Admission Nursing Assessment- - V 7

Client:	Effective Date:	Date of Birth:
Physician:	Facility:	

A. ADMISSION DETAILS

1a. Reason for admission according to resident / POA:

1b. Reason for admission from paperwork:

1c. Other reasons for admission:

- [ ] 1. Infection(s) requiring Isolation
- [ ] 2. Dialysis
- [ ] 3. IV medications & / or fluids

2a. Admitted from:

2b. Accompanied by:

3. Additional notes:

B. LOC/ ORIENTATION/ NEUROLOGICAL

1. LOC

1a. Unrousable / Coma / Persistent Vegetative State

( ) a. Yes ( ) b. No

1b. [ ] Alert

2. ORIENTATION

2a. Person

( ) a. Yes ( ) b. No ( ) c. Unable to determine

2b. Place

( ) a. Yes ( ) b. No ( ) c. Unable to determine

2c. Time

( ) a. Yes ( ) b. No ( ) c. Unable to determine

2d. Situation

( ) a. Yes ( ) b. No ( ) c. Unable to determine

3.COMMUNICATION

3a. [ ] Speaks English

3b. Primary language other than English

3c. [ ] Difficulty understanding others

3d. [ ] Difficulty being understood

3e. [ ] Aphasia

3f. Other methods of Communication

- [ ] 1. Sigh Language

- [ ] 2. Communication Board
- [ ] 3. Writing on paper / pad / white board

3g. Notes:

4. MOTOR CONTROL

4a. [ ] Paralysis / Hemiplegia / Quadriplegia

4b. [ ] Tremors

4c. Falls:

- [ ] 1. History of Falls (Last 30 days)
- [ ] 2. History of Falls (Last 2-6 months)
- [ ] 3. History of Falls (Last 6 months)
- [ ] 4. No fall history

4d. Fall Interventions:

- [ ] a. Evaluated room for immediate safety needs
- [ ] b. Oriented to room, facility routine, and use of call light

4e. Notes:

5. BIMS

5a. [ ] Not Applicable-Resident is / in Unrousable / Coma / Persistent Vegetative State

5b. Short Term Memory (Recalls if arrived to facility on gurney or in a W/C)

- ( ) 1. Memory OK
- ( ) 2. Memory problem

5c. Long Term Memory (Recalls DOB)

- ( ) 1. Memory OK
- ( ) 2. Memory problem

5d. Memory / Recall Ability

- [ ] 1. Current Season
- [ ] 2. Location of own room
- [ ] 3. Staff names and faces
- [ ] 4. That he / she is in a nursing home
- [ ] 5. None of the above were recalled

5e. Cognitive Skills for Daily Decision Making:

- ( ) 1. Independent- decisions consistent / reasonable
- ( ) 2. Modified Independence - some difficulty in new situations only
- ( ) 3. Moderately impaired - decisions poor; cues / supervision required
- ( ) 4. Severly impaired-never / rarely makes decisions

If the resident is not independent in decision making, add an example of why not.

5f. Example: Modified Independence might be coded when the resident doesn't remember where the call light is.

C. SOCIAL HISTORY/ LIFESTYLE CONCERNS / PREFERENCES

1. Uses Tobacco / Smoker

- ( ) a. Current smoker
- ( ) b. Past Smoker
- ( ) c. Never smoked
- ( ) d. UTD / No response

2. Uses Alcohol

( ) a. Regularly - Daily ( ) b. Regularly - Weekly or less ( ) c. Rarely ( ) d. Never ( ) e. UTD / No response

3. Uses Drugs

( ) a. Regularly - Daily ( ) b. Regularly - Weekly or less ( ) c. Rarely ( ) d. Never ( ) e. UTD / No response

Mood and Behavior:

4a. [ ] Angry
4b. [ ] Withdrawn
4c. [ ] Aggressive
4d. [ ] Resistive
4e. [ ] Flat affect
4f. [ ] Trouble falling or staying asleep
4g. [ ] Sad
4h. [ ] Feeling tired or having little energy
4i. [ ] Poor appetite or overeating
4j. Other:

4k. Notes:

