

Comprehensive Nursing Assessment

To be performed by a Registered Nurse

Individual	Date of Birth	Today's Date
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I. Review

Review of Health Care Team

	Health Care Practitioners	Date Last Seen	Comments
Primary Care			
Psychiatrist			
Neurologist			
Dentist			
Optometrist			

Natural Supports	Relationship	Telephone No.
Client Responsible Adult (CRA)		
Guardian		

Health History

Axis I:

Axis II:

Axis III:

Axis IV:

History of Major Medical/Surgical Occurrences:

RN _____

Individual _____ Date _____

II. Current Status

Current medical and psychiatric history

Briefly describe recent changes in health or behavioral status, hospitalizations, falls, seizure activity, restraints, etc., within the past year.

What is of primary concern/greatest expressed needs of the individual, legally authorized representative (LAR) or client's responsible adult (CRA) from their own perspective?

Vital Signs

Blood pressure	Pulse		Respirations	
	Rate	Rhythm	Rate	Rhythm
Temperature	Pain level	Blood sugar	Weight	Height

Comments

RN _____

Individual _____ Date _____

Labs

Briefly review ordered labs, dates and abnormal values within the past year.

Fall Risk Assessment

Has a fall risk assessment been completed?

No

Yes (attached). Fall risk due to:

Neurological

Musculoskeletal

Unknown

Comments

III. Review of Systems

Neurological

Abnormal Involuntary Movement Scale (AIMS) Assessment: Attached Deferred

	Y	N		Y	N		Y	N
Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	Pupils equal and reactive to light and accommodation.....	<input type="checkbox"/>	<input type="checkbox"/>	Tremors.....	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness.....	<input type="checkbox"/>	<input type="checkbox"/>	Tremors.....	<input type="checkbox"/>	<input type="checkbox"/>	Heat/cold reflex.....	<input type="checkbox"/>	<input type="checkbox"/>
Impaired balance/coordination.....	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling/Paresthesia.....	<input type="checkbox"/>	<input type="checkbox"/>	Extrapyramidal symptoms.....	<input type="checkbox"/>	<input type="checkbox"/>
Medication side effects.....	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis.....	<input type="checkbox"/>	<input type="checkbox"/>			
	Y	N		Y	N		Y	N
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Petit Mal.....	<input type="checkbox"/>	<input type="checkbox"/>	Clonic (repetitive jerking).....	<input type="checkbox"/>	<input type="checkbox"/>
Frequency _____			Absence.....	<input type="checkbox"/>	<input type="checkbox"/>	Tonic (muscle rigidity).....	<input type="checkbox"/>	<input type="checkbox"/>
Duration _____			Myoclonic (sporadic jerking)...	<input type="checkbox"/>	<input type="checkbox"/>	Atonic (loss of muscle tone)....	<input type="checkbox"/>	<input type="checkbox"/>
Comments								

RN _____

Individual _____ Date _____

Eye, Ear, Nose and Throat

Eyes/Vision	
<input type="checkbox"/> Clear <input type="checkbox"/> Red <input type="checkbox"/> Right impaired <input type="checkbox"/> Left impaired <input type="checkbox"/> Adaptive aid	
Ears/Hearing	
<input type="checkbox"/> Normal <input type="checkbox"/> Ringing <input type="checkbox"/> Right impaired <input type="checkbox"/> Left impaired <input type="checkbox"/> Adaptive aid	
Nose/Smell	
<input type="checkbox"/> Within normal limits Smell: <input type="checkbox"/> intact <input type="checkbox"/> not intact <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Frequent sinus congestion <input type="checkbox"/> Frequent sinus infection	
Oral	
<input type="checkbox"/> Within normal limits <input type="checkbox"/> Difficulty chewing <input type="checkbox"/> Mouth pain <input type="checkbox"/> Halitosis <input type="checkbox"/> Dentures <input type="checkbox"/> Edentulous <input type="checkbox"/> Involuntary tongue movement <input type="checkbox"/> Dry mouth from medications	
Throat	
<input type="checkbox"/> Within normal limits <input type="checkbox"/> Sore throats <input type="checkbox"/> Difficulty speaking <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Tonsil enlargement <input type="checkbox"/> History of choking <input type="checkbox"/> Thyroid enlargement	
Swallow Study: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ Results: _____	
Comments	

