

CONSUMER PLACEMENT AND TRANSFER

AGENCY RN ASSESSMENT AND HEALTH PLAN

Health Management / Health History Section

Name:	General Health Status:	Surgical History:
Age:	Allergies: Type of reaction	

Previous care setting / level of care: natural home, RCF, SNF, hospital, other

Diagnosis:

1)	5)	9)
2)	6)	10)
3)	7)	11)
4)	8)	12)

Current Medication/Treatment /Equipment Orders

#	Name	Dosage	Frequency	Reason
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				
11)				
12)				
13)				
14)				
15)				

The Agency RN is to review the Personal Safety Assessment Tool, the Functional Assessment Areas Form (in order to arrange for necessary supports) and the Provider Training Record (identifies specialized staff training for individual support needs) prior to completing the plan sections of this form. All yes answers require plan review.

Health Management	Y	N		Comments
1) Alcohol use				
2) Tobacco use				
3) Recreational drug use				
4) Noncompliant with prescribed medications and treatment				
5) Needs adult immunizations / other risk factor for disease				
Health History	Y	N		
Please list name and telephone number of the treating consultant /specialist under comment section				
6) Cancer				
7) Respiratory problems				
A: Pneumonia (list if pneumovax was received and date)				
B: Tuberculosis (list if known reactor or date of last test)				
8) Heart/Cardiac disease				
9) Renal / Kidney disease				
10) High blood pressure /Hypertension/Stroke				
11)Diabetes				
12)Gastrointestinal disorders				
13) Bleeding				
14) Hepatitis (list dates of injections or last screen completed for consumer)				
15) Glaucoma / Cataracts				

16) Seizures				
17) Mental Illness /Depression/Mental Disorder Disease				
18) Medications				
RN Review	Y	N		Comments
Does the health history place the consumer at high risk for infection, injury or non-compliance				
Are additional measures necessary to ensure safety				
Nursing Plan : Susceptibility to Hazard				
Cognitive Sensory Perception Please list date of last known exam and the physician under comments Please list glasses and other aids or adaptive equipment under comments				Y= impaired N= no problem
Hearing				
Vision				
Taste				
Smell				
Communication (list primary language if other than English)				
Touch				
Other				
RN Review Is additional staff training required to ensure staff are knowledgeable of techniques as related to impaired verbal communication or sensory alteration				
Nursing Plan: Communication/Sensory / Perception				
Behavior /Coping/Stress / Self Concept	Y	N		Y= presence N = absence
List level/ frequency and how it is currently managed / treated				
Pain / Discomfort				
Anxiety / Agitation				
Fear				
Confusion / Dementia				
Verbal aggression				
Physical aggression / Combative				
Self abusive / Injurious				
Hopelessness / Powerlessness				
Depression				
Body image disturbance				
Withdrawn				
Uncooperative				
Difficulty sleeping / not rested after sleep				
Sexually inappropriate				
Other				
RN Review				
See the psychotropic monitoring form for additional quality assurance measures for use of antipsychotic / psychotropic medications				
Is a psychiatric consult for evaluation indicated				

Are the services of a Behavioral Specialist indicated to develop a behavioral support plan				
Is a sleep study indicated				
Is staff training indicated for interventions, necessary precautions, monitoring, signs and symptoms of potential complications, reportable conditions and emergency procedures				
Is staff training indicated for psychotropic medications/restraint procedures / use of a CPAP / other				
Nursing Plan: Psychosocial				
Sexual / Reproduction	Y	N		Date of last exam
Females / post menopausal (if no, record date of last menstrual period)				
Birth control used				
Absence of record of Mammogram / Inflammatory Breast Cancer Screen				
Absence of record of Pap test/pelvic examination				
Absence / PSA / prostate examination as indicated by age and sex				
Unsafe sexual practices / Need for information				
Inappropriate sexual behaviors / risk to staff or peers				
AIDS/ HIV / STD				
Nursing Plan: Sexual				
Nutrition / Metabolic	Y	N		Record under comments
Record current height and weight				
Score / results of the Braden scale indicates risk (see Braden form)				
History of Diabetes and / or Thyroid condition				
Record the method and frequency of blood sugar monitoring Date and reading of last blood sugar if indicated				
Oral mucosa: dry/lesions/other abnormal finding				
Recent weight changes (amount and time) 5% in 30 days and/or 10% in 180 days must be addressed				
Pica / Choking precautions/ risk for aspiration				
Special diet order (specify)				
Fluid restrictions / refuses fluids/ excess fluids (note in comments)				
History of abnormal lab results (note H&H and serum albumin)				
History of anemia / vitamin deficiency / nutritional deficit				
Frequent refusal of meals or leaves 50% or more of meals uneaten				
Uses adaptive equipment at meal time (list)				
Special positioning precautions during or after meals				
Tube Feeding (include orders)				
Non healing skin lesions				
Recent experience with fever or chills / past dehydration/ dry skin				
RN Review				
Need for additional information or physician's orders for diet and/or interventions related to the consumer needs				
Is staff training indicated for the tasks and techniques specific to care				
Are there health care concerns related to nutrition, fluid volume, risk for aspiration and / or impaired skin integrity				
Nursing Plan: Nutrition / Metabolic				

Elimination	Y	N		Record under comments
Bladder: urgency, retention, frequency, dribbling, frequent UTI, incontinence, dribbling, catheter, hematuria, other				
Bowel : no problem, constipation, diarrhea, incontinence, hemorrhoids, blood in stool, colostomy, other				
Bowel Medications / Treatments and frequency of use (see next line)				
laxatives, enemas, digital removal of impaction				
Date of last bowel movement				
Dialysis				
Other				
RN Review				
Is there an alteration in urinary and/or bowel elimination that requires additional staff training in the tasks and/ or techniques specific to consumer and care				
Nursing Plan: Bowel and Bladder Elimination				
Activity / Functional	Y	N		Comments
Mobility status : assist with ambulation , non weight bearing				
Assistive devices : cane, walker, crutches, wheelchair, other				
Does adaptive equipment /assistive device require repair				
Limitations : weakness, fatigue, short of breath, dizzy, fainting, pain, cough, other on exertion or activity				
The Hendrich II scale for fall risk assessment should be completed if RN answered yes to an above question				
Activities of daily living				Y = staff complete or assist N = consumer is independent
Eating				
Toileting				
Grooming				
Dressing				
Bath / Shower				
Housework/cooking				
RN Review				
Do the following care concerns exist: impaired mobility, fall risk, self care needs, activity intolerance, ineffective breathing pattern, decreased cardiac output, altered tissue circulation, impaired home maintenance mgmt. or other				
Is an evaluation / consultation with therapy indicated				
Is additional staff training required for safety				
Nursing Plan:				
Signature:				
Date completed:				
Date copied to QMRP:				
CC:				