ADLs: Plan of Care

Key Steps

- Diagnosis and functional ability identification
- Develop plan of care
- Implement selected interventions
- Manage general health throughout all stages of treatment
- Measure, monitor, and document outcomes
- Review and revise plan of care

Key Elements

- Identify clinical conditions impacting ADL decline
- Develop Plan of Care
  - Match interventions with specific conditions
  - Coordinate plan and care with health care team, resident, family, caregivers
- Implement Selected Interventions
  - Functional training in self-care ADLs
  - Functional training in simulated environments
  - Exercise
  - Device and equipment use and training
  - Task adaptation
  - Barrier accommodation or modification
  - Safety awareness training
  - Injury prevention or reduction education
  - Restorative nursing program
  - Family, caregiver education, training
  - Referrals to other health professionals as appropriate

- Continue to monitor:
  - Comorbid conditions
  - Acute illness
  - Nutrition, hydration
  - Bowel, bladder function
- Prevent complications from developing:
  - Deep vein thrombosis
  - Dysphagia, aspiration
  - Skin breakdown
  - UTI
  - Falls
  - Loss of ROM
  - Immobility
  - Edema
  - Adverse drug reaction
  - Depression

- Record clinical condition, expected outcomes, frequency, duration of interventions, resp to treatment, education, progress toward goals
- Review, revise plan of care
  - Based on resident’s response, team feedback

From Clinical Practice Guideline, Post-Stroke Rehabilitation, Quick Reference Guide 16, AHCPR