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| **[ADULT FAMILY HOME RESIDENT](file:///C:\\Users\\CaryD\\Documents\\Custom%20Office%20Templates\\NCP%20DRAFT%20082321.dotx" \l "NEGOTIATED_CARE_PLAN" \o " The Negotiated Care Plan is required by WAC 388-76-10355 and other applicable regulations. You are required to be familiar with and to follow all applicable laws and rules. The screen tips provided are given to you to assist your compliance with the laws and )** **[NEGOTIATED CARE PLAN](file:///C:\\Users\\CaryD\\Documents\\Custom%20Office%20Templates\\NCP%20DRAFT%20082321.dotx" \l "NEGOTIATED_CARE_PLAN" \o " The Negotiated Care Plan is required by WAC 388-76-10355 and other applicable regulations. You are required to be familiar with and to follow all applicable laws and rules. The screen tips provided are given to you to assist your compliance with the laws and ) (NCP)** Negotiated Care Plans are unique to each resident. You are required to develop the NCP by using the resident assessment. The NCP must include a list of the care and services to be provided, with details on the resident’s preferences and choices, and how services will be delivered to accommodate these preferences and choices.[WAC 388-76-0355](#WAC_10355" \o "WAC 388-76-10355Negotiated care plan.The adult family home must use the resident assessment and preliminary care plan to develop a written negotiated care plan. The home must ensure each resident's negotiated care plan includes:(1) A list of the care and services to be provided;(2) Identification of who will provide the care and services;(3) When and how the care and services will be provided;(4) How medications will be managed, including how the resident will get their medications when the resident is not in the home;(5) The resident's activities preferences and how the preferences will be met;(6) Other preferences and choices about issues important to the resident, including, but not limited to:(a) Food;(b) Daily routine;(c) Grooming; and(d) How the home will accommodate the preferences and choices.(7) If needed, a plan to:(a) Follow in case of a foreseeable crisis due to a resident's assessed needs;(b) Reduce tension, agitation and problem behaviors;(c) Respond to resident's special needs, including, but not limited to medical devices and related safety plans;(d) Respond to a resident's refusal of care or treatment, including when the resident's physician or practitioner should be notified of the refusal;(8) Identification of any communication barriers the resident may have and how the home will use behaviors and nonverbal gestures to communicate with the resident;(9) A statement of the ability for resident to be left unattended for a specific length of time; and(10) A hospice care plan if the resident is receiving services for hospice care delivered by a licensed hospice agency.). You must ensure the initial NCP is developed and completed within 30 days of your resident’s admission. You must involve the resident, their family (if the resident agrees), personal representative (if there is one), any professionals involved in their care, any person the resident requested, and their case manager (if there is one) when developing the NCP. The negotiated care plan is reviewed and agreed to, signed, and dated by the resident/representative and AFH provider/representative.[WACs](#WAC_10360" \o "WAC 388-76-10360Negotiated care plan—Timing of development—Required.The adult family home must ensure the negotiated care plan is developed and completed within thirty days of the resident's admission.) [388-76-10360](#WAC_10360" \o "WAC 388-76-10360Negotiated care plan—Timing of development—Required.The adult family home must ensure the negotiated care plan is developed and completed within thirty days of the resident's admission.),[388-76-10370](#WAC_10370" \o "WAC 388-76-10370Negotiated care plan—Persons involved in development.The adult family home must involve the following people in developing the negotiated care plan:(1) The resident, to the greatest extent he or she can participate;(2) The resident's family, if approved by the resident;(3) The resident's representative, if the resident has a representative;(4) Professionals involved in the care of the resident;(5) Other individuals the resident wants included; and(6) The department case manager, if the resident is receiving care and services paid for by the department.),  [388-76-10375](#WAC_10375" \o "WAC 388-76-10375Negotiated care plan—Signatures—Required.The adult family home must ensure that the negotiated care plan is agreed to and signed and dated by the:(1) Resident; and(2) Adult family home.)  **Instructions:**  *[Place your mouse over this](#How_use_form" \o " How To Use This FormAdditional information/instructions have been provided using ‘screen tips’. Anywhere you see blue text, you can move your mouse/cursor over the text to see useful information to help you develop your NCP. The form has been set up to 'repeat headers' If a section of the form flows over to another page. What this means is the header that describes the section will duplicate at the top of the next page.  As this is just a 'copy' of the original header, it will not display the screen tip.  If you do not see a screen tip pop up when you are hovering over blue text, look to see if the section flowed to a second page. Scroll up to the top of the section and you will be able to view the instructions.Ignore the ‘Ctrl+Click’ displayed at the bottom of the screen tip – this is for development purposes only, and will not take you anywhere. )* ***[BLUE TEXT](#How_use_form" \o " How To Use This FormAdditional information/instructions have been provided using ‘screen tips’. Anywhere you see blue text, you can move your mouse/cursor over the text to see useful information to help you develop your NCP. The form has been set up to 'repeat headers' If a section of the form flows over to another page. What this means is the header that describes the section will duplicate at the top of the next page.  As this is just a 'copy' of the original header, it will not display the screen tip.  If you do not see a screen tip pop up when you are hovering over blue text, look to see if the section flowed to a second page. Scroll up to the top of the section and you will be able to view the instructions.Ignore the ‘Ctrl+Click’ displayed at the bottom of the screen tip – this is for development purposes only, and will not take you anywhere. )*** *[for instructions on how to use this form.](#How_use_form" \o " How To Use This FormAdditional information/instructions have been provided using ‘screen tips’. Anywhere you see blue text, you can move your mouse/cursor over the text to see useful information to help you develop your NCP. The form has been set up to 'repeat headers' If a section of the form flows over to another page. What this means is the header that describes the section will duplicate at the top of the next page.  As this is just a 'copy' of the original header, it will not display the screen tip.  If you do not see a screen tip pop up when you are hovering over blue text, look to see if the section flowed to a second page. Scroll up to the top of the section and you will be able to view the instructions.Ignore the ‘Ctrl+Click’ displayed at the bottom of the screen tip – this is for development purposes only, and will not take you anywhere. )**Hover the mouse over the blue text throughout the document for WAC references and tips.* | | | | | | | | |