Cardiovascular

	Y	N		Y	N		Y	N
Edema.....	<input type="checkbox"/>	<input type="checkbox"/>	Cool/Numb extremities.....	<input type="checkbox"/>	<input type="checkbox"/>	Capillary refill less than or equal to two seconds.....	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Activities of daily living (ADL) limitations.....	<input type="checkbox"/>	<input type="checkbox"/>	Compression stockings.....	<input type="checkbox"/>	<input type="checkbox"/>
High/Low blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>						
Normal range _____								
Comments								

RN _____

Individual _____ Date _____

Respiratory

Breathing: <input type="checkbox"/> Slow <input type="checkbox"/> Normal <input type="checkbox"/> Rapid <input type="checkbox"/> Shallow <input type="checkbox"/> Painful											
		Y	N			Y	N			Y	N
Short of breath	<input type="checkbox"/>	<input type="checkbox"/>		Feeding tube	<input type="checkbox"/>	<input type="checkbox"/>		Tracheostomy	<input type="checkbox"/>	<input type="checkbox"/>	
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>		Positioning orders	<input type="checkbox"/>	<input type="checkbox"/>		Continuous positive airway pressure (CPAP).....	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>		Aspiration history	<input type="checkbox"/>	<input type="checkbox"/>		Inhalation agent	<input type="checkbox"/>	<input type="checkbox"/>	
Cough.....	<input type="checkbox"/>	<input type="checkbox"/>		Pneumonia history	<input type="checkbox"/>	<input type="checkbox"/>		Oxygen @	<input type="checkbox"/>	<input type="checkbox"/>	
Productive	<input type="checkbox"/>	<input type="checkbox"/>									
Comments											

Gastrointestinal

<input type="checkbox"/> Gastrostomy <input type="checkbox"/> Jejunostomy <input type="checkbox"/> No tube											
Bowel sounds				Last bowel movement				Bowel habits (frequency and description)			
		Y	N			Y	N			Y	N
Continent.....	<input type="checkbox"/>	<input type="checkbox"/>		Reflux.....	<input type="checkbox"/>	<input type="checkbox"/>		History of risk constipation	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent nausea	<input type="checkbox"/>	<input type="checkbox"/>		Straining pain.....	<input type="checkbox"/>	<input type="checkbox"/>		History of risk impaction	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent vomiting	<input type="checkbox"/>	<input type="checkbox"/>		Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>		Bowel program	<input type="checkbox"/>	<input type="checkbox"/>	
Indigestion.....	<input type="checkbox"/>	<input type="checkbox"/>		Odd stools.....	<input type="checkbox"/>	<input type="checkbox"/>					
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>		Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>		Medications influencing bowels (laxatives, anti-diarrheals, Iron, Calcium, Anticholinergics, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
Appetite loss.....	<input type="checkbox"/>	<input type="checkbox"/>		Independent toileting.....	<input type="checkbox"/>	<input type="checkbox"/>					
Comments											

RN _____

Individual _____ Date _____

Musculoskeletal

	Y	N		Y	N		Y	N
Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Prosthesis.....	<input type="checkbox"/>	<input type="checkbox"/>	Impaired range of motion.....	<input type="checkbox"/>	<input type="checkbox"/>
Weakness.....	<input type="checkbox"/>	<input type="checkbox"/>	Deformity.....	<input type="checkbox"/>	<input type="checkbox"/>	Impaired gait.....	<input type="checkbox"/>	<input type="checkbox"/>
Stiffness.....	<input type="checkbox"/>	<input type="checkbox"/>	Contractures.....	<input type="checkbox"/>	<input type="checkbox"/>	Adaptive equipment.....	<input type="checkbox"/>	<input type="checkbox"/>
Comments								

