**Infection/Sepsis Healthcare Plan**

| **Name:** | FirstName LastName | **Date of Birth:** | Enter DOB Here |
| --- | --- | --- | --- |
| **These are my medical diagnoses and conditions that make me more prone to infection:** | List all diagnoses or conditions that increase my risk of infection. |
| **I am allergic or sensitive to these things:** | List all known allergies and sensitivities. |
| **The goal of this Healthcare Plan is:** | [ ]  I will be free of signs and symptoms of acute infection for the duration of the ISP year.[ ]  I will receive all preventative healthcare and screening during the ISP year to reduce my risk of preventable infection.[ ]  Describe any other goal for management of infection risk here.  |
| **Progress in the past year:** | Describe the status of my health for the past year related to risk of infection/sepsis. |
| **In an EMERGENCY****Call 911 IMMEDIATELY if I:****🡪 lose consciousness (become unresponsive);****🡪 develop a high fever (above ###** °).**🡪 have a rapid or irregular pulse and/or fast breathing.****🡪 have low blood pressure (under ###/###**).**🡪 suddenly develop red, splotchy skin.****🡪 am confused and/or dizzy.****🡪 Describe any additional signs of infection requiring emergency medical attention 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 infection and sepsis:** | [ ]  I am at moderate or high risk of aspiration. (Pneumonia, including aspiration pneumonia, is an infection.)[ ]  I have frequent constipation.[ ]  I have experienced a bowel obstruction in my lifetime.[ ]  I am incontinent.[ ]  I have trouble voiding urine.[ ]  I need a lot of help with hygiene, such as bathing, brushing teeth, and hand washing.[ ]  I am often in close contact with someone who has a contagious infection.[ ]  I am 65 or older.[ ]  I have a condition that makes it hard for my immune system to work right, like cancer or HIV, and/or I am taking a medication that has this as a side effect.[ ]  I have been in the hospital recently.[ ]  **Other:** Describe any other conditions or circumstances that increase my risk for infection/sepsis or indicate if there are none. |
| **These are the things supporters can do with and for me to help prevent infections:** | [ ]  Help me wash my hands frequently . . . You need to wash yours too![ ]  Help me follow directions from my doctor about caring for any open areas on my skin.[ ]  Make sure I receive my flu and pneumonia vaccines on time.[ ]  When you are sick, avoid contact that could expose me to illness.[ ]  Help me treat any infections I develop quickly, especially urinary tract infections.[ ]  **Other:** Describe any other strategies supports can use to help me decrease my risk for developing infections, or indicate if there are none. |
| **Supporters should help me seek medical attention FAST whenever these the early signs are present:** | **ONCE AN INFECTION DEVELOPS INTO SEPSIS, IT IS ALWAYS A LIFE-THREATENING MEDICAL EMERGENCY. SEPSIS IS CAN BE AVOIDED IF INFECTIONS ARE NOTICED AND TREATED EARLY.** [ ]  I have a fever and chills. [ ]  I am short of breath or have rapid breathing. [ ]  I have a rash or severe pain. [ ]  My behavior changes and it does not seem to be a response to something in my environment (e.g., I am not angry or sad about something that happened.) [ ]  My skin looks different. (This could look like a rash, redness, open area, drainage, discoloration, ulcer or a wound.) [ ]  I have signs of the flu (fever, headache, muscle aches, chills, lack of energy, sore throat and/or cough). [ ]  I have signs of pneumonia (cough, fever, shortness of breath, pain in chest, loss of energy, and/or loss of appetite). [ ]  I have signs of a urinary tract or kidney infection (pain in my lower abdomen or back, blood in urine, difficulty urinating, discolored urine, foul-smelling urine). [ ]  I have signs of a gastrointestinal infection (pain or cramps in my abdomen, diarrhea, nausea, vomiting, loss of appetite, fever, and/or loss of energy). [ ]  **Other**: Describe any other early symptoms of infection, 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 allergies and sensitivities, 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

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