|  |
| --- |
| **ADULT FAMILY HOME RESIDENT** **NEGOTIATED CARE PLAN** ([NCP](https://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10355))***NOTE: Place an X in the bracket [] - [x] - to indicate/select your choice****. Form Version:9/19/2023* |
| **Provider’s Name:**  | **Date NCP Started:** | **Moved In Date:**  | **[Date Completed](#Date_comp" \o "The NCP must be completed within 30 days of admit, or 30 days after the assessment has been completed/moved to current.Ignore the Ctrl+Click message below:):** | **Date Discharged:** |
| **Resident’s Name:****Pronouns:** | **Date of Birth/Age:** | **Primary Language:****Speaks English?** **Interpreter needed?**  | **ALLERGIES:** |
| **Legal Documents:** **[]** None**[]** Advanced Directives **[ ]** POLST Form**[ ]** Other: **Specialty Needs:** **[ ]** No**[ ]** Dementia**[ ]** Mental Health**[ ]** Developmental Disability**[ ]** Other:  | **EMERGENCY EVACUATION** |
|  | **EVACUATION ASSISTANCE REQUIRED:** **[] NONE – RESIDENT IS INDEPENDENT:** Resident is physically and mentally capable of independently evacuating the home without the assistance of another individual or the use of mobility aids. The department will consider a resident independent if capable of getting out of the home after one cue.**[]** **ASSISTANCE REQUIRED:** Resident is not physically or mentally capable of evacuating the home without assistance from another individual, mobility aids, or multiple cues.Caregiver will keep walkways clear and ensure there are no barriers to evacuation routes. **RESIDENT’S EVACUATION and SAFETY INSTRUCTIONS:**  Caregiver will |

| **MENTAL/PHYSICAL HEALTH – CURRENT MEDICAL STATUS/DIAGNOSIS**  |
| --- |
|  |

[Activities/Social](#act_soc2)

[Allergies](#Allergies)

[Ambulation/Mobility](#Amb_Mob2)

[Bathing](#bathing2)

[Bed Mobility/Transfer](#bed_mob_res)

[Behavior](#Disrupt_behav2)

[Case Management](#CM2)

[Communication](#Communication2)

[Decision Making](#decision_make2)

[Dressing](#dressing2)

[Eating](#eating2)

[Falls (Ambulation](#Fall_amb2))

[Falls (Bed)](#Fall_bed2)

[Finances](#fin2)

[Foot Care](#Bod_care2)

[Health Indicators](#health_indicators2)

[Left Alone](#Left_alone2)

[Medication Management](#Med_man2)

[Memory](#sleep2)

[Mental/Phy. Health/Diag.](#MH_Medical_stat_diagnosis)

[NCP Review/Signatures](#NCP_Review_sig2)

[Other Issues/Concerns](#Other_issue_concern2)

[Pain](#pain)

[Personal Hygiene](#Per_hyg2)

[Shopping](#shop2)

[Skin Care](#skin_care2)

[Sleep](#sleep)

[Smoking](#smoke2)

[Specialized Beh. Prog.](#Specialized_Beh_Prog2)

[Toilet Use/Continence](#toilet_cont2)

[Transportation](#transport2)

[Treat/Prog/Therapies](#Treat_Prog_Therapies)

[Universal Precautions](#Univ_Prec2)

[Vision](#vision)

| **RESPONSIBLE PARTIES – CONTACTS** Add those involved in care planning for your resident: Case Manager, DPOA, Guardian, Medical/Mental Health Providers, Pharmacy, Hospice, etc. – Indicate which contact method is preferred . |
| --- |
| **Name** | **[Relationship](#_top" \o "Enter the Relationship of this person to your resident. Are they the guardian, Durable Power Of Attorney for health care or financial, Doctor, Dentist, Family?Ignore the Ctrl+Click message below:)** | **Home/Business Phone** | **Cell Phone/FAX** | **Address/Email** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

*(Place your cursor in the last box and hit your tab key to add another row)*

| **COMMUNICATION** |
| --- |
| **SPEECH/HEARING/VISION** | **Resident Strengths And Abilities****Prefers To Do Independently****Preferences and Personal Goals** | **Assistance Required****Caregiver Instructions****Who, How, When/How Often** |
| **Modes of Expression:** **Problems with Mode of Expression - [ ]** Yes **[ ]** NoDescribe: Equipment:  | **How resident makes self-understood:** **How resident understands others:** **[Strength and Abilities](#Speech_res" \o "Explain how the resident can manage these areas. Do they wear glasses or need assistance when using the phone?  Is their primary language something other than English? Can you understand them? Can they understand you?Ignore the Ctrl+Click message below:)** | **[Assistance Required](#Speech_pro" \o "Explain how caregivers assist the resident with this task.You may choose to write something such as -after dressing, help Mrs. Jones put her hearing aids in before she leaves her room for breakfast. Identify any communication barriers the resident may have. Explain how the caregivers will communicate with the resident or how the resident makes themselves understood. Indicate if you need to use behaviors and nonverbal gestures to communicate with the resident. WAC 388-76-10355Ignore the Ctrl+Click message below:)**Caregiver will |
| **Problems with Hearing - [ ]** Yes **[ ]** NoDescribe: Equipment:  |
| **Problems with Vision - [ ]** Yes **[ ]** NoDescribe: Equipment:  |
| **Ability to Use the Phone****[ ]** Independent **[ ]** Assistance Needed **[ ]** Dependent**[ ]** Resident has own phone, number:  |
| **Preferred Language:** **Comments:**  |

| **[MEDICATION MANAGEMENT](#Med_man" \o "Medications WAC 388-76-10430 through 388-76-10490) - Overview** |
| --- |
| **[ ]** **MEDICATION ALLERGIES:** **[ ]** Resident needs more than one kind of medication assistance need **[ ]** Resident is prescribed psychopharmacologic medications – *see behavior section for strategies and modification to address symptoms addressed by this/these medications* | **[ ]** See **MAR** for current medications, dosage, frequency, and routeMeds are ordered by: Meds are delivered by: **[ ]** Meds are [Pharmacy Packed](#Pharm_pack" \o "Bubble pack, pill bottle, pouches, bingo cards, etc.Ignore the Ctrl+Click message below:): Note:  |