Genitourinary

	Y	N		Y	N		Y	N
Incontinent.....	<input type="checkbox"/>	<input type="checkbox"/>	Flank pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Sexually active.....	<input type="checkbox"/>	<input type="checkbox"/>
Stress.....	<input type="checkbox"/>	<input type="checkbox"/>	History of urinary tract infections.....	<input type="checkbox"/>	<input type="checkbox"/>	Prostate issues.....	<input type="checkbox"/>	<input type="checkbox"/>
Urge.....	<input type="checkbox"/>	<input type="checkbox"/>	Nocturia.....	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual cycle regular.....	<input type="checkbox"/>	<input type="checkbox"/>
Bladder program.....	<input type="checkbox"/>	<input type="checkbox"/>	Discharge.....	<input type="checkbox"/>	<input type="checkbox"/>	Date of last menstrual period:	_____	
Frequent urination.....	<input type="checkbox"/>	<input type="checkbox"/>	Itching.....	<input type="checkbox"/>	<input type="checkbox"/>	Menopausal:	<input type="checkbox"/>	<input type="checkbox"/>
Cloudy/dark urine.....	<input type="checkbox"/>	<input type="checkbox"/>	Hemodialysis.....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of onset:	_____	
Bloody urine.....	<input type="checkbox"/>	<input type="checkbox"/>	Peritoneal dialysis.....	<input type="checkbox"/>	<input type="checkbox"/>			
Comments								

Integumentary

Skin Assessment: Attached Deferred

Skin: Normal Moist Dry Cyanotic Warm Pale Jaundice Cold Dusky Flushed

	Y	N		Y	N		Y	N
Open wound.....	<input type="checkbox"/>	<input type="checkbox"/>	Rash.....	<input type="checkbox"/>	<input type="checkbox"/>	Blemished.....	<input type="checkbox"/>	<input type="checkbox"/>
Bruising.....	<input type="checkbox"/>	<input type="checkbox"/>	Diaphoretic.....	<input type="checkbox"/>	<input type="checkbox"/>	Poor skin turgor.....	<input type="checkbox"/>	<input type="checkbox"/>
Breakdown related to adaptive aids/prosthesis.....	<input type="checkbox"/>	<input type="checkbox"/>	Risk for breakdown.....	<input type="checkbox"/>	<input type="checkbox"/>	History of breakdown.....	<input type="checkbox"/>	<input type="checkbox"/>
Comments								

Right Left Left Right

Individual _____ Date _____

Endocrine

	Y	N		Y	N	
Thyroid dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	If yes, type _____
Atypical antipsychotics or other medications affecting blood sugar.....	<input type="checkbox"/>	<input type="checkbox"/>	Management: <input type="checkbox"/> Diet	<input type="checkbox"/> Oral medications	<input type="checkbox"/> Insulin	
			<input type="checkbox"/> Other injectable medication to manage diabetes			
Pre-Diabetic hypoglycemic/ hyperglycemic episodes	<input type="checkbox"/>	<input type="checkbox"/>	Desired blood sugar range:			
Comments						

