w1, 1w1
Reassess d/c plan at every visit
If further visits needed – at least 1 weeks prior to planned D/C date:

- Obtain approval from A.D.N.
- Speak with MD, obtain verbal orders, write and send Interim Orders,
- Write Managed Care Report 1 week prior to any change

INTERVENTIONS to OCCUR DURING CARE PERIOD	
1. Assess and reconcile all medications including any pain meds.. Instruct in purpose, route, frequency, side effects.	
2. Assess LE edema, DVT: negative Homan's sign, SOB, cardiac complications	
3. Assess surgical site for s/s infection	
4. Assess home safety and instruct basic home safety precautions to prevent injuries/falls	
5. Instruct in how and when to call for help; s/s to report to RN or MD	
6. Instruct pain management with prescribed meds and other modalities, as indicated	
7. Collaborate with ordered Rehab Therapist	
PATIENT/CAREGIVER OUTCOMES (V) Verbalizes (D) Demonstrates	
1. Knowledge of reasons to take medications as ordered with understanding of route, frequency, purpose and side effects, as appropriate (V)	2. Compliance with DVT prophylaxis, if indicated.
3. Understanding of pain regimen and purpose for pain management for rehab. (V)	4. Compliance w/home safety recommendations (D & V)
5. Knowledge of when to call for help; s/s to report to RN/ PT/MD. (V)	6. Compliance with Rehab and Home Exercise Program, if indicated. (D)
7. Ability to safely ambulate and safely transfer. (D)	

Bariatric Surgery Care Path

Patient Education Tools in Patient's Primary Language	☐Bariatric Surgery: Nutrition and Exercise Guide ☐General Discharge Instructions

Assessment and Planning

First visit and ongoing:
Assess for other disciplines: OT, HHA, SW, if needed:

- Obtain approval from A.D.N.
- Speak with MD, obtain verbal orders; write and send Interim Orders
- Request in Managed Care Report

SN Visit Frequency: 1 wk 2
Reassess d/c plan at every visit
If further visits needed – at least 1 weeks prior to planned D/C date:

- Obtain approval from A.D.N.
- Speak with MD, obtain verbal orders, write and send Interim Orders

INTERVENTIONS to OCCUR DURING CARE PERIOD

2. Assess the patient's ability to learn upon admission and on an ongoing basis at each visit.
   a. Are there sensory deficits?
   b. Language barriers?
   c. What is the patient's health literacy?
   d. Cognitive deficits?
   e. Depressed, anxious, tired, feel too sick or is in too much pain to learn?
3. Assess and reconcile all medications. Instruct in purpose, route, frequency, side effects.
4. Instruct to crush medications and mix with water or obtain in liquid form for 2 wks or longer if large pills.
5. Assess skin integrity, surgical incisions for healing and assess/instruct in symptoms of infection.
6. Assess bowel function. Instruct in ways to treat constipation. Avoid straining.
7. Assess as per the pain scale on every visit. Notify MD, if pain isn't controlled.
8. Instruct in Bariatric Diet – see handout and MD orders
9. Instruct in the importance of hydration. Sip like hot liquids, do not use a straw. Avoid carbonated beverages.
10. Assess/Instruct patient in simple deep breathing and coughing exercises.
11. Instruct and have patient provide return demonstration of incentive spirometer. Encourage use 10x/hr, initially.
12. Instruct and have patient provide return demonstration of ankle pumping.
13. Instruct patient in expected recovery period for type of surgery and physical activity/strengthening exercises.
14. Instruct in activity restrictions:
    a. Shower; No bathing or swimming for 2 wks.
    b. Walk often as tolerated.
    c. No heavy lifting for 6 wks.
    d. No driving for 1 wk.
    e. Can return to work in 1-2 wks.
15. Encourage strengthening exercises (See D'C instructions handout)
16. Instruct in "Red Flags" to call MD (See D'C instructions handout)
17. Instruct patients to follow up with their surgeon in 1 wk.
18. Instruct patients with diabetes and/or hypertension to follow up with their Endocrinologist or MD for medication adjustments.

PATIENT/CAREGIVER OUTCOMES (V) Verbalizes (D) Demonstrates

1. 3 S/S of infection to report (V) a) Surgical incisions healing without complications(V)	5. Correct use of use of incentive spirometer (D)
2. Importance of hydration (V) (6-8 glasses of water per day.)	6. Correct use of ankle pumping (D)
3. Progression of Bariatric Diet Can state 3 nutrition guidelines(V)	7. Patient able to verbalize the importance of strengthening exercises and physical activity (V)
4. Red flags – when to call the doctor. (V)	