# NURSING HEALTH AND SAFETY ASSESSMENT FORM B

## Interpretive Guidelines

General Guidelines: This assessment is to be utilized by a Registered Nurse (RN) in assessing adults with ID/DD challenges living in less restrictive environments. It is designed for individuals receiving 20 hours or less of staff support each week. However, whether to use Nursing Assessment Form A or Form B for an individual, is always at the discretion of the Director of Nursing in that setting. 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 an 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. A focused physical exam may be needed depending on information found in the record review or during the interview.

Section One: Identifying Information

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

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

3. Check one of the three options regarding the purpose of the evaluation. If *Other* is checked, please specify the purpose.

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

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




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6. List the current diagnoses as noted in the Health Passport and/or most recent medical examination.

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

8. Describe the individual's ability to ambulate.

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

10. Indicate whether medical supplies and equipment are needed. If so, please indicate the specific type and frequency of use. Describe the individual's ability to utilize equipment independently.

11. Indicate whether this individual has a history of falls. If so, indicate frequency and actions taken to prevent re-occurrence. If a separate fall assessment has been completed indicate here that it is attached at the end of assessment form.

Section Two: Brief Health History

12. Indicate the dates and reasons for all hospitalizations and emergency room visits during the past year. Write none in the space provided if indicated.

13. Describe illnesses that the individual has experienced during the past year. Write none in the space provided if indicated.

14. 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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15-20. Describe any known problems that family members had as appropriate to the category and their relationship to the individual.

Section III: Health Data

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

22. List current medical problems that need nursing monitoring along with dates diagnosed. This may include health problems that occurred in the past, but need nursing monitoring, e.g. history of anemia, history of UTI. Nursing interventions for this section are placed within the Health Management Care Plan. For short term diagnoses, give date resolved. This same information should be on the individual's health passport. Under each medical problem give the date and describe results of last medical evaluation related to the specific problem.

23. 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. Give the date and results of the last psychological exam or check box that none is indicated. Give date and results of last psychiatric exam or check box that none is indicated.

24. 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. List the targeted behaviors on the BSP. Also give the date for the consent to the BSP.

25. 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.




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

27. Indicate whether the individual has a seizure disorder and summarize the data regarding the type and frequency of seizures. Describe the individual's awareness of his/her seizure disorder, auras preceding seizures, and coping strategies for dealing with this.

28. 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.

29. 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.

30. Indicate whether a self medication program is being utilized for any of the individual's current medications. If yes, indicate whether it is for all or some of the medications. If some, list the medications. Provide the date of the most recent self administration assessment.

31. Write the date that vital signs and height/weight are taken. Indicate ideal body weight if it is available. Indicate type of diet and in comment section indicate any special nutritional considerations and/or needs. Indicate whether individual does his/her own grocery shopping and prepares own meals. If not, indicate level of assistance needed for these tasks.

Section III: Health Skills Assessment

32 – 53. Complete yes or no for each question, and write out descriptive comments as needed for each response.

54 – 61. Indicate yes, no, or emerging responses for each number. Provide comments when indicated to more fully understand the responses.




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62 – 66. 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.

67. Indicate whether or not, how to use the health passport, was or was not reviewed with the individual. Note findings or reason review was not done.

68. Indicate 'yes' or 'no' related to the Health Form 1 data. List any laboratory or screening tests that are currently pending for this individual. Also, provide a listing of tests that need to be discussed with the primary care physician on the next visit.

69. 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.

70. 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 supports for this individual may be attached to the Nursing Assessment i.e. fall risk assessment, dementia screening assessment.




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