IV. Additional Health Status Information

Immunizations: Date last received

DPT	TOPV	HIB	MMR	TD	TDS	Flu Shot
Comments						

Nutritional Assessment

How receive nutrition:	<input type="checkbox"/> Orally <input type="checkbox"/> Via gastrostomy tube if residual _____	<input type="checkbox"/> Via jejunostomy tube <input type="checkbox"/> Other	
Therapeutic diet _____		Liquid consistency _____	
Food texture _____		Reason/date/ordered by: _____	
	Y N		
Recent weight change	<input type="checkbox"/> <input type="checkbox"/>	_____ lbs. <input type="checkbox"/> gain <input type="checkbox"/> loss over _____	
Recent changes in appetite/medication	<input type="checkbox"/> <input type="checkbox"/>		
Satisfied with current weight.....	<input type="checkbox"/> <input type="checkbox"/>	Desired weight range _____	
Food use as a coping mechanism.....	<input type="checkbox"/> <input type="checkbox"/>	Number of meals/snacks per day _____	
Assistive devices with eating.....	<input type="checkbox"/> <input type="checkbox"/>		
Use of medications that can cause difficulty swallowing (e.g., Abilify, other psychoactives).....	<input type="checkbox"/> <input type="checkbox"/>		
Knowledge of 4 basic food groups.....	<input type="checkbox"/> <input type="checkbox"/>		
Access to healthy/appropriate diet.....	<input type="checkbox"/> <input type="checkbox"/>		
Dietary deficiencies	<input type="checkbox"/> <input type="checkbox"/>		
Adequate fluid intake	<input type="checkbox"/> <input type="checkbox"/>		
Nutritional supplements	<input type="checkbox"/> <input type="checkbox"/>		
Interactions with medications and food.....	<input type="checkbox"/> <input type="checkbox"/>		
Comments			

RN _____

Individual _____ Date _____

Sleep Patterns

Average number of hours per night; difficulty falling asleep; number of times awake at night; number of naps during a day

Activity Level/Exercise

Substance Use/Abuse

Caffeine, tobacco, alcohol, recreational drugs, history of non-compliance with prescribed medications

Home Life

Satisfaction/Desires

Work/School/Day Activity

Satisfaction/Desires

Social Life

Satisfaction/Desires

Spiritual Life

Satisfaction/Desires

Coping Skills

RN _____

Individual _____ Date _____

Mental Status

Appearance

Posture: Normal Rigid Slouched Other:

Grooming and Dress: Appropriate Inappropriate Disheveled Neat

Facial Expression: Calm Alert Stressed Perplexed Tense Dazed Other:

Eye contact: Eyes not open Good contact Avoids contact Stares

Speech Quality: Clear Slow Slurred Loud Rapid Incoherent Mute

Mood

- | | | | |
|---|--|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Cooperative | <input type="checkbox"/> Uncooperative | <input type="checkbox"/> Depressed | <input type="checkbox"/> Euphoric |
| <input type="checkbox"/> Excited | <input type="checkbox"/> Agitated | <input type="checkbox"/> Anxious | <input type="checkbox"/> Suspicious |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Scared | <input type="checkbox"/> Hostile | <input type="checkbox"/> Angry |
| <input type="checkbox"/> Other/Describe | | | |

Cognition

	Y	N		Y	N		Y	N
Cognitive impairment			Oriented			Attention span		
Mild.....	<input type="checkbox"/>	<input type="checkbox"/>	Person.....	<input type="checkbox"/>	<input type="checkbox"/>	Easily distracted.....	<input type="checkbox"/>	<input type="checkbox"/>
Moderate.....	<input type="checkbox"/>	<input type="checkbox"/>	Place.....	<input type="checkbox"/>	<input type="checkbox"/>			
Severe.....	<input type="checkbox"/>	<input type="checkbox"/>	Time.....	<input type="checkbox"/>	<input type="checkbox"/>			
Profound.....	<input type="checkbox"/>	<input type="checkbox"/>						
Memory								
Remote.....	<input type="checkbox"/>	<input type="checkbox"/>						
Recent.....	<input type="checkbox"/>	<input type="checkbox"/>						
Immediate recall.....	<input type="checkbox"/>	<input type="checkbox"/>						
Emotions								
Euphoric.....	<input type="checkbox"/>	<input type="checkbox"/>	Depressed.....	<input type="checkbox"/>	<input type="checkbox"/>	Hostile feelings.....	<input type="checkbox"/>	<input type="checkbox"/>
Happy.....	<input type="checkbox"/>	<input type="checkbox"/>	Anxious.....	<input type="checkbox"/>	<input type="checkbox"/>	Emotional lability.....	<input type="checkbox"/>	<input type="checkbox"/>
Apathetic.....	<input type="checkbox"/>	<input type="checkbox"/>	Irritable.....	<input type="checkbox"/>	<input type="checkbox"/>	Inappropriate affect.....	<input type="checkbox"/>	<input type="checkbox"/>
Sadness.....	<input type="checkbox"/>	<input type="checkbox"/>						

