Patient Name:_____

LONG TERM CARE NEEDS ASSESSMENT FORM CONTENTS

Patient Name:_____

LONG TERM CARE NEEDS ASSESSMENT FORM		
Date of Assessment (dd/mmm/yyyy): ☐ Initial ☐ Reassessment	Care Setting: Contact Info: Phone:	Admit Date (dd/mmm/yyyy): E-Mail:
Source of Information: ☐ Patient ☐ Family ☐ Physician ☐ Medical notes ☐ Caregiver ☐ Nurse		

BASELINE DEMOGRAPHIC INFORMATION

1. PATIENT INFORMATION

Name:		Date of Birth (dd/mmm/yyyy):	Gender: ☐ Female ☐ Male
Address (House name, #, Street name):		Insurance Number: Provider: ☐ NONE ☐ HIP ☐ FC ☐ WV ☐ GEHI ☐ BF&M ☐ ARGUS ☐ COLONIAL ☐ OTHER _____	
Parish:	Postal Code	Home Phone Number:	
Directions:		Cell Phone #:	
Contact for health and welfare decisions (Name):		Relationship to Patient:	
Email Address:	Contact Phone #:	Is there a Power of Attorney? ☐ Yes ☐ No Name and Contact:	
Do you have advanced directives? ☐ Yes ☐ No ☐ Copy in Chart ☐ Copy Requested ☐ Provided with Brochure/Packet			
Language: ☐ English ☐ Other If Other, specify language spoken:			

2. HEALTH CARE PROVIDER INFORMATION

Who is your regular Doctor? ☐ None		
Address/Phone:	Date of last visit (dd/mmm,/yyyy):	Reason
Who is your regular Dentist? ☐ None		
Address/Phone:	Date of last visit (dd/mmm/yyyy):	Reason:

Are you seeing any other doctors, such as a psychiatrist, or specialists of any kind?

☐ Yes (List Below) ☐ No ☐ Don't Know

Name	Specialty	Phone	Address

3. MEDICAL DIAGNOSIS OR HEALTH CONDITIONS

Diagnosis: list primary diagnosis first/Current problems	Comments	Date of onset (dd/mmm/yyyy)

4. MEDICATIONS

4.1 Medication Risk Factors

Does the patient have any medication or food allergies?	☐ No	☐ Yes	If Yes, please list:
Has the patient had significant side effects from medications?	☐ No	☐ Yes	If Yes, explain:
Has the patient had problems with taking or being given the incorrect number of medications?	No ☐	Yes ☐	If Yes, explain:

4.2 Prescription Medications

Prescription Medications	Dosage	Route	Frequency	Purpose

Indicate if the patient receives the following vaccination:

☐ A. Influenza Administered (dd/mmm/yyyy): ☐ B. Pneumococcal Administered (dd/mmm/yyyy):

4.3 OTC Medications or Herbal Remedies

OTC Medications or Herbal Remedies	Dosage	Route	Frequency	Purpose

5. RISK FACTORS

5.2 ER/HOSPITAL UTILIZATION

In the past year, has the patient gone to a hospital emergency room? ☐ Yes ☐ No Date of last visit (dd/mmm/yyyy): If yes, how many times? Why?
In the past year, has the patient stayed overnight or longer in a hospital? ☐ Yes ☐ No Date of last visit (dd/mmm/yyyy): If yes, how many times? Why?

5.3 ALCOHOL/TOBACCO/SUBSTANCE USE

On average, counting beer, wine and other alcoholic beverages, how many drinks do you have each day?
Do you smoke or use tobacco? ☐ Yes ☐ No If yes, how much and how often? (frequency per day)
Has tobacco use caused you any problems? ☐ Yes ☐ No If yes, please describe:
Do you use any other substances such as marijuana, cocaine or amphetamines? ☐ Yes ☐ No If yes, specify:

6. CURRENT HEALTH SERVICES

Do you regularly receive any of the following medical treatments or home service?			Days per week	Hours per day	Source/Agency
Nursing/District	☐ No	☐ Yes			
Physical Therapy	☐ No	☐ Yes			
Occupational Therapy	☐ No	☐ Yes			
Speech Therapy	☐ No	☐ Yes			
Dialysis	☐ No	☐ Yes			
Caregivers	☐ No	☐ Yes			
Wound Care Clinic	☐ No	☐ Yes			
Other	☐ No	☐ Yes			

7. NUTRITION

Eating and Swallowing
☐ A. Loss of liquids/solids from mouth when eating or drinking.
☐ B. Holding food in mouth/cheeks or residual food in mouth after meals.
☐ C. Coughing or choking during meals or when swallowing medications.
☐ D. Complaints of difficulty or pain with swallowing.
☐ E. Chewing: ☐ Some difficulty ☐ More difficulty
☐ F. Unable to chew.
☐ G. None of the above.
Diet – Specify Details:
☐ A. Mechanically altered diet – require change in texture of food or liquids (e.g. pureed food, thickened liquids).
☐ B. Therapeutic diet (e.g. low salt, diabetic, low cholesterol).
☐ C. Regular diet.
☐ D. Nutritional supplement.
☐ E. Food preferences.
☐ F. Dislike.
☐ G. Religious related diet.

