

Electronic Resident Assessment Instructional Guide

**State of Vermont
Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306**

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RESIDENT ASSESSMENT

The Resident Assessment (RA) is a uniform process for gathering information that describes the residents living in Residential, Therapeutic, and Assisted Living Care Homes. The resident assessment has been updated by a collaborative effort of a workgroup that was comprised of the owners and staff of Residential Care, Therapeutic Care and Assisted Living Homes throughout Vermont and staff from the Department of Disabilities, Aging and Independent Living. The common goal was to review and update the assessment tool to ensure it would gather, record, and reflect the best information possible about the residents who reside in any of Vermont's licensed homes. The format of the assessment has also changed. Many facilities have updated their technology and manage much of their facility by computer. Facilities requested an electronic assessment that would reduce redundant paperwork and save time. The new electronic assessment is now available in a hard copy paper version, a WORD locked template for completing on the computer as a WORD document or in an electronic if your facility has a computer software database. The ILA assessment used by Community Providers is now also in the electronic format. The ILA and Resident Assessment ask the same questions, the same way, for 95% of the information gathered. There are a few questions on the resident assessment that are specific to gather information related to the residential client, and specific questions on the ILA that address the special needs for the home based client.

A standard assessment across provider types will provide:

- A uniform process for gathering information that describes the client.
- A tool that promotes consistent rating scales among providers.
- A tool that provides a common language for the ready exchange of information across providers.

Questions and Answers about the assessment process:

HOW IS THE ASSESSMENT HELPFUL?

- Provides the same type of complete information about each of the client's in your home.
- Presents a picture of the client's strengths, needs, and preferences.
- Targets what a client needs for care and help.
- Assists all to focus on what the client can do.
- Provides information on which to base your decisions and plans.
- Establishes a knowledge base which provides the staff and client the ability to work together for common, shared goals.
- Provides an information link.

Information allows you to make decisions and plans that assist the client and the staff to achieve goals, to place the focus on constant improvement, and a better quality of life.

HOW DOES THE ASSESSMENT PROCESS WORK?

An assessment must be completed on each client in all Residential Care Homes and Assisted Living Facilities and is currently optional for Therapeutic Care Homes.

The new electronic assessment form was implemented for use of facilities as of January 2009 in one of the three formats. It is expected to be used when a new client is admitted to a facility or as clients that already reside in the facility are due for annual re-assessments or have a significant change. As of January 2010, all clients will be assessed using the new form. The manager of the home is responsible for having the appropriate individuals complete the Resident Assessment. In some facilities, the manager or designated staff will complete the Resident Assessment, in others the nurse may be responsible for completion, or the nurse and manager will work together to complete an accurate Resident Assessment. All individuals who are involved with the resident's assessment must sign and date the assessment, indicating which portions they completed.

WHY DO WE GATHER, MEASURE, EVALUATE, AND RECORD?

Once you have good information about a client's needs, you can make sound decisions that will benefit each client who lives in your home. You will be better able to judge and understand clients who are arriving or leaving your home. A uniform Resident Assessment system will be an **information link** with other members of the health care team.

HOW DO YOU GATHER THE NEEDED INFORMATION?

You will need to gather information from different sources. Your role is to gather all the information prior to the client's admission or readmission. The next step is to determine the accuracy of this information. This will be done through observation, interviewing, interacting with the resident and family members, and reviewing medical information from prior facilities.

❖ Review the resident's records

Focus on the past 1-3 months. For new admissions, review records from the hospital, other care homes, physician reports, or any other records that the family or resident shares with you. For the annual re-assessment, focus on the specific time frames specified in the assessment. Review staff notes, medication records, accident/illness experiences, physician's progress notes, physician orders, or care plans (if available).

- **Talk with and observe the client.**
- **Talk with your staff from all shifts.**
- **Talk with professionals who have been recently involved with the resident, i.e., nurses, social workers, counselors, case managers.**
- **Talk with the client's physician.**
- **Talk with the client's family.**

IS THERE A BEST WAY TO PROCEED?

Review the assessment and get comfortable with the questions on the form before you start the interviewing/observation process. Note that the assessment is divided into different sections. Review and identify who is the appropriate person to complete each section before starting. Instructions are provided in the various sections that will help direct the time frame to be used in the process, and whether to use a check or number code for the answer.

WHEN DOES AN ASSESSMENT NEED TO BE DONE?

A resident assessment must be completed for each client upon **admission, annually,** and with a **significant change. The Demographic Information Section (A.0, A.1.) and Medication Section (L.1) are the two sections that must be completed on the day of admission.** You have up to fourteen days from the date of admission to complete the remainder of the assessment. Some facilities use the RA to see if potential admissions are appropriate. These facilities may require the assessment be as complete as possible. If a resident goes to the hospital and returns, **it is not** necessary to complete a re-assessment unless the client has experienced a status change. However, you should record the hospitalization in **Section A.1.**

WHAT IS A SIGNIFICANT CHANGE?

Clients will have good and bad days. Although conditions may fluctuate, these changes do not affect a client's status. For these clients, an assessment is required on an annual basis. Clients may experience what is called a significant change. A significant change may be a decline or an improvement in the resident's health status that is believed to be ongoing (see definition below). If a client experiences a significant change, a new assessment is required and must be completed in 14 days. It is the responsibility of the manager and nurse to monitor changes in client's condition. These changes must be documented in the client's record.

If a client is experiencing a short term illness that affects their physical abilities, behavior, or mood and the changes are expected to only last two or three weeks, then a significant change assessment is not required. A short term illness, or expected short term cognitive changes, should be documented. You should document what changes are being seen, who was consulted about them, any evaluations performed, and state that the changes are expected to be short in duration. Examples would be changes that may be seen with a UTI or cognitive changes seen after a new medication was started. If after three or four weeks the resident does not appear to be returning to baseline, then a significant change assessment should be completed.

GUIDELINES FOR SIGNIFICANT CHANGE

- Deterioration in two or more activities of daily living (ADL) For example, decreased ability to walk and toilet.
- Loss (or return of) ability to walk freely or use one's hands to grasp small objects (such as a spoon, toothbrush, or comb). Major and significant changes in these areas require close attention and follow up.
- Deterioration in behavior or mood to the point where daily problems arise, or a relationship has become problematic. If changes in psychological status are deemed by mental health professionals as likely to improve without any special intervention, or if the resident is responding to treatment, reassessment is not necessary.
- Unplanned weight loss (5% in 30 days, 10% in 180 days.)
- Life threatening event (stroke, heart attack, metastatic cancer, etc.)
- Development of a pressure ulcer.
- Prolonged state of mental confusion or decline in mental alertness.
- A new diagnosis which is likely to effect the resident's well-being.
- Improved behavior, mood, or functional status to the extent that the established assessment no longer matches the resident.

WHAT ABOUT CHANGING ERRORS ON THE ASSESSMENT FORM?

Factual errors may be corrected whenever noted. If a change is made on an electronic form, it should be saved with a name reflecting the date of change (i.e., *Doe_RA_03.24.09*). If using only the hard copy you can alter the demographic information as changes occur. Minor changes in the resident's condition can be noted on the hard copy. All changes should be dated. **Significant changes** require that a new assessment be completed. It is not acceptable with a significant change, to use the existing hard copy assessment and to cross off the previous ADL coding and re-code with the updated ADL level on the side of the form.

WHERE IS THE ASSESSMENT EXPECTED TO BE KEPT?

The assessment is part of the client's record and must be stored with the rest of the client's current records. The initial assessment from admission and the most recent assessment should be kept in the resident's active file. Other assessments should be kept, and made accessible if required. If using the electronic assessment, print a current hard copy for the chart and store a copy in the electronic file so it will be easy to update when the next assessment is due.

SUGGESTIONS AND HELPFUL HINTS FOR INTERVIEWING THE CLIENT

Guidance for Interviewing Resident

For best results, choose a comfortable environment. Inform the client that you need to gather some information about his/her needs, medical background, and special interests or wishes. Share with the resident that you hope to gain an understanding of what is important and necessary for this new living arrangement to be successful. Let the resident know that you may jot down a note but mostly you will be talking with each other. If a friend or family member is present, ask if the client is comfortable having this discussion with that person there. Though it may be necessary to ask questions of the following type, ask only as many as required until the client volunteers the information needed to complete this section. Prompt(s) may be highly individualized.