RN _____

Individual _____ Date _____

Thoughts

	Y	N		Y	N		Y	N		Y	N
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations ...	<input type="checkbox"/>	<input type="checkbox"/>	Thought process	<input type="checkbox"/>	<input type="checkbox"/>	Thought content	<input type="checkbox"/>	<input type="checkbox"/>
If yes:			If yes:			If yes:			If yes:		
Grandeur	<input type="checkbox"/>	<input type="checkbox"/>	Visual	<input type="checkbox"/>	<input type="checkbox"/>	Coherent organized.....	<input type="checkbox"/>	<input type="checkbox"/>	Phobias	<input type="checkbox"/>	<input type="checkbox"/>
Persecutory	<input type="checkbox"/>	<input type="checkbox"/>	Auditory.....	<input type="checkbox"/>	<input type="checkbox"/>	Logical.....	<input type="checkbox"/>	<input type="checkbox"/>	Hypochondria	<input type="checkbox"/>	<input type="checkbox"/>
Somatic	<input type="checkbox"/>	<input type="checkbox"/>	Tactile	<input type="checkbox"/>	<input type="checkbox"/>				Antisocial urges.....	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	Olfactory	<input type="checkbox"/>	<input type="checkbox"/>				Obsessions	<input type="checkbox"/>	<input type="checkbox"/>
									Suicidal ideations	<input type="checkbox"/>	<input type="checkbox"/>
									Homicidal ideations...	<input type="checkbox"/>	<input type="checkbox"/>
Comments											

Challenging Behaviors

Are medications used to control any behaviors? Y N Currently has a formal Behavior Plan? Y N

Use the following scales below for frequency and severity:

For frequency: 1 = less than once per month; 2 = 1 to 3 x month; 3 = 1 to 6 x week; 4 = 1 to 10 x day; and 5 = 1 or more x hour.

For severity: 1 = mild; 2 = moderate; 3 = severe; and 4 = critical.

	Frequency	Severity	Last Exhibited
Hurtful to self	_____	_____	_____
Hurtful to others	_____	_____	_____
Destructive to property	_____	_____	_____
Pica	_____	_____	_____
Resists care	_____	_____	_____
Socially offensive/Disruptive Behavior	_____	_____	_____
Sexually inappropriate behavior	_____	_____	_____
At risk behavior, such as:			
Wandering	_____	_____	_____
Elopement	_____	_____	_____
Sexually aggressive behavior	_____	_____	_____
History of suicide attempt	_____	_____	_____
Other serious behavior	_____	_____	_____
Comments			

RN _____

Individual _____ Date _____

Communication

Primary language:

Mark ways the individual commonly communicates.

	Y	N		Y	N		Y	N
Verbal	<input type="checkbox"/>	<input type="checkbox"/>	Facial expressions.....	<input type="checkbox"/>	<input type="checkbox"/>	Touch	<input type="checkbox"/>	<input type="checkbox"/>
Limited verbal	<input type="checkbox"/>	<input type="checkbox"/>	Eye movement	<input type="checkbox"/>	<input type="checkbox"/>	Body language.....	<input type="checkbox"/>	<input type="checkbox"/>
Gestures.....	<input type="checkbox"/>	<input type="checkbox"/>	Paralinguistics (sounds)	<input type="checkbox"/>	<input type="checkbox"/>	Acting out	<input type="checkbox"/>	<input type="checkbox"/>
Sign language.....	<input type="checkbox"/>	<input type="checkbox"/>	Augmented communication device.....	<input type="checkbox"/>	<input type="checkbox"/>	Head banging	<input type="checkbox"/>	<input type="checkbox"/>
			If yes, device type: _____			Other behaviors (describe)	<input type="checkbox"/>	<input type="checkbox"/>

Mark ways that pain is communicated.