8. COMMUNICATION AND SENSORY PATTERN

Hearing - Ability to hear (with hearing aid or hearing appliances if normally used).
☐ Adequate – no difficulty in normal conversation, social interaction, listening to TV.
☐ Minimal difficulty – difficulty in some environments (e.g. when person speaks softly or setting is noisy).
☐ Moderate difficulty – speaker has to increase volume and speak distinctly.
☐ Highly impaired – absence of useful hearing.
Speech Clarity - Select best description of speech pattern.
☐ Clear speech – distinct intelligible words.
☐ Unclear speech – slurred or mumbled words.
☐ No speech – absence of spoken words.
Makes Self Understood - Ability to express ideas and wants, consider both verbal and non-verbal expression
☐ Understood
☐ Usually understood – difficulty communicating some words or finishing thoughts but is able if prompted or given time.
☐ Sometimes understood – ability is limited to making concrete requests.
☐ Rarely/Never understood.
Ability to Understand Others - Understanding verbal content, however able (with hearing aid or device if used)
☐ Understands – clear comprehension
☐ Usually understands – misses some part/intent of message but comprehends most conversation.
☐ Sometimes understands – responds adequately to simple direct communication only.
☐ Communicates with sign language – symbol board, written messages, gestures or interpreter.
☐ Rarely/Never understands.
Vision - Ability to see in adequate light (with glasses or other visual appliances)
☐ Adequate – sees fine detail, such as regular print in newspapers/books.
☐ Impaired – sees large print, but not regular print in newspapers/books.
☐ Moderately impaired – limited vision; not able to see newspaper headlines but can identify objects.
☐ Highly impaired – object identification in question, but eyes appear to follow objects.
☐ Severely impaired – no vision or sees only light, colors or shapes; eyes do not appear to follow objects.
Sensory Perception (e.g. – taste, smell, tactile, spatial)
☐ No impairment. ☐ Impaired – Specify:

9. BEHAVIOUR

Indicate any behavioural symptoms or concerns observed or reported over the last 2 weeks.

9.1 POTENTIAL INDICATORS OF PSYCHOSIS – Check all that apply:

☐ A. Hallucinations (perceptual experiences in the absence of real external sensory stimuli)
☐ B. Delusions (misconceptions or beliefs that are firmly held, contrary to reality)
☐ C. None of the above

Patient Name:_____

9.2 BEHAVIOURAL SYMPTOM – PRESENCE & FREQUENCY

Scoring: Enter score in end box. 0 = Behaviour not exhibited. 1 = Behaviour of this type occurred 1 to 3 days. 2 = Behaviour of this type occurred 4 to 6 days, but less than daily. 3= Behaviour of this type occurred daily.

Presence and Frequency	Score
Physical behavioural symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually).	
Verbal behavioural symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others).	
Other behavioural symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds).	
Rejection of Care – Presence & Frequency Did the patient reject evaluation or care (e.g., blood work, taking medications ADL assistance) that is necessary to achieve the patient's goals for health and well-being? Do not include behaviors' that have already been addressed (e.g., by discussion or care planning with the patient or family), and determined to be consistent with patient values, preferences, or goals.	
Wandering – Presence & Frequency Has the patient wandered?	
Total Score (Part 1)	

Review each question below and answer either "Yes" or "No". If "No", enter 0 (zero) in the corresponding box. If the Answer is "Yes", enter 1 in the box. Tally the total score in the "Total Score (Part 2) cell.

Impact of Behavioral symptoms	Score
Overall Presence of Behavioural Symptoms	
Were any behavioural symptoms in presence & frequency coded 1 or 2?	
Impact on Patient - Did any of the identified symptom(s)	
Put the patient at significant risk for physical illness or injury?	
Significantly interfere with the patient's care?	
Significantly interfere with the patient's participation in activities or social interactions?	
Impact on Others - Did any of the identified symptom(s):	
Put others at significant risk for physical injury?	
Significantly intrude on the privacy or activity of others?	
Significantly disrupt care or living environment?	
Wandering – Impact	
Does the wandering place the patient at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility)?	
Does the wandering significantly intrude on the privacy or activities of others?	
Does patient exhibit Sundowning symptoms? That is, in the late afternoon, early evening, appears restless, anxious or upset, confused, disoriented, suspicious, yell, pace, wander, hear or see things that aren't there.	
If the patient does exhibit Sundowning symptoms, during what time of day are the symptoms most prevalent: ☐ Morning ☐ Afternoon ☐ Evening	
Total Score (Part 2)	

Behavioural Symptoms Guidance Total Score (add Part 1 and Part 2):_____

0 – 6 Moderate Supervision **(Personal Care)**
7 – 11 Institute additional safety measures **(Intermediate Care)**
12 – 16 If score is between 12 to 16, consider psychiatrist/psychologist plus safety measures **(Complex Care)**

9.3 CHANGE IN BEHAVIOUR OR OTHER SYMPTONS – Consider all of the symptoms assessed above.

How does patient's current behaviour status, care rejection, or wandering compare to prior assessment?
☐ Same
☐ Improved
☐ Worse
☐ N/A because no prior assessment