| [**MEDICATION MANAGEMENT**](#Med_man) |
| --- |
| *The amount of assistance required to receive prescription medications, over the counter medications, or herbal supplements.* | **Resident Strengths And Abilities****Prefers To Do Independently****Preferences and Personal Goals** | **Assistance Required****Caregiver Instruction****Who, How, When/How Often** |
| **[ ]** **[SELF-ADMINISTRATION](https://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10445)****[ ]** **[SELF-ADMINISTRATION W/ ASSISTANCE](https://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10450)****[ ]** **[MEDICATION ADMINISTRATION](https://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10455)**Equipment: Type of Medication Management is Needed: **[ ]** Oral**[ ]** Topical**[ ]** Eye drops/ointment**[ ]** Inhalers**[ ]** Sprays**[ ]** **Injections:**  **[ ]** Resident **[ ]** Surrogate **[ ]** By Family **[ ]** Licensed Professional **[ ]** Qualified CG under Nurse Delegation (insulin Only)**[ ]** Allergy Kits**[ ]** Suppositories**[ ]** Other: **[ ]** Requires [Nurse Delegation](#RN_DEL" \o "The Nurse Delegation (ND) program, allows long-term care workers (LTCW) working in certain settings to perform certain nursing tasks-such as administration of prescription medications, blood glucose testing, and insulin injections; normally done by licensed nurses. Ignore the Ctrl+Click message below:) **RN Delegator*** **Name:**
* **Phone:**
* **FAX:**
* **Email:**
 | **[Strengths and Abilities](#Rx_res" \o "Is the resident able to self-administer any medication? For example, they may be able to use an inhaler by themselves, but other medications must be administered by a caregiver. List the medications, if any, the resident can use on their own.Ignore the Ctrl+Click message below:)** | **Describe the reason the resident needs this amount of medication assistance:** **[Assistance Required](#Rx_pro" \o "Are there any special directions on how the resident takes their own medication? You may state that a caregiver will ask the resident if they need assistance or check to see if a medication is running low. Does the resident’s ability fluctuate and they need assistance occassionally?Ignore the Ctrl+Click message below:)**Caregiver willCG will follow the 5 rights of medication administration + 2 **every time**:* Right resident
* Right medication
* Right dose
* Right route
* Right time

+ Right documentation+ Follow strategy for resident’s right to refuseCG is to follow Dr. orders, follow RND instructions; document in MAR and report significant changes, concerns/adverse reactions to Dr. immediately.  |
| **[Medication Plan When Resident is not in the AFH](#RX_plan_offsite_title" \o "WAC 388-76-10460 (2) Medicaiton - Negotiated Care Plan The AFH must ensure that each resident's NCP addresses how the resident will get their medications when the resident is away from the home or when a family member or resident representative is assisting with medication is not available.Ignore the Ctrl+Click message below:)** | **Strengths and Abilities** | **[Assistance Required](#Rx_Plan_offsite" \o "Explain what the plan is for the resident to get their medication when they are away from the home. For example, provider will tear off medication bubble from bubble pack for the dates resident will be with family. Family will assist/administer medication. Document in the resident's MAR.Ignore the Ctrl+Click message below:)**Caregiver will |
| **[Medication Refusal Plan](#Med_refusal" \o " What is your strategy when your resident refuses one or more of their medications? For example, do you come back and offer it a second time ? When do you notify the resident's health professional?WAC 388-76-10435 Medication refusal.(1) Each resident has the right to refuse to take medications.(2) If the adult family home is assisting with or administering a resident's medications and the resident refuses to take or does not receive a prescribed medication:(a) The home must notify the resident's practitioner; unless(b) The provider, entity representative, resident manager or caregiver is a nurse or other health professional, acting within their scope of practice, is able to make a judgment about the impact of the resident's refusal.(3) If the home becomes aware that a resident who self-administers, or takes their own medications, refuses to take a prescribed medication:(a) The home must notify the practitioner; unless(b) The provider, entity representative, resident manager or caregiver is a nurse or other health professional, acting within their scope of practice, is able to make a judgment about the impact of the resident's refusal.Ignore the Ctrl+Click message below: )** | **Strengths and Abilities** | **Assistance Required**Caregiver will |

| **[HEALTH IN](#health_indicators" \o "Health Indicators help identify the stability of the resident’s health related to factors such as weight loss or gain, self-rating of health, and frequency of hospitalization or emergency room care. Significant unintended declines in weight can indicate failure to thrive, a symptom of a potentially serious medical problem, poor nutritional intake due to physical cognitive, or social/economic factors. Weight loss or gain secondary to appetite or swallowing may indicate a need to refer to nursing services. Also consider physical and mental health fluctuations, fatigue, shortness of breath, general muscle weakness, etc.Ignore the Ctrl+Click message below:)****[DICATORS](#health_indicators" \o "Health Indicators help identify the stability of the resident’s health related to factors such as weight loss or gain, self-rating of health, and frequency of hospitalization or emergency room care. Significant unintended declines in weight can indicate failure to thrive, a symptom of a potentially serious medical problem, poor nutritional intake due to physical cognitive, or social/economic factors. Weight loss or gain secondary to appetite or swallowing may indicate a need to refer to nursing services. Also consider physical and mental health fluctuations, fatigue, shortness of breath, general muscle weakness, etc.Ignore the Ctrl+Click message below:)** |
| --- |
| **Health Indicator Monitoring and Support** | **Resident Strengths And Abilities****Prefers To Do Independently****Preferences and Personal Goals** | **Assistance Required****Who Will Provide, When, And How** |
| **[ ]**  [Pain](#_top" \o "Be sure to address where the resident is experiencing pain, the level of pain, how often the resident complains or shows evidence of pain, how the pain will be managed, and the impact – for example, are activities limited?Ignore the Ctrl+Click message below:) Pain Impact: **[ ]** Weight Loss/Gain  Current Weight:  Current Height: **[ ]** Vital Signs**[ ]** Hospitalization or Emergency Visits**[ ]** [Other](#Other_treat):  | **Strengths and Abilities** | **Assistance Required****Monitoring/Reporting significant changes and/or concerns:** Caregiver is to report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.). |
| **Allergies** | **Substance:** | **Reaction:** |

