**Healthcare Plan for Risk of Diarrhea**

| **Name:** | FirstName LastName | **Date of Birth:** | Enter DOB Here |
| --- | --- | --- | --- |
| **These are my medical diagnoses related to my risk of diarrhea:** | List all diagnoses or conditions that contribute to risk of diarrhea. |
| **I am allergic or sensitive to these things:** | List all known allergies and sensitivities. |
| **The goal of this Healthcare Plan is:** | [ ]  I will not experience any instances of diarrhea for the duration of the ISP year.[ ]  I will not experience any instances of skin breakdown related to diarrhea for the duration of the ISP year.[ ]  I will follow diet order to reduce risk of diarrhea for the duration of the ISP year.[ ]  Describe any other goal for management of my risk of diarrhea here. |
| **Progress in the past year:** | Describe the status of my health for the past year related to my risk for diarrhea. |
| **In an EMERGENCY****Call 911 IMMEDIATELY if I:****🡪 have large amounts of blood in my stool;****🡪 have been unable to urinate for ### hours and am experiencing diarrhea.****🡪 have a fever over ###**°.**🡪 lose consciousness (become unresponsive).****🡪 Describe any additional instructions here.** |
| **DO NOTMAKE NOTIFICATIONS PHONE CALLS UNTIL****I AM STABLE AND/OR EMERGENCY SERVICES HAVE BEEN NOTIFIED.** |
| **These are the things that increase my risk of developing diarrhea:** | [ ]  I drink a lot of liquids.[ ]  I am thirsty a lot of the time. (Sometimes this is called polydipsia.)[ ]  I am taking antibiotics.[ ]  I have one or more food allergies/sensitivities.[ ]  I have irritable bowel syndrome, ulcerative colitis, or Chron’s disease.[ ]  I take fiber supplements and/or laxatives regularly.[ ]  I take medications to treat GERD regularly.[ ]  I have a history of C Diff.[ ]  I have diabetes.[ ]  **Other:** Describe any other conditions or circumstances that increase my risk for developing diarrhea or indicate if there are none. |
| **These are the things supporters can do with and for me to help avoid developing diarrhea or complications from diarrhea:** | [ ]  Help me wash my hands throughout the day.[ ]  Make sure I practice appropriate hygiene skills when I use the bathroom.[ ]  Help me avoid food/beverages to which I have a known allergy or sensitivity.[ ]  Talk to my nurse or doctor about my laxative use if I am having loose stools regularly.[ ]  If I am experiencing diarrhea, monitor me closely for signs of dehydration, and report this to my nurse.[ ]  If I am experiencing diarrhea, monitor me closely for signs of skin breakdown, and report these to my nurse.[ ]  If I am experiencing diarrhea, ensure that all areas where I use the restroom and/or receive personal care are cleaned and sterilized before and after I use them.[ ]  **Other:** Describe any other interventions I should take to avoid diarrhea, or indicate if there are none. |
| **When these symptoms occur, supporters should help me to get an assessment and medical care:** | [ ]  I have more than ### bowel movements in a day, which is unusual for me.[ ]  Have bowel movements that are watery or even liquid. My bowel movements may be discolored. [ ]  I have a fever. [ ]  I am letting you know that I am having cramping or pain in my abdominal or rectal area. [ ]  I have any redness or skin breakdown in my perineal area. [ ]  **Other**: Describe any other signs that I have diarrhea or indicate if there are none. |
| **Documentation:**  | Describe the things supporters should write down and where they should write them down. |
| **Nursing Intervention:** | Describe those things that must be done by the nurse relative to my risk of diarrhea, including those non-delegable duties listed in O.C.G.A. § 43-26-32 or HRST Q Score. |

**Signature of RN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 RN Typed Name and Agency

This healthcare plan is reviewed at least annually and promptly revised as my diagnosis/risk status changes.

**Review date: \_\_\_\_\_\_\_\_ Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan revision required?** [ ] Yes [ ] No

 RN Typed Name and Agency

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