| **[PROVIDER’S NAME](#Prov_name_strart_here" \o " Remember to add your Resident’s name to the footer of the document. This will assure your Resident’s name appears on all pages of the NCP.Save the document under your Resident’s name):** Click here to enter Provider’s Name. | | | | | | | | |
| **RESIDENT’S NAME:**  Click here to enter the Resident’s Name. It will automatically be added to the footer and repeated on every page. | | | **TODAY’S DATE:**  Click or tap to enter a date. | | **MOVED IN DATE:**  Click or tap to enter a date. | **[DATE COMPLETED](#Date_comp" \o "Must be completed within 30 days of admit):**  Click or tap to enter a date. | | **DATE DISCHARGED:**  Click or tap to enter a date. |
| **DATE OF BIRTH:**  Click or tap here to enter text. | **[AGE](#Age" \o "Located uner Client Information)**:  Click or tap here to enter text. | | **[RESPONSIBLE PARTY](#Responsible_party" \o "Located under Contacts) (1):**  Click or tap here to enter text.  **RELATIONSHIP (Guardian, DPOA, Family, etc.):** Click or tap here to enter text.  **ADDRESS/EMAIL:**  Click or tap here to enter text. | | | **RESPONSIBLE PARTY (2):**  Click or tap here to enter text.  **RELATIONSHIP (Guardian, DPOA, Family, etc.):**  Click or tap here to enter text.  **ADDRESS/EMAIL:**  Click or tap here to enter text. | | |
| **PRIMARY LANGUAGE:**  Click or tap here to enter text. | | |  | | |  | | |
| **ALLERGIES:** Click or tap here to enter text. | | | **HOME PHONE:**  Click or tap here to enter text. | | **CELL PHONE:**  Click or tap here to enter text. | **HOME PHONE:**  Click or tap here to enter text. | | **CELL PHONE:**  Click or tap here to enter text. |
| **ADVANCED DIRECTIVES:** Specify Types: Click or tap here to enter text.  [**POLST FORM:**](#polst) | | | [**LEGAL DOCUMENTS**](#LEG_DOC_EXAMPLE)**:** Click or tap here to enter text. | | | **PHARMACY:**  Click or tap here to enter text.  **Phone:** Click or tap here to enter text.  **FAX:**  Click or tap here to enter text. | | |
| **PHYSICIAN/MEDICAL GROUP (1):**  Click or tap here to enter text.  **Phone:** Click or tap here to enter text.  **FAX:**  Click or tap here to enter text. | | | **PHYSICIAN/MEDICAL GROUP (2):**  Click or tap here to enter text.  **Phone:** Click or tap here to enter text.  **FAX:**  Click or tap here to enter text. | | | **DENTIST/DENTAL GROUP:**  Click or tap here to enter text.  **Phone:** Click or tap here to enter text.  **FAX:**  Click or tap here to enter text. | | |
| **CURRENT MEDICAL STATUS/DIAGNOSIS/**  **[HEALTH IN](#health_indicators" \o "Health Indicators help identify stability of client’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, or poor nutritional intake due to physical cognitive, and 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 fluctuates, fatigue, shortness of breath, general muscle weakness, etc.)****[DICATORS](#health_indicators" \o "Health Indicators help identify stability of client’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, or poor nutritional intake due to physical cognitive, and 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 fluctuates, fatigue, shortness of breath, general muscle weakness, etc.):**  Click here to enter Resident’s current medical status and health indicators  **MEDICAL HISTORY:**  Click here to enter Resident’s medical history. | | | | | | | | |
| **SPECIALITY NEEDS** | | | | | | | | |
| **DEMENTIA/COGNITIVE ISSUES:** | | **Comments:** Click or tap here to enter text. | | | | | | |
| **MENTAL HEALTH:** | | **Comments:** Click or tap here to enter text. | | | | | | |
| **DEVELOPMENTAL DISABILITY:** | | **Comments:** Click or tap here to enter text. | | | | | | |
| **EMERGENCY EVACUATION** | | | | | | | | |
| Is resident willing to participate in evacuation drills? YES NO | | If **NO**, estimate how long you think it would take to evacuate the resident and how you came to this estimate.  Click or tap here to enter text. | | | | | | |
| **ASSISTANCE REQUIRED:**  **NONE – RESIDENT IS INDEPENDENT:** Resident is physically and mentally able to evacuate the home after one verbal cue and does not require the assistance of another individual or use of a mobility aid.  **ASSISTANCE REQUIRED:** Resident Is not physically or mentally capable of getting out of the house without assistance from another individual, mobility aids, or multiple cues.  **EVACUATION INSTRUCTIONS:**  Click or tap here to enter text. | | | | | | | | |
| ***[COMMUNICATION](#Communication" \o "Negotiated Care Plan WAC 388-76-10355)*[:](#Communication" \o "Negotiated Care Plan WAC 388-76-10355)**  **SPEECH/HEARING/VISION** | | | | **RESIDENT STRENGTHS AND ABILITIES**  **PREFERS TO DO INDEPENDENTLY** | | | **ASSISTANCE REQUIRED**  **WHO WILL PROVIDE, WHEN, AND HOW** | |
| **Problems with Speech?**  Describe: Click or tap here to enter text.  Equipment: Click or tap here to enter text. | | | | **[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?)**  **Speech:** Click or tap here to enter text.  **Hearing:** Click or tap here to enter text.  **Vision:** Click or tap here to enter text.  **Phone:** Click or tap here to enter text.  **Comprehension:**  **How resident makes self-understood:** Click or tap here to enter text.  **How resident understands others:** Click or tap here to enter text. | | | **[Assistance Required](#Speech_pro" \o )**  **Speech:**  **WHO:** Click or tap here to enter text.  **WHEN/FREQUENCY:** Click or tap here to enter text.  **HOW:** Click or tap here to enter text.  **Hearing:**  **WHO:** Click or tap here to enter text.  **WHEN/FREQUENCY:** Click or tap here to enter text.  **HOW:** Click or tap here to enter text.  **Vision:**  **WHO:** Click or tap here to enter text.  **WHEN/FREQUENCY:** Click or tap here to enter text.  **HOW:** Click or tap here to enter text.  **Phone:**  **WHO:** Click or tap here to enter text.  **WHEN/FREQUENCY:** Click or tap here to enter text.  **HOW:** Click or tap here to enter text.  Click here to add any additional information.  [**Monitoring/Reporting significant changes and/or concerns**](#Monitor_report_label)**:** Click or tap here to enter text. | |
| **Problems with Hearing?**  Describe: Click or tap here to enter text.  Equipment: Click or tap here to enter text. | | | |  | | |  | |
| **Problems with Vision?**  Describe: Click or tap here to enter text.  Equipment: Click or tap here to enter text. | | | |  | | |  | |
| **Ability to Use the Phone**  Independent  Assistance Needed  Dependent  Resident has own phone, number: Click or tap here to enter text. | | | |  | | |  | |
| **Preferred Language:** Click or tap here to enter text. | | | |  | | |  | |

| **[MEDICATION MANAGEMENT](#Med_man" \o "Medications WAC 388-76-10430 through 388-76-10490)**  Check all that apply | **RESIDENT STRENGTHS AND ABILITIES**  **PREFERS TO DO INDEPENDENTLY** | **ASSISTANCE REQUIRED**  **WHO WILL PROVIDE, WHEN, AND HOW** |
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| **MEDICATION ALLERGIES:** Click or tap here to enter text.  Resident needs more than one kind of mediation assistance-need indicated below  Describe: Click or tap here to enter text.  Resident is prescribed psychopharmacologic medications – see behavior section for strategies and modification to address symptoms addressed by this/these medications  Meds are order by: Click or tap here to enter text.  Meds are delivered by: Click or tap here to enter text.  [Pharmacy Packed](#Pharm_pack" \o "Bubble pack, pill bottle, pouches, bingo cards, etc.): Click or tap here to enter text.  Pharmacy: Click or tap here to enter text.  Contact Numbers/Information: Click or tap here to enter text. | | See Medication Administration Record (MAR)/Medication Log for current medications, dosage, frequency, and route  Click or tap here to enter text. |