5a. **Elopement Risk Factors:**

[ ] 1. History of Elopement in last 6 months [ ] 2. Repetitive Pacing or Aimless Wandering [ ] 3. Asking to leave or purposeful exit-seeking [ ] 4. Expresses desire to leave facility or go home [ ] 5. None of the above

5b. [ ] Self mobile by ambulation or wheelchair

5c. Elopement Risk:

( ) 1. No to self mobile; not considered at risk for elopement ( ) 2. Yes to self-mobile and NO to risk factors- currently not considered at risk for elopement, review again at 72 hr. Walking Round ( ) 3. Yes to self-mobile and YES to 1 or more risk factors; might be considered at risk for elopement, **Complete Elopement Risk assessment<b/>**

Lifestyle Query:<b/>

6a. Do you have any preferences that must be considered in your daily routines, such as wake-times, bath-times, meal-times, bed-times, medication times, or any other caregiver preferences?

( ) 1. No ( ) 2. Yes, see below. ( ) 3. Unable or no response given

6b. Lifestyle Preferences: **(S)**

[ ] 1. Early morning riser [ ] 2. Late morning riser [ ] 3. Prefers bath rather than showers [ ] 4. Prefers male caregivers [ ] 5. Prefers female caregivers

[ ] 6. Prefers baths rather than showers [ ] 7. Prefers showers on specific days

6c. Other preferences that must be considered: **(S)**

6d. Are there any religious or cultural preferences you'd like to share?

1. No 2. Yes, see below. 3. Unable or no response given

6e. Religious or cultural preferences: **(S)**

D. VITAL SIGNS

1. Most Recent Temperature
   - Temperature: _____ Date: _____
   - Route: _____
2. Most Recent Pulse
   - Pulse: _____ Date: _____
   - Pulse Type: _____
3. Most Recent Respiration
   - Respiration: _____ Date: _____
4. Most Recent Blood Pressure
   - Blood Pressure: _____ Date: _____
   - Position: _____
5. Most Recent Weight
   - Weight: _____ Date: _____
   - Scale: _____
6. Most Recent Height
   - Height: _____ Date: _____
   - Method: _____

E. GENERAL APPEARANCE

1. ☐ Well-nourished
2. ☐ Thin
3. ☐ Obese
4. ☐ Anxious
5. ☐ Calm
6. ☐ No acute distress
7. Other:
8. Notes:

F. HEENT

1. HEAD

1a. ☐ No visible trauma

1b. ☐ Scalp normal

1c. Notes:

2. EYES

2a. ☐ PERRLA

2b. ☐ Adequate vision

2c. ☐ Wears glasses

2d. Notes:

3. EARS

3a. ☐ Adequate hearing

3b. ☐ Some hearing loss

3c. ☐ Hearing Aid(s) used

3d. ☐ External ear intact

3e. Notes:

4. NOSE

4a. ☐ Unremarkable

4b. ☐ Congestion

4c. ☐ Hx / Presence sinus issues

4d. ☐ Epistaxis

4e. Notes:

5. THROAT

5a. ☐ Clear, pink

5b. ☐ Glandular swelling

5c. ☐ Hoarseness

5d. ☐ Trouble swallowing

5e. ☐ Sore throat

5f. Notes:

6. MOUTH

6a. ☐ Pink

6b. ☐ Moist

6c. ☐ Lesions / Sores

6d. ☐ Lips pink

6e. ☐ Lips moist

6f. ☐ Upper Dentures

6g. ☐ Lower Dentures

6h. ☐ Upper bridge / partial

6i. ☐ Lower bridge / partial

6j. ☐ Tongue moist / pink

6k. ☐ No natural teeth (edentulous)

6l. ☐ Dental caries

6m. ☐ Broken teeth

6n. Notes:

G. RESPIRATORY/ CHEST

1. INSPECTION

1a. ☐ Normal chest

1b. ☐ Barrel chest

1c. ☐ Symmetrical expansion

1d. ☐ Cyanosis

1e. ☐ SOB on exertion

1f. ☐ SOB when lying flat

1g. ☐ SOB at rest

1h. Most Recent O2 sats **(S)**

O2 sats: _____(%) Date: _____

Method: _____

1i. Oxygen:

- ○ 1. No
- ○ 2. Yes

1j. If yes, describe order(s). **(S)**

1k. Notes:

2. AUSCULTATION

2a. ☐ Normal Lung Sounds

2b. ☐ Rhonchi

2c. ☐ Wheezes

2d. ☐ Crackles

2e. ☐ Rales

2f. Notes:

H. CARDIAC/ CIRCULATION

1. PULSE

1a. ☐ Regular rate and rhythm.