	Y	N		Y	N		Y	N
Verbal	<input type="checkbox"/>	<input type="checkbox"/>	Facial expressions.....	<input type="checkbox"/>	<input type="checkbox"/>	Touch	<input type="checkbox"/>	<input type="checkbox"/>
Limited verbal	<input type="checkbox"/>	<input type="checkbox"/>	Eye movement	<input type="checkbox"/>	<input type="checkbox"/>	Body language.....	<input type="checkbox"/>	<input type="checkbox"/>
Gestures.....	<input type="checkbox"/>	<input type="checkbox"/>	Paralinguistics (sounds)	<input type="checkbox"/>	<input type="checkbox"/>	Acting out	<input type="checkbox"/>	<input type="checkbox"/>
Sign language.....	<input type="checkbox"/>	<input type="checkbox"/>	Augmented communication device.....	<input type="checkbox"/>	<input type="checkbox"/>	Head banging	<input type="checkbox"/>	<input type="checkbox"/>
			If yes, device type: _____			Other behaviors (describe below)	<input type="checkbox"/>	<input type="checkbox"/>

Able to use pain scale

If able to use pain scale, list type/name of pain scale: _____

Comments

RN _____

Individual _____ Date _____

V. Implementation Assessment

Health care and Decision Making Capacity

The preceding review of functional capabilities, physical and cognitive status, and limitations indicate this individual's highest level of ability to make health care decisions.

Probably can make higher level decisions (such as whether to undergo or withdraw life sustaining treatments that require understanding the nature, probable consequences, burdens and risks of proposed treatment).

Probably can make limited decisions that require simple understanding, able to direct own health care, including delegated tasks.

Probably can express agreement with decisions proposed by someone else.

Cannot effectively participate in any kind of health care decision making.

Support Systems: Discuss the adequacy, reliability, availability, ability to communicate effectively.

	Adequate		Reliable		Available		Effective Communicator	
	Y	N	Y	N	Y	N	Y	N
CRA	<input type="checkbox"/>							
Host Home or Companion Care (HH/CC) Provider	<input type="checkbox"/>							
Guardian/Other	<input type="checkbox"/>							

Stability and Predictability and Need to Reassess

Health Topic	Is a long-term need non-fluctuating consistent?		Status change possible, or likely to need regular nursing care		Frequency of RN reassessment
	Y	N	Y	N	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Knowledge: Describe key health understandings/demonstrations.

Health Topic		Individual			CRA			HH/CC		
		Y	N	N/A	Y	N	N/A	Y	N	N/A
	Knowledgeable	<input type="checkbox"/>								
	Demonstrates Technique	<input type="checkbox"/>								
	Knowledgeable	<input type="checkbox"/>								
	Demonstrates Technique	<input type="checkbox"/>								

Individual _____ Date _____

Health Topic		Individual			CRA			HH/CC		
		Y	N	N/A	Y	N	N/A	Y	N	N/A
	Knowledgeable	<input type="checkbox"/>								
	Demonstrates Technique	<input type="checkbox"/>								
	Knowledgeable	<input type="checkbox"/>								
	Demonstrates Technique	<input type="checkbox"/>								
	Knowledgeable	<input type="checkbox"/>								
	Demonstrates Technique	<input type="checkbox"/>								
	Knowledgeable	<input type="checkbox"/>								
	Demonstrates Technique	<input type="checkbox"/>								
	Knowledgeable	<input type="checkbox"/>								
	Demonstrates Technique	<input type="checkbox"/>								
	Knowledgeable	<input type="checkbox"/>								
	Demonstrates Technique	<input type="checkbox"/>								

Comments

RN _____

Individual _____ Date _____

Participants in Comprehensive Assessment (Must complete section A, B or C; and RN section)

Option A: In this situation, the individual does not have a guardian/LAR and is able to make decisions regarding health care.