| **[SELF-ADMINISTRATION](#Rx_self_ad" \o "WAC 388-76-10445)** | **[Strengths and Abilities](#Rx_res" \o " Is the resident able to self-administer any medication? They may use a medication, such as an inhaler, by themselves but other medications are administered by a caregiver. List the medications, if any, the resident uses on their own.  )**  **Preferences/Choices:** Click or tap here to enter text.  **Strengths/Abilities:** Click or tap here to enter text.  **Prefers to do independently:**  Click or tap here to enter text. | **[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 to be monitored for change? )**  Click or tap here to enter text.  [**Monitoring/Reporting adverse reactions,** **significant changes and/or concerns**](#Monitor_report_label)**:** Click or tap here to enter text. |
| Equipment: Click or tap here to enter text. |  |  |
| Oral  Topical  Eye drops/ointment  Inhalers  Keeps Meds locked in room/lockbox or agreed upon secure location  Sprays  Injections  Allergy Kits  Topical  Other: Click or tap here to enter text. |  |  |
| **[SELF-ADMINISTRATION W/ ASSISTANCE](#Rx_self_ad_with_assist" \o "WAC 388-76-10450)** | **[Strengths and Abilities](#self_med_assist_res" \o "Is the resident able to put their medication in their mouth but needs a caregiver to bring it to them? Maybe they use eye drops and need a caregiver to hold the dropper steady, but they are able to expel the drops)**  **Preferences/Choices:** Click or tap here to enter text.  **Strengths/Abilities:** Click or tap here to enter text.  **Prefers to do independently:**  Click or tap here to enter text. | **[Assistance Required](#self_med_assist_provider" \o " How does this happen. Explain the routine for this resident. This is where you describe the details of how the medication/s are given.You may say Mrs. Jones is to have 1 drop of prescription XYZ in her left eye twice daily. Bring the bottle to her and help her steady it above her eye while she squeezes the bottle. Monitor and report any changes to her doctor and her daughter. Order medication when it is running low. )**  **Describe reason resident needs this amount of medication assistance:**  Click or tap here to enter text.  **#1 -** Click here to add a type of medication that will need assistance, such as: Oral Medications, Inhaler, Topical, Eye Drops, etc.  **WHO:** Click here to indicate who will be helping with this task.  **WHEN/FREQUENCY:** Click here to add when assistance is needed and how often.  **HOW:** Click here to add how the assistance will be provided.  **#2 -** Click here to add a type of medication that will need assistance, such as: Oral Medications, Inhaler, Topical, Eye Drops, etc.  **WHO:** Click or tap here to enter text.  **WHEN/FREQUENCY:** Click her to add when assistance is needed and how often.  **HOW:** Click here to add how the assistance will be provided.  **#3 -** Click here to each a type of medication that will need assistance, such as: Oral Medications, Inhaler, Topical, Eye Drops, etc.  **WHO:** Click or tap here to enter text.  **WHEN/FREQUENCY:** Click her to add when assistance is needed and how often.  **HOW:** Click here to add how the assistance will be provided.  [**Monitoring/Reporting adverse reactions,** **significant changes and/or concerns**](#Monitor_report_label)**:** Click or tap here to enter text.  **#4 -** Click here to add a type of medication that will need assistance, such as: Oral Medications, Inhaler, Topical, Eye Drops, etc.  **WHO:** Click or tap here to enter text.  **WHEN/FREQUENCY:** Click her to add when assistance is needed and how often.  **HOW:** Click here to add how the assistance will be provided.    Click here to add additional medications or information.  **Follow the 7 Rights of Medication Administration every time:**   1. Right Resident 2. Right Medication 3. Right Dose 4. Right Route 5. Right Time 6. Right to Refuse 7. Right documentation/MAR |
| Equipment: Click or tap here to enter text. |  |  |
| Oral  Topical  Eye drops/ointment  Inhalers  Other: Click or tap here to enter text.  Sprays  Injections  Allergy Kits  Topical  Other: Click or tap here to enter text. |  |  |
| **[MEDICATION ADMINISTRATION](#Rx_Admin" \o "WAC 388-76-10455)** | **[Strengths and Abilities](#Med_Admin_res" \o "If a resident requires you to put medication in their mouth or is unaware they are taking medication, then this is administration. Residents will likely require nurse delegation to have a medication administered by caregivers unless the task is done by a family member. An example of a task that may be delegated is insulin injections that the resident is unable to do on their own.)**  Click or tap here to enter text. | **[Assistance Required](#Med_Admin_pro" \o "Explain how the medication is administered. Is the task delegated? Maybe a family member completes the task. If a medication has to be prepared, explain how that is done here. For more information on nurse delegation see WACs 246-840-910 through 246-840-970)**  **Describe reason resident needs this amount of medication assistance:**  Click or tap here to enter text.  **#1 -** Click here to add a type of medication that will need to be administered, such as: Oral Medications, Inhaler, Topical, Eye Drops, etc.  **WHO:** Click here to indicate who will be administering the medication.  **WHEN/FREQUENCY:** Click here to add when administration is needed and how often.  **HOW:** Click here to add how the administration will be provided.  **#2 -** Click here to add a heading for each type of medication that will need assistance, such as: Oral Medications, Inhaler, Topical, Eye Drops, etc.  **WHO:** Click here to indicate who will be administering the medication.  **WHEN/FREQUENCY:** Click here to add when administration is needed and how often.  **HOW:** Click here to add how the administration will be provided.  **#3 -** Click here to add a heading for each type of medication that will need assistance, such as: Oral Medications, Inhaler, Topical, Eye Drops, etc.  **WHO:** Click here to indicate who will be administering the medication.  **WHEN/FREQUENCY:** Click here to add when administration is needed and how often.  **HOW:** Click here to add how the administration will be provided.  **#4 -** Click here to add a heading for each type of medication that will need assistance, such as: Oral Medications, Inhaler, Topical, Eye Drops, etc.  **WHO:** Click here to indicate who will be administering the medication.  **WHEN/FREQUENCY:** Click here to add when administration is needed and how often.  **HOW:** Click here to add how the administration will be provided.    Click here to add additional medications or information.  **Follow the 7 Rights of Medication Administration every time:**   1. Right Resident 2. Right Medication 3. Right Dose 4. Right Route 5. Right Time 6. Right to Refuse 7. Right documentation/MAR   [**Monitoring/Reporting adverse reactions,** **significant changes and/or concerns**](#Monitor_report_label)**:** Click or tap here to enter text. |
| Requires [Nurse Delegation](#RN_DEL)  **RN Delegator**   * **Name:** Click or tap here to enter text. * **Phone:** Click or tap here to enter text. * **FAX:** Click or tap here to enter text. * **Email:** Click or tap here to enter text. |  |  |