1b. ☐ Irregular rate

1c. ☐ Irregular rhythm

1d. Other:

2. CIRCULATION

2a. Capillary Refil

- ○ a. < or = 3 sec - Normal
- ○ b. < or = 5 sec - Sluggish
- ○ c. > 5 sec - Abnormal

2b. ☐ Edema present

2c. Location

2d. Pitting

- 0. None
- 1+. slight pitting / 2 mm, disappears rapidly
- 2+. somewhat deeper pit / 4mm, disappears in 10-15 sec
- 3+. deep pit / 6mm, may last > minute. dependent extremity swollen
- 4+. very deep pit / 8mm, last 2-5min, dependent extremity grossly distorted.

3. Notes:

I. GI / BOWEL

1. BOWELS

1a. ☐ Bowel sounds present

1b. ☐ Incontinent of bowels

1c. ☐ Constipation

1d. ☐ Diarrhea

1e. ☐ Regular cramping / pain

1f. ☐ Hemorrhoids

1g. ☐ Colostomy

1h. ☐ Ileostomy

2. ABDOMEN

2a. ☐ Soft

2b. ☐ Non-tender

2c. ☐ Non-distended

2d. ☐ Ascites

2e. Girth

3. Notes:

J. GU / BLADDER

1. BLADDER

1a. ☐ Non-distended bladder

1b. ☐ Incontinent of bladder

1c. Notes:

2. CATHETER / OSTOMY

2a. ☐ Foley Catheter

2b. ☐ Suprapubic Catheter

2c. ☐ Urostomy

2d. ☐ External Catheter

2e. Notes:

3. OTHER

3a. ☐ Mastectomy

3b. Notes: **(S)**

K. EXTREMETIES

1. Right Arm

1a. ☐ ROM WNL in all joints.

1b. Notes:

2. Left Arm

2a. ☐ ROM WNL in all joints.

2c. Notes:

3. Right Leg

3a. ☐ ROM WNL in all joints.

3b. Notes:

4. Left Leg

4a. ☐ ROM WNL in all joints.

4b. Notes:

L. SKIN

1a. Relevant History / Dx:

Skin Assessment & Condition on Admission:

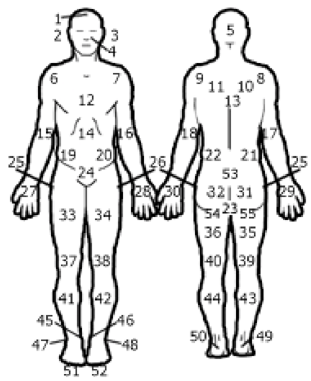
1b. ☐ Clear, intact - no skin issues.

Skin Condition(s) Identified: (Stage ONLY pressure wounds.)

1c. **Complete a Wound Assessment for each identified wound.**

Client: **Effective Date:** **Date of Birth:**

Physician: **Facility:**



Suspected Deep Tissue Injury - Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Stage I - Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

Stage II - Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

Stage III - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Stage IV - Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Unstageable - Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

N/A - Not Available

Units of measure : centimeters

Site	Type	Length	Width	Depth	Stage

2. ☐ Treatment ordered or required

3. Notes:

M. DEVICES

DEVICES / AIDS: (Check all that apply)

1. ☐ Manual Wheelchair

6. ☐ Cane

Client: Effective Date: Date of Birth:
Physician: Facility:

1a. Manual W/C: **(S)**
- 1. Used by the resident prior to the current illness, exacerbation, or injury
- 2. New device / Aid since this current illness, exacerbation, or injury.

2. ☐ Motorized wheel chair and or scooter

2a. Motorized W/C or Scooter: **(S)**
- 1. Used by the resident prior to the current illness, exacerbation, or injury
- 2. New device / Aid since this current illness, exacerbation, or injury.