- ❖ You might ask the client: "Tell me, how you would spend a typical day before coming here." "What were some of the things you liked to do?" Listen for specific information about sleep patterns, eating patterns, preferences for timing of baths or showers, and social and involvement activities. Realize that a resident who has been in a facility for many years prior to coming to your home may no longer be able to describe this period.
- ❖ Prompts for additional items: If resident has difficulty responding to an item, say that you are going to ask some questions that will help you know how the usual day was spent, and how certain things were done. It may be necessary to ask a number of open-ended questions to obtain necessary information. Prompts should be highly individualized.
- ❖ Walk the resident through the typical day. Focus on usual habits, involvement with others, and activities. Phase the questions in the past tense. Periodically remind resident that you are interested in her/his routine before admission. For example:
 - After you retired from your job, did you get up at the same time every morning?
 - What time did you usually get up in the morning?
 - What was the first thing you did after you woke up?
 - What time did you usually have breakfast? What foods did you like then?
 - What happened after breakfast? (Probe for naps, regular post breakfast activity – reading the paper, taking a walk.)
 - When did you have lunch? Was it usually a big meal or just a snack?
 - What did you do after lunch? Did you take a short rest? Did you often go out or have friends in to visit?
 - What time did you usually bathe? Did you usually take a shower, tub, or sponge bath? How often did you bathe?
 - What time did you usually go to bed? Did you usually wake up during the night?

ASSESSMENT SECTION INSTRUCTIONS

The following pages include specific instructions for completing the electronic Resident Assessment. Although the instructions cannot address all possible variations or examples that you may encounter in the different sections, the instructions will provide you with guidance. There are also examples to help with the physical function section. If you are unsure of how to best proceed in any section, either because the instructions are unclear or you are unsure where your resident fits, please contact the Division of Licensing and Protection at 802-241-2345.

Section A.0. Individual Identification

- 1a. Enter Client's first name
- 1b. Enter Client's last name
2. Enter Name of Facility
3. Enter date of most recent admission
4. Check type of Assessment being done.

Admission assessment: is done within 14 days of the initial admission or on a re-admission.

Significant change assessment: is done if there is a decline or an improvement in the client's health status. This is not a temporary status change but one that has lasted longer than 3 weeks and the client is not expected to return to previous baseline.

Reassessment or Annual: Is the assessment that is required to be done on a yearly basis.

Other Assessment: This is an assessment that is done for another reason. *Example:* Choices for Care nurse or DLP has asked for a reassessment due to conflicting assessment data. If you check *other* for assessment type, enter why assessment was done.

5. Enter Assessment Reference date. **The Assessment Reference date** establishes a common reference point for all staff participating in the assessment and designates the end of the 14 day observation period. The observation period begins on the day of admission and ends on the Assessment Reference date, which is the 14th day after admission.

Section A.1. Demographic Information

This section is one of the two sections that must be completed on the day of admission.

1. Enter Client's gender
2. Enter Client's Date of Birth
3. Enter Client's Social Security number
- 3a. Enter 12 digit unique identifier number for client. The unique identifier is made by using the client's date of birth plus the last 4 digits of Social Security number. *Example:* Date of Birth 12-12-1964 and SS# 006-52-2366 unique identifier would be 121219642366
4. Enter Medicare number (if applicable)
- 4a. Enter Medicaid number (if applicable)
5. Enter private insurance company (if applicable)
6. Enter name of primary medical care provider
- 7a. Enter name of secondary medical care provider (if applicable). This could be any physician/medical provider that client uses and facility would like listed for easy contact

- 7b.** Enter name of any other medical care provider (if applicable). This could be a podiatrist, cardiologist, or any other physician/medical provider that client uses and facility would like listed for easy contact.
- 8.** Enter client's primary language spoken.
- 9.** Enter the secondary language that the client speaks (if applicable).
- 10.** Check client's current marital status.
- 10a.** Enter name of client's spouse/partner (if applicable).
- 10b.** Enter emergency contact phone number for client's spouse/partner (if applicable).
- 11.** Check type of residence the client lived in prior to admission. "House" can be their own home or the home or apartment where they lived with a family member or another adult.
- 12.** Check if client came to facility directly the hospital or other location.
- 13a.** Enter name of client's emergency **contact 1**
- 13b.** Enter emergency contact's relationship to client
- 13c.** Enter the street address of emergency contact 1
- 13d.** Enter town/city of emergency contact 1
- 13e.** Enter state of emergency contact 1
- 13f.** Enter zip code of emergency contact 1
- 13g.** Enter home number of emergency contact 1 (if applicable)
- 13h.** Enter cell number of emergency contact 1(if applicable)
- 13i.** Enter work number of emergency contact 1 (if applicable)
- 14a.** Name of client's emergency **contact 2**
- 14b.** Enter the emergency contact's relationship to client
- 14c.** Enter the street address of emergency contact 2
- 14d.** Enter the town/city of emergency contact 2
- 14e.** Enter state of emergency contact 2
- 14f.** Enter zip code of emergency contact 2
- 14g.** Enter the home number of emergency contact 2 (if applicable)
- 14h.** Enter the cell number of emergency contact 2 (if applicable)
- 14i.** Enter work number of emergency contact 2 (if applicable)
- 15a.** Check Yes or No if client has legal guardian
- 15b.** If yes above, name of legal guardian
- 15c.** Home number of guardian if applicable
- 15d.** Work number of guardian if applicable
- 16a.** Check yes or no if client has power of attorney
- 16b.** If yes above, name of power of attorney
- 16c.** Home number of power of attorney if applicable
- 16d.** Work number of power of attorney if applicable
- 17a.** Check yes or no if client has representative payee
- 17b.** If yes above, name of representative payee
- 17c.** Home number of representative payee if applicable
- 17d.** Work number of representative payee if applicable

- 18a. Check yes or no if client has DPOA for health care
- 18b. If yes above, name of DPOA
- 18c. Home number of DPOA if applicable
- 18d. Work number of DPOA if applicable
- 19a. Check yes or no if client is receiving case management services
- 19b. If yes above, name of current case manager
- 19c. Phone number of case management agency if applicable
- 20a. Check yes or no if client has advanced directives
- 20b. If yes to advance directives, check all directives that have supported documentation.
- 20c. Check yes or no if client has a prepaid funeral/burial fund
- 21. List all client allergies, if none enter N/A
- 22. Enter the client's most recent occupation (if applicable)
- 23. Enter client's religious affiliation (if applicable)
- 24. Check total times client has stayed overnight in the hospital in last year
- 25a. If client has been hospitalized in past year, what was the date of the first admission.
- 25b. Enter the discharge date from first admission.
- 26a. If client had second admission to hospital in last year, enter that admission date.
- 26b. Enter the discharge date of second admission.

Section B.1. Customary Routine

Select all that apply regarding the client's normal routine. These items provide information on the resident's usual community or previous facility lifestyle and daily routine in the year prior to their date of entry. The information gathered here will be useful individualizing a plan of care.

Section C.1. Cognitive Patterns

Cognition is how a person thinks (judgment), remembers, and makes decisions about their daily lives. Cognition is one of the hardest areas to assess. Consider that many things impact on a resident's cognition; new settings, medications, time of day, infections. Conversing with the resident and listening to their response will give you clues on how they think (judgment), and if they understand their strengths and weaknesses.

Keep in mind that questions about cognitive function and memory can be sensitive issues for some residents. Some residents may become defensive, agitated, or very emotional which is a common reaction to performance anxiety. Asking about these issues in a private area and using a nonjudgmental approach will help develop a needed sense of trust between staff and the resident.

- ✓ Interview in a private, quiet area without distractions.
- ✓ Engage the resident in general conversation.
- ✓ Actively listen and observe for clues to help complete your assessment.
- ✓ Be open, supportive, and reassuring during your conversation with the resident (e.g., Do you sometimes have trouble remembering things? Tell me what happens...we understand and will try to help you.

Repetitiveness, inattention, rambling, speech, defensiveness, or agitation may be challenging to deal with during an interview but does provide important information about the resident's cognitive function.