| **TREATMENTS/PROGRAMS/THERAPIES** |
| --- |
| **Treatment/Program****Therapy/Interventions** | **Resident Strengths And Abilities****Prefers To Do Independently****Preferences and Personal Goals** | **Assistance Required****Who Will Provide, When, And How** |
| **Type of Treatment:****[ ]** Oxygen Use – Vendor: **[ ]** Dialysis – Health Provider: **[ ]** Blood Thinners **[ ]** INR/LAB – Health Provider: **[ ]** Easily bruised/Anti coagulation therapy**[ ]** Blood Glucose Monitoring**[ ]** Injection **[ ]** CPAP/BIPAP**[ ]** Nebulizer **[ ]** [Range of Motion](#ROM" \o " Range of motion: The extent or limit to which a part of the body can be moved around a joint (or a fixed point); the totality of movement a joint is capable of doing. Range of motion exercise is a program of passive or active movements to maintain flexibility and useful motion in the joints of the body. Active Range of Motion - Exercises performed by an individual to maintain their joint function to its optimal range (may be with cueing or reminders by caregivers).  A formal, active Range of Motion program needs to be first established by a qualified nurse (RN) or therapist.Ignore the Ctrl+Click message below:)**[ ]** PT/OT/ST**[ ]**  **Nurse Delegation** for Treatments/Therapies – Tasks:**[ ]**  [Other:](#Other_treat" \o "Other health issues to monitor may include, but are not limited to, a seizure plan, bowel program, braces/prostetics, pacemaker, etc. Add all that apply here.Ignore the Ctrl+Click message below:)  | **[Strengths and Abilities](#Treatment_strength_res" \o " Explain if the resident receives any therapies or treatments. For example a resident may use oxygen, receive PT/OT or wound care. Explain any needs listed in the assessment here. If there is a new treatment or therapy prescribed after the assessment, write it in and be sure to note the start date or end date if there is one.   What is the resident’s assessed need to use the piece of equipment?What are the resident’s needs around pain control? Does the resident require wound care?Ignore the Ctrl+Click message below: )** | **[Assistance Required](#Treatment_assess_req_prov" \o " Explain how the therapy or treatment happens. If a caregiver is helping, provide directions on how to complete the task here.If the resident receives home health or any treatments from an outside source, explain how that happens here. Indicate what your caregivers can expect.  Has a risk assessment been done for any medical devices to ensure safety for this particular resident? How do caregivers monitor or help the resident use the equipment safely?  WAC 388-76-10650 - Medical devices.(1) The adult family home must not use a medical device with a known safety risk as a restraint or for staff convenience.(2) Before a medical device with a known safety risk is used by a resident, the home must:     (a) Ensure an assessment has been completed that identifies the resident's need and ability to safely use the medical device;     (b) Provide the resident and his or her family or legal representative with information about the device's benefits and safety risks to enable them to make an informed decision about whether to use the device;     (c) Ensure the resident's negotiated care plan includes how the resident will use the medical device; and     (d) Ensure the medical device is properly installed.Ignore the Ctrl+Click message below:)**Caregiver will |
| **Programs Resident Requires/Attends:****[ ]** [Home Health](#Home_Health" \o "Home Health may include physical/occupational/speech therapy and skilled nursing services.Ignore the Ctrl+Click message below:)**[ ]** Adult Day Health**[ ]** [Hospice](#hospice" \o "If the resident is on hospice, what is the hospice plan? Include the hospice plan in you NCP. WAC 388-76-10355 (10)Ignore the Ctrl+Click message below:)– Agency: **[ ]** Hospice Plan**[ ]** Other:  |  |  |
| **Interventions****[ ]** Meaningful Day |  |  |
| [Physical Enablers](#physical_enabler" \o "Does the resident use any assistive devices such as bedrails, trapeze, transfer pole, walker, wheelchair, etc.? Has there been an evaluation? Ignore the Ctrl+Click message below:) | **Strengths and Abilities** | **[Assistance Required](#Enabler_Assist_Req_pro" \o " WAC 388-76-10650 Medical devices.(1) The adult family home must not use a medical device with a known safety risk as a restraint or for staff convenience.(2) Before a medical device with a known safety risk is used by a resident, the home must:(a) Ensure an assessment has been completed that identifies the resident's need and ability to safely use the medical device;(b) Provide the resident and his or her family or legal representative with information about the device's benefits and safety risks to enable them to make an informed decision about whether to use the device;(c) Ensure the resident's negotiated care plan includes how the resident will use the medical device; and(d) Ensure the medical device is properly installed.Ignore the Ctrl+Click message below:)**Caregiver will |
| **TREATMENT/PROGRAM/THERAPY REFUSAL PLAN** | **Strengths and Abilities** | **[Assistance Required](#treat_refusal" \o "Indicate how you will respond to a resident's refusal of care or treatment. Include when the resident's physician or practitioner should be notified of the refusal. WAC 388-76-10355 (7)(d)Ignore the Ctrl+Click message below:)**Caregiver will |

