NURSING HEALTH AND SAFETY ASSESSMENT FORM A

Interpretive Guidelines

General Guidelines: This assessment is to be utilized by a Registered Nurse RN) in assessing adults with significant ID/DD challenges. This assessment is designed for individuals needing an ICF level of care or 24 hour staff supports. In addition, the Director of Nursing in any setting may decide to use this form in order to best assess an individual's health care status. 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 individual; 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 individual's full name along with age, date of birth, and gender.

2. Write in the individual's residential address.

3. Write in the full name of the 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. If *other* is checked, please specify the purpose.

5. Check one of the five options regarding the living situation. If *Other* is checked, please specify the type.

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

7. List the current diagnoses 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 individual. Give a brief descriptor of communication skills and/or needs.

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

10. List all of the individual'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 individual 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.

14. Describe illnesses that the individual has experienced during the past year including dates. Write none in the space provided, if indicated.

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

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16-21. Describe any known problems that family members had as appropriate to the category and their relationship to the individual.

Section III: Health Data

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

23. List current medical problems along with dates diagnosed. For short term diagnoses, give date resolved. This same information should be on the individual's health passport.

24. Indicate whether the individual has the capacity to make medical decisions or whether a substitute health care decision maker is in place. If so, indicate name and contact number. Note whether advanced directives/do not resuscitate orders (DNR) have been written.

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

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

27. For each medication the individual 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.

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

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

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

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

33. Indicate whether or not the individual is sexually active and add brief descriptor as indicated in the comments section. Indicator whether there is a known history of abuse with a brief descriptor in the comments section as appropriate.

Section IV: Review of Systems

34. Write the date that vital signs and height/weight are taken. Indicate ideal body weight if it is available. Indicate type of diet ordered and if there is any food supplementation ordered and the type and frequency. Also state whether there are any food restrictions and/or food allergies. Conclude with listing nutritional recommendations and descriptive comments related to the individual's needs.

35 – 54. General Instructions

a) Document findings as WNL (within normal limits/negative) or NWNL (not within normal limits). Further explanation is needed for all NWNL findings. Individualize and describe NWNL findings fully. The boxes can be extended to accommodate lengthy descriptions as needed.
b) **The sections marked in italics in this section require physical assessment by the RN.**
c) Give dates of last medical examinations in each section as applicable to the individual. Summarize important results/findings including lab results for each of these examinations. Please note that routine CBC blood work can be placed at the end of #52 under the pertinent lab/diagnostic results section.

55. Describe orientation to time, place, self, and others under *functional orientation.* For 2 – 5, indicate frequency, duration, and precipitators that have been identified to changes in emotional status.

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56. Describe frequency, duration, and known precipitators for all maladaptive behaviors. Indicate whether the individual 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.

57. Describe any other pertinent information regarding this individual related to the review of systems that is not included above.

58 – 62. Select one of these numbers which best describes the individual, and then indicate the level of prompts needed. Provide additional information in the comment section as indicated. It may be helpful to utilize a pain screening tool such as the Wong-Baker Faces Pain Rating Scale to assess the individual's pain level.

63. Give date and immunization status of each vaccine on record. Please note that Zostavax (vaccine to prevent shingles) is recommended for use on a one time basis for persons 60 years old and over. Check with PCP if it is indicated for each individual in this age group.

64. Provide a concise, complete summary highlighting the pertinent findings of each section. Based on the summary, identify specific areas of concern and expected outcomes for the Health Management Care Plan and attach it to the Nursing Assessment. When indicated, other assessments as appropriate to the nursing care of the individual may be attached to the Nursing Assessment, i.e. Braden Scale, fall risk assessment, dementia screening assessment.

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