| Equipment: Click or tap here to enter text. |  |  |
| Oral  Topical  Eye drops/ointment  Inhalers  Allergy Kits  Other: Click or tap here to enter text.  Sprays  Injections  Allergy Kits  Topical  Suppositories  Other: Click or tap here to enter text. |  |  |
| **[Medication Plan When Resident is not in the AFH](#RX_plan_offsite_title" \o "WAC 388-76-10455 (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)** | **Strengths and Abilities**  Click or tap here to enter text. | **[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.)**  Click or tap here to enter text. |
| **[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 ? At what time 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 )** | **Strengths and Abilities**  Click or tap here to enter text. | **Assistance Required**  Click or tap here to enter text. |

| **TREATMENTS/PROGRAMS/THERAPIES** | **RESIDENT STRENGTHS AND ABILITIES**  **PREFERS TO DO INDEPENDENTLY** | **ASSISTANCE REQUIRED**  **WHO WILL PROVIDE, WHEN, AND HOW** |
| --- | --- | --- |
| **Health Issue to Monitor:** | **[Strengths and Abilities](#Treatment_strength_res" \o " Explain if the resident receives any therapies or treatments. For example a resident may use oxygen or 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? )**  **Preferences/Choices:** Click or tap here to enter text.  **Strengths/Abilities:** Click or tap here to enter text.  **Prefers to do independently:**  Click or tap here to enter text.  Click or tap here to enter text. | **[Assistance Required](#Treatment_assess_req_prov" \o " Explain how the therapy or treatment happens. If it is a caregiver helping with something provide directions on how to complete the task here.If the resident receives home health or some other kind of treatment from an outside source explain how that happens here so your caregivers know what to expect.  Has a risk assessment been done to ensure this is safe for this particular resident? See WAC 388-76-10650 for more information.How do caregivers monitor or help the resident use the equipment safely?  )**  Click or tap here to enter text.  **#1 –** Click here to add which Treatment/ Program/ Therapy you need to plan for.  **WHO:** Click here to enter who will assist with the task.  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  **#2 –** Click here to add which Treatment/ Program/ Therapy you need to plan for.  **WHO:** Click here to enter who will assist with the task.  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  **#3 –** Click here to add which Treatment/ Program/ Therapy you need to plan for.  **WHO:** Click here to enter who will assist with the task.  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  **#4 –** Click here to add which Treatment/ Program/ Therapy you need to plan for.  **WHO:** Click here to enter who will assist with the task.  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  Click here to add additional information if needed.  [**Suggestions when Monitoring/Reporting adverse reactions, significant changes and/or concerns**](#Monitor_report_label)**:** Click or tap here to enter text. |
| Oxygen Use  Click to add Vendor contact information.  Pain  Dialysis  Click to add Vendor contact information.  Weight Loss/Gain  Blood Thinners  INR/LAB  Click to add Vendor contact information.  Vital Signs  Blood Glucose Monitoring  **Delegation for Treatments/Therapies**  Click or tap here to enter RN Delegated Tasks.  [**Hospice**](#hospice)  Click to add Vendor contact information. |  |  |
| **Programs Resident Requires/Attends:** |  |  |
| [Home Health](#Home_Health" \o "Home Health may include physical/occupational/speech therapy and skilled nursing services)  Click to add Vendor contact information.  Adult Day Health  [Other:](#Other_treat) Click or tap here to enter text.  Other: Click or tap here to enter text.  Other: Click or tap here to enter text. |  |  |
| **[Physical Enablers](#physical_enabler" \o "Does the resident use any assistive devices such as bedrails, trapeze, transfer pole, walker, wheelchair, etc.?):**  Click or tap here to enter text. | **Strengths and Abilities**  Click or tap here to enter text. | **[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.)**  Click or tap here to enter text. |
| **TREATMENT/PROGRAM/THERAPY REFUSAL PLAN** | **Strengths and Abilities**  Click or tap here to enter text. | **[Assistance Required](#treat_refusal" \o "Indicate how you will respond to a resident's refusal of care or treatment, including when the resident's physician or practitioner should be notified of the refusal. WAC 388-76-10360)**  Click or tap here to enter text. |
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| **PSYCH/SOCIAL/COGNITIVE STATUS** | **RESIDENT STRENGTHS AND ABILITIES**  **PREFERS TO DO INDEPENDENTLY** | **ASSISTANCE REQUIRED**  **WHO WILL PROVIDE, WHEN, AND HOW** |
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| [Sleep disturbance](#sleep_disturb" \o " Sleep disturbance is difficulty falling asleep, fewer, or more hours of sleep than is usual for the individual, waking up too early and unable to fall back to sleep. Disrupts household  at night when others are sleeping and requires intervention(s).) | **[Strengths and Abilities](#Psych_Strenght_abil" \o " Some of these will be listed in the resident’s assessment but others will develop over time. Be sure to have current information listed for behaviors.  If a behavior is no longer happening, be sure to say so.See WAC 338-76-10355 (7)(a): It requires that a plan to be developed and followed in the case of a foreseeable crisis due to a resident’s assessed needs.   )**  **Describe Behaviors – be specific:**  **#1 - Behavior/Symptom:** Click here to add the name of the Behavior/Symptom.  **Description:** Enter a description of the behavior/symptom  **Resident Strategies:** Enter strategies the resident uses to address the behavior/symptom.  **#2 - Behavior/Symptom:** Click here to add the name of the Behavior/Symptom.  **Description:** Enter a description of the behavior/symptom  **Resident Strategies:** Enter strategies the resident uses to address the behavior/symptom.  **#3 - Behavior/Symptom:** Click here to add the name of the Behavior/Symptom.  **Description:** Enter a description of the behavior/symptom  **Resident Strategies:** Enter strategies the resident uses to address the behavior/symptom.  **#4 - Behavior/Symptom:** Click here to add the name of the Behavior/Symptom.  **Description:** Enter a description of the behavior/symptom  **Resident Strategies:** Enter strategies the resident uses to address the behavior/symptom.  Click here to add additional Behaviors/Symptoms or information as needed. | **[Assistance Required](#Psych_assis_req" \o " What is it that a caregiver can do to address the behaviors a resident is displaying? Document any non-medication interventions that she/he should attempt prior to giving a resident a medication (if prescribed 'as needed or PRN' You may say something such as 'Mrs. Jones is often tearful at night. Speak to her gently and reassure her she is safe. Give her time to express herself and listen to her concerns. If she continues to be tearful she may have XYZ to help her sleep.  If the behavior continues, contact her doctor and her daughter.')