3. ☐ Mechanical Lift

3a. Mechanical Lift: **(S)**
- 1. Used by the resident prior to the current illness, exacerbation, or injury
- 2. New device / Aid since this current illness, exacerbation, or injury.

4. ☐ Walker

4a. Walker: **(S)**
- 1. Used by the resident prior to the current illness, exacerbation, or injury.
- 2. New device / Aid since this current illness, exacerbation, or injury.

5. ☐ Orthotics / Prosthetics

5a. Orthotics / Prosthetics: **(S)**
- 1. Used by the resident prior to the current illness, exacerbation, or injury.
- 2. New device / Aid since this current illness, exacerbation, or injury.

7. ☐ Quad Cane

8. ☐ Rollator

9. ☐ Recliner

10. ☐ Transfer board

11. ☐ Transfer Pole

12. ☐ Trapeze

13. ☐ Wedge cushion

14. ☐ Scoop Mattress

15. Other:

16. Comments:

N. PAIN

1. PAIN

1a. Resident has pain?

- a. Yes
- b. No
- c. Unable to determine

1b. Describe location and type of pain: **(S)**

1c. Numerical Rating Scale (for verbal/able residents). 1 Mild Pain to 10 Worst possible pain. **(S)**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

1d. PAIN **(S)**

Client:	Effective Date:	Date of Birth:
Physician:	Facility:	

No Hurt	Hurts a Little Bit	Hurts a Little More	Hurts Even More	Hurts a Whole Lot	Hurts Worst

P. OTHER OBSERVATIONS/ CONCERNS

1.

2. ☐ Acute care transfer orders verified with attending MD

2a. Describe any changes or revisions to the transfer orders:

CP. CARE PLANS

Client:	Effective Date:	Date of Birth:
Physician:	Facility:	

1. ADL Care Plan

- ☐ **Focus:** Self-Care Deficit As Evidenced by: Needs (SPECIFY) assistance with ADLs
  Related to (SPECIFY)
- ☐ **Goal:** Resident will continue to perform current level of ADL function through review date
- ☐ **Goal:** Resident will be clean, dry, well-groomed through review date
- ☐ **Intervention:** Custom Kardex Item- type here
- ☐ **Intervention:** Bed Mobility - Independent required
- ☐ **Intervention:** Bed Mobility - Supervision required
- ☐ **Intervention:** Bed Mobility - Setup help only / Cueing required
- ☐ **Intervention:** Bed Mobility - One person physical assist required
- ☐ **Intervention:** Bed Mobility - Two person physical assistance required
- ☐ **Intervention:** Bed Mobility - uses adaptive devices (SPECIFY)
- ☐ **Intervention:** Bed Mobility - Maintain proper body alignment
- ☐ **Intervention:** Bed Mobility - Encourage frequent repositioning to redistribute weight/shift weight
- ☐ **Intervention:** Bed Mobility - Assist to turn & reposition every 2 hours in bed & wheelchair
- ☐ **Intervention:** Out of Bed Positioning - Sits in (SPECIFY)
- ☐ **Intervention:** Out of Bed Positioning - positioning device (SPECIFY)
- ☐ **Intervention:** Transfer: Independent required
- ☐ **Intervention:** Transfer: Supervision required
- ☐ **Intervention:** Transfer: Setup-up help only / Cueing
- ☐ **Intervention:** Transfer: One person physical assistance required
- ☐ **Intervention:** Transfer: Two person physical assistance required
- ☐ **Intervention:** Transfer: Mechanical Lift required
- ☐ **Intervention:** Transfer - Restrictions / Precautions (SPECIFY)
- ☐ **Intervention:** Transfer - uses adaptive devices (SPECIFY)
- ☐ **Intervention:** Eating - Independent required
- ☐ **Intervention:** Eating - Supervision required
- ☐ **Intervention:** Eating - Setup help only / Cueing required
- ☐ **Intervention:** Eating - One person physical assist required
- ☐ **Intervention:** Eating - Restrictions / Precautions (SPECIFY)
- ☐ **Intervention:** Toilet Use - Independent required
- ☐ **Intervention:** Toilet Use - Supervision required
- ☐ **Intervention:** Toilet Use - Setup help only / Cueing required
- ☐ **Intervention:** Toilet Use - One person physical assist required
- ☐ **Intervention:** Toilet Use: Two person physical assistance required
- ☐ **Intervention:** Toilet Use - Uses adaptive devices (SPECIFY)
- ☐ **Intervention:** Toilet Use - Restrictions / Precautions (SPECIFY)
- ☐ **Intervention:** Ambulation - uses adaptive devices (SPECIFY cane, walker, wheelchair, etc)
- ☐ **Intervention:** Ambulation - Weight bearing status (SPECIFY)
- ☐ **Intervention:** Ambulation - Restrictions / Precautions (SPECIFY)
- ☐ **Intervention:** Bathing - Supervision required
- ☐ **Intervention:** Bathing - Setup help only / Cueing required
- ☐ **Intervention:** Bathing - One person physical assist required
- ☐ **Intervention:** Bathing: Two person physical assistance required
- ☐ **Intervention:** Bathing - uses adaptive devices (SPECIFY)
- ☐ **Intervention:** Bathing - Shower/bed bath at least 2X/week and PRN
- ☐ **Intervention:** BEDFAST: The resident is bedfast all or most of the time.
- ☐ **Intervention:** CONTRACTURES: The resident has contractures of the (SPECIFY location of contracture). Provide skin care

