Client: _____ Date: _____

Nursing Assessment/Reassessment for Home Care Services

☒Initial Assessment ☐Reassessment- 60 day ☐Change in Client Condition

Reassessment, post-hospitalization (date): _____ Interruption in service, from (date): _____

Client Address: _____

Phone: _____ ☐Male ☐Female Age: _____ Date of Birth: _____

Existing Medical Diagnosis or Problems: _____

_____

Past Medical History: _____

_____

Primary MD: _____ Primary MD Phone: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Emergency Contact Relationship: _____

Family Member/Significant Other/Responsible Party

Name: _____ Phone: _____ Relationship: _____

Primary Caregiver: _____ Relationship: _____

Case Manager: _____ **Phone:** _____

Advance Directives: ☐Yes ☐No (See also Advance Directives Verification form)

Is the Advance Directive posted? ☐Yes ☐No If yes, location: _____

Does the client have a Medical Power of Attorney? ☐Yes ☐No If yes, location: _____

Emergency Preparedness Priority Level: I (PHC to contact within 24 hrs) II(contact 24-48 hrs) III(contact 48-72 hrs)

Emergency Plan (check one): ☐Remain in the home ☐Evacuate w help from family/friend ☐Evacuate w help from PHC ☐Call 911]

Emergency Preparedness info & education provided: ☐Yes ☐No Special Instructions given if any: _____

Special Needs: ☐N/A ☐Restricted Mobility ☐Uses life-saving equipment: _____ ☐Other special needs: _____

Functional Status

ADLs	Independent	Requires Assistance	Dependent	Comments
Bathing				
Dressing/Grooming				
Eating/Feeding				
Toileting				
Transferring				
Ambulation				
IADLs				
Use of phone				
Grocery Shopping				
Meal Prep				

Client: _____ Date: _____

Housekeeping				
Money Management				
Laundry				
Ability to take medication				
Transportation				
Manage Appointments				

Expected outcomes/goals for care services: _____

_____

Equipment/assistive used: ☐Walker ☐Cane ☐Quad Cane ☐Crutches ☐Wheelchair ☐Prothesis ☐Transfer Board ☐Commode

☐Hoyer Lift ☐Shower Seat ☐Raised Toilet Seat ☐Incontinent Pads ☐Trapeze Other _____ ☐None

Equipment/assistive devices needed: _____ ☐None

Instructions related to use of equipment: ☐Yes ☐No ☐N/A If yes, specify: _____

Medications (continue on back, if needed)	**Dose**	**Route**	**Frequency**

Who sets up medications: ☐Self ☐Family/Spouse ☐Rn/LPN Other: _____

Who administers medications: ☐Self ☐Family/Spouse ☐Rn/LPN Other: _____

Is there a mediset or pre-poured bill boxes in place in the home? ☐Yes ☐No If yes, who prepares? _____

Comments: _____

Allergies: NKA Medication: _____ Food: _____ Other: _____

Vital Signs: Temp: _____ Pulse: _____ Blood Pressure: _____ Height: _____ Weight: _____

Pain: ☐Yes, location: _____ ☐No

Level of Pain: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible)

Frequency: _____ Any treatments: _____

Effectiveness of treatments: _____

Systems Review

Skin ☐WNL ☐Pale ☐Ruddy ☐Cool ☐Warm ☐Moist ☐Dry ☐Pruritus ☐Rash ☐Bruises ☐Abrasions ☐Pressure areas

Describe any of above & location: _____

If decubitus, describe: _____

If breakdown or wounds, describe: _____

Comments: _____

Nutrition: ☐Adequate ☐Poor ☐Malnourished ☐Recent weight loss/gain: _____

Appetite: ☐Poor ☐Good ☐Recent changes in appetite ☐ Eats only certain foods: _____

Diet: ☐Regular ☐Special Dietary Requirements: _____

Fluids: ☐Encourage ☐Limit ☐Nectar thick ☐Thickened ☐Difficulty Chewing: Yes, explain _____ ☐No

Client: _____ Date: _____

Choking or swallowing risk: ☐Yes- list precautions: _____ ☐No
Comments: _____

GASTROINTESTINAL: WNL Nausea Vomiting Indigestion Heartburn Pain Jaundice
Bowel Function: WNL Constipation Diarrhea Incontinence Bleeding Uses adult diapers
Ostomy: _____ Lax dependent Pattern: Daily Other: _____
Teeth: No Problems Missing Teeth Dentures: Upper/Lower/Partial Poor teeth/gums
Comments: _____