**  **Describe specific non-medication (behavioral/environmental) interventions to address the symptoms:**  **#1 - Behavior/Symptom:** Click here to add which Behavior/Symptom you are addressing.  **WHO:** Click here to enter who will assist with the behavior strategy  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  **\*** **Psychopharmacological Medication** prescribed to address behaviorIf yes, list medication and describe symptom for each medication (*for example Lorazepam – for Anxiety*)  Click here to add medication and symptom/behavior.  **Staff strategies/environmental modifications to address behavior** Click or tap here indicate staff intervention/environmental modifications.  **#2- Behavior/Symptom:** Click here to add which Behavior/Symptom you are addressing.  **WHO:** Click here to enter who will assist with the behavior strategy  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  **\*** **Psychopharmacological Medication** prescribed to address behaviorIf yes, list medication and describe symptom for each medication (*for example Lorazepam – for Anxiety*)  Click here to add medication and symptom/behavior.  **Staff strategies/environmental modifications to address behavior** Click or tap here indicate staff intervention/environmental modifications.  **#3 - Behavior/Symptom:** Click here to add which Behavior/Symptom you are addressing.  **WHO:** Click here to enter who will assist with the behavior strategy  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  **\*** **Psychopharmacological Medication** prescribed to address behaviorIf yes, list medication and describe symptom for each medication (*for example Lorazepam – for Anxiety*)  Click here to add medication and symptom/behavior.  **Staff strategies/environmental modifications to address behavior** Click or tap here indicate staff intervention/environmental modifications.  **#4 - Behavior/Symptom:** Click here to add which Behavior/Symptom you are addressing.  **WHO:** Click here to enter who will assist with the behavior strategy  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  **\*** **Psychopharmacological Medication** prescribed to address behaviorIf yes, list medication and describe symptom for each medication (*for example Lorazepam – for Anxiety*)  Click here to add medication and symptom/behavior.  **Staff strategies/environmental modifications to address behavior** Click or tap here indicate staff intervention/environmental modifications.  Click here to add additional Behaviors/Symptoms or information as needed.  Safety Plan (if needed)  Click or tap here to enter text.  [**Monitoring/Reporting adverse reactions,** **significant changes and/or concerns**](#Monitor_report_label)**:** Click or tap here to enter text.  **NOTE: If resident becomes a danger to themselves or others, caregiver is to call 911 immediately.** |
| 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 number)  [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 children) |  |  |
| [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.) |  |  |
| [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 – During personal care, hits, shoves, scratches, bites, pinches, or engages in other behaviors which could result in injury to individuals. ) |  |  |
| [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. ) |  |  |
| [Resistive](#Resistive) |  |  |
| [Depression](#depression" \o "An emotional state in which there are extreme feelings of sadness, lack of worth or emptiness.) |  |  |
| [Anxiety](#anxiety" \o "A state of uneasiness and apprehension as about future uncertainties.  An emotion characterized by an unpleasant state of inner turmoil.) |  |  |
| [Disorientation](#Disorientation" \o "Disorientation to person, place - such as City, State, and County, or Time, such as day, month, and year.) |  |  |
| [Wandering](#wandering" \o "Wandering is the act of moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction. Wandering may or may not be aimless. The wandering resident may be oblivious to theirr physical or safety needs. The resident may have a purpose such as searching to find something, but they persist without knowing the exact direction or location of the object, person, or place. The behavior may or may not be driven by confused thoughts or delusional ideas - for example: when a resident believes they must find their mother who is deceased. ) in home |  |  |
| [Exit seeking](#exit_seek" \o "To get outside or off the property.) |  |  |
| [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.There are incidences where “hallucinations” are considered to be within the range of normal experiences.  For example, the religious experiences in certain cultural contexts or those that occur while falling asleep or waking up.  Isolated experiences of hearing ones name called or experiences like hearing humming in one’s head are also not considered to be hallucinations.) - If checked, describe: Click or tap here to enter text. |  |  |
| [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.) - If checked, describe: Click or tap here to enter text. |  |  |
| [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 "Assaultive (not during personal care), Combative during personal care, Hiding Items, Hoarding, Intimidating/threatening, rummages takes belongings of others, deliverage sexual violence, wanders/exit seeking, wanders/not exit seeking) |  |  |
| [Inappropriate or unsafe behavior](#Inappropriate_behavior) |  |  |
| [Suicidal Ideation](#Suicidal_Ideation" \o "Suicidal ideation is when you think about killing yourself. The thoughts might or might not include a plan to die by suicide.) |  |  |
| Other: Click or tap here to enter text. |  |  |
| Other: Click or tap here to enter text. |  |  |
| Other: Click or tap here to enter text. |  |  |
| Other: Click or tap here to enter text. |  |  |
| \*Requires psychopharmacological medications.  [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.)  Behavioral Health Support Crisis Plan (See attached crisis plan) |  |  |
| DSHS Specialized Behavioral Programs:  Meaningful Day  Expanded Community Services  Specialized Behavior Services  Mental Health Provider/Program  Contact info: Click or tap here to enter text. |  |  |
| **Narrative (optional) – What does a typical day look like?** | | |

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| **Left Alone** | **RESIDENT STRENGTHS AND ABILITIES**  **PREFERS TO DO INDEPENDENTLY** | **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)** | **Strengths and Abilities**  **Preferences/Choices:** Click or tap here to enter text.  **Strengths/Abilities:** Click or tap here to enter text.  **Prefers to do independently:**  Click or tap here to enter text. | **Assistance Required**  Click or tap here to enter text.  [**Monitoring/Reporting,** **significant changes and/or concerns**](#Monitor_report_label)**:** Click or tap here to enter text. |

| **UNIVERSIAL PRECAUTIONS** | **RESIDENT STRENGTHS AND ABILITIES**  **PREFERS TO DO INDEPENDENTLY** | **ASSISTANCE REQUIRED**  **WHO WILL PROVIDE, WHEN, AND HOW** |
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| **Always**  [Special Precautions](#Sp_prec" \o "MRSA, Hepatitis, C. Diff, HIV/AIDS, etc.): Click or tap here to enter any special precautions such as COVID.  Alternative method for visitation Click or tap here to enter text.  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)  Click here to enter which vaccinations the resident has had.  Resident shares the following medical equipment: Click or tap here to enter text.  Other: Click or tap here to enter text. | Click here to enter text. Be sure to address each checked/identified item. | 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.  Click or tap here to enter text.  [**Monitoring/Reporting,** **significant changes and/or concerns**](#Monitor_report_label)**:** Click or tap here to enter text. |