3. Skin Care Plan

- ☐ **Focus:** Potential for impaired skin integrity related to:
- ☐ **Goal:** No new pressure ulcers will develop in the x 90 days.
- ☐ **Goal:** The resident will have no complications from skin issues through the review date
- ☐ **Intervention:** Pressure redistribution mattress to bed
- ☐ **Intervention:** Pressure redistribution cushion - wheelchair
- ☐ **Intervention:** Apply Lotion to skin following bathing
- ☐ **Intervention:** Observe skin integrity during am/pm care
- ☐ **Intervention:** Maintain HOB in lowest possible position
- ☐ **Intervention:** Notify MD promptly of skin breakdown
- ☐ **Intervention:** Refer to RD PRN to evaluate diet/needs
- ☐ **Intervention:** Bath/shower per schedule
- ☐ **Intervention:** Encourage PO intake
- ☐ **Intervention:** Provide diet as ordered
- ☐ **Intervention:** Labs as ordered
- ☐ **Intervention:** Monitor incontinence
- ☐ **Intervention:** Provide pericare
- ☐ **Intervention:** Evaluate Skin Weekly
- ☐ **Intervention:** Medications as ordered
- ☐ **Intervention:** Encourage to reposition as able
- ☐ **Intervention:** Provide therapeutic device as ordered: (specify: bed type: and wheel chair type:)
- ☐ **Intervention:** Reposition every 2 hours in bed
- ☐ **Intervention:** Reposition every one hour in bed.
- ☐ **Intervention:** Reposition every hour in wheel chair

(SPECIFY FREQ) to keep clean and prevent skin breakdown.

- ☐ **Intervention:** SIDE RAILS: (SPECIFY) full/half rails up as per Dr.s order for safety during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition (FREQ) and as necessary to avoid injury.
- ☐ **Intervention:** PT/OT evaluation and treatment as per MD orders.
- ☐ **Intervention:** Early Morning Riser
- ☐ **Intervention:** Late Morning Riser
- ☐ **Intervention:** Prefers baths rather than showers
- ☐ **Intervention:** Prefers Female Caregivers
- ☐ **Intervention:** Prefers Male Caregivers
- ☐ **Intervention:** Prefers showers on ___ days.

