DSHS
WASHINGTON STATE Department of Social and Health Services

Nursing Services Assessment

Date of Visit	Date of Last Visit	Date of Care
Case Manager's Name		

I. General Information

A. Client Information and Housing Arrangement

Client's Name	Date of Birth	Age	Client ID	Gender
				☐ Male ☐ Female ☐ Other:

Address City State Zip Code

Residence Type

☐ Parent Home
☐ Relative Home
☐ Provider's Home
☐ Own Home (own, lease, rent from non-provider)
☐ Adult Family Home
☐ Adult Residential Center

☐ Current and correct on CARE
☐ New Information:

B. Significant Other Information

Name	Telephone Number (include area code)

Address City State Zip Code

Relationship to Client

☐ Legal Representative: ☐ Full Legal Guardian ☐ Partial Legal Guardian ☐ Power of Attorney
☐ Parent: ☐ No Guardianship ☐ Full Legal Guardian ☐ Partial Legal Guardian ☐ Power of Attorney
☐ Other Relative / No Legal Relationship
☐ Other / No Legal Relationship

☐ Current and correct on CARE
☐ New Information:

C. Assessment Participants

Assessment Participants

Name	Telephone Number (include area code)

D. Emergency Contact Information

☐ Current and correct on CARE
☐ New Information:

E. Demographic and Language Information

☐ Current and correct on CARE
☐ New Information:

II. Health Status

A. Healthcare Professionals

Treating Provider's Name	Date Last Seen
Reason	
Findings	
Treatment / Prescriptions	

Other Treating Provider's Name	Date Last Seen
Reason	
Findings	
Treatment / Prescriptions	

B. Diagnoses

List

☐ Current and correct on CARE
☐ New Information:

☐ Concerns:

C. Medications and Assistance Required

☐ Current and correct on CARE
☐ New Information:

☐ Provider is working within their scope of practice
☐ Nurse Delegation needed
☐ Recommendations:

D. Bladder Control, Appliances, Program, and Management

☐ Current and correct on CARE
☐ New Information:

☐ Concerns:

☐ Recommendations:

E. Bowel Control, Appliances, Program and Management

☐ Current and correct on CARE
☐ New Information:

☐ Concerns:

☐ Recommendations:

F. Other Health Indicators

Speech, sight, hearing:
☐ Current and correct on CARE
☐ New Information:

☐ Recommendations:

Tobacco use, substance abuse:
☐ Current and correct on CARE
☐ New Information:

☐ Recommendations:

Allergies:
☐ Current and correct on CARE
☐ New Information:

☐ Recommendations:

Special diet:
☐ Current and correct on CARE
☐ New Information:

☐ Recommendations:

Nutrition, height, and weight:

☐ Current and correct on CARE

☐ New Information:

☐ Concerns:

☐ Recommendations:

G. Health Indicators Related to the Household Environment

NOTE: Assessor is not expected to do a household inspection but is reporting on what is observed during visit. Suspicion of abuse of neglect requires a referral to APS (in-home), CRU (licensed facilities) or CPS.

Observations of conditions that place the client's health at risk:

III. Skin Care Issues

A. Skin Problems within the Last 14 Days (skin tears, rash, bruises, wound care, pressure ulcers)

☐ Yes ☐ No

Risk indicators for skin breakdown related to pressure exist:

☐ Incontinent of bladder or bowel
☐ Wheelchair dependent
☐ Quadriplegia
☐ Paraplegia
☐ Bedfast
☐ Diabetic
☐ Cognitive Impairment (CPS>3)
☐ Other:

If any of the skin observation protocol risk indicators exist initiate the skin observation protocol.

Skin observation protocol initiated: ☐ Yes ☐ No

If yes:

What was done?

What was found?

What action was taken?

What follow-up is needed?

Other skin care needs not related to the skin observation protocol:

☐ Recommendations:

B. Treatment and Therapies

☐ Current and correct on CARE
☐ New Information:

☐ Concerns:

☐ Recommendations:

C. Self-Care Training Needs

☐ Current and correct on CARE
☐ New Information:

☐ Concerns:

☐ Recommendations:

IV. Moods and Behaviors

A. Impaired judgment, hallucinations, delusions, aphasia, verbally abusive, depression, withdrawn, assaultive, danger to self, other behavior impairments:

☐ Current and correct on CARE
☐ New Information:

☐ Concerns:

☐ Recommendations:

B. Accuses, rummages, takes belongings, sexual issues, exposes self, disrobes in public, combative during care, screaming:

☐ Current and correct on CARE
☐ New Information:

☐ Concerns:

☐ Recommendations:

C. Wandering

☐ Current and correct on CARE
☐ New Information:

☐ Concerns:

☐ Recommendations:

D. Short Term Memory

☐ Current and correct on CARE
☐ New Information:

☐ Concerns:

☐ Recommendations:

E. Long Term Memory and Orientation

☐ Current and correct on CARE
☐ New Information:

☐ Concerns:

☐ Recommendations:

F. Anxiety Issues

☐ Current and correct on CARE
☐ New Information:

☐ Concerns:

☐ Recommendations:

V. Personal Care Needs

A. Functional ADLS

☐ Current and correct on CARE
☐ New Information:

☐ Concerns:

☐ Recommendations:

B. Supervision Needs

☐ Current and correct on CARE
☐ New Information:

☐ Concerns:

☐ Recommendations:

VI. Caregiver Information

A. Caregiver Information

☐ Current and correct on CARE
☐ New Information:

☐ Concerns:

☐ Recommendations:

B. Provider Issues

Service provided by: ☐ Individual provider ☐ Homecare agency ☐ AFH ☐ BH

Number of IPs providing service:

Training (applicable to IPs only):

☐ Training needs assessed. Provider name:

☐ If serving an adult, the IP has completed the required training.

☐ IP has not completed required training.

☐ Training provided by RN to _____ (Name of Provider)

Describe training:

☐ Training recommendations for

Describe recommendations:

Performance:

☐ No concerns regarding caregiver performance

☐ I have the following concerns regarding caregiver performance:

This Summary Report is to become Page One of the completed document.

VI. Caregiver Information

☐ **No concerns. No change required in client care plan.**

☐ **Immediate actions taken by nurse:**

Describe issue and action taken:

Persons / agencies notified:

☐ **Response required of case resource manager**

Recommended changes to the assessment and/or service plan based on new information entered into the following assessment section of this form:

- ☐ Client information or demographics
- ☐ Client living situation
- ☐ Significant other information
- ☐ Health Status (diagnosis, bowel and bladder control, med assistance, other)
- ☐ Health risks in environment
- ☐ Skin care issues
- ☐ Treatments and therapies
- ☐ Moods and behaviors
- ☐ Wandering
- ☐ Memory and orientation
- ☐ Anxiety issue
- ☐ Plan of care supervision and caregiver information
- ☐ Functional ADLS
- ☐ Supervision needs
- ☐ Provider issues

Recommendations for additional nursing service activities:

Approximate date of next RN visit:

APS / CPS must be notified of suspicion of abuse, neglect, or exploitation. Call 1-866-363-4273 (1-866-ENDHARM).

My signature indicates that I have assessed the above client. To the best of my knowledge, the information contained on this assessment is true and correct.

Nurse's Signature	Date

Distribution:

☐ DDD — Date sent:

☐ Family member / guardian (by request): — Date sent:

CRM Response to RN Recommendations

☐ **See addendum for additional documentation.**

CMR'S Signature	Date