| **PSYCH/SOCIAL/COGNITIVE STATUS** | **Resident Strengths And Abilities****Prefers To Do Independently****Preferences and Personal Goals** | **Assistance Required****Who Will Provide, When, And How** |
| --- | --- | --- |
| Sleep**[ ]**  [Sleep disturbance](#sleep_disturb" \o " Sleep disturbance is difficulty falling asleep, fewer, or more hours of sleep than is usual for the individual, or waking up too early and unable to fall back to sleep. The resident disrupts the household at night when others are sleeping and requires intervention(s).Ignore the Ctrl+Click message below:)**[ ]** [Nighttime](#sleep_disturb" \o " Sleep disturbance is difficulty falling asleep, fewer, or more hours of sleep than is usual for the individual, or waking up too early and unable to fall back to sleep. The resident disrupts the household at night when others are sleeping and requires intervention(s).Ignore the Ctrl+Click message below:) assistance needed | **Resident Strengths And Abilities****Prefers To Do Independently****Preferences and Personal Goals** | **Assistance Required****Who Will Provide, When And How** |
| Memory Impairment**[ ]** [Short-term](#Mem_Imp_short" \o "The following may be evidence of short term memory loss:- Forgets food cooking on the stove- Doesn't remember son visiting in the last week - Can't remember what they had for breakfastThe following are NOT good indicators of short term memory loss: - Report that memory isn't what it used to be - Has to write notes in order to remember appointments - Can't remember the doctor's phone numberIgnore the Ctrl+Click message below:) **[ ]**  [Long-term](#Mem_Imp_long" \o "The following may be evidence of long term memory loss: - Doesn't remember birthplace - Doesn't remember the names of their childrenIgnore the Ctrl+Click message below:)**[ ]** Orientated to Person |
| If any behavior is checked, describe in the column to the right.**[ ]** [Impaired decision making](#Imp_dec_making" \o "Decision Making: - Moderately impaired - meaning decisions are poor and the resident is unaware of consequences. The resident requires reminders, cues, and supervision in planning, organizing, and correcting daily routines, or - Severely impaired - meaning the resident never makes decisions or rarely makes decisions about activities of daily living.Ignore the Ctrl+Click message below:) |
| **[ ]**  [Disruptive behavior](#Disrupt_behav"\o" Behavioral symptoms that cause distress to the resident or are distressing or disruptive to others with whom the resident comes in contact. Focus on the resident’s action not the reason for the behavior. IInclude behaviors potentially harmful to the individual or disruptive to others.Combative during personal care –The resident hits, shoves, scratches, bites, pinches, or engages in other behaviors which could result in injury to individuals. Ignore the Ctrl+Click message below:) |
| **[ ]**  [Assaultive](#Assaultive" \o "Assaultive (not during personal care) –The individual is physically abusive/ combative toward others. Examples include hitting, kicking, pushing, scratching, biting or any other behavior which could result in injury to others at times other than during the provision of personal care. Breaks, throws their own things or other's property.Ignore the Ctrl+Click message below: ) |
| **[ ]** [Resistive to care](#Resistive" \o "Resistive to care with words/gestures (does not include informed choice) – Resists taking medications, injections, ADL assistance, help with eating or treatments. The signs of resistance are limited to words or gestures not physical actions.Ignore the Ctrl+Click message below:) |
| **[ ]**  [Depression](#depression" \o "An emotional state in which there are extreme feelings of sadness, lack of worth, or emptiness.Ignore the Ctrl+Click message below:) |
| **[ ]** [Anxiety](#Irritability" \o "A tendency to get excited, angry, or upset easily.Ignore the Ctrl+Click message below:) |
| **[ ]**  [Irritability](#Irritability" \o "A tendency to get excited, angry, or upset easily.Ignore the Ctrl+Click message below:) |
| **[ ]**  [Disorientation](#Disorientation" \o "Disorientation to person, place, such as City, State, and County, or Time, such as day, month, and year.Ignore the Ctrl+Click message below:) |
| **[ ]**  [Wandering in home](#wandering)/Pacing |
| **[ ]**  [Exit seeking](#exit_seek" \o "To get outside or off the property.Ignore the Ctrl+Click message below:) |
| **[ ]**  [Hallucinations](#Hallucinations" \o "Hallucination as sensory experiences that can't ve verified by anyone other than the person experiencing them.  Hallucination may occur in all senses.  - Hearing (auditory hallucinations) - Voices that are familiar or unfamiliar that are perceived as distinct from the person’s own thoughts. Derogatory or threatening voices are especially common, two or more voices conversing with one another or voices maintaining a running commentary on the person’s thoughts or behavior. Auditory hallucinations are the most common.- Seeing (visual hallucinations) - Seeing objects or people that no one else can see. - Feeling (tactile hallucinations). Feeling strange sensations, odd feelings in the body or feeling that something is crawling on them. - Tasting (gustatory hallucinations).  Resident feels that there is a strange taste in their mouth e.g., metal, electricity, poisons, etc. - Smelling (olfactory hallucinations). Resident thinks there is a strange odor that cannot be accounted for, e.g., something burning, sewage, odd smells from their own body, dead spirits, etc.).- Command hallucinations. These are hallucinations that direct the resident to do something or act in a particular manner. It is a voice telling the individual to hurt or kill himself or herself or someone else or perform some other dramatic act. Command hallucinations are separated out from the others because of their severity and the potential lethality of the content of the hallucination.Ignore the Ctrl+Click message below: )  |
| **[ ]**  [Delusions](#Delusions" \o "Delusions are a fixed, false belief of any of the following types: - Delusions of grandeur- a false belief that one’s own importance is greatly exaggerated; - Paranoid/persecutory delusions- a false belief of being attacked, harassed, cheated, persecuted, poisoned or conspired against. - Somatic delusions- the central theme of this type of delusion involves body functions or sensations. (E.g., the individual has a false belief related to the body such as believing that they have cancer despite exhaustive negative testing, or that they emit a foul odor from their skin or mouth, etc.) - Jealous type delusions- the central theme of this type of delusion is the individual’s persistent belief that their spouse, partner or lover is unfaithful. This belief has no basis for truth and is arrived at without due cause. - Religious delusions-persistent belief that he or she is God, Jesus Christ, other deities or a representative of a deity. Many items can be misrepresented as delusions when the complaint is the result of a medical change or condition. Examples include: metal tastes in an individual’s mouth, undiagnosed conditions that impact well being and allergic reactions to medications, food or chemicals that result in unusual skin sensations. Utilize nursing resources and other medical/health care resources if you have concerns that experiences related may be medically based.Ignore the Ctrl+Click message below:) |
| **[ ]**  [Verbally agitated/aggressive](#Ver_agit_agress" \o "Such as: accuses others of stealing, inappropriate verbal noises, resistive to care with words/gestures (does not include informed choice), Uses offensive language, verbally abusive, or yelling/screaming.) |
| **[ ]**  [Physically agitated/aggressive](#Physical_agitated" \o " The individual was physically abusive/ combative toward others. Examples include hitting, kicking, pushing, scratching, biting or any other behavior which could result in injury to others at times other than during the provision of personal care.  Breaks, throws items – Breaks and/or throws their own or other’s property.Ignore the Ctrl+Click message below:) |
| **[ ]**  [Inappropriate or unsafe behavior](#Inappropriate_behavior" \o "Inappropriate nakedness, eats non-edible substances/objects (Pica)(persistent for at least a month), deliberate fire setting behaviors, inappropriate toileting/menses activity (specify), intentional self-injury, left home and gotten lost, law breaking, sexual acting out, inappropriate spitting, disrupts household at night requiring intervention, unsafe smoking, etc.Ignore the Ctrl+Click message below:) |
| **[ ]**  [Suicidal Ideation](#Suicidal_Ideation" \o " Many of our residents are experiencing some very difficult problems and are struggling with many issues.  Suicidal ideation is when a person thinks about killing themselves. The thoughts might or might not include a plan to die by suicide.Ignore the Ctrl+Click message below:) |
| **[ ]**  Difficulty in new or unfamiliar situations |
| **[ ]**  Disrobing |
| **[ ]**  Weeping/Crying |
| **[ ]** Unaware of Consequences |
| **[ ]**  Unrealistic fears and suspicions |
| **[ ]**  Inappropriate spitting |
| **[ ]**  Breaks/throws things |
| **[ ]**  Other |
| [ ] Requires psychopharmacological medications. If checked, describe symptoms each medication is addressing) See Current MAR [WAC 388-76-10463](#WAC_10463" \o " WAC 388-76-10463Medication—Psychopharmacologic.For residents who are given psychopharmacologic medications, the adult family home must ensure:(1) The resident assessment indicates that a psychopharmacologic medication is necessary to treat the resident's medical symptoms;(2) The drug is prescribed by a physician or health care professional with prescriptive authority;(3) The resident's negotiated care plan includes strategies and modifications of the environment and staff behavior to address the symptoms for which the medication is prescribed;(4) Changes in medication only occur when the prescriber decides it is medically necessary; and(5) The resident or resident representative is aware the resident is taking the psychopharmacologic medication and its purpose.) ([link](https://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10463)) **[ ]** Behavioral Health Support Crisis Plan (See attached crisis plan)**[ ]** CounselingMental Health Provider (MHP): Past Behaviors: |
| **DSHS Specialized Behavioral Programs:****[ ]** Expanded Community Services**[ ]** Specialized Behavior Services**[ ]** Mental Health Provider/ProgramContact info:  |  |  |
| **Interventions****[ ]** Meaningful Day**[ ]** Other:  |  |  |
| **Narrative (optional) – What does a typical day look like?**  |