CARDIOVASCULAR: WNL Tachycardia Bradycardia Palpitations Arrhythmia Syncope Chest pain: _____
Pacemaker Defibrillator Color- grey/dusky/cyanotic/mottled Edema- location/degree:_____
Comments: _____

ENDOCRINE: Malaise Sweats Hair Loss Hot/Cold Tolerance Diabetes Onset: _____ Blood Sugar Range: _____
Treatment: Insulin Sliding Scale Freq. Oral Meds Diets

RESPIRATORY: WNL SOB on exertion SOB at rest Cough: dry/productive Sputum Wheezing Orthopnea Oxygen
If yes, liters/minute: _____
Comments: _____

GENITOURINARY: WNL Pain Frequency Urgency Burning Nocturia Dribbling Retention Incontinence Uses Adult Diapers Hx UTI Urinal Catheter: _____
Comments: _____

MUSCULOSKELETAL: WNL Stiffness Joint pain Swollen joints Weakness Limited ROM Deformities Paralysis
Amputation:_____ Gait: Steady Unsteady Gait Problems Distance: Less than 10' More than 10'
Comments: _____

NEUROLOGICAL: WNL Dizziness Headaches Numbness Tremors Seizures Neuralgia Neuropathy Cognitive Impairment Dementia
Comments: _____

VISION: WNL Impaired Bling Cataracts Glaucoma Eye Glasses
HEARING: WNL Impaired Deaf Tinnitus Hearing Aid: Right Left Both
SPEECH: WNL Inarticulate Speech Aphasia: Receptive Expressive
Comments: _____

MENTAL STATE/BEHAVIOR: WNL Confused Forgetful Agitated Anxious Depressed Withdrawn Uncooperative Wandering
Behavior Problems Oriented _____ Disoriented Reasoning: _____ Judgment: _____ Memory:_____
Comments: _____

SLEEP ISSUES: No Yes: _____
LIVE-IN: Not applicable Live-in care needed (Care Manager to follow up for specific considerations)

PYSCHOLOGICAL REVIEW RELEVANT TO PLAN OF CARE:
Involvement with social and community activities: _____
Primary language: _____ Communication Barriers: Yes _____ No
Cultural/religious beliefs: _____
Family issues relevant to care? Yes _____ No
Financial Resource review: See intake form
Any other services in place: Yes_____ No Visiting Nurse Hospice
Other_____ Phone: _____ Additional Services Needed:_____

Client: _____ Date: _____

Home Health Aid Skills Checklist

Home Health Aid Name: _____

D= Direct Observation and/or Demonstration
O= Oral Questions and answer
(circle the appropriate method below)

Skills	Supervisor Assessment Method	Supervisor		Evaluation- Supervisor initials & Dates
Communication	D or O	☐Met	☐ Not Met	
Observation, reporting and documentation of patient status and the care of services provided	D or O	☐Met	☐ Not Met	
Reading and recording temperature, pulse and respiration	D or O	☐Met	☐ Not Met	
Universal Precautions	D or O	☐Met	☐ Not Met	
Basic elements of body functions and changes in condition that must be reported	D or O	☐Met	☐ Not Met	
Maintaining a clean, safe and healthy environment	D or O	☐Met	☐ Not Met	
Ability to recognize emergency situations	D or O	☐Met	☐ Not Met	
Ability to recognize physical & emotional needs & work with the client & respect their privacy & property	D or O	☐Met	☐ Not Met	
Appropriate & safe techniques in personal hygiene & grooming	D or O	☐Met	☐ Not Met	
Bed Bath	D or O	☐Met	☐ Not Met	
Sponge Bath	D or O	☐Met	☐ Not Met	
Shampoo (skin tub or bed)	D or O	☐Met	☐ Not Met	
Nail Care	D or O	☐Met	☐ Not Met	
Skin Care	D or O	☐Met	☐ Not Met	
Oral Hygiene	D or O	☐Met	☐ Not Met	
Toileting & Elimination	D or O	☐Met	☐ Not Met	
Safe transfer techniques	D or O	☐Met	☐ Not Met	
Safe Ambulation	D or O	☐Met	☐ Not Met	
Normal positioning with proper body alignment	D or O	☐Met	☐ Not Met	
Ability to recognize adequate nutrition & intake	D or O	☐Met	☐ Not Met	
Other:	D or O	☐Met	☐ Not Met	

