# NURSING HEALTH AND SAFETY ASSESSMENT

Interpretive Guidelines

General Guidelines: This assessment is to be utilized by a Registered Nurse (RN) in assessing adults with ID/DD challenges. This assessment is designed to be used with people receiving services in either an ICF or waiver programs. This assessment will enable the RN to develop desired health outcomes for the Health Care Management Plan (HCMP). The HCMP is the concluding part of this assessment, and is an integral part of it. No assessment will be considered complete unless the HCMP is attached.

Sources of Information: Information for this assessment is obtained through a direct physical examination and interview with the person; a thorough record review; an interview with the staff member(s) providing direct service; and (when possible) communication with a family member.

**Section One: Identifying Information**

1. Write in the person's full name along with age, date of birth, and gender.

2. Write in the person's residential address.

3. Write in the full name of the registered nurse performing the assessment including credentials. Give the date on which the assessment is being done.

4. Check one of the three options regarding the purpose of the evaluation.

5. Check one of the two options regarding the living situation.

6. Check one of the six options regarding race. If *other* is checked, please specify the ethnicity.

7. List the current medical information as noted in the Health Passport and/or most recent medical examination. Make sure there is consistency of diagnoses in all areas.

8. Check all the communication areas that apply for this person. Give a brief descriptor of communication skills and/or needs.

9. Rate the self care abilities of the person from 0 – 4 as noted. Describe the person's ability to ambulate.

10. List all of the person's adaptive equipment related to physical, occupational, and speech therapy needs. In addition, list special equipment needed to maximize meal time success.

11. Indicate whether medical supplies and equipment are needed. If so, please indicate the specific type and frequency of use.

12. Indicate whether this person has a history of falls. If so, indicate frequency and actions taken to prevent re-occurrence. Complete a separate fall assessment if indicated and attach it to the nursing assessment form.

**Section Two: Brief Health History**

13. Indicate the dates and reasons for all hospitalizations and emergency room visits during the past year. Write none in the space provided, if indicated. Describe illnesses that the person has experienced during the past year including dates. Write none in the space provided, if indicated.

Indicate whether family history information was obtained from health records and/or family member. If family member is contacted; list name, relationship to the person, and the date.

14-19. Describe any known problems that family members had as appropriate to the category and their relationship to the person.

**Section III: Health Data**

20. Indicate allergies and clinical reactions or check no known allergy. Also, state whether or not an EpiPen is needed.

21. Ask the person (if able), the care provider, a family member (if available), to each give his/her perspective about the person's health concerns.

22. Indicate whether the person has a seizure disorder and summarize the data regarding the type and frequency of seizures.

23. For each medication the person is currently receiving, indicate date started, name of medication, dosage, time, route, and reason for the medication. If medication is a short term medication, indicate date it is to be discontinued.

24. Describe the best approach for administering medications specific to each person including whether medication tablets should be crushed, taken with specific foods, or a liquid form of the medication should be used.

25. Indicate whether or not there have been changes to the person's medication regime during the past three months. If yes, or if there are other concerns related to medications, please describe these changes.

26. Indicate if there are any medication concerns regarding the person's medication (note: symptomatology, change request, refusals, etc.).

27. Indicate whether a self medication program is being utilized for any of the person's current medications. If so, please describe.

28. Provide the date of the most recent self administration assessment.

29. Indicate whether or not the person is sexually active and if so, if the person has multiple sex partners. Add a brief descriptor as indicated in the comments section. Record if the person has ever had a sexually transmitted disease and contraception method(s). Indicate the need for sex education, referral and date of the referral.

30. Indicator whether there is a known history of abuse with a brief descriptor in the comments section as appropriate.

**Section IV: Review of Systems**

31. Record the vital signs to include the blood pressure (sitting, lying and standing positions), temperature, pulse and respirations. Indicate the date of last annual medical review with primary care practitioner (please note that routine CBC blood work and other labs can be recorded in the Additional Information Section under the pertinent lab/diagnostic results section or attached to the nursing assessment).

32-47. Document findings by marking the appropriate boxes as indicated from the review of the systems. All abnormalitites will need to be addressed further by the PCP if not already addressed within the HCMP. If a particular review system doesn't apply or is not applicable for any reason (i.e., gender) please indicate as such. Additional clarification is provided with those system with the (*) asterisk sign.

- Skin
- Stoma
- Fingernails & Toenails
- Head & Neck
- Nose & Sinuses
- Mouth & Pharynx
- Eyes
- Ears
- Heart & Vascular
- Thorax & Lungs
- Abdomen
- *Nutritional/Metabolic Patterns: indicate height and ideal body weight (less or more than indicated) and the BMI. Indicate type of diet ordered to include food supplementation (type and frequency) and if a mealtime protocol applies. Also state whether there are any food restrictions and/or food allergies.

Conclude with listing nutritional recommendations and descriptive comments related to the person's needs.

- Genitourinary & Gynecologic
- Musculoskeletal
- Mental & Emotional Status
- Sensory Function
- *Behavior: indicate whether the person is taking psychotropic medications. If yes, give date of consent and who is providing the consent. If there is a behavior support plan (BSP), give date of last one and also the date for the consent to the BSP.
- *Glasgow Depression Scale Questionnaire: is designed to screen for depression in people with an intellectual disability by assessing behavioral symptoms of clinical depression. There are two versions of the questionnaire (self-reporting and care-giver supplemental). The self-report version is for people who can report on their own symptoms, whereas the care-giver supplement version is used for people who are nonverbal and can't self-report and the registered nurse would need to complete. At the conclusion of the interview, add up the score. A score of 13 or greater will require the registered nurse to seek a referral for mental health consultation or from a psychologist (if the person resides in an ICF-IDD setting). All actions shall be documented in the progress notes and shared with the interdisciplinary team and DDA Service Coordinator. The Glasgow Depression Scale Questionnaire shall be completed annually and as changes occur in mood.

48. Abbey Pain Scale is important to use with people who have demenitia and are unable to verbalize their pain. There are six subgroups that provide cues/prompts to help rate the pain. While observing the person in areas to include: vocalization, facial expression, change in body language, behavioral change, physiological change, and physical changes, the pain is scored (If pain is assessed, the RN shall develop a pain management plan).

49. It may be helpful to utilize a pain screening tool such as Wong-Baker Faces Pain Rating Scale to assess the person's pain level. Select <u>one</u> of these numbers which best describes the person, and then indicate the level of prompts needed. Provide additional information in the comment section as indicated (If pain is assessed, the RN shall develop a pain management plan).

50. Additional information and date section shall highlight information regarding specific areas of concern and expected outcomes to further discuss (this should be addressed in the HCMP). Also, note that there may be other assessments as appropriate to the nursing care of the person attached to the Nursing Assessment, i.e. Braden scale, fall risk assessment dementia screening assessment.