|  |  |  |
| --- | --- | --- |
| **Left Alone** | **Resident Strengths And Abilities****Prefers To Do Independently****Preferences and Personal Goals** | **Assistance Required****Who Will Provide, When, And How** |
| **[Ability of Resident to Be Left Unattended](#Left_unattended" \o "Document the ability for resident to be left unattended for a specific length of time. WAC 388-76-0355(9)Ignore the Ctrl+Click message below:)** | **Strengths and Abilities** | **Assistance Required**Caregiver will |

| **UNIVERSAL PRECAUTIONS** | **Resident Strengths And Abilities****Prefers To Do Independently****Preferences and Personal Goals** | **Assistance Required****Who Will Provide, When, And How** |
| --- | --- | --- |
| **[ ] Always****[ ]** [Special Precautions](#Sp_prec" \o "MRSA, Hepatitis, C. Diff, HIV/AIDS, etc.Ignore the Ctrl+Click message below:): **[ ]** Alternative method for visitation Mask – Resident is:**[ ]** Able to wear a mask**[ ]** Not able to wear a mask**[ ]** Resident is safe to have sanitizer or disinfectant wipes left out for caregiver and client use. **[ ]** Resident has been/or is up to date on [vaccinations](#vaccinated" \o "COVID (up-to-date per DOH guidance), Pneumonia, Flu, etc.Ignore the Ctrl+Click message below:): **[ ]** Resident shares the following medical equipment: **[ ]** Other:  | **Strengths and Abilities** | Caregiver will always use latex/plastic gloves when in contact with any secretions to prevent spread of infection. Thorough hand washing with soap will be done before and after gloving. Gloves will be put on and discarded at the end of each task. If the AFH provider orders these gloves they can be paid for through the medical coupon.**Assistance Required** |