Home Health Aid Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Client: _____ Date: _____

Fall Risk Assessment

Assess one point for each core element "yes" Score based on your clinical judgment. Info may be gathered from medical records, assessment and/or client/caregiver	**Points**
Age 65+	
Diagnosis (3 or more co-existing)- includes only documented medical diagnosis	
Prior history of falls within 3 months	
Incontinence- including frequency, urgency and/or nocturia	
Visual impairment	
Impaired functional mobility- clients who need help with IADLS or ADLS or have gait pr transfer problems, arthritis, pain, fear of falling, foot problems, impaired sensation, impaired coordination, improper use of assistive devices	
Environmental hazards- for example, poor illumination, equipment tubing, inappropriate footwear, pets, hard-to-reach items, floor surfaces that are uneven or cluttered, or outdoor entry and exits. See Home Safety Checklist.	
Poly Pharmacy (4 or more prescriptions/OTC meds- any type)	
Pain affecting level of function- for example, pain causing decreased desire or ability to move	
Cognitive impairment	
A score of 4 or more is considered a risk for falling **Total**	

Home Safety Review- See Home Safety Checklist

Client Education Provided:
Home Safety: Yes No If yes, specify: _____
Infection control: Yes No If yes, specify: _____
Disease management as appropriate to plan of care: N/A Yes No If yes, specify: _____
Other instructions given: _____

Plan of Care- Reassessments Only
Plan of care reviewed? ☐Yes ☐No Any changes in the client's condition? ☐Yes ☐No
Progress toward expected care outcomes/goals? ☐Yes ☐No If no, explain: _____
Care/services provided still needed? ☐Yes ☐No
Is the client satisfied with the care/service provided? ☐Yes ☐No If no, explain: _____
Plan of care reviewed with client/significant other? ☐Yes ☐No
Plan of care changes needed, if any: _____

Name of CHHA present: _____ License Status: _____
Plan of care reviewed with CHHA: ☐Yes ☐No
Instructions given: _____
CHHA supervised: ☐Yes ☐No Skill(s) observed at the time of the home visit (check only those that apply):
☐Handwashing ☐ bath, specify:_____ ☐ shampoo, specify: _____ ☐ skin care ☐ nail care ☐ grooming
☐ oral hygiene ☐ hygiene related to toileting ☐ ambulation assistance ☐ transfers ☐ Hoyer lift ☐ positioning
☐ ROM exercises ☐ temp/pulse/respiration ☐ feeding ☐ meal prep ☐ light housekeeping

Comments:

Recommendations and Follow-Ups:

RN Signature/Title: _____ Date: _____

Client: _____ Date: _____

Client- Last, First, MI: _____ Sex: _____ Date of first visit:_____
Caregiver: _____ Days: _____ Hours: _____
Birthdate: _____ Diagnosis: _____
Address: _____ Phone: _____
Temperature: _____ Blood Pressure: _____ Pulse: _____ Respirations: _____
Weight: _____ Height: _____

Bathing	Total Support	Assist	Self-Care	Frequency	Activity	Total Support	Assist	Self-Care	Frequency
Tub Shower	☐	☐	☐		Ambulation	☐	☐	☐	
Bed Bath	☐	☐	☐		Walker/ Wheelchair	☐	☐	☐	
Assist Bath	☐	☐	☐		Transfers	☐	☐	☐	
Shampoo	☐	☐	☐		Toileting	☐	☐	☐	
Comb Hair	☐	☐	☐		Exercise per PT	☐	☐	☐	
Oral Care	☐	☐	☐		Meals				
Electric Shave	☐	☐	☐		Prepare	☐	☐	☐	
Dressing	☐	☐	☐		Feed	☐	☐	☐	
Moisturizing	☐	☐	☐		Cleaning up	☐	☐	☐	
Elimination					Special Diet	☐	☐	☐	
Incontinence Care	☐	☐	☐		Housekeeping				
Empty Cath Bag	☐	☐	☐		Change Linens	☐	☐	☐	
Comments:					Make Bed	☐	☐	☐	
					Straighten Room	☐	☐	☐	
					Laundry	☐	☐	☐	

