GOVERNMENT OF BERMUDA
Ministry of Health

LTC Needs Assessment Form Guidance

The LTC Needs Assessment form provides:

- comprehensive information for person-centered care plans in care homes, home care and the hospital;
- standardized information for transfers between care settings; and
- data for long term care systems planning

Who completes the assessment?

- A Registered Nurse or Enrolled Nurse (LPN) must complete the assessment. Caregivers and healthcare professionals may assist but the Nurse is ultimately responsible to ensure accurate and current information.

How do I get the information needed to complete the assessment?

- By interviewing:
  - the person being assessed, their needs and preferences must be of primary consideration;
  - the responsible person or family member; including persons power of attorney; receivership and/or with a care or support role (e.g. friend, family etc)
  - Any caregivers in place; and
- By direct observation or hands on assessment; and
- From current, existing assessments e.g. medication administration records (MAR); the MOCA. In the relevant section of the form, write the completion date and source of the existing assessment and input the results and/or attach a copy.

When is the assessment completed?

- The assessment is completed within 72 hours of admission, or before if there are pre-identified risks.
- A copy of the completed assessment is kept on file and accompanies persons transferred to new care settings.

What are the requirements for reassessment?

- If only minimal changes, the reassessment section (p.19) is completed to update the form. Substantial changes require a new assessment.
- Reassessment occurs:
  - After the first 3months for all new admissions to a new care setting.
  - A minimum of once per year for persons with stable conditions.
  - As a result of changing needs or circumstances including:
    a. After significant treatment process, or lack thereof;
    b. After new symptoms are identified or significant medical changes occur;
    c. When significant behavioral changes are observed;
    d. When there is a change in functioning;
    e. When transferred to a new care setting.

How to Complete the Form:

General:

- **Complete all sections of the form and write NA (Not Applicable) when not appropriate for the care setting.**
- If additional space is required use 8x 11 paper and attach to the form

4.3 Medications

- If a current MAR is available, attach a copy and write 'see attached' in the area provided to list medications.

5.3 Instrumental Activities of Daily Living (IADL)

- To be completed in all care setting, including care homes to encourage people to engage in IADLs.

6. Social/Recreational Preferences

- Life books (e.g. This is me, All About Me) provide current and historical information about the person, including quality of life and care preferences, in an accessible format to facilitate person centered care and support by providers. They are used predominately for persons with limited or diminished communication or cognitive ability.

6.5 Housing/Environment:

- Obtain details of the person's current living environment to record any issue / barrier that may hinder them returning or remaining in their home.
- Write NA if obvious the person is not able to be supported in their own home.

7. Nursing Physical Assessment

- Head to Toe: complete on all patient/client, please check all relevant boxes.
- Pain assessment, face pain scale: Use with cognitively impaired or persons with verbal limitations. Match person's facial expression with picture or the person can point to the picture.
- Braden Scale- ensure a score is put in each column and all columns added for the total score.

9. Sign off

- To be signed by the Registered Nurse who completes the assessment.

10. Level of Care Calculation

- The level of care with the most ticks is the level assigned to the person.
- Staffing levels provided are guidance based on best practice and a single level of care. Most care settings have multiple levels of care and each setting must account for this when determining the:
    - Appropriateness of client for admission
    - Required staffing levels
    - Developing person centered care plans

Personal Home Care Needs Calculation Guide

- Only to be used for persons returning to or remaining in their own home. This is only guidance each calculation must be particular to the specific care needs of the person.

Transfers:

- When transferring a person to a new care setting (e.g. ER, care home), complete this section on the copy of the assessment form sent to the new care setting. Ensure the original form kept at your location is also updated.