GOVERNMENT OF BERMUDA
Ministry of Health

LONG TERM CARE NEEDS ASSESSMENT FORM

1. ASSESSMENT DETAILS

Date of Assessment (DD/MMM/YYYY): ☐ Initial ☐ Reassessment	Care Setting: Contact Info: Phone:	Admit Date: E-Mail:
Source of Information: ☐ Patient ☐ Family ☐ Physician ☐ Medical notes ☐ Caregiver ☐ Nurse		

2. PATIENT INFORMATION

Name:		Date of Birth (DD/MMM/YYYY):	Gender: ☐ Female ☐ Male
Address (House name, #, Street name):		Insurance Number: Provider: ☐ HIP ☐ FC ☐ WV ☐ GEHI ☐ BF&M ☐ ARGUS ☐ COLONIAL ☐ OTHER ☐ NONE	
Parish:	Postal Code	Home Phone Number:	
Directions:		Cell Phone #:	
Alternate Contact/Responsible Party 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:			

3. 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

Patient Name:

4. GENERAL HEALTH STATUS

4.1. HEALTH SELF PERCEPTION

Overall, how would you rate your physical health?

☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ No Response

4.2. MEDICAL DIAGNOSIS OR CONDITIONS

Diagnosis: list primary diagnosis first/Current problems	Comments	Date of onset

4.3. MEDICATIONS

4.3.1. 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:

4.3.2. PRESCRIPTION MEDICATIONS

Prescription Medications	Dosage	Route	Frequency	Purpose
Indicate if the patient receives the following vaccination: ☐ A. Influenza Administered: ☐ B. Pneumococcal Administered:				

4.3.3. OTC MEDICATIONS OR HERBAL REMEDIES

OTC Medications or Herbal Remedies	Dosage	Route	Frequency	Purpose

4.4. RISK FACTORS

4.4.1. ER/HOSPITAL UTILIZATION

In the past year, has the patient gone to a hospital emergency room? ☐ Yes ☐ No Date of last visit: 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: If yes, how many times? Why?

4.4.2. 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:

4.5. 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			

4.6. 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.

4.7. 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, colours or shapes; eyes do not appear to follow objects.
Sensory Perception (e.g. – taste, smell, tactile, spatial)
☐ No impairment. ☐ Impaired – Specify:

4.8. 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

4.9. MEMORY

4.9.1. BRIEF INTERVIEW FOR MENTAL STATUS (BIMS) - Attempt to conduct interview with all patients

Repetition of Three Words

Ask patient: "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

Number of words repeated after first attempt:	Points
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 color; bed, a piece of furniture.* You may repeat the words up to two more times.

Temporal Orientation (orientation to year, month)

Ask patient: "Please tell me what year it is right now."

A. Able to report correct year

Number of words repeated after first attempt:	Points
Missed by more than 5 years or no answer	0 ☐
Missed by 2-5 years	1 ☐
Missed by less than 2 years	2 ☐
Correct	3 ☐

Ask patient: "What month are we in right now?"

B. Able to report correct month

Number of words repeated after first attempt:	Points
Missed by more than 1 month or no answer	0 ☐
Missed by 6 days to 1 month	1 ☐
Accurate within 5 days	2 ☐

Ask patient: "What day of the week is today?"

C. Able to report correct day of the week

Number of words repeated after first attempt:	Points
Incorrect or no answer	0 ☐
Correct	1 ☐

Recall

Ask patient: "Let's go back to an earlier question. What were those three words that I asked you to repeat?"
If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

A. Able to recall "sock"

Number of words repeated after first attempt:	Points
No – could not recall	0 ☐
Yes, after cueing ("something to wear")	1 ☐
Yes, no cue required	2 ☐

B. Able to recall "blue"

Number of words repeated after first attempt:	Points
No – could not recall	0 ☐
Yes, after cueing ("a color")	1 ☐
Yes, no cue required	2 ☐

C. Able to recall "bed"

Number of words repeated after first attempt:	Points
No – could not recall	0 ☐
Yes, after cueing ("a piece of furniture")	1 ☐
Yes, no cue required	2 ☐

BIMS SCORE (Total):

Interpretation of Score: 13-15 Points: cognitively intact. 9-12 points: moderately impaired. 0-7 points severely impaired.

4.9.2. 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
☐ E. None of the above were recalled
☐ F. Day of the week or date

4.9.3. COGNITIVE SKILLS FOR DAILY DECISION MAKING – Use nursing judgment on the patient's ability to make decisions regarding tasks of daily life.