| **ACTIVITIES OF DAILY LIVING** | **RESIDENT STRENGTHS AND ABILITIES**  **PREFERS TO DO INDEPENDENTLY** | **ASSISTANCE REQUIRED**  **WHO WILL PROVIDE, WHEN, AND HOW** |
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| **Resident functional limitations that impact ADL functioning:**  Click or tap here to enter text. | | |
| **MOBILITY**  **In room & immediate living environment:**  Independent  Assistance Needed  Dependent  **Outside of immediate living environment (including outdoors):**  Independent  Assistance Needed  Dependent  **Risks for falls**  **Fall prevention plan:** Click or tap here to enter text.    [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;)  **Equipment/Supplies/Procedures:** Click or tap here to enter text.  **Limitations:** Click or tap here to enter text. | **[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. )**  **Preferences/Choices:** Click or tap here to enter text.  **Strengths/Abilities:** Click or tap here to enter text.  **Prefers to do independently:**  Click or tap here to enter text.  **Evacuation addressed under Evacuation Plan** | **[Assistance Required](#Mobility_pro" \o " What do caregivers do to help the resident get around? Do they provide a one person assist when walking or remind them to use their walker?)**  Click or tap here to enter text.  **WHO:** Click here to enter who will assist with the task.  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  Click here to add any additional information if needed.  **[Monitoring/Reporting significant changes and/or concerns](#Monitor_report_label" \o "Caregiver is to monitor the resident during the ADL, report concerns and significant changes immediately to relevant individuals (Health care provider, POA, CM, etc.) ):** Click or tap here to enter text. |
| **BED MOBILITY/TRANSFER**  *Transfer includes moving between bed, chair, wheelchair, standing position – excludes to/from bath/toilet*  Independent  Assistance Needed  Dependent  **Skin care required due to inability to position self:**  Click or tap here to enter text.  **Equipment/Supplies:** Click or tap here to enter text.  **Turning and Repositioning needed - Frequency:** Click or tap here to enter text.  **Safety assessment, alternatives explored; how to keep resident safe**: Click or tap here to enter text.  **Risks for falls**: Click or tap here to enter text.  **Fall prevention plan**  **Enablers**  **Enabler Risk Assessment:** Click or tap here to enter text.  **Nighttime care needs**  Click or tap here to enter text. | **[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.  See WAC 388-76-10650)**  **Preferences/Choices:** Click or tap here to enter text.  **Strengths/Abilities:** Click or tap here to enter text.  **Prefers to do independently:**  Click or tap here to enter text. | **[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?  )**  **WHO:** Click here to enter who will assist with the task.  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  Click here to add any additional information if needed.  [**Monitoring/Reporting significant changes and/or concerns**](#Monitor_report_label)**:** Click or tap here to enter text. |
| **EATING**  Independent  Assistance Needed  Dependent  **Special Diet/Supplements:** Click or tap here to enter text.  **Eating Habits:**Click or tap here to enter text.  **Food Allergies:** Click or tap here to enter text.  **Equipment/Supplies/Procedures:** Click or tap here to enter text.  **Limitations:** Click or tap here to enter text. | **[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? )**  **Preferences/Choices:** Click or tap here to enter text.  **Strengths/Abilities:** Click or tap here to enter text.  **Prefers to do independently:**  Click or tap here to enter text. | **[Assistance Required](#eating_pro" \o " What does the caregiver do to help the resident eat? Do they prepare meals or ask the resident what his/her preferences are? Do they provide assistance and if so, how?If a resident receives a supplement shake make sure they have been approved by the resident’s doctor first.)**  **WHO:** Click here to enter who will assist with the task.  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  Click here to add any additional information if needed.  [**Monitoring/Reporting significant changes and/or concerns**](#Monitor_report_label)**:** Click or tap here to enter text. |
| **TOILETING/CONTINENCE ISSUES**  Independent  Assistance Needed  Dependent  **Frequency/How Often:** Click or tap here to enter text.  **Bladder Incontinence**  **Bowel Incontinence**  **Skin care due to bowel/bladder incontinence**  **Equipment/Supplies/Procedures:** Click or tap here to enter text.  **Limitations:** Click or tap here to enter text. | **[Strengths and Abilities](#toilet_res" \o " Explain what needs to be done 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 his/her own incontinent care?  If resident can assist with peri care, what can they do?)**  **Preferences/Choices:** Click or tap here to enter text.  **Strengths/Abilities:** Click or tap here to enter text.  **Prefers to do independently:**  Click or tap here to enter text. | **[Assistance Required](C:\\Users\\CaryD\\Documents\\Custom Office Templates\\do" \l "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 caregivers protect the resident 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 not disturb during the night - make a note here for caregiving staff. )**  **WHO:** Click here to enter who will assist with the task.  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  Click here to add any additional information if needed.  [**Monitoring/Reporting significant changes and/or concerns**](#Monitor_report_label)**:** Click or tap here to enter text. |
| **DRESSING**  Independent  Assistance Needed  Dependent  **Equipment/Supplies/Procedures:** Click or tap here to enter text.  **Limitations:** Click or tap here to enter text. | **[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?)**  **Preferences/Choices:** Click or tap here to enter text.  **Strengths/Abilities:** Click or tap here to enter text.  **Prefers to do independently:**  Click or tap here to enter text. | **[Assistance Required](#dress_pro" \o " If the resident requires assist, how many staff are needed?  If the resident requires set up, should the staff 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 resident has, such as 'no sweatpants,' 'likes to wear a sweater at all times')**  **WHO:** Click here to enter who will assist with the task.  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  Click here to add any additional information if needed.  [**Monitoring/Reporting significant changes and/or concerns**](#Monitor_report_label)**:** Click or tap here to enter text. |
