|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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) |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **D. Emergency Contact Information** |
| **[ ]**  Current and correct on CARE**[ ]**  New Information:  |
| **E. Demographic and Language Information** |
| **[ ]**  Current and correct on CARE**[ ]**  New Information:  |
| **II. Health Status** |
| **A. Healthcare Professionals** |
| TREATING PROVIDER’S NAME | DATE LAST SEEN |
| REASON |
| FINDINGS |
| TREATMENT / PRESCRIPTIONS |
|  |
| OTHER TREATING PROVIDER’S NAME | DATE LAST SEEN |
| REASON |
| FINDINGS |
| TREATMENT / PRESCRIPTIONS |
| **B. Diagnoses** |
| LIST |
| **[ ]**  Current and correct on CARE**[ ]**  New Information:  |
| **[ ]**  Concerns:  |
| **C. Medications and Assistance Required** |
| **[ ]**  Current and correct on CARE**[ ]**  New Information:  |
| **[ ]**  Provider is working within their scope of practice**[ ]**  Nurse Delegation needed**[ ]**  Recommendations:  |
| **D. Bladder Control, Appliances, Program, and Management** |
| **[ ]**  Current and correct on CARE**[ ]**  New Information:  |
| **[ ]**  Concerns:  |
| **[ ]**  Recommendations:  |
| **E. Bowel Control, Appliances, Program and Management** |
| **[ ]**  Current and correct on CARE**[ ]**  New Information:  |
| **[ ]**  Concerns:  |
| **[ ]**  Recommendations:  |
| **F. Other Health Indicators** |
| **Speech, sight, hearing:****[ ]**  Current and correct on CARE**[ ]**  New Information:  |
| **[ ]**  Recommendations:  |
| **Tobacco use, substance abuse:****[ ]**  Current and correct on CARE**[ ]**  New Information:  |
| **[ ]**  Recommendations:  |
| **Allergies:****[ ]**  Current and correct on CARE**[ ]**  New Information:  |
| **[ ]**  Recommendations:  |
| **Special diet:****[ ]**  Current and correct on CARE**[ ]**  New Information:  |
| **[ ]**  Recommendations:  |
| **Nutrition, height, and weight:****[ ]**  Current and correct on CARE**[ ]**  New Information:  |
| **[ ]**  Concerns:  |
| **[ ]**  Recommendations:  |
| **G. Health Indicators Related to the Household Environment** |
| NOTE: Assessor is not expected to do a household inspection but is reporting on what is observed during visit. Suspicion of abuse of neglect requires a referral to APS (in-home), CRU (licensed facilities) or CPS.Observations of conditions that place the client’s health at risk: |
|  |
| **III. Skin Care Issues** |
| **A. Skin Problems within the Last 14 Days (skin tears, rash, bruises, wound care, pressure ulcers)** |
| **[ ]**  Yes **[ ]**  No**Risk indicators for skin breakdown related to pressure exist:****[ ]**  Incontinent of bladder or bowel**[ ]**  Wheelchair dependent**[ ]**  Quadriplegia**[ ]**  Paraplegia**[ ]**  Bedfast**[ ]**  Diabetic**[ ]**  Cognitive Impairment (CPS>3)**[ ]**  Other:   |
| **If any of the skin observation protocol risk indicators exist initiate the skin observation protocol.**Skin observation protocol initiated: **[ ]**  Yes **[ ]**  NoIf 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 **[ ]**  BHNumber of IPs providing service: **Training (applicable to IPs only):****[ ]**  Training needs assessed. Provider name:  **[ ]**  If serving an adult, the IP has completed the required training. **[ ]**  IP has not completed required training. |
| **[ ]**  Training provided by RN to  (Name of Provider) Describe training:  |
| **[ ]**  Training recommendations for  Describe recommendations:  |
| **Performance:****[ ]**  No concerns regarding caregiver performance **[ ]**  I have the following concerns regarding caregiver performance:  |

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