To be completed by the Individual:

- I have participated in decisions about the overall management of my health care [§225.1(2)], can make all of my own decisions, am able to direct own health care, and
- will not be directing health maintenance activities (HMAs) [§225.8(2)(D)(i)],
- or**
- agree to train unlicensed personnel in the performance of HMAs.

Printed Name

Signature

Date

Option B: In this situation, the individual cannot make decisions regarding health care or has asked for assistance.

To be completed by the CRA:

- I have participated in decisions about the overall management of health care. [§225.1(2)]
- I will be participating in decisions only, not directing care. No HMAs will be performed by unlicensed personnel.
- or**
- I agree to train unlicensed personnel in the proper performance of tasks identified as HMAs, be present when the task is performed or, if not present, will have observed the unlicensed person perform the task and will be immediately accessible in person or by phone to the unlicensed personnel when the task is performed. [§225.8(2)(D)(ii)(I-II)]

Printed Name

Signature

Date

Option C: In this situation, the individual cannot make decisions regarding health care and does not have a single identified adult who is willing and able to participate in decisions about the overall management of the individual's health care. [§225.1(a)(2)]

- Provider Advocate Committee (PAC) will act as CRA (form attached).**

Registered Nurse (RN)

I have developed this plan and retain accountability for delegated tasks. Each unlicensed personnel's competency will be verified before allowing delegated tasks to be performed without direct nursing supervision. An RN will be immediately accessible by phone to the unlicensed personnel when the task is performed.

Printed Name

Signature

Date

RN _____

Individual _____ Date _____

Safe Administration of Medications

A comprehensive review of functional capabilities, physical and cognitive status, limitations and natural supports rate this individual's ability to take his/her own medications in a safe and appropriate manner according to the five Rights of Medication Administration (correct person, medication [what, why], dose, time, route). **RN Delegation Worksheet** Attached N/A

Self-Administration of Medication. Individual knows how to safely take each medication (what, why) dose, route, time of each medication. The individual is competent to safely self-administer medications independently or independently with ancillary aid provided to the individual in the individual's self-administered medication treatment or regimen, such as reminding an individual to take a medication at the prescribed time, opening and closing a medication container, pouring a predetermined quantity of liquid to be ingested, returning a medication to the proper storing area, and assisting in reordering medications from a pharmacy.

No RN Delegation is necessary. [§225.1(3)]

Administration of medication to an individual by a paid unlicensed person(s) to ensure that medications are received safely. Administration of medications includes removal of an individual/unit dose from a previously dispensed, properly labeled container; verifying it with the medication order; giving the correct medication and the correct dose to the proper individual at the proper time by the proper route; and accurately recording the time and dose given. [TX BON §225.4(2)]. Check all that apply:

CRA can safely direct as an HMA.

No RN delegation is necessary. The individual has a single identified CRA whose knowledge, abilities and availability qualifies the administration of oral medications (by mouth or through a permanently placed feeding tube) as an HMA exempt from delegation and is appropriate per RN judgment. Medications may be administered for stable and predictable conditions (not initial doses and/or for acute conditions) without RN supervision provided that the CRA is willing, able and agrees in writing to train the unlicensed person(s) in performing the task at least once to assure competence and will be immediately accessible in person or by telecommunications to the unlicensed person(s) when the task is performed. [§225.4(8), §225.8]

RN delegation necessary to ensure safe medication administration.

RN can safely authorize unlicensed personnel to administer medications for stable and predictable conditions as defined in §225.4(11) not requiring nursing judgment. Competency of each unlicensed personnel, including the ability to recognize and inform the RN of client changes related to the task must be verified by RN. The six rights of delegation (the right task, the right person to whom the delegation is made, the right circumstances, the right direction and communication by the RN, the right supervision, and the right documentation) and all criteria at §225.9 must be met. CRA lacks knowledge, abilities and/or availability per §225.8 to direct as an HMA. Individual (if competent), CRA (if one exists) or Provider Advocate Committee (PAC) must approve the decision of the RN to delegate tasks in writing. See delegation criteria at §225.9, §225.10