| **PERSONAL HYGIENE**  Independent  Assistance Needed  Dependent  **Oral Hygiene:** Click or tap here to enter text.  Own teeth  Partials  Dentures  Flossing  Brushing  Soaking  **Hair Care:** Click or tap here to enter text.  **Menses Care:** Click or tap here to enter text.  **Equipment/Supplies/Procedures:** Click or tap here to enter text.  **Limitations:** Click or tap here to enter text. | **[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?)**  **Preferences/Choices:** Click or tap here to enter text.  **Strengths/Abilities:** Click or tap here to enter text.  **Prefers to do independently:**  Click or tap here to enter text. | **[Assistance Required](#PerHyg_pro" \o " What will staff need to do to assist resident with brushing hair, brushing teeth, cleaning dentures, shaving, putting on makeup?  Do staff set up items and cue resident or do staff complete the task for the resident?  Does resident have beard or moustache they want to keep?  How will staff assist in grooming facial hair if resident does not want it shaved off?Does 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?)**  **WHO:** Click here to enter who will assist with the task.  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  **WHO:** Click here to enter who will assist with the task.  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  Click here to add any additional information if needed.  [**Monitoring/Reporting significant changes and/or concerns**](#Monitor_report_label)**:** Click or tap here to enter text. |
| **BATHING**  Independent  Assistance Needed  Dependent  **How often:** Click or tap here to enter text.  **Equipment/Supplies/Procedures:** Click or tap here to enter text.  **Limitations:** Click or tap here to enter text. | **[Strengths and Abilities](#bath_res" \o " Will resident prefer a bath or a shower? How often does resident prefer to bathe? Can resident do own bedside bath between routine showers?)**  **Preferences/Choices:** Click or tap here to enter text.  **Strengths/Abilities:** Click or tap here to enter text.  **Prefers to do independently:**  Click or tap here to enter text. | **[Assistance Required](#bath_pro" \o " How will staff assist with bathing?  Stand by assist, total assist, wash resident's back but allow resident to do everything else?  Does the staff person need to be in the bathroom while resident is in shower/bath?How many times a week will the staff assist the resident with bathing?Include any special equipment staff will use such as shower chairs, transfer board, equipment to help resident reach feet or back , etc.)**  **WHO:** Click here to enter who will assist with the task.  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  Click here to add any additional information if needed.  [**Monitoring/Reporting significant changes and/or concerns**](#Monitor_report_label)**:** Click or tap here to enter text. |
| **BODY CARE**  Independent  Assistance Needed  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: Click or tap here to enter text.    [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.) Click here add additional information.  Nail Care    [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.)  **Skin Care -** How Often: Click or tap here to enter text.  **Skin Problems**  Describe: Click or tap here to enter text.  **Dressing Changes:** How Often: Click or tap here to enter text.  [**Home Health Agency**](#Home_health_agency)**:** Click or tap here to enter text.  **Nurse Delegated**  **Equipment/Supplies/Procedures:** Click or tap here to enter text.  **Limitations:** Click or tap here to enter text. | **[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?)**  **Preferences/Choices:** Click or tap here to enter text.  **Strengths/Abilities:** Click or tap here to enter text.  **Prefers to do independently:**  Click or tap here to enter text. | **[Assistance Required](#body_pro" \o " If the resident has needs around body care, what are caregivers expected to do to help them? For example, this 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?)**  **WHO:** Click here to enter who will assist with the task.  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  **WHO:** Click here to enter who will assist with the task.  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  **WHO:** Click here to enter who will assist with the task.  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  Click here to add any additional information if needed.  [**Monitoring/Reporting significant changes and/or concerns**](#Monitor_report_label)**:** Click or tap here to enter text. |

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| **INSTRUMENTAL ACTIVITIES OF DAILY LIVING** | | **RESIDENT STRENGTHS AND ABILITIES**  **PREFERS TO DO INDEPENDENTLY** | | **ASSISTANCE REQUIRED**  **WHO WILL PROVIDE, WHEN, AND HOW** |
| **MANAGING FINANCES**  Independent  Assistance Needed  Dependent  **Manages Finances:** Click or tap here to enter text.  **Financial Records:** Click or tap here to enter text.  Payee Name and Contact information:  Click or tap here to enter text. | | **[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?)**  **Preferences/Choices:** Click or tap here to enter text.  **Strengths/Abilities:** Click or tap here to enter text.  **Prefers to do independently:**  Click or tap here to enter text. | | **[Assistance Required](#fin_pro" \o " What will the staff do to assist the resident in managing the finances? If the home manages the resident’s funds, how will this be managed and monitored? How will the resident access funds if they need petty cash or need a bill paid?If the facility doesn’t manage the resident funds, how will the facility make sure resident can access funds in a timely fashion if they were to go on an outing or purchase items?  How will the facility assist the resident in keeping the funds/checkbook/bank statements/etc. safe?  )**  **WHO:** Click here to enter who will assist with the task.  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  Click here to add any additional information if needed.  [**Monitoring/Reporting significant changes and/or concerns**](#Monitor_report_label)**:** Click or tap here to enter text. |
| **SHOPPING**  Independent  Assistance Needed  Dependent  [**Special transportation needs**](#Trans_Special_needs)**:** Click or tap here to enter text.  **How often:** Click or tap here to enter text.  **Equipment/Supplies/Procedures:** Click or tap here to enter text.  **Limitations:** Click or tap here to enter text. | | **[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. )**  **Preferences/Choices:** Click or tap here to enter text.  **Strengths/Abilities:** Click or tap here to enter text.  **Prefers to do independently:**  Click or tap here to enter text. | | **[Assistance Required](#shop_pro" \o " Generally speaking, 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.  )**  **WHO:** Click here to enter who will assist with the task.  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  Click here to add any additional information if needed.  [**Monitoring/Reporting significant changes and/or concerns**](#Monitor_report_label)**:** Click or tap here to enter text. |