| **ACTIVITIES OF DAILY LIVING** | **Resident Strengths And Abilities****Prefers To Do Independently****Preferences and Personal Goals** | **Assistance Required****Who Will Provide, When, And How** |
| --- | --- | --- |
| **Resident functional limitations that impact ADL functioning:**  |
| **AMBULATION/MOBILITY****Locomotion in room and immediate living environment:****[ ]** Independent **[ ]** Supervision/Cueing**[ ]** Assistance Needed **[ ]** Totally Dependent**Locomotion outside of immediate living environment (including outdoors):****[ ]** Independent **[ ]** Supervision/Cueing**[ ]** Assistance Needed **[ ]** Totally Dependent**[ ]** **Risks for falls****[ ]** **Fall prevention plan:** **[ ]** [Resident chooses bedroom door lock](#WAC_10685_10401" \o "WAC 388-76-10685(6)(6) Give each resident the opportunity to have a lock on their bedroom door if they choose to unless having a locked door would be unsafe for the resident and this is documented according to WAC 388-76-10401.WAC 388-76-10401(1)(a) WAC 388-76-10401Home and community-based setting requirements.(1) The home must ensure that the following conditions are present for each resident:(a) Privacy in each resident's bedroom, including lockable doors when chosen, with only the resident or residents who live in the room and appropriate staff having the key.Ignore the Ctrl+Click message below:)**Equipment/Supplies:**  Vendor:**Limitations:**  | **[Strengths and Abilities](#Mobility_res" \o " Explain how the resident gets around. Do they walk independently or with assistance? Do they use a walker or a cane or are they wheelchair bound? What does their assessment say and what is happening currently? Be sure to document any changes and any discrepancies between the NCP and the assessment.    If there is a fall prevention plan, explain it here.Ignore the Ctrl+Click message below: )****Evacuation addressed under Evacuation Plan**  | **Monitoring/Reporting significant changes and/or concerns:** Caregiver is to monitor the resident during the ADL, report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.)**[Assistance Required](#Mobility_pro" \o " Describe what caregivers do to help the resident get around. Do they provide a one person assist when walking, or remind them to use their walker?Ignore the Ctrl+Click message below:)**Caregiver will |
| **BED MOBILITY/TRANSFER***Transfer includes moving between bed, chair, wheelchair, standing position – excludes to/from bath/toilet. Bed mobility includes the ability to move in bed.***[ ]** Independent **[ ]** Supervision/Cueing**[ ]** Assistance Needed **[ ]** Totally Dependent**[ ]** Skin care required due to inability to position self: Equipment/Supplies: **[ ]** Turning and Repositioning needed - Frequency: **[ ]** Safety assessment, alternatives explored; how to keep resident safe: **[ ]** Risks for falls: **[ ]** Fall prevention plan**[ ]** Safety plan**[ ]** [Medical Device(s)](#Medical_devices" \o "MEDICAL DEVICES -  Be sure the safety plan includes how the medical device will be used.WAC 388-76-10355(c) – Negotiated care plan(7) If needed, a plan to:(c) Respond to resident's special needs, including, but not limited to medical devices and related safety plans;WAC 388-76-10650 - Medical devices(1) The adult family home must not use a medical device with a known safety risk as a restraint or for staff convenience.(2) Before a medical device with a known safety risk is used by a resident, the home must:(a) Ensure an assessment has been completed that identifies the resident's need and ability to safely use the medical device;(b) Provide the resident and his or her family or legal representative with information about the device's benefits and safety risks to enable them to make an informed decision about whether to use the device;(c) Ensure the resident's negotiated care plan includes how the resident will use the medical device; and (d) Ensure the medical device is properly installed.Ignore the Ctrl+Click Below): **[ ]** Enablers:**[ ] Hoyer Lift****[ ] Transfer Pole****[ ]** Medical Device/Enabler Risk Assessment: **[ ]** Nighttime care needsEquipment/supplies: | **[Strengths and Abilities](#bed_mob_res" \o " How does the resident reposition themselves in bed? Do they require assistance or turning on a schedule? Do they have special equipment or procedures such as bridging to prevent bed sores? If the resident uses a bedrail, trapeze or transfer pole, has there been an assessment completed to explain the dangers to the resident and or their family? This assessment must be in the resident’s file. Be sure to include how the resident will use the medical device here. See WAC 388-76-10650(2)(c).Ignore the Ctrl+Click message below:)** | **Monitoring/Reporting significant changes and/or concerns:** Caregiver is to monitor the resident during the ADL, report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.)**[Assistance Required](#bed_mob_pro" \o " Specifically, what will the caregiver need to do to help this resident while they are in bed? If any specialized equipment is used to help the resident transfer, how is it used?Is the resident a fall risk and if so, what is being done to prevent falls?Ignore the Ctrl+Click message below: )**Caregiver will |
| **EATING***How the Resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)***[ ]** Independent **[ ]** Supervision/Cueing**[ ]** Assistance Needed **[ ]** Totally Dependent**[ ]** **Special Diet/Supplements**: **[ ]** **Eating Habits**:**[ ]** **Food Allergies:** **[ ]** **Equipment/Supplies/Procedures:** **Limitations:**  | **[Strengths and Abilities](#eating_res" \o " What kind of food does the resident like to eat? Do they have a special diet prescribed by their doctor? Do they need assistance eating or monitoring for choking? Do they require a soft diet or have any allergies? Ignore the Ctrl+Click message below:)** | **Monitoring/Reporting significant changes and/or concerns:** Caregiver is to monitor the resident during the ADL, report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.)**[Assistance Required](#eating_pro" \o " What does the caregiver do to help the resident eat? Do they prepare meals or ask the resident what their preferences are? Do they provide assistance and if so, how?If a resident asks for a supplement shake make sure they have been approved by the resident’s doctor first.Ignore the Ctrl+Click message below:)**Caregiver will |
| **TOILETING/CONTINENCE ISSUES***How individual uses the toilet room (or commode, bed pan, urinal); transfers on/off toilet, cleanses, changes incontinence pads, manages ostomy or catheter, adjusts clothes***[ ]** Independent **[ ]** Supervision/Cueing**[ ]** Assistance Needed **[ ]** Totally Dependent**Frequency/How Often:** Continence Issues:**[ ]** **Bladder Incontinence** **[ ]** **Bowel Incontinence****[ ]** **Skin care due to bowel/bladder incontinence****Equipment/Supplies/Procedures:** **Limitations:**  | **[Strengths and Abilities](#toilet_res" \o "Explain the tasks required to toilet the resident.  Can they assist in the process? How does the resident prefer to toilet (bedside commode, bathroom)? Does the resident require special equipment such as a Hoyer?If incontinent, how often? Does the resident wear incontinent care products, or do they prefer to wear clothes and change if wet? Does the resident have a potential for skin breakdown due to incontinence? Can the resident complete their own incontinent care? If resident can assist with peri care, what can they do?Ignore the Ctrl+Click message below:)** | **Monitoring/Reporting significant changes and/or concerns:** Caregiver is to monitor the resident during the ADL, report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.)**[Assistance Required](#toilet_pro" \o "What does the caregiver need to do to help? How many caregivers should assist? Does the caregiver need to remain with the resident in the bathroom for safety? If required, how should the caregiver use special equipment such as a Hoyer? How often should the resident be toileted? For incontinent residents, how should the caregiver protect the resident's skin? Is there a barrier cream? A particular way to cleanse the area? How often should the client be cleaned and changed? If a resident has a special request such as - do ot disturb during the night - make a note here for the caregiver.Ignore the Ctrl+Click message below:)**Caregiver will |
| **DRESSING***How individual puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis***[ ]** Independent **[ ]** Supervision/Cueing**[ ]** Assistance Needed **[ ]** Totally Dependent**Equipment/Supplies/Procedures:** **Limitations:**  | **[Strengths and Abilities](#dress_res" \o " What assistance does the resident require for dressing? Can they complete the task by themselves? Do they require stand by, minimal, total assist?  Does the resident have special equipment (shoe horn, grabber device)? Do they require set up of these items for use?Ignore the Ctrl+Click message below:)** | **Monitoring/Reporting significant changes and/or concerns:** Caregiver is to monitor the resident during the ADL, report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.)**[Assistance Required](#dress_pro" \o " If the resident requires assistance, how many caregivers are needed? If the resident requires set up, should the caregiver stay in the room or just check on the resident periodically? What does the caregiver do to help the resident dress?Make a note of any special preferences the resident has, such as 'no sweatpants', 'likes to wear a sweater at all times'.Ignore the Ctrl+Click message below:)**Caregiver will |
| **PERSONAL HYGIENE**– *How individual maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum***[ ]** Independent **[ ]** Supervision/Cueing**[ ]** Assistance Needed **[ ]** Totally Dependent**[ ]** Own teeth **[ ]** Partials **[ ]** Dentures**[ ] Oral Hygiene** (including dentures): **[ ]** Flossing**[ ]** Brushing**[ ]** Soaking**[ ] Hair Care:** **[ ] Menses Care:** **When/how often:** **Equipment/Supplies/Procedures:** **Limitations:**  | **[Strengths and Abilities](#PerHyg_res" \o " What hygiene tasks, such as brushing teeth, cleaning dentures, brushing hair, washing face, grooming self, shaving can the resident do independently or need some help with? Can resident do tasks independently if needed items are set up?Ignore the Ctrl+Click message below:)** | **Monitoring/Reporting significant changes and/or concerns:** Caregiver is to monitor the resident during the ADL, report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.)**[Assistance Required](#PerHyg_pro" \o " How will the caregiver assist the resident with brushing hair, brushing teeth, cleaning dentures, shaving, putting on makeup? Does the caregiver set up items and cue the resident, or does the caregiver complete the task for the resident?  Does the resident have a beard or moustache they want to keep? How will staff assist in grooming facial hair if resident does not want it shaved off?Does the resident have any special personal care items or brand/product preferences the resident likes to use (favorite shaving cream, certain type of brush, favorite toothpaste)?  Who will provide this if it is not an item normally offered by your AFH?Ignore the Ctrl+Click message below:)**Caregiver will |
| **BATHING***How individual takes full-body shower, sponge bath, and transfer in/out of tub/shower***[ ]** Independent **[ ]** Supervision/Cueing**[ ]** Assistance Needed **[ ]** Totally Dependent**When/how often:** **Equipment/Supplies/Procedures:** **Limitations:**  | **[Strengths and Abilities](#bath_res" \o " Does the resident prefer a bath or a shower? How often does the resident prefer to bathe? Can the resident do their own bedside bath between routine showers?Ignore the Ctrl+Click message below:)** | **Monitoring/Reporting significant changes and/or concerns:** Caregiver is to monitor the resident during the ADL, report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.)**[Assistance Required](#bath_pro" \o " How will the caregiver assist with bathing? Stand by assist, total assist, wash resident's back but allow resident to do everything else? Does the caregiver need to be in the bathroom while the resident is in shower/bath?How many times a week will the caregiver assist the resident with bathing?Include any special equipment the caregiver will use such as shower chairs, transfer board, equipment to help resident reach feet or back , etc.Ignore the Ctrl+Click message below:)**Caregiver will |
| **FOOT CARE****[ ]** Independent **[ ]** Supervision/Cueing**[ ]** Assistance Needed **[ ]** Totally Dependent**[ ]** [Foot Care:](#Foot_care" \o " Foot care for non-diabetic residents that may need nails filed, foot soaks, pads, protective booties, etc.  ) How Often: **[ ]** [Diabetic Foot Care](#Foot_care_Diabetic" \o " Diabetic foot care: Includes unskilled tasks such as keeping feet clean and dry, using tepid water to wash feet, drying feet well, especially between the toes, daily inspection of feet, toes and between toes for skin and nail changes (blisters, sores, swelling, redness or sore toenails), rubbing lotion on the feet (not between the toes), making sure client wears protective foot coverings (shoes or slippers), reporting to health care professionals any observed changes in skin or nails. Be sure to add the professional that will be involved.Ignore the Ctrl+Click message below:) **[ ]** Nail Care**When/how often:**  **[ ]** [Home Health Agency](#Home_health_agency" \o "Add name, address, and phone number is the resident uses a Home Health Agency.Ignore the Ctrl+Click message below:): **Equipment/Supplies/Procedures:** **Limitations:**  | **[Strengths and Abilities](#body_res" \o " What are the resident’s needs for body care? For example, if they are assessed as having dry skin and they need to have lotion applied after each bath or incontinence episode, document it here. They may need to have a medication applied. If so, is there nurse delegation in place?Also, the resident may have dry skin and requires lotion, but they are able to apply it themselves. Be sure to say how this activity takes place.If the resident is diabetic, what is the plan around foot care?Ignore the Ctrl+Click message below:)** | **Monitoring/Reporting significant changes and/or concerns:** Caregiver is to monitor the resident during the ADL, report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.)**[Assistance Required](#body_pro" \o " If the resident has needs around body care, what are caregivers expected to do to help them? For example, you may say something like apply lotion to arms and legs after each bath.  Do you need to file toe/finger nails to keep them from getting long and breaking/chipping?Ignore the Ctrl+Click message below:)**Caregiver will |
| **SKIN CARE** **[ ]** Independent **[ ]** Supervision/Cueing**[ ]** Assistance Needed **[ ]** Totally Dependent**[ ]** **Skin Care -** How Often: **[ ]** Status: **[ ]** **Skin Problems -** Describe: **[ ]** Status: **[ ]** **Pressure Injuries -** Describe: **[ ]** **Dressing Changes -** How Often: **[ ]** **Nurse Delegated****When/how often:** **[ ]** [Home Health Agency](#Home_health_agency" \o "Add name, address, and phone number is the resident uses a Home Health Agency.Ignore the Ctrl+Click message below:): **Equipment/Supplies/Procedures:** **Limitations:**  |  | Caregiver will |