10.FUNCTIONAL ABILITIES

10.1 Activities of Daily Living

Activity	Independent	Supervision or verbal Prompts/Cueing	Physical Assistance			Total Dependence
			1 person	2 persons	1 person + lift	
A. Eating	☐	☐	☐	☐	☐	☐
B. Grooming & personal hygiene	☐	☐	☐	☐	☐	☐
C. Bathing	☐	☐	☐	☐	☐	☐
D. Dressing	☐	☐	☐	☐	☐	☐
E. Mobility in bed	☐	☐	☐	☐	☐	☐
F. Transferring	☐	☐	☐	☐	☐	☐
G. Walking	☐	☐	☐	☐	☐	☐
H. Stair climbing	☐	☐	☐	☐	☐	☐
I. Mobility with wheelchair	☐	☐	☐	☐	☐	☐
J. Toileting	☐	☐	☐	☐	☐	☐
☐ Continent – Bowel and bladder						
☐ Continent with verbal or physical prompts						
☐ Continent except for specified periods of time (e.g. enuresis)						
☐ Incontinent – bladder						
☐ Incontinent – bowel						
Comments: Usual bowel pattern time and frequency (Specify):						
☐ Inappropriate toileting habits (e.g. fails to close door, use toilet paper, or wash hands, etc.)						

10.2 ASSISTIVE DEVICES/SPECIAL EQUIPMENT

Do you use (or need) any of the following special equipment or aids? ☐ None

(If a Patient doesn't have an item but needs it, mark the "Needs" box)

Uses	Needs	Equipment/Aid	Uses	Needs	Equipment/Aid
☐	☐	Corrective Lenses (specify)	☐	☐	Harness/gait belt
☐	☐	Hearing aid	☐	☐	Raised Toilet Seat
☐	☐	Dentures	☐	☐	Shower/tub bench, grab rail
☐	☐	Helmet	☐	☐	Bedside commode
☐	☐	Communication Devices	☐	☐	Transfer equipment
☐	☐	Adaptive eating equipment	☐	☐	Hospital Bed
☐	☐	Cane	☐	☐	Weighted blankets or vest
☐	☐	Walker	☐	☐	Medical phone alert
☐	☐	Wheelchair (manual, electric)	☐	☐	Supplies, e.g. Incontinence pads
☐	☐	Brace (leg, back, prosthesis)	☐	☐	Other (Specify):

Patient Name:_____

PRE-ADMISSION CONFERENCE

11.RISK FACTORS

11.1 HEALTH SELF PERCEPTION

Overall, how would you rate your physical health?	☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ No Response

12.SOCIAL/RECREATIONAL PREFERENCES

12.1 LIFE HISTORY

Does the person have a life history book or "This is me" book in place? ☐ Yes ☐ No

12.2 SOCIAL/RECREATIONAL

What is a typical day like for you? (Or ask: What do you usually do, starting from the morning?)
What activities or things do you enjoy doing? For example, hobbies and interests.
What, if anything, would you change about your typical day? Are there activities you would like to do more frequently?
If you choose to practice a religion, are you able to attend as often as desired? ☐ Yes (specify where) ☐ No ☐ N/A
Who are the people in your life who are important to you?

12.3 EDUCATION/OCCUPATION

Highest level of education completed:
Prior occupation or role:

12.4 LITERACY – Assessor: Is the patient able to:

Read? Yes ☐ No ☐	Write? Yes ☐ No ☐	Sign his/her name? Yes ☐ No ☐

Patient Name:_____

12.5 HOUSING AND ENVIRONMENT (To be completed for home care and discharging to an individual's home)

What is your current housing type?

☐ Own Home (includes parent/guardian's home for children)
☐ Friend/Relative Home
☐ Foster Care
☐ Residential / Nursing Facility
☐ Homeless
☐ Other (Specify):

Who lives in the home with the patient?

Would you like to continue to live where you do now, or is there somewhere else you would prefer to live?

☐ Continue to live here
☐ Don't know
☐ Prefer to live elsewhere (Specify and briefly describe the barriers, if any):

Does someone regularly helps you care for your home or yourself, or who regularly helps with errands or other things? (For children, do NOT include the parent/guardian, but do include others who assist the parent/guardian.)

☐ Yes ☐ No If yes, how often?

Caregiver's name: Contact #:

Is the Patient at risk at home because of any of these conditions?

Yes	No		Yes	No	
☐	☐	Structural damage	☐	☐	Insufficient water or no hot water
☐	☐	Barriers to accessibility (step, etc.)	☐	☐	Insufficient heat
☐	☐	Electricity hazards	☐	☐	Fire hazard
☐	☐	Signs of careless smoking	☐	☐	Tripping hazards
☐	☐	Insects or pests	☐	☐	Unsanitary conditions
☐	☐	Poor lighting	☐	☐	Other - Specify

Are any home modifications needed? ☐ No ☐ Yes (specify):

ASSESSOR: Does the patient have deficits that pose a threat to his/her ability to live in the community?