| **TRANSPORTATION**  Independent  Assistance Needed  Dependent  **Medical services:** Click or tap here to enter text.  **Shopping:** Click or tap here to enter text.  [**Special transportation needs**](#Trans_Special_needs)**:** Click or tap here to enter text.  Escort Required  **How often:** Click or tap here to enter text.  **Equipment/Supplies/Procedures:** Click or tap here to enter text.  **Limitations:** Click or tap here to enter text. | | **[Strengths and Abilities](#tran_res" \o " What are the resident’s transportation needs? Do they have a standing appointment or require special transportation? )**  **Preferences/Choices:** Click or tap here to enter text.  **Strengths/Abilities:** Click or tap here to enter text.  **Prefers to do independently:**  Click or tap here to enter text. | | **[Assistance Required](#tran_pro" \o " Generally speaking, the AFH is not required to provide transportation for residents. You do, however, need to coordinate transportation for the resident. Explain how transportation happens for the resident. For example, their family member may transport to medical appointments or they may use medical transportation services.  )**  **WHO:** Click here to enter who will assist with the task.  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  **WHO:** Click here to enter who will assist with the task.  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  **WHO:** Click here to enter who will assist with the task.  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  **WHO:** Click here to enter who will assist with the task.  Click here to add any additional information if needed.  [**Monitoring/Reporting significant changes and/or concerns**](#Monitor_report_label)**:** Click or tap here to enter text. |
| **ACTIVITIES/SOCIAL**  *Social/Cultural considerations, traditions, or preferences*   * Interests/Activities/Religious Activities: Click or tap here to enter text. * Social/Cultural Traditions/Preferences: Click or tap here to enter text. * Family/Friends/Relationships: Click or tap here to enter text. * Employment Support: Click or tap here to enter text. * Clubs/Groups/Day Health: Click or tap here to enter text. | | **[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?  )**  **Preferences/Choices:** Click or tap here to enter text.  **Strengths/Abilities:** Click or tap here to enter text.  **Prefers to do independently:**  Click or tap here to enter text. | | **[Assistance Required](#ActSoc_pro" \o " What do caregivers do to 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 Sunday’s by 9:45.' )**  **WHO:** Click here to enter who will assist with the task.  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  Click here to add any additional information if needed.  [Special Arrangements](#sp_arrange" \o "For example: arranging/scheduling  transportation/activities, etc.): Click or tap here to enter text.  [Participation Assistance](#part_assist" \o "For example: accompanying/assisting a resident with an activity, ): Click or tap here to enter text.  [**Monitoring/Reporting significant changes and/or concerns**](#Monitor_report_label)**:** Click or tap here to enter text. |
| **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: Click or tap here to enter text.  Other: Click or tap here to enter text. | |
| Activity Narrative:  Click or tap here to enter text. |  | |  | |
| **SMOKING**  Resident Smokes  Safety Concerns:Click or tap here to enter text.  Smoking Policy reviewed with resident. Signed by resident and placed in their record  **Storage of Cigarettes/lighter:** Click or tap here to enter text. | | **[Strengths and Abilities](#smoke_res" \o " Does the resident smoke? If so are they safe to smoke independently?)**  **Preferences/Choices:** Click or tap here to enter text.  **Strengths/Abilities:** Click or tap here to enter text.  **Prefers to do independently:**  Click or tap here to enter text. | | **[Assistance Required](#smoke_pro" \o " Do caregivers need to provide any assistance or supervision with smoking? )**  **WHO:** Click here to enter who will assist with the task.  **WHEN/FREQUENCY:** Click here to enter when assistance is needed and how often.  **HOW:** Click here to indication how the assistance will be provided.  Click here to add any additional information if needed.  [**Monitoring/Reporting significant changes and/or concerns**](#Monitor_report_label)**:** Click or tap here to enter text. |
| **CASE MANAGEMENT**  **Resident receives case management**  CM/CRM Name, agency, and contact information:  Click or tap here to enter text. | | **[Strengths and Abilities](#CM_res" \o " Does the resident have a case manager? If so, are they with DDA, RSN, HCS?)**  **Preferences/Choices:** | | CM/CRM 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   Click or tap here to enter text. |
| **OTHER ISSUES/CONCERNS/PROBLEMS**  Click or tap here to enter text. | | Click or tap here to enter text. | | Click or tap here to enter text. |
| **[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 )** | | The resident will participate in their NCP development/reviews to the extent they are able. | | This NCP will be reviewed:   * 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.   Click or tap here to enter text. |

**Negotiated Care Plan Review and Approval**

### DATE OF ORIGINAL PLAN: Click or tap to enter a date. Date 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 months):** Click or tap to enter a date.

| **[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/CRM for Medicaid clients. WAC 388-76-10370)** | **PERSON SIGNING/APPROVING PLAN** | **SIGNATURE** | DATE\* |
| --- | --- | --- | --- |
| Resident  Resident Representative  Parent Health Professional  Click here to add Name/Title.  Other: Click here to add Name/Title.  Other: Click here to add Name/Title.  Other: Click here to add Name/Title. | **[PROVIDER](#Prov_sig" \o "Signature Requreed - WAC 388-76-10375)**  Click here to add name. |  |  |
|  | [RESIDENT](#Res_sig" \o "Signature Requreed - WAC 388-76-10375) Click here to add name. |  |  |
|  | **RESIDENT REPRESENTATIVE**  Click here to add name.  Click here to add name. |  |  |
| Resident verbally agreed to NCP – Date: Click or tap to enter a date.  [Resident Recommendations:](#Res_Recommendations_NCP" \o "Document any NCP recommendations the resident has and the plan to address them.)  Click or tap here to enter resident’s recommendations to the NCP and the plan to address them.  NCP sent to DSHS CM on Click enter date sent to HCS/DDA CM.  [WAC 388-76-10385](#WAC_10385" \o "WAC 388-76-10385Negotiated care plan—Copy to department case manager—Required.When the resident's services are paid for by the department, the adult family home must give the department case manager a copy of the negotiated care plan each time the plan is completed or updated, and after it has been signed and dated.) | | | |

\*Enter the date you **actually read** and agreed to the plan.

Follow these brief instructions based on WAC 388-76-10355 through 388-76-10385 when developing your NCP.

Key Points for Negotiated Care Plan development:

1. Must be developed within 30 days of admission based on the Assessment and the Preliminary Service Plan.
2. Describes/identifies: (a) The services to be provided; (b) Who will provide the services; and (c) When and How the services will be provided.
3. Is designed to meet the Resident’s Needs, Preferences, and Choices.
4. Is developed with input from the Resident and/or the Resident’s Representative / Surrogate Decision Maker, appropriate professionals, and the case manager, if applicable (indicate on the signature page all parties that participated in the NCP development)
5. Is Agreed to, Signed and Dated by the Resident and/or the Resident’s Representative / Surrogate Decision Maker, and the provider.
6. **Must be reviewed and Revised: (a) at least every 12 months; (b) upon any significant change in Resident’s physical or mental condition; and (c) upon resident request.**
7. The signed copy of the NCP must be given to the Case Manager if the Resident is receiving services (Medicaid) paid for fully or partially by the department.