2. Fall Care Plan

- **Focus:** At risk for falls and injuries r/t Medications: (SPECIFY Which): Pychotropic Meds/ Diuretic Meds/ Cardiovascular Meds/ Pain Meds/ Other Medications). Medical Factors:
- **Goal:** Decrease risk of fall and/or minimize injuries from falls x 90 days
- **Intervention:** Assess toileting needs
- **Intervention:** Encourage use of call light
- **Intervention:** Instruct to avoid sudden position changes
- **Intervention:** Keep call light within reach
- **Intervention:** Keep environment clutter free
- **Intervention:** Keep personal belongings within reach
- **Intervention:** Low Bed
- **Intervention:** Mat at bedside when in bed
- **Intervention:** Observe for side effect of meds
- **Intervention:** Observe for unsteady gait and balance
- **Intervention:** Provide adequate lighting
- **Intervention:** Provide verbal safety cues
- **Intervention:** Provide/Reinforce use of assistive devices: (Specify: Reacher , Walker, Cane, Wheel Chair, Transfer Pole, Other__)
- **Intervention:** Provide/Reinforce use of non-skid foot wear
- **Intervention:** Wear Clean eye wear
- **Intervention:** Scoop Mattress
- **Intervention:** Wedge Cushion

4. Pain Care Plan

- **Focus:** The resident has (SPECIFY acute/chronic) pain r/t
- **Goal:** The resident will not have an interruption in normal activities due to pain through review date.
- **Goal:** The resident will display a decrease in behaviors of inadequate pain control (SPECIFY: irritability, agitation, restlessness, grimacing, perspiring, hyperventilation, groaning, crying) through review date.
- **Goal:** The resident will voice a level of comfort of (SPECIFY residents states range of comfort) out of (SPECIFY) through review date.
- **Goal:** The resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through review date.
- **Goal:** The resident will not have discomfort related to side effects of analgesia through review date.
- **Intervention:** Provide the resident with reassurance that pain is time limited. Encourage (SPECIFY: resident, NAME, me)to try different pain relieving methods i.e. positioning, relaxation therapy, progressive relaxation, bathing, heat and cold application, muscle stimulation, ultra-sound.
- **Intervention:** Monitor/record pain level Q shift.
- **Intervention:** Identify and record previous pain history and management of that pain and impact on function. Identify previous response to analgesia including pain relief, side effects and impact on function.
- **Intervention:** Provide the residentand family with information about pain and options available for pain management. Discuss and record preferences.
- **Intervention:** Monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician.
- **Intervention:** Identify, record and treat The resident's existing conditions which may increase pain and or discomfort (SPECIFY: arthritis, neuropathies, cancer, osteoporosis, fractures, shingles, peripheral vascular disease, ulcers, contractures, parathesia r/t stroke)
- **Intervention:** Administer analgesia as per orders.
- **Intervention:** The resident prefers to have pain controlled by: (SPECIFY medication, treatment)
- **Intervention:** Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain.
- **Intervention:** Monitor/document for probable cause of each pain episode. Remove/limit causes where possible.
- **Intervention:** Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition.
- **Intervention:** The resident's pain is aggravated by: (SPECIFY)
- **Intervention:** The resident's pain is alleviated/relieved by: (SPECIFY)
- **Intervention:** Anticipate the resident's need for pain relief and respond immediately to any complaint of pain.
- **Intervention:** Report to Nurse any change in usual activity attendance patterns or refusal to attend activities related to s/sx or c/o pain or discomfort.
- **Intervention:** The resident is able to: (SPECIFY: call for assistance when in pain, reposition self, ask for medication, tell you how much pain is experienced, tell you what increase or alleviates pain).
- **Intervention:** Monitor/record/report to Nurse any s/sx of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored,

fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing).

- ☐ **Intervention:** Monitor/record/report to nurse loss of appetite, refusal to eat and weight loss.
- ☐ **Intervention:** Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment.
- ☐ **Intervention:** Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM, withdrawal or resistance to care.

5. Elopement Care Plan:

- ☐ **Focus:** Potential Risk of Elopement
- ☐ **Goal:** Resident will remain safely in facility through review date
- ☐ **Intervention:** *Place Electronic Sensor Device to alert staff of exit attempt (or if unavailable, place on 1:1 observation): Routinely
  * Check Device Placement
  * Check Battery Function
  * Eval effectiveness
- ☐ **Intervention:** Maintain adequate I.D.
- ☐ **Intervention:** Monitor Residents interactions with peers to identify escalating tension, frustration, or Aggression; Intervene
- ☐ **Intervention:** Provide re-direction and Diversion as needed
- ☐ **Intervention:** Respond to any alarm activation promptly