- 1a.** Check **yes or no** if clients short term memory appears to recall after 5 minutes. If the resident is able to recall two of the three items then **check yes**, client has short term memory recall.

Examples to Test Short Term Memory

- Ask resident to describe what they had for breakfast or an activity they just completed.
- Let the resident know that you are going to ask them to remember three items (e.g., book, watch, and table) and then recall those items in a few minutes. After listing the three items, ask resident to repeat them (to verify that they heard the words) then continue with normal conversation. After approximately five minutes, ask the resident to name the three items you asked them to remember.

- 1b.** Check **yes or no** if client's long term memory appears to recall long term past. If able to respond correctly to long term memory questions, **check yes**, appears to have long term memory recall. To help determine if client has long term memory recall try to engage in conversation that is meaningful to the resident. Ask questions for which you already know the answers (from review of records, general knowledge, and family).

Sample Questions for determining Long Term Memory Recall

- Where did you live before you came here to live?
- Are you married or were you married. If yes, what is/was your spouse's name?
- Do you have any children? If yes, how many? names?
- When is your birthday or in what year were you born?

- 2.** Check the client's ability to make decisions regarding tasks of daily life.

To help determine the resident's ability to make everyday decisions about the tasks or activities of daily living, review records, consult family and caregivers, and observe resident. The intent is to record what the resident is doing (performance). Can they make their own decisions? Focus on whether or not the resident is actively making these decisions, not on what the staff or family believes the resident may or may not be capable of doing.

Some of the task or activities may include:

- Choosing items of clothing.
- Determining meal-times including making the correct decision concerning how to get to the dining area.
- Using environmental cues to organize and plan (e.g., clocks, calendars, posted listings of upcoming events).
- Using awareness of one's own strengths and limitations in regulating the day's events (e.g., asks for help when necessary).

CODING:

- A. Independent**- the resident's decisions in organizing daily routine and making decisions were consistent, reasonable and organized reflecting lifestyle, culture and values.
- B. Modified Independence**- The resident organizes their daily routine and makes safe decisions in familiar situations and surroundings, but experiences some difficulty in decision-making when faced with new tasks, situations, or surroundings.

C. **Moderately Impaired** - The resident makes poor decisions that put his/her health and safety at risk. The resident requires reminders, cues and supervision in planning, organizing and correcting daily routines.

D. **Severely Impaired** – The resident’s decision making is severely impaired. The resident rarely or never makes decisions.

3. Check what most accurately describes the client’s use of information
4. Check if the client’s cognitive status, skill, or abilities has changed in last 90 days.

Section D.1. Communication/Hearing Patterns

Document the resident’s ability to hear, understand, and communicate with others.

1. Check client’s current ability to hear (with a hearing appliance if used). Interview and observe the resident and ask about hearing function and consult the resident’s family and direct care staff. If resident uses a hearing appliance, have it in place before the interview.
2. Check all the modes of expression that apply on how the client makes needs known. Consult with family and direct care staff. Interact with the resident and observe for any reliance on non-verbal expression (physical gesture, such as pointing to objects) either in one-on-one communication or in group situations.
3. Check the client’s current ability to make him/her self understood. You are determining the client’s ability to express or communicate requests, needs, opinions, urgent problems, and social conversation (whether in speech, writing, sign language, or a combination of these).
4. Check the client’s current ability to understand others. Describe the resident’s ability to comprehend verbal information. **Emphasis is on comprehension rather than hearing.**

Section E.1 Vision

1. Check client’s current vision quality, with glasses if used. Ask the resident about his or her visual abilities. Ask if they are able to read newsprint, menus, and greeting cards. Test the accuracy of your finding by asking the resident to look at regular size print in a book or newspaper with whatever visual appliance he or she customarily uses for close vision and see if it is readable. Be sensitive that some residents are not literate or are unable to read English.
2. If client does wear glasses, check **yes or no** if the client is able to get them on without assistance. For residents who are unable to verbalize or communicate their visual abilities, the assessor needs to conduct their observation and consult with staff and family members.

Section F.1. Mood and Behavior (Indicators of depression/anxiety)

Record the client’s response to the three questions that pertain to depression and anxiety. If resident is unable to respond mark appropriate box.

1. Check client’s response to feeling down hearted or blue
2. Check client’s response to feeling anxious
3. Check client’s response to feeling hopeless or helpless

These questions help identify a sad/anxious or persistent mood. Feelings of distress may be expressed directly by the resident who is depressed, anxious, or sad. Mood distress is a serious condition and is associated with significant morbidity. It is important to identify signs and symptoms of mood distress since it is treatable.

Section F.2. Mood and Behavior (Behavioral Symptoms (7 day look back))

Identify the presence of problem behaviors in the **last seven days** that cause disruption to facility residents or staff members, including those that are potentially harmful to the resident or disruptive in the environment.

Review clinical/medical records, consult with staff and observe the resident. The coding focuses on the resident's action not intent. It is important that input is gathered from staff working days, evenings, and nights since some behaviors may only happen in the evening or at night.

1. **Wandering** – Locomotion with no rational purpose. A wandering resident may be unaware of his or her physical or safety needs. Wandering behavior should be differentiated from purposeful movement (e.g. a hungry person moving about the home in search of food). Wandering may be manifested by walking or by wheelchair.
2. **Verbally aggressive** – resident threatens, screams at, or curses at other residents or staff.
3. **Physically aggressive** – resident hits, shoves, scratches, or assaults other residents or staff.
4. **Socially Inappropriate**– This includes disruptive sounds, excessive noise including screaming, self-abusive acts, sexual behavior, disrobing in public, smearing or throwing food or feces, hoarding, or rummaging through other resident belongings.
5. **Resist Care** – Resident resists taking medication or injections or assistance with ADLs. *This does not include instances where the resident has made an informed choice not to follow a course of care.* Signs of resistance may be verbal and or physical.
 - a. **Problem Behavior**- Record the frequency of behavioral symptoms manifested by the resident for day, evening, and night.
 - 0 **Never** if the behavior symptom described was not exhibited in the last seven days
 - 1 **Less than daily** if the described behavioral symptom occurred 1 to 6 out of past 7
 - 2 **Daily** if the described behavior symptom occurred daily or multiple times each day.
 - b. **Behavior symptom alterability** – Record if symptoms are alterable with interventions.
 - 0 If the **behavior not present or was easily altered**.
 - 1 If the **behavior was not easily altered** and occurred with a degree of intensity that was not responsive to staff attempt to reduce the behavioral symptom through limit setting, diversion, adapting routines, activities, comfort measures, environmental modification, or appropriate drug treatment.

Section F.3. Mood and Behavior (Wandering Risk)

1. Select the choice that most accurately describe the client's wandering tendency if they wander. If they do not, please check E. Does not wander.

Section F.4. Mood and Behavior (Special programs)

1. Check **yes or no** if client has an ongoing interdisciplinary program to evaluate behaviors to help implement a plan of care to reduce distressing symptoms.
2. Check **yes or no** if the client has a special program that involves making specific changes in their environment to address their mood, behavior, or cognitive patterns.
3. Check **yes or no** if the client has been evaluated by a qualified mental health specialist since last assessment or within last 90 days if new admit.
4. Check **yes or no** if the client is currently receiving any group therapy.

Section F.5. Mood and Behavior (Change in behavioral symptoms)

1. Check any change in client's behavior status in the past 90 days.

Section G.1. Physical Functioning Activities of Daily Living (ADL)

Tasks performed routinely by a person to maintain bodily functions.

Helpful hints to complete an accurate physical assessment of ADLs

- Review previous documentation if any is available.
- During a re-assessment, interview staff from all shifts to determine if the client requires different levels of care during a 24 hour period.
- Observe the resident on how they move and re-position while you are having a normal conversation.
- Have the client perform the activity or part of the activity you are assessing.
- If this is a new assessment, ask the client and family separately what the client does for self but do not rely solely on what the family or resident says he/she *can* or *cannot* do. See the following example questions to help gather ADL information.

Use the following decision structure to help turn item definitions and time frames into questions that can be asked of staff or family members. This may be done by adding "How does...?" "Is...?" etc. to the item topic. To further clarify this process, review the following examples for Bed Mobility and Transfer.