| **INSTRUMENTAL ACTIVITIES OF DAILY LIVING** | **Resident Strengths And Abilities****Prefers To Do Independently****Preferences and Personal Goals** | **Assistance Required****Who Will Provide, When And How** |
| --- | --- | --- |
| **MANAGING FINANCES****[ ]** Independent **[ ]** Assistance Needed **[ ]** Dependent**[ ]** **Who Manages Finances:** **[ ]** **Who Manages** **Financial Records:** **[ ]** Payee Name and Contact information:  | **[Strengths and Abilities](#fin_res" \o " Does the resident keep their own money and handle their own accounts/checkbook? Is the resident working on a money management program with a goal of independence?Ignore the Ctrl+Click message below:)****Prefers to do independently:**  | **[Assistance Required](#fin_pro" \o " What will the AFH do to assist the resident in managing the finances? If the AFH manages the resident’s funds, how will this be managed and monitored? How will the resident access funds if they need petty cash or to pay a bill?If the AFH doesn’t manage the resident funds, how will the AFH make sure the resident can access funds timely if they were to go on an outing or to purchase items? How will the facility assist the resident in keeping the funds/checkbook/bank statements/etc. safe? Ignore the Ctrl+Click message below:)**Caregiver will |
| **SHOPPING****[ ]** Independent **[ ]** Assistance Needed **[ ]** Dependent**[ ]** **[Special transportation needs](#Trans_Special_needs" \o "Special transportation needs may include using a lift van, assistive devices to help get in or out of the car, seatbelt extension, etc.Ignore the Ctrl+Click message below:):** **How often/when:** **Equipment/Supplies/Procedures:** **Limitations:**  | **[Strengths and Abilities](#shop_res" \o " How does the resident do their personal shopping? They may like to go with a family member or purchase special items. Ignore the Ctrl+Click message below:)** | **[Assistance Required](#shop_pro" \o "The AFH will provide most of the shopping for food, toiletries, etc. but some residents or their families may do some shopping. Explain how this happens for the resident.Ignore the Ctrl+Click message below:)**Caregiver will |
| **TRANSPORTATION** **[ ]** Independent **[ ]** Assistance Needed **[ ]** Dependent**[ ]** **Medical services:** **[ ]** **[Special transportation needs](#Trans_Special_needs" \o "Special transportation needs may include using a lift van, assistive devices to help get in or out of the car, seatbelt extension, etc.Ignore the Ctrl+Click message below:):** **[ ]** **Escort Required****How often/when:** **Equipment/Supplies/Procedures:** **Limitations:**  | **[Strengths and Abilities](#tran_res" \o " What are the resident’s transportation needs? Do they have a standing appointment or require special transportation? Ignore the Ctrl+Click message below:)** | **[Assistance Required](#tran_pro" \o "The AFH is not required to provide transportation for residents. You do, however, need to coordinate the resident's transportation. Explain how transportation happens for the resident. For example, their family member may transport the resident to medical appointments.Ignore the Ctrl+Click message below:)**Caregiver will |
| **ACTIVITIES/SOCIAL***Social/Cultural considerations, traditions, or preferences***[ ]** Independent **[ ]** Assistance Needed **[ ]** Dependent**[ ]** Interests/Activities/Religious Activities: **[ ]** Social/Cultural Traditions/Preferences: **[ ]** Family/Friends/Relationships: **[ ]** Employment Support: **[ ]** Clubs/Groups/Day Health: **[ ]** Special Arrangements: **[ ]** Participation Issues: Emergency Numbers: ***See face sheet in resident binder*** | **[Strengths and Abilities](#ActSoc_res" \o " What activities does the resident like? Do they go to church on Sunday or meet with family at a particular time? Do they enjoy sitting outside or playing cards?  Ignore the Ctrl+Click message below:)** | **[Assistance Required](#ActSoc_pro" \o " How do caregivers assist the resident in their activities? Do they set up transportation or facilitate an activity? The directions may read something like 'Make sure Mrs. Johnson is up, showered and dressed for church on Sundays by 9:45.Ignore the Ctrl+Click message below:)**Caregiver will**[Special Arrangements](#sp_arrange" \o "For example: arranging/scheduling transportation/activities, etc.Ignore the Ctrl+Click message below:)**: **[Participation Assistance](#part_assist" \o "For example: accompanying/assisting a resident with an activity.Ignore the Ctrl+Click message below: )**:  |
| **ACTIVITY PREFERENCES AT A GLANCE** |
| **[ ]** Reading book and/or magazines**[ ]** Listening to audio books and/or podcasts**[ ]** Storytelling**[ ]** Phone conversation/visiting**[ ]** Reminiscing**[ ]** Current events**[ ]** Discussion group**[ ]** Bible study or church**[ ]** Visitors | **[ ]** Gardening**[ ]** Outings with family or provider**[ ]** Visiting zoos and/ or spending time with pets and animals**[ ]** Exercises/range of motion**[ ]** Therapeutic Walking**[ ]** Cooking or baking**[ ]** House chore activities**[ ]** Watching TV, movies, or favorite shows | **[ ]** Parties and social gatherings**[ ]** Arts and crafts**[ ]** Table games, Bingo, cards, puzzles**[ ]** Beauty time, beautician visit**[ ]** Music appreciation/therapy/singing**[ ]** Employment support**[ ]** Community Integration**[ ]** Other: **[ ]** Other:  |
| **ACTIVITY NARRATIVE**: |
| **SMOKING**[ ] Resident Smokes [ ] Safety Concerns: [ ] Smoking Policy reviewed with resident. Signed by resident and placed in their record.Storage of Cigarettes/lighter:  | **[Strengths and Abilities](#smoke_res" \o " Does the resident smoke? If so are they safe to smoke independently?Ignore the Ctrl+Click message below:)** | **[Assistance Required](#smoke_pro" \o " Do caregivers need to provide any assistance or supervision with smoking? Ignore the Ctrl+Click message below:)**Caregiver will |
| **CASE MANAGEMENT****[ ]** Resident receives Case ManagementName:Agency: Phone: Email: FAX: |  | CM will be contacted when: * The resident needs assistive device or other services to meet their needs
* When the provider need help with the care plan
* Significant changes with the condition/needs that necessitate changes with the care plan
 |
| **OTHER ISSUES/CONCERNS/PROBLEMS** |
| **[NEGOTIATED CARE PLAN REVIEW](#NCP_Review" \o "Did you remember to include other topics that may be required, but are not included in the template such planning for: a service dog.Ignore the Ctrl+Click message below: )** | The resident will participate in their NCP development/reviews to the extent they are able. | This NCP will be reviewed/revised:* After an assessment for a significant change in the resident's physical or mental condition;
* When the plan, or parts of the plan, no longer address the resident's needs and preferences;
* At the request of the resident or the resident representative; or
* At least every twelve months.
 |