☐ Yes ☐ No ☐ Unsure

Additional Comments:

13.MEMORY

13.1 BRIEF INTERVIEW FOR MENTAL STATUS (BIMS) – Attempt to conduct interview with all patients

Repetition:	
Question 1: ***"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words."***	
Number of words repeated after first attempt:	**Points for Score**
None	0 ☐
One	1 ☐
Two	2 ☐
Three	3 ☐
After the patient's first attempt, repeat the words using cues *("sock, something to wear; blue, a colour; bed, a piece of furniture.* You may repeat the cues up to two more times	
Temporal orientation:	
Question 2: ***Tell me what year it is right now?***	**Points for Score**
Missed by greater than5 years or no answer	0 ☐
Missed by 2-5 years	1 ☐
Missed by less than2 years	2 ☐
Correct	3 ☐
Question 3: What month are we in right now?"	
Missed by greater than 1 month or no answer	0 ☐
Missed by 6 days to 1 month	1 ☐
Accurate within 5 days	2 ☐
Question 4: What day of the week is today?"	
Incorrect or no answer	0 ☐
Correct	1 ☐
Recall:	
Question 5: Let's go back to an earlier question. What were those three words that I asked you to repeat?"	**Points for score**
a. Able to recall "sock":	
No – could not recall	0 ☐
Yes, after cueing ("something to wear")	1 ☐
Yes, no cue required	2 ☐
b. Able to recall "blue":	
No – could not recall	0 ☐
Yes, after cueing ("a color")	1 ☐
Yes, no cue required	2 ☐
c. Able to recall "bed":	
No – could not recall	0 ☐
Yes, after cueing ("a piece of furniture")	1
Yes, no cue required	2 ☐
Total BIMS Score (add the points for each question)	
Interpretation of Score: 13-15 Points: cognitively intact. 8-12 points: moderately impaired. 0-7 points severely impaired.	

13.2 MEMORY/RECALL ABILITY

Check all that the patient was normally able to recall

☐ A. Current Season
☐ B. Location of own rooms or address of current residence
☐ C. Names and faces of family or staff
☐ D. That he or she is in a nursing home/hospital/receiving homecare (as appropriate)
☐ E. None of the above were recalled
☐ F. Day of the week or date

14.DELIRIUM – SIGNS AND SYMPTOMS: check all that apply

☐ A.	Inattention – Did the patient have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)?
☐ B.	Disorganized thinking – Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
☐ C.	Altered level of consciousness – Did the patient have altered level of consciousness (e.g., vigilant – startled easily to any sound or touch; lethargic – repeatedly dozed off when being asked questions, but responded to voice or touch; stuporous – very difficult to arouse and keep aroused for the interview; comatose – could not be aroused)?
☐ D.	Psychomotor retardation – Did the patient have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly?

Acute Onset Mental Status Change			
Is there evidence of an acute change in mental status from the patient's baseline?	☐ No	☐ Yes	☐ Initial

15.MOOD

15.1 SHOULD PATIENT MOOD INTERVIEW BE CONDUCTED? – Attempt to conduct interview with all patients

☐ Yes (Continue to Patient Mood Interview)

☐ No (patient is rarely/never understood)

15.2 PATIENT MOOD INTERVIEW

Say to patient: "Over the last 2 weeks, have you been bothered by any of the following problems?"
If symptom is present, tick column 1, Symptom Presence, If yes in column 1, then ask the patient: "About how often have you been bothered by this?" Enter score in column 2, Symptom Frequency. Score as follow: 0 = never or one day; 1 = 2 to 6 days (several days); 2 = 7 to 11 days (half or more of the days); 3 = 12 to 14 days (nearly every day).

To score mood symptoms total Column 2. If score greater than 22, consult psychiatrist/psychologist.

	1.Presence	2.Frequency
A. Little interest or pleasure in doing things	☐	
B. Feeling down, depressed, or hopeless	☐	
C. Trouble falling or staying asleep, or sleeping too much	☐	
D. Feeling tired or having little energy	☐	
E. Poor appetite or overeating	☐	
F. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	
G. Trouble concentrating on things, such as reading the newspaper or watching television	☐	
H. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	
I. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	
J. Being short-tempered or easily annoyed	☐	
K. Have you been anxious	☐	
		Total =

16.FUNCTIONAL ABILITIES

16.1 INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

Activity: How well can you…	Independent: Need no help or supervision	Need some help or occasional supervision	Need a lot of help or constant supervision	Total Dependence: Can't do it at all
Manage own medication?	☐	☐	☐	☐
Prepare meals for yourself?	☐	☐	☐	☐
Answer the telephone?	☐	☐	☐	☐
Make a telephone call?	☐	☐	☐	☐
Handle your own money?	☐	☐	☐	☐
Manage shopping for food and other things you need?	☐	☐	☐	☐
Manage to do light housekeeping, like dusting or sweeping?	☐	☐	☐	☐
Do heavy housekeeping, like yard work, or emptying the garbage?	☐	☐	☐	☐
Do your own laundry, including putting clothes in the washer or dryer, starting and stopping the machine, and drying the clothes?	☐	☐	☐	☐
Do you know your telephone number? ☐ Yes ☐ No ☐ N/A				
Do you know your address? ☐ Yes ☐ No ☐ N/A				
Transportation- How do you get to the places you want to go? (Check all that apply)				
☐ Walk		☐ Friend or family member drives		
☐ Bicycle		☐ Staff/Provider		
☐ Drive		☐ Take a bus or taxi		
☐ Other:				

Patient Name:_____

NURSE PHYSICAL ASSESSMENT

17.NURSING PHYSICAL ASSESSMENT

17.1 GENERAL

Arrived by: ☐ Ambulatory ☐ Stretcher ☐ Wheelchair ☐ Other:	Height: feet inches Weight: ☐ kg ☐ lb.
T: P: R: BP:	O_2sat:

17.2 EENT

☐ No problem noted

☐ Impaired vision ☐ Impaired hearing ☐ Gums/teeth ☐ Redness ☐ Drainage ☐ Lesion

Comments:

17.3 NEUROLOGICAL

☐ No problem noted

☐ GCS Score: /15	☐ Sedated	☐ Vertigo	☐ Headache	☐ Numbness
☐ Confused	☐ Lethargic	☐ Unsteady	☐ Paralyzed	☐ Tingling
☐ Slurred speech	☐ Unresponsive	☐ Weakness	☐ Aphasic	☐ Tremors
☐ Pupil size – Right: mm Left: mm		☐ Seizures	☐ Gag reflex diminished or absent	

Comments:

17.4 RESPIRATORY

☐ No problem noted		Upper	Lower
☐ Oxygen: FiO2: % L/min	☐ Crackles:	☐ Right ☐ Left	☐ Right ☐ Left
Mode: ☐ Nasal Cannula	☐ Diminished:	☐ Right ☐ Left	☐ Right ☐ Left
☐ Venti-Mask ☐ Non-rebreather	☐ Wheezes:	☐ Right ☐ Left	☐ Right ☐ Left
☐ Ventilator ☐ CPAP/BiPAP	☐ Absent:	☐ Right ☐ Left	☐ Right ☐ Left
☐ Asymmetric ☐ Tachypnea	☐ Barrel chest	☐ Bradypnea	☐ Dyspnea
☐ Shallow ☐ Cough	☐ Sputum:		

Comments:

17.5 CARDIOVASCULAR

☐ No problem noted

☐ Tachycardia	☐ Irregular	☐ Numbness	☐ Chest pain	☐ Edema	☐ Diminished pulse:
☐ Bradycardia	☐ Murmur	☐ Tingling	☐ Dizziness	☐ Fatigue	☐ Absent Pulses:
☐ Pacemaker/Defibrillator		☐ AV fistula:		☐ Peripheral IV:	

Comments:

17.6 GASTROINTESTINAL

☐ No problem noted

☐ Hypo BS	☐ Distention	☐ Anorexia	☐ Dysphagia	☐ Incontinent	☐ Last BM: dd/mmm
☐ Hyper BS	☐ Absent BS	☐ Nausea/emesis	☐ Diarrhea	☐ Constipation	☐ Rigidity
☐ Tubes (type):			☐ Ostomy:		

Malnutrition Screening Tool (Source: Ferguson M, Capra S, Bauer J, Banks M. 1999. Adapted with permission):
Does the patient have:
Unintentional weight loss or gain? ☐ No (0) ☐ Yes (check the applicable measure below, scores are in the brackets)
☐ 2 – 13 lb. (1) ☐ Unsure (2) ☐ 14 – 23 lb. (2) ☐ 24 – 33 lb. (3) ☐ Greater than 33 lb. (4)

Decreased appetite? ☐ No (0) ☐ Yes (1) **Total Score:**
For scores of 2 or more, refer to Dietitian

Comments:

17.7 GENITOURINARY & REPRODUCTIVE

☐ No problem noted

☐ Dysuria	☐ Frequency	☐ Hesitancy/Spasm	☐ Distention	☐ Urostomy	☐ Colour
☐ Anuria	☐ Incontinent	☐ Scrotal edema	☐ Menopausal	☐ Hematuria	☐ Odor
☐ Discharge	☐ Pregnancy	☐ LMP: dd/mmm	☐ Catheter (size, date of insertion):		F, dd/mmm:

Comments:

17.8 PAIN ASSESSMENT

☐ Denies any pain

Pain Score:(check which scale was used and insert the score) Pain Goal:

☐ Numeric Scale (1 – 10): ☐ Face Scale (0 – 5):

Circle (or note above) Indicated Number Numeric Scale: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
No Pain Worst Pain

Circle (or note above) Indicated Number Face :

Location(s): Onset (*when did it begin?):* ☐ Acute ☐ Chronic

Characteristics:

☐ Ache	☐ Shooting	☐ Burning/Hot	☐ Heavy	☐ Numbness	☐ Pins & needles
☐ Dull	☐ Throbbing	☐ Gnawing	☐ Tender	☐ Other:	
☐ Sharp	☐ Cramping	☐ Crushing	☐ Stabbing		

Duration (*how long does it last?):* ☐ Continuous ☐ Intermittent, describe:

Aggravating Factors (*what makes it worse?*):
☐ Movement ☐ Breathing ☐ Light ☐ Other:

Alleviating Factors (*what makes it better?*):
☐ Sleep ☐ Rest/Quiet ☐ Cold ☐ Massage ☐ Heat ☐ Dark
☐ Exercise ☐ Distraction ☐ Relaxation ☐ Other:

Pain Medications (*indicate past & current*):

Effects of Pain (*does your pain affect your daily function or quality of life?*): ☐ Sleep ☐ Activity
☐ N/V ☐ Relationships ☐ Appetite ☐ Other:

17.9 MUSCULOSKELETAL & SKIN

☐ Swelling ☐ Hot ☐ Moist ☐ Prosthesis ☐ Decreased ADLs
☐ Skin color ☐ Cool ☐ Flushed ☐ Gait ☐ Atrophy/Deformity
☐ Poor turgor ☐ Diaphoretic ☐ Drainage ☐ Immobility ☐ Contractures

