Canterbury
District Health Board
Te Poari Hauora ō Waitaha
Medical Surgical Division
Ashburton and Rural Services

(Attach Label here or Complete Details)

NAME:_____ NHI:_____

GENDER: ____ DOB:_____ AGE:_____ WARD:_____

Care Plan – 24 Hour

This plan must be rewritten each 24 hour period. Identify management requirements and documents strategies including frequency. Document "NC" if there has been no change from the previous shift's strategies.

	MANAGEMENT / GOALS (Tick appropriate boxes) Consulted with patient on __/__/__	**Date:** **Night / AM / PM**	**Date:** **Night / AM / PM**	**Date:** **Night / AM / PM**
		STRATEGIES (document within shift columns)		
Patient or Area Specific	☐ Patient specific goal/s ☐ Education			
Risk Screening	**Daily Braden score** _____ ☐ Clinical Judgement added ☐ **At risk:** ☐ Heels protected ☐ Encourage mobilisation ☐ Frequent position changes ☐ Manage Moisture *(specify)* ☐ Manage Nutrition *(specify)* ☐ Manage Friction & Shear (specify) ☐ **Moderate to High Risk:** ☐ Foam wedges ☐ Two hourly tuning ☐ **Very High Risk:** ☐ Pressure relieving mattress ☐ **PI** (specify location/mgmt) ☐ **Current PI Stage** 1 2 3 4 Deep tissue Unstageable (Circle) ☐ Stage deterioration (Contact wound specialist nurse) **Daily Fall Risk (Re)Screen** ☐ **A** Previous fall/trip/collapse ☐ **B** Unable/difficulty to get up & go *(see ADL section)* ☐ **C** Risk taking behaviours ☐ **D** Complex meds/side effects ☐ **E** Confusion / Sensory deficits / Disorientation ☐ **F Altered elimination** (see elimination section) ☐ 2 or more categories ticked OR Clinical Judgement = HIGH RISK *(specify)* ☐ Patient Whānau discussion / Education given / sign above bed / bracelet / Community referral **OR** ☐ No Risk ☐ **Follow Advanced Care Plan** ☐ **Cognitive function** MSQ/CAM score: _____ ☐ **Nicotine Dependance Mgmt** ☐ **Restraint** (type/commenced/discontinued) ☐ **Alcohol / Drug dependence management** ☐ **Communication deficits** ☐ **Other** *(specify)*			

CARE PLAN 24 HOUR

C240076B

MEDISTOCK 153391

	MANAGEMENT / GOALS discussed with Patient/Whānau Consulted Date/Month/Year (Tick appropriate boxes)	**Date:** **Night / AM / PM**	**Date:** **Night / AM / PM**	**Date:** **Night / AM / PM**
		STRATEGIES (document within shift columns)		
Airway Resp	☐ Oxygen requirements ☐ Inhaled medications ☐ Safe swallowing ☐ Tracheostomy ☐ Sleep devices/treatment			
Symptom Observation/Monitoring	☐ Pain relief strategies ☐ Nausea relief strategies ☐ Vital observations (freq) ☐ Fluid balance ☐ Weight ☐ Neurological ☐ BGL ☐ Circulation checks ☐ Orthostatic BP ☐ Fall prevention			
Fluid/Meds/IV management	☐ Medications/fluids ☐ Peripheral cannula change due ☐ Flushes due ☐ IV tubing change due ☐ CVAD management care plan ☐ S/C management ☐ Change due			
Nutrition/ Hydration	☐ NBM/special/modified diet ☐ Fluid restriction ☐ Malnutrition rescreen due ☐ Parenteral/ enteral feeds/ oral nutrition supplements ☐ PEG/NGT management ☐ Food/Fluid chart			
ADL	☐ Mobility Plan ☐ Assistance / Monitoring ☐ Equipment ☐ Enablers ☐ TEDs ☐ Manual handling plan			
Elimination	☐ Toileting plan ☐ Equipment ☐ IDC/SPC ☐ Assistance / supervision ☐ Ostomy ☐ Bowel chart ☐ Bowel management regime			
Wound	☐ Wound management / dressings (specify next due) ☐ Wound Chart ☐ Drain care ☐ Pin care			
Specs	☐ Routine blood/drug levels ☐ MSU ☐ Urinalysis ☐ Sputum ☐ Other *(specify)*			
Culture Disability	☐ Cultural / wairua practices (specify) ☐ Disability requirements (specify) ☐ Or use Health Passport			
Discharge Planning	☐ MDT care coordination for safe discharge ☐ Accommodation / transport difficulties on discharge ☐ Home supports ☐ EDD ☐ External agency notification/ referral prior to d/c ☐ Other *(specify)*			
Sign Off	**Name:** **Designation:** **Time:** **Signature:**			