BED MOBILITY

- How does Mrs. K. position herself in bed?
- Is Mrs. K. involved when this is done?
- In the past week, did you (or others) guide her body only (not supporting weight of limbs) while she was positioning in bed or did you need to assist by supporting the weight of any of her limbs and/or body during positioning?
- What kind of extended help did she receive?
- Were one, two, or more people needed to help Mrs. K. with bed mobility?
- How many times during the past seven days has she received this type of help?

TRANSFER

- During the last week has Mrs. K. gotten out of bed/chair?
- How was this done?
- How did she do it?
- How much help was provided?
- How many times during the past seven days has this help been provided?
- Was she guided or was other non weight-bearing assistance provided?
- Did you or others have to lift or support Mrs. K during the transfer by bending your knees and providing weight-bearing assistance?

TOILET USE

- Is Mrs. K able to use the Toilet? If yes, by herself or does she need help?
- What kind of help does she need?
- Does someone guide her or need to support her weight as she sits and rises from the toilet?
- Is she able to clean self after toilet use?
- If incontinent, is she able to manage own incontinence care?

Codes Choices for ADL Self Performance

Self-Performance Categories: Measure what resident *actually did* and not on what the staff or family believes the resident might be capable of doing.

Coding: For each self-performance category, code appropriate response for the client's actual performance during the past seven days. (Consider the resident's performance during all shifts).

- 0 **Independent** – No help or staff oversight – **OR** - staff assistance or oversight provided only 1 or 2 *times* during last seven days.
- 1 **Supervision** – Oversight, cueing, encouragement and direction (**Eyes only, no touching**) provided 3 or more times during last seven days –**OR** -Supervision plus staff assistance provided only 1 or 2 *times* during last seven days.
- 2 **Limited Assistance** – Client highly involved in activity, receiving physical help/assistance in guided maneuvering of limbs (**touch to guide**) or help with maneuvering of limbs but not supporting weight of limbs on 3 or more occasions during last seven days –**OR**- providing weight-bearing support only 1 or 2 *times* during last seven days. *Example:* Due to limited Range of Motion, client is able to hold up arm to attempt to put arm in sleeve of shirt but not able to hold high enough so staff supports and guides the arm into the sleeve. Staff *is not* supporting total weight of affected arm.
3. **Extensive Assistance** – while resident performed part of activity over last seven day period, help of following type(s) was provided 3 or more times in the last seven days. Weight-bearing support (**caregiver needs to lift or pick up limb(s) or needs to bend legs to support the weight**). Full staff performance 3 or more times in last seven days but not for all seven days. *Example:* Due to a stroke the client is unable to move their right arm and leg. Staff must pick up and support the total weight of the right arm to put in the sleeve of the shirt and total weight of the right leg to place in pants.
4. **Total Dependence** – Full staff performance of activity during entire seven day period.
Note: If resident is not **totally dependent** on staff then do not code as “4”.

Code choices for ADL Support Provided

Support provided categories: To measure amount of **staff assistance needed** by the resident and the **type and amount of staff support actually provided** to the resident for each ADL.

Coding: For each support provided category, code amount of staff assistance or support that actually was provided to the client for each ADL during the last 7 days.

- 0 **No setup or physical help from staff**
- 1 **Setup help only** – Resident is provided with materials or devices necessary to perform the activity of daily living independently.
Examples of Set up help only
 - For personal hygiene – providing grooming articles, wash basin, cloth, and towel
 - For locomotion – handing resident a walker or locking wheels on wheelchair.
 - For eating - cutting meat and opening containers at meals.
 - For dressing – retrieving clothes from closet and laying out on resident's bed.
 - For bathing – placing bathing articles at tub side within resident's reach.
- 2 **One-person physical assist- Hands on physical help of one person**
- 3 **Two-person physical assist.** Hands on help of two people

- 1a. Bed Mobility**-Code client's ability to move self in bed (pulling self up in bed and turning side to side) in past 7 days. Client is still coded as independent if they use side rails or trapeze to assist with their bed mobility.
- 1b.** Code how much staff assistance was provided client with bed mobility in the past 7 days.
- 2a. Transfer**-Code client's ability to transfer self. Transfer includes from bed to chair (wheelchair), and on and off toilet.
- 2b.** Code how much staff assistance was provided client with transfer in the past 7 days.
- 3a. Locomotion in residence**-Code how the client moves self around in home setting. Includes moving in bedroom and around facility. Code client as independent if uses wheelchair for mobility and is able to move self independently in wheelchair around home.
- 3b.** Code how much staff assistance was provided client with mobility in residence.
- 4a. Dressing**-Code client's ability to dress self. If adaptive device is used, code ability with use of adaptive device.
- 4b.** Code how much staff assistance was provided client during dressing in the past 7 days.
- 5a. Eating**- Code client's ability to feed self. If adaptive device is used, code ability with use of adaptive device.
- 5b.** Code how much staff assistance was provided the client during eating in the past 7 days.
- 6a. Toilet use**- Code client's ability to toilet self. Includes ability to wipe self and take down and pull up clothing. If adaptive device is used, code ability with use of adaptive device.
- 6b.** Code how much staff assistance was provided client during toileting in the past 7 days
- 7a. Personal hygiene**- Code client's ability to perform personal hygiene on self. Includes washing face and hands, brushing teeth, and combing hair.
- 7b.** Code how much staff assistance was provided client during personal hygiene care in the past 7 days.
- 8a. Bathing**- *Bathing is the only ADL activity that has a unique set of Self-Performance codes to be used only in the bathing assessment and are described below.*

Coding: Record the resident's self-performance in bathing according to the codes listed below. When coding, apply the code number that reflects the maximum amount of assistance the client received during bathing episodes.

- 0** Independent- No help provided.
- 1** Supervision- Oversight only.
- 2** Physical help limited to handing supplies to client like soap, cloth and towel ***also includes any transfer assist.***
- 3** Physical help in actual bathing activity (excluding assist with washing back and hair).
- 4** Total dependence

Code client's ability to take a shower, tub bath, or bed bath. Does not include how the client washes back or hair. If needs assist with only transfer into or out of shower or tub, code only as a "2".

- 8b.** Code how much staff assistance was provided the client during bathing in the past 7 days.

- 9a. Adaptive Devices-**Code client's ability to manage by putting on and off assistive devices.
- 9b.** Code how much staff assistance provided client with assistive devices in the past 7 days.
- 10. Stair Climbing-** Code client's ability to climb stairs in facility if applicable.
- 10b.** Code how much staff assistance was provided client with stair climbing if applicable in past 7 days.

The following examples are designed to help clarify coding for both Self-Performance and Support. The answers appear to the right of the client descriptions. Cover the answers, read and score the example, then compare your answers with those provided.