6. Admission Baseline Care Plan

- ☐ **Focus:** Admission Baseline

- ☐ **Goal:** The patient will begin planning a safe discharge.
- ☐ **Goal:** The patient will adjust to the new environment in long term care.
- ☐ **Goal:** The patient will receive adequate nutrition and hydration.
- ☐ **Goal:** The patient has an infection. Infections will not be spread to or from other patients/staff.
- ☐ **Goal:** The patient smokes and has a risk for injury.
- ☐ **Goal:** The patient has utilized devices to assist with activities of daily living that may present hazards.
- ☐ **Goal:** The patient will not have any symptoms of decline in respiratory status.
- ☐ **Goal:** The patient will receive the specialty treatment as ordered without complications.
- ☐ **Goal:** The patient and representative (if indicated) will be provided with the screening response if the screening triggers an evaluation.
- ☐ **Goal:** Resident will not experience complications from urinary or bowel appliance each week through review date
- ☐ **Goal:** The resident will have no adverse reactions from medication(s) through review date
- ☐ **Goal:** Resident wishes will be honored thru next review Code status reviewed:
- ☐ **Goal:** Skin issue will progress towards healing without signs and symptoms of infection.
- ☐ **Goal:** IV Medications & / or Fluids will be administered as per MD order.
- ☐ **Intervention:** The care team will identify any obstacles or barriers to a safe discharge
- ☐ **Intervention:** The staff will monitor for signs of adjustment difficulty
- ☐ **Intervention:** The staff will provide the diet ordered by the Physician.
- ☐ **Intervention:** There are Physician orders for a fluid restriction, the staff will provide fluids within this ordered range
- ☐ **Intervention:** There are Physician orders for Intravenous Fluids (& / or IV Medications) due to needing more fluids, the staff will provide fluids to improve hydration
- ☐ **Intervention:** The care team will provide isolation to prevent the spread of infections to or from other patients and staff.
  -MICROORGANISM (Specify)
  -TYPE OF PRECAUTION (Specify)

- ☐ **Intervention:** The care team will supervise smoking and smoking materials
- ☐ **Intervention:** Side rails will not be used until a lesser restrictive device has been attempted.
- ☐ **Intervention:** A referral will be made to Therapy the care team to evaluate for appropriate assistive devices
- ☐ **Intervention:** The nursing staff will monitor:
  BREATHING PATTERN,O2 SATURATION, & RESPIRATORY RATE

- ☐ **Intervention:** The nurse will follow the MD orders for specialty care with: (Specify which are used)
  -BiPAP
  -CPAP
  -OXYGEN
  -TRACH
  -VENT
  -SUCTION
  -PLEUREX TUBE

Client:	Effective Date:	Date of Birth:
Physician:	Facility:	

- ☐ **Intervention:** The nurse will follow the MD orders for special treatments and procedures
- ☐ **Intervention:** The care team will review and plan interventions based on the recommendations in the screening response
- ☐ **Intervention:** In the event of cardiac arrest, CPR will be initiated, and continue until EMS arrival to take over compressions, and/or physician gives order to stop compressions, if not effective.
- ☐ **Intervention:** No CPR
- ☐ **Intervention:** Full CPR
- ☐ **Intervention:** The nurse will administer the medication(s) per MD order and monitor for adverse reactions: (Specify type)
  -Psychotropic medications, including PRN
  -Diuretics
  -Insulin
  -Antibiotics
  -Anticoagulants
  -Opiods
  - Black Box medications
- ☐ **Intervention:** The nurse will follow the MD orders for specialty care with: (Specify which are used)
  -Indwelling catheter (including suprapubic catheter and nephrostomy tube)
  -External catheter
  -Ostomy (including urostomy, ileostomy, and colostomy)
  -Intermittent catheterization
- ☐ **Intervention:** The nurse will follow the MD orders for skin issues.

- ☐ **Intervention:** The nurse will follow the MD orders regarding:
  The patient requires: (Specify)
  -TRANSFUSIONS
  -RADIATION
  -CHEMOTHERAPY
  -DIALYSIS
  -VASCULAR ACCESS DEVICE
  -LVAD
  -LIFE VEST
  -DRAINS (Specify Type/Site)

Signature	Date
_____	_____