**Abbreviations used in this NCP:**

|  |  |  |  |
| --- | --- | --- | --- |
| ADL= Activities of Daily Living | DPOA = Durable Power of Attorney | MD = medical doctor | W/c= Wheelchair |
| AFH = Adult Family Home | D/t = due to | PCP = primary care physician |  |
| CG = Caregiver | Hx = history | PRN = As needed |  |
| Dr. = Doctor | MAR = medication assistance record | RND = Register Nurse Delegator |  |

 **Negotiated Care Plan Review and Approval**

**DATE OF ORIGINAL PLAN:**

Dates of Review/

[Revision](#Revision" \o " WAC 388-76-10380Negotiated care plan—Timing of reviews and revisions.The adult family home must ensure that each resident's negotiated care plan is reviewed and revised as follows:(1) After an assessment for a significant change in the resident's physical or mental condition;(2) When the plan, or parts of the plan, no longer address the resident's needs and preferences;(3) At the request of the resident or the resident representative; or(4) At least every twelve monthsIgnore the Ctrl+Click message below:):

| **[INVOLVED IN NCP DEVELOPMENT](#Involved_NCP_dev" \o " When developing the NCP, the AFH must involve the resident, their family (if the resident requests), the resident’s representative (if there is one), professionals involved in the care of the resident, other individuals the resident requested, and the CM for residents receiving care and services paid through Medicaid. WAC 388-76-10370.Ignore the Ctrl+Click message below:)** | **PERSON APPROVING PLAN**  | **SIGNATURE**  | DATE\* | SIGNATURE DATE\* |
| --- | --- | --- | --- | --- |
| **[ ]** Resident**[ ]** Resident Representative[ ] Parent**[ ]** Health Professional**[ ]** Other: **[ ]** Other: **[ ]** Other:  | **[PROVIDER](#Prov_sig" \o "Signature Required - WAC 388-76-10375.Ignore the Ctrl+Click message below:)** |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  | [RESIDENT](#Res_sig" \o "Signature Requreed - WAC 388-76-10375.Ignore the Ctrl+Click message below:) |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  | **RESIDENT REPRESENTATIVE** |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| [ ] Resident verbally agreed to NCP – Date:  | **[]** NCP sent to DSHS CM on**:**  |
| [Resident Recommendations:](#Res_Recommendations_NCP" \o "Document any NCP recommendations the resident has and the plan to address them.Ignore the Ctrl+Click message below:)  |

\*The person signing writes the date they actually read and agreed to the plan. If the participant has verbally agreed to the plan, the provider should note below: (a) the name and role of the participant; (b) the date the participant had the plan to read to them; and (c) what if any changes the participant recommended for the plan.