☐ A. Independent – decisions consistent/reasonable
☐ B. Modified independence – some difficulty in new situations only
☐ C. Moderately impaired – decisions poor; cues/supervision required
☐ D. Correct Severely impaired – never/rarely made decisions

Patient Name:

4.10. MOOD

4.10.1. 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)

4.10.2. <u>PATIENT MOOD INTERVIEW</u>

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 =

4.11. BEHAVIOR – Indicate any behavioral symptoms or concerns observed or reported over the last 2 weeks.

4.11.1. 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

4.11.2. BEHAVIORAL SYMPTOM – PRESENCE & FREQUENCY

Scoring: Enter score in end box. 0 = Behavior not exhibited. 1 = Behavior of this type occurred 1 to 3 days. 2 = Behavior of this type occurred 4 to 6 days, but less than daily. Behavior 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).	
<u>Rejection of Care – Presence & Frequency</u> 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.	
<u>Wandering – Presence & Frequency</u> Has the patient wandered?	
Total Score (Part 1)	

Patient Name:

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 Behavioral Symptoms	
Were any behavioral 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)	

Behavioral Symptoms Guidance Score (add Part 1 and Part 2): TOTAL SCORE:

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

4.11.3. CHANGE IN BEHAVIOR OR OTHER SYMPTOMS – Consider all of the symptoms assessed above.

How does patient's current behavior status, care rejection, or wandering compare to prior assessment?	Score
Same	☐ 0
Improved	☐ 1
Worse	☐ 2
N/A because no prior assessment	☐ 3

Patient Name:

5. FUNCTIONAL ABILITIES

5.1. ACTIVITIES OF DAILY LIVING

Activity	Independent	Supervision or verbal Prompts/Cueing	Physical Assistance	Total Dependence
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.)				

5.2. 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):

5.3. 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:				

6. SOCIAL/RECREATIONAL PREFERENCES

6.1. LIFE HISTORY

Does patient have Life Book or This is Me book completed? ☐ Yes ☐ No

6.2. SOCIAL/RECREATIONAL

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

6.3. EDUCATION/OCCUPATION

Highest level of education completed:
Prior occupation or role:

6.4. LITERACY – Assessor: Is the patient able to:

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

6.5. HOUSING AND ENVIRONMENT

What is your current housing type?	
☐ Own Home (includes parent/guardian's home for children)	☐ Residential / Nursing Facility
☐ Friend/Relative Home	☐ Homeless
☐ Foster Care	☐ 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):

Is there someone who 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

7. NURSING PHYSICAL ASSESSMENT

7.1. GENERAL

Arrived by: ☐ Ambulatory ☐ Stretcher ☐ Wheelchair ☐ Other:	Height: feet inches Weight: ☐ kg ☐ lb.
T: P: R: BP:	O_{2sat}:

7.2. EENT

☐ No problem noted
☐ Impaired vision ☐ Impaired hearing ☐ Gums/teeth ☐ Redness ☐ Drainage ☐ Lesion
Comments:

7.3. 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: Left:		☐ Seizures	☐ Gag reflex diminished or absent	
Comments:				

7.4. 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:				

7.5. 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:					

7.6. GASTROINTESTINAL

☐ No problem noted					
☐ Hypo BS	☐ Distention	☐ Anorexia	☐ Dysphagia	☐ Incontinent	☐ Last BM:
☐ 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)
☐ 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:

7.7. GENITOURINARY & REPRODUCTIVE

☐ No problem noted					
☐ Dysuria	☐ Frequency	☐ Hesitancy/Spasm	☐ Distention	☐ Urostomy	☐ Color
☐ Anuria	☐ Incontinent	☐ Scrotal edema	☐ Menopausal	☐ Hematuria	☐ Odor
☐ Discharge	☐ Pregnancy	☐ LMP:	☐ Catheter (size, date of insertion):		
Comments:					

Patient Name:

7.8. PAIN ASSESSMENT

☐ Denies any pain

Pain Score: ☐ Numeric Scale (1 – 10) ☐ Face Scale (0 – 10) Pain Goal:

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:

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

Circle (note) Indicated Number Face

Scale:

7.9. 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

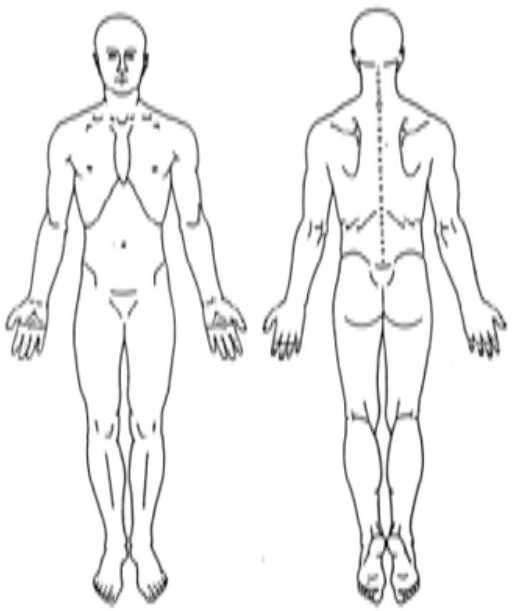
Comments:

Patient Name:

7.10. WOUND/INCISION ASSESSMENT

☐ None

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



7.11. 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:**		

7.12. 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

Patient Name:

8. 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)**		
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 daily a 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)**		

Patient Name:

9. GENERAL COMMENTS AND SIGN OFF

GENERAL COMMENTS, OBSERVATIONS AND RECOMMENDATIONS:

Date (DD/MMM/YYYY):

_____

Signature:

_____

Contact Information:

_____

Patient Name:

10. 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 behavioral conditions that post **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. Recommended Minimum Staffing: RN 24/7 on-site Average total nursing care hours 4 hrs/day/pt includes RN time of 1.6 hours/day/pt. MD on-site for assessment for admission, monthly for first 3 months and then quarterly as needed for change, transfers. MD on-call 24/7
○ **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 behavioral 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) Recommended Minimum Staffing: RN on site 24/7 Average total nursing care hours 2.5/day/pt. MD on-site assessment for admission, monthly for first 3 months and then quarterly, as needed for change, transfers. MD on-call 24/7
○ 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 (more 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:** Recommended Minimum Staffing: MD on site assessment for admission and then quarterly, or as needed for change, transfers MD on-call 24/7

Patient Name:

HEALTH INSURANCE DEPARTMENT
PERSONAL HOME CARE NEEDS CALCULATION GUIDE

Use the table below to assist in estimating the number of care hours a person staying in or returning to their own home may require to meet their care needs.

Care hour calculations should be adjusted for the following assumptions:

- Utilize community or charity services as first options, e. g. Meals on Wheels, Project Action, and community nursing for home health aide.
- Daycare, part time or full time, is most beneficial for mild to moderate dementia, depression, social isolation, decreased mobility due to fear of falling, night time agitation or difficulty sleeping (increased stimulation during the day often aids sleep at night).
- Family responsibility to provide some of care, minimum of 8 but up to 12 hours per day x 7 days/week.

1. Activity of Daily Living (ADLs) – if assistance prompting or supervision needed allow 1 hour per day	**Time Estimate**
* Mobility – Transfer self from chair to chair, chair to bed.	
* Mobility – Ambulation or moving self in wheelchair	
* Mobility –In bed	
Toileting	
Eating	
2. Risk factors that may require more care time	
If impairment with mobility* or dementia: Add more time if assistance needed for IADLs – changing bed linens, meal preparation, light cleaning, grocery shopping, and transport.	
If age more than 85 years, history of falls, or observed unsteadiness, then consider time to supervise bathing and ambulation.	
If unable to turn self in bed, consider adding time for positioning.	
If unable to communicate needs or call for help, consider additional time for personal safety.	
3. **Complex Health Needs** – specify additional time needed	
Tube feeding	
Ostomy or catheter care	
Wound dressing	
Range of motion exercises	
Respiratory suctioning, postural drainage and chest PT	
Seizures more than twice per week and requires physical assistance to maintain safety	
4. **Dementia Related Care** – adjust care calculation to consider risk factors below to provide 8 hours per day, 5 days per week. Additional hours require family support.	
Personal safety risk – due to wandering	
Impaired judgment putting self at risk (e.g. fire) or unable to seek help when alone	
Social/recreational activities	
Behaviors – resistance to care, excess anxiety or aggression	

Total estimated care hours per day _____

Date (DD/MMM/YYYY):

_____

Signature:

_____

Contact Information:

_____

Patient Name:

LONG TERM CARE NEEDS REASSESSMENT

Care Setting: ☐ No Change ☐ Change, specify location and admission date:

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	

Behavioral 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):

_____

Signature:

_____

Contact Information:

_____

Patient Name:

LONG TERM CARE NEEDS REASSESSMENT

Care Setting: ☐ No Change ☐ Change, specify location and admission date:

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	

Behavioral 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):

_____

Signature:

_____

Contact Information:

_____

Patient Name:

TRANSFER INFORMATION

Patient Details Name: Date of Birth:	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 of Transfer: (DD/MMM/YYYY):

Signature:

_____

_____

Contact Information:

_____