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| Transforming Lives | **Nursing Services Assessment** | | DATE OF VISIT | | | DATE OF LAST VISIT | | | DATE OF CARE |
|  |  | | CASE MANAGER’S NAME | | | | | | |
| **I. General Information** | | | | | | | | | |
| **A. Client Information and Housing Arrangement** | | | | | | | | | |
| CLIENT’S NAME | | DATE OF BIRTH | | AGE | CLIENT ID | | | GENDER  Male  Female | |
| ADDRESS CITY STATE ZIP CODE | | | | | | | | | |
| RESIDENCE TYPE  Parent Home  Own Home (own, lease, rent from non-provider)  Relative Home  Adult Family Home  Provider’s Home  Adult Residential Center  Current and correct on CARE  New Information: | | | | | | | | | |
| **B. Significant Other Information** | | | | | | | | | |
| NAME | | | | | | TELEPHONE NUMBER (INCLUDE AREA CODE) | | | |
| ADDRESS CITY STATE ZIP CODE | | | | | | | | | |
| RELATIONSHIP TO CLIENT  Legal Representative:  Full Legal Guardian  Partial Legal Guardian  Power of Attorney  Parent:  No Guardianship  Full Legal Guardian  Partial Legal Guardian  Power of Attorney  Other Relative / No Legal Relationship  Other / No Legal Relationship  Current and correct on CARE  New Information: | | | | | | | | | |
| **C. Assessment Participants** | | | | | | | | | |
| **Assessment Participants** | | | | | | | | | |
| NAME | | | | | | | TELEPHONE NUMBER  (INCLUDE AREA CODE) | | |
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| **D. Emergency Contact Information** | | | | | | | | | |
| Current and correct on CARE  New Information: | | | | | | | | | |
| **E. Demographic and Language Information** | | | | | | | | | |
| Current and correct on CARE  New Information: | | | | | | | | | |
| **II. Health Status** | | | | | | | | | |
| **A. Healthcare Professionals** | | | | | | | | | |
| TREATING PROVIDER’S NAME | | | | | | | | DATE LAST SEEN | |
| REASON | | | | | | | | | |
| FINDINGS | | | | | | | | | |
| TREATMENT / PRESCRIPTIONS | | | | | | | | | |
|  | | | | | | | | | |
| OTHER TREATING PROVIDER’S NAME | | | | | | | | DATE LAST SEEN | |
| REASON | | | | | | | | | |
| FINDINGS | | | | | | | | | |
| TREATMENT / PRESCRIPTIONS | | | | | | | | | |
| **B. Diagnoses** | | | | | | | | | |
| LIST | | | | | | | | | |
| Current and correct on CARE  New Information: | | | | | | | | | |
| Concerns: | | | | | | | | | |
| **C. Medications and Assistance Required** | | | | | | | | | |
| Current and correct on CARE  New Information: | | | | | | | | | |
| Provider is working within their scope of practice  Nurse Delegation needed  Recommendations: | | | | | | | | | |
| **D. Bladder Control, Appliances, Program, and Management** | | | | | | | | | |
| Current and correct on CARE  New Information: | | | | | | | | | |
| Concerns: | | | | | | | | | |
| Recommendations: | | | | | | | | | |
| **E. Bowel Control, Appliances, Program and Management** | | | | | | | | | |
| Current and correct on CARE  New Information: | | | | | | | | | |
| Concerns: | | | | | | | | | |
| Recommendations: | | | | | | | | | |
| **F. Other Health Indicators** | | | | | | | | | |
| **Speech, sight, hearing:**  Current and correct on CARE  New Information: | | | | | | | | | |
| Recommendations: | | | | | | | | | |
| **Tobacco use, substance abuse:**  Current and correct on CARE  New Information: | | | | | | | | | |
| Recommendations: | | | | | | | | | |
| **Allergies:**  Current and correct on CARE  New Information: | | | | | | | | | |
| Recommendations: | | | | | | | | | |
| **Special diet:**  Current and correct on CARE  New Information: | | | | | | | | | |
| Recommendations: | | | | | | | | | |
| **Nutrition, height, and weight:**  Current and correct on CARE  New Information: | | | | | | | | | |
| Concerns: | | | | | | | | | |
| Recommendations: | | | | | | | | | |
| **G. Health Indicators Related to the Household Environment** | | | | | | | | | |
| NOTE: Assessor is not expected to do a household inspection but is reporting on what is observed during visit. Suspicion of abuse of neglect requires a referral to APS (in-home), CRU (licensed facilities) or CPS.  Observations of conditions that place the client’s health at risk: | | | | | | | | | |
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| **III. Skin Care Issues** | | | | | | | | | |
| **A. Skin Problems within the Last 14 Days (skin tears, rash, bruises, wound care, pressure ulcers)** | | | | | | | | | |
| Yes  No  **Risk indicators for skin breakdown related to pressure exist:**  Incontinent of bladder or bowel  Wheelchair dependent  Quadriplegia  Paraplegia  Bedfast  Diabetic  Cognitive Impairment (CPS>3)  Other: | | | | | | | | | |
| **If any of the skin observation protocol risk indicators exist initiate the skin observation protocol.**  Skin observation protocol initiated:  Yes  No  If yes: | | | | | | | | | |
| What was done? | | | | | | | | | |
| What was found? | | | | | | | | | |
| What action was taken? | | | | | | | | | |