Routes that may be delegated

The RN has determined that delegation is not required because the parent/LAR/foster care provider can assume responsibility and accountability for the individual's health care. The RN has considered the length of time the individual has been living in the home, the relationship of the individual and foster care provider, the supports available to the foster care provider, and has determined that the foster care provider can safely assume this responsibility. The RN will serve as a resource, consultant or educator, and will intervene when necessary to ensure safe and effective care. [§225.6(a)(3)] Documentation of subsequent interventions, including when additional follow-up is needed, will be a part of the RN's nursing care plan.

The RN has determined that delegation is not required for oral, topical and metered dose inhalers. The RN has determined that the medications not being delegated to paid unlicensed personnel are for a stable or predictable condition. The RN or LVN, under the direction of an RN, has trained and determined the paid unlicensed personnel competency. [Human Resources Code, Chapter 161, Subchapter D]

Must be administered by a licensed nurse. Medications that **may not be delegated** are:

RN _____

Individual _____ Date _____

Nurse Supervision

For each unlicensed personnel, determine in consultation with the individual CRA, LAR or PAC the level of supervision and frequency of supervisory visits, taking into account: the stability of the individual's status; the training, experience and capability of the unlicensed personnel to whom the nursing task is delegated; the nature of the nursing task being delegated; the proximity and availability of the RN to the unlicensed person when the task will be performed and the level of participation of the individual or CRA. [§225.9(a)(3)(A-E)]

Name of Unlicensed Personnel: _____

List all who were consulted in determining the level of nurse supervision for the above named unlicensed personnel:

- Individual
- Client Responsible Adult (CRA)
- Legally Authorized Representative (LAR)
- Provider Advocate Committee (PAC)
- Other: _____

RN follow-up to monitor competency of the above named unlicensed personnel of the following delegated task(s):

Frequency of required RN monitoring:

- once additionally within the first _____, then
 - monthly
 - quarterly
 - once additionally within the year
 - annually
- other

Frequency of additional RN or LVN monitoring:

- not applicable; no additional monitoring is needed
- once additionally within the first _____, then
 - monthly
 - quarterly
 - once additionally within the year

Notes

RN _____

Individual _____ Date _____

VI. Summary

Summary/Clinical Impressions

Strengths as related to health
Consultations recommended
Summary

Nursing Service Plan

Concerns/Nursing Diagnoses

Intervention/Strategies

Implementation Strategy Objectives	Start Date	Target Completion	Calculation of Units (if applicable)	Total Units (per strategy)

Total Nursing Units Needed

RN	RN Specialized	LVN	LVN Specialized

Desired Outcomes/Goals

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Print Name and Credentials

Signature

Date

RN _____

Individual _____ Date _____

Review of Comprehensive Nursing Assessment by RN:

Note: The nursing assessment must be reviewed at least annually to verify information remains current and decisions remain appropriate.

Date of Review:

Purpose (must check one):

- review of a temporary or permanent change in the individual's physical health, support system, mental status, social functioning, ability to perform activities of daily living or health maintenance activities, or medication or treatment regimen;
- review assessments, documentation and decisions made by a previous RN; or
- annual review of assessments, documentation and decisions to verify information remains current and decisions remain appropriate.

Description of Review:

Action Taken by RN:

Change(s) in Nursing Service Plan:

- No change required
- Nursing service plan revisions:

Signature – RN

Date

Date of Review:

Purpose (must check one):

- review of a temporary or permanent change in the individual's physical health, support system, mental status, social functioning, ability to perform activities of daily living or health maintenance activities, or medication or treatment regimen;
- review assessments, documentation and decisions made by a previous RN; or
- annual review of assessments, documentation and decisions to verify information remains current and decisions remain appropriate.

Description of Review:

Action Taken by RN:

Change(s) in Nursing Service Plan:

- No change required
- Nursing service plan revisions:

Signature – RN

Date