Examples: ADL Self-Performance and Staff Support	Self	Staff
<p><u>BED MOBILITY:</u> Resident was physically able to reposition self in bed but had a tendency to favor and remain on left side; needed frequent reminders and monitoring to reposition self while in bed.</p> <p>Received supervision and verbal cuing for using a trapeze for all bed mobility. On two occasions when arms were fatigued, resident received heavier physical assistance of two persons.</p> <p>Resident was physically able to bend knees and hold on to side rails to assist in repositioning up in bed but required the assist of two to hold under arms and pull up in bed while resident pushed with legs.</p> <p>Because of severe and painful joint deformities, resident was totally dependent on two persons for all bed mobility. Although unable to contribute physically to positioning process, resident was able to cue staff for the position she wanted to assume and at what point she felt comfortable.</p>	1 1 3 4	0 3 3 3
<p><u>TRANSFER</u> Despite bilateral above the knee amputations, resident always moved independently from bed to wheelchair (and back to bed) using a transfer board while a staff member locked wheelchair and observed transfer.</p> <p>Resident moved independently in and out of armchairs but always received light physical guidance of one person to get in and out of bed safely.</p> <p>Transferring ability varied throughout each day over the last 7 days. Received no assistance at times and heavy weight-bearing assistance from one person on at least three occasions.</p>	0 2 3	1 2 2
<p><u>LOCOMOTION</u> Resident ambulated slowly on unit pushing a wheelchair for support; stopped to rest every 15-20 feet; has good safety awareness and has never fallen. Staff felt she was reliable enough to be on her own.</p> <p>Ambulated independently around, socialized with others and attended activities during the day. Loves dancing and yoga. Because she can become afraid at night, she received contact guidance of one person to walk her to the bathroom at least twice every night.</p> <p>During last week, resident was learning to walk short distances with new leg prosthesis with heavy partial assistance of two people. Refused to ride in a wheelchair.</p>	0 2 3	0 2 3
<p><u>DRESSING</u> Usually dressed self. After a seizure, received total help from several staff members once during the week.</p> <p>Nursing assistant provided weight-bearing help with dressing every morning (supporting weight of limbs) over the last week. Later each day, as resident felt better (joints were more flexible), she required staff assistance only to undo buttons and guide her arms in/out of sleeves every pm.</p>	0 3	0 2
<p><u>EATING</u> Resident arose daily after 9 am; preferred to skip breakfast and just munch on fresh fruit late in the morning. She ate lunch and dinner independently in the facility's dining room.</p> <p>Resident is blind and confused. He ate independently once staff opened containers, oriented him to the location and types of food on his tray and instructed him to eat.</p> <p>Over the course of a week the Resident feeds himself during breakfast and lunch with staff monitoring and encouragement but is tired later in the day so is fed at the supper meal.</p>	0 1 3	0 1 2

<u>TOILETING</u>		
Resident used bathroom independently once up in a wheelchair; used bedpan independently at night after it was set up on bedside table.	0	1
When awake, resident was toileted every two hours with minor assistance of one person for all toileting activities (e.g., contact guard for transfers to/from toilet, drying hands, pulling up, zipping/buttoning pants.	2	2
Resident received heavy assist of two persons to lower and raise off toilet. Resident was able to wipe self, once toilet tissue was handed to him.	3	3
<u>PERSONAL HYGIENE</u>		
New resident, in home adjustment phase, liked to sleep in his clothes in case of fire and remained in the same clothes for 2-3 days at a time. He cleaned his hands and face independently and would not let others help with any personal hygiene activities.	0	0
Resident able to carry out personal hygiene but was not motivated; received daily cueing and positive feedback from staff to keep self clean and neat. Once started, could be left alone to complete tasks successfully.	1	1
Resident required total daily help combing her long hair and arranging it in a bun; otherwise resident was independent in personal hygiene.	0	1
<u>BATHING</u>		
On Monday, one staff member helped transfer resident into the tub but resident washed self completely after the staff member handed her the soap and her cloth. On Thursday, resident by physical help of one person got into the tub but needed assist washing her back and hair.	2	2
Resident received verbal cuing and encouragement to take twice-weekly showers. Once staff walked resident to bathroom, he bathed himself with periodic oversight.	1	0
Resident afraid of Hoyer lift; was given a full sponge/ bed bath by staff twice weekly; resident was involved in this activity.	3	2

Section G.2. Physical Functioning (Body Control)

- 1a.** Check **yes or no** if client is bed bound. A client is considered bed bound if the client is in bed or in a recliner in own room for 22 hours or more per day.
- 1b.** Check **yes or no** if client has an unsteady gait. Consider what is the client's normal gait on a day to day basis. If the normal gait is unsteady, check yes.
- 1c.** Check **yes or no** if client has hemiplegia or hemiparesis. If client has paralysis of only one half of body, check yes.
- 1d.** Check **yes or no** if client has any amputations. If client has any limb amputations, check yes. Do not count missing fingers or toes as amputations.

Section G.3. Physical Functioning (Modes of Locomotion)

Check the types of assistive appliances or devices that the client uses on a regular basis for locomotion around the home, including their bedroom.

Section G.4. Physical Functioning (Modes of Transfer)

Check all appliances or assistive devices the client uses in transferring in and out of bed, chair and for bed mobility.

Section G.5. Physical Functioning (Self Performance in ADLs)

Check if the client's ADL self-performance status has stayed the same or changed in last 90 days.

Section G.6. Physical Functioning (Instrumental Activities of Daily Living)

- 1a. Shopping (self-performance)** Check client's ability to shop in the past 7 days.
- 1b. Shopping (support provided)** Check the highest level of staff support given to client with shopping in the past 7 days.
- 2a. Transportation (self-performance)** Check the client's ability to perform transportation coordination which includes arranging transportation like a taxi, or ride from a family member, and also includes performance (if the client is able to get on the bus or in a taxi).
- 2b. Transportation (support provided)** Check the highest level of staff support the client required with arranging transportation in past 7 days.
- 3a. Money Management (self-performance)** Check the client's ability to manage money in the past 7 days if applicable.
- 3b. Money Management (support provided)** Check the highest level of staff support the client required with money management during the past 7 days.
- 4a. Meal Preparation (self-performance)** Check the client's ability to prepare a meal in the past 7 days if applicable.
- 4b. Meal Preparation (support provided)** Check the highest level of staff support given to the client for meal preparation if applicable.
- 5a. Phone (self-performance)** Check the client's ability to use the telephone in the past 7 days if applicable.
- 5b. Phone (support provided)** Check the highest level of staff support given to the client with telephone support in the past 7 days if applicable.
- 6a. Light Housework (self-performance)** Check the client's ability to do light housework (dusting, sweeping, making bed) in the past 7 days if applicable.
- 6b. Light Housework (support provided)** Check the highest level of staff support given to the client with light housework if applicable.
- 7a. Managing Medications (self-performance)** Check the client's ability to self-manage medications during the past 7 days if applicable.
- 7b. Managing Medication (support provided)** Check the highest level of staff support given to the client to manage medications in the past 7 days if applicable.
- 8a. Heavy Housework (self-performance)** Check the client's ability to do heavy housework (vacuuming, washing floors, washing dishes) in the past 7 days if applicable.
- 8b. Heavy Housework (support provided)** Check the highest level of staff support given to the client with doing heavy housework in the past 7 days if applicable.
- 9a. Laundry (self-performance)** Check the client's ability to do own laundry in past 7 days if applicable.
- 9b. Laundry (support provided)** Check the highest level of staff support given to the client with doing laundry in the past 7 days if applicable.
- 10a. Equipment Management (self-performance)** Check the client's ability to self-manage their medical equipment in the past 7 days if applicable.
- 10b. Equipment Management (support provided)** Check the highest level of staff support given to the client to help manage medical equipment in past 7 days if applicable.

Section G.7. Physical Functioning (Rehabilitation)

1. Check all the functional rehabilitation or improvement potential of the client from the list provided if applicable.
2. Check yes if the client requires assistive devices or adaptive equipment.
3. Check yes if staff needed to break ADL activities into subtasks during the past 7 days so client could perform them.

Section G.8. Physical Functioning (Skills Training)

1. If the client has received any of the listed skill training in the past 30 days for at least 15 minutes per day, write in how many days for each activity the client received training. If no training was provided, leave blank or put in 0.

Section G.9. Physical Functioning (Devices Needed)

1. Check if client needs any of the listed devices or equipment. If the client uses any device or equipment that is not listed, check other and enter the equipment or device used.

Section H.1. Continence (in last 14 days)

1. Check the appropriate response related to client's bladder continence for the past 14 days. If the client wears a pad inside their underwear or an adult pad due to a weak bladder, and they tend to dribble on occasion (coughing, sneezing, strenuous activity) or if the client has a catheter, client is to be coded as continent.
2. Check the appropriate response related to client's bowel continence in the past 14 days. If bowel movement is controlled by appliance (colostomy bag) or is on a bowel program for bowel movements and is not incontinent in between toileting, client is considered continent.

Section H.2. Continence (Appliance and Programs)

1. Check all that apply regarding incontinence appliance usage and/or programs. If client does not use an appliance or is not on a toileting plan, check none of the above. If the client has scheduled toileting by either staff reminding client to go to the toilet at specified times or taking client to toilet at routine times through out the day, check scheduled toileting plan.

Section H.3. Continence (Change in Urinary Continence)

1. Check the appropriate response if the client's bladder incontinence has changed in the past 90 days or since the last assessment.

Section I.1. Diagnosis

1. Enter client's current primary diagnosis. The diagnosis must be a physician/medical provider document diagnosis.
2. Check all the current active diagnoses and conditions from the list provided. All diagnoses must have been diagnosed by a physician or medical provider.
3. Check all active infections from the list provided. Do not list any infections that have been resolved. If client has no current infections, check none of the above.

4. Check from the provided list any problems or conditions that the client is experiencing or has experienced in the past week. Check none of the above if the client has not had any of the listed conditions.
5. Enter any inactive health conditions that facility should be aware of.

Section J.1. Oral/Nutrition Status

1. Enter how tall the client is in **inches** without shoes. (5'4= 64 inches).
2. Enter how much the client weighs in pounds without shoes.
3. Check if client has lost or gained weight in last 6 months. A gain or loss would be considered to be 5 pounds or greater. Check no change, if client has stayed within 5 pounds of previous weight.
4. Check from the list all the nutritional approaches used on client. If client does not use any, check none of the above.
- 4a. List any restricted foods.
5. Check all that apply related to the client's current oral and dental status.

Section K.1. Skin Conditions (Ulcers)

In this section, you will record the number of skin ulcers at each ulcer stage on any part of the body. For an accurate assessment a full body check should be done.

Staging an Ulcer:

- Stage 1** A persistent area of skin redness without a break in the skin that does not disappear when pressure is relieved.
- Stage 2** A partial thickness loss of skin layers that presents clinically as an abrasion, blister, scab, or shallow crater.
- Stage 3** A full thickness of skin is lost, exposing the subcutaneous tissue. It presents as a deep crater with or without undermining adjacent tissue.
- Stage 4** A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

- 1a. Check how many Stage 1 Ulcers the client has. If none, check 0.
- 1b. Check how many Stage 2 Ulcers the client has. If none, check 0.
- 1c. Check how many Stage 3 Ulcers the client has. If none, check 0.
- 1d. Check how many Stage 4 Ulcers the client has. If none, check 0.

Section K.2. Skin Conditions (type of ulcer)

In this section you will record the highest stage for two types of skin ulcers, Pressure and Stasis.

Pressure ulcer – Reddened area or open area on skin over a bony prominence due to pressure or friction. Other terms used to indicate this condition include bed sores and decubitus ulcers.

Stasis ulcer – A skin ulcer, usually in the lower extremities, caused by decreased blood flow from chronic venous insufficiency.

- 1a. Enter the highest ulcer stage (1-4) for any pressure ulcers. Enter 0, if no pressure ulcers.

Section K.3. Skin Conditions (other problems or lesions)

Check from the list, all current skin problems that the client has that requires treatment. If none, check none of the above.

Section K.4. Skin Conditions (foot problems)

1a. Check yes or no if the client has foot problems. If no, skip question 1b.

1b. If Client has foot problems, enter what type of foot care the client needs.

Section K.5. Skin Conditions (skin treatments)

1. Check from the list, all current skin treatments that the client has received in the past 7 days. If none, check none of the above.

Section K.6. Skin Conditions (pain status)

1. Check how often client experiences pain that interferes with their activity or movement. If client is not experiencing pain, check no pain. If client does not have any pain, go on to Section L.1.

2. Check yes or no if intensity of the client's pain disrupts their normal usual routine activities.

Section L.1. Medications

The medication section will help the facility determine and document if the client:

- **Takes medication including over-the-counter medicine.**
- **Needs medication management and if so administration or assistance**
- **Needs physician follow-up**

1. Check **yes or no** to the question: Is the client taking medication. If no, skip to section M.1.

2. Check **yes or no** to the question: Does the client have any problems with taking medication as instructed or prescribed. If yes, client needs medication administration.

3. Check **yes or no** to the question: Does the client know what his/her medication is for. If No, client needs medication administration.

4. Check **yes or no** to the question: Does the client know how often to take medications. If No, client needs medication administration.

5. Check **yes or no** to the question: Does the client communicate desired effect of the medication or unintended side effects. If No, client needs medication administration.

6. Check **yes or no** if client controls own prescription medications.

7. Check **yes or no** if client controls own over-the-counter medication.

8. Enter number of days that the client received any type of injection in the past 7 days. Enter 0 if none and skip to #12.

9. If client gets injections, check the appropriate response on who gives the client their injection.

10. Enter date of the last medication review by the client's physician/medical provider.

11. Check client's compliance with medications as prescribed by their physician/medical provider.

12. Enter number of days during the past 7 that the client received an antipsychotic medication. If none, enter "0" and for long acting medication used less than weekly, enter "1".
13. Enter number of days during the past 7 that the client received an anti-anxiety medication. If none, enter "0" and for long acting medication used less than weekly, enter "1".
14. Enter number of days during the past 7 that the client received an anti-depressant medication. If none, enter "0" and for long acting medication used less than weekly, enter "1".
15. Enter number of days during the past 7 that the client received a hypnotic medication. If none, enter "0" and for long acting medication used less than weekly, enter "1".
16. Enter number of days during the past 7 that the client received a diuretic medication. If none, enter "0" and for long acting medication used less than weekly, enter "1".

Section M.1. Special Treatments (Procedures)

1. Check all the medical treatments that the client has received in the past 14 days. If none, check none of the above.

Section M.2. Special Treatments (Providers/Services)

- 1a. Check from the list provided all the services or programs the client participates in. There are definitions on page 30 of this instructional guide for all the providers and services listed.

Section M.3. Special Treatment (Rehabilitation/Restorative Care)

Enter the number of days for each rehabilitation service that was provided to the client for at least 15 minutes per day in the past 7 days. Enter "0" if none or if it was provided but for less than 15 minutes per day.

Section M.4. Special Treatments (Home Health Therapies)

1. Check yes or no if client is receiving any treatment or therapies from a Home Health agency. If no, skip to section M.5.
2. Check how frequently a nurse from the Home health agency sees the client. If client is not seen by a nurse, skip and go to #3
3. Check how frequently a Nurse aide for the home health agency sees the client. If client is not seen by a nurse aide, skip to #4.
4. Check how frequently a therapist (speech therapist, physical therapist, occupational therapist) from the home health agency sees the client. If client is not seen by a therapist, skip to Section M.5.

Section M.5. Special Treatments (Devices and Restraints)

In this section you will record if the client was restrained by any of the restraints listed at any time during the day or night in the last 7 days.

This includes restraints by any device that the resident cannot easily remove and that restricts freedom of movement or normal access to his/her body.

1. Check if full bed rails were used as a restraint in the past 7 days. Includes a bed rail that goes from head to foot of bed, even one-sided.

2. Check if trunk restraints were used on the client in the past 7 days. Includes vests, belts, sheets, etc. placed around the resident's trunk and a chair or bed. May be considered "positioning devices" by some.
3. Check if any combination of partial rails have been used as a restraint on the client's bed in the past 7 days.
4. Check if the client was placed in a chair with a lapboard for means of preventing the client from getting up in the past 7 days. Includes "Geri chairs", loungers, wheelchairs with lapboards strapped on them, etc.
5. Check if a limb restraint was used on the client in the past 7 days. Includes wrist or ankle cuffs and mitts or anything used to restrict arm and/ or leg movement.
6. Check if any chemical restraints (medications) were used for the purpose of discipline or convenience and not required to treat the client's medical symptoms in the past 7 days.

Section N.1. SIGNATURE, TITLE AND DATES

At completion of the assessment the person who completed the Assessment is required to sign and date the Assessment. The Signature indicates completion and accuracy of the assessment.

- 1a. The person who completes the assessment must enter their name and sign on a hard copy.
2. Enter the facility or agency that the person who completed the assessment works for.
3. This signature is **Optional**. If the client or their legal representative would like to review the assessment their signature indicates that the client and or their legal representative has reviewed the completed assessment and feel that it is accurate.
4. Name and signature is required by the Registered Nurse. The signature indicates that the Registered Nurse reviewed the assessment and feels that it is accurate.
5. Enter the date that assessment was completed.

- **ADDITIONAL FOR AAA MANAGED CLIENTS**

Section O. INTAKE FOR AOA (for AAA case Managed clients ONLY)

O.1: Demographic Information- Check the appropriate response for Clients demographic information on item 1a. - 6a.

O.2. The NSI Determine Your Nutritional Health Checklist

The NSI checklist is a nationally recognized tool. It was adapted from the “DETERMINE Your Nutritional Health” checklist developed by the Nutrition Screening Initiative (NSI). The purpose of this tool is to generate a score that helps the individual determine if they are at nutritional risk and whether nutritional intervention is necessary.

Ask the individual the questions. If they are unable to answer, you may get this information from other sources, such as family or caregivers. If there are not other sources to help answer the questions indicate this on the assessment. If the individual answers “Yes” to any question, add the corresponding scores.

1. Have you made changes in lifelong eating habits because of health problems?

“Yes” = 2 score

To help you get an accurate response, you may ask:

- “Do you find yourself avoiding certain foods because they make you feel lousy?”
- “Have you been told by a doctor or a dietitian not to eat certain foods for health reasons such as diabetes or high blood pressure?”

2. Do you eat fewer than 2 complete meals a day?

“Yes” = 3 score

Many people may state that they TRY to eat three meals a day, but in reality, they only eat one or two meals a day. A “meal” must include a source of protein along with some complex carbohydrate and a little fat. Examples of protein foods include peanut butter, eggs, cheese, milk, yogurt, meat, fish, poultry, kidney beans, etc. A cup of coffee and a piece of toast is NOT a meal!

To help you get an accurate response, you may ask:

- “Tell me about what you usually eat for breakfast.”
- “Tell me about what you usually eat for supper.”
- “Do you ever find yourself saving half of your lunch meal from the meal site for supper?”

3. Do you eat fewer than 5 servings (1/2 cup each) of fruit or vegetables each day?

“Yes” = 1 score

To help you get an accurate response, you may ask:

- “Tell me about the fruit (and fruit juice) that you eat each day.”
- “Tell me about the serving sizes of fruit that you eat each day.”
- “Are there any fruits that you don’t eat because they bother you or you simply “don’t enjoy eating them?”
- “Tell me about the vegetables that you eat each day.”
- “Tell me about the serving size of the vegetables that you eat each day.”
- “Are there any vegetables that you avoid eating?”

4. **Do you have fewer than 2 servings of dairy products (milk, yogurt, cheese) or tofu every day?** 1 serving of milk/yogurt=1 cup; 1 serving of cheese=1 ounce; 1 serving of tofu= ½ cup
“Yes” = 1 score

To help you get an accurate response, you may ask:

- “Tell me about the milk that you buy from the store. Is it skim, 1%, 2% or whole milk?”
- “Do you avoid milk because it bothers you when you drink it?”

5. **Do you have trouble eating well due to problems with biting/chewing/swallowing?**

“Yes” = 2 score

To help you get an accurate response, you may ask:

- “Tell me about any problems that you have with your teeth when you are eating.”
- “If you have dentures, do you wear them?”
- “Do you ever have problems swallowing, such as getting food caught in your throat or being unable to swallow certain foods?”
- “How often do you have the above-mentioned problems? Every day?”

6. **Do you sometimes not have enough money to buy the food?**

“Yes” = 4 score

To help you get an accurate response, you may ask:

- “Tell me about any difficulties that you’re experiencing with buying food each month.”
- “Does the amount of money you are required to spend on medicine ever interfere with the money you have left to buy food each month?”
- “Would you like me to find assistance with the money you have to buy food?”

7. **Do you eat most meals alone?**

“Yes” = 1 score

If the only time the participant eats with others is at the congregate meal site, then they eat alone most of the time.

8. **Do you take 3 or more prescribed or over-the-counter medications each day?** (Including aspirin, laxatives, antacids, herbs, inhalers, vitamin/mineral supplements)

“Yes” = 1 score

If the participant is unsure what you mean, go back to the health problems mentioned in question #1 and go from there.

To help you get an accurate response, you may ask:

- “Tell me about the medications that you take for your heart problem or diabetes, etc.”
- “Tell me about any nutrition supplements or herbal remedies that you take each day.”
- “Tell me about any laxatives or antacids that you use each day.”

9. **Without wanting to, have you lost or gained 10 pounds in the last 6 months?**

“Yes” = 2 score

Make sure to check “Loss” or “Gain”. Stress to the participant that the weight loss/gain refers to involuntary change and NOT something they were trying to do.

To help you get an accurate response, you may ask:

- “Tell me about your weight. Has it been staying the same or changing a lot?”
- “Tell me about what caused this change in your weight.”

10. Are there times when you are not physically able to shop, cook and/or feed yourself (or get someone to do it for you)?

“Yes” = 2 score

To help you get an accurate response, you may ask:

- “Tell me about your shopping. Does someone else shop for you or do you do it yourself?”
- “Is transportation a difficult factor involved with your shopping?”
- “Tell me about your cooking habits. Do you usually cook for yourself?”
- “Do you find it difficult to open cans, open or close your stove, or lift containers in and out of the stove by yourself?”
- “Do you find it difficult to hold or use regular silverware by yourself?”
- “Do you feel that you would benefit from assistance with your shopping, cooking or eating?”

11. Do you have 3 or more drinks of beer, wine or liquor almost every day?

“Yes” = 2 score

To help you get an accurate response, you may ask:

- “Tell me about any alcoholic beverages that you drink (beer wine, hard liquor such as gin, whiskey, rum, etc.).
- “Tell me about the serving sizes of alcoholic beverages that you drink.”

12. Total “Yes” Scores

After all questions have been answered, add the scores from each “Yes” answer to determine a nutritional risk score. If using the OMNIA assessment system, this will automatically calculate. Review the score with the individual/family/caregiver(s) and recommend referrals if necessary.

Nutritional Risk Score Means:

<u>Score</u>	<u>Rating</u>	<u>Recommendation</u>
0-2	GOOD	Re-check your score in 6 months
3-5	MODERATE RISK	Re-check your score in 3 months
6+	HIGH RISK	May need to talk to a doctor or dietitian

DEFINITIONS FOR PROVIDERS AND SERVICES

A. Home Health Aide (LNA) – Provides personal care including assistance with bathing, dressing, toileting, grooming, and other personal care activities. A physician's order is required for coverage by insurance. Only Medicare Certified Home Health Agencies may provide this service under Medicare and Medicaid.

B. Homemaker Services– Home Health Agencies provide services to help with "housekeeping chores" such as housecleaning, laundry, shopping and errands to individuals who are unable to perform these tasks and yet wish to remain in their own homes.

C. Hospice Services – Provide end of life care at home for individuals diagnosed with a terminal illness. Services include nursing, aide, homemaker, therapy, social services, and volunteers. Hospice staff are trained specifically to support and comfort the individual and family with the primary goal of dying at home. A physician's order is required for coverage by insurance.

D. Nursing (RN) – Skilled medical care and treatment, provided by a licensed professional designed to meet specific medical needs. This service is provided by home health agencies and private nursing services. A physician's order is required for coverage by insurance. Only Medicare Certified Home Health Agencies may provide this service under Medicare and Medicaid.

E. Social Work Services – Local home health agencies offer social work services to individuals who require short-term counseling and service coordination. A physician's order is required for coverage by insurance.

F1, F2, F3 Therapies – Therapeutic treatment provided by a licensed professional to promote recovery or rehabilitation from an illness or injury by both physical and mechanical means. Types of therapy include Physical (PT), Occupational (OT), and Speech (ST). Physician's orders are required for coverage by insurance.

G. Adult Day Services/Day Health Rehab – State certified day programs provide personal care, meals, planned activities and companionship for older persons and persons with disabilities. Medicaid pays for eligible individuals (Day Health Rehab).

H. Attendant Services Program (ASP) – ASP is a state administered program which provides funding to help pay for a personal care attendant to assist with daily personal care such as dressing, bathing, eating and other activities which will help individuals remain at home.

I. Developmental Disability Services – Funding provided to serve individuals with developmental disabilities in the community.

J. Choices for Care Medicaid Waiver – HB or ERC – There are two Community-Based options available under the Choices for Care programs. Both are administered by the Division of Disabilities and Aging Services (DDAS) at the Department of Disabilities, Aging and Independent Living (DAIL).

- Home-Based Option — Provides in-home personal care, case management, respite, companion, adult day, personal emergency response, and assistive devices/home modifications to an eligible person who needs nursing home level of care, but who wants to remain at home. In order to be eligible, the individual must be financially eligible for Long-Term-Care Medicaid and must require the level of care provided in a nursing home.

- Enhanced Residential Care Option— Provides increased residential care options for adults who need nursing home level of care while residing in a participating licensed Residential Care Home or Assisted Living Residence. Services include nursing overview, personal care services, case management, medication assistance, recreational and social activities, and support for individuals with cognitive impairments, 24-hour on-site supervision, laundry and household services.

K. Medicaid High-Tech – Individuals who have at least two modalities (e.g. ventilator, trach, tube feeding), have a need for skilled nursing care, and qualify for Vermont Medicaid, may be eligible for in-home nursing care paid for by Medicaid.

L. Traumatic Brain Injury Waiver (TBI) – Are state administered services provided to individuals who have had a traumatic brain injury and require rehabilitation and personal care specific to the brain injury. Short-term services are provided to eligible individuals who have had a recent injury and are currently in a rehab facility. Long-term services are limited to individuals identified as a priority due to specific long-term TBI issues.

M. USDA Commodity Supplemental Food Program – Individuals who are 60 years or older may be eligible for a monthly package of food, including nutrition education, recipes and information about a range of health and social services.

N. Congregate Meals – Hot meals and companionship are available to persons 60 or older and their spouses at over 90 meal sites across the state. Most meal sites also offer services like nutrition education, transportation to and from the meal site, information about senior programs, and recreational activities. The local Area Agency on Aging has information about congregate meal services in their area.

O. Emergency Food Shelf/Pantry – Provide food in an emergency by offering groceries to take home. Some communities offer food kitchens that provide food by serving sit-down meals at various locations throughout the state.

P. Home Delivered Meals – Often referred to as “Meals on Wheels”, are delivered to the home of individuals who are frail and/or homebound. The meals are usually provided by a senior center or congregate meal site. Type and frequency of meals available vary by region.

Q. Senior Farmer’s Market Nutrition Program – Provides low income seniors with fresh, nutritious, locally grown fruits, vegetables and herbs from farmers’ markets and farms.

R. Area Agency on Aging Case Management – Area Agencies on Aging provide professional case managers to help people age 60 and older assess their situation, explore available options, obtain community services and benefits, and protect their rights.

S. Community Action Program – Each community statewide has a Community Action Program that offers assistance to low-income individuals. Individual may receive help in regards to public benefits, housing, utilities, and food assistance among other things.

T. Community Mental Health Services – Each region of the state has a Community Mental Health office that offers variety of in-home and office-based mental health services.

U. Dementia Respite Grant Program/NFCSP –Funding available through the Dementia Respite Grant and the National Family Caregiver Support Program (NFCSP) to provide supportive services for primary caregivers.

V. Eldercare Clinician – Local Area Agencies of Aging (AAA) offer free in-home mental health counseling (Eldercare Clinician) for adults 60 and over.

W. Job Counseling/Vocational Rehabilitation – Job training, and help in finding a job are available to persons with disabilities at the Division of Vocational Rehabilitation. In addition, there are also programs offering employment counseling, aptitude testing, retraining, and information about available jobs at the local office of the Vermont Job Service.

X. Office of Public Guardian – The Department of Disabilities, Aging and Independent Living (DAIL) provides guardian services for a limited number of adults who are deemed “incompetent” by a court of law. Contact DAIL or the local AAA for more information.

Y. Senior Companion – This program provides support for low-income seniors to visit and provide assistance to other seniors who are isolated. Senior Companions visit for several hours each week to write letters, prepare an occasional meal, play cards, or just talk. The companions receive a small stipend, but there is no cost to the person being visited. The local Area Agency on Aging can assist with referrals to this program.

Z. VCIL Peer Counseling – The Vermont Center for Independent Living (VCIL) offers Peer Advocate Counselors (PACs) who work with Vermonters with disabilities, helping them to learn about the choices available to enable them to live more independently.

AA. VT Association for the Blind and Visually Impaired (VABVI) – Provides consultation, education and referrals for visually impaired individuals. Home evaluations are available. Contact your local VABVI or AAA for information.

BB. VT Legal Aid Services – Vermont Legal Aid provides a variety of legal services to low-income individuals who require certain legal services. Referral services are available to individuals not eligible for VT Legal Aid services.

CC. Assistive Community Care Services (ACCS) – Medicaid pays for eligible individuals to receive services at a licensed Level III Residential Care Home (RCH) or Assisted Living Residence (ALR). This program reimbursement is called ACCS and is only available at participating RCH’s or ALR’s.

DD. Housing and Supportive Services –The Housing and Supportive Services (HASS) program provides supportive services in congregate housing settings for elders and adults with disabilities.

EE. Section 8 Voucher – The VT State Housing Authority and certain local Housing Authorities offer vouchers to eligible low-income individuals. The voucher pays a portion of their monthly apartment rent. Individuals must contact the VT Housing Authority or local housing authority to apply.

FF. Subsidized Housing –Many communities statewide offer congregate (group) housing to low-income individuals. The rent is reduced (subsidized) depending on the individual’s finances and the type of housing subsidy being offered.

GG. Aid to Needy Families with Children (ANFC) – ANFC is the program which provides financial assistance for medical care, food, and other needs to families with dependent children.

HH. Essential Person – Brings extra income into the home of an eligible low-income person and his/her live-in caregiver. DCF sets specific requirements as to who may qualify as an "essential person" and the income and resource limits for applicants.

II. Food Stamps - The Food Stamp program is designed to provide financial assistance to purchase food for households with limited income and resources.

JJ. Fuel Assistance - Low-income people who need on-going or one-time assistance to pay for their heat and related energy costs can apply for this program.

KK. General Assistance – Emergency financial assistance for housing, utilities, food and medical expenses.

LL. Medicaid – Medicaid is a State program of medical assistance for low-income persons. Medicaid does not directly provide health care services or money for individuals to purchase health services. Instead, it reimburses health care providers directly (pharmacists, physicians, hospitals, etc.) who provide covered services.

MM. QMB/SLMB – Qualified Medicare Beneficiaries (QMBs) and Special Low Income Medicare Beneficiaries (SLMBs) are individuals entitled to Medicare Part A whose income and resources fall below the limits set for this program. Medicaid will pay for their Medicare premiums and, depending on their income and resources, may also pay for their Medicare deductibles and co-payments.

NN. Telephone Lifeline – Monthly telephone credit is available to income eligible people over the age of 65 or households of any age that are eligible and receive any benefits through DCF.

OO. VHAP – (VT Health Access Program) – Provides health insurance to Vermonters who do not have health insurance and are not eligible for Medicaid. Participants must meet certain financial criteria. Premiums are on a sliding scale and there may be a small co-pay.

PP. VHAP Pharmacy –Helps low-income individual’s who are 65 and older or disabled pay for medications. Call 1-800-250-8427 for more information.

QQ. V-Script - State-funded pharmaceutical assistance program offers a subsidy for older Vermonters and individuals with disabilities who have limited income. Call 1-800-250-8427 for more information.

RR. Emergency Response System – Sometimes referred to as Lifeline or Life Alert, this is an emergency system that connects an individual's telephone directly to a local hospital. If the individual is alone at home and needs help, she/he can push a button which will automatically call the hospital for assistance. The local Area Agency on Aging, Home Health agency and hospital have information about this service.

SS. Supplemental Security Income (SSI) – Provides income to low-income individuals who are considered aged (age 65 and older), blind or disabled. Eligibility for SSI means a person is automatically eligible for Medicaid. Apply at the Social Security Administration.

TT. Veteran’s Benefits – The Veterans Administration (VA) offers income and medical benefits to qualified military veterans. Contact the VA for more information.

UU. Weatherization Program – This is a program to help low-income persons by providing labor and materials to help insulate and winterize their homes.

VV. Assistive Devices – Assistive devices are generally tools to help a person with day to day activities, such as a grab bar for transferring or adapted utensils for eating. Contact your local medical supply store, VCIL, home health agency, or AAA for more information.