| What follow-up is needed? | | | | | | | | | |
| Other skin care needs not related to the skin observation protocol: | | | | | | | | | |
| Recommendations: | | | | | | | | | |
| **B. Treatment and Therapies** | | | | | | | | | |
| Current and correct on CARE  New Information: | | | | | | | | | |
| Concerns: | | | | | | | | | |
| Recommendations: | | | | | | | | | |
| **C. Self-Care Training Needs** | | | | | | | | | |
| Current and correct on CARE  New Information: | | | | | | | | | |
| Concerns: | | | | | | | | | |
| Recommendations: | | | | | | | | | |
| **IV. Moods and Behaviors** | | | | | | | | | |
| **A. Impaired judgment, hallucinations, delusions, aphasia, verbally abusive, depression, withdrawn, assaultive, danger to self, other behavior impairments:** | | | | | | | | | |
| Current and correct on CARE  New Information: | | | | | | | | | |
| Concerns: | | | | | | | | | |
| Recommendations: | | | | | | | | | |
| **B. Accuses, rummages, takes belongings, sexual issues, exposes self, disrobes in public, combative during care, screaming:** | | | | | | | | | |
| Current and correct on CARE  New Information: | | | | | | | | | |
| Concerns: | | | | | | | | | |
| Recommendations: | | | | | | | | | |
| **C. Wandering** | | | | | | | | | |
| Current and correct on CARE  New Information: | | | | | | | | | |
| Concerns: | | | | | | | | | |
| Recommendations: | | | | | | | | | |
| **D. Short Term Memory** | | | | | | | | | |
| Current and correct on CARE  New Information: | | | | | | | | | |
| Concerns: | | | | | | | | | |
| Recommendations: | | | | | | | | | |
| **E. Long Term Memory and Orientation** | | | | | | | | | |
| Current and correct on CARE  New Information: | | | | | | | | | |
| Concerns: | | | | | | | | | |
| Recommendations: | | | | | | | | | |
| **F. Anxiety Issues** | | | | | | | | | |
| Current and correct on CARE  New Information: | | | | | | | | | |
| Concerns: | | | | | | | | | |
| Recommendations: | | | | | | | | | |
| **V. Personal Care Needs** | | | | | | | | | |
| **A. Functional ADLS** | | | | | | | | | |
| Current and correct on CARE  New Information: | | | | | | | | | |
| Concerns: | | | | | | | | | |
| Recommendations: | | | | | | | | | |
| **B. Supervision Needs** | | | | | | | | | |
| Current and correct on CARE  New Information: | | | | | | | | | |
| Concerns: | | | | | | | | | |
| Recommendations: | | | | | | | | | |
| **VI. Caregiver Information** | | | | | | | | | |
| **A. Caregiver Information** | | | | | | | | | |
| Current and correct on CARE  New Information: | | | | | | | | | |
| Concerns: | | | | | | | | | |
| Recommendations: | | | | | | | | | |
| **B. Provider Issues** | | | | | | | | | |
| Service provided by:  Individual provider  Homecare agency  AFH  BH  Number of IPs providing service:  **Training (applicable to IPs only):**  Training needs assessed. Provider name:  If serving an adult, the IP has completed the required training.  IP has not completed required training. | | | | | | | | | |
| Training provided by RN to  (Name of Provider)  Describe training: | | | | | | | | | |
| Training recommendations for  Describe recommendations: | | | | | | | | | |
| **Performance:**  No concerns regarding caregiver performance  I have the following concerns regarding caregiver performance: | | | | | | | | | |

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| --- | --- | --- |
| **This Summary Report is to become Page One of the completed document.** | | |
| **VI. Caregiver Information** | | |
| **No concerns. No change required in client care plan.**  **Immediate actions taken by nurse:** | | |
| Describe issue and action taken: | | |
| Persons / agencies notified: | | |
| **Response required of case resource manager**  Recommended changes to the assessment and/or service plan based on new information entered into the following assessment section of this form:  Client information or demographics  Client living situation  Significant other information  Health Status (diagnosis, bowel and bladder control, med assistance, other)  Health risks in environment  Skin care issues  Treatments and therapies  Moods and behaviors  Wandering  Memory and orientation  Anxiety issue  Plan of care supervision and caregiver information  Functional ADLS  Supervision needs  Provider issues  **Recommendations for additional nursing service activities:**  **Approximate date of next RN visit:** | | |
| **APS / CPS must be notified of suspicion of abuse, neglect, or exploitation. Call 1-866-363-4273 (1-866-ENDHARM).** | | |
| **My signature indicates that I have assessed the above client. To the best of my knowledge, the information contained on this assessment is true and correct.** | | |
| NURSE’S SIGNATURE | | DATE |
| **Distribution:**  DDD  Family member / guardian (by request): | Date sent:  Date sent: | |
| CRM RESPONSE TO RN RECOMMENDATIONS | | |
| **See addendum for additional documentation.** | | |
| CMR’S SIGNATURE | | DATE |