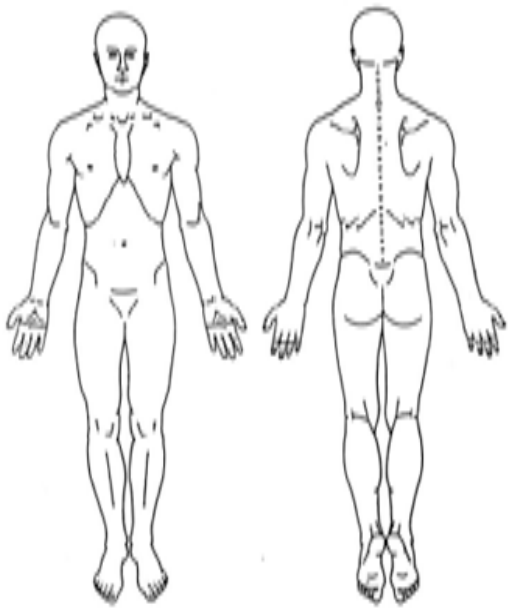
Impaired muscle tone: Lower extremity ☐ Left ☐ Right Upper extremity ☐ Left ☐ Right

Comments:

17.10 WOUND/INCISION ASSESSMENT

☐ None

Assign A, B, C to each wound Location (A, B, C, etc.): Site Description:



17.11 BRADEN SCORE FOR PREDICTING PRESSURE ULCER RISK – *Source: Barbara Braden and Nancy Bergstrom. Copyright, 1988. Reprinted with permission)*

Sensory Perception	Moisture	Activity	Mobility	Nutrition	Friction & Shear
1 = Completely limited	1 = Constantly moist	1 = Bed rest	1 = Completely immobile	1 = Very Poor	1 = Problem
2 = Very limited	2 = Very moist	2 = Chair fast	2 = Very limited	2 = Probably adequate	2 = Potential problem
3 = Slightly limited	3 = Occasionally moist	3 = Walks occasionally	3 = Slightly limited	3 = Adequate	3 = No apparent problem
4 = No impairment	4 = Rarely moist	4 = Walks frequently	4 = No limitations	4 = Excellent	
Score:	**Score:**	**Score:**	**Score:**	**Score:**	**Score:**
If total score is 12 or less, patient is at high risk for a pressure ulcer; implement skin care plan.			**TOTAL SCORE:**		

17.12 FALL RISK – Review each item. In the Score column, enter 0 (zero) for "No" or enter 5 for "Yes"

Incontinence and urgency		Postural hypotension	
Greater than 65 years old		Environmental hazards	
Anxiety and emotional liability		Neurological Deficit	
Level of cooperation		Unable to ambulate on own	
Confused		Attachments (IV, O2, Foley, chest tube)	
Current medications		Unable to transfer	
Impaired judgment		History of falls (if "Yes" score 15)	
Assistance required for transfer			
		Total Score	

For scores of 15 or more, implement SAFE fall Interventions ☐ Initiated

18.HEALTH NEEDS REQUIRING RN INTERVENTIONS

Key: **C** – Complex Care **I** – Intermediate Care **P** – Personal Care

Health Related Need	Description of Need	Time Required
Tube Feeding (Intermediate Care)		
Bolus Feedings		
Continuous tube feeding lasting longer than 12 hours/day		
Parenteral/IV Therapy (Complex Care)		
IV therapy more than two times per week lasting longer than 4 hours for each treatment		
Total parenteral nutrition (TPN) Daily		
Central-line Catheter Care		
Wounds (Complex or Intermediate Care)		
Wound Vac Care **(C)**		
Stage III or IV wounds **(C)**		
Multiple wounds (greater than 1) **(C)**		
Stage I or II wounds **(I)**		
Sterile or clean dressing changes **(I)**		
Open lesions or sites that require specialized care such as burns, fistulas, tube sites or ostomy sites **(I)**		

Patient Name:_____

Respiratory Interventions (Intermediate Care or Complex Care Depending on stability of condition or frequency of care)		
Oxygen Therapy (Emergency BELCO Power/generator in place?) ☐ Yes ☐ No		
Suctioning		
Tracheostomy Care		
BiPAP / CPAP		
Chronic Ventilator or Respirator Care **(C)**		
Nebulizer		
Chest PT		
Elimination Interventions (Intermediate or Personal Care)		
Sterile catheter changes more than 1 time/month		
Clean self-catheterization more than 6 times/day		
Ostomy care		
Bowel Program completed more than 2 times/week requiring more than 30 minutes completing e.g. enema.		
Isolation Precaution (Intermediate Care)		
Isolation precaution for active infectious diseases.	Type:	
Neurological Intervention (Intermediate Care)		
Seizures more than 2 times/week and requires significant physical assistance to maintain safety		
Swallowing disorders diagnosed by a physician and requires specialized assistance from another on a daily basis		
Pain Management		
Chronic Pain Management requires RN nursing assessment and judgment more than twice daily **(C)**		
Intermediate Pain Management requires RN nursing assessment and judgment less than once daily **(I)**		
Safety Risks		
Wandering		
Combative		
Skin Care		
Falls Risk		
Allied Health Referral for Intervention		
Muscular Skeletal (PT/OT and Seating)		
Feeding and Swallowing		

19.GENERAL COMMENTS AND SIGN OFF

GENERAL COMMENTS, OBSERVATIONS AND RECOMMENDATIONS:

Date (dd/mmm/yyyy):

_____

Print Name:

_____

Signature:

_____

Contact Information:

_____

Patient Name:_____

LEVEL OF CARE CALCULATION

- **Check all items that best describe medical/nursing and functional care needs.**
- **Choose care level that has the most items.**

Medical & Nursing Care Needs	Functional Care Needs for ADL's	Level of Care
○ **3 or more chronic fluctuating medical conditions, needing unscheduled medical adjustments** to treatment plan, ○ Mood, memory or behavioural conditions that pose **moderate to severe risk to self or others,** ○ Includes **predicted and unpredicted nursing assessments** due to changing conditions, ○ Greater than once **daily pain management,** ○ Skin and wound care for **Stage 3 & 4** complex wounds, ○ IV therapy includes daily infusions, or central line care or TPN, ○ Tube feedings, ○ Isolation precautions for skin and stool antibiotic resistant bacteria, ○ Oxygen, airway, and/or chronic ventilator management, ○ Care planning and coordination	○ **Needs physical assistance or has total dependence** for **3 or more ADL** limitations, ○ **Total dependence** for mobility/positioning self in bed.	○ **Complex Care:** (Complex skilled nursing) • Predictable and unpredictable complex care needs. • Frequent need for revisions to care plan, treatments or medications. • May have 6-8 episodes of health exacerbations/year requiring extra MD visits. • Mood, memory or behaviour pose moderate to severe risk and frequent interventions. Estimated minimum hours of direct care: 4 hrs./day/pt. includes 1.6 hours/day/pt. of RN time
○ **Complex but stable** chronic medical conditions, needing unscheduled medical adjustments to treatment plan. ○ **Predicted and unpredicted nursing assessments** due to changing conditions, ○ Mood, memory or behavioural conditions that may pose moderate to severe risk to self or others, **easily redirected** ○ **Episodic** pain management ○ Skin and wound care for **Stage 1 & 2** wounds ○ Tube feedings ○ Isolation precautions for skin and stool antibiotic resistant bacteria, ○ Ostomy care, with well-established and intact stoma ○ IV therapy, **episodic or infrequent** ○ Care planning and coordination	○ **Physical assistance or total dependence** for 2 or more ADL, ○ May need cueing or supervision for some ADLs ○ **Total dependence** for mobility/positioning in bed	○ **Intermediate Care:** (Skilled Nursing) • Complex but stable care needs mostly predictable. • Rare to infrequent need for revisions to care plan, treatments or medications. • May have 4 or less episodes of health exacerbations/year requiring extra MD visits. • Mood, memory or behaviour conditions easily redirected or episodic Estimated minimum hours of direct care: 2.5 hours/day/pt includes 0.5-1.5 of RN time
○ Relatively stabilized (physical or mental) chronic disease, ○ Mild – moderate dementia ○ **Predictable** health assessments ○ **Episodic** nursing for medication management, interventions, assessments or treatments, ○ Simple wound care ○ Elder fragility (greater than 85 yrs.) ○ Care planning and coordination	○ Supervision or verbal cueing for ADLS or personal safety ○ Physical assist for mobility ○ Needs assist for IADLs (meal prep, grocery shopping, housekeeping, transport, laundry, etc.)	○ **Personal Care:** • Stable health conditions. • Episodic nursing interventions • Mood, memory or behaviour conditions mild to moderate. • May require minimal additional care or minor adjustments to care plan. Estimated minimum hours of direct care: 1-2 hours/day/pt. includes. RN care time determined by number of patients, care needs and supervision roles

Patient Name:_____

PERSONAL HOME CARE GUIDE
To determine care hours to support person in their own home

Assumptions:

a. The family has responsibility to provide some of the care in addition to what the benefit covers (e.g. a minimum of 8 to 12 hours per day, 7 days per week depending on their resources).
b. Community or charity services are used to support care needs as much as possible (e.g. Meals on Wheels, Project Action, Community Nursing, Bermuda Red Cross, etc.)
c. Adult Day Programs, part time or full time, are used when many care hours are required. Persons benefiting most from these programs are those with mild to moderate dementia, depression, social isolation, decreased mobility due to fear of falling, nighttime agitation or difficulty sleeping (increasing stimulation during day often aids sleep at night).
d. Personal caregivers (PC) may provide the following:
    - Prompting and cueing, supervision for personal safety and Activities of Daily Living (ADL's).
    - Hands on assistance for person needing bathing, dressing, mobility, feeding, toileting or incontinence care may be provided by personal caregiver for cooperative persons, with health/medical stability.
    - All Instrumental Activities of Daily Living (IADL's).
    - Training of personal caregivers may be required for Dementia, fall prevention, moving and handling, etc.
e. Skilled caregiver (Nursing Associate, NA) may provide:
    - ADL's of frail elderly person, when non- ambulatory, or bed ridden person, with or without contractures, skin fragility, breakdown or open skin areas, behavioural agitation, excess anxiety, resistance or aggression.
    - Daily monitoring and recording of fluid intake, blood sugar, BP, weights, swallowing difficulties for persons with complex health conditions such as congestive heart failure, brittle diabetes, COPD, end of life comfort care. NOTE- Personal caregivers that are family members may be taught to complete these tasks.
f. Medications cannot be administered by personal caregivers or skilled caregivers. Personal and skilled caregivers may provide prompting or cueing, and monitoring of medications taken if doses are premeasured in prefilled pill box with written medication schedule. Prefilling should be by family, or RN.
g. Registered Nurse (RN) is required to provide skilled nursing care in accordance with their scope of practice. This includes but is not limited to medication management, health assessments, care planning, patient and family education, oversight and guidance to nurse associates and caregivers.