Patient Information

☐DNR ☐Partial Weight Bearing ☐ L ☐ R ☐ Dentures ☐ Oriented ☐ Bleeding ☐ Lives Alone
☐ Non-Weight Bearing ☐ Hearing Deficit ☐ Confused ☐ Pain Meds ☐ Lives w/ other ☐ Hip Precautions
☐ Speech Deficit ☐ Wanderer ☐ Allergies: _____
☐ Bed Bound ☐ Prothesis ☐ Vision Deficit ☐ Diabetic ☐ Fall Risk ☐ Amputee, Specific: _____ ☐ Seizure
☐ Prone to fracture: _____ ☐ Special Equipment: _____ ☐ Open Wounds: _____
☐ Call 911 for emergencies ☐ Call Hospice for emergencies.

Safety Notes:

Expected client outcome/short & long-term goals/goals for discharge:

Changes to report to Platinum Nurse:

Review Date/RN Signature: _____ Review Date/Caregiver Signature: _____
Review Date/RN Signature: _____ Review Date/Caregiver Signature: _____
RN Signature: _____ Date: _____
Client Signature: _____ Date: _____
Caregiver Signature: _____ Date: _____

Client: _____ Date: _____

Home Safety Checklist

Room/Question	Yes	No	Do Not Know	N/A
Living Room & Family Room				
Can you walk in a dark room?				
Are lamp, extension, or phone cords out of the foot traffic?				
Are passageways in this room free from objects and clutter?				
Are curtains and furniture at least 12 in from baseboard or portable heaters?				
Do your carpets lie flat?				
Do small rugs and runners stay put (don't slide or roll up) when you push them w/ your foot?				
Kitchen				
Are your stove controls easy to see?				
Do you keep loose-fitting clothes towels and curtains that match fire away from burners and ovens?				
Can you reach regularly used items without climbing to reach them?				
Do you have a step stool that is sturdy and in good repair				
Bedrooms				
Do you have working smoke detectors on the ceiling outside bedroom doors?				
Can you turn on a light without having to walk in a dark room?				
Do you have a lamp or light switch with an easy reach of your bed?				
Is a phone with an easy reach of your bed?				
Is a light left on at night between your bed and the toilet?				
Are the curtains and furniture at least 12 inches from baseboard heater or portable heater?				
Bathrooms				
Does your shower or tub have a nonskid surface: mat, decals or abrasive strips?				
Does your tub slash shower have a sturdy grab bar? (not just a towel rack)				
Is your hot water temperature set to 120 degrees or lower?				
Does your floor have non slip surface or does the rug have a non skid backing?				
Are you able to get on and off the toilet easily?				
Stairways				
Is there a light switch at both the top and bottom of inside stairs?				
With the light on, can you clearly see the outline in each steps as you go down the stairs?				
Do all stairwells have sturdy handrails on both sides?				
Do handrails run the full length of the stairs, slightly beyond the steps?				
Are all the steps in good repair (not loose, broken, missing or worn in places)?				
Are stair coverings (rugs, threads) in good repair, without holes, loose, torn, or worn?				
Hallways and Passageways				
Do small rugs and runners stay put (don't slide or roll up) when you push them w/ your foot?				
Do your carpets lay flat?				
Are all lamp, ext, and phone cords out of the flow of foot traffic?				
Front and back entrances				
Do all entrances to your home have outside lights?				
Are walkways to your entry free from cracks or holes?				
Throughout your house				
Do you have an emergency exit plan in case of a fire?				
Do you have emergency phone numbers listed on your phone?				
Are there other hazards or unsafe areas in your home not mentioned in this checklist that you are concerned about? If so, what?				
Making your home safer: what home safety changes do you want to make?				
1.				
2.				
3.				

Client: _____ Date: _____

Home Health Aid Skills Checklist

Home Health Aide Name: _____

D= Direct Observation and/or demonstration
O= Oral Question & Answer
Check the appropriate method below:

Skills	Supervisor Assessment Method	Supervisor		Evaluation- Supervisor initials & Dates
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Other:	D or O	☐Met	☐ Not Met	

Home Health Aid Signature: _____ Date:_____
Supervisor Signature: _____ Date:_____

Client: _____ Date: _____

CLOSE YOUR EYES.

Write a Sentence below.

_____

Copy the diagram below.