RESIDENT ASSESSMENT

Determining the strengths and skills that can be used to enhance quality of life for both the caregiver and residents… is the first step. Identify the specific need of your resident and also help to maintain or slow down the process of a chronic disease or illness.

Completing this information will assist you with:

- Determining the most critical areas of assistance (setting your priorities and putting your energies where they are most needed).
- Sharing information with others on the care giving team (this is important information to share with someone who might be providing respite care).
- Providing a baseline that you can use to track behaviors and abilities or make changes in the resident's activities.

TIP:*This is important information to share with someone who might be providing memory care.*

The assessment has been divided into five areas of abilities and behaviors:

1. Physical abilities
2. Communication and Socialization
3. Alertness and Orientation
4. Homemaking
5. Community.

Note: When the assessment has been completed place it on the resident's file.

General Identifying Information: (Sample only)

Resident's Name: _____

Address: _____

Date of Birth: _____ Age: _____ SS#: _____

Name of Person completing this assessment: _____

Relationship to Resident: _____

Doctors Name: _____ Phone #: _____

Diagnosis: _____

RESIDENT'S PRELIMINARY ASSESMENTS:

1. **PHYSICAL ABILITIES**

A. Dressing/Grooming

O Independent O Needs some help O Total assistance

Comments: _____

B. Eating/Feeding

O Independent O Needs some help O Needs to be fed

Comments: _____

C. Swallowing

O No Problems O Chokes/Coughs sometimes O Often chokes when eating/drinking

Comments: _____

D. Toileting

O Independent O Needs Assistance O Needs Total Assistance

Comments: _____

E. Bowel Function

O Independent O Occasional loss of control O Incontinence (no control)

Comments: _____

F. Bladder function

O Independent O Occasional accidents O Incontinence (no control)

Comments: _____

G. Transferring (into/out of bed, chairs, toilet, etc.)

O Independent O Needs some assistance O Needs total assistance

Comments: _____

H. Bathing/Showering

O Independent O Needs some assistance O Needs total assistance

Comments: _____

I. Changing Positions (in bed or chair)

O Independent O Needs some assistance O Needs total assistance

Comments: _____

J. Walking in the home environment

O Independent O Needs some assistance O Needs constant assistance

Comments: _____

K. Managing Medications

O Independent O Needs supervision O Needs to be administered/monitored

Comments: _____

2. Communication/Socialization

A. Vision

O Normal/minimal loss O Moderate loss (cannot read newsprint) O Legally blind, or blind

Comments: _____

B. Hearing

O Normal/minimal loss O Moderate loss (can hear in a quiet room) O Severe loss/deaf

Comments: _____

C. Expressive Communication

O Communicates feelings/needs O Has Difficulty O Often cannot convey message

Comments: _____

D. Understand Communication

O Understands general conversation/instructions O Does not always understand message

O Unable to comprehend conversation/instructions

Comments: _____

E. Telephone Communication

O Independent O Needs some help done by others (note by whom)

Comments: _____

F. Interaction with Visitors

O Enjoys/welcomes visitors O Prefers to limit visitors/time O Unwilling to have visitors

Comments_____

G. Cooperation

O Helpful Varies O Depends on activity O Usually uncooperative

Comments: _____

H. Attitude/Mood

O Positive most of the time O Varies usually negative

Comments: _____

I. Recreational Activities

O Enjoys/participates in activities/hobbies O Will participate if encouraged O Unwilling/inactive

Comments: _____

J. Finances

O Independent O Needs assistance done by others (note by whom)

Comments: _____

3. Alertness/ Orientation

A. Sleep Problems

O Never Sometimes (note trigger & solution) O Always (note trigger & solution)

Comments: _____

B. Confused/disoriented

O Never Sometimes (note trigger & solution) O Always (note trigger & solution)

Comments: _____

C. Wandering

O Never Sometimes (note trigger & solution) O Always (note trigger & solution)

Comments:_____

D. Suspicious/ Hostile

O Never Sometimes (note trigger & solution) O Always (note trigger & solution)

Comments: _____

E. Agitated/ Aggressive

O Never Sometimes (note trigger & solution) O Always note trigger & solution)

Comments: _____

F. Memory, long term (Events, people, etc., from past)

O Intact Decreased-intermittent O Does not recall events that happened from a distant past

Comments: _____

G. Memory, short term

O Recalls day to day activities O Sometimes forgets Often forgets- safety issue

Comments: _____

H. Repetitious Questions

O Never Sometimes (note trigger & solution) O Always (note trigger & solution)

Comments: _____

I. Safety

O Aware/Safe O Inconsistent O Unsafe

Comments: _____

4. Homemaking

A. Food/Meal Preparation

O Independent O Can assist O Dependent on others

Comments: _____

B. Using Microwave Oven

Independent Needs help/ supervision Unable to use

Comments: _____

C. Using the Stove

O Uses safely O Needs help, supervision O Unable to use

Comments:_____

D. Housekeeping

O Independent Needs help/ supervision O Done by others (note by whom)

Comments: _____

E. Laundry

O Independent Needs help/ supervision O Done by others (note by whom)

Comments: _____

5. Community

A. Shopping

O Independent Needs help/supervision O Done by others (note by whom)

Comments: _____

B. Transportation

O Drives self O Uses public transportation O Depends on others (note by whom)

Comments: _____

C. Social Activities

O Capable/ attends outside activities O Not capable of attending O Unwilling to attend

Comments: _____

D. Community Mobility

O Independent O Needs assistance O Dependent

Comments: _____

ASSESSING THE NEEDS AND ABILITIES OF YOUR RESIDENT

Summarizing Needs:

Now that you have completed the check list, determine what issues are of greatest importance in delivery of care. Write them down starting with your priority concerns.

Summarizing Strengths/ Skills:

Now list your resident's strengths and skills (for example, the resident cannot cook but can assist with meal preparation, has good attitude and tries very hard, etc).

Client's Name: _____

Medical Condition/Diagnosis:

_____

Payer Source: ___Private Pay __ALTCS pending ___ALTCS

Room Desire: Private/Semi Private

Referred By: _____ Budget: _____

Age: _____ **Height:** _____ **Weight:** _____ **Oxygen:** Yes No

Diabetic: Yes No Insulin: _____ **Sliding scale:** _____

Diet: Regular low salt Soft other: _____

Incontinent: __ Yes __ No __Bowel ___Urine __Both **Pull ups**: _____

ADL's: ___Eating ____Bathing ____Dressing ___Transfer sleeping at night? ____

DME: __wheelchair ___walker ___Cane ___ Care facility bed ___ stand by assist

Wounds/Ulcers/Sores _____ **Catheter?** _____ **other:**_____

Emotional State: __calm __pleasant __happy __depressed ___anxiety ___combative

0ther: _____

Level of Confusion: ___Dementia ___Alzheimer ___Parkinson other: _____

Level of Consciousness: ___Alert ___oriented ___confuse ___Can comprehend ____Functional

Hospice:
_____

Notes:
_____
_____
_____

Contact Name _____ Phone Number: _____

Potential Move in: _____

Assessed by:_____Date: _____