Instructions for completing table:

Complete all sections of the table on the following page.

For each section indicate the estimated care hours required for the care needs and by which type of care provider: Personal Caregiver (PC), Skilled Caregiver (NA) or Registered Nurse (RN).

The calculation of care hours is determined by the assessment findings and the individual needs of the client for daily functioning.

Patient Name:_____

PERSONAL HOME CARE NEEDS	Care hours per day by care provider type:		
	PC	NA	RN
1. <u>Activity of Daily Living (ADLs)</u>- if assistance, prompting or supervision needed, estimate time per activity for usual day**.**			
Mobility –assist needed to transfer chair to chair, chair to bed, 3 times per day minimum			
Mobility –assist needed to Ambulate or stand, or wheelchair push – allow 10 min 4 times per day			
Mobility– in bed, if bedridden for turning, or reposition every 2 hours			
Toileting or incontinence care for hygiene but also consider time to supervise/cue getting to and from, on and off toilet if history of falls, observed unsteadiness or dementia			
Bathing and dressing assist needed but also consider time if observed unsteadiness, history of falls, or dementia			
Eating, feeding or assisting with drinking fluids. Include time for meal prep if assist is needed			
2. <u>Instrumental Activities of Daily Living (IADL)-</u> If impairment with mobility or dementia is present then consider following:			
Assistance needed for IADLs- e.g. changing bed linens, meal prep, light cleaning, grocery shopping, put out trash			
Transport to and from daycare			
Transport to and from medical appointments if more than 1 time per week, e.g Dialysis, day rehab			
If unable to communicate needs or call for help, consider additional time for supervision/ personal safety to prevent being home alone.			
3. <u>Complex Health Needs</u>- specify time if needed for the following:			
Daily monitoring and recording of health measures such as fluid intake, BP, blood sugar, weights, O2 sat that person/ family are unable to learn or perform			
Tube feedings			
Ostomy or catheter care or handling			
Wound dressings -simple or protective			
Range of motion exercises 2-3 times daily			
Respiratory suctioning, postural drainage and chest PT.			
First Aid for seizures more than 2 times per week and physical assistance required to maintain safety.			
4. <u>Dementia Related Care</u> if risk factors are present, adjust care calculation to provide for supervision for the following:			
Personal safety risk –due to wandering			
Impaired judgment, putting self at risk (e.g. fire) or unable to seek help when alone			
Behavioural difficulties- resistance to care, excess anxiety, or aggression			
5. <u>Social /recreational/spiritual (interactive) activities</u>-			
Needs assistance to engage in conversation, puzzles, games, stretching, in home and events outside of home. If day care recommended indicate at end of table.*			
Total estimated care hours per day for each care provider type:			
***If day care is recommended, indicated how many half or full days per week:**			

Patient Name:_____

LONG TERM CARE NEEDS REASSESSMENT

Care Setting: ☐ No Change ☐ Change, specify location and admission date (dd/mmm/yyyy):

ORIGINAL LEVEL OF CARE REQUIRED BASED ON FULL ASSESSMENT	☐ Complex Care ☐ Intermediate Care ☐ Personal Care

Reassessment Category	Changes Noted::
Medical Conditions ☐ No Change	

Medications ☐ No Change	

Functional Abilities ☐ No Change	

Behavioural Cognitive Status ☐ No Change	

Nursing related treatments and Interventions ☐ No Change	

Other: ☐ No Change	

LEVEL OF CARE REQUIRED BASED ON REASSESSMENT	☐ Complex Care ☐ Intermediate Care ☐ Personal Care

Date (dd/mmm/yyyy): _____

Print Name:_____

Signature: _____

Contact Information: _____

Patient Name:_____

LONG TERM CARE NEEDS REASSESSMENT

Care Setting: ☐ No Change ☐ Change, specify location and admission date (dd/mmm/yyyy):

ORIGINAL LEVEL OF CARE REQUIRED BASED ON FULL ASSESSMENT	☐ Complex Care ☐ Intermediate Care ☐ Personal Care

Reassessment Category	Changes Noted::
Medical Conditions ☐ No Change	

Medications ☐ No Change	

Functional Abilities ☐ No Change	

Behavioural Cognitive Status ☐ No Change	

Nursing related treatments and Interventions ☐ No Change	

Other: ☐ No Change	

LEVEL OF CARE REQUIRED BASED ON REASSESSMENT	☐ Complex Care ☐ Intermediate Care ☐ Personal Care

Date (dd/mmm/yyyy): _____

Print Name:_____

Signature: _____

Contact Information: _____

Patient Name:_____

TRANSFER/DISCHARGE INFORMATION

Patient Details Name: Date of Birth (dd/mmm/yyyy):	Transfer from (Location): Transfer to (Location):

LEVEL OF CARE REQUIRED AT TIME OF TRANSFER	☐ Complex Care ☐ Intermediate Care ☐ Personal Care

Advanced Care Directive Attached? ☐ Yes ☐ No

Reason for Transfer:

Date (dd/mmm/yyyy): _____

Print Name:_____

